Exceptional Life Journeys: Personal Stories About Childhood Disorder

Meaning is all you need; Relationship is all you have: Meaning-centered play therapy with a teen girl's depression

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Overview of the professionals

I have worked with children and adolescents for many years, as School Psychologist, Psycho-educational Consultant, and Psychotherapist. For the past ten years, as a counselling psychology professor. At the present, I am in independent practice, and giving lectures and workshops on play therapy (www.drlilianwong.com). In this case, we applied a meaning-centered play therapy in treating a girl suffering from depression.

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The context

An 11-old girl named Helen was referred to me by her mother's therapist who believed that Helen might benefit more from someone specialized in children's mental disorders. Her mother reported that Helen needed professional help because of her non-compliance with school expectations (e.g., repeated incomplete assignments), verbal aggression towards peers, and non-participation in class activities and school socials. Her parents also complained about her eating problems (i.e., often throwing away sandwiches prepared at home, skipping breakfast, picky eater at dinner), habitual lying, and defiant behavior (e.g., talking back with angry words). Her only sibling, John, two years younger, has been diagnosed with Autism Spectrum Disorder (ASD) since 18 months old. Her mother, Joan, is a social worker, and her father, Peter, is an engineer working for a large firm.

In the school system, it typically takes a long time and many referral processes, before the children are assessed, diagnosed, and given appropriate interventions. More often than not, the identified children with serious clinical issues would receive inadequate amount of psychotherapy to resolve their deep-seated issues, because of lack of funding and qualified clinical psychologists in the school system. Helen had not been diagnosed or seen by a school psychologist before she was referred to me.

The description of the client's background and situation

Helen was 10 years and 10 months old in Grade Five, when she first came to see me for counselling, which was funded by the Employee Assistance Program (EAP) through her father's company. She attended a private parochial elementary school with her brother, because her parents considered a private school setting would give their son more care and attention. Helen had to stay at the School Home Work Club, while John attended The After School Care Program. Helen was rather resentful of the fact that she was not able to socialize with her peers after school.

At home, John received Intensive Behavioral Intervention (IBI) after supper for two evenings a week, funded by the government since John was three years old. In a small house, his training required a specially equipped room, and a trained educational therapist to carry out the IBI program. Helen complained that her bedroom was much smaller and that she did not even have a proper desk or chair to do her homework. She felt short-changed and neglected because so much time, money and energy of her parents was devoted to John. Her resentment and anger towards John were further aggravated by John's frequent physical assault.

Another major source of stress was the marital problems of Helen's parents. Due to the recent economic downturn, Peter anticipated losing his job as many of his colleagues had been laid off. Mother worked part-time to supplement the funding for John's education, in addition to tirelessly working government funding agencies to secure on-going funding for John's IBI training. The financial stress coupled with the tension of raising an autistic son led to frequent flare-ups and fights. The situation got so bad that the parents were separated for half a year. But after they got back together, the martial conflicts continued, making the home situation toxic and traumatic. Helen felt completely trapped in a helpless and hopeless situation.

At home, she had to help with household chores, look after her brother, and try to de-escalate the conflicts between the parents. At school, she had very few friends, because she was conscious of her family financial situation as compared to the rich kids in the private school. Also, she was very sensitive about her physical stature – she was noticeably smaller than other girls of the same age.

Prolonged stress on so many fronts has overwhelmed Helen to the extent of developing major depression and acting out. Her inner tumult and self-doubt simply amplified the negativity of her circumstances. My focus was on Helen and her struggles to overcome life problems and become what she was meant to be through meaning-centered play therapy.

Overview of my life journey in helping the client overcome her depressive moods

During in-take, her parents were concerned with Helen's weight loss due to poor eating habits, and mood swings in addition to her defiant attitudes. They also described her as accident-prone. They were concerned with her apparent underachievement (e.g., incomplete assignments, lack of concentration). The concerns for counselling as expressed by Helen's mother included possible depression, non-compliance with school requirements, and difficulty to communicate with her.

However, as the journey continued, it soon became clear that the problems of non-compliance at school and defiant ways of talking to parents were just symptoms of a very depressed child with a great deal of anger as a result of growing up in a dysfunctional family. The challenge was how to help the child grow without first fixing the dysfunctional family system.

Over the past three decades, I have worked with a variety of childhood mental disorders from autism to depression. I typically employ appropriate psycho-educational tools. My counselling approach tends to be eclectic, including active listening and empathy, cognitive-behavior techniques, communicating with parents on family issues, and using play and art therapy, mini-sessions with the parents, for example, playing "Ungame" together.

Recently, my approach has become more meaning-centered, focusing on relationship and client-centered meaning systems. My first attempt in meaning-centered assessment was L. Wong, Ishiyama, & P. Wong (1999). A more complete statement of meaning therapy can be found in P. Wong (2010), and my meaning-centered approach to play therapy (www.drlilianwong.com).

Simply put, meaning therapy consists of a two-prolonged approach to facilitating personal growth and transforming negativity through meaning. Meaning is defined as PURE (Purpose, Understanding, Responsibility and Enjoyment), which serves as a conceptual framework to clarify what really matters and how to achieve a more desirable future. Meaning transformation is accomplished primarily through ABCDE (Acceptance, Belief, Commitment, Discovery, and Evaluation), which allows the clients to manage life stress in a more adaptive manner. In this paper, I will use Helen's case to illustrate how a meaning-centered play therapy serves both as an assessment tool and therapeutic modality.

Helen's family is like a pressure cooker. Apart from the stress of financial problems and the difficulties of raising an autistic child, there were also complicated cultural conflicts, because the mother was raised in an upper class family in Hong Kong, while father was born to a working class family in Mainland China, and the children

were born and raised in Canada. The inter-generational gap was compounded by inter-cultural conflicts, since the parents practiced the traditional authoritarian parenting style, while Helen wanted to be more like her peers. Consequently, she suffered from a sense of alienation and loneliness at home and school.

A meaning-centered approach emphasizes the imperative of building trust and understanding to overcome the cultural barriers and personal biases. In addition, a meaning-therapist believes that positive relationship has curative benefits, because it meets the client's basic need for connectivity and also demonstrates new ways of communication and relating. Meaning therapy equips clients with the tools to transform their negative circumstances through ABCDE and create a better future through PURE.

My journey with Helen is a journey into her world of meanings and beyond; it is a journey of healing and discovery of a brave new world in the future. In this paper, we will also briefly illustrate the efficacy of meaning-centered play therapy and will describe the progress that has been made by Helen during the seven month of counselliing.

Clinical Characteristics

Based on all the symptoms reported and observed, Helen suffered from Major Depression Disorder resulting primarily from chronic and extreme adjustment problems.

It remains difficult to have a clear diagnosis of childhood depression for a number of reasons, such as dynamic maturation process, the immature cognitive development, and the complexity of family system.

In general, the diagnostic criteria and defining features of major depressive disorder in children and adolescents are very similar to those for adults, based on DSM-IV (1994). However, children and adolescents express their emotions and mood states differently in terms of manifest behaviours and verbal expressions. For example, they often appear irritable and restless when they feel sad, and may act out their inner turmoil, giving the impression of being rebellious. Caregivers or educators often misinterpret adolescent depression as teen rebellion.

The common signs of Major Depressive Disorder in children, and adolescents may include: Persistent sad or irritable mood, and anger; loss of interest in activities once enjoyed; significant change in appetite or body weight; difficulty sleeping or oversleeping; crying; fear of having diseases and death; poor academic performance; extreme sensitivity of rejection and failure; feelings of worthlessness or inappropriate guilt and difficulty concentrating, complaint of tiredness (MedicineNet.com).

The parents completed the Achenbach Behaviour Checklists Parent Forms and Helen completed the Youth Form. The summaries revealed these themes: insecurity, high anxiety, high-strung, sometimes lying, high frequency of constipation, eating problems, accident-prone, feeling the need to be perfect, always biting fingernails, lack of concentration, and frequently disobedient. It appeared that Helen had many of the signs of Adolescent Depression, wanting acceptance from parents, and not accepting self.

During the early part of the journey together, which has lasted more than 7 months, Helen clearly met most of the above diagnostic criteria. However, she has also shown signs of inner strengths and resilience (Wong & Wong, in press). An important aspect of meaning therapy is to bring out the best in addition to repair the worst (Wong, 2010); this dual-system approach facilitates healing and personal growth.

The Journey begins

During the early part of the journey, the focus was on building rapport and trust with Helen. She began at first by declaring: "Mom has a therapist, mom and dad go to counselling, and now I have my therapist." She was open and eager to unload her negative feelings, regarding her relationships with each member of her family.

She vividly described some of the scenarios at home: She had to hide her spaghetti, because mom controlled her intake of food. She was forced to eat things she was not familiar with, such as some Chinese cuisine in the restaurant. Her main complaint was about unfair treatment she had received as compared to her brother. "He got away with everything, and I got yelled at. Mom lectured me even it was not my fault. Everything is about John. Dad was impatient with my piano practice, telling me how to play when he really didn't know anything."

Helen was articulate and insightful. She sighed often when she related her experiences, as she poured out her sadness, frustration, and a sense of helplessness. She clearly revealed maturity and intelligence in spite of her small size.

I gave her The Piers-Harris Children's Self-Concept Scale to complete. She scored High on Anxiety and Unpopularity, and low on Happiness and satisfaction. She admitted that she cried easily but asserted that "I am a good person" with the qualification that she "got angry for no reason." She clearly had a problem with self-esteem, but she was also confident about her own inner goodness – a point that was often reinforced in the journey of self-discovery. I often pointed out that in spite of all her negative feelings towards her parents and brother, her sandtray displays and musings often revealed her concerns and caring attitudes towards all her family members.

Discussion of significant experiences

After five sessions, she showed clear improvement in managing her school assignments and homework. She was excited about her class presentations. Her declared purpose in life of getting into a good profession, and her Understanding of her own academic abilities, especially in mathematics and science, provided the intrinsic motivation to do well in school. She also realized that non-compliance was a counter-productive and self-handicapping strategy of expressing her unhappiness. She was willing to assuming the responsibility for creating her own happiness and her own future. As a result, she found school work much more enjoyable. Thus, the PURE framework worked well for Helen, because it is all very intuitive and practical. It makes good sense to her. Thus, I could get across the essence of living a meaningful life without getting into philosophical issues or existential musings.

Another milestone of progress was her understanding of the adaptive value of ABCED. Acceptance is one of the key steps in meaning therapy. She came to accept the fact that she would not be able to change her parents, but she declared that "I can change myself!" Almost in the same breath, "I wish there are no fights between my parents. They fought on Thanksgiving because dad was tired and mom was very emotional. I was in the middle of it." Then she sighed, "It was so bad, I'm used to it, I don't have feelings any more, just hang in there."

In one of the sessions, she went straight to the sandtray to play and self-talked. Putting two cars into the sandtray, on two separate tracks, she said, "Mom drives to work, dad drives one hour to work." She paused, and then said, "Mom gets up at 5:00 am, freaked; gets breakfast, freaked, comes home after work, freaked, put John to bed, and freaked." She illustrated a dysfunctional family with two parents going their separate ways, and each stressed out by the demands of life.

Next session, she was sitting on the floor, playing with a few toys, reflecting her feelings, "I am being ignored, my needs were rarely met." Then she picked up a small soft plastic monster head, saying 'This is John,' and picked up a plastic fork, jabbing into it, showing more negative emotions. She whispered, "So annoying, a brother is a pain. I get into trouble if I do anything to him. Life sucks." She changed the topic and told me that her classmates were talking about getting menstrual periods and wearing bras. She was really worried about her own lack of development.

After seven months, I witnessed clear change in her outlook in life, and coping strategies. For an eleven-year-old young girl, Helen learned to accept the ups and downs of life, the imperfect family, the extra burden of having an Autistic only sibling. Once she said to me, "I really don't know what it's like to have a normal sister or brother," but she had accepted her lot.

Her views of her future and her family also changed. She had also learned the second step of meaning-therapy, which was Belief. She believed that she could make

a difference in her life, if she kept thinking positive thoughts, pushing away negative emotions. She became less preoccupied with her present worries, and more optimistic about creating her future.

In one session, her sand picture depicted a large bedroom with sitting and dining rooms, occupying half of the sandtray, with barracks and cannons along the length of the home. She labeled the picture, "Over-protected family." At the same time, she told me that she had A's and B+ on her report card. She began to feel more positive about home and school.

At this time, her highlights were small group activities at her church where she felt belonging. She was happy with her academic achievement. Her low lights were being bullied and teased by the boys at school. She said, "God is in charge of my life, but sometimes it seems that mom is in charge of my life." Her belief in God was helpful in strengthening her belief in future change – God is bigger than her parents, and God is bigger than all her problems.

She also learned the third step of meaning therapy – Commitment. In addition to her commitment to excel at school, she was also committed to improving her coping strategies. To cope with mother's yelling and nagging, she said, "I do my things and go to bed." Or "I don't think about it, focus on candy or computer."

I posted this question to her: "This is the second last session before the New Year, what may be some differences in you between May when I first saw you and now?" She responded, "I used to carry many worries on my shoulders, but now I don't care. The other day, they had a big fight. I know if the fight stops in a few hours, that's not serious, but if it lasts for a day or more, that's serious." I asked, "What do you mean?" She answered, "They are …my mom is going to divorce him." I responded, "How do you feel?" She said, "I now take the positive view… I joke, 'Could I still have my room and take the bigger bed? To cope, I change myself and used humour."

Her report card showed four A's and seven B's. She really discovered that hard work paid off and she really enjoyed her new status at school. However, her problems at home proved to be more intractable and she depended heavily on acceptance in order to make the situation more bearable.

In the following session, she revealed, "There isn't one weekend that they don't fight. If dad gets angry, mom yelled at me, and John gets angry. I go to my room, and close the door and read." An example, of her outlet of her anger was "Scream into the pillow, sometimes cry myself to sleep. Feeling safer at school than at home, but I get used to it." Again she expressed her coping skills, "When I am in pain, go to my room, shut the door, and scream. Right now it's bad enough, one more bad thing happens our family will be toast. Nothing I can do, I have to go to orphanage, or foster home."

She has become more resilient and self-understanding. The home situation did not

change much but her relationships with her parents and brother had improved. She has gained self-confidence and control. She drew up her ideal bedroom on a piece of paper, and was hopeful that her dad would fulfill her wishes. She claimed that her father began to trust her more, but complained about her mother's unpredictable behaviours. However, the family as a whole had planned fun activities together, father rewarded her for completing chores, and mother gave her validations.

She has demonstrated a number of strengths, such as resilience, intelligence, leadership ability, a sense of humour, openness to new ideas, and having a caring heart in spite of her being treated unfairly.

Most difficult challenges and barriers

Working with the child without involving the family can be very frustrating and challenging. Whatever progress the child has made can be wiped out by a sudden worsening of the family circumstances. The prospect of domestic violence and divorce always hangs over the child's head like a threatening storm. The endless fighting between parents can drive anyone to a breaking point.

From my observation, she expressed sadness and hopelessness that her home situation would ever get better. She perceived herself as "a Punching Bag" when her parents argued and fought.

In a session, she confessed: "I am a worry head. Dad has hives that may cause sudden death, may lose his job. Grandpa died, he had diabetes and leukemia. Hope it will not happen to me, like skips a generation. Mom's cousin died of liver cancer. Other grandpa died when dad was only two." It is one of the signs of an adolescent with depressive moods to think about death of self and loved ones. In the play room, she was in control of her environment and felt safe to share her death anxiety; at the same time, she gained some understanding that family connections and her faith in God could help deal with her fear of death.

Although the home front has not changed, Helen was able to recognize some positive changes in her parents. She stated, "Things are getting better, when dad's depressed, he buys things, and bought me a guitar. When mom is depressed, she eats; she's an emotional eater."

Strategies used to address the challenges and barriers

I made the point of frequently talking to the parents either separately or together. I even planned a couple of mini-sessions with the parents. I kept them updated about the progress without violating confidentiality. I shared with them the strategies of meaning-centered play therapy.

What worked and what did not work

The psycho-educational component of meaning therapy works. By teaching her the importance of PURE facilitate goal-setting and of positive orientation. For example, after a few sessioins, she wanted to set new goals for herself: At school, she wanted to strive to get on the honour roll; at home, she said that she would try not to let negative thoughts and feelings get the better of her.

It is also helpful not to label her. By adopting a holistically approach, the focus is no longer on the symptoms of depression. Even though she used the word "depression" several times, she did not see herself as a patient suffering from depression. In stead, she focused on depressive thoughts and behaviors as something that can be overcome. .

There are many questions that beg for answers: How can we minimize the adverse effect of having an autistic child on the family, especially siblings? How a meaning-centered approach be applied to the whole family as the best way to facilitate healing and wholeness for both my client, her brother, and parents?

Play therapy worked well for Helen. It allowed the child personal space to reflect and express her thoughts and feelings freely.

The ABCDE intervention strategy also worked well, because it provides a logical and practical sequence of step to deal with uncontrollable and chronic adversity. The discovery component of ABCED did not work as well in this case, because it would take a longer journey before she can fully discover the joy of recovery and fulfilling a new dream.

"Highs" and "Lows"

The lows are typically related to the aftermath of a family crisis. The highs are related to periods when Helen was able to make some progress in spite of the difficulty home situation.

Significant memories and reflections

They are related to some of her sandtray pictures and her own reflection that demonstrated understanding, responsibility and insight.

Most important things I have learned

Create a safe and trusting environment. Earn the trust of the child with unconditional love and empathy. It is equally important to earn the parents' trust and try to connect with them in order to have a positive influence on them as well.

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Meaning centered approach to play therapy

Meaning-centered counselling and therapy, as developed by Paul & Lilian Wong, emphasizes the following:

Basic assumptions about children:

- Children, like adults, are meaning seeking and meaning making creatures
- Children wants to makes sense of events that happen to them
- Children make attributions and often blame themselves for bad things happening in the family
- Children are hopeful and want to believe that tomorrow things will be better
- Children are intuitive spiritual and there spiritual and make-belief world are just as real as the physical reality

- Children feel better about life if they can have a sense of meaning and purpose
- Children feel better about life if they can feel securely attached to some significant adults
- Children feel better about life if their faith in God is encouraged or validated

Basic assumptions about children's play:

- Play is instinctual for children
- Play is a creative process of self-explorations
- Play is a communicative process of self-expressions
- Play is the social process of relating to others
- Play is the therapeutic process of self-healing
- Play is the developmental process of personal growth
- Play is often irrational but reflective of their consciousness and unconscious needs
- Play can be used not only for diagnosis and healing but also for children to learn responsibility and discover happiness

Basis assumptions about the sand tray

- Touching the sand creates a sense of grounded
- Working with the sand represents a natural way to reveal one's natural feelings, desires and needs
- Playing with the sand and toys gives the child a sense of control and responsibility
- Acting out a story gives the child a sense of re-creating his or her life
- Creating a pattern of beauty and harmony reflects healing and wholeness

Basic assumptions about MCC:

(1) Meaning is all we need – The main task is to understand the client's world of meaning through:

- Verbal communications – what is being said

- Non-verbal communications – what is expressed non-verbally
- Habitual behavior – how the child typically behaves and interacts
- Play behavior – how the child plays (solo or with other people)
- Symbolic act – how verbal and visual metaphors reflect the child's needs

(2) Basic definition of meaning – meaning is cognitive, motivational and existential

The PURE model

P – Purpose and goal of

U – Understand self and situation

R – Right response or responsible action

E – Evaluation of the above three steps to see whether life is getting better

This definition provides a framework for understanding and guiding the child.

(2) Relationship is all we have -- The main counselling tool is to bring about positive change through the here-and-now of relationships:

- Building rapport in the first couple of sessions
- Creating a safe, supportive and trusting environment
- Establishing clear boundary and rules
- Facilitating playfulness and creative expressions
- Modeling a new pattern of relating
- Being non-directive when the child prefers to play solo
- Being interactive when the child wants to share
- Being directive when the child needs direct intervention
- Playing the roles of a friend and a counselor

(3) Basic therapeutic strategy – the ABCD model can be implemented throughout the interactions during a play therapy session

Acceptance – Accept what cannot be change

Belief – Believe that things can get better

Commitment – Commit to making the necessary changes

Discovery – Discover the joy of positive change

Below this line, you may find some relevant materials.

If your child has been displaying one or more of these signs of depression for at least two weeks, and they are interfering with his/her ability to function, then he/she may be depressed and eligible to take part in this research:

Frequent sadness, or crying
Decreased interest in activities
Persistent boredom; low energy
Social isolation
Low self-esteem and guilt
Extreme sensitivity to rejection or failure
Increased irritability, anger, or hostility
Frequent absences from school or poor performance in school
Poor concentration
A major change in eating and/or sleeping patterns
Talk of, or efforts to run away from home

Researchers are studying an investigational medication to see if it may help children with depression, also called Major Depressive Disorder (MDD).

Source: http://www.medicinenet.com/script/main/art.asp?articlekey=42217

Depression in Children

Can children really suffer from depression?
How can I tell if my child is depressed?
Which children get depressed?
What causes depression in children?
Can depression in children be prevented?
How is the diagnosis made?

What are the treatment options?
What can I expect long-term?
A parent's perspective
Signs of risk for suicide

Can Children Really Suffer From Depression?

Yes. Childhood depression is different from the normal "blues" and everyday emotions that occur as a child develops. Just because a child seems depressed or sad, does not necessarily mean they have depression. But if these symptoms become persistent, disruptive, and interfere with social activities, interests, schoolwork and family life, it may indicate that he or she has the medical illness called depression. Keep in mind that while depression is a serious illness, it is also a treatable one.

How Can I Tell if My Child is Depressed?

The symptoms of depression in children vary. It is often undiagnosed and untreated because they are passed off as normal emotional and psychological changes that occur during growth. Early medical studies focused on "masked" depression, where a child's depressed mood was evidenced by acting out or angry behavior. While this does occur, particularly in younger children, many children display sadness or low mood similar to adults who are depressed. The primary symptoms of depression revolve around sadness, a feeling of hopelessness, and mood changes.

Signs and symptoms of depression in children include:

Irritability or anger
Continuous feelings of sadness, hopelessness
Social withdrawal
Increased sensitivity to rejection
Changes in appetite -- either increased or decreased
Changes in sleep -- sleeplessness or excessive sleep
Vocal outbursts or crying
Difficulty concentrating
Fatigue and low energy
Physical complaints (such as stomachaches, headaches) that do not respond to treatment
Reduced ability to function during events and activities at home or with friends, in school, extracurricular activities, and in other hobbies or interests
Feelings of worthlessness or guilt
Impaired thinking or concentration
Thoughts of death or suicide

Not all children have all of these symptoms. In fact, most will display different symptoms at different times and in different settings. Although some children may continue to function reasonably well in structured environments, most kids with significant depression will suffer a noticeable change in social activities, loss of interest in school and poor academic performance, or a change in appearance. Children may also begin using drugs or alcohol, especially if they are over the age of 12.

Although relatively rare in youths under 12, young children do attempt suicide -- and may do so impulsively when they are upset or angry. Girls are more likely to attempt suicide, but boys are more likely to actually kill themselves when they make an attempt. Children with a family history of violence, alcohol abuse, or physical or sexual abuse are at greater risk for suicide, as are those with depressive symptoms.

Which Children Get Depressed?

It is estimated that 2.5% of children in the U.S. suffer from depression. Depression is significantly more common in boys under the age of 10. But by age 16, girls have a greater incidence of depression.

Bipolar disorder is more common in adolescents than in younger children. Bipolar disorder in children can, however, be more severe than in adolescents. It may also co-occur with, or be hidden by, attention deficit hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), or conduct disorder (CD). According to the National Institute of Mental Health, 20-40% of adolescents with major depression develop bipolar disorder within five years after having depression.

What Causes Depression in Children?

As in adults, depression in children can be caused by any combination of factors that relate to physical health, life events, family history, environment, genetic vulnerability, and biochemical disturbance. Depression is not a passing mood, nor is it a condition that will go away without proper treatment.

Can Depression in Children Be Prevented?

Children with a family history of depression are at greater risk of experiencing depression themselves. Children who have parents that suffer from depression tend to develop their first episode of depression earlier than children whose parents do not. Children from chaotic or conflicted families, or children and teens who abuse substances like alcohol and drugs, are also at greater risk of depression.

How is the Diagnosis Made?

If the symptoms of depression in your child have lasted for at least two weeks, you

should schedule a visit with his or her doctor to make sure there are no physical reasons for the symptoms and to make sure that your child receives proper treatment. A consultation with a mental healthcare professional who specializes in children is also recommended.

A mental health evaluation should include interviews with you (as the parents) and your child, and any additional psychological testing that is necessary. Information from teachers, friends, and classmates can be useful for showing that these symptoms are consistent during your child's various activities and are a marked change from previous behavior.

There are no specific tests -- medical or psychological -- that can clearly show depression, but tools such as questionnaires (for both the child and parents) combined with personal information can be very useful.

What Are the Treatment Options?

Treatment options for children with depression are similar to those for adults, including psychotherapy (counseling) and medicine . The role that family and the child's environment play in the treatment process is different from that of adults. Your child's doctor may suggest psychotherapy first, and consider antidepressant medicine as an additional option if there is no significant improvement. Currently, there are no good studies documenting the effectiveness of medicine over psychotherapy in children. However, three studies do show that the antidepressant Prozac is effective in treating depression in children and teens. The drug is officially recognized by the FDA for treatment of children 8-18 with depression.

Treating children with bipolar disorder

Children with bipolar disorder are usually treated with psychotherapy and a combination of medicines, usually an antidepressant and a mood stabilizer. Use of an antidepressant alone can trigger bouts of mania.

The FDA has determined that antidepressant medications increase the risk of suicidal thinking and behavior in children and adolescents with depression and other psychiatric disorders. If you have questions or concerns, discuss them with your health care provider. Learn more

What Can I Expect Long-Term?

Studies have found that first-time depression in children is occurring at younger ages than previously. As in adults, it may occur again later in life. Depression often occurs at the same time as other physical illnesses. And because studies have shown that depression may precede more serious mental illness later in life, diagnosis,

early treatment, and close monitoring are crucial.

A Parent's Perspective

As a parent, it is sometimes easier to deny that your child has depression. You may put off seeking the help of a mental healthcare professional because of the social stigmas associated with mental illness. It is very important for you -- as the parent -- to understand depression and realize the importance of treatment so that your child may continue to grow physically and emotionally in a healthy way. It is also important to seek education about the future effects depression may have on your child throughout adolescence and adulthood.

Parents should be particularly vigilant for signs that may indicate that their child is at risk for suicide.

Warning signs of suicidal behavior in children include:

- Many depressive symptoms (changes in eating, sleeping, activities)
- Social isolation
- Talk of suicide, hopelessness, or helplessness
- Increased acting-out behaviors (sexual/behavioral)
- Increased risk-taking behaviors
- Frequent accidents
- Substance abuse
- Focus on morbid and negative themes
- Talk about death and dying
- Increased crying and reduced emotional expression
- Giving away possessions

Reviewed by the doctors at The Cleveland Clinic Department of Psychiatry and Psychology. Edited by Charlotte E. Grayson, MD, WebMD, October. 2004.

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All information from: http://www.aafp.org/afp/2007/0101/p73.html

Major depressive disorder is the most severe of the depressive mood disorders. The *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., criteria for diagnosing major depressive disorder in children and adolescents are similar to those for adults *(Table 3)*.[20-24]

If substance abuse is present, an independent diagnosis of major depression requires the presence of depression before substance abuse or during periods of remission. Concurrent treatment of substance use disorder and depression is needed to improve outcomes for both.[25]

Adjustment disorder with depressed mood is the most common depressive mood disorder in children and adolescents. Symptoms start within three months of an identifiable stressor (e.g., loss of a relationship), with distress in excess of what would be expected and interference with social, occupational, or school functioning. Symptoms should not meet criteria for another psychiatric disorder, are not caused by bereavement, and do not last longer than six months after the stressor has stopped.

Dysthymic disorder is a chronic, milder form of depression characterized by a depressed or irritable mood (indicated subjectively or described by others) present for more days than not for at least one year (as opposed to two years for adults). Two of the following additional symptoms also are required: changes in appetite, sleep difficulty, fatigue, low self-esteem, poor concentration or difficulty with making decisions, and feelings of hopelessness.[20] About 70 percent of children and adolescents with dysthymic disorder eventually develop major depression.[26]

TABLE 2
Key Clinical Decision Points for Depressive Disorders

Question	***Action***
Is this depression caused by	Rule out other causes of depressive mood disorders.

Question	*Action*
a general medical condition, a medication, or both?	
Is this depression related to drug or alcohol abuse?	Determine whether secondary to or complicated by substance abuse.
Is this depression related to a reaction to a stressful life event?	Consider a diagnosis of adjustment disorder.
Is this a chronic, mild depression?	Consider dysthymic disorder.
Is this another type of depressive disorder?	Consider minor depression, bipolar depression, depression caused by seasonal affective disorder, or atypical depression.
Is this major depression?	Apply DSM-IV criteria (see Table 3). Assess for severity and psychotic features.
Is there a coexisting mental illness?	Dysthymic disorder, anxiety disorders, attention-deficit/hyperactivity disorder, oppositional defiant disorder, and substance use disorder are common comorbidities.
Is this a dangerous depression?	Perform suicide risk assessment.

DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, *4th ed*.

TABLE 3
Criteria for Major Depressive Episode in Adults, Children, and Adolescents

Adults	*Children and adolescents*
A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of	

Adults	*Children and adolescents*
the symptoms is (1) depressed mood or (2) loss of interest or pleasure.	
(1) Depressed mood most of the day, nearly every day, as indicated by subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)	Mood can be depressed or irritable. Children with immature cognitive-linguistic development may not be able to describe inner mood states and therefore may present with vague physical complaints, sad facialexpression, or poor eye contact. Irritable mood may appear as "acting out"; reckless behavior; or hostile, angry interactions. Adult-like mood disturbance may occur in older adolescents.
(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective account or observation made by others)	Loss of interest can be in peer play or school activities.
(3) Significant weight loss when not dieting, or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day	Children may fail to make expected weight gain rather than losing weight.
(4) Insomnia or hypersomnia nearly every day	Similar to adults
(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feeling of restlessness or	Concomitant with mood change, hyperactive behavior may be observed.

Adults	*Children and adolescents*
being slowed down)	
(6) Fatigue or loss of energy nearly every day	Disengagement from peer play, school refusal, or frequent school absences may be symptoms of fatigue.
(7) Feeling of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)	Child may present with self-depreciation (e.g., "I'm stupid," "I'm a retard"). Delusional guilt usually is not present.
(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (by subjective account or as observed by others)	Problems with attention and concentration may be apparent as behavioral difficulties or poor performance in school.
(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide	There may be additional nonverbal cues for potentially suicidal behavior, such as giving away a favorite collection of music or stamps.
B. Symptoms do not meet the criteria for mixed bipolar disorder.	Same as adults
C. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Clinically significant impairment of social or school functioning is present. Adolescents also may have occupational dysfunction.
D. Symptoms are not caused by the direct	Similar to adults

Adults	*Children and adolescents*
physiologic effects of a substance (e.g., drug of abuse, medication) or a general medical condition (e.g., hypothyroidism).	
E. Symptoms are not caused by bereavement—i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.	Psychotic symptoms in severe major depression, if present, are more often auditory hallucinations (usually criticizing the patient) than delusions.

Adapted with permission from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR. 4th ed. rev. Washington, D.C.: American Psychiatric Association, 2000:356, with additional information from references 21 through 24.

Diagnostic criteria

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association, characterizes dysthymic disorder.[8] The essential symptom involves the individual feeling depressed for the majority of days and parts of the day for at least two years. Low energy, disturbances in sleep or in appetite, and low self-esteem typically contribute to the clinical picture as well. Sufferers have often experienced dysthymia for many years before it is diagnosed. People around them come to believe that the sufferer is 'just a moody person'. Note the following diagnostic criteria:[1]

1. During a majority of days for two years or more, the adult patient reports depressed mood or appears depressed to others for most of the day.
2. When depressed, the patient has two or more of:
    1. decreased or increased appetite
    2. decreased or increased sleep (insomnia or hypersomnia)
    3. Fatigue or low energy
    4. Reduced self-esteem
    5. Decreased concentration or problems making decisions

6. Feels hopeless or pessimistic

3. During this two-year period, the above symptoms are never absent longer than two consecutive months.
4. During the first two years of this syndrome, the patient has not had a Major Depressive Episode.
5. The patient has not had any Manic, Hypomanic or Mixed Episodes.
6. The patient has never fulfilled criteria for cyclothymic disorder.
7. The depression does not exist only as part of a chronic psychosis (such as schizophrenia or delusional disorder).
8. The symptoms are often not directly caused by a medical illness or by substances, including drug abuse, or other medications.
9. The symptoms may cause significant problems or distress in social, work, academic, or other major areas of life functioning.[8]

People suffering from dysthymia are usually well capable of coping with their everyday lives, usually by following particular routines that provide certainty.

In children and adolescents, mood can be irritable and duration must be at least one year, in contrast to two years needed for diagnosis in adults.

Chapter 4

Interparental Conflict, Violence and Psychopathology

Jennifer L. Hudson

There has been considerable research estabhshing a Hnk between interparental conflict and child adjustment (Cummings & Davies, 2002; Fincham, Grych, & Osborne, 1994). Although spousal relationships can frequently bring conflict to the family environment, not all children develop psychological difficulties, suggesting that certain factors such as the content, history and degree of resolution of the conflict may alter the effect of conflict on a child's psychological functioning (Grych & Fincham, 1990). Research has also estab- lished a clear link between interparental violence and child adjustment with studies consistently showing higher levels of psychopathology in children from violent homes (Fergusson & Horwood, 1998; Kitzmann, Gaylord, Holt, & Kenny, 2003; McCloskey, Figueredo, & Koss, 1995). Children exposed to interparental violence are also more likely themselves to be at risk of being exposed to physical abuse and other forms of maltreatment such as sexual abuse, neglect and emotional abuse (Saunders, 1994; Straus & Gelles, 1990). Clearly, children exposed to interparental conflict and violence are at greater risk for negative psychological outcomes. Recently, there have been an increasing number of process-oriented studies that have attempted to understand the mechanisms behind the detrimental effects of interparental conflict (Crockenberg & Langrock, 2001; Davies & Windle, 2001; Grych, Harold, & Miles, 2003). The possible pathways towards maladjustment resulting from a child's exposure to interparental conflict and violence are complex. Some theorists have proposed that exposure to

conflict impacts on the child's emotional security and this in turn impacts on the child's adjustment (Cummings & Cummings, 1988). Others have suggested that marital conflict has a direct impact on the parenting skills/style and it is the deficit in parenting that impacts on the child's adjustment (Fauber, Forehand, Thomas, & Wierson, 1990). Children's poor adjustment has also been hypothesised to result from modelling of the parent's aggression or dysfunctional conflict tactics (Bandura, 1973). This chapter will review the evidence for the impact of interparental conflict and violence on the psychological outcome of the child. Focus will be given to the presence of psychopathology such as anxiety, depression, oppositional defiance, conduct problems and

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