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The child care worker

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NACCW

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'The smallest democracy'

On page 13 we fire a warning shot across your bows relating to 1994 as the International Year of the Family. NACCW members and readers of this journal will be challenged to make a difference for families during this coming year. We have, in *The Child Care Worker* over the past several months, included a fairly concentrated diet of material on work with families.
There has been a gratifying response to last month's article on the Ethelbert Children's Home family programme.
Six years ago, say people, it was an idea about which many were sceptical; today we see it as an idea which went on to have a number of undeniable successes — for children and families. How can we make it happen in our children's home?

Theme for the year
In proclaiming 1994 as the International Year of the Family, the United Nations suggested a theme for the year: "The Family: Resources and Responsibilities in a Changing World". This represents a sensible balance between society's awareness of families' needs on the one hand, and society's expectations of families on the other. The ultimately disempowering charity is the one which asks nothing in return. Families need basic resources in order to function; when they have those resources, society expects them to function.
The word *function* is important here. It is a mistake to expect any family to be perfect — in terms of some idealised standards which our institution may cherish. The most we can expect of a family (our own included) is that it should meet, more often than not, the basic needs of its members for food, shelter and warmth (both kinds). The third of these needs can be expanded at will, but will probably be adequate if they meet American poet Robert Frost's expectation that 'home is the one place that, when you go back there, they have to take you in'.
But for too many families in South Africa, it is the first two needs that present a problem. The combination of world-wide depression compounded by sanctions and unemployment, massive urbanisation and a searing drought, has left too many families in our country without even the basic resources, and here will lie our priorities in any observance of the 'year of the family'.

Slogan
We have an International Year, we have a theme, and (see page 13) we have an official emblem. There is also a slogan for the 1994 family: "Building the smallest democracy at the heart of society". Again, this represents a sensible reminder that democracy is a grass-roots phenomenon which grows out of the attitudes and aspirations of individuals, families, streets and neighbourhoods — not something which is imposed from above. The family can be a prototype of democracy, a place where everyone can be heard, where basic needs can be attended to, and where all can participate in the daily round.
Shaw's Alfred Doolittle suggested that it was only the rich who could afford morality. What about democracy? As we contemplate the family's role in the building of an equitable society in our country, we need, again, to ask whether democracy is also a luxury beyond the resources of those those struggling to survive.
It is when the people of a country have the time to lift their heads above daily drudgery, to appraise their immediate and national environment, and to participate in its affairs and accept responsibility for its directions, that we can speak of the family as 'the smallest democracy'. And then we may have hope for the larger family, the larger democracy.

All interested in the International Year of the Family are welcome to write to the journal SA Family Mirror, or to Dr Eddie Harvey, Committee for Marriage and Family Life, Private Bag X828, Pretoria 0001

The PG Foundation has sponsored this journal in 1993. NACCW staff and members express their appreciation.

THE PG FOUNDATION
A PUBLICATION SPONSORSHIP

Regarded as a national leader in the field in the USA, ***Professor Norman Alessi*** has all the professional knowledge, experience, insights and creative energy to translate the mystifying medical diagnosis of childhood depression into realistic and understandable concepts and interventions for those who work with the children

Myths about depressed children and adolescents

It has been only 23 years since the publication of the first papers identifying depression in children. Since that time we have come to understand better the scope of this problem. Nevertheless childhood and adolescent depression often goes unrecognised. Even those who have daily contact with children and adolescents often either fail to recognise this serious disturbance, or mislabel the youth as having a behavioural problem.

Unquestionably there are a number of reasons why there continues to be a lack of understanding about childhood and adolescent depression. Possibly the greatest source of confusion about these problems are various "myths" about childhood that, ultimately, determine our perceptions and actions. What are these myths, and what are the facts about child and adolescent depression?

*Myth #**1**. Childhood is a happy time*

Fact: Everyone experiences difficulties in childhood and adolescence that can have life-long impact: loss, failure, an inability to live up to one's own or others' expectations. But the plight of our children and adolescents is much worse. Child abuse, poverty, and homelessness are only a few factors that make the lives of a growing portion of our children miserable at best — and chronically impaired at worst. No longer can or should we harbour the notion of childhood as being pristine, without pain and suffering.

*Myth #**2**. Children and adolescents are unable to talk about their feelings.*

Fact: Children as young as three and four have been shown to demonstrate an understanding of their feelings. The ability to identify one's feelings and communicate about them has less to do with age than with innate ability.

Not surprisingly, there are some children who are far better able to discuss their feelings than are most adults. When approaching a child or adolescent, you should assume that they can express their feelings and communicate with you.

An important source of difficulty is the potential presence of speech and language disorders among children and adolescents with psychopathology. This is not a rare phenomenon, but a rarely noted phenomenon. Studies have clearly noted that up to 75% of in-patient populations and 45% of out-patient populations have some form of communication disturbance, with the majority never being identified.

*Myth #**3**. Prepubertal children are too young to be depressed.*

Fact: Toddlers as young as four years old have been identified as being depressed, though at a rate less than among adults and adolescents. These children are not just unhappy or sad; they have major depressive disorders. This should not come as a surprise, given the early work of Spitz and his identification of "anaclitic depression" among infants. The limiting factor is not the age of the child, but the ability of the observer to identify the depression.

When depression is seen in such a young child, it is often asked, "What could a child that young have experienced that would make him or her depressed?" There are three answers: First, even extremely young children can experience severe trauma, the consequence of which is depression. Second, because of genetic disposition, some children will be more sensitive to stress that other children; and even the normal stresses of life can result in depression for these children. Third, with enough loading, these children may have a spontaneous onset of depression.

*Myth # **4**. Depression in children and adolescents is always due to something.*

Fact: This idea presupposes that a trauma or conflict in an individual's life is the "factor" that leads to depression.

The problem with this assumption is that not all children, adolescents, or for that matter even adults, will experience depression as a consequence of a "trauma". Also, there are those who will not experience relief even if a "trauma" is identified. This often is seen when patients are in psychotherapy or family therapy for protracted periods of time without progress.

*Myth #**5**. Expressed sadness always accompanies depression.*

Fact: One would assume that a depressed person should look sad or "depressed". Nothing could be further from the truth, especially in children and adolescents. A number of studies have demonstrated that "depression" in children and adolescents often is seen as anxiety (especially separation anxiety in younger children), phobias (often of school), opposition, aggression, or irritability, which then is labelled as either an oppositional disorder or a conduct disorder. These symptoms, not the depression, then become the main target for treatment.

One may ask, "Isn't this masked depression?" No! If the depression is not identified, then it is an unidentified depression, not a masked depression. The mislabelling of aggression or other symptoms leads one to apply a "therapy" that does not deal specifically with the problem of depression. Given the new diagnostic procedures, there is no reason to assume that a child, regardless of his or her symptoms, cannot be diagnosed, if depression exists.

*Myth #**6**. Depressed and sad feelings are short lived.*

Fact: For some, they are. But for those with a mood disorder, they are not. Often, children and adolescents will describe having been depressed for a number of years, with extremely severe

periods and extended times of boredom, poor concentration, and irritability. Yet they are repeatedly told, "This will pass with time." It is often this statement that makes the child or adolescent feel embittered and hopeless; it can and does lead them to question the value of life and to desire that life come to an end.

*Myth #**7**. They will outgrow the depression. It's nothing to worry about.*

Fact: Several longitudinal studies have shown that if a child has a major depressive disorder, the likelihood is greater than 60% that they will have a recurrence within five years. And if a dysthymic disorder is present, the child is more than 75% likely to have a Major Depressive Disorder within 5 years. If a child or adolescent has either of these depressive conditions, they should be monitored closely for either recurrence or relapses. For some children, adolescents, and their families, depression is a way of life, not a passing phase.

*Myth #**8**. Withdrawal is just a part of being an adolescent.*

Fact: At one time, it was thought that all adolescents experienced "adolescent turmoil" and, as a consequence, were not able to be diagnosed as having a major psychiatric disorder. Whether called "adolescent turmoil" or "adolescent crazies", this undermines the ability adequately to assess adolescents, and when necessary, administer needed care. Social withdrawal is an issue of significance, and to mislabel it as a matter of normal development will unquestionably have lifelong impact.
When a child becomes withdrawn, it is important to assess why. Following a traumatic event, the adolescent may have the onset of a major depressive disorder, a psychotic disorder, or a substance abuse disorder. It is important to not turn your back on them or ignore them.

*Myth #**9**. Anger versus sadness.*

Fact: Irritability is one of the most frequent symptoms seen in this population. It is most disconcerting when it is expressed as overt aggression, such as verbal outbursts, the destruction of property, or in extreme situations, physical aggression toward self or others.
Children and adolescents with depressive disorders often have "conduct disorders" or "oppositional defiant disorders" as well. The presence of diagnostic disorders occurring together is referred to as "co-morbid disorders." Research has shown several disorders occurring frequently in children and adolescents with depression. In their order of frequency of co-occurrence are anxiety disorders (separation anxiety, phobias, panic attacks, and general anxiety), then disruptive behavioural disorders (attention deficit hyperactive disorders, oppositional defiant disorders, or conduct disorders).
Certainly, the hallmark of the disruptive behavioural disorder is the presence of aggressive symptoms that are extremely bothersome to those professionals who interact with depressed children and youth. One of the most difficult features of this complex illness is the ability to empathise with a chronically angry person who is depressed. Therefore, the therapist, rather than providing a bridge for children and youth to return from their depression, can get caught up in the chronic anger and end up also alienating them.

*Myth #**10**. All it takes to make a depressed child or adolescent better is kindness.*

Fact: This myth may be rephrased as "love will make it all better" or, when medications are suggested, "Hugs not drugs." One should not assume that these children will respond to kindness, nor should therapists be disappointed when their kindness is not rewarded. Many of these patients are unable to respond to the attempts of the therapist to be empathic. In fact, being with these children often can produce within their caregivers enormous feelings of pain, lethargy, and actual fatigue. Until a therapist becomes acutely aware that these conditions exist in himself, he will unconsciously withdraw from the patient, causing the patient to sense rejection.
The ability to make oneself aware of these myths and their consequences is of utmost importance if one wishes to be of help to these children and adolescents.
We all harbour myths. It is the ability to rise above the myths in the pursuit of truth that determines the true worth of any profession and its professionals.

The Summer 1993 issue of the *Journal of Emotional and Behavioural Problems* (JEB-P) is devoted to the problem of depression. To whet your appetite for this excellent publication, over the next two months we will print short extracts on the subject by Professor Alessi. For information or subscriptions to JEB-P, write to National Education Service/JEB-P, P.O. Box 55, Bloomington IN47402, USA

Is your child or adolescent depressed?

One of the most frequent questions I am asked is "How can I tell if my student or child is depressed?" The following checklist is an attempt to provide a method by which you might determine if a youth is depressed. The first step in helping those with depression is its identification. The following is a checklist of general symptoms. If four or more symptoms are evident, the need for a professional assessment exists.

Difficulties experienced
Expressed sadness or "emptiness".
Expressed hopelessness or pessimism.
Expressed unnecessary "guilt".
Expressed worthlessness.
Unable to make decisions.
Loss of interest or pleasure in ordinary activities.
Increased boredom.

Physical Complaints
Complain of loss of energy — seems slowed down.
Trouble going to sleep, staying asleep, or getting up.
Appetite problems — losing or gaining weight.
Headaches, stomach aches or backaches.
Chronic aches and pains.
Restless or irritable.

Difficulties in school
More than usual problems with school work, as well as difficulties at home.
Unable to concentrate or remember.
Wants to be alone.
Avoiding social contact with friends.
Cutting classes.

Dropping activities
Expression of irritability.
Increased shouting and screaming.
Increased intolerance of everyday events that would have been seen as nothing.
Talked about death. Talked about suicide or attempted suicide.
May be drinking or taking drugs.

'Sometimes I feel all alone' — A 10-year-old girl in a day treatment centre in Illinois