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Depression as seen from the psychotherapy perspective

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SUMMARY

Childhood and adolescent depression have been the point of interest of child and adolescent psychiatrists since the 60's of the last century. The antidepressants have not brought the expected results in treatment. Some – because of the immaturity of the metabolic system; others – due to the risk of suicide.
The earliest links between understanding and treating of childhood and adolescent depression are these of the psychoanalytical and psychodynamic tradition; although depression described in the psychodynamic psychopathology language is different from this described by descriptive psychopathology. The important publications are these of Anna Freud, Eva Frommer, Gerhardt Nissen and – later – of Antoni Kępiński.
Lack of safe support during adolescence has been discussed as pathogenic for adolescent depression. The concept of adolescent depression was introduced by Antoni Kępiński.
The last years' studies of family relations (e.g. Stierlin) and brain development (Fonagy, Schore) point out the importance of care continuity, adjusted to the developing child's needs, from babyhood till full individuation. The main problem – from the psychotherapeutic perspective – is not the support, which the patient can get from the therapist, but the patients' own possibility of taking advantage of it.

depression / psychotherapy

Clinicians in child and adolescent psychiatry got involved in problems of depression in childhood and adolescence through '60 last century. There is a possibility that this concentration of attention had been connected to the results of transcultural studies on symptom manifestation of depression in adults and the concept of masked depression published earlier [1]. One can see similar involvement in research on Bipolar Affective Disorder in the early years of life at the beginning of this century.

The problem of depression was the main topic of the European congress of child and adolescent psychiatrists in Stockholm 1971. Results of the on-going research presented there were edited by Anne-Lise Annel [2]. This volume reflects efforts aiming at the systematisation of knowledge on depression in the early stages of development and its nature.

At the beginning of the second half of 20th century psychoanalytic and psychodynamic theories provided the main ways for understanding of depression in children, and formed background for therapy. Nevertheless the debate concerned also the nosological position of childhood depression. It is worth noticing, that Soviet psychiatrists presented an opinion (popular also in Poland at that time) on the dependence of symptom manifestation of depression on the maturity level; with growing – they claimed – depression becomes more similar to its forms in adults [3]. At the Stockholm Congress one of the first epidemiological studies on depression in children were also presented [4]. Epidemio-

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logical study and sociological approach led also to the formulation of a very interesting concept of adolescent depression as an adaptive mechanism to unfriendly social conditions [5].

It seems that concentration on depression, child and adolescent depression including, could have been influenced by discovery and registration of antidepressive compounds, as well as with rapid progress in the pharmacotherapy of depression. Researchers' efforts aimed at the identification of a biological marker of depression and biological predictors of tricyclic antidepressants response. Similar efforts were also present in child and adolescent psychiatry, and required a solution of the problem of nosological position of depression/depressions appearing early in life [6, 7 , 8, 9]. Child and adolescent psychiatrists tried also to develop objective measures of depression, valid for children and adolescents [10, 11,12]. The objective tool was to help in diagnosis, and to monitor effects of the therapies applied, especially pharmacological ones. Antidepressants had been introduced in the treatment of children and adolescents. Nevertheless, their effectiveness was much lower then expected. This was later explained with the immaturity of metabolic system, and with a specific response increasing the activity level prior to mood improvement resulting in a high risk of suicide [13, 14, 15]. The most recent studies on effectiveness of treatment for depressive children and adolescents usually suggest combining psychotherapy and pharmacotherapy, but emphasise, that the latter is still method of choice [16, 17, 18, 19, 20]. However, the question what kind of psychotherapy is the method which should be applied is still without decisive answer.

Child and adolescent depression understanding and treatment at first were approached from a psychoanalytic and psychodynamic point of view. However, it should be remembered, that depression described in the language of psychodynamic psychopathology has not been identical with that delineated by descriptive psychopathology nor by criteria of affective disorders in present classifications, both American and international. Adrian Angold [21] studied this problem extensively.

Depression, in clinical practice is diagnosed according to the above mentioned criteria for affective disorders included in ICD and DSM. In consequence any depression is understood as a form of affective disorders, supposedly of heterogeneous pathogenesis. However, any reflection on depression, also depression in children and adolescents, should take into account that the borders of the idea of depression are not clear-cut.

Spitz and Wolf who studied early infant development had described a stage characterized by a temporary growth arrest, hypo-activity and weepiness in the second part of the first year of life [22] and called it anaclytic depression. This way they introduced the term from psychopathology to the normative description of development. Similarly, Melanie Klein [23] used an adjective "depressive" for a specific developmental phase following leaving the "paranoid" one. It seems, that the close connection between individual development and forms of mental disorders later in life, characteristic for psychoanalytic theories justifies such a practice.

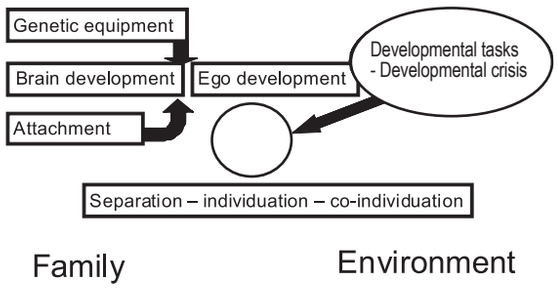
Presumptions of Antoni Kępiński [24], who coined the term "adolescent depression" to call a variant of individual development in the transition from childhood to adulthood, seem to be different. He understood adolescence as a developmental crisis resulting in depressive symptoms which often cover other, serious mental disorders appearing in this age. His approach was closer to Anna Freud, who described a similar course of adolescence as ascetic [25]. But, psychoanalysts were interested in child and adolescent depression too. They discussed symptomathology, and above all the problem of the child's ability to develop symptoms of depression. The discussions are to be found in writings of John Bowlby [26], and later Irvin Philips [27], Eva Frommer with co-workers [28], Philip Graham [29] and Gerhard Nissen [30, 31]. Frommer, and especially Nissen, had founded a background for diagnosing depression in children. They presented also, a psychodynamically oriented understanding of specificity in depressive manifestation in childhood.

Clinical, empirical studies [32, 33] enabled the confirmation of Kępiński's concept of adolescent depression and building a hypothesis that deficit in safe support in interpersonal relations plays a role in its pathomechanism. The hypothesis has been a background for psychotherapy of depressive adolescents.

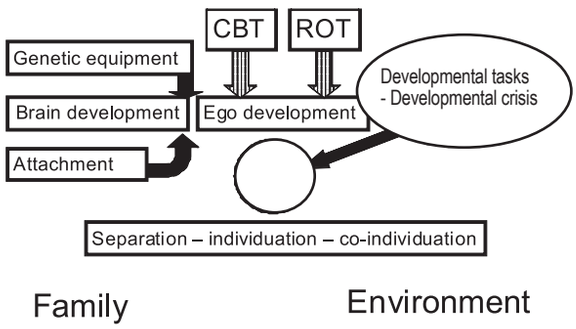
Results of the studies on family relations [eg. 34] and on the brain development [eg. 35, 36], also in animals [37, 38] gave evidence for the importance of stable care, elastically adjusted to the developing needs of the child since infancy to individuation. There is a vast evidence for dropping isolation enforced by thinking strictly in terms of one theory: psychoanalysis or biology. An integrative approach is possible. Biological factors, such as genetic equipment, water and food supply, brain cell migration, neuronal network building etc. and psychosocial factors, such as interpersonal relations, mental function development etc. can, and should be seen together in their interwoven unity, not as separate realities.

Tendencies seen in the last decades in psychotherapy have been in precise delineation of psychotherapy goals and methods used to achieve them. In treatment of depressive children and adolescents especially cognitive-behavioural therapy (CBT) and relations oriented therapy (ROT) have been used. Both are widely recognised as the most effective in the treatment of depressive children and adolescents [16, 20], even if some of the studies undermine reliability of data on CBT effectiveness [40]. It is worth to mention, that both approaches: traditional psychodynamic and modern CBT and ROT, however using different techniques and different terminology, aim at the same goal: to support the patient's development.

Hypothetic insufficient safe support model



CBT and ROT locus of action



Psychodynamic psychotherapy presents its task, also in treatment of depressive children and adolescents, as building conditions for adequate support and helping the patient to complete his/her developmental goals. It means, in psychodynamic theory language, enrichment of defence mechanism repertoire and ego strength, and supporting the individuation process. Fulfilling these tasks requires orientation in the patient's individual development and consequences of trauma reparation (or, the solution of developmental problems unsolved in proper time).

Family psychiatry turned attention [34, 39] to the fact, that the developmental process takes place not in isolation and orientation in it, and its change, requires a family diagnosis and family therapy.

However, for psychotherapy the key problem is not only offering a possibility of safe support, but careful assessment of the patient's ability to use it, and adjustment of the offer to the patient abilities.

Cognitive patterns and their change from dysfunctional to functional, crucial for CBT from a psychodynamic perspective can be seen as thinking, actually understood as ego function. ROT aims a correction of interpersonal relations, actually correction of patterns of interpersonal relations building and supporting. Skills in using safe (therefore functional) support in others are the tasks of psychodynamic psychotherapy too. The significant difference lies in aiming these tasks.

Sherrill and Kovacs' [16] meta-analysis of studies on effectiveness of psychotherapy in treatment of depressive children and adolescents found that CBT and ROT are effective in 50–87%, other psychotherapies in 21–75%, and that depression recedes spontaneously in 5–48% cases. Effectiveness indexes for CBT and ROT are significantly higher, however significantly various. The same is evident for other therapies and for spontaneous remissions too. It should be empha-

sised, that not all studies findings prove differences in various approach effectiveness. But all point out that the results of psychotherapy are transient [19]. There is also one more question put forward. It asks why psychotherapy, even the most effective is not successful always, in all the cases treated. The eternal question on choosing therapy adequate for the particular patient comes back. Sherrill and Kovacs come with one more question: is it the problem of "psychotherapy resistance", or the problem of various kinds of psychotherapy limits [16]. Solution of these questions is looked for in studies aiming at the effectiveness of psychotherapy in changing hypothetic mechanisms of depression.

Weersing and co-workers [20] had analysed the published results of studies on psychotherapy effectiveness in the treatment for depressive adolescents. They aimed at a comparison of various psychotherapeutic treatments, looking for relations between task achievement and depression withdrawal. Review of relevant literature allowed them to arrange the hypothetic factors and mechanisms of child and adolescent depression as follows:

a) the experience of stressful life events (Kendler et al.)
b) genetic vulnerability towards mood deregulation in response to stress (Caspi et al.)
c) maladaptive behavioural responses to stress (e.g. avoiding) (Gazelle and Rudolph)
d) inaccurate, overly negative cognitive interpretations of stressful events (Gladstone, Kaslow).

Many therapeutic programmes for depressive adolescents have been developed to meet the goal formulated as the change of mechanisms supposed to be fundaments of depression. CBT programmes aim to change cognitive styles and maladaptive behaviours. ROTones – aim to limit interpersonal stress and to develop profitable behavioural response in interpersonal relations. Family therapy programmes tend to solve intrafamilial conflicts, improve communication, and develop a warm, satisfactory atmosphere.

Assessment of therapy effects and comparison of results of various therapies appears to be quite difficult. It was found that the earlier studies on CBT effectiveness brought better results than those performed later. Therapies identified as CBT significantly varied between themselves in the selection of important cognitive and behavioural strategies, implementation of techniques imported from other psychotherapeutic approaches, therapy modality (individual, group, joined groups of adolescents and their families etc.), setting (number and time of sessions), strictness in following the protocol, therapist elasticity. Effectiveness assessment of symptom improvement (subjective depressiveness) and on the relation between realisation of transitional goals and symptom improvement brings ambiguous results. No study proved that a change in cognitive styles, behaviour or interpersonal functioning mediates a withdrawal of depressive symptoms in adolescents.

Weersing et al. [20] also made an effort to understand varying results in the assessment of CBT and ROT effectiveness. The authors suppose that "laboratory" therapy is more effective than the same performed in everyday clinical practice. The reason for this difference may be sought for in a more precise following of established rules of treatment (the therapy protocol) and regular supervision in "laboratory" therapy. It is possible, that in everyday practice, the therapy protocol is not strictly followed and supervision is irregular or nonexistent at all. Emphasis on strict following of the protocol seems to reflect the impact of evidence based medicine. EBM has adopted scientific criteria requiring repetition of results with the same method of treatment used. To some extent it reminds the idea of philosophical stone changing every metal in gold.

A scientific approach to child and adolescent depression psychotherapy (probably not only to this problem) aims to prove, that specific action is changing specific (still hypothetic) mechanisms, and in this way to the withdrawal of the disorder. More and more precise methods of mathematic analysis have been employed to find out the relation techniques, mechanisms and improvement. However, it is quite possible that the selection of transitional goals based on theoretical models of adolescent depression may postpone the factors and mechanism of importance for its pathogenesis. Taking into account that child and adolescent depression is not of a homogenous nature and its mechanisms are varying and more complicated, the probability for this would be stronger.

REFERENCES:

1. Angst J. Masked depression viewed from the cross-cultural standpoint. In: Kielholz P, Ed. Masked depression. Bern: Huber;1973. p. 269–274.
2. Annel A-L, Ed. Depressive states in childhood and adolescence. Stockholm: Almquist/Wiksell; 1971.
3. Uszakow GH, GirichYP. Special features of psychogenic depression in children and adolescents. In: Annel A-L, Ed. Depressive states in childhood and adolescence. Stockholm: Almquist/Wiksell; 1971, p. 510–516.
4. Cebiroglu R, Summer E, Polvan O. Etiology and pathogenesis of depression in Turkish children. In: Annel A-L, Ed. Depressive states in childhood and adolescence. Stockholm: Almquist/Wiksell; 1971, p. 133–136.
5. Mastropaolo C. Depression in adolescence. In: Annel A-L, Ed. Depressive states in childhood and adolescence. Stockholm: Almquist/Wiksell; 1971, p. 289–295.
6. Puigh-Antich J, Blau S, Marx N, Greenhill L, Chambers W. Prepubertal major depressive dirosEdon: a pilot study. J. Child Psychiatr. 1978; 17, 4: 695–707.
7. Puigh-Antich J. Cortisol secretion in adolescents with depressive disorders. Psychiatr. Clin. North Am. 1981; 4: 527–529.
8. Puigh-Antich J. Biological factors in prepubertal major depression. Psychiatr. Ann. 1985; 6: 365–367.
9. Puig-Antich J, Goetz D, Davies M, Kaplan T, Davies S, Ostrow L, Asnis L, Twomey J, Iyengar S, Ryan ND. A controlled family history study of prepubertal major depressive disorder. Arch. Gen. Psychiatry 1989, 46: 406–418.
10. Kovacs M, Beck AT. An empirical-clinical approach towards a definition of childhood depression. In: Schulterbrandt JG, Ruskin A, Ed. Depression in childhood. Rockville: NIMH: 1977. p. 1–26.
11. Poznansky EO, Cook SC, Carroll BJ. A depression rating scale for children. Pediatr. 1979; 64, 4: 442–450.
12. Kovacs M. Rating scales to assess depression in school age children. Acta Paedopsychiatr. 1980/81; 46: 305–315.
13. Rajewski A. Farmakoterapia zaburzeń psychicznych u dzieci i młodzieży. In: Namysłowska I, Ed. Psychiatria dzieci i młodzieży. Warszawa: Wydawnictwo Lekarskie PZWL; 2004: p. 491–510.
14. Varley ChK. Treating depression in children and adolescents: What options now? CNS Drugs 2006; 20 (1): 1–13.
15. Bachmann M, Bachmann C, Rief W, Mattejat F. Wirksamkeit psychiatrischer und psychotherapeutischer Behandlungen bei psychischen Störungen von Kindern und Jugendlichen. Eine systematische Auswertung der Ergebnisse von Metaanalysen und Reviews. Teil I: Angststörungen und depressive Störungen. Z. Kinder Jugendpsychiatr. Psychother. 2008: 36 (5): 309–320.
16. Sherrill JT, Kovacs M. Nonsomatic treatment of depression. Child. Adolesc. Psychiatr. Clin. N. Am. 2002; 11(3): 579–93.
17. Bostic JQ, Rubin DH, Prince J, Schlozman S. Treatment of depression in children and adolescents. J. Psychiatr. Practice 2005; 11(3): 141–154.
18. Brunstein-Klomek A, Stanley B. Psychosocial treatment of depression and suicidality in adolescents. CNS Spectr. 2007; 12 (2): 135–144.
19. Watanabe N, Hunot V, Omori IM, Churchill R, Furukawa TA. Psychotherapy for depression among children and adolescents: a systematic review. Acta Psychiatr. Scand. 2007; 116 (2): 84–95.
20. Weersing VR, Rosenman M, Goznales A. Core components of therapy in youth. Do we know what we disseminate? Behav. Modif; 2009, 33(1): 24–47.
21. Angold A. Childhood and adolescent depression. I. Epidemiological and aetiological aspects. Brit. J. Psychiatry. 1988, 152: 601–617.
22. Spitz R, Wolf KM. Analytic depression: an enquiry into the genesis of psychiatric conditions in early childhood. Psychoanal. Study Child 1946; 2: 313–333.
23. Klein M. Mourning and its relation to manic-depressive states (1940). Contribution to psycho–analysis 1921–1945. London: Hogarth Press; 1948. p. 311–338.
24. Kępiński A. Melancholia. Warszawa: PZWL; 1974.
25. Freud A. Adolescence. Psychoanalytic Study of the Child, 13, 255–278.
26. Bowlby J. Grief and mourning in infancy and early childhood. Psychoanal. Study Child, 1960; 15: 9–52.
27. Philips I. Childhood depression: The mirror of experience, interpersonal interactions, and depressive phenomena. In: French AP, Berlin JN, Ed. Depression in children and adolescents. London, New York: Human Sciences Press; 1979, p. 69–86.
28. Frommer EA, Mendelson WB, Reid MA. Differential diagnosis of psychiatric disturbances in pre-school children. Brit. J. Psychiatry. 1972; 121: 71–74.
29. Graham P. Depression in pre-pubertal children. Develop. Med. Child Neurol. 1974; 16: 340–349.
30. Nissen G. Masked depression in children and adolescents. In: Kielholz P, Ed. Masked depression. Bern: Huber; 1973, s. 133–143.
31. Nissen G. Depressives Syndrome bei Kinder und Jugendlichen. Nervenarzt 1975; 46: 302–307.
32. Bomba J. Psychopatologia i przebieg depresji u młodzieży. Psychoter. 1981; 39: 3–11.
33. Bomba J. Depresja u młodzieży. Analiza kliniczna. Psychiatr. Pol. 1981; 16, 1–2: 25–30.
34. Stierlin H. Separating parents and adolescents. New York: Jason Aronson; 1981.

35. Fonagy P. Attachment in infancy and the problem of conduct disorders in adolescence: The role of reflective function. International Association of Adolescent Psychiatry, San Francisco; 2000.
36. Schore AN. Effects of a secure attachment. Relationship on right brain development, affect regulation, and infant mental health. Infant Ment. Health J. 2001; 22 (1–2): 7–66.
37. Sullivan RM, Landers M, Yeaman B. et al. Good memories of bad events in infancy. Nature 2000; 407: 38–39.
38. Moriceau S, Sullivan RM. Maternal presence serves as a switch between learning fear and attraction in infancy. Nat. Neurosc. 2006; 9 (8): 1004–1006.
39. Orwid M. Zaburzenia psychiczne u młodzieży. Warszawa: PZWL; 1981.
40. Weisz JR, McCarty CA, Valeri SM. Effects of psychotherapy for depression in children and adolescents: a meta–analysis. Psychol. Bull. 2006; 132 (1): 132–149.