The Children's Depression Scale in Family Therapy: Hearing the Hurt

Miriam Tisher

In this article I review the changes in thinking about childhood depression since the 1950s, with an emphasis on the struggles to find language for childhood depression. My interface with these changes is described, with a particular focus on the development of the Children's Depression Scale (CDS). Clinical applications of family therapy using the CDS in treatment of childhood depression are then illustrated with a composite case example. The idea is developed that depression in children can be seen as a blocked communication, and that increasing emotional expressiveness in families is an appropriate therapeutic aim and intervention. The relevance of the historical context to current practice is considered.

Keywords: childhood depression, adolescent depression, depression in family therapy

The Professional Context

From Denial to Pathology in 50 Years

Childhood depression is a commonly used term today, both in the professional literature and in popular parlance. The print media refer to it, and talkback shows invite experts to have conversations about signs, symptoms, causes and treatments of childhood depression. But it was not always so. Indeed, prior to 1960, reference to childhood depression in the professional literature was very much the exception rather than the rule. Psychoanalytic writers such as Klein (1935) drew attention to infantile depression. Spitz (1946) described depression in young infants, noting sleep and eating disturbance, withdrawal and failure to thrive. However, depression in pre-pubertal children was not referred to and the term did not generally appear in child psychiatry texts up to the late 1970s. Some psychoanalysts asserted that children did not have the psychic maturity to be depressed (e.g. Rie, 1966).

How then to reconcile this absence of reference with the experience of children who were depressed? The process took two decades, approximately 1960–1980. Clinicians began to document their perceptions of depressed children, to describe these children's behaviours and to reflect on similarities and differences in depression between children and adults. Writers described behaviours which they believed to be consistent with depression and set up the first sets of criteria for childhood depression (Burks & Harrison, 1962; Glaser, 1967; Sandler & Joffe, 1965; Toolan, 1962). They also noted that children may express depression differently to adults and raised the concept of 'masked depression', considering behaviours such as school refusal, aggressiveness and bed wetting as ways in which children might give expression to depression. These behaviours were termed 'depressive equivalents' (Cytryn & McKnew, 1972; Glaser, 1967; Toolan, 1962).

During the 1970s, definitions of childhood depression continued to be refined (Tisher & Lang, 1983; Tisher, Lang-Takac & Lang, 1992). Some key questions that were considered included:

- Is depression in children the same as in adults, or is it something different, which needs consideration from a fresh theoretical and empirical perspective? Are developmental factors relevant (Bakwin, 1972; Carlson & Cantwell, 1979; Philips, 1979)?
- Is masked depression a useful concept (Carlson & Cantwell, 1979; McConville, Boag & Purohit, 1973; Murray, 1970; Nowells, 1977)?
- Is childhood depression 'normal', a 'symptom', a 'syndrome' or an 'illness' (Annell, 1972; Cytryn & McKnew, 1972; Kovacs, 1977)?

As part of the emerging acceptance of childhood depression, measures were developed and reported (Kovacs, 1977; Poznanski & Zrull, 1970) and published (Lang & Tisher, 1978). Also, research was reported into the uses of medication and into possible organic bases of childhood depression (Gittelman-Klein & Klein, 1973; Ossofsky, 1974; Werry & Quay, 1971).

By the 1980s, the professional literature reached general agreement that childhood depression was a multifaceted clinical entity. Relevant conceptual frameworks include biochemical (Puig-Antich, 1986), genetic (Cantwell &

Miriam Tisher, Alma Family Therapy Centre, 403 Alma Road, North Caulfield, Vic 3161; miriamtisher@almafamilytherapy.com

Carlson, 1983), learned helplessness (Seligman & Peterson, 1986), life stressors (Beck, Rush, Shaw & Emery, 1979; Tisher, Tonge & Horne, 1994), cognitive and behavioural distortion and sociological models (Kashani et al., 1981), and competency and normal development models (Cicchetti & Schneider-Rosen, 1986). There was consensus that depression manifests differently in children of different ages (Cicchetti & Schneider-Rosen, 1986; Helsel & Matson, 1984; Rutter, Izard & Read, 1986). Criteria for childhood depression were first included in the DSM-III (American Psychiatric Association, 1980).

At the beginning of the 21st century, we rely on the most updated version of the DSM, at the time of writing, the DSM-IV-TR (American Psychiatric Association, 2000). Its diagnosis assumes that childhood depression is an extension of adult depression and therefore uses the criteria for adults with some reference to different symptoms for children. This assumption has been challenged by writers such as Rey (1988) and Rutter et al. (1986), who argue that this assumption does not take into account the developmental milestones of normal childhood development. Nonetheless, the DSM criteria enjoy wide acceptance. These criteria essentially require the presence of either depressed mood or loss of interest or lack of pleasure for a two-week period, this representing a change from previous functioning, alongside five of nine additional behaviours.

Psychological treatment models reported for depressed children and adolescents include cognitive behavioural therapy (CBT), family therapy and child psychotherapy (Birmaher et al., 2000; Brent et al., 1997; Brent, Kolko, Birmaher, Baugher & Bridge, 1999). In respect to family therapy treatments, Larner (2003) offers an integrative model and Campbell (2003) explicates the importance of new narratives.

In 1960, it would have been difficult to find much information about how to work with children who were depressed. There were no scales measuring childhood depression, little reporting in the literature, and no diagnostic criteria. Yet children were presumably depressed then as they are today. What has changed is our perspective: we now have a *language* for childhood depression.

Developing the Language

I have been a part of this journey towards increasing awareness of childhood depression. Between 1967 and 1972, I was working as a psychologist at Bouverie Clinic, a child psychotherapy mental health clinic in Melbourne, Australia. Until 1970, Moshe Lang and I, as the two psychologists, worked with children in individual and group therapy whilst other professionals, psychiatrists and social workers, saw their parents.[1]

Moshe and I saw children who we considered depressed, but as I said above, there was little mention in the professional literature of the idea that children might be depressed. One group we became particularly interested in was school refusing children, who did not attend school and stayed home with their parents' knowledge, as distinct from truants, who absented themselves from school without their parents' knowledge. From our clinical work, we believed that the former were depressed and set out to clarify this hypothesis by comparing this group of children with another clinical group and a normal community group. We reported some of our findings concerning these children and their families (Lang, 1982; Tisher, 1983).

In conversations with academics and researchers in psychology it emerged that there were scales for anxiety in children, but none for depression, probably reflecting the idea of the time that children became anxious, but not depressed. Professor Nick Cox, responding to our clinical experience, suggested that we develop a scale of childhood depression. Thus a process began of giving meaning and language to experiences previously unlabelled or denied in children.

In order to develop a scale, we first needed to come to a definition of childhood depression. The process of development is described in detail in the manual of the first edition of the Children's Depression Scale (Lang & Tisher, 1978). We conceptualised childhood depression as a normal response, which varies in intensity and quality. We arrived at our definition by examining the literature and summarising the features that were described. We found six groups of features that were described in the literature of the day as being consistent with childhood depression. These were affective response, negative self-concept, decrease in mental productivity and drive, psychosomatic problems, preoccupation with death or illness of self or others, and difficulties with aggression.

A pool of items was developed to reflect each of the features of childhood depression identified by Moshe Lang and myself in our clinical work and in the literature. We aimed to phrase the items so that a child would recognise any feelings or attitudes that were part of his or her personal experience. The initial pool of items was given to a group of children who were receiving psychological treatment. The children were asked to comment on the items and to modify and/or suggest new items as they thought appropriate. The final scale included 66 items: 48 depression items and 18 positive items. Six subscales were identified on the basis of item content and included affective response, social problems, self-esteem, preoccupation with own sickness, and death, guilt and pleasure.

The format used was to have each item printed on a separate card which the child posted into one of five boxes, *Very right*, *Right*, *Don't know/not sure*, *Wrong* and *Very wrong*. A form for parents was also developed, with the items rephrased; for example, from *Often I feel I'm not worth much* to *Often s/he feels s/he is not worth much*.

The development of the Parents' Questionnaires offered another indicator of the child's depression, with the opportunity for mothers' and fathers' assessments to be compared, and for children's and parents' responses to each item to be compared. This format also facilitated communication within families about the child's depression, offering family

members a language for the depression, a new experience for families who 'don't talk about feelings'.

Since its publication in 1978, the CDS has been used in many countries including Australia, Brazil, Canada, Egypt, Holland, India, Italy, Japan, Mexico, Nigeria, North America and Spain. The scale has been translated into Arabic, Dutch, Hindi, Italian, Japanese and Spanish, and research reports show that the scale is relevant across different cultures. Research use has included studies of the prevalence and correlates of child and adolescent depression, depression among psychiatric populations, comparisons of depressive symptomatology across clinical and nonclinical populations, the relationship between adult and child reports of child depression, and the relationship between youth unemployment and depression. Many studies have focused on the psychometric properties of the scale. Excellent internal consistency has been reported for both the Depression and Positive Scales of the CDS and the CDS Parent Questionnaires. Two studies have reported adequate test-retest reliability. Content, construct and criterion validity have also been established (Lang & Tisher, 2004).

Clinicians have reported on the usefulness of the scale as a therapeutic tool for use with children and families. They have noted that children enjoy the scale, particularly the 'game-like' quality of posting cards in boxes. Clinicians have also reported that the CDS offers a way of engaging children in therapy and facilitating communication between children and parents.

The publication of the CDS in 1978 took place whilst professionals were debating whether the children's experience of depression was similar to that of adults or different, and whether depression in children was normal, a symptom or a syndrome and at the time when the *DSM* made no reference to depression in children. Views in the general community were reflected by responses from callers to an interview that Moshe Lang and I had with Elizabeth Bond, host of the then 3LO ABC radio station program. Many callers expressed concern that we had developed a depression scale for children. Callers argued that childhood was a time of happiness and that the scale should be called a 'happiness scale'.

On the other side of the Pacific, Maria Kovacs and her team had also been working on a scale of childhood depression, the Children's Depression Inventory (CDI) derived from the Beck Depression Inventory. The assumptions underpinning the CDI were that children expressed depression similarly to adults, whilst in developing the CDS we worked from the basis that children experience and express depression differently from adults.

My interest in childhood depression has continued over nearly 40 years of practice. During that time, I piloted a shorter version of the CDS and 10-item teacher and clinician questionnaires as part of my Ph.D. thesis (Tisher, 1992; Tisher, 1995). In 2004, Moshe and I published the third edition of this scale (Lang & Tisher, 2004), recommended for children and adolescents aged 7 to 18 years. The key features of this edition include the shortened scale (50 items), comprehensive Australian norms and 10-item questionnaires for teachers and health practitioners, providing an opportunity for obtaining additional information to assist and enrich the assessment and therapeutic process. The revised version retains two scales, Depression and Positive.[2]

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Clinical Applications

What is the meaning of the developments in language around childhood depression? By attributing meaning to symptoms, and checking the number and breadth of symptoms reported by children and/or their parents, and then labelling the children's behaviour as 'depressed' or 'not depressed', how have we contributed to both '… the "transformation of experience" and "what we can experience"'(Goolishian & Anderson 1987: 532)? Have we advanced because we now offer a normalising label for children and families, who previously had to suppress their feelings of depression? Or have we pathologised aspects of children's experience, which would otherwise be seen as part of normal development, or as an appropriate reaction to particular situations? Is childhood depression now seen as a mental illness, which can and should be treated with evidence-based treatments such as medication and psychotherapy? How do we as family therapists view childhood depression? And how do we interact with families about childhood depression? How do we listen to the child's and family's attributions of meaning to the depressive experience? What about the attributions of others in the family's helping system, for example, treating doctors and teachers?

Some of these issues are elaborated in the following composite case example.

The Initial Contact

Jane Smith, aged 39, requests an appointment for her son, Tom, 12 years old. Jane says that he has been withdrawn for some weeks, not seeing his friends, and she is concerned that he might be depressed. Tom's teacher may have suggested she call, or Jane may have visited her GP who may have suggested she call. At the point of the call, the meaning that we as therapists give to Tom's behaviour is immediately significant.

1. One response might be to agree with Jane's idea about her child's depression, along the lines of 'Yes, it sounds like your son needs to see me, I can see him at 10.00 am on Tuesday'. This response reinforces the mother's view of Tom's behaviour as the problem, and reflects an individual psychopathology model. Treatment or intervention paradigms might then include CBT and/or psychodynamic therapy. There might be interviews with parents, offering them psychotherapy or psychoeducation. This is how I might have responded when I worked as an individual therapist at Bouverie Clinic prior to 1970, when we adopted a family therapy paradigm.
2. Another response might be to respond by saying 'Isn't it great that your son can let you know how he feels. It sounds like you have open communication in your family. Would you like to come and tell me more about your family as a starter?' This response reflects family therapy approaches with solution focused and positive reframing models. It would be consistent with the direction suggested by Goolishian & Anderson (1987), where the therapist can

   > interact and react with such members and their discrepant ideas so as to create a space for change — the flexibility, or the loosening up of ideas, meanings, or behaviours (Goolishian & Anderson, 1987: 534).

3. Another response might be to ask for more information about the family, and to state, for example, that my practice is to obtain information from both parents. This response might be consistent with structural family therapy paradigms, identifying the view that both parents are important in understanding Tom's behaviour, and indicating an inclination to empower the parents in dealing with his behaviour, rather than taking over the management in the first instance.
4. Yet another response might be to have a conversation with Jane to clarify whether she has discussed her concerns with Tom, whether he knows she is making this call, and if so, whether he is interested in meeting you as the therapist, or if not, how he might feel if he were told. A similar set of conversations might take place with regard to Tom's father. Does he share Jane's concerns, does he know of her concerns, if so, would he be interested in attending for a session, or if not, how might he feel if he were told? This response would be consistent with circular questioning in the systemic family therapy paradigm, inviting Jane to consider how other family members might respond.

Currently, many referrals of children make reference to the child's depression. I find it useful early in my contact with parents/teachers to ask them what they mean when they say that a child is depressed. For example, parents may have had discussion with the GP or others about medication as a possible treatment. Or there may have been a discussion about biochemical causes of depression, perhaps genetic, if others in the family have depression. Some parents understand the term to mean that they have failed as parents — if they were good parents their child would not be depressed. Yet other meanings might include responses to stress, family or school variables, migration, or loss. Unravelling the meaning of childhood depression for families is an important step.

The First Appointment

The first appointment might be set up in accordance with Response 3 set out above. Jane and Mark, Tom's parents, attend for this consultation.

After taking a history, drawing a genogram, establishing significant life events and responses to these and clarifying any patterns of depression in the family, I might say to Jane and Mark that I am interested in further information about Tom's feelings and request that they each complete a questionnaire. They are invited to complete this separately, but at the same time and during the consultation.

The CDS Parents' Questionnaire includes 50 items. The directions appearing on the front of the Parents' Questionnaire are as follows:

> This questionnaire is designed to find out how the child (named below) feels and thinks about different things. Next to each statement there are five columns: *Very Wrong, Wrong, Don't Know/Not Sure, Right* and *Very Right*. Please think about each statement and then put a tick in the column, which, according to your knowledge of the child, best describes how *you think the statement fits the child.* Please note that your independent assessment of the child is required, not a guess as to how you think the child would respond to the statement (Lang & Tisher, 2004: 14).

Jane and Mark seem reassured by the structure of the task; they are the experts about Tom and are eager to give the therapist further information. They appear relieved that other children have depressed feelings and that perhaps Tom is not alone in his sadness. Similarly, they may be heartened that they, as parents of a depressed child, are not alone. Mark might express some consternation, saying things like, 'I wish someone had thought of this when I was a child' or 'Now I realise that I was depressed as a child', 'My dad never had time to think about my feelings'. Every so often, while completing the questionnaires, Jane or Mark may ask each other 'What did you tick for this question?' Thus a conversation about Tom's depression is begun between Jane and Mark. There are likely to be questions which they respond to differently, for example, Jane might tick the question 'Most of the time he feels nobody understands him' as *Very wrong* while Mark might tick the same question as *Right* or *Very right*. There may be many questions which one or both parents tick as *Don't know/Not sure*.[3]

When they have completed the questionnaires, I might offer an opportunity for discussion between Jane and Mark about the process of filling out the questionnaire, and in particular about any questions they wish to discuss between themselves. One or both parents might state that they would like to discuss some of these questions with Tom. I might encourage them to do this and come back for a further consultation after they have had this opportunity, in order to talk about how they went, any issues that might have arisen, and to develop any further strategies or discussions.

Use of the CDS offers affirmation that having depressed feelings is a common experience for children. Having the items on a questionnaire normalises them. Asking parents to complete the questionnaire turns them into experts about the child, rather than what they might have been feeling, that they have failed because their child is depressed. Finally, and most importantly, parents are empowered to think about their child differently, and to begin to open up conversations with their child about feelings because the questionnaire offers a language for these feelings.

Another option that may arise at the end of this initial consultation is that Jane and Mark decide that they wish to discuss with Tom the consultation that they have had and invite him to see me at the next session.

Yet another option is that Mark and Jane might start to clash with one another, perhaps blaming each other for Tom's difficulties, or raising different issues that they have conflict about, such as money, their sexual relationship, or in-law problems. This might suggest that Tom's depression is reflecting parental discord. If this is happening, I might open up the question of whether Mark and Jane wish to work on their relationship in addition to, or instead of, engaging with Tom, even though Tom's behaviour or feelings are the presenting problems. This pattern has been described elsewhere (Campbell, 2003; Tonge, 1982). The use of the parents' questionnaire can elucidate differences between parents early on and such difference may reflect healthy difference in perspectives, at one end of the continuum, or significant resentment and hurt between the parents, at the other end.

The Second Consultation

Suppose that Jane and Mark have discussed the session with Tom and he has decided to attend on his own. Accordingly, Tom comes alone to the second consultation.

After developing rapport and clarifying Tom's perspective on what has been happening to him, I might invite Tom to post cards in boxes, to complete the CDS child form.

The instructions given to the child are as follows:

> I have been talking to many children and teenagers for a long time and they have told me how they feel and think about different things. Some of the important things they have told me have been written down and you will find them on these cards. I am interested in how you feel and think about different things and would like you to do the following: In front of you there are five boxes and they say *Very right, Right, Don't know/Not sure, Right* and *Very right*. I want you to take each card, read the sentence on the card and put it into the box that best describes how well you think the sentence fits for you. If you don't understand any of the sentences, please ask me to explain (Lang & Tisher, 2004: 13–14).

There are many messages on these cards about inner hurt, including having the experience of sadness and hopelessness, thoughts of failure and inadequacy, feelings of shame and guilt. There are also messages about the capacity to enjoy life. In posting the cards, Tom understands that other children feel like he does, that he is not alone in his hurt. He understands that he can confirm or deny the experiences in question and that it appears OK to have these feelings. There is a message that I am accepting of the feelings in question and that I respect Tom's information about his feelings, that is, I validate his experience and his right to share or not share the experience. Also, since his parents have undertaken a similar task and have encouraged him to attend, Tom may feel that his parents have sanctioned his responding to the items. Thus, many important messages are offered through the use of the structured CDS.

While posting the cards, Tom may ask 'Can I change where this card goes?' or may clarify meanings, 'Does this mean during the week or on weekends'. When he has finished, he may want to look back over some of the boxes to see what cards he posted in different boxes. He may be happy to leave them there or wish to post them in another box. He may talk further about some items and elaborate on the feelings concerned.

Having completed the CDS, Tom might be interested in talking about the items a little, asking about other children and how they respond. Tom might appear relieved and ask if he can do the posting again when he next comes. This is a very common response of children, as if the process of posting the items into boxes is a cathartic way of 'posting the feelings away'.

He is likely to have been told by his parents that they completed questionnaires also; he might ask

how they responded. This might offer the opportunity for some circular questions around the theme of 'Who in the family understands your feelings best?' 'How do you know when other family members are sad?'

I may offer three options for the next session: first, that Tom comes back alone for a further session; second, that Tom invites his brother and sister to come in with him or on their own; third, that Tom come in with his parents (with or without siblings).

I may also raise the question of how Tom is doing at school. If Tom were to indicate that he is having trouble at school, for example, that he does not like going to school and that he has no friends, I might ask whether his parents know how he feels about school. If not, I might ask Tom how he thinks they might react if he were to tell them. I might also ask whether he would be happy for me to make contact with his school and seek permission also from his parents.

The 2004 edition of the CDS provides a short (10-item) questionnaire for teachers. Completion of this form offers two benefits. It yields an indicator of the teacher's perception of the child's behaviour in the school setting, and it invites the teacher to think about the child in another way. For example, Tom's teacher might have seen his withdrawn behaviour as lazy and antisocial rather than as depressed. This can introduce a new language for Tom's behaviour in the classroom, a language that might offer Tom and the teacher/school a new way of relating, hopefully reducing any cycle which may be maintaining Tom's depression in the school environment.

Thus I may make contact with Tom's teacher and request that s/he complete the CDS Teachers' Questionnaire. The responses might shed additional light on the difficulties that Tom is having and may also open up new conversations between Tom and his teacher, Tom and his parents, his parents and the teacher, the teacher and myself.

The Third Consultation

Suppose that Tom elected to come in with his parents.

By the time of this session, it is likely that significant changes have taken place in the family. In particular, both Tom and his parents are likely to be less fearful about depression. They are likely to have conversed about Tom's feelings, and perhaps Mark has told Tom some of how he felt when he was a child, his feelings that no one had time or cared about his sadness, and that he wants to be a better parent. Tom's parents may have spoken about extended family members and how they responded to episodes of depression, and perhaps admitted to fear that what happened to some of those family members might also happen to Tom. Tom may have begun to share some of his distress, asking questions of his parents or talking about some of his issues at home, with his peers or at school.

Jane might use the session to ask Tom to clarify some of his responses to the CDS. A common example is Jane saying to Tom: 'I wasn't sure how to answer this one: "Most of the time he feels nobody understands him". Do you feel that nobody understands you?' Tom might respond by saying, 'Well yes, that is how I feel' or 'Sometimes I feel like that', or 'Dad understands me but you don't' or 'No, I feel understood – that is not my problem'. Whatever the direction of the communication, a language for Tom's depression has been opened up within the family.

I might use this opportunity to focus on the changes that have occurred, to spotlight the family's strengths, flexibility and resilience in identifying Tom's hurt and responding to it.

Overview of Therapeutic Intervention

The changes that have occurred in the family can be reviewed using a number of theoretical paradigms. In the first telephone conversation, I did not see Tom's depression as an illness, but rather as an expression of inner hurt. I saw Jane's sensitivity to Tom's changes in behaviour as a sign of open communication, care and concern, and her request for help as a sign of strength. I responded to Jane's request for help for Tom by affirming Jane and Mark's parenting role. I used a structured questionnaire to obtain information from them, clarify areas of agreement and disagreement between them about Tom's depression, and opened up the possibility of a new conversation within the family about Tom's and other family members' depression. These conversations took place as a prelude to Tom's coming on his own for a consultation, with a choice about attending or not. When Tom attended, he was invited to share his depression through a structured scale, which affirmed for him that he was not alone in having such feelings. His parents had presumably set the stage for conversation about depressive feelings and facilitated his sense of comfort.

In the composite case example above, I omitted siblings for simplicity of presentation. However, in my experience, involving siblings is an important part of the therapeutic process. It is very common that parents are focused only on the child they see to be the problem, the child whose behaviour is evoking attention. They will often say that the other children are okay. However, when

other children attend, and in particular when they also complete the CDS, they often express significant depressive feelings, comparable to the identified patient's, or even greater than his/hers. Again, this opens up fruitful opportunities for conversation. Parents as well as the identified patient can be quite surprised, and siblings can be relieved that they are heard. A normalising process occurs and new opportunities for conversation about depression emerge.

In order to open up the lines of communication and hear the hurt within the family, someone has to first be aware of the hurt. Then that person has to risk talking about the hurt to others in the family, hoping that others will hear the hurt and validate it, rather than reject it. As family members start talking about feeling low, their awareness of the experience changes. And as the awareness of the experience increases within the family, they have greater access to language to describe the experience. Depression needs to be talked about in a supportive environment. The hurt needs to be articulated and to be heard. Hearing the hurt can be as difficult, or perhaps more difficult, than communicating it.

Many factors conspire to block a family's awareness of depression, their ability to talk about it, and their receptiveness to hearing about it. These factors may include modelling from previous generations, absence of a language in which to describe negative feelings, fear of being overwhelmed by sadness and fear that talking about depression will make it worse. The conviction that one should suffer in silence can be quite strong, and the sense that feeling depressed is an indicator of failure may also be present.

Family therapy offers a way of understanding a child's depression in the context of family functioning. Creating an environment where the child's depression can be expressed and heard by family members requires therapists to introduce a vocabulary for these experiences, often in families where such a vocabulary does not exist or exists only minimally. The Children's Depression Scale offers a structured way of introducing that vocabulary and then assisting family members to use it, opening up a new conversation about the child's (and possibly other family members') depression.

Endnotes

1 From 1970, the clinic adopted a family therapy approach, where a single clinician saw all members of the family.

2 Although the six subscales offered clinically relevant information, there was insufficient evidence from factor analysis to substantiate their continued use (Lang & Tisher, 2004).

3 Different patterns of perception and reporting of depression (and stress) between parents and children have been studied. For example, a study comparing the relationship between depression in prepubertal children and depression in their parents showed that depressed children and their mothers reported higher levels of depression and stress than other children and their mothers, while there were no differences between scores of fathers of depressed children and other fathers (Tisher, 1992; Tisher, Tonge and de L Horne, 1994). More recently, Tan & Rey (2005) also reported different reporting patterns between mothers and fathers of depressed children.

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