Childhood Depression

Childhood depression has been a challenge for researchers and clinicians for many decades. The previous controversy over whether the phenomenon of childhood depression actually exists has evolved into a generally accepted view that it does exist, even in young school children.

If this paper at times takes on an alarmist flavor, this was not my initial purpose. My aim was, and still is, to provide the reader with insight into recent research and developments around the diagnosis, aetiology and management of Childhood Depression.

In doing so I felt compelled to comment on the widely documented tendency of parents (and teachers) to under-report symptoms of depression in their children (unless accompanied by antisocial behaviour) which feeds into the appalling legal and social apathy that exists around the infringement of basic children's rights. Discussion of research pertaining to the above has lent the text a somewhat accusatory tone. However, a comprehensive paper on childhood depression, of necessity, has to firstly dispel the notion that childhood is a happy time: a sort of Wonderland where children wander safe, innocent and carefree, and secondly draw attention to the fact that children are extremely vulnerable to all kinds of abuse that is not recognised as such by the adult population. Sadly they rely on these same adults to seek help for them when depression sets in!

To avoid these social truths would surely require buying into a pedagogical approach to child rearing practice and the essence of childhood depression would elude us.

Distinction between Sadness and Depression in Childhood

In defining childhood depression it becomes essential to distinguish between sadness and depression. Sadness, 'Weltschmerz', is a universal, empathic, quiet, conflict-free emotion in which we are aware of inescapable pain. Sadness is embraced by a capacity to weep and be alone, and an awareness of having, holding and sometimes losing. Mostly, feelings of sadness are congruent with the events that prompt them. We find it relatively easy to tune in with the child who chooses to keep his feelings secret when someone close to him has died or he has lost face in a humiliating situation. Once we come to know what lies behind his sadness, we understand both the content and of his feelings as well as his wish to keep them secret. Both sadness and secrecy make sense, seem reasonable. Through the sheer process of growing up, children have to cope with many painful experiences, which they may choose to keep secret, or which they bury without knowing they do so.

Repressing painful experiences lies at the heart of the distinction between sadness and depression. The word 'depression' starts out with the core idea of 'pressing down' as an action (I am pressing down on something) or as a state (I am being pressed down, lowered or sunk by something). In the context of emotions, the word 'depression' has come to signify being in low spirits, gloomy and melancholy it also implies that one or more people are involved. The possibility of conflict, which is absent from sadness, now arises. With conflict goes aggression, which brings us to complicated psychological moves such as turning aggression and anger inwards. As a result, unlike sadness, in depression there is often not the same congruency between the feelings and the events that cause them. It is easy to see why depression, with all its hidden meanings, can antagonise all parties concerned, depressed and undepressed alike (Higgins, 1992).

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Definition and Description

Many authors have attempted to define the clinical features of depressive disorder in a child (Refer Annexure 1). Nearly all propose a central, core set of symptoms of lowered mood, loss of pleasure in normal activities and low self-esteem, added to impairments of normal functioning, a certain number of which must be present for diagnosis(such as sleeplessness, appetite change, morbid ideation, lowered concentration and performance at school, and agitation). There is less consensus on the number of 'non-core' symptoms and the duration of symptoms and much less consensus on symptomatic And behavioural 'depressive equivalents' such as somatic symptoms, aggressive behaviour, school refusal, other phobias, obsessions, clinging, wetting, and soiling (Brockless, 1997).

ICD-10 and DSM-IV use similar criteria to diagnose major depressive disorder in both children and adults. DSM-IV allows for a depressed mood to be substituted by a persistently irritable mood in the case of children.

DSM-IV prescribes that symptoms need not meet criteria for a manic, mixed or hypomanic episode. The mood disturbance must not be better accounted for by a psychotic disorder. The symptoms must cause distress and/or impairment in functioning.

Dysthymic Disorder shares similar symptoms with Major Depressive Disorder but differs in respect of onset, duration persistence, and severity. The essential feature of Dysthymic Disorder in children and adolescents is a chronically depressed or irritable mood for at least one year. At least two of the following symptoms will be present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration and feelings of hopelessness. During the one-year period, the child or adolescent has never been without some of the above symptoms for more than two months at a time. There has never been a manic, mixed or hypomanic episode. The mood disturbance does not occur during the course of a psychotic disorder, is not due to substance use or a general medical condition. The disturbance causes the child or adolescent distress and/or impairs functioning.

For a detailed description of the diagnostic criteria as they may apply to Major Depressive Disorder and Dysthymia, the reader is referred to the DSM-IV (1994) pp.317-350.

Assessment: Diagnosis and Differential Diagnosis

Defining the between extremes of normal behaviours and psychopathology is a dilemma that pervades all of psychiatry and psychology. It is especially a problematic to establish the limits of depressive disorder in young people because of the cognitive and physical changes that take place during this time. Assessment of children and adolescents who present symptoms of depression must, therefore, begin with the basic question of diagnosis. This entails interviewing the child alone. It is not sufficient to rely on accounts obtained from the parents since they often do not notice or acknowledge depression in their off spring, and may not even be aware of suicidal attempts. It is now common to practice to obtain information from several sources. Children and adolescents usually give a better account of symptoms related to internal experience, whereas parents are likely to be better informants on overt behavioural difficulties. Accounts from children and parents should in turn be supplemented by information from teachers and other persons in close contact with the child in question (Harrington, 2001).

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Although the interviewing of multiple informants often yields valuable information, the diagnosis of depressive disorder in children can still be difficult. Standardised diagnostic systems such as the DSM-IV and structured clinical interviews can help in deciding whether the client has serious depressive symptomatology that requires treatment. Unfortunately, these diagnostic symptoms tend to be over-inclusive in this age group, and many dysphoric children and adolescents who meet criteria for major depression remit within a few weeks. Therefore, it is important that clinicians assess carefully to what extent the symptoms and the presence of symptoms have impaired everyday functioning with unequivocal psychopathological significance, such as suicidal planning, and marked weight loss. Probably the best single indicator of whether or not the child has a serious depressive disorder is the duration of the problem. Polysymptomatic depressive states that persist for more than six weeks usually require intervention (Harrington, 2001).

Benefits of direct assessment

Returning briefly to importance of direct assessment (this is interviewing the child directly), as well as multiple informants such as parents and teachers in the assessment of childhood depression, Puura et al (1998) conducted research to establish whether parents and teachers report depressive symptoms in children with self-reported depression and which features are connected with sought psychiatric care. The authors reiterated that the assessment of child psychopathology is complicated by the rapid cognitive and psychosocial development typical for this age. In other words, behaviour regarded as normal in a toddler may be a sign of serious psychopathology in an older child. Although parental accounts are essential for gathering information on the development of a child and the type of behaviour that the child manifests at home, the value of direct assessment is receiving increasing attention of late. Puura et al refer to numerous studies confirming the hypothesis that parents report fewer depressive symptoms in their children than the children report themselves. Parents also report more symptoms of conduct disorder in than do their children. Parents are fairly insensitive to the inner experiences and emotions of their children but are very sensitive to external behaviour such as attention deficit disorder.

Most of the symptoms of depressive disorders consist of highly subjective feelings and experiences, such as feelings of unhappiness or guilt. Therefore, the young client should be questioned directly about the presence of these symptoms. Although recent studies have shown that children are able to experience depressive effect and cognitions, their ability to report them reliably has been questioned. Puura et al reported that children from 8 years of age upwards are able to consider their own affect separate from environmental context and also to separate sadness from dysphoria. However, the capacity of children under 10 years of age to report onset and duration of symptoms is limited.

Puura et al found that the teachers involved in their study suggested psychological help for only a small number of boys and for an even smaller number of depressed girls. The most alarming items for teachers included depressed or miserable moods, together with antisocial behaviour. Parents in the study similarly only responded to the depressive symptoms of their children by seeking help when the when the behaviour included features such as disobedience, restlessness, asthma and soiling. Features in depressive children that attract parental attention will vary between different cultures, of course. The study concluded that most parents in the study were aware of their children's depressed state but did not seek help unless the depressive symptoms were combined with antisocial behavior or affected school performance negatively. Puura et al suggested that early intervention in childhood depression could be promoted by including a self-report questionnaire, with items of depressive symptoms,

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in medical checkups for children at school. Of course, such intervention presupposes that schools receive visits from state doctors and nurses, which is not the case in many countries.

Interviewing the child – What to look for

The interview with the child allows the clinician not only to explore the subjective symptoms of depression, but also to observe the child's appearance and behaviour carefully. Is the child clean, and appropriately dressed, or are there signs of neglect? How do the child and parents cope with separation? Further, is the level of separation anxiety appropriate to the age of the child? It is also important at this point to assess the child's approximate developmental level. Developmental delay and physical and emotional immaturity are obvious disadvantages to the child. Some children are unusually well grown and emotionally mature or gifted for their age. This too could have a bearing on the assessment. The clinician should also assess the child's social skills in this one-to-one setting. Does the child make good eye contact? Can the child develop a rapport with the clinician? Is the child's behaviour socially appropriate, bearing in mind cultural differences? Observation of affect is particularly important in the diagnosis of depression. Does the child show facial expression? Does he or she smile appropriately? Is the child tearful? Is the child emotionally responsive? Likewise motor activity may be affected by depression. Is the child over active and agitated? Is he or she under active and slow? The presence of motor abnormalities such as tics or stereotypes should also be noted. The child's speech is also assessed. Slow, stumbling speech may occur in depression. Is the content of the speech appropriate? Is there any sign of thought disorder? Does the child have any unusual preoccupations or beliefs? Severe psychotic depression in childhood is rare, but does occur, and may involve persecutory auditory hallucinations or delusions of guilt and self-blame.

Evaluation of the risk of suicide and self-harm is a vital part of the clinical assessment. Children should be asked about the frequency and persistence of thoughts of self-harm, the method they might employ, and whether they have ever acted on their thoughts. Some indication of their view of themselves and their future should be sought because hopelessness and self-blame have been linked to suicidal intent. Lastly, a brief assessment of cognitive functions, such as concentration and short-term memory, may be helpful (Davison, 1997).

Other diagnostic tools

A variety of tools for assessing depression have been developed as research interest in childhood depression has grown in recent years. Self-rating questionnaires such as the Child Depression Inventory (Kovacs, 1981) are widely used. This includes twenty-seven items relating to the signs and symptoms of depression. The child reads them and selects one of three alternative statements that are most applicable to him/her during the last two weeks. This inventory has been shown to be internally consistent and reliable over time. It is particularly useful as a screening tool (Kazdin, 1990).

A number of standardised interviews have also been developed. The Schedule for Affective Disorders and Schizophrenia (Kiddie SADS) is typical of these. It begins with a general inquiry about the child's symptoms and adjustments, followed by a large number of specific questions about a wide range of symptoms across a number of psychiatric disorders. The parents and child are interviewed separately. Several studies have shown that these interviews provide reliable and valid diagnoses of depression (Kazdin, 1990).

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There has been much interest in developing psychobiological markers of depression. In adults, the Dexamethasone Suppression Test has been used to distinguish patients with endogenous depression from those with reactive depression. Unfortunately, the Dexamethasone Suppression test has not been shown to be helpful in distinguishing between depressed and non-depressed cases in children (Tyrer et al, 1991).

Differential diagnosis and co-morbid disorders

Although the accurate diagnosis of depressive disorder is an important part of clinical management, it does not stop with it. Depressed children and adolescents usually have multiple problems, such as educational failure, impaired psychosocial functioning, and co-morbid psychological disorders. Most children and adolescents who meet research criteria for depressive disorder are given some other primary diagnosis by clinicians involved in their care. This overlap of depression and other psychological diagnoses has been one of the most consistent findings from research in referred clinical populations, where an association has been found with conditions as diverse as conduct disorder, anxiety states, learning problems, hyperactivity, anorexia nervosa and school refusal. Moreover, depressed children and adolescents tend to come from families with high rates of psychopathology and may have experienced adverse life events. All these problems need to be identified and the causes of each assessed (Harrington, 2001).

The co-morbidity of substance use and other mental health disorders is particularly important, with positive correlations between substance use and suicide, depression, conduct disorder, school drop out and poor scholastic achievement. A study conducted among twenty-one boys diagnosed with major depression and/or dysthymia showed that the depressed boys were more likely than the non-depressed boys to have a diagnosis of substance dependence and to use more drugs regularly, although unlike adults, the depression did not improve with abstinence. The depressed group tended to have developed conduct symptoms earlier and have increased co-morbid anxiety and attention problems. Other studies conducted in adolescent addiction facilities indicate that up to a third suffer affective disorders, the majority of which are major depression and dysthymia (Gilvarry, 2000).

Windle and Windle (1997) studied inter-relationships among suicidal behaviours, depressive symptoms, and substance use behaviours. In order to do so the authors tested the independent and combined effects of depressive symptoms and substance abuse on the occurrence of suicide thoughts and attempts among a school based sample of adolescents. Their findings were consistent with previous research suggesting that the combination of depressive symptoms and substance abuse convey a stronger risk for suicidal behavior than does problem drinking or depressive symptoms alone. The causal processes by which this added risk of co-morbid substance abuse and depression is conveyed still require more research. It is likely that adolescents engaging in suicidal behaviour are likely to have experienced stressful life events and instead of implementing constructive problem solving strategies that would facilitate their adaptive coping with the stresses; they use substances to alleviate their experience of negative effect. When this coping strategy proves ineffective in reducing feelings of depression, more stress is created which leads to increased substance abuse in and eventually suicide seems the only means to interrupt the cycle.

The DSM-IV differential diagnosis for substance abuse induced mood disorders prescribes that the latter is only diagnosed if the substance is etiologically related to the symptoms. If the depressive symptoms persist during prolonged abstinence from substance abuse, as in the Gilvarry study, the diagnosis would remain Major Depressive Disorder or Dysthymia depending on which criteria were met.

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If psychotic features are present, but do not occur in the absence of mood symptoms, Mood Disorder with Psychotic Features is diagnosed. It is essential to make sure that the mood disturbance is not the direct physiological consequence of a specific medical condition such as hyperthyroidism. Adjustment Disorder with depressed mood is distinguished from Major Depressive Disorder by the fact that the former is in response to a psychosocial stressor and does not meet the criteria for Major Depressive Episode. If the criteria for Major Depressive Episode are met, but someone very close to the child has just recently died, Bereavement should be considered unless the grieving persists for longer than two months, impairs functioning, and there is evidence of suicidal ideation (DSM IV, 1994)

The final part of the assessment involves an overall evaluation of the child's personal and social resources. Garmezy and Masten (1994) provided evidence that success at school and other areas of life can protect children from the effects of adverse life experiences. It seems as if the best guide to the child's ability to deal with future problems is his or her record with dealing with adversities in the past. It is also essential to evaluate the ability of the family to support the young client.

Epidemiology

Rates of depressive disorder vary a great deal between studies, depending on how it is defined. The one-year prevalence is around 2%. Almost all recent epidemiological research has found that the depressive disorder is much less common among pre-adolescent children than among adolescents. Pre-adolescent depression shows an equal gender ratio, but by mid-adolescence the female preponderance found in adult depression is established. Recent research indicates that the prevalence of depressive disorders may be increasing among children and adolescents, although most of this evidence comes from retrospective reports of age at onset of depression in family and community studies of depressed adults (Harrington, 2001)

Aetiology

The aetiology of child and adolescent depressive disorders is likely to be multifactorial, including both genetic and environmental factors. Genetic factors account for a substantial amount of the variance in liability to bipolar illness in adults, but probably play a less substantial, though still significant, part in unipolar depressive conditions. Interest in the genetics of depressive disorders arising in young people has been stimulated by data from several sources. Firstly, it seems that among adult samples, earlier age of onset is associated with an increased familial loading for depression. Secondly, the children of depressed parents have greater than expected rates of depression and thirdly, there are high rates of affective disorders among the first-degree relatives of depressed child probands (Harrington, 2001).

It is important to remember that just because a disorder runs in families, it does not necessarily follow that the linkages are mediated genetically. Family environmental influences must be considered. For example, unhappy intra-familial relationships seem to be strong predictors of depressive disorders among the young.

Much research has been conducted recently to investigate the genetic and environmental influences in childhood depression. Agreement has not yet been reached. I wish to refer to just a few articles to illustrate the disparity in this area of research.

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Thapar and McGuffin (1997) in their twin study used a sample of one hundred and seventy two twin pairs aged eight to sixteen years to examine the causes of co-variation of maternally rated anxiety and depressive symptoms. Anxiety and depressive symptoms commonly co-occur yet the underlying mechanisms for this co-variation remains poorly understood. The aim of this study was to examine whether genetic factors influence this co-variation of anxiety and depression in childhood and adolescence. Results showed that most of the co-variation between anxiety and depressive symptoms can be explained by a common genetic influence. Co-variation also appears to be influenced by the same non-shared environmental factors although the genetic factors are more substantial in this particular study. What is still not clear is whether the common set of genes that influence anxiety and depression in childhood do so directly or by influencing some other mediating attribute such as cognitive style or temperament.

Plomin et al (1998), in their paper referred to the results of five twin studies (including the Thapar and McGuffin study referred to above) that addressed the aetilogy of depressive symptoms in children and adolescents, in an effort to untangle the contribution of genetic and environmental effects. Overall the evidence from these twin studies suggests the genes account for between one third and one half of the variance in individual differences in self-reported depressive symptoms, and for a greater proportion in parent-reported depressive symptoms. The twin study evidence concerning shared environment is less consistent, but the hint of shared environmental influence is noteworthy because it is rare in twin studies to find any suggestion of shared environmental influence in the development of psychopathology. Whereas, the twin method is unable to provide a direct test of the shared environment, adoption studies are able to test the influence of shared environment. Plomin et al conducted such a sibling adoption study by comparing biologically related siblings placed into the same family, and biologically unrelated siblings placed into the same family and found no evidence for genetic influence for depressive symptoms (children were all of middle childhood age). These findings obviously conflict with the results of most twin studies. Plomin et al have no clear explanation regarding this discrepancy but suggest that their findings do at least serve to raise doubts about genetic influence on depressive symptoms in middle childhood and encourage more research. The findings of this research also emphasised the importance of non-shared environmental influences, which will not come as a surprise to developmental psychologists who are accustomed to considering the role of life events, especially loss events, in the aetiology of depression among children. Although all members of the family experience the death of a family member, the effects can be individual-specific, and are thus potentially non-shared environment influences. Serious illness between birth and five years is also a significant predictor of subsequent depression and a non-shared factor. Friendship problems are similarly thought to be child specific in their depressive effect, and are considered non-shared environmental factors. Plomin et al conclude their paper suggesting that non-shared environment, rather than genes, largely account for variance in depressive symptoms in middle childhood.

Boyle and Pickles (1997) in their study focused on the association between maternal depressive symptoms and emotional disorder in children and adolescents. Substantial evidence has accrued over the past few years documenting the adverse effects of parental psychopathology on the emotional and behavioural functioning of children. There seems to be a consensus that the offspring of depressed parents are at risk for a full range of adjustment problems and at special risk for depression. As mentioned previously, less agreement exists in respect of why this should be so. Some researchers rely on genetic predisposition to explain this phenomenon; others have researched the effect of depression on parental behavior, cognitions, and/or emotions.

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Such effects, it is suggested, may directly undermine the parent's ability to nurture, supervise, and protect the offspring all important prerequisites for healthy child development. Alternately, these same effects may lead to family disruption and marital discord, which in turn adversely affects the children.

Boyle and Pickles used information collected on two occasions from a probability sample of families with eight to twelve year-old children. The data suggested that maternal depressive symptoms were associated with emotional disorders in girls but not boys. This could be because mothers are closer emotionally to their daughters, spend more time with them, and are more privy to their inner life. This closeness also allows for more accurate ratings of the daughter's feelings than the son's. A close mother-daughter relationship could well provide the means for maternal depressive to impact on their interpersonal functioning and elicit more depressive symptoms in their daughters. Perhaps there is a reciprocal effect between mothers and daughters. More research is needed in this area. Interestingly, when the authors controlled for family dysfunction and economic disadvantage the association between maternal depressive symptoms and emotional disorder in girls weakened but was not eliminated. Boyle and Pickles concluded that maternal depression is likely to be a part of a causal chain that can precipitate or result from a variety of contextual variables that jeopardise parent-child relations.

Olsson et al (1999) further illustrated the adverse effect of a negative family climate on offspring. The authors also emphasise that parents in general are not aware of all the symptoms and feelings of their children, hence it is essential to interview the child alone. Olsson et al set out to investigate social network in depressed adolescents (age sixteen to seventeen years), with and without co-morbid conduct disorder, and compare it to social network among non-depressed controls. The first question was whether depressed youths have a more limited and insufficient social network. The second was whether they perceive the emotional climate in their family as more negative. The authors interviewed one hundred and seventy seven adolescents with self-reported depressive symptoms and controls (with no life time diagnosis of depression) matched for sex, age and class. The results were interesting. Adolescents with an episode of major depression do not differ from healthy controls in an evaluation of their social interaction, attachment, or family climate. Dysthymic adolescents, with or without episodes of major depression, reported less satisfying social interaction and also have a more negative family climate. When depression is combined with conduct disorder, the adolescents have very poor social interaction, but above all, they have a very negative family climate and inadequate support from attachment persons.

Current models of depression in young people emphasise the importance of bi-directional influences. Depression and its associated symptoms, such as irritability, can be a cause of family and peer difficulties, as well as consequence. It is possible that negative cycles of interaction are started, in which depression causes family environmental problems, which in turn worsen the depression (Harrington, 2001).

From this small sample of research regarding the aetiology of childhood depression it becomes painstakingly clear that childhood is seldom the wondrous time it is made out to be. Parents like to think that children are immune to the stressful complexities and troubles of the rapidly changing adult world. They see childhood as a carefree, irresponsible time, with no financial worries, societal pressures, or work-related troubles. Many adults who consider themselves child advocates do not understand children's perceptions. Normal child development involves a series of cognitive, physical, emotional and social changes. Almost all children at some time experience difficulty adjusting to these changes, and the accompanying stress or conflict can lead to learning or behavior problems.

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Internal factors such as genetic predisposition render some children more vulnerable to emotional disorders than others. External factors such as home and school relocations, death or divorce in the family, as well as major illnesses require children to adapt under difficult circumstances. Add the stresses and conflicts of a rapidly changing society – which even adults find difficult to understand – to normal development concerns, and the child's world no longer looks so appealing.

The danger of focusing on endogenous factors in the aetiology of childhood depression is that we may not be sufficiently vigilant for the possibility of child neglect or abuse as a cause for depression. Researchers are increasingly linking child sexual abuse to a whole range of psychological problems. Collings (1995) conducted research around issues of prevalence and long-term effects of sexual abuse in childhood. Collings used a retrospective questionnaire approach among a sample of 640 South African university women. The findings for the student sample, among other things, confirmed hypothesised differences between abused and non-abused subjects in psychological adjustment. After controlling for the effects of punitive and non-supportive parenting styles, a history of child sexual abuse had a pronounced effect on measures of self-esteem, sexual conflict, and suicidal feelings.

The aetiology of childhood depression requires an in depth consideration of both internal and external factors, as well as the interaction between the two.

Course and Outcome

According to Harrington (2001), by comparison with non-depressed subjects, young people diagnosed as depressed are more likely to have subsequent episodes of depression. This increased risk of recurrence extends into adulthood. Harrington followed up sixty-three depressed children and adolescents, an average eighteen years after their initial contact. The depressed group was four times more likely to have an episode of depression after the age of seventeen years than a control group who had been matched on a large number of variables, including non-depressive symptoms. Harrington emphasises that although the risk of recurrence of juvenile depression is high, the prognosis for the index episode is quite good. The available data suggests that the majority of children with major depression will recover within two years. Harrington cites Kovacs and colleagues, who reported that the cumulative probability of recovery from major depression by one year after onset was 74% and by two years was 92%. It seems, then, that most young people with major depression will recover significantly, but that a substantial proportion of those who recover will relapse.

Management and Treatment

Initial Management

The initial management of depressed children and adolescents depends largely on the nature of the problems identified during the assessment. The assessment may indicate to the clinician that the child's reaction is appropriate for the situation. In such cases, if the depression is mild and intervention was sought timeously, an early approach could consist of a few empathetic discussions with the child and the parents, simple measures to reduce stress, and encouraging support. Around one third of mild or moderately depressed adolescents will remit following this kind of non-specific intervention (Harrington, 2001).

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However, cases that persist will require more specific and lengthy forms of treatment. Several issues must receive consideration. Is the depression severe enough to warrant admission to hospital? Indications for admission would include severe suicidality, psychotic symptoms, or refusal to eat or drink. Should the child remain at school? For mild depression, school could be a valuable distraction from depressive thinking. On the other hand, when the disorder is more severe, symptoms such as poor concentration and motor retardation may exacerbate feelings of hopelessness. In such cases, home tutoring or attending a sheltered school may be considered.

As mentioned previously, it is also imperative to determine whether the depression is complicated by other disorders such a behavioural problems. If it is, then measures to deal with these or other problems must be included in the treatment programme. It may be prudent to deal with co-morbid problems before embarking on therapy for depression. For example, a patient who is dangerously underweight because of co-morbid anorexia nervosa may not respond to therapy that focuses only on the current depression. IN some cases it may be possible to treat the co-morbid problem at the same time as the depression.

Management of the stresses that are associated with many cases of major depression is central to treatment. Sometimes these stresses are easily alleviated, for example, intense bullying at school can be addressed by calling the Head of Department at the school. In many cases, however, acute stresses are just one of a number of causes of the young person's depression. Such stresses commonly arise out of chronic difficulties, such as family discord/dysfunction and may be hard to remedy. In these cases, when it is blatantly obvious that the depression occurs in the context of chronic adversity that is likely to persist, symptomatic treatments may be appropriate. (Thompson & Rudolph, 2000).

Psychosocial Interventions

The best studied of the psychological interventions is Cognitive Behaviour Therapy. Cognitive behavioural treatment (CBT) programmes were developed to address the cognitive distortions and deficits identified in depressed adolescents. Depressed children often suffer from distortions in attributions, self-evaluation, and perceptions of past and present events. They exhibit more external focus of control (an indication that they feel less capable), and low self-esteem, resulting from a perceived inability to succeed academically and socially. CBT provides effective help for depressed children by providing training in self-control, self-evaluation, assertiveness, and social skills. Social skills training include initiating and maintaining interactions and conflict resolution. Many varieties of CBT exist for childhood depression, but they all share the following characteristics. Firstly, the adolescent is the focus of treatment though most CBT programs also involve the parents. Secondly, the child or adolescent and the therapist collaborate to solve problems. Thirdly, the therapist teaches the adolescent to monitor and keep a record of thoughts and behaviour. Regular diary entries and homework assignments form an integral part of CBT. Lastly, treatment usually combines several different procedures, including behavioural techniques (such as activity scheduling) and cognitive strategies (such as cognitive restructuring) (Harrington, 2001).

In a meta-analysis, Durlak, Fuhrman & Lampman (1991) found that cognitive behavioural approaches were almost twice as effective in children who could be assumed to have reached formal operational thinking (Piaget, 1977), aged around eleven to thirteen years, when compared with younger children.

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The study concluded that cognitive behavioural therapy was equally effective in all types of childhood problems, at all degrees of severity, regardless of the components that constituted the treatment. In the most frequently studied group (seven to eleven-year-olds), treatment gains were sustained at follow up, which took place after an average of four months.

More recently Harrington, Whittaker, Shoebridge and Campbell (1998) conducted a meta-analysis of six randomized trials with clinically diagnosed cases of depressive disorder and found that CBT was significantly superior to comparison conditions such as remaining on a waiting list or having relaxation training.

Harrington (2001) refers to two other psychological treatments that have been evaluated in randomised trials with clinically depressed children and adolescents. Interpersonal psychotherapy, which is like CBT, is a brief time limited therapy, aims to help the adolescent deal with the interpersonal problems that are strongly associated with adolescent depression. Harrington makes reference to a randomised trial that showed significant benefits of interpersonal psychotherapy over non-specific counseling (Mufson et al, cited in Harrington, 2001 p. 57).

Family interventions are based on the reliable observation that adolescent depression often occurs in the context of family dysfunction. Harrington (2001) refers to four randomised controlled trials of family therapy in child and adolescent depressive disorder (p. 57). Two involved a family intervention only and two examined the value of parental sessions given in parallel with individual CBT. None has found a significant benefit of the family treatment. Harrington therefore concludes that until there is a firmer empirical basis for family therapy, other interventions such as CBT and interpersonal psychotherapy will be the treatment of choice. I came to wonder whether the lack of success associate with family therapy could be seen as an indictment on the 'family' whose primary role is to nurture and protect children yet so often 'chooses' to ignore the plight of its younger members. Not only do parents under report depression in children, they often do not seek treatment unless the depression is accompanied by antisocial behaviour, and seemingly the family does not play a significant role in the treatment of childhood depression.

Last but not least, I would like to mention a psychoanalytic interpretation of and treatment of depression in childhood. For a psychoanalytic psychotherapist, depression is a condition of the person's internal world. It is a description of an individual's state when she feels her internal resources to be attacked or depleted. In extreme cases the fear may be that there is nothing life enhancing inside, and that the capacity to interact purposefully with the outside world has been lost. It is of course, also a condition that is related to the external world in a very real sense. For children, depression is often reactive. Precipitating factors such as losing someone close to them due to death or divorce, bullying at school, under-performance, illness and conditions of poverty are important indicators. Psychoanalytically oriented therapists therefore see depression as one that may be activated by external events but it is a condition of the internal world, rooted in the individual's object relations and stemming from the interplay in early life between an individual's constitution and primary relationships. That is not to say that early nurturing relationships provide complete immunisation against depression, but rather, that the introjections of good experiences and the establishment of strong internal objects provide the individual with the internal structure on which to draw when depression threatens.

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Youell (1997) cites Alvarez (p.62) on this subject. Alvarez identifies 'reclamation' as an essential part of the psychotherapeutic technique, just as it is an essential component of normal maternal functioning, crucial to the child's emotional and cognitive development. Alvarez sees mothers or caregivers as alerters, arousers, and enliveners of their babies and describes the rhythmical, cyclic interaction of mother and infant that involves approach and retreat, periods of quiet and periods of intensity. Alvarez has worked extensively in therapeutic settings with severely deprived and neglected children suffering from depression. She sees active pursuit of contact as the therapist's crucial function. The therapist working in this way faces the challenging task of convincing the child that there is a receptive object, a lively interested mind making itself available. When depression borders on despair, Alvarez suggests that even the defensive manoeuvres of omnipotence and despair should be respected as indicators that something lively and potentially creative has survived in the child. She warns that therapists who are too quick to challenge these defence mechanisms may be robbing he child of what little internal resilience he or she has.

Annexure Two contains clinical examples from short and long-term psychotherapy conducted by psychoanalytic psychotherapist, Biddy Youell (1997). Philip, Simon, and Beth all responded to psychotherapy in a somewhat positive way. These examples emphasise that recognising depression for what it is can be a very important stage in moving towards greater mental health. When depression is identified, experienced and contained in the psychotherapeutic setting, the sense of relief and the ensuing growth of trust in strengthened internal structures can lead to a more hopeful developmental path. What is also noteworthy is that the causes for depression may not always be glaringly obvious. In the case of Philip, outsiders may not have recognised the shortcomings of his Mother and Father as parental figures. However, the viability of extensive psychotherapy has to be questioned in a country like South Africa where the large majority of the population either do not have the financial resources to afford this treatment option or for cultural reasons find it difficult to trust an 'outsider'.

Pharmacotherapy

Most of the research on Pharmacotherapy has been with the tricyclic antidepressants. (TCAs). A meta-analysis of the tricyclic trials found that the response rate was around one-third less than that generally found when tricyclics are given to depressed adults. (Harrington, 2001)

According to Ryan and Varma (1998) young people may be more responsive to anti-depressants that act preferentially on seratonergic rather than noradrenergic systems.

Kutcher (1997) provides a useful discussion of long-term therapy with antidepressant medications. According to Kutcher, most mental health professionals would consider that one or more psychotherapeutic modalities, possibly in combination with psychopharmacologic treatments, would be the preferred initial intervention in adolescents with major depressive disorder. He advocates the use of active, interpersonally directed problem-based and cognitively focused psychotherapeutic strategies dealing with issues in the 'here and now'.

When considering the need for antidepressants in the treatment of childhood depression, the clinician must ascertain whether there is a history of previous manic or hypomanic symptomology. The identification of one or more of these features should alert the physician to the possibility that they are dealing with depressive phase of bipolar disorder.

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In such cases, the prescription of antidepressants without concurrent 'covering' with lithium could 'flip' the adolescent from depression into mania. The presence of psychotic features should alert the clinician to consider psychotic disorders (for example, schizoaffective disorder). Again the pharmacological treatment of these illnesses differs significantly from uncomplicated cases of depression. What is important for us then, as psychologists, is to distinguish depressive features from psychotic or manic features. If the latter are present, the client would obviously have to be referred to a psychiatrist for assessment.

Electroconvulsive therapy is very seldom used with adolescents, and then only for the most life threatening depressions that have failed to respond to other treatments.

Concluding Remarks – The way ahead

By its very nature, childhood is a vulnerable time for all species, particularly for the human child. Born prematurely, we require much longer than do other species to reach a point where we can fend for ourselves. In addition to this developmental lag, we are endowed from our earliest years with a capacity to reflect on how things are or how they might have been. These constraints are imposed on us by our human biology. Sadly, in addition to this, childhood is further clouded by social issues. Parents are increasingly pressured to juggle their time between work and raising a family, that is, parents are often battling to find time or 'space' for their child. The roles of children and parents in the family are increasingly blurred; in South Africa many children are heading households instead of belonging to them. Child abuse and neglect remains a serious problem of huge proportions. Laws in most countries, even today, rarely give much protection to children against assault. Incest is usually considered a minor felony, and most sexual abuse still goes unpunished, either because it is undiscovered or not prosecuted or routinely plea-bargained. Statistics proving this high incidence of child abuse are mostly buried in little- read journals. Often looking the other way, society is guilty of betraying the child (Miller, 1998).

In the paper I identified specific groups of children that are at an increased risk of becoming depressed. That is, children with a family history of major depressive disorders. Children that have been sexually abused and those who have suffered neglect in dysfunctional families.

Where does all this leave us? Dwivedi and Varma (1997) suggest that three stages are necessary in the development of a comprehensive service for depressed children. The first is recognition that depression in children is a reality that the condition is common. Considering all the literature recently released on the subject of childhood depression, such awareness has been achieved. The second is the closer study of depressed children, their families, schools and the wider context. This is really where we are at right now. The third stage, on which we have scarcely embarked in the South Africa context, is that of prevention. We require urgent inter-disciplinary research around the development and prevention of depression in children in order to raise public awareness and in so doing place pressure on the legal system to protect the child and punish the offender. Dwivedi et al suggests that the internet may prove to be a cost effective means of disseminating knowledge, which may contribute to prevention, early diagnosis and even, through providing up to date information to professionals in the field, more effective treatment. As things stand, we still require much more research into both pharmacological and non-pharmacological treatment methods and how they can be combined in the most cost-effective ways.

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In the meantime, professionals working with children should perhaps stop asking 'why should this child be depressed?' and instead reflect on the question' why shouldn't this child be depressed?'

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