

Major depressive disorder in children

[Family](#), [Children](#)



Depression is fast becoming one of the most widespread illnesses affecting the youth today. It is often described in layman's terms as a condition in which a certain individual feels sadder than normal, as having the case of "the blues", or of being uncharacteristically disheartened and miserable. However, Major Depressive Disorder (MDD), also known as clinical depression, is characterized as a psychological disorder wherein an individual is rendered incapable of removing himself or herself from a persistent sense of sadness and a lessened interest in all of his or her activities.

These symptoms must persist for a period of no less than 2 weeks in order for a diagnosis of Major Depressive Disorder to be made. (Watt & Markham, 2005) Other symptoms of MDD include feelings of worthlessness, significant weight change, listlessness, thoughts of death.

Watt & Markham (2005) posit that MDD has biological factors in its etiology in children. These involve genetic make-up and hormonal imbalance. Other factors contributing to MDD include psychological and environmental factors. Psychological factors may involve functions of learned helplessness, melancholia, and depressive character traits which all contribute to the eventual self-defeating way by which the child will view the world.

Environmental factors include stressful life events such as the loss of a loved one or a child's negative experience in one of the social roles he or she plays. Social roles in children often include those they have in their families and in school. Not being able to successfully fulfill these roles can again lead to self-defeating thoughts and to feelings of worthlessness in the child.

Psychological, environmental and biological factors all play an equal role in contributing to a child's eventual experience of MDD. It is most likely that all these factors are at play to a certain degree in a clinically depressed child. What is clear, however, is that the foundation of MDD in the depressive child's life is far-reaching and broad. It stems from many different aspects of the child's persona and as such affects all these aspects in turn. All three factors must be taken into consideration.

However, because children are still in an unbalanced state of development, their psychological and biological states are still in a precarious condition. This renders Major Depressive Disorder in this age group closed to certain types of treatment for depression. Only a few types of treatment have been found to have efficacy in reducing depressive symptoms in children. And even then, these few treatments have not all been able to provide truly child-friendly ways of dealing with depression.

One of the treatments for MDD, which has received much interest from researchers, is pharmacotherapy. This involves the intake of drugs, tricyclic antidepressants (TCA's) and selective serotonin reuptake inhibitors (SSRI's), to suppress and decrease the symptoms of MDD. However, it has been seen that most research findings conflict in presentation of efficacy of pharmacotherapy treatment for adolescents and prepubescent children. (Milin et al, 2003)

Electroconvulsive therapy, which involves introducing an electric shock to the individual's system, also has greater efficacy in treating MDD in adults. However, the application of this treatment on adolescents and prepubescent

children proves to be problematic. (Milin et al, 2003) Numerous ethical issues must be considered before psychologists and psychiatrists can test electroconvulsive therapy on children.

One of the safest and least dangerous treatments that are applicable to clinically depressive children is psychosocial therapy. This includes Cognitive Behavioral Therapy (CBT), interpersonal therapy, and family therapy.

Treatment for Major Depressive Disorder, however, may not be limited to merely one type. Combinations of the different classes of treatment can be made in order to create a greater chance of improvement and recovery for the individual. (Milin et al, 2003)

Combining CBT with antidepressant medication has shown results that prove the combination to be more effective in treating depression than simply applying one of the given treatments alone. (Rupke et al, 2006) Combining CBT with different psychosocial therapies such as family therapy, wherein the family is educated on the condition of the child, has also proven to be a much more effective treatment style. (Asarnow et al, 2002)

Personally, I would choose to administer CBT over the other therapies because it provides the most flexibility in terms of addressing specific types of depression experienced by the individual. (Asarnow et al, 2002) In treating a child with MDD, individualization is essential. The treatment style that would best fit the child's lifestyle and personality should be chosen. The CBT sessions will be fitted to match specific aspects of the child's depression.

The first step I would take would be to assess the child in terms of the type of depression he or she has. We would then pinpoint, together, the negative automatic thoughts he or she is prone to have. We would trace the specific situations and environments which lead him or her to this kind of negative thinking and to behavior characteristic of depression. Upon establishment of the child's behavior patterns, goals for the CBT sessions will be set. To what extent does the child want to reduce his or her symptoms of depression? This will allow him or her to develop a sense of involvement in his or her own treatment. Having the child set his own goals gives him or her greater motivation to accomplish them.

At first the child will be asked to simply monitor himself or herself by keeping a log of his or her behavior. The log will consist of the initially pinpointed negative thoughts and behaviors that the child has chosen to change. The instances he or she has pinpointed will also be monitored and kept in the log. The first 2 weeks of data in the log will serve as the baseline. The log will be assessed by the child with my guidance after baseline is set.

He or she will be guided to acknowledge the cognitive distortions he or she makes in certain situations. These may include catastrophizing, black and white thinking, fortune telling and the like. These are maladaptive and only increase the child's sense of misery, which is a chief characteristic of MDD. For example, if the child admits to always thinking that everything that goes wrong is his or her fault, he or she will be shown the irrational foundations of this belief. Afterwards, different ways of reacting and behaving will be conceptualized in order to replace the previous behavior and cognitions. The

child will be guided to realize that external situations and individuals are outside his or her control but that the way he or she reacts, his or her perception of these events is what he or she can control.

The log will be continued in order for the child and myself to monitor his or her progress. In it, he or she will also place details of assigned homework. Homework will involve practicing the new behaviors and way of thinking we devised together. This is essential to the CBT sessions. The bulk of the therapy's success will rely on the child's constant practice. Coping mechanism such as relaxation techniques, meditation and the like will be taught in order to assure continued progress in the child's treatment from depression. These coping and relaxation mechanisms will also be assigned as homework.

Later on, activities which the child previously avoided will be performed in the hopes of creating for the child a new schema. This will instill in the child a renewed self-confidence and a new self-image. Other social activities will also be pinpointed, in which the child will engage, as a means of reinforcing the positive schema he or she is gaining about himself or herself and the world. Family intervention therapy may also be an option should the child's family want it.

References

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