

## Tavistock and Portman E-Prints Online

### JOURNAL ARTICLE

**Original citation:**

Pentecost, David and McNab, Sue (2007) [Keeping company with hope and despair. Family therapists' reflections and experience of working with childhood depression.](#) Journal of Family Therapy, 29 (4). pp. 403-419. ISSN 0163-4445

© 2007 David Pentecost

This version available at: <http://taviporttest.da.ulcc.ac.uk/>

Available in Tavistock and Portman E-Prints Online: Oct 2009

The Trust has developed the Repository so that users may access the clinical, academic and research work of the Trust.

Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in Tavistock and Portman E-Prints Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain. You may freely distribute the URL (<http://taviporttest.da.ulcc.ac.uk/>) of Tavistock and Portman E-Prints Online.

This document is the published version of '*Keeping company with hope and despair. Family therapists' reflections and experience of working with childhood depression*'. It is freely available online. You are encouraged to consult the remainder of this publication if you wish to cite from it.

## **Keeping company with hope and despair: family therapists' reflections and experience of working with childhood depression**

David Pentecost<sup>a</sup> and Sue McNab<sup>b</sup>

The BIOMED international outcome study on childhood depression offered a unique opportunity for the systematic treatment of children and families with major depression using systemic psychotherapy. This paper describes the experiences of clinicians working with the families referred and the theoretical and clinical models that evolved during the treatment process. The concept of 'keeping company with hope and despair' emerged as an overarching framework for thinking about the quality of the therapeutic relationship in this developing area of clinical practice. We illustrate our systemically informed interventions with case examples and discuss the role played by therapists' 'use of self' in engaging and fostering change in families gripped by depression.

### **Introduction**

Our recent contribution to the development of research and clinical practice in the area of childhood depression (Campbell *et al.*, 2005) led to conversations between us about the importance of a therapist's experience when working in this clinical area. This article is about what is demanded of systemic psychotherapists embarking on family work where a child has been diagnosed with depression. It speaks to the emotions we experienced both during and after family sessions and what sense we have made of these in order to work effectively. A systematic approach to clinical discussion among clinicians proved to be the key to theory building and the interventions described. This paper demonstrates what happens when clinicians talk and think together about what they do. Its conclusions about working with childhood depression have emerged from reflecting on the emotive experience of the therapist during the therapeutic encounter. We do

---

<sup>a</sup> Consultant Systemic Psychotherapist, Islington PCT – CAMHS, 580 Holloway Road, Islington, London N7 6LB. E-mail: David.Pentecost@islingtonpct.nhs.uk.

<sup>b</sup> Systemic Psychotherapist, Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust, Warneford Hospital, Oxford OX3 7JX. E-mail: Sue.McNab@abmh.nhs.uk.

not claim to be 'experts' on childhood depression. Instead we take this opportunity to open up a dialogue with our professional colleagues about clinical practice in a relatively unexplored area for the systemic field.

### **Background to our involvement with childhood depression**

Our participation in the BIOMED outcome study based in three European cities forms the basis of our involvement in working with families where a child has been identified as depressed. This study followed a comparative design comparing family treatment with child psychotherapy and parallel parent work with children who meet the diagnostic criteria for clinical depression. The design of the study required the creation of two treatment teams – one treating whole families, the other meeting individual children with separate work with parents – in each participating city. The London family therapy team, of which we were part, consisted of four therapists working in pairs, co-working together in the room or via a one-way screen. The clinical work of the team was supervised at monthly review meetings where video tape was shown and clinical discussion took place and, on occasion, by live supervision behind the one-way screen. Between us our team met with twelve families who were seen for a maximum of fourteen sessions at regular intervals. Some of the working practices, such as the fourteen-session requirement and joint work, were set out by the protocols of the research project. However, the frequency of meetings, the development and detailed direction that the work took and the development of interventions grew out of our thinking together both as colleagues and as part of the wider supervision team.

The preoccupations of the wider research project were, in truth, fascinating but remote. Our concerns overlapped in respect to identifying evidence of the effectiveness of our work. However, while our research colleagues struggled with questionnaire completion and data gathering, we wrestled with the task of seeing families and creating a context for change within a time limit. As such we became preoccupied with a number of practice issues including how we, as therapists, work systemically when the problem has already been named as depression and devising the most effective way to intervene systemically. We also wondered what the effect of such work would be on us as therapists and how our own 'depression stories' may play their part in the therapeutic process.

### **Some thoughts about depictions of childhood depression**

Before presenting our experience in detail we want to share our responses as systemic practitioners to working within the 'childhood depression' frame.

The term 'Depression', it seems to us, carries the potential of bringing idiomatic experiences of sadness, malaise and melancholia into a medicalized domain. Angold (1993) and Carroll (1984) have highlighted the ill-defined nature and classification of the disorder within existing medical discourses. From the first we felt uneasy conceptualizing and hypothesizing around a label that seemed destined to conflict with other ideas we hold. Ideas like the 'taken for grantedness' of labels and the ability of medical discourses to marginalize the 'local' knowledge of patients and to medicalize people's experiences. Seifer *et al.* (1989) and Nurcombe *et al.* (1998) have highlighted the questionable epistemology surrounding the aetiology and DSM IV classifications of depression. In line with their concerns we were dubious about the usefulness of 'illness' constructions, particularly in psychologically oriented treatment domains. Illness constructions often depersonalize and categorize people's experience – i.e. into moderate, mild, chronic depression, anadonia and so on – in ways that we do not find clinically fruitful.

Notwithstanding the reservations detailed above, we assume a multi-systems perspective in our work which tries to take account of the biological, medical and psychosocial components of depression. From biology we pay attention to the influence of a child's temperament, their genetic disposition and potential for resilience or vulnerability. On the medical front we try to temper our concerns over the ethics and safety of pharmacological interventions with the knowledge that for many adults, at least, medication has often proved to be a lifeline in managing their difficulties. When it comes to depression in children, we note the relative powerlessness of children to have their voices heard. Within their family context, children often wield little power in relation to marital violence, family separations and continuing contact with an out-of-house parent. They have little say about decisions around immigration and perhaps are uncertain how to manage depression or other mental or physical health problems in other family members. Powerlessness and hopelessness are connected.

Finally we are committed to a relational approach to understanding childhood sadness. Depression gains a foothold in families over time

through external events such as loss, bereavement, trauma, abuse, war and conflict, and family separation. As a result, despair, hopelessness and a dread of the future can get into the grain of family life – the monotony of greyness. We are convinced that the families we see carry stories generated over time and generations which can lead to two, three or more members of the family becoming preoccupied by loss and hopelessness. We think depression is both ‘individual’ and ‘interactional’. It is influenced by and in turn influences the complex network of interactions that make up family life. The child may be one of a number of family members who are in the grip of ‘depression’. We often wonder if children present themselves or their families for help when the children feel the odds against change are stacked too high.

### **Exploring the therapeutic experience of working with childhood depression**

We have conceptualized three major and interweaving themes that presented themselves time after time in our therapeutic work:

- Striking the balance between action and reflection;
- Bearing witness to emotional pain;
- Keeping hope alive.

In the sections that follow we will explore each of these themes in detail. We want to show how the links between the presenting difficulties, the experience of the therapeutic relationship and the process of reflection as a team led us towards these themes. Case material will be used as illustrations.

#### *Striking the balance between action and reflection*

In our experience depression in children manifests itself in diverse and often surprising ways. We did not always encounter the sad face of depression among the young people whom we met. Many of the children we saw were angry, aggressive, defiant and impulsive and parents often cited conduct problems as the major factor in their seeking help.

Working with distressed and troubled children bears a close similarity to working with other life-and-death issues, such as anorexia nervosa, where the symptom itself cries out for attention and respect. In some families children had actively self-harmed by overdose or

were risking their safety through not eating or dangerous antisocial behaviours. We suspected these were driven by emotional pain but we noticed that parents often presented these worries as ‘complaints’ about their child’s behaviour expressed in a particularly static, monotonous and repetitive way. Parents either felt powerless to help lift their children out of the mire, or seemed caught in cycles of blame and criticism. We found a preoccupation with personal loss and a quality of negativism in parental communication. These factors, together with a general unwillingness to take ‘action’ around safety issues, frequently made a subtle contribution to the escalation of risk.

*Reena is a 14-year-old Asian girl who had spent the past few months in her darkened room refusing to go to school due to the spots on her face. She had taken a number of serious paracetamol overdoses prior to our work starting. The drama of the family’s life over the past few years was spread before the therapists in the first meeting. Reena’s older brother had died of a brain tumour six years previously – a death his father felt responsible for as he had dealt his son blows to the head when he failed in his academic work. Reena’s parents, Sujit and Ravinda, had entered into an arranged marriage and felt locked in a relationship dominated by conflict from which they could see no escape. They both talked of being depressed and Sujit had just completed treatment for leukaemia. Furthermore one of their nephews, aged 19, had tragically hanged himself a year earlier. In our initial sessions we wanted to communicate a strong message that therapy was a place where these emotional issues could be explored and given voice. However, each new session with the family seemed to be an occasion for further revelation of family tragedy that grabbed our attention. Between us we began to recognize a tension in what we were each holding on to: the interviewing therapist was creating opportunities to open up exploration about the family’s trauma while the observing therapist was very concerned about the ongoing risk of self-harm to Reena. This difference in focus between the therapists revealed that as a therapeutic system there was a need to find the balance between the wish to explore meaning and the need to move to action.*

*We met with Sujit and Ravinda to address how they (not us) could keep the risk to Reena in mind. They took time in the session to speak about the pattern of violence from husband to wife. Deep emotions such as pain, shame, grief, disappointment and fear were alive in the room. Our challenge again was holding open a space to address the conflicts in the marriage while keeping a watchful eye on risk factors for Reena. Our growing hypothesis centred on seeing the function of Reena’s depression as bringing an end to the violence in the marriage. In therapy we sought on the one hand to cling to the emotional intensity of this new information but at the same time to maintain a focus on*

themes of 'danger' and 'responsibility'. When the point came to confront the couple about their need to find their own structured steps to safeguard the safety of their daughter – through actively monitoring Reena's risky behaviour, increasing their vigilance and stopping the couple violence – we were struck by their apparent readiness to take on board what they needed to do. On reflection we believe that the parents' growing realization that therapy is an accepting emotional space for both them as well as their child made them more able to listen to our more strident message about the need to act. Of course breaking off from the emotionally charged couple material to confront risk posed numerous dilemmas for the therapists. Were we sufficiently in tune with the cross-cultural nature of this work? Was the interventive style of our questioning sensitive enough to the highly emotional state of these family members? Was the balance between reflection and action good enough? There were moments when as therapists we feared that becoming directive ran the risk of losing the family – by this point we were pushing the parents to actively consider the possibility of an inpatient admission for Reena. However, we found that raising the stakes in this way actually allowed the parents the chance to find their own solution. Far from ending therapy the couple returned to the next session explaining that they had now invited a counsellor from their own culture to help them with their relationship, explaining to us that while they could allow us to work with their daughter, discussing their own marital difficulties with people from another culture had been too shameful. Shame was a very potent emotion for the whole family. Reena, who had refused to speak and had kept her hands over her face throughout so many sessions, later revealed that it had been shame of the violence in her family as much as 'spots' that meant she had literally not been able to show her face in public.

So what do experiences like this tell us about the effect of depression on family and therapist functioning? We think 'depressed' children may protect the emotional needs of a vulnerable and depressed parent by abandoning attempts to get connected to them (the parents) and instead recruit into the parenting relationship a wider professional system, whose job it becomes – through fear for the child's safety – to strike a balance between the quest for meaning and the need for action.

Byng-Hall (1999) talks of the need to provide a secure therapeutic base by being willing and able to address the most worrying concerns either of the family, or of the therapeutic system early on in the work. This may mean suspending exploration of meanings initially in sessions in favour of a more structured approach to minimize risk. It may also mean having to hold back on our own urge to 'explore'

change – as in Reena’s case – so that time is given to forming this ‘secure base’ from which therapists can impel the parents’ attention to high levels of risk and boost the executive functioning of the parents so that they act on plans for safety strategies. Of course the desire to ‘take charge’ of risk also deserves to be unpacked. As a therapy team we always became more curious about those times, when we became increasingly wedded to a predominantly ‘risk management’ stance in the work. One hypothesis we shared was that risky situations and the contagious power of depression can invite us to be more ‘directive’ in our approach.

The timing of our move from reflection/exploration to action may also be an attempt to counteract our and the family’s despair, so that we are being propelled into becoming more directive and authoritative, as if we (not the parents, grandparents) are the ones able to throw out a lifeline that will pull the families and ourselves out of the depths.

A second example illustrates the tensions of sitting with despair rather than running towards action.

*Fourteen-year-old Omar, a boy of dual parentage, was referred to the project by his GP. Omar was unhappy at school, he was bright but struggling academically, he complained of constant tiredness but could not sleep at night. He felt he had few friends and saw himself as a victim of teacher and pupil bullying. The main concern of Omar’s mother, Anita B., was her son’s verbal aggression, violent mood swings, and constant protest that ‘everyone is against me’. Omar lived with Anita and her boyfriend Delroy and had only sporadic contact with his Somali father and his father’s girlfriend, despite the fact that they lived in an upmarket apartment only minutes away from the tough housing estate where Omar and his mother lived.*

*Omar’s pattern of non-compliance and disruptive behaviour at home and school was a source of bitter complaint and recrimination between mother and son, but we also heard of a three-generational familial history of loss, abuse and abandonment, Ms B specifically, describing an unhappy childhood characterized by physical and emotional abuse, multiple separations and disruptions through illness. Exploring the connections that could be made about the place ‘depression’ occupies in the life and history of their relationships seemed crucial. But Anita’s insistence that sessions focus on Omar’s problem behaviour meant that family meetings became a place where blame was apportioned and then vigorously defended. The pull to enter these battles as a referee was strong; the problem-saturated descriptions made us worry that our attempts to reflect on what the sadness in the family might tell us were going to lose the family from*

therapy. However, withstanding the urge to be propelled into action around behaviour management allowed Anita's distress to emerge in sessions. As Anita cries during one of the sessions the conversation moves to exploration with Omar of his understanding of his mother's despair.

**Therapist:** Omar was saying that he has been aware that there are times when you are tearful. . . .much more than in the past?

**Anita:** Yeah seems to . . . as I get older . . . yeah . . . I cry much more . . . I can't control it. That's something I'm trying to deal with in my own counselling.

**T:** What does Omar know about why you are having counselling?

**A:** [Crying at this point] I explained it in relation to why we were coming here . . . and the issue was depression . . . so that it doesn't go from generation to generation . . . it's quite a difficult subject . . . but if Omar wants to ask me anything I will answer. . . . Don't you agree?

**Omar:** No!

**A:** No?. . . . Oh OK. . . . [sounding hurt and irritated, which in the past has been a trigger for more argument]

**T:** Do you ask Mum about those feelings? How she feels?

**O:** I used to . . . I don't any more.

**T:** What stops you?

**O:** She cries about the littlest thing . . . it's really difficult . . . and if she cries I cry. . . . And I ain't doing that every time she does. She does it too often!

**T:** So there was a time when you cried when your Mum cried.

**O:** Yes, but I wasn't happy with her crying. . . . it's not nice. . . . now it's something tolerable.

**T:** You have kind of got used to it?

**O:** Yeah exactly.

. . .

**A:** But Omar always seems to know when I'm going to cry because I see him looking at me in a special way . . . so I think he must understand what triggers it . . . [Crying again]

**T:** Is that right Omar?

**O:** What! There's times when even treading on an ant will start you crying . . . it's so unnecessary . . .

I can't deal with it! . . . [Looking at Delroy] We don't listen . . . we leave her to cry..

**A:** Delroy pretends it's not happening . . .

**O:** Can I ask you [looking directly at his mother]. . . . Why do you cry?..

**A:** [Crying] . . . I can't help it.

**O:** Is it like something must have happened to you when you were a kid? . . . to trigger off this side . . . Is it like our dog?. . . . I know someone must have hurt

*her when she was a puppy . . . and kicked her about . . . because it's triggered off something inside . . . that's why she fights with every dog she meets.*

*A: The truth is Omar hates me crying because of the way it makes him feel . . .*

*Here Omar shares for the first time his confusion about his mother's distress. He seems unable to fathom what triggers her tears and tells all present that his lack of understanding, their inability to talk together, has led him to ignore or dismiss the weeping as a part of everyday life. The disconnection between mother and son over the meaning of Anita's despair has been replaced in their relationship by anger and frustration. A familiar cycle of argument and criticism has become a safer way for mother and son to relate and avoids the exploration of the place that 'depression' occupies in their life together. Therapeutically it seemed crucial to sit with the despair and hopelessness, attempting to understand how the family's life 'with depression' is constructed.*

In this case the 'pull' was to locate the problems in Omar's defiance and aggression. We suspect that one function that the focus upon disruption serves for the family is in dragging everyone out and away from the deep well of despair that depression can open up in the room. This idea has close links with our next theme.

#### *Bearing witness to emotional pain*

For experienced therapists like ourselves, who have grown up with traditions in systemic practice that call for active and at times directive participation and conducting of sessions, forging emotional connections with families in the grip of depression is a complex task. As therapists, one of the primary tools of our trade is the use of language and the construction of meanings and stories through conversations. Depression has the tendency to silence people, denying them full access to the spoken word and hence to their stories. This can be exacerbated during adolescence when at the best of times self-expression – particularly with adults – is a difficult process. Building connections through language can therefore be painfully hard. Working with Reena meant trying to interpret her shrugs, nods and shakes of the head throughout the fourteen sessions of our work together. We had to be more creative in our work – using different ways of communicating through writing, using the one-way screen in collaborative ways and not depending solely on the spoken word.

Similarly, therapists rely on joining skills to engage emotionally with clients through the subtle nuances of body language, facial

expressions and tone of voice. Minuchin and Fishman (1981) speak of this as mimesis – the mirroring by the therapist of the client's interactions and actions. However, once again, depression can render a sufferer's affect flat, 'un'interactional and disconnected. Hopelessness and despair can feel like an impenetrable wall encircling the family which the therapist throws herself against time and time again in an attempt to find a foothold. Co-therapists often observed the therapy as moving very slowly and at times feeling distracted or disengaged. In contrast the interviewing therapist feels the therapeutic process as very active and demanding despite the long silences and the client's commitment to the idea that nothing can change. There is a wariness, a prickliness to the engagement process that makes even the most experienced therapist feel de-skilled, useless and even foolish. At times like these the temptation to give up and withdraw is strong especially when this rejection evokes a sense of failure in our ability to connect.

So what has helped keep the therapists potent and connected in these situations? 'The self' of the therapist emerged as a crucial component influencing the ability of the therapeutic team to work through these impasses in treatment. In our conversations we returned again and again to the idea of self-reflexivity as a tool in our joint thinking. This relies on the opportunity to reflect on our own stories of loss and despair, of optimism and negativity, and the ability to link these crucial dynamics to our work with families. This is not easy to do – we too feel the stigma that is attached to these 'mental health' issues.

We found that all of us had been touched by the experience of depression either ourselves or through someone close to us. A 'safe' therapeutic team allows consideration of how our own personal stories feed into the dilemmas described by our clients. It is a place where one can disentangle personal and professional issues. For example, a sense of failure about having not been watchful enough in a personal context may encourage therapists to reflect on their tendency to privilege the importance of risk management and interventive practice. Failure to keep the hope alive in a personal story may encourage perseverance and stick-ability in a clinical context where the feeling is that giving up is not an option. This may result in overworking, doubling one's efforts and perhaps taking too much responsibility for change. Conversely, it may promote a high sense of despondency and despair and freeze a therapist's creative possibilities.

We also recognize the importance of questioning how our own personal stories might lead us into drawing back from staying with the stress or the monotony of greyness, as some of our clients perceive their lives. We have come to see the perturbation that this sets up in the therapist as an expected part of the work. There are a number of emotions that we have come to anticipate and find useful in thinking about what is happening in the therapeutic process. These include humour, mania and depression. We see these emotions as companions to the work we are doing and as resources in reflecting and hypothesizing about what we need to do next.

*The Talbot family had attended six out of the possible fourteen sessions that had been planned. Our colleagues who had been working with the family presented a video extract for discussion in supervision. The clip chosen presents a conversation between the therapist and Mrs Talbot who is describing a compulsion she has developed to steal from shops. The client reveals how the pattern began with small items of cosmetics and has grown into more audacious thefts of expensive clothes, which incur greater and greater risks. The therapist explores the underlying feelings which are linked to the client's unhappiness and despair. The shame of discovery and prosecution would be an outward manifestation of her inner turmoil and stark choices she gives herself between incarceration or suicide. As the account of internal torment unfolds, certain members of the observing/supervising team appear to be fascinated by details of what the client has stolen. Soon this is superseded by humorous speculations about how 'Mrs T' gets 'away with it. . . what is her technique'? The accompanying laughter that gets hold of the group for a few moments seems at odds with the seriousness of the narrative the team is witness to. Fortunately at one point a member of the team was able to disconnect from the interaction and comment on the process. Subsequent reflections enabled the team to identify how being witness to the client's confusion and distress was hard to bear and the humour therefore provided a buffer and defence against the complex feelings evoked in us as observers.*

This issue of 'mania' cannot be overestimated. We have come to know when we are working on the 'edge of life', i.e. with depression or anorexia, by the level of high-energy laughter that is around us. The uncontrollable and overexcitable nature of our responses to the work at times shocked us, but in conversation with colleagues working on this project in other European centres, we found that this was not an uncommon experience.

One way we have spoken of using these emotional experiences as resources is by referring among ourselves to the idea of a 'third eye'. By this we mean a process whereby in our work we monitor simultaneously what is going on in the family, what is going on in the person of the therapist, but what is also going on within the therapeutic team. The third eye watches over the whole process, providing moments when different members of the team speculate about where 'despair' is located, where hopelessness has found a home. This metaphor enables us to reflect as a team about the timing of our mania or our humour so that we can think again about what function these emotions might have in the therapeutic process.

### *Keeping hope alive*

We agree with Flaskas (2007) when she says that it is the job of therapists to hold on to hope for their clients in seemingly hopeless situations. Keeping hope alive is a crucial part of the work we do with 'depressed systems'. But is it in any way different to the hope we try to instil in other areas of our therapeutic practice? We do think that work with childhood depression does present a different emotional quality in this regard.

We have had to continually monitor the extent to which we felt drowned in depression ourselves, mentally overwhelmed and useless. As already highlighted, we frequently found ourselves working on the edge between hope and desolation, at times witness to the stultifying effects of depression on people's lives and at other times amazed by families' ability to take the modest flicker of optimism from a therapeutic session and return next time reporting new changes they have made.

However, we have to be careful about resolving these polarizations in us by simply 'talking up the positives'. In our experience families can quickly see through these contributions if they are not grounded in an authentic in-session experience of hope or change. Most clients have ridden the merry-go-round of false hope and are therefore suspicious of those moments when we clinicians cling on to some enthusiasm or jollity in the session as confirmation that things are on the 'up'.

More often though it was the need to increase our sense of hopefulness that we needed to address. Our preferred approach for this is built around the idea that we can only be effective in therapy as long as

two therapists are working closely together. Co-work provides the opportunity for one member of the therapeutic team to become, as we call it, 'inducted into the depressive position'. Minuchin and Fishman (1981) describe a process whereby the therapist gets pulled into the interactional pattern of the family and thereby gains a unique perspective on the dynamics operating therein. We have found it helpful to recognize that one member of the team may become inducted into the despair, which may show itself as frustration, lack of curiosity, a feeling that minimal or no change is happening. As challenging fixed narratives about the futility of change is such a crucial aspect of this work, the second member of the pair is needed to occupy a role in cheering on the smallest change, positively connoting family stories of entrenched behaviour and immutable personalities.

This 'binocular' approach allowed us to notice and expand the 'sparkling moments' (White and Epston, 1990) during our conversations with families. In many cases, working towards 'preferred futures' rather than dwelling in hopeless pasts became our preferred path and instilled hope into the system. Setting small goals for young people, who had not been in school for long periods and seeing these successfully achieved spurred us all on. We often became 'cheerleaders for change'!

A further aspect to keeping hope alive links to the necessity to build dependable and encouraging networks around the children – particularly for those young people who were out of the formal education process. It felt essential to include the school system directly in our work with families and we were fortunate enough to find very willing and able colleagues in teachers and support workers. Depression can shrink and lose some of its grip in the face of a steadfast team tackling the problem.

*John is the middle son of divorced parents and had experienced extreme bullying at school for a number of years. When his father left the family, John's school attendance declined dramatically and by the time he joined the project he had been out of school for over a year. John is a very bright boy with many academic aspirations and his lack of formal education exacerbated his depression. The relationship between family and school was understandably difficult and bringing these two systems closer together was part of our systemic work. It did also involve the therapist visiting the school and spending some time in the sixth-form common-room, from which experience she could fully understand John's reluctance in returning!*

In considering what keeps hope alive for families and for therapists and how these threads interweave we began to appreciate that in order to provide a safe and hopeful environment for families, we had to pay attention to making ourselves as safe as possible in our surroundings. Jones and Asen (2000) talk of the importance of having some control over the work environment in a research project and for us this was not without its complications. We often worked late into the evening, in an institution that was not our primary workplace and where rooms had to be negotiated, files found and new equipment struggled with. We would therefore recommend that more than 'good enough' opportunities for supervision and support be available for co-workers embarking on this work.

### **Finding an irreverent position within the research process**

In preparing this paper we wondered if readers would be interested in hearing about how the context of the Biomed study may have influenced our systemic epistemology. Cecchin's (1992) description of irreverence proved to be one of the mainstays of our survival kit as therapists in relation to the wider study. Initially we found it hard to promote our own irreverence to the discourses underpinning the research method and design. This was largely because we were invited to join the project by a team of experienced and respected colleagues who in the distant past had been our tutors. Feeling flattered, excited to be 'part of something' led to a momentary lapse in our ability to be irreverent or at least to give voice to it.

Early on we noted the process through which the systems group on the project began to construct language that made us susceptible to the know-ability of this 'out-there' entity called depression. In retrospect we realize that the imperatives of the research – testing hypotheses, gathering a sample, thresholds and cut-offs developed through psychiatric assessment – placed a burden on our systemic thinking. The highest context marker for the families for the idea of depression in their child was that medical colleagues had said it was so. The effect of this dominant discourse on local practices was that the systems group became comfortable for a while – until we drew attention to it – with the use of such phrases as 'these depressed families', 'these depressed mothers' and 'these types of children'. Adopting an irreverent position towards medicalization enabled us to hold on to more hopeful discourses about the clients' own capacity to get themselves better.

Jones and Asen (2000) talk of an approach towards clinical work that 'prides itself on being "context-minded", which cannot continue to ignore the contexts of gender, poverty, inequity and power in the attempt to find ways of dealing with depression'. Putting depression into a wider societal context can dilute a 'personal deficit' frame and inspires more hope for the possibility of change – both in clients and in us. We think 'depression' lends itself well to being externalized. Thus we get client families to unite around a battle with the condition rather than with one another. We have also spoken to families about how depression has become a family member – sometimes through the generations – and built on family resources for giving it a more 'junior' position in the system.

A position of 'authoritative doubt' (Mason, 1993) towards the meaning and relevance of the concept of depression does not in our case represent a lack of respect for the other epistemologies. Instead it freed us up to get on and do the work we felt was important, enabling us to experiment, follow hunches and improvise. We see families for whom stories of loss, things never being good enough, life being unfair, have taken a too powerful hold. If this is what depression is up to, so be it. But a side-effect of becoming too reverent about labels like depression is conceptual inertia. Arguably, systemic practitioners need to use the skills they know best – questioning, curiosity and serious play – to challenge depression ideas and stories that remain fixed in the present. Thus we invite our families to be actively 'anti-depressant' in recognition of how this 'condition' is wrecking their lives.

Finally, a comment about how working with childhood depression has influenced our work in other clinical settings. These days we are more irreverent to our own 'taken-for-granted' ideas about the manifestation of depression. We now pay more attention to the range of behaviours that might signify depression. Hyperactivity, school refusal, disruptive behaviour and drug and alcohol misuse are all areas where we may now explore the role of sadness, despair and hopelessness in the individual, or in the system. We have constructed a number of questions we would ask in relation to the presenting problems that can introduce an alternative perspective on sadness or depression. For example:

- 'If sadness had a voice in your family, what would it be saying?'
- 'If feeling low is also part of what you have been experiencing, what thoughts do you have about the part it may play?'

- ‘When we meet a family where one person is as angry as this (or as hyper), we sometimes wonder what place unhappiness had within your family.’

## Conclusion

In this article we have presented a detailed description of our own experience as therapists of working within an under-researched area for systemic practice. We have tried to give an account of the key aspects of the therapists’ experience in working intensively with families where depression has been identified as a factor. We have tried to show that keeping company with despair, as we have come to think of this work, can have a profound influence on one’s usual practice, thinking processes and application of systemic theory. We have come to appreciate the importance of therapists’ ability to hold on to hope when all seems hopeless – for the family and for themselves. We began by saying that this article was an attempt to promote a dialogue. We would hope that to be the case within the systemic community but a broader hope would be to think about our ideas together with our colleagues in related disciplines, for whom the area of childhood depression may prove a magnet for interest, research and intervention.

## Acknowledgements

We would like to thank our many colleagues on the Biomed Project both in London, Athens and Helsinki. Special thanks and acknowledgement must go to Vicki Bianco and Henia Goldberg – our co-therapists on the project – who have contributed many ideas to this paper; Sara Barratt, David Campbell, Emilia Dowling and Renos Papadopoulos for their supervisory input; Helena Lounavaara-Rintala, Jan-Christer Wahlbeck and Valeria Pomani for their trans-European contributions, and Dr Judith Trowell, Dr Fred Almqvist and Dr John Tsiantis for heading up the project, and in memory of Dr I. Kolvin.

## References

- Angold, A. (1993) Why do we not know the cause of depression in children? In D. Hay and A. Angold, *Precursors and Causes in Development and Psychopathology*. London: John Wiley & Sons.

- Byng-Hall, J. (1999) Family and couple therapy: toward greater security. In J. Cassidy and P. Shaver (eds) *Handbook of Attachment; Theory, Research and Clinical Applications*. New York: Guilford Press.
- Campbell, D., Bianco, V., Dowling, E., Goldberg, H., McNab, S. and Pentecost, D. (2005) Family therapy for childhood depression: researching significant moments. *Journal of Family Therapy*, **25**: 417–435.
- Carroll, B. J. (1984) Problems with diagnostic criteria for depression. *Journal of Clinical Psychiatry*, **45**: 14–18.
- Cecchin, G. (1992) Constructing therapeutic possibilities. In S. McNamee and K. Gergen (eds) *Therapy as Social Construction*. London: Sage.
- Flaskas, C. (2007) The balance of hope and hopelessness. In C. Flaskas, I. McCarthy and J. Sheehan, *Hope and Despair in Narrative and Family Therapy: Adversity, Forgiveness and Reconciliation*. London: Routledge.
- Jones, E. and Asen, E. (2000) *Systemic Couple Therapy and Depression*. London: Karnac.
- Mason, B. (1993) Towards positions of safe uncertainty. *Journal of Systemic Consultation and Management*, **4**: 189–200.
- Minuchin, S. and Fishman, C. (1981) *Family Therapy Techniques*. Cambridge, MA: Harvard University Press.
- Nurcombe, B., Seifer, R., Scioli, A., Tramontana, M., Grapetine, W. L. and Beauchesne, H. C. (1989) Is major depressive disorder in adolescence a distinct diagnostic entity? *Journal of the American Academy of Child and Adolescent Psychiatry*, **28**: 333–342.
- Seifer, R., Nurcome, B., Scioli, A. and Grapetine, W. L. (1989) Is major depressive disorder in childhood a distinct diagnostic entity? *Journal of the American Academy of Child and Adolescent Psychiatry*, **28**: 935–941.
- White, M. and Epston, D. (1990) *Narrative Means to Therapeutic Ends*. New York and London: W. W. Norton.