Child depression: anthropological approach

ABSTRACT

OBJECTIVE: To understand the sociocultural meanings of childhood depression, from the medical-scientific concept of the disease.

METHODS: This was a qualitative study carried out in the metropolitan region of São Paulo, State of São Paulo, Brazil, in 2003. It consisted of ethnographic observation and in-depth interviews with eight psychiatrists from a public health service and nine relatives (parents or guardians) of children who had been diagnosed with and were being treated for childhood depression. The analysis sought to identify categories that would make it possible to isolate different notions of the disease, as expressed in the discourse of these groups.

RESULTS: Different notions of the disease were identified, in accordance with the cultural patterns of the discourse. For the psychiatrists, the concept of childhood depression was related to inappropriate child behavior, or “bad functioning”, which then had to be adjusted by medical intervention. For the relatives, childhood depression meant “dissatisfaction” and “discomfort” with life and “intolerance” of adults to child behavior. It was seen that the discourse of the psychiatrists and relatives interviewed showed great diversity of subjects, concepts and categories, according to the logic of their particular understandings and explanations for childhood depression.

CONCLUSIONS: In the light of the results obtained, the phenomenon of childhood depression can be analyzed not as an event determined by medical-scientific knowledge, but as a dynamic process of “creative reinvention” of categories and concepts that are fundamental to this discourse. It is therefore concluded that childhood depression presents as a differentiated disease, in the form of a broad category that is capable of integrating different connotations and contexts under the same term.

INTRODUCTION

Over recent years, so-called affective disorders, and depression among these, have acquired greater prominence within the scientific environment and have also started to attract the attention of the general public. Depression in particular has become more evident since the 1970s, when interest in the field of investigation and in scientific circles increased, and significant presence of this disorder among children and adolescents has been recognized. Since then, there has been discussion identifying child depression as a clinical entity that is independent from what is found among adults. The medical notion of the disease has confirmed this, concomitantly with the consolidation of childhood psychiatry as a specialization separate from adult psychiatry and from pediatrics.1

Alongside the greater volume of information available on childhood depression and its individual and social consequences, there has been growing concern regarding this disease. In the 1990s, reports on mental health and the consequences of mental problems for the population were published by the World Health Organization. According to these reports, depression has been increasing in populations around the world, such that in the 1990s it affected around 330 million people, particularly women, among whom the incidence of the disease is twice as great as among men. The reports also stated that, by 2020, depression would be the second biggest cause of disease, only losing out to heart diseases, and that its treatment would have a high cost, which was estimated as 44 billion dollars per year for the United States.

Although increasing incidence of depression may be more evident among women, its appearance in the male adult population cannot be neglected, nor can its occurrence in the young population, i.e. among children and adolescents.

Child depression is identified by the dominant medical-scientific discourse as a serious disease, especially because of its associated social incapacitation.6,15 Information on child depression has been disseminated rapidly in the population by means of the press, and this has not always occurred within an associated restricted to the notion of disease. It is generally seen that this notion is simplified, such that the term is absorbed in a vague manner by the population.

In the present study, the process of disseminating the medical-scientific concept of child depression is understood through two complementary approaches within the critical perspective of medical anthropology. The first of these, regarding the specificity of the representations of the disease, is expressed as particular notions and meanings. The other relates to the sociocultural mechanisms that explain the impossibility of translating the medical-scientific notion into the logic of other social players.2,5,13

Despite the wide-ranging bibliography on this matter, it can be seen that, among studies relating depression to cultural questions, there is a predominance of research in the field of transcultural psychiatry. Authors like Lecrubier10 and Patel18 have compared the distribution of child depression in different populations, starting from the transcultural variation observed in recognizing, diagnosing and treating the disease, emphasizing the influence of culture on epidemiological studies on depression.

In the field of medical anthropology, which is considered to be a privileged field for studies on diseases, studies that have contributed towards a deeper critical approach towards the subject of depression are prominent. In these, concepts and notions produced by biomedical discourse are analyzed.5,8,12 Medical anthropology proposes a broader and also critical approach towards the relationship between disease and culture, in terms of the notions and practices involved in this relationship.19 It makes it possible in studies on mental diseases for culture to cease to be just one of the areas contributing towards psychopathology, such that its contribution starts to reveal matters that are little known among health professionals, such as behavioral patterns and disease representations for the population. In particular, in studies on mental diseases in childhood, notions of diseases appear linked to the specific way in which children and their behavior are perceived in different societies. This allows diseases to be classified in accordance with parameters for what is or is not socially acceptable as normal.17

From this perspective, the cultural language for expressing suffering and affliction must be considered. Likewise, it has to be recognized that psychiatry forms part of a given culture and that the imposition of certain categories does not properly fit or completely embrace the experiences of suffering that affect people in other societies. The clinical presentation of depression and anxiety is therefore not only a function of the patient’s ethnocultural context, but also depends on the structure of the health system, the diagnostic categories, and the concepts that are found in the media and in dialogue with family, friends and doctors.9

The studies mentioned show the possible contributions of an anthropological study towards the subject
of child depression, thereby demarcating the boundaries between the different perspective adopted by this science and by medical science, while at the same time defining possible interfaces. The aim of expanding the medical focus in choosing the particular subject is evident, while at the same time shifting it in seeking to understand child depression as a sociocultural phenomenon. Thus, the objective of the present study was to understand the sociocultural meanings of child depression, from the medical-scientific concept of the disease.

METHODS

This was a qualitative study conducted among psychiatrists at a public service specializing in child and adolescent psychiatry, located in the municipality of São Paulo, State of Sao Paulo. Relatives, i.e. the parents or persons responsible for children (aged 6 to 12 years) with a diagnosis of child depression who were followed up within the same service were also included.

The fieldwork was guided by ethnographic practices, thus delimiting a particular approach towards the subject of child depression that differed from other studies such as those traditionally conducted within medicine.

In ethnographic work, researchers deal with the realities in a singular manner, in an interpretive process of observation of the conditions and context within which the information is collected. Subsequently, this information is systematized and put together in order to develop broader and deeper knowledge of these realities, thus revealing specific experiences and not wide-ranging generalizations.

The study had the main objective of investigating the discourse on child depression produced by different social players, in accordance with their opinions, feelings, attitudes and different views of the world that are associated with the phenomenon: fundamental questions in research within medical anthropology.

The starting point taken was the notion of childhood depression as a disease elaborated through medical-scientific discourse, in order to understand the transformations that the notion goes through in the discourse of psychiatrists and relatives of depressed children (parents or the persons responsible).

To identify and include children and their relatives, various criteria were established, which are explained in the following.

a) Diagnosis of depression. Only cases of major depression were considered. These were diagnosed by psychiatrists in accordance with the criteria of the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) and those of the International Statistical Classification of Diseases and Health-Related Problems (ICD-10), and followed up at their services.

b) Age group: children between six and 12 years of age. Only patients within the age range from six to 12 years were included. Younger children were excluded because they are in a phase in which social ties are still limited. Adolescents were excluded because they experience situations that are considered to be more favorable for developing depression.

Nine children were identified, and their relatives (parents or the persons responsible) were contacted and invited to participate in the interviews.

c) Place where they lived. All the children identified and their relatives lived on the periphery of Sao Paulo and other municipalities in the metropolitan region: a frequent situation among the users of public health services.

The group of relatives was constituted as a homogeneous sociocultural group, because they shared the experience of dealing with the child depression of their children.

All the psychiatrists involved in attending the depressed children were invited to participate in the study. The group of professionals from within medicine was given preference, because it is numerically larger and dominant, considering also the fact that these are the principal agents diffusing scientific knowledge. They were considered to be key informants for understanding matters relevant to biomedical discourse.

Interviews were conducted with eight psychiatrists and the relatives of the nine children with a diagnosis of depression.

The interviews with the psychiatrists were conducted at the health service or in their consultation offices. It was sought to understand their discourse regarding child depression in terms of the notion of the disease, the definition of a sick child (from symptoms, referrals and diagnosis) and the perceptions of relatives’ behavior when faced with the diagnosis.

The interviews with relatives were held in their homes and divided into two stages. In the first, it was sought to understand what the relatives knew about child depression and how they reacted towards the phe-
nomenon, in relation to both the diagnosis and the treatment given to the children. In the second, the perception of child behavior was emphasized, as a function of the relationships established by the children with their friends and with their own families.

The picture of the interviewees’ different realities was complemented by observation of the contexts that make up each particular picture, in the following situations:

- monitoring of meetings for discussing cases of childhood depression, meetings with the families and other events held within the health service, in order to understand the procedures that are specific to medical logic in the process of formulating the diagnosis of child depression;
- home visits, to gain greater knowledge of family realities, the places they lived in and the children’s behavior and, insofar as possible, without the influences exerted on this population’s opinions by the health service and by the professionals who work there.

The observed facts were noted by the researcher and analyzed as a complement to the testimonies. The recorded and transcribed material was classified on the basis of narrative extracts and repetitive and unusual phrases identified in the testimonies, and was analyzed by identifying specific subjects that were considered relevant for understanding the meaning of the objective studied. The material thus broken up was systematized into classificatory categories, which were considered to be important conceptual tools “for isolating abstract notions and joining them into propositions” that were associated with child behavior, the disease and the treatment.

The interviews analyzed, complemented by the observations of the particular contexts, were shown to be sufficient for providing expressive descriptions of experiences, opinions and particular practices.

Qualitative analysis, especially as utilized in anthropological research, “(...) consists essentially of utilizing acts, facts, words and interpretations to form a logic model that will explain the realities that are usually inaccessible to individuals”.

To this end, through analysis of the set of information expressing the interviewees’ particular experiences, it was sought to explain the different meanings and notions of child depression in the discourse. From the anthropologist’s interpretative and explanatory work, the internal logic and the possible relationships established between these disparate ways of expressive realities that were so diverse were revealed.

All the interviews and observations were conducted after a statement of consent was signed. This ensured that participation was voluntary and participants remained anonymous, thereby observing the norms of the Ethics Committee for Research Project Analysis (CAPPesq) of Hospital das Clínicas, Faculdade de Medicina of Universidade de Sao Paulo.

RESULTS AND DISCUSSION

Medical discourse regarding child depression

In the discourse of the psychiatrists interviewed, the notion of child depression appears as a disease and not as a state of any kind. It was classified from well-defined biomedical parameters. It is a disease explained mainly by genetic or organic and psychosocial factors, although the influence of external factors is not totally rejected.

“(...) when you speak of depression in psychiatry, theoretically you are speaking about a disease (...) So you are speaking about a mood alteration, with a tendency towards sadness and lack of pleasure with things, without a relationship with other diseases, including physical ones, and without a relationship with precipitating events”. (Professional n. 2)

The interviewees evaluate and qualify certain child behavioral patterns to build up the diagnostic picture, from information brought in by the family, which may limit the professional action, in view of the filter imposed by lay, family or other people’s perceptions. This implies judging and assessing child behavioral patterns from different manners of perception, or in accordance with distinct degrees of tolerance.

“(...) the younger the child is, the more he is tied to or dependent on the family that brings him in (...) in our field, we really need to have a good notion of normal development, of what a normal child is, because sometimes the family transforms something they think is abnormal into a symptom, but it is not necessarily so. Sometimes, it is just a normal reaction by the child to an abnormal environmental situation”. (Professional n. 4)

In general, this is because the population confounds certain child behavioral patterns, according to the interviewees.

“The parents may consider that it is laziness: the child is slothful or stubborn. They think it forms part of the development process. It is a phase: the child is not sick, but is going through a phase”. (Professional n. 5)

According to the psychiatrists, families perceive and
classify certain child behavioral patterns according to their own reference points. Most of them show both tolerance towards the problem and an inability to manage it, which is the determining factor in deciding whether or not to resort to professional help.

“Children are brought in because they are tiresome or because they do not live up to the expectations”. (Professional n. 2)

It is for this reason that the professionals generally perceive satisfaction and relief with the proposed diagnosis among the families, since the diagnosis explains part of their problems and their anxieties that had not been understood.

The diagnosis and treatment are, however, often resisted. In the professionals’ view, this occurs especially when the family has not been given much information, does not know what childhood depression is, or does not accept that depression can occur among children.

“Generally, they [the families] are unable to conceive how children can be depressed. Children are supposed to play, be happy, not have worries, not have problems, not have bigger commitments beyond studying (...) So adults have the conception that depression is a disease of adults, not of children”. (Professional n. 5)

With regard to the forms of treatment, the professionals were unanimous about the need to use medications and for the most immediate results to be recognized. Although therapeutic follow-up may also be recommended in multiple approaches, in a way differing from what takes place with medications, there is controversy regarding its adoption. This is because of the problems relating to duration, the existence of professionals and the costs, especially because this is a public service.

Professional intervention should diminish child suffering, increase the “adaptive capacity” and provide for adjustment among these children. The use of medications seems to meet these needs more immediately, and is maintained as an effective practice because of the rapidity of the results observed. It is in keeping with medical-scientific discourse, since what is important for doctors is diagnosis and cure.

In labeling certain child behavioral patterns as disease and prescribing treatment, the professionals made clear a notion of childhood depression that relates to the idea of adaptation and adjustment. For them, childhood depression is linked to “bad functioning” in the children, for which the medical-scientific logic assures the possibility of intervention.

Popular notions among families regarding child depression

One important fact in family experiences relating to child depression, in the spontaneous words of the family members interviewed, was the lack of understanding about what was happening to their children. The interviewees did not have clear ideas and perceptions about the problem, which would have delayed the seeking of professional health, the identification of the disease and also the acceptance that a child could be depressed. The signs that pointed out the disease were only perceived when they became part of a picture of attitudes and behavior that was strange enough to be distinguished from other patterns and recurrent to the point of drawing the adults’ attention.

“He was very agitated, very irritated, so sometimes we didn’t know what this was (...) we were taking it in slowly, that’s to say, it passed by as unnoticed”. (Family n. 7)

These childhood states may pass by unnoticed or acquire importance, depending on who observed them, what was observed and how tolerant the observer was in these situations. The families often showed a certain confusion regarding the different childhood states that are defined by the use of terms like “whiny”, “stubborn”, “irritable” or “impolite”.

“We thought it was whining (...) we didn’t understand”. (Family n. 7)

When perceived to be different, the children’s behavior and the children themselves became incorporated as problems that actually bothered the adults. Thus, an evident relationship was established between the degree of tolerance or intolerance of these behavioral patterns and the family’s general living conditions. In the interviewees’ testimonies, family dramas like separations, rows, deaths, alcoholism and socioeconomic questions, especially unemployment and low salaries, were mentioned as factors that altered the family dynamics and could affect the children.

“I’m separated: when I separated from my husband, he [the boy] was three years old. He was also very close to his father and the separation was very violent: there were a lot of rows; there were a lot of things. We even thought, me and my ex, that it wouldn’t affect him, especially because he was only three. Quite the opposite: it did and even too much”. (Family n. 6)

In these situations, the children often went from the
role of victims to the main focus of these problems, thus worsening the adults’ dissatisfaction with their socioeconomic situation and having the result that the relatives, in a confused state, did not know how to face the situation. As the situation slipped out of control or outside of what the families took to be normal or acceptable, the lack of knowledge, incomprehension and doubts gave way to despair, fear and even disgust, caused by a certain feeling of impotence in relation to their own lives.

“\textit{I felt very disgusted (\ldots) You know, when you say something like ‘there’s no solution any more! There’s no way out’: that’s what I thought’}. (Family n. 3)

For the family members who were interviewed, the perception of the problem and its seriousness were directly linked not to the clinical characteristics that define the notion of depression as a disease, but to the sociocultural discomfort it caused.

From this perspective, the notion of childhood depression expressed through the discourse of family members revealed dissatisfaction and discomfort regarding how to deal with certain uncertainties in life, which was related to situations of lack of control regarding the problem.

Child depression arises as one of the possible explanations for the dramas experienced by these families. The identification of a term to describe the confused and special situation characterized by the newness of a strange and different child for the family calls a halt to the infinity of attempts to comprehend the problem.

**Relationship between different types of discourse**

Because of specific contexts, the observation of differences between the discourse from doctors and the children’s relatives makes it possible to analyze the phenomenon of child depression not as an event determined by medical-scientific knowledge, but from this knowledge and through a “game of reinterpretation” (Boltanski2), in analyzing the representations of the disease. In this dynamic process of creation and reinvention, or of “creative reinvention”, according to this author, the categories and fundamental concepts within medical-scientific discourse undergo alterations, such that the strange and unknown universe of medicine is adapted to the needs of other social players.

Analyzed in its specific contexts, the discourse from the psychiatrists and the relatives interviewed revealed differences in content, concepts and categories. The discourse correlates through the logic of comprehension and explanation of the phenomenon, according to the world views of these different social players.

Possible similarities between the discourse types can be indicated only on a more immediate level of understanding how, in the dialog between the psychiatrists and the relatives interviewed, an exchange was established in which concepts associated with the medical-scientific notion of child depression circulated.

The impossibility of simple assimilation between the discourse types becomes evident, since it can be seen that differences are demarcated and correspondence or translation from one logic to the other is impossible, as became transparent in the analysis. The representations regarding child depression drawn up by the psychiatrists and relatives referred to world views and real experiences that differed from each other. Likewise, their particular notions of child depression reflected the field of variation in meaning that were attributed to certain terms.

The apparent indiscriminate utilization of the term childhood depression therefore does not correspond to the incorporation of the same logic that is the foundation of the notion of disease elaborated in medical-scientific discourse by different groups within society. According to Lévi-Strauss,13 it is at the level of unconscious structures that an apparently simple form of repetition is contrasted with the complexity of the different discourse types. This reveals specific structured logic via a mechanism that is considered to be fundamental: \textit{bricolage}. Here, this mechanism is emphasized as one of the principal cultural operating elements, in different social players’ perceptions of and explanations for the phenomenon of childhood depression. \textit{Bricolage} allows comprehension of how different notions of childhood depression are manifested within a context marked by efforts to homogenize medical-scientific discourse.

From the elements introduced by culture, and through scientific discourse (information, concepts and categories relating to the disease), arrangements that are considered to be most appropriate for each group of social players are established. Thus, people organize their lives by responding to the cultural need for ordering their thoughts in the light of real events, in accordance with their culture.

**FINAL CONSIDERATIONS**

Child depression is a possible category for a variety of aspects of reality. It allows different orders of problems to be classified: organic, socioeconomic and cultural dysfunctions. These correspond, respectively,
to notions relating to malfunctioning of children and to dissatisfaction, intolerance and unhappiness of adults in relation to life and its events. As happens in relation to the disease categories in different cultures that allow diseases and illnesses to be classified, it is necessary to organize what appears to be disorganized through reestablishing order.

Child depression can be considered to be a differentiated disease, because it operates culturally in a way that differs from other diseases, including mental diseases. It has been shown to be a new and improvised possibility for categorization of different realities. It becomes fundamentally necessary for identifying and organizing certain child behavioral patterns and other emerging sociocultural characteristics. It therefore acts as a key term for operating various notions with particular meanings that are equivalent in that, thanks to mechanisms of several orders, it is possible to explain and, at the same time, intervene in different real problems.

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