

# Clinical Characteristics of Depressed Youths in Child Psychiatry

Jean-Jacques Breton MD, MSc<sup>1,2,4</sup>; Réal Labelle PhD<sup>1,3,4</sup>; Christophe Huynh MSc, PhD(cand.)<sup>1,4</sup>; Claude Berthiaume MSc<sup>1</sup>; Marie St-Georges MPs<sup>1</sup>; Jean-Marc Guilé MD, MSc<sup>1,4</sup>

## Abstract

**Objective:** To describe the clinical characteristics of depressed children and adolescents according to age groups and sex. **Methods:** A retrospective *chart review study* was conducted on 75 youths aged 6-17 years referred for depressive disorders to child psychiatry in 2002-2003. Descriptive statistics and tests of association were completed to compare boys aged 6-11 years, boys aged 12-17 years and girls aged 12-17 years. **Results:** One out of two youths has repeated a school year. About 60% of depressed boys aged 6-11 years are referred to child psychiatry services for behavioral difficulties and 71% of boys in this age group have a depressive disorder comorbid with disruptive behavior disorder. Adolescent boys and girls are more likely to present internalized symptoms than children. However, suicidal ideation is as widespread in children (71%) as in adolescent population, both boys (72%) and girls (85%). Parent-child relational problems are observed in the majority of the sample with a higher prevalence among adolescent girls. **Conclusion:** It is as important to assess depressive symptoms and suicidal ideation among young boys with behavioral difficulties as in adolescent boys and girls. Family functioning is important to consider in evaluating and treating youth.

**Key words:** *depressive disorders, suicidal ideas, child and adolescent, chart reviews*

## Introduction

Chart review is a low-cost but highly informative method to gain information on the clinical profile of children and adolescents attending child psychiatry services. Such studies contribute to adjustment of assessment and intervention modalities in view of the clinical realities of youth and their families. Data from clinical files can also generate research hypotheses (Gearing, Mian, Barber, & Ickowicz, 2006).

A review of recent studies on clinical populations indicates that young people are referred to child psychiatry services for hyperactivity (18%), distractibility (17.5%), and school failure (15.7%) (Aras, Varol Tas, & Unlu, 2007). The most frequent diagnoses are adaptation disorders (17.5%), disruptive behavior disorders (12.7%), anxiety disorders (8.8-12.8%), mood disorders (8.0-8.8%) and ADHD (7.2%) (Aras et al., 2007; Dean, McDermott, & Marshall, 2006).

Suicidal ideation and suicide attempts are reported respectively by 12% and 10% of young people (Dean et al., 2006). One patient out of four is medicated and pharmacotherapy is associated with longer treatment duration, medicated patients being followed for 32.3±23.0 weeks compared to 11.4±16.9 weeks for non medicated patients (Dean et al., 2006). These descriptive studies, like several others in recent decades, include all youths admitted to a given child psychiatric service. Other studies target suicidal behavior (Jay, Graham, & Flowers, 1989; Milling, Gyure, Davenport, & Bair, 1991), self-harm (Jacobson, Muehlenkamp, Miller, & Turner, 2008), dropping-out from treatment (Otino, 1995) or use of various categories of psychotropic drugs such as antidepressants (Wilens et al., 2003), mood stabilizers (DelBello et al., 2002) or antipsychotics (Marchand, Wirth, & Simon, 2004).

<sup>1</sup>Research Service, Rivière-des-Prairies Hospital & Fernand-Seguin Research Centre, Montreal, Quebec

<sup>2</sup>McGill Group for Suicide Studies, McGill University, Montreal, Quebec

<sup>3</sup>Centre for Research and Intervention on Suicide and Euthanasia, Université du Québec à Montréal, Montreal, Quebec

<sup>4</sup>Department of Psychiatry, Faculty of Medicine, Université de Montréal, Montreal, Quebec

Corresponding email: [jj.breton.hrdp@ssss.gouv.qc.ca](mailto:jj.breton.hrdp@ssss.gouv.qc.ca)

Submitted: February 13, 2011; Accepted: May 27, 2011

In terms of depressive symptoms, a study in an outpatient clinic showed that boys are more likely to experience difficulties concentrating and other cognitive symptoms while girls tend to present more self-esteem problems (Fu & Wang, 2008). A five year follow-up study of children and adolescents hospitalized for major depressive disorder revealed that a complete remission of the initial episode within a year was observed for 98% of the youth. However 61% had another depressive episode during the 5-year follow-up period, 47% relapsing in the first year (Emslie et al., 1997). In a study on self harm in adolescents, based on outpatient records, the most common diagnoses were major depressive disorder (52%) and anxiety disorders (36%), regardless of the presence of self-harming behaviors. One youth out of five had a borderline personality disorder (Jacobson et al., 2008).

Overall, there are few descriptive studies on clinical populations of youth with depressive disorders whereas it is the category of mental disorders most often associated with suicidal behavior in children and adolescents. In addition 15 to 20% of adolescents in the general population present a depressive disorder. The proposed study aims to describe the clinical characteristics of depressed youth in child psychiatry by age groups and sex and to present the clinical implications of these results.

## Methods

The retrospective chart review has been completed within the child psychiatry program at Hôpital Rivière-des-Prairies, a child psychiatric centre affiliated with the Université de Montréal. In the year 2002-2003, 450 children and adolescents were registered and 81 (18%) had a clinical diagnosis of depressive disorder given by a child psychiatrist based on all available information included in the patient's file (best estimate). Two preschool children were excluded from the study for a total of 79 selected files. Agreement from the hospital's director of professional services was obtained allowing researchers and research assistants to get access to the content of the files.

An analysis grid, based on earlier studies in the research service of Hôpital Rivière-des-Prairies, was developed by the first two authors. They rated the grid items by reviewing the content of ten files in the medical records department and then an additional data collection was completed separately by the two research assistants on ten other files to ensure a similar understanding of items. At the end of several meetings between the two research assistants and the first two authors, a final version of the grid was produced. Items were grouped into seven categories: socio-demographic characteristics, request for services, life events, symptoms, diagnoses according to the five DSM-IV axes, types of treatment, and reasons for closing the file. Data collection was conducted from July to November 2004.

As a first step, the data were analyzed by sex combining the two age groups. Interpretation was certainly informative on the influence of the sex variable (for example, showing that the boys aged 6-17 years had more depressive disorders comorbid with disruptive behavior than girls in the same age group) but it did not assess the impact of age on the clinical characteristics (Breton et al., 2005). In a second step, other analyses were conducted on three groups of boys 6-11 and 12-17 years of age and girls 12-17 years of age. The group of girls aged 6-11 years could not be retained because it included only four subjects. Data were analyzed using the SPSS software. Tests of association were conducted to compare the groups. The significance level was set at 0.05. Due to the exploratory nature of the study and the limited number of subjects, no correction has been applied for the multiplicity of tests. Such corrections become quickly too conservative when the number of tests is elevated and the various measures used for the statistical tests are highly correlated.

## Results

Youths live in similar proportion in two-parent and single-parent families and 24% are part of a reconstituted family. One youth out of four is from an ethnic base other than Quebec origin. About one out of two in adolescence has repeated a school year and the difference of proportion between the three groups of boys aged 6-11, boys aged 12-17 and girls aged 12-17 years is significant ( $p=0.010$ ;  $\chi^2=9.15$ ;  $df=2$ ). The three groups differ significantly for reasons of consultation ( $p=0.017$ ;  $\chi^2=18.63$ ;  $df=8$ ). Indeed, behavioral problems are the reason for consultation for a greater proportion of boys 6-11 years (59%) in comparison to the two groups of adolescents (32% for boys 12-17 years and 9% for girls). In contrast, girls consult in a higher proportion for manifestations of depression ( $p=0.002$ ;  $\chi^2=16.44$ ;  $df=4$ ).

Analysis of life events reveals a significant difference between the three groups for parental disputes ( $p=0.036$ ;  $\chi^2=6.65$ ;  $df=2$ ), found in a higher proportion among boys than girls (boys 6-11 years vs. girls:  $p=0.020$ ;  $\chi^2=5.45$ ;  $df=1$ ; and boys age 12-17 vs. girls:  $p=0.049$ ;  $\chi^2=3.87$ ;  $df=1$ ), and, the arrival/departure of a spouse ( $p=0.043$ ;  $\chi^2=6.31$ ;  $df=2$ ) found in higher proportion among young boys than adolescent girls ( $p=0.012$ ;  $\chi^2=6.27$ ;  $df=1$ ). Regarding symptoms, parent-child relational problems are reported for 80% of young people, the difference being significant among the three groups ( $p=0.011$ ;  $\chi^2=9.02$ ;  $df=2$ ), a parent-child relational problem being reported in a significantly higher proportion in adolescent girls than among boys 6-11 years ( $p=0.002$ ;  $\chi^2=9.37$ ;  $df=1$ ). The proportion of subjects with suicidal ideas is as high among young boys (71%) as in the two groups of adolescents (72% and 85%). There is a significant difference between the three groups for attention seeking ( $p=0.014$ ;  $\chi^2=8.56$ ;  $df=2$ ), the proportion being higher among young boys than among the older ones ( $p=0.047$ ;  $\chi^2=3.95$ ;  $df=1$ ) and adolescent girls ( $p=0.003$ ;

**Table 1. Sociodemographic characteristics**

	Boys		Girls	Total
	6-11 years (n=17)	12-17 years (n=25)	12-17 years (n=33)	6-17 years (n=75)
<b>Family structure</b>				
Two-parent	5 (29%)	11 (44%)	13 (39%)	29 (39%)
Single-parent	8 (47%)	5 (20%)	15 (46%)	28 (37%)
Reconstituted	4 (24%)	9 (36%)	5 (15%)	18 (24%)
<b>Ethnic origin</b>				
Quebecer	13 (77%)	16 (64%)	28 (85%)	57 (76%)
Others (Central and south America, Europe, Asia)	4 (24%)	9 (36%)	5 (15%)	18 (24%)
<b>Schooling— Repeated grade*</b>				
Yes <sup>a</sup>	2 (12%)	13 (59%)	13 (45%)	28 (41%)

\*These data are not available for three boys aged 12 to 17 years and four girls aged 12 to 17.

<sup>a</sup> p ≤ 0,01.

**Table 2. Request for services**

	Boys		Girls	Total
	6-11 years (n=17)	12-17 years (n=25)	12-17 years (n=33)	6-17 years (n=75)
<b>Referral source—type of service</b>				
Hospital	4 (24%)	9 (36%)	20 (61%)	33 (44%)
Medical clinic	6 (35%)	5 (20%)	4 (12%)	15 (20%)
Local community health center	3 (18%)	6 (24%)	4 (12%)	13 (17%)
Youth center	1 (6%)	4 (16%)	3 (9%)	8 (11%)
School	3 (18%)	1 (4%)	2 (6%)	6 (8%)
<b>Reasons for consultation <sup>a</sup></b>				
Manifestations of depression with suicidal behavior	3 (18%)	7 (28%)	15 (46%)	25 (33%)
Behavior problems	10 (59%)	8 (32%)	3 (9%)	21 (28%)
Manifestations of depression	1 (6%)	5 (20%)	8 (24%)	14 (19%)
Worries and nervousness	2 (12%)	4 (16%)	2 (6%)	8 (11%)
Manifestations of depression with behavior problems	1 (6%)	1 (4%)	5 (15%)	7 (9%)

<sup>a</sup> p ≤ 0,05

$\chi^2=8.56$ ;  $df=1$ ). Significant differences are observed for sadness between groups ( $p=0.043$ ;  $\chi^2=6.27$ ;  $df=2$ ), the proportion being significantly higher among adolescent girls than in young boys ( $p=0.007$ ;  $\chi^2=7.22$ ;  $df=1$ ). There is also a significant difference between the groups for loss of interest ( $p<0.001$ ;  $\chi^2=21.36$ ;  $df=2$ ), the proportion being significantly lower among young boys than among adolescent boys ( $p=0.013$ ;  $\chi^2=6.18$ ;  $df=1$ ) and adolescent girls ( $p<0.001$ ;  $\chi^2=21.51$ ;  $df=1$ ). Overall, 63% of youths reported a sleep problem, the proportions being similar from one group to the other.

Analysis of diagnoses at axis I reveals significant differences between the three groups ( $p=0.002$ ;  $\chi^2=16.81$ ;  $df=4$ ).

Young boys have a higher proportion of depressive disorder comorbid with a disruptive disorder than the adolescents, the difference being observed between young boys and adolescent girls ( $p<0.001$ ;  $\chi^2=16.78$ ;  $df=2$ ). Family problems reported by 68% of youth are the main source of psychosocial problems at axis IV.

Analysis of treatments shows a significant difference between the three groups with regard to the type of drug, antidepressants not being used for young boys ( $p=0.006$ ;  $\chi^2=17.91$ ;  $df=6$ ). Analysis of the reasons for closing the file shows a significant difference between the three groups ( $p=0.037$ ;  $\chi^2=10.21$ ;  $df=4$ ), lack of motivation being found in a significantly lower proportion among young boys than

**Table 3. Life events and most frequent symptoms**

	Boys		Girls	Total
	6-11 years (n=17)	12-17 years (n=25)	12-17 years (n=33)	6-17 years (n=75)
<b>Life events</b>				
Parent separation/divorce	13 (77%)	14 (56%)	18 (55%)	45 (60%)
Birth of another child	11 (65%)	17 (68%)	17 (52%)	45 (60%)
Disagreement and/or conjugal violence	12 (71%)	14 (56%)	12 (36%)	38 (51%)
Parental disputes <sup>a</sup>	11 (65%)	14 (56%)	10 (30%)	35 (47%)
Arrival of a new spouse or spouse leaving home <sup>a</sup>	12 (71%)	11 (44%)	11 (33%)	34 (45%)
<b>Symptoms</b>				
Parent-child relational problem <sup>a</sup>	10 (59%)	19 (76%)	31 (94%)	60 (80%)
Sadness <sup>a</sup>	10 (59%)	18 (72%)	30 (91%)	58 (77%)
Suicidal ideation	12 (71%)	18 (72%)	28 (85%)	58 (77%)
Anxiety	14 (82%)	16 (64%)	25 (76%)	55 (73%)
Problems concentrating <sup>a</sup>	14 (82%)	19 (76%)	17 (52%)	50 (67%)
Problems achieving in school <sup>a</sup>	14 (82%)	19 (76%)	15 (46%)	48 (64%)
Sleep problems	10 (59%)	15 (60%)	22 (67%)	47 (63%)
Low self-esteem	9 (53%)	18 (72%)	19 (58%)	46 (61%)
Attention seeking <sup>a</sup>	15 (88%)	15 (60%)	15 (46%)	45 (60%)
Loss of interest <sup>b</sup>	3 (18%)	14 (56%)	28 (85%)	45 (60%)
Does not fulfil his/her potential at school	12 (71%)	15 (60%)	17 (52%)	44 (59%)
Oppositional, sarcastic, hostile	12 (71%)	15 (60%)	15 (46%)	42 (56%)
Fit of rage	10 (59%)	17 (68%)	14 (42%)	41 (55%)
Feeling devalued	5 (29%)	14 (56%)	20 (61%)	39 (52%)
Difficult to control <sup>a</sup>	11 (65%)	17 (68%)	11 (33%)	39 (52%)

<sup>a</sup>  $p \leq 0,05$

<sup>b</sup>  $p \leq 0,01$

in adolescent boys ( $p=0.039$ ;  $\chi^2=6.51$ ;  $df=2$ ) and adolescent girls ( $p=0.008$ ;  $\chi^2=9.75$ ;  $df=2$ ).

## Discussion

This study has limitations as do other chart review studies. The information collected at each step of the file development may be incomplete and errors may occur in the coding of data by research assistants. In addition, the study is completed in a specific context of care. Finally, the absence of a group of girls aged 6-11 years does not allow the study of this age group.

School failure is observed in one out of two adolescents, which can contribute to depressive symptoms and suggests that taking account of the cognitive functioning of these youngsters would be relevant for the definition of the intervention plan. Parent-child relational problems are found with a high proportion in the three groups but particularly among teenagers. The mother-daughter conflicts related to requests for referrals would be correlated with more intense depressive symptoms among girls (Zahn-Waxler, Shirlcliff, & Marceau, 2008). Family dynamics is thus an important

dimension to consider in the evaluation process and psychiatric treatment (Villeneuve, 2006).

Depression among boys 6-11 years implies a more behavioral profile than in the two other groups since more than 50% of the boys with a diagnosis of depressive disorder are referred for disruptive behavior problems. Indeed behavioral difficulties can hide depressive symptoms and it seems that depression without behavioral problems can go unnoticed in this age group. This hypothesis could explain that only four depressed girls aged 6-11 years are included in this study, girls from 6-11 years showing a lower prevalence of disruptive behavior disorders than boys in the same age group in the general population, yet showing a prevalence of depressive disorders comparable to boys and girls in this age group (Birmaher et al., 1996; Breton et al., 1999). The boys also demand more attention (88% versus 46-60% for adolescent groups), which can be understood as a request for help and not a disruptive behavior only.

Suicidal ideation is as common in children (71%) than in adolescent boys (72%) and adolescent girls (84%). Thus, the proportion of depressed children who are suicidal in

**Table 4. DSM-IV Diagnoses**

	Boys		Girls	Total
	6-11 years	12-17 years	12-17 years	6-17 years
Axis I <sup>a</sup>	(n=17)	(n=25)	(n=33)	(n=75)
Major depressive disorder/Dysthymia	2 (12%)	10 (40%)	21 (64%)	33 (44%)
Major depressive disorder with disruptive behavior disorders	12 (71%)	10 (40%)	5 (15%)	27 (36%)
Major depressive disorder with anxiety disorders	3 (18 %)	5 (20%)	7 (21%)	15 (20%)
Axe II	(n=15)	(n=23)	(n=31)	(n=69)
Mental retardation or limited intellectual functioning	2 (13%)	1 (4%)	2 (7%)	5 (7%)
Personality traits	1 (7%)	4 (17%)	1 (3%)	6 (9%)
None	12 (80%)	18 (78%)	28 (90%)	58 (84%)
Axe III	(n=17)	(n=23)	(n=33)	(n=73)
Present	5 (29%)	6 (26%)	7 (21%)	18 (25%)
Axe IV	(n=17)	(n=25)	(n=33)	(n=75)
Family problems	12 (71%)	17 (68%)	22 (67%)	51(68%)
School problems	4 (24%)	1 (4%)	3 (9%)	8 (11%)
Other problems	0 (0%)	4 (16%)	1 (3%)	5 (7%)
None	1 (6%)	3 (12%)	7 (21%)	11 (15%)
Axe V	(n=16)	(n=23)	(n=33)	(n=72)
Absent-mild (61-100)	5 (31%)	5 (22%)	10 (30%)	20 (28%)
Moderate-serious (0-60)	11 (69%)	18 (78%)	23 (70%)	52 (72%)

<sup>a</sup> p ≤ 0,01**Table 5. Types of treatment and reasons for closing the file**

	Boys		Girls	Total
	6-11 years	12-17 years	12-17 years	6-17 years
Types of treatment				
Psychotherapy	(n=16)	(n=23)	(n=27)	(n=66)
	13 (81%)	13 (57%)	20 (74%)	46 (70%)
Parental or family intervention	(n=16)	(n=23)	(n=29)	(n=68)
	9 (56%)	9 (39%)	9 (31%)	27 (40%)
Medication	(n=16)	(n=23)	(n=30)	(n=69)
Present	10 (63%)	18 (78%)	22 (73%)	50 (73%)
Type of medication <sup>a</sup>				
Antidepressants or mood stabilizers	0 (0%)	5 (22%)	15 (50%)	20 (29%)
Antidepressants with other drugs	6 (38%)	6 (26%)	6 (20%)	18 (26%)
Others	4 (25%)	7 (30%)	1 (3%)	12 (17%)
Hospitalisation	(n=16)	(n=24)	(n=30)	(n=70)
	2 (13%)	6 (25%)	8 (27%)	16 (23%)
Reasons for closing the file <sup>b</sup>	(n=7)	(n=10)	(n=18)	(n=35)
Improvement	5 (71%)	3 (30%)	3 (17%)	11 (31%)
Lack of motivation	0 (0%)	6 (60%)	12 (67%)	18 (51%)
Transfer/moving	2 (29%)	1 (10%)	3 (17%)	6 (17%)

<sup>a</sup> p ≤ 0,01<sup>b</sup> p ≤ 0,05



clinical settings is far from marginal, suggesting the relevance of screening for suicidal ideas among young children referred in child psychiatry. Internalized symptoms such as sadness (72%), anxiety (64%), and suicidal ideas (72%) are as common among adolescent boys as adolescent girls (91%, 76%, and 85% respectively). Adolescent boys however present more school problems than girls. Young and older boys have a higher proportion of problem concentrating, as in the study of Fu & Wang (2008), whereas girls tend to have a lower self-esteem, which was not observed in this study. Difficulties sleeping, observed in 10% of the adolescents in the general population, are reported by a majority of youths in the present study, which confirms the importance of assessing this symptom in major depressive disorder (Roberts, Roberts, & Xing, 2011).

Fifty-one percent of adolescents for whom the file was closed dropped out from treatment due to lack of motivation. This elevated proportion was observed in other studies (Ottino, 1995). Adherence to treatment is low among suicidal adolescents with rates of dropping-out between 41.3% and 57.7% (Burns, Cortell, & Wagner, 2008). Several studies have attempted to identify different variables predicting dropping-out from treatment for suicidal adolescents with various results (Granboulan, Roudot-Thoraval, Lemerle, & Alvin, 2001; King, Hovey, Brand, Wilson, & Ghaziuddin, 1997; Ottino, 1995; Piacentini et al., 1995; Rotheram-Borus et al., 1999), which could be explained, in part, by difficulties defining the concept of drop-out. On the other hand, the lack of motivation was not the reason to end treatment for 6-11 year-old boys in our sample whose files were closed because of improvement.

## Conclusion

The clinical profile of depressed youth referred in child psychiatry, as it appears in our study, confirms that depression in the prepubescent child is closely tied to externalized disorders. Reasons for consultation as well as observed symptoms and diagnoses confirm this observation. Moreover the study shows that suicidal ideation is as present in boys aged 6-11 years than among adolescent boys and girls. With regard to the risk of suicide, this observation calls for greater vigilance on the part of clinicians. Any assessment of disruptive behavior disorders among boys aged 6-11 years should include the screening of depressive symptoms. The importance of the relational and familial dimensions contributing to the development of depression in the three age groups confirms the relevance of a systemic approach in the assessment and treatment of depressed youth.

## Acknowledgements / Conflicts of Interest

The authors thank Sophie Huneau, B.Sc. and Andrea Martin, Ph.D. who acted as research assistants for data collection.

## References

- Aras, S., Varol Tas, F., & Unlu, G. (2007). Medication prescribing practices in a child and adolescent psychiatry outpatient clinic. *Child: Care, Health and Development*, 33(4), 482-490.
- Birmaher, B., Ryan, N. D., Williamson, D. E., Brent, D. A., Kaufman, J., Dahl, R. E.,... Nelson, B. (1996). Childhood and adolescent depression: A review of the past 10 years. Part I. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(11), 1427-1439.
- Breton, J. J., Bergeron, L., Valla, J. P., Berthiaume, C., Gaudet, N., Lambert, J.,... Lépine, S. (1999). Quebec child mental health survey: Prevalence of DSM-III-R mental health disorders. *Journal of Child Psychology and Psychiatry*, 40(3), 375-384.
- Breton, J. J., Labelle, R., Berthiaume, C., Guile, J. M., St-Georges, M., Huneau, S., Martin A. (2005). *Caractéristiques cliniques de jeunes déprimés pris en charge en pédopsychiatrie*. 39ième congrès de l'Association des médecins psychiatres du Québec, Paris.
- Burns, C. D., Cortell, R., & Wagner, B. M. (2008). Treatment compliance in adolescents after attempted suicide: A 2-year follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47(8), 948-957.
- Dean, A. J., McDermott, B. M., & Marshall, R. T. (2006). Psychotropic medication utilization in a child and adolescent mental health service. *Journal of Child and Adolescent Psychopharmacology*, 16(3), 273-285.
- DelBello, M. P., Kowatch, R. A., Warner, J., Schwiers, M. L., Rappaport, K. B., Daniels, J. P.,... Strakowski, S. M. (2002). Adjunctive topiramate treatment for pediatric bipolar disorder: A retrospective chart review. *Journal of Child and Adolescent Psychopharmacology*, 12(4), 323-330.
- Emslie, G. J., Rush, A. J., Weinberg, W. A., Gullion, C. M., Rintelmann, J., & Hughes, C. W. (1997). Recurrence of major depressive disorder in hospitalized children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(6), 785-792.
- Fu, I. L., & Wang, Y. P. (2008). Comparison of demographic and clinical characteristics between children and adolescents with major depressive disorder. *Revista Brasileira de Psiquiatria*, 30(2), 124-131.
- Gearing, R. E., Mian, I. A., Barber, J., & Ickowicz, A. (2006). A methodology for conducting retrospective chart review research in child and adolescent psychiatry. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 15(3), 126-134.
- Granboulan, V., Roudot-Thoraval, F., Lemerle, S., & Alvin, P. (2001). Predictive factors of post-discharge follow-up care among adolescent suicide attempters. *Acta Psychiatrica Scandinavica*, 104(1), 31-36.
- Jacobson, C. M., Muehlenkamp, J. J., Miller, A. L., & Turner, J. B. (2008). Psychiatric impairment among adolescents engaging in different types of deliberate self-harm. *Journal of Clinical Child and Adolescent Psychology*, 37(2), 363-375.
- Jay, M. S., Graham, C. J., & Flowers, C. (1989). Adolescent suicide attempters presenting to a pediatric facility. *Adolescence*, 24(94), 467-472.
- King, C. A., Hovey, J. D., Brand, E., Wilson, R., & Ghaziuddin, N. (1997). Suicidal adolescents after hospitalization: Parent and family impacts on treatment follow-through. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36(1), 85-93.
- Marchand, W. R., Wirth, L., & Simon, C. (2004). Quetiapine adjunctive and monotherapy for pediatric bipolar disorder: A retrospective chart review. *Journal of Child and Adolescent Psychopharmacology*, 14(3), 405-411.

- Milling, L., Gyure, K., Davenport, C. W., & Bair, P. (1991). Suicidal behavior among psychiatric outpatient children: An estimate of prevalence. *Child Psychiatry and Human Development, 21*(4), 283-289.
- Ottino, J. (1995). Suicidal adolescents: Psychotherapy and treatment interruption. Results of a controlled study. *Psychiatrie de l'enfant, 38*(2), 573-602.
- Piacentini, J., Rotheram-Borus, M. J., Gillis, J. R., Graae, F., Trautman, P., Cantwell, C.,... Shaffer, D. (1995). Demographic predictors of treatment attendance among adolescent suicide attempters. *Journal of Consulting and Clinical Psychology, 63*(3), 469-473.
- Roberts R. E., Roberts C. R., & Xing Y. (2011). Restricted sleep among adolescents: Prevalence, incidence, persistence, and associated factors. *Behavioral Sleep Medicine, 9*(1), 18-30.
- Rotheram-Borus, M. J., Piacentini, J., Van Rossem, R., Graae, F., Cantwell, C., Castro-Blanco, D., & Feldman, J. (1999). Treatment adherence among Latina female adolescent suicide attempters. *Suicide and Life Threatening Behavior, 29*(4), 319-331.
- Villeneuve, C. (2006). L'intervention en santé mentale: le pouvoir thérapeutique de la famille, Les Presses de l'Université de Montréal.
- Wilens, T. E., Biederman, J., Forkner, P., Ditterline, J., Morris, M., Moore, H.,... Wozniak, J. (2003). Patterns of comorbidity and dysfunction in clinically referred preschool and school-age children with bipolar disorder. *Journal of Child and Adolescent Psychopharmacology, 13*(4), 495-505.
- Zahn-Waxler, C., Shirtcliff, E. A., & Marceau, K. (2008). Disorders of childhood and adolescence: Gender and psychopathology. *Annual Review of Clinical Psychology, 4*, 275-303.