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NARRATIVE THERAPY IN CHILDHOOD DEPRESSION

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Abstract

Childhood is a critical period of well-being and development of mental health problems. The aim of the present study is to investigate the usefulness of narrative therapy in cases of childhood depression at the level of a literature review. More specifically, it attempts to highlight the potential and effectiveness of narrative therapy and its role in reducing depressive mood, developing and improving self-esteem and self-image and enhancing feelings of optimism. According to narrative therapy, children try to understand personal experience through storytelling in order to rewrite their story, acknowledging and revising any internal and external limitations. Within this re-narration of the facts and facts of mental life, children with depression manage and can cope successfully within this reflective action by facing the impossibility of depressive symptoms.

Key words: Childhood depression, narrative therapy

1. Introduction

Depression in childhood is an emotion disorder, which until a few decades ago was not understood by the scientific world, as children were considered developmentally immature to experience a depressive disorder, while the abrupt changes in mood and prolonged periods of sadness in adolescents were perceived as the main characteristics of adolescence. Through the developmental studies that followed, this picture has changed decisively, and no one can now dispute this reality, namely that childhood depression is a serious emotional disorder with several undesirable effects on the child's life.

According to Garaigordobil et. al. (2019), when referring to childhood and adolescent depression, one should take seriously that in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSMV), depression is considered a disorder of adult life with only a brief reference to childhood depression, where sadness is replaced by irritability in specific cases. Based on the DSM-V classification system, the basic criteria for the diagnosis of depression are inability to enjoy pleasure (anhedonia), problems with appetite (weight gain or loss), insomnia or hypersomnia, psychomotor agitation or slowing, feelings of fatigue, feelings of worthlessness, excessive guilt, reduced ability to concentrate and thoughts of death. Five or more of the above symptoms must be noticed within a period of two consecutive weeks to make a diagnosis of depression, and at least one of these symptoms must be depressed mood or anhedonia (APA, 2013). There is often difficulty in diagnosing childhood depression since children may not be able to fully understand their symptoms and therefore information from a variety of sources must be provided. In addition, many symptoms may be linked to disorders such as ADHD, learning difficulties or even attachment disorder. Information about the child's daily functioning or mood changes may be disclosed either by parents, caregivers, or even teachers. In addition, there are weighted scales such as the Children's Depression Rating Scale-Revised (CDRS-R) and the Children's Depression Inventory that can be administered by clinicians for a more reliable diagnosis (Carr, 2006).

Mullen (2019) argues that usually in children between 3-8 years of age depression presents with masked symptoms. They often complain of physical pain, are more irritable, show fewer signs of depression, have anxiety and behavioural problems. As they progress into adolescence and adulthood, the symptomatology more closely matches that described in the DSM-V. There is also less hypersomnia and more fluctuations in weight and appetite than in adults. The clinical symptoms of childhood depression are age-related, and more specifically, at the ages 3 to 5, difficulties in expressing emotions, reduced desire to play, suicidal thoughts and feelings of worthlessness are reported. At the age of 6 to 8 years difficulty in expressing emotions, increased physical pain, crying outbursts, shouting, unexplained irritability, observed anhedonia may be observed. In children aged 9 to 12 years, low self-confidence, hopelessness, feelings of flight and fear of death are observed. Finally, at ages 13 to 18, symptoms of increased irritability, impulsivity and behavioural changes such as low school performance, sleep and appetite disturbance and suicidality similar to adults (Cummings, Caporino & Kendall, 2014).

2. Prevalence and differential diagnosis of depression in children

Depression in childhood is not a rare disorder. Epidemiological studies vary depending on the assessment tools and methods used. Depression is more common in adolescents than in pre-adolescence, with higher rates found in adolescent girls, while in pre-adolescence boys have higher rates of depression. Major Depressive Disorder occurs at a rate of less than 1% in preschool children, 2% - 8% in school-aged children (6 -12 years) and 5% - 6% in adolescents (13 -18 years) (Kerig et. Al., 2012). Girls have 1.5 to 3 times higher rates of depression than boys by early adolescence (APA, 2013). The World Health Organization on the prevalence of childhood depression in the general population, states that 2% to 4% of children suffer from depression. This percentage increases with age, reaching about 13% for children as young as 10 years of age and about 20% - 30% for people in late adolescence and post-adolescence. It is also estimated that about 1 in 5 children referred to child psychiatric departments have depressive symptoms (Bernaras, 2019).

Clinical studies on depression in young people confirm that this emotional disorder is often a chronic and recurrent condition and although most episodes resolve within a year, there is a high risk of recurrence of depression, and 50-70% of cases may experience at least one more episode within five years (Dunn & Goodyer, 2006). In terms of gender differences, as noted above, these are not significant in childhood, unlike in adolescence, where rates are higher in girls than boys and are similar to rates of depression in adults. This difference is even observed between discrete epidemiological and clinical samples in different evaluation methods. Therefore, it is likely to be due to help-seeking, but may also be more closely associated with hormonal changes in girls (Hyde et al., 2008).

In terms of differential diagnosis of the disorder, childhood depression often presents some common symptoms and coexists with a variety of other psychological disorders, leading to diagnostic errors and possibly the prescription of inappropriate treatment. This means that childhood depression is often characterised by comorbidity. The literature related to the differential diagnosis of childhood depression takes particular care to examine the similarities and differences between depression and co-occurring disorders such as anxiety disorders, conduct disorders and attention deficit/hyperactivity disorder (Allen-Meares, 2003).
In studies conducted among school-aged children (Hazel et al., 2000), approximately two-thirds of children with depression were found to have at least one other psychiatric disorder, while a proportion of over 10% were found to have two or more co-occurring psychiatric disorders. Overlap with other psychiatric disorders, such as Attention Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), are common co-occurring disorders, as are other emotional disorders and anxiety disorders. In preschool samples, comorbidity rates are even higher, and three out of four depressed preschool children reported having other psychological disorders The comorbidity of depression and Attention Deficit/Hyperactivity Disorder (ADHD) is the most common in children with depression, with Oppositional Defiant Disorder (ODD), Conduct Disorder and anxiety disorders following, with substance use disorders, enuresis/attention-deficit disorder and separation anxiety disorder.

3. Causes and treatment

Understanding the pathogenesis of childhood depression is a challenging task as environmental and genetic factors are involved in its development. Although there are some assessments as well as diagnostic criteria, the clinical manifestations of depression have a wide range, making its diagnosis a huge challenge. Besides, there can be a misdiagnosis, given its co-existence with other disorders, making it necessary to develop individual diagnoses. Childhood depression can be the result of a variety of factors. Physical health is an indicator of good or poor mental health.

Children with chronic or serious medical conditions, as well as children with an increased body mass index, are more likely to experience depression. Another factor is stressful events, such as sudden changes in different areas of a child's life, which can increase the risk of depression. The family environment is an important component of a child's mental health, as a chaotic, stressful or abusive home life can put a child at greater risk for a depressive disorder. Finally, children who have family members with mood disorders are more likely to develop depression at a young age (Nelson, Barnard & Cain, 2003).

A large body of studies in both adults and adolescents and school- and preschool-aged children demonstrate the fact that a family history of depression, as well as exposure to stressful life events, are the strongest risk factors for depression. The incidence of depression is three to four times higher in children of depressed parents (Kountouras, 2020). Hereditary factors are partly responsible for these effects, although genome-wide association studies have not yet identified clear gene variants associated with depression. This may be because genes associated with depressive disorder operate in more complex ways that cannot yet be understood, or because the best possible genetic research strategies have not been used (Thapar et al., 2012). Adverse experiences in childhood, in particular, are risk factors for depressive disorder.

Psychosocial factors play an important role in the development of depression in children with several studies suggesting that this risk is increased in environments where the mother has experienced depression (Tully, et al., 2008), which increases anxiety in both children and parents, who become more distant with negative attitudes and behaviours. It is important to note that child abuse (physical/emotional) and neglect, bullying and maltreatment are associated with an increased risk of depression in both childhood and adulthood (Infurna et al., 2015). The aforementioned family behaviours reinforce feelings of hopelessness in their members increasing the chance of depression in children.

Treatment options for children with depression are similar to those for adults. They include psychotherapy and medication. The clinician may suggest psychotherapy first and then consider antidepressant medication as an additional option if symptoms are severe or if there is no significant improvement with psychotherapy alone. Several studies report that a combination of psychotherapy and medication is the most effective method for successfully treating childhood depression (Taylor, 2011).

The American Academy of Child and Adolescent Psychiatry states that psychotherapy is a component of treatment for childhood depression with a particular emphasis on cognitive and interpersonal therapy (CBT), which, as it says, has been shown to be quite effective in treating childhood depression. CBT usually consists of behavioural activation techniques and methods to increase coping skills, improve communication and peer relationships, and combat negative thought patterns and emotion regulation (David-Ferdon & Kaslow, 2008).

In contrast, interpersonal therapy generally focuses on adjustment, change, personal roles and the formation of interpersonal relationships (Weisz, McCarty & Valeri, 2006). It is important that the treatment regimens chosen be appropriate to the child's developmental level, difficulties encountered, degree of cooperation with the family, and more. In any case, alongside any form of therapeutic intervention, it is important to support the family in psychoeducation to answer questions and provide guidance on attitudes and how members can be close to the child (Lopes et al., 2014).

4. Talking about narrative therapy

Narrative therapy was originally developed by White & Epston (1990), during the period 1970-1980, with the basic consideration that through the stories told by subjects during therapy, they express the meaning they attach to the interpretation of their life experiences (Nylund & Nylund, 2003). Their problems are objectified and separated so that they do not see themselves as a problem but as something separate from the problem and once this happens, the individual has the opportunity for a change (White & Epson, 1990). In a respectful and non-judgmental way, narrative therapy argues that people are experts in their own lives therefore they have the appropriate skills and ability to reduce the impact of problems in their lives (Carey & Russell, 2004). Furthermore, narrative therapy has the basic idea that all people are born into stories and these stories shape their social reality (Combs & Freedman, 2004) and that a person's culture influences and acts as a therapeutic mechanism. Parry & Doan (1994) consider Freud to be the first narrative therapist, as it was he who began listening to his analysands' stories when they described their experiences, which were usually provided through the words of their parents.

According to the theory of structuralism, which was the basis for the development of narrative therapy, one cannot know the truth unless one reaches beneath the surface, into latent reality. Therapists who apply structuralist thinking are led to therapeutic practices such as observation, analysis, comparison, evaluation, diagnosis, and also counseling and education (Young, 2008). According to Abels & Abels (2001), narrative therapy, with its emergence in the constructivist movement, helped to deconstruct privileged approaches to help, as it minimized the role of the therapist as an expert, since it recognized that no matter how aware the therapist is, he or she cannot know exactly the meaning of the problem for the client.

From the perspective of narrative therapy, when people consult therapists they tell stories. In doing so, they connect events and everyday life experiences into sequences that unfold through time according to a theme or meaning influenced by the larger cultural context. People perceive their stories as 'absolutely' true and unchanging and so over time and repetition these stories become reality for those who created them. These stories have the effect of influencing the clients' sense of identity and the options available to them in solving their problems. The process of identifying one's identity through storytelling is the first step in escaping from the oppression and control of one's problems (Duvall & Berres, 2011).

The role of the therapist in the application of narrative therapy is that of a partner and active mediator. During narrative therapy, the therapist listens to the stories of his/her clients and his/her main task is to help them construct a different story. Similarly, the role of the therapist is crucial since he and only he is seen as the only "expert" in his life. Narrative therapists treat the session as a conversation, a conversation designed to help the therapist. This means that as few questions as possible are asked during the first session. The language used by therapists is of great importance. For example, the therapist might say that "depression has invaded your life" rather than "you are depressed" or that "you have been affected by anxiety" rather than "you are anxious" (Payne, 2015). The therapist then uses various therapeutic tools such as mapping, externalizing the problem, and others to try to free the person from resistance, fears, and various other personal difficulties to create a sense of release from their problems without the fear of losing a sense of personal control. This results in the therapist drawing on the narration of the stories, remembering ways in which he/she has successfully dealt with his problems in the past, focusing on his/her ability to cope with difficulties on his own. The relationship that is formed during narrative therapy between the therapist and the person is an equal relationship, without roles of omnipotence, authority or imposition. In this therapeutic endeavor the relationship between the two is active and collaborative with the main concern being to bring out the strengths of the person in therapy through a powerful look into the future (Slasberg & Beresford, 2017).

Narrative therapy focuses on how the process of storytelling affects the organisation of the individual's experience, knowledge and behaviour. Problems emerge as autobiographical narratives but are limited to the difficult parts rather than the opportunities that arise through them. The therapist engages the client in the process of rewriting these narratives through three phases. The deconstruction phase, where the central aim is to understand the problem in its context, circumstances, effects and influence on the person's life, in an attempt to separate the problem from the person, mainly through externalization. Once an individual perceives the problem as something separate from his or her own identity, then the conditions for a change are created. This change may mean either modifying the individual's behaviour, or resisting or negotiating one's relationship with the problem.

In the second phase, that of rewriting, the aim is to extend the narrative treatment to experiences that do not fall within the problematic narrative and that gradually create a different biographical narrative. These new narrative elements, called unique effects, are explored and contribute to a reassessment of the therapist's story and significant others in his or her life.

In the third and final phase of the treatment, that of termination, the goal is to integrate the alternative autobiographical narrative and adapt it to the network of sociocultural discourses and practices. White and Epston extended the framework of the theory by allowing individuals to include their cultural, social and political experiences, thus making sense of change beyond the self and within these broader contexts (Etchison & Kleist, 2000; Saltzburg, 2007).

5. Narrative therapy and children with depression

Stories have the power to reconstruct and transfer experiences, but most importantly of all, through them, and especially through the stories one tells about oneself, one can shape oneself. Every story a child tells is a portrait of the self, it is a medium through which the child can look at it, change it, refer to it and think about it in different ways.

However, the same portrait can also be used by others to better understand the child telling the story. Storytelling is a way for the child to gain the control and power that is missing in their life and gain empathy for the characters they include in their narrative. In this context, the narrative therapist collaborates and constructs with the child various stories drawn from the child's thoughts and daily life (Cattanach, 2008).
It is often difficult for the child to say how they feel about an adult who has harmed them because it is likely that other influential adults such as a parent, teacher etc. may express a different opinion about whether or not this event happened or whether it is the product of a misperception. But when the child's story is heard and acknowledged, the child is empowered. If the child and therapist co-create a narrative through the therapeutic relationship, then the child can "use" the therapist to be heard and discover alternative stories within a safe therapeutic context. It is often observed that children have low, possibly, motivation for therapy and so creating a therapeutic relationship can prove to be a difficult task. And although not all theoretical models of intervention emphasize the creation of a strong therapeutic relationship, the cooperation and motivation of the patient to participate in the therapeutic process is essential. The therapist and the child build a relationship so that the child can develop a personal and social identity, seeking stories to tell about themselves and the world.

The therapist draws information about each child through his or her needs, conflicts and stressors in life and then begins to create stories in which the heroes have the same problems as each child. The story is designed so that the hero finds new ways to overcome their problems (Rahmania & Moheba, 2010).

Narrative therapy provides children with the opportunity to develop their skills and be ready for any change needed to manage their problem in a constructive way.

Current scientific knowledge states that storytelling requires certain skills that are not fully developed in early childhood. Autobiographical memory develops over time. Infants and young children process and retain information, but events that occur before the age of two or three years cannot be recalled through narrative. Some traumatic events can be recalled in memory even in early childhood and some memories may be extremely accurate. Research has shown that very young children aged 2-5 years, who cannot express narratives coherently, can recall some memories in fragments, which are nevertheless accurate and correct even when the traumatic events occurred some time ago. Also, misperceptions and memory loss were observed in histories with incidents of violence. However, treatment with memory restoration techniques involving discussion of the traumatic event and its aftermath appeared to improve memory in older children (Schauer et al., 2004).

Jalali et al. (2019), stresses that although depression and anxiety in childhood are seen as two different disorders, there is often comorbidity. That is, quite often depression in children and adolescents is accompanied by severe symptoms of anxiety. Children cannot express their feelings accurately because their ability to abstract thinking is not fully developed. Thus, by having difficulty expressing their emotions and repressing them, they put their mental health at risk. Therapies such as play therapy help the child to express themselves through different means (Bratton et al., 2005). Narrative therapy for children is a type of therapy using play. Narrative therapy does not directly aim to reduce symptoms, but instead, it focuses on changing the child suffering from depression in relation to the problem and enables them to change dominant narratives about themselves and their problem. Thus, the main goal of narrative therapy for the child with depression is for the child with depression to experience a general sense of closeness to themselves and to the problem (Combs & Freedman, 2012)

Narrative therapy, therefore, helps children with depression as it highlights some of the alternative stories that are also present in their lives. These are what are referred to in narrative therapy as preferred or alternative stories and involve events, moments, thoughts, intentions, which contrast with the dominant narratives that the child adopts about their life as they are outside the domain of the problematic story (Beaudoin, 2005). Through the rearticulation of these stories, the child (perhaps for the first time) recognizes the skills and abilities he or she has already used in the past to solve difficulties, which he or she has either forgotten or overlooked because of the dominance of problems in his or her life. So by discovering these stories with the help of the specialist, they are reinterpreted and in this way a promising outlook for the future is created for the child with depression, a future that provides satisfaction, hope and strength. Narrative therapists working with children with depression ground their work in social constructivist and meta-structural theory and are challenged to highlight how the power of stories shapes people's identities and ultimately their own lives.

Since children often need more help to process their experiences, narrative therapy makes use of life-line exercise when appropriate (Schauer et al., 2004). A rope is used to represent the child's life-line. Also, flowers are used to mark positive experiences along the rope, while stones are used to mark negative and traumatic experiences. Children recreate their life line and make a drawing of it. They are encouraged to name the events for which they place an object (flower or stone), for example "when we had to leave home", or "death of uncle" and the therapist writes the title. In subsequent sessions the therapist can use the drawing for explanatory purposes. At the end of the session, children are encouraged to unwind some of the unused part of the rope and discuss their future fears and hopes.

One approach for children in the context of narrative therapy is "The Tree of Life". The concept of the tree of life is very simple, as it is a visual metaphor in which a tree represents the child's life and the elements that make up the tree are the past, present and future. By pointing out these parts, the child not only begins to discover (or rediscover) aspects of themselves that were shaped by the past, but can begin to actively cultivate their tree so that it reflects the kind of person they want to become, changing attitudes, beliefs and values that are dysfunctional in their lives as well. The stories of the child's life are the events that the child chooses to highlight, discovering alternative paths from his or her past, which in turn create new horizons in his or her future (Jacobs, 2018).

Lock (2016) in her study of narrative approaches focuses on the Tree of Life, which is ultimately used as a narrative tool created to help vulnerable children to rewrite their life story, as discussed above. The Tree of Life uses metaphors and questions that encourage them to tell stories that empower them, but also to hear stories of hope and strength. This intervention uses principles from solution-finding-based therapeutic approaches and principles that go back to narrative therapy, such as the client being the sole expert on their life, identifying their strengths.

The key features of the Tree of Life have been adapted to incorporate narrative therapy approaches. The therapy consists of four parts. In the first part, the therapist asks the child/children to draw a tree. In this the roots symbolize the child/children's origin, family, ancestors and culture. The trunk represents skills and memories, the leaves represent wishes, wishes and dreams for the future and the important people in their lives, and finally the fruits symbolize gifts from significant others. At the same time as drawing, the child is invited to discuss all of the above and talk about their difficult experiences, but also to retell their story through a new perspective, as during the narrative an effort is made to bring out all the strengths, overcome obstacles and the narrative ends up with a hopeful story. In the second part, the forest of life is presented, where a discussion takes place about the children's other trees, comparisons are made where the trees are similar and the narratives converge. In the third part, called «when the storm comes," the metaphor of the tree facing storms and dangers is presented and analyzed in a parable about the difficulties the children face in their own lives. The fourth and final part is that of closure.

Research demonstrates that the Tree of Life is an effective psychosocial approach in cases of childhood depression, as it can be an effective tool to help children and inform and support the people who are related to them and their problem. Furthermore, research shows that in addition to the positive effects it has with children, it can also be used with those who are difficult to reach, as it helps to create a safe place to manage feelings and experiences, to feel valued and that one is respected and understood. In addition, the Tree of Life is a flexible psychosocial narrative approach for children and young people, as it can be used both as an assessment tool and as an intervention strategy. Finally, due to the diversity of modern societies, people and especially children, deserve an opportunity to create their preferred autobiographical narratives and gain the capacity for reflection to create meaning and their own identity as well (Lock, 2016).

Several studies show encouraging results regarding the application of narrative therapy in children with depression. Some studies focus on the main phases of the treatment and more specifically, externalizing the problem, assessment by the therapist and rewriting the story. In relation to all of these, the treatment was shown to be effective in reducing symptoms of depression, delinquency, improving body image perception and general psychological recovery in children with depression. Other studies have reported the benefits of treatment for depressed adolescents with depression who are substance abusers and their families, alcoholics, and improvement in aggressive behaviors (Hammer et al., 2012). In these studies it was shown that individual as well as group narrative therapy reduced the level of depression and anxiety in children and in most cases improved their quality of life.

A study by Jalali et al. (2019) reflected the effectiveness of narrative group therapy, in reducing depression and anxiety in children with incarcerated parents. Eighty-five children with incarcerated parents were selected and randomly assigned to the experimental and control groups. The experimental group attended narrative group therapy, while the control group did not. Findings showed that children who participated in narrative therapy groups had significant reductions in anxiety and depression. These interventions focused on many areas of children's lives that are associated with the onset of depression and other mental health problems. In particular, the focus on developing communication and empathy skills significantly enhanced the children's self-esteem levels which was instrumental in reducing their anxiety about the future. Furthermore, the children were able to cope with everyday problems by thinking of new solutions. Still, they learned ways to manage their anger. Finally, these children were able to recognize the emotions of the protagonists who took part in each story and identified with the characters who faced problems similar to their own, which in resulted reducing depressive feelings. It seems that in research by Schauer, Neuner, Elbert (2011) a narrative therapy is also quite effective in improving self-confidence, school performance and adaptation to new environments in children who are experiencing depressive feelings.

6. Discussion

Narrative therapy is a worldview and a way of life. People who are attracted to narrative modes of therapeutic work tend to be more interested in meaning than in facts, more interested in complexity and multiple possibilities than in standardization and uniformity. Narratives organize human experience by integrating it into a coherent and continuous story-like structure. An illness can pose a serious threat to a person; it can dramatically change the ways in which they perceive themselves, their illness and the world around them. This is where we encounter childhood depression, which is a growing global disorder affecting children. Due to children's difficulty in expressing their feelings, often the problem of depression at these ages is overlooked and no attempt is made to provide therapeutic intervention. In cases where help is sought, one can choose between several therapeutic interventions and follow the one that suits best. One of these is narrative therapy, which separates the individual from his or her problem. Through narrative therapy, people redefine meaning in dysfunctional stories, which helps form a new identity for them. The application of narrative therapy in cases of children with depression is increasingly being used. This is because it does not seek to transform the child through therapy, but aims to transform the effects of the problem that has led to the onset of depression. According to various studies, narrative therapy is quite effective and is often chosen for cases of childhood depression (Weber et al., 2006).

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