Childhood depression: a comprehensive literature review

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CHILDHOOD DEPRESSION: 
A COMPREHENSIVE LITERATURE REVIEW

by
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CHAPTER I
Introduction

Depression in children was found to be a serious psychological disorder that warranted clinical attention. Childhood depression was neither normal developmental phenomena nor transient disturbances that the children outgrew. The people in Korea are rarely aware of depression in children. In fact, they do not believe in the existence of depression in children. But traditional morals and family structure have rapidly changed since the 1970's. Children who grow up in a nuclear family do not receive the same emotional and psychological support that used to be provided by extended family members. In addition, society has become more competitive than ever before. From early childhood, the children face a high competition with their peers and struggle with reaching their parents' expectations as well as those of society. Under these circumstances the number of children who suffer from depression has increased unbelievably.

Therefore, childhood depression was dealt with so that Korean parents and teachers could have a framework from which to work. The writer addressed the prevalence, etiology, nature and treatment of childhood...
depression, and the impact of the mother's depression on the children. In addition, the implication and intervention strategies which could be used by educators were addressed. Recognizing the signs of depression, people who were working with children could help them. Korean educators have a great responsibility to help the children where there is no school counselor and/or social worker.

**Purpose**

The purpose of the paper is to acquaint the readers with childhood depression. Thus, the paper dealt with focusing on research in cognitive characteristics of depression in children, influence of the home environment of children, and their treatment. Lastly, information was suggested concerning how to work with and help the children.

**Scope and Limitations**

The paper was limited to research published from 1980 to June, 1991, in North America and in New Zealand. It focused on elementary school children from kindergarten to eighth grade in North America. The children from regular classes, special learning classes, and inpatient and outpatient care were included in the paper. Also, the parents' depressive level ranged from normal to severe depression.
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Definitions

**anhedonia** - the loss of the pleasure response and/or incapacity for experiencing happiness.

**bipolar depression** - a mental illness that involves episodes of serious mania and depression. The person's mood usually swings from overly high and irritable to sad and hopeless and then back again, with periods of normal mood in between.

**clinical depression** - depression that is severe enough to require treatment.

**depressive disorder** - a whole-body illness involving body, mood and thought. It affects sleeping, eating, feelings and thinking patterns.

**dysthymia** - a subtype of depression that involves long-term, chronic symptoms which keep people from functioning normally or feeling good.

**hypersomnia** - the condition of sleeping excessive periods at intervals with intervening periods of normal duration of sleeping and waking. Usually it is sleeping more in a 24-hour period than is normal for the child's age.

**major depression** - a subtype of depression that is manifested in a combination of symptoms that interfere with ability to work, sleep, eat and enjoy once- pleasurable activities. These disabling episodes of
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depression occur once, twice or several times in a lifetime.

**manic episodes** - depression that is characterized by sleeplessness, irritability, hallucinations and delusions. Manic episodes usually begin suddenly, and symptoms increase over a few days or a few months.

**mild episodes** - a subcategory of depression that causes personal distress and discomfort and lasts only a few days or a week.

**moderate depression** - a subcategory of depression that continues for more than two weeks with anxiety, sleep difficulty, loss of interest and pleasure in usual activities with accompanying physical pain.

**severe depression** - a subcategory of depression that continues for many weeks and that involves thoughts of death, suicidal attempts, impaired judgement and marked mood swings.

**suicidal ideation** - thinking about killing oneself.

**unipolar depression** - depressive episodes which do not occur in association with mania.

**Summary**

Childhood depression is a relatively current issue in Korea because with rapidly changing society and increasing demands in academic areas, children have
suffered with depression. Their parents and teachers often overlooked childhood depression considering it merely growing pains. Therefore, it was necessary to explore what childhood depression was. The prevalence, the nature of the depression, appropriate treatment, and the home environment were discussed.

Lastly, useful suggestions for persons who work with the children were addressed. Depression has a great impact on interpersonal success, social competence and academic achievement. In extreme cases, depression leads to suicidal behavior. The people who work with children should know what depression is so that they can understand the children's behavior as well as prevent more serious problems.
CHAPTER II
Literature Review

In a relatively short time, the existence of childhood depression had been denied and overlooked, although case studies on childhood depression appeared as early as the late forties. After The Nervous Child Journal devoted a special issue to manic-depression in 1952, childhood depression has recently received widespread attention from mental health specialists. Its inclusion in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, 1980) signaled a growing acceptance of the diagnostic entity of depressive disorders in childhood.

Etiology

Several studies attempted to identify factors in the etiology of childhood depression. The theories held that the cause of affective disorders in children are not identified with, but similar to those of adulthood depression. There were several different models according to schools of thought. However, the genetic, biochemical, psychodynamic, behavioral, cognitive and transactional theories were addressed in this paper.

Genetic model. Above all, in the genetic model, several researchers have reported consistent findings
that depression is inherited from generation to
generation through examining twins, adoptive studies,
and family studies. Sargent (1986) pointed out that
monozygotic twins showed 70% likelihood for affective
disorders compared to 15% for dizygotic twins. Gerson
and his colleagues also reported similar evidence that
65% of occurrences were found among monozygotic twins,
whereas about 14% of occurrences were reported among
dizygotic twins regardless of whether the twins were
raised together or apart (cited in Kazdin, 1990). In
adoptive studies depression was three times more common
among adopted children whose biological relatives had
suffered depression (American Psychiatric Association,
1989). In addition, a greater incidence of depression
was found among the biological parents of adopted
children than among their adoptive parents who raised
them from early childhood (Lobel & Hirschfeld, 1984;
Sargent, 1986; Mendlewicz, 1985).

The same evidence that a genetic factor was
involved in depressive illness was found in the family
studies as well. The children of mothers with unipolar
and bipolar depression had a very high rate of
diagnosis (Rutter, 1990; Conrad & Hammen, 1987;
Beardslee, Bemporad, Keller, & Klerman, 1983). The
children of mothers with bipolar depression showed a
greater predisposition for affective disorders than those of mothers with unipolar (Rutter, 1990; Conrad & Hamm, 1987). The lifetime risk for the affective disorders in relatives of depression probands was significantly higher than the risk in the general population (Sargent, 1986; Lobel & Hirschfeld, 1984; Mendlewicz, 1985). Interestingly, the morbidity risks for affective disorders were significantly decreased as the degree of consanguinity was lowered. Sargent (1986) reported that siblings and other first-degree relatives had a 50% chance of diagnosis, whereas the risk of affective disorders among second-degree relatives dropped to about 7%.

The investigations about twins, adoptive and family studies showed the same consistent evidences that affective disorders ran in families. These genetic evidences have helped foster diverse types of research such as identification of subtypes of disorders, biological correlates and family histories.

Biochemical model. Most biological theories of depression centered around proposed disturbances of one or more neurochemical systems functioning within the brain, especially focusing on possible abnormalities in the regulation of noradrenaline, serotonin, and acetylcholine (Kazdin, 1990). Each of these substances
was known to function as a neurotransmitter within the central nervous system, has been localized in high concentrations in several regions, and was involved with regulation of appetitive, sleep and emotional processes (Thase, Frank, & Kupfer, 1985). These neurotransmitters controlled behaviors, feelings and thoughts through setting chemical interactions.

Moreover, it was reported that a decreased number of serotonin receptors was cited in depressed people compared to nondepressed children or people suffering from psychiatric conditions (Baron et al., cited in Thase et al., 1985). Approximately 45% of major depressive people had a reduction outside the normal range (Meltzer et al., cited in Thase et al., 1985). Sargent (1986) reported that the disturbances in serotonin resulted in irritability, anxiety and sleep disturbances. More recently investigators have examined the possibility of nonadrenergic overactivity in depression. Kaslow et al. suggested that a significant minority of hospitalized depressives showed evidence of elevated levels of catecholamines and their metabolites in cerebrospinal fluid and peripheral specimens (cited in Thase et al., 1985). These disturbances related to high levels of agitation, pain or anxiety and obsessive thinking (Sargent, 1986).
Another transmitter that caused disturbances within the central nervous system was acetylcholine. Acetylcholine was examined based on the growing knowledge of the interrelationship between acetylcholine and the monoamines in the central nervous system as well as observations of the effects of cholinergic agonists in normal and clinical samples. Depressed clients have showed a hypersecretion of cortisol when they were exposed to stressful situations, or when they were frightened (Kazdin, 1990; Sargent, 1986). In normal people, the level of cortisol in the blood stream peaked in the morning and then decreased as the day progressed. The level of cortisol in depressed people, however, did not decrease in the afternoon nor in the evening (Sargent, 1986). The disturbance in cortisol resulted in stress, anger or fear (Sargent, 1986). The study of biochemical disturbances contributed to the examination of antidepressants.

**Psychodynamic theory.** Psychodynamic theory focused on intrapsychic influences in which Freud emphasized that affective disorders resulted from unsatisfied libidinal strivings, especially object loss (Kazdin, 1990). The relationship between children and their parents during very early childhood was
considered a very important factor in this model. In addition self-criticism and self-rejection of depressed children contributed to the conflict of the ego and superego. Internal conflict and anger reflected hostility toward the parents with whom the depressed children did not establish a warm relationship or from whom they had suffered abuse or abandonment (Lobel & Hirschfeld, 1984). Ambivalent feelings of anger and love toward parents caused children to feel guilty. The superego unconsciously led to aggression, introversion, excessive craving for narcissistic gratification and loss of self-esteem rather than feelings of anger toward the parents (Kazdin, 1990). The feelings of helplessness and excessive guilt feelings resulting from an unsatisfied need for affection became the cause of depression. Introversion together with neuroticism were meaningfully correlated with certain types of depression. Beck and Young (1985) reported that introverted meant being withdrawn, shy, seriously deliberate, while neuroticism was a predisposition to break down under stress and the tendency to ruminate.

Behavioral theory. On the other hand, the behavioral model focused on learning, environmental consequence, and skill acquisition and deficit.
Symptoms of depression were considered to have resulted from problems of interacting with an environment where there was a lack of positive reinforcement. In other words, depression developed from reduced positive reinforcement in an individual who had a deficit in the social skills needed to elicit positive reinforcement. Furthermore, social skill deficits caused the depressed children to fail to meet interpersonal demands and to suffer anxiety.

As a consequence of failure, the depressed children perceived themselves as having less control over their environment because they thought that they were unable to influence their environment (Seligman et al., 1984). In addition, parental resentment, rejection of the children, and lack of affective and emotional detachment during early childhood contributed to subsequent childhood depression (Lefkowitz & Tesiny, 1984). Also lack of social skills led individuals to become passive and withdraw from interactions. Consequently, the children with social skill deficits showed affective and cognitive symptoms of depression.

Cognitive theory. Likewise, the cognitive theory considered depression as thought disorder that caused children to distort their perceptions of self, environment and the future. The negative, distorted
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perceptions were thought to affect the children's judgment about the world and interpersonal interactions, and to account for affective, motivational and behavioral symptoms of depression (Kazdin, 1990). The patterns of cognitive distortion developed in early childhood reflected logical errors, misinterpretation of events occurring in daily life. For example, a learned helplessness led to passivity, social impairment and other symptoms of depression. In response to negative events or stress and current problems of daily living, depressive symptoms were more likely to emerge because of deficits in problem-solving and because of distorted perceptions of self, the environment and the future (Kazdin, 1990).

Transactional theory. Transactional theory emphasized the potential role of a variety of factors in childhood depression and provided a place for the activity of children themselves in the pathological process (Cicchetti & Schneider-Rosen, 1984). The children themselves, family, society, genetic factors and environment all played roles in developing depression in the children. For example, a genetic diathesis might have constituted a disposition to biochemical anomalies. In addition, the children's developmental outcome had many historical and causal
determinants. For instance, depression could be attributed to a dysfunctional relationship between the children's coping abilities and developmental stage, and resources in the immediate environment.

In other words, if the environment was responsive to the children's needs, it could suffer developmental difficulties and the children's inadequate coping abilities. On the other hand, if the environment was not sufficient to respond to the children's needs, it did not reduce the children's psychopathological vulnerability. Consequently, the environment that lacked adequate resources and was less responsible and more stressful contributed to depression (Allen-Meares, 1987). However, all factors did not function as major causes of depression. Some factors acted as permissive causes, while other factors functioned as major causes in developing depression. This primarily depended upon the way the children perceived their environment as well as their own predisposition (Allen-Meares, 1987).

Definition Criteria

Many researchers have investigated childhood depression as a syndrome or disorder over the past ten years. Depression was considered part of a larger category referred to as mood disorders (Kazdin, 1990). There were many symptoms required for major depression
in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III-R) (American Psychiatric Association, 1987). According to DSM III-R at least five of the symptoms had to be present during the same two-week period, with at least one of the symptoms being either depressed mood or loss of interest or pleasure. The symptoms required for major depression in DSM III-R were listed:

1. Depressed mood most of the day, nearly every day, (either by subjective account, e.g., feels "down" or "low" or was observed by others to look sad or depressed)
2. Loss of interest or pleasure in all or almost all activities nearly every day (either by subjective account or was observed by others to be apathetic)
3. Significant weight loss or weight gain (when not dieting or binge-eating) (e.g., more than 5% of body weight in a month) or decrease or increase in appetite nearly every day (in children consider failure to make expected weight gains)
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down) (in children under six, hypoactivity)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (either may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness nearly every day (either by subjective account or observed by others)
9. Thoughts that he or she would be better off dead or suicidal ideation, nearly every day; or suicide attempt (p. 222)
Prevalence

Age. The considerations in prevalence were age and sex. In age an onset of depression appeared as early as 12 months. The age of the onset of any lifetime disorder was most frequently adolescence (13 years and above), followed by school-aged children (7-12 years) and preschoolers (0-6 years). Finch, Saylor, and Edwards (1985) reported that older children, seventh and eighth graders, showed more depressive moods than did primary graders in the study. In another study 13% of the children between ten and eleven years of age in the general population showed depressed moods. When the same children were reassessed at age fourteen and fifteen years, over 40% of them showed feelings of misery and depression (Kazdin, 1990). This implied that developmental levels also affected the prevalence rates.

Sex. Regarding gender, depression generally was more prevalent among women than men. Even though there was no sex difference in prevalence of depressive disorder in children between ages six and twelve, depression was more common among girls than boys at the age of about thirteen. Moreover, depressive symptoms were found twice as frequently in boys among prepubertal children, whereas they were twice as common
Likewise, the percentage of boys manifesting severe depression tended to decrease at the age in which the onset of puberty occurs, while the rate of severe depression among girls tended to increase at the age of puberty (Lefkowitz & Tesiny, 1985). These factors indicated that difference of prevalence in depression between males and females appeared to begin in early adolescence. Further, the sharp differences in depression as symptom were evident as a function of pubertal status and sex.

**Symptoms.** Moreover, pubertal status, age and gender affected not only prevalences but also the pattern of symptoms. Girls showed withdrawals, being secretive, shy, and timid and were likely to be alone (Kazdin, 1990; Salvagno & Teglasi, 1987; Rutter et al., 1986). They were more disturbed in showing affection and in internalizing behaviors. They also showed signs of worrying about doing things wrong and having bad things happen to them as well as to others. On the other hand, boys exhibited suicidal talk with other symptoms of depression (Kazdin, 1990) and more externalizing behaviors (Puig-Antich & Gittelman, 1982; Worchel, Nolan & Willson, 1987).
Developmental level. In a function of development, prepubertal children demonstrated more somatic complaints, psychosomatic agitation and hallucination than did postpubertal children (Kazdin, 1990). On the other hand, postpubertal children showed greater anhedonia, hopelessness, hypersonnia, weight change, and lethality of suicidal attempt (Weissman et al., 1987; Kazdin, 1990). Weissman et al. (1987) pointed out that children with later onset of depression were significantly more likely to have weight loss, initial and terminal insomnia, and boredom. Postpubertal children also presented greater lack of interest than prepubertal children. There were changes in other behaviors with age. Lefkowitz and Burton reported that crying diminished dramatically with age (cited in Clarizio, 1989). Whereas 18% cried two or three times a week at age six, only 2% were reported to do so at puberty. The loss of appetite was manifested by 33% of children at age six, but only 7.5% at age nine (MacFarlane et al, cited in Clarizio, 1989). Likewise, whining behavior showed a dramatic decrease with age.

Cognitive Symptoms

Self-perception. Several studies have paid attention to the cognitive aspects of depression and

Depressive children tended to have lower expectations in their performance and more negative patterns of evaluation about themselves than did peers, despite similar task performance and achievement levels (Kendall et al., 1990; Meyer et al., 1989; McGee et al., 1986).

This indicated that the self-appraisals of the depressed children reflected a negative interpretation of events rather than the actual events themselves. More specifically, the depressed children when compared with their peers had a negative view of themselves by consistently evaluating themselves less favorably than the others (Meyer et al., 1989; Hammen & Zupan, 1984; Scacio & Graves, 1984; McLean, 1984). In addition, the depressed children especially girls, set more stringent criteria for success (Kaslow, Rehm, & Siegel, 1984; Blechman, McEnroe, & Carella, 1986; McLean, 1984).
punished themselves more, and rewarded themselves less than nondepressed children (McLean, 1984). They also exhibited specific beliefs concerning need for approval, perfectionism and excessive empathy with the problems of others (Robins & Hinkley, 1989).

**Attributional style.** Likewise, unique attributional styles were found among the depressed children (Seligman et al., 1984; McLean, 1984; Asarnow & Bates, 1988; McCauley et al., 1988). The depressed children were likely to demonstrate internal, stable, and global causes in negative outcomes, and external, unstable, and specific causes in positive outcomes. These attributional styles were more predictive of self-esteem and more strongly related to depression rather than to ability as an important factor in failure. In addition, cognitive attribution, self-perception and attributional scales were significantly associated with age. With increasing age, the depressed children reported lower self-esteem, more depressive attributional style, and a great depressive symptomatology than nondepressed children (McCauley et al., 1988).

Interestingly, the children showing negative cognitive patterns and attributions of causality were more likely to experience hopelessness and lower self-
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perceptions (Asarnow & Bates, 1988). Hopelessness and negative self-perception were likely to be associated with social withdrawal and lack of confidence in social encounters. It was noted that hopelessness was positively correlated with depression and negatively with self-esteem (Kazdin, Rodgers & Colbus, 1986).

The children high in hopelessness showed lower levels of social skills and participated less in activities. The children who were depressed and hopeless believed that their current situation was worse and unpleasant, and they had no hope either for things getting better in themselves or in their future. These children could not see any hope for solving their problems and believed that the only way to escape from a miserable situation was to commit suicide (Stark, 1990; Kazdin et al., 1983).

Suicide. For these reasons, suicidal ideation and behavior have received serious attention in terms of its relationship with depression. Although suicide was rare before the age of 10, older children did think about and did commit suicide (Rutter et al., 1986). Many authorities have linked depression to childhood suicidal behavior (Kazdin et al., 1983; Asarnow, Carlson & Guthrie, 1987; Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990; Fasko, 1989; Kazdin, 1990;
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Lefkowitz & Tesiny, 1985; Ryan et al., 1987). Their studies consistently reported that depression has been strongly linked with suicidal ideation and behavior in children, even though there were other possible factors which contributed to childhood suicidal behavior. The current evidence indicated that between 27% and 52% of child clinic samples met the criteria for depressive disorders and felt suicidal or made suicidal attempts (Asarnow et al., 1987). Rates of completed suicides were low prior to the age of 14 years. However, the rate increased sharply during adolescence, continued throughout adulthood and reached a peak in old age (Kazdin, 1990). Likewise, attempted suicide was also rare before puberty and showed a dramatic rise during adolescence (Kazdin, 1996; Rutter et al., 1986).

Asarnow and his colleagues (1987) examined the relationship between negative self-perception, depression and suicidal behavior, and assessed the degree of bias toward negative self-perception among depressed children between the ages of 8 and 13. They found that the depressed samples showed negative self-perception as well as a negative world view. The depressed subjects also exhibited a greater hopelessness than normal subjects. This finding was consistent with that which concluded that the children
who were highly hopeless were significantly more depressed (Kazdin et al., 1983). Thus, it was evident that there was significant relation between low self-esteem and suicidal behavior. This supported the notion of a cognitive triad in depression that was characterized by negative views of the self, the world and the future (Kazdin et al., 1983; Fasko, 1989).

Further, generally the depressed children were lower in using coping strategies in dealing with stressful life events than the nondepressed children. The coping skills deficits predicted depression and suicidal behavior (Armsden et al., 1990). In particular, the depressed children generated elevated rates of physically aggressive coping strategies (Asarnow et al., 1987), which had a strong correlation with externalizing problems among boys (Fasko, 1989).

Suicidal behavior has been found to be more frequent in children with family histories of depression (Kaslow et al., 1984; Lefkowitz & Tesiny, 1985; Fasko, 1989). Chronically depressed children had more severe suicidal ideation, greater seriousness of suicide attempt and lethality of suicide attempt, and a higher number of suicide attempts (Ryan et al., 1987). The children who had attempted suicide were more likely than other children to make another attempt (Stark, 1990).
Thinking patterns. Furthermore, Kendall and his colleagues (1990) investigated the nature of cognitive disturbances among children with depression. They pointed out that the depressed samples exhibited a distorted style of thinking. Depression was associated with a distortion rather than a deficiency in information processing. High levels of irrational thinking were found to be associated with a greater intensity and variability of depression. Especially, a distorted style of thinking was more dominated by unpleasant day-to-day experiences among the depressed children (Kendall et al., 1990; Seligman, 1984).

Academic performance. Investigators have also tried to determine whether depression was associated with academic achievement. The investigators did not report consistent evidence that depression directly affected academic functioning. Lefkowitz and Tesiny (1985) reported that there was significant correlation between depression and reading and math achievement among girls, but there was no relationships between depression and those academic areas among boys. Vincenzi (1987) noted a significant relationship between depression and the scores of standardized measures of reading achievement. The level of depression was negatively correlated with reading
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He further pointed out that depression resulted in a lack of adequate problem solving skills and in deficit use of imagery as a learning strategy.

Moreover, Kaslow et al. (1984) explored the relationship between specific intellectual abilities and depression. They found that there was a significant negative correlation between scores on the Children's Depression Inventory (CDI) and scores on the Wechsler Intelligence Scale for Children-Revised (WISC-R), especially scores on the Block Design, Digit Span and Coding subtests. Puig-Antich et al. (1985a) completed an investigation of the effects of depression on academic achievement among endogenous and nonendogenous depressed children, a psychiatric control group of other neurotically disordered children and a normal control group. The mothers of all three psychiatric children reported that these children had significantly poor academic performance. In particular, the endogenously depressed children were most severely impaired in academic areas. In a follow-up study Puig-Antich et al. (1985b) examined the change in academic achievement that followed recovery from a depressive illness. According to the mothers' report, all the depressed children had significantly improved
in their school performance, which was similar to that of the normal controls and significantly better than that of the nondepressed neurotic children. The results suggested that depression was associated with a reduction in school achievement.

However, inconsistent finding was substantiated in McGee and his colleagues' study. They failed to find the relationship between depression and intellectual performance on the Block Design, Coding, and Digit Span subtests. Nor did they find that the performance of children on other subscales was adversely affected by depression. These findings contrasted with the study of Kaslow and his colleagues (1984), who have found that there was correlation between depression and intellectual abilities.

Furthermore, Brumback, Weinberg and Jaokoway, (1980) noted that there was no difference between the depressed and nondepressed children in their achievement on a standardized measure of reading, spelling or arithmetic. The authors concluded that the poor school performance among the depressed children was not a cause of their depression, nor did it hamper achievement in their academic skills. Rather, the poor school performance resulted from depression-related cognitive inabilities or self-deprecatory ideation.
Several studies supported Brumback and his colleagues' conclusion. Worchel, Little and Alcala, (1990) found that the depressed children displayed more negative expectations of their performance task than did the nondepressed children. The depressed children lacked active information processing rather than actual ability (Meyer et al., 1989). Moreover, the children with depression tended to feel that their performance of the task was worse than that of their peers regardless of similar achievement levels (Meyer et al., 1989; Kendall et al., 1990). The academic skills were associated with significantly lower self-esteem and with a poorer perception of ability regarding academic skills (McGee et al., 1986). Interestingly, Gold (1987) found that the children who had suffered from depression showed lower creativity and curiosity than the nondepressed children. Obviously, these results of investigations suggested that depression affected academic performances either directly or indirectly, even though the results showed discrepancies.

Social interaction. Another important concern regarding depression was social skill deficits among the children with depression. A lack of social reinforcement and discontinuance of close interpersonal relationships influenced development and maintenance of
depressive symptoms. The depressed children appeared more isolated and less effective in their social interactions than nondepressed children (McLean, 1984). They performed less skillfully on some tasks of interpersonal problem solving and were preferred less often as play-or-workmates (Altman & Gotlib, 1988; Blechman et al, 1986; Saccio & Graves, 1984; McLean, 1984).

McLean (1984) investigated twenty depressed and twenty nondepressed children in the fourth and fifth grades. The depressed samples spent more time alone and less time interacting with others in a free-play situation. When the depressed samples were interacting with their peers, they demonstrated more aggressive and negative behaviors than nondepressed samples, especially among boys. The aggressiveness of the depressed samples might be related to developmental limitations in their ability to recognize their feelings of anger. The depressed samples perceived themselves as less socially competent in their daily functioning as well. Surprisingly, although the depressed samples spent less time interacting with others, they initiated a greater number of interaction than did their peers, and were approached by their peers more frequently.
Puig-Antich et al. (1985a, 1985b) confirmed these findings. They studied the social behavior of depressed children in terms of friendships. The children with depression were less able to maintain special or best friendships than normal and psychiatric children. The depressed children had significantly lower overall ability to make and maintain positive peer relationships, and were teased significantly more by their peers than nondepressed children. Especially, the prepubertal children during an episode of major depressive disorder presented serious deficits in social functioning as well as in peer relationships. These findings implied that the depressed children might have a history of more intact peer relationships that became impaired secondary to change in the children's affective state.

Armsden et al. (1990) also mentioned that the depressed children who began to perceive their friendships as less satisfactory or felt rejected became more withdrawn secondary to change in their internal mood state rather than experiencing peer rejection. The absence of a supportive relationship with a best friend might be a particular risk factor associated with affective disorder in childhood (Weissman et al., 1987).
Furthermore, Larson, Raffaelli, Richards, Ham, and Jewell (1990) investigated daily states and time-use patterns associated with depression. The depressed boys spent significantly less time with friends, particularly with the same-sex friends. Interestingly, the depressed boys spent more time with friends when others were present. It was worth noting that there was no age increase in the amount of time spent with a single member of the opposite sex for the depressed boys although there was a great increase for the depressed girls. The children with depression spent less time in playing sports and in public, and more time in their bedrooms, even though they thought about and wanted friends as nondepressed children.

This behavior predicted the possibility of increasing social isolation as they grew older. Spending less time in playing sports led to greater social isolation because participation in sports was typically associated with very positive mood states. In particular, among boys sports were a major activity in spending time with the same-sex friends. Puig-Antich et al. (1985b) pointed out that even though peer relationships were improved considerably after recovery, they were not completely improved. It was evident that deficits in social relations persisted
after recovering from depression because interpersonal transactions required a very sophisticated form which was very difficult to develop without deep and frank sharing of feelings.

One factor that hampered interpersonal relationships was the lack of ability to interpret emotions and nonverbal behavior. The depressed children had difficulty in interpreting emotional expressions. The children were more likely to interpret positive or natural emotions as negative emotions (Walker, 1981). In particular, surprise and curiosity were often labeled as fear or sadness by the depressed children. The misperception of nonverbal, social clues reduced the perceived predictability of social interaction as well as exacerbated the depressed state in these children. Such misperception led to inappropriate social responses and increased withdrawal from social interactions.

Guilt. Guilt was another characteristic of the depressed children which was classified as one of the cognitive symptoms because it assumed to reflect the children's attributional style. Several researchers have attempted to investigate the frequency and importance of guilt in depression and have examined cases to determine whether guilt correlated with the
degree of depression. Most children experienced normal feelings of guilt on occasion. The feeling became symptomatic when it occurred for unusually long periods of time, in excess of two hours per day, three days per week (Stark, 1990). Kashani et al. (cited in Stark, 1990) reported that approximately 62% of depressed children experienced excessive or inappropriate guilt. Low and negative self-esteem was strongly related with excessive guilt (Prosen, Clark, Harrow, & Fawcett, 1983; Ryan et al., 1987).

Prosen and his colleagues found that children with depression showed more guilt than normal children in their study. The depressed children with a great degree of guilt tended to have a more severe depression. It was found that the children who expressed feelings of guilt made internal, stable and global attributions for negative outcomes (Seligman et al., 1984), and they were more likely to report depressive symptoms than did the nondepressed children (Zahn-Waxler, Kochanska, Krupnick, & McKnew, 1990). Developmental differences observed for guilt-response showed that younger children in the five- and six-years range did not systematically link guilt to controllable causes. On the other hand, children of six and seven typically expressed feelings of guilt for accidental
outcomes (Graham, Doubleday & Guarino, 1984). When the children got older, they were more likely to express feelings of guilt for clear wrongdoing.

In gender differences, girls showed more signs of emotional involvement and identification with other's problems than boys. For example, girls expressed more empathy and concern about maintaining interpersonal relationships (Zahn-Waxler et al., 1990). This gender-difference in guilt suggested that girls were more vulnerable to guilt which caused depression. In addition, the children of depressed mothers exhibited intense guilt, interpersonal conflict and distress (Zahn-Waxler et al., 1990; Longfellow & Szpiro, 1983). However, Prosen et al. (1983) concluded that even though guilt was an important feature of depression and was more frequently exhibited by the depressed children than the nondepressed children, guilt was not the major factor in the severity of the depressive disorder.

Environmental Effect

So far, childhood depression has been discussed in its emotional, cognitive and physical symptoms and in its prevalence among children. In this section the literature related to the nature of interaction of families with the depressed children is discussed, focusing on the relationship between children and
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parents, especially depressed mothers.

Home environment. Numerous theories of childhood psychopathology emphasized the role of the family in the development and maintenance of psychological disorders. However, there was, in fact, little family-related research. It was suggested that negative home environment could influence depression directly as well as indirectly through their impact on the frequency of problems and the level of problem-solving abilities. Beck & Rosenberg (1986) noted that even though the impact of life events was not necessarily more negative for depressed children, these children experienced more stress and behavioral-problems than normal children in their study. They indicated that "the cumulative effect of events outside the control of children required more adjustment and higher levels of change for the children with high depression scores" (p. 864). Also the children with depression lacked the ability to solve interpersonal and social problems effectively, and problem-solving itself was directly stressful on them (Nezu & Ronan, 1985).

In addition, the home atmosphere of the depressed children had a unique character. One of the most consistent findings was that the families with the depressed children were perceived to be significantly
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less democratic than other families (Nezu & Ronan, 1986). The depressed children were not given a chance to talk in decision-making in their families, even though the decisions made by family members affected the children. This lack of input in decision-making within the family could lead to a sense of helplessness because they could not control the decisions in their families which affected them. Moreover, they did not have an opportunity to learn how to make decisions in general. This might hamper their ability to solve problems and to interact with others appropriately. Thus, Nezu & Ronan emphasized that family therapy should be a component of the treatment for depressed children.

Likewise, the power in the family typically resided in one dominant parent who was highly critical and intolerant of behavior that deviated from parental norms (Arieti & Bemparad, cited in Stark, 1990). The dominant parent used punitive and psychologically damaging means such as guilt and shame. The children who grew up under this home environment showed less secure parental attachment which reflected the cognitive distortion frequently found with depression (Armsden et al., 1990). They also became submissive (Stark, 1990). Especially, the children in working
class families showed higher scores in depression than those in the middle class because the parents from the working class families were less democratic (Larson et al., 1990). Especially older boys reported more depression than younger ones.

**Relationship between parents and children.**

Another factor that strongly impacted depression in the children was the relationship between parents and their children. The relationship between parents and depressive children was very recently examined by several researchers (Puig-Antich et al., 1985a; 1985b; Armsden et al., 1990; Rutter, 1990). Above all, in the relationship between mothers and depressed children, there was a lack of trust; attachment was cool and insecure (Armsden et al., 1990). The mother-child communication was significantly lower in both amount and depth (Puig-Antich et al., 1985a). Tension and severity of punishment methods were present in the depressed children's relationship with their mothers. The mother-child relationship was markedly impaired in prepubertal children with major depression.

Similarly, the depressed children showed a significantly lower quality of communication than did normal groups in the father-child relationship (Puig-Antich et al., 1985a). The relationships between
fathers and children were more likely to be marked by higher tension and less warmth among depressives than among controls. Even though the children recovered from depression, they still had worse relationships with their parents than normal children. Surprisingly, it was noted that poor relationships between parents and children contributed to difficulty in developing interpersonal relationships (Armsden et al., 1990). It was assumed that the parents were the primary caregivers who were supposed to establish secure attachment with their own children from birth. The children who did not establish secure attachments and warm relationships were more likely to manifest depression (Armsden et al., 1990). In other words, the family environment of the depressed family member consisted of less cohesiveness and expressiveness and more conflict. There was less organization in the planning of family activities and less allocation of individual responsibilities (McLean, 1984).

Effects of mother's depression. Another factor that was a high risk in childhood depression was the mother's affective disorder. A strong genetic component in severe depressive disorders has been noted (Weissman et al., 1987; Hammen et al., 1987; Rutter, 1990; Klein, Clark, Dansky, & Margolis, 1988). The
children of mothers with unipolar and bipolar depression had a very high rate of psychiatric diagnoses. However, when compared with the children of mothers with bipolar disorders, the children of mothers with unipolar disorders had higher rates of significant depressive problems (Hammen et al., 1987). Klein et al. (1988) confirmed this finding. They reported that there was a significantly higher rate of dysthymia in the offspring of patients with unipolar depression than in the offspring of patients with orthopedic conditions and the offspring of parents without any personal or family history of psychiatric disorders. An early onset of the parental major depression, a greater number of relatives with affective disorders and chronic parental depression were associated with an increased risk for psychopathology in the offspring of unipolar parents.

How the mother's affective disorder affected the children has been investigated in terms of child-rearing styles by Susman, Trickett, Iannotti, Hollenbeck and Zahn-Waxler (1985). They pointed out that the depressive symptoms of the mothers strongly influenced the rearing, teaching and disciplining of their children. The depressive symptoms such as sadness, irritability, guilt and cognitive confusion...
influenced mother-child interactions. The parental vulnerability to pain and tiredness led to a special sensitivity to issues of blame, suffering and feelings of heavy responsibility.

These mothers were especially likely to use guilt and anxiety methods in teaching social and emotional actions. In fact, they used guilt- and anxiety-induction techniques in conjunction with stated feelings of disappointment about their children (Susman et al., 1985). As a result of using guilt- and anxiety-induction techniques, the children of the depressed mothers exhibited higher levels of guilt and distress than those of the nondepressed mothers (Zahn-Waxler et al., 1990).

Moreover, studies consistently reported that the depressed mothers expressed more difficulty in raising their children than did nondepressed mothers. They displayed negative critical comments in interacting with their children (Longfellow & Szpiro, 1983; Conrad & Hammen, 1989; Panaccione & Wahler, 1986; Hops et al, 1987) and had communication problems with their children (Dodge, 1990). These mothers also set more stringent criteria for success than did the nondepressed mothers (McLean, 1984).

In addition, they tended to make negative
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Lawson's depression about their children and to use
disciplinary techniques that put high maturity demands
on young children (McLean, 1984). As a result, younger
children of the depressed mothers expressed more guilt
feelings and had heavy responsibility that they were
not capable of handling. These mothers were unlikely
to encourage the children to do their best and did not
let the children make their own decisions (Susman et
al., 1985). They were less supportive and lacked
nurturing and warmth (Longfellow & Szpiro, 1983).

There were several factors that contributed to
these problems, besides genetic component. The
depressed mothers had a lower tolerance for the
children's misbehaviors than the nondepressed mothers
(Schaughency & Lahey, 1985). The studies clearly
demonstrated that the depressed mothers tended to
consider their children's behavior as bothersome and
non-compliant when the nondepressed mothers would have
considered it normal behavior (Brody & Forehend, 1986;
Longfellow & Szpiro, 1983). It was reported that the
depressed mothers had more problems related to
attachment, role restriction, low sense of competence,
social isolation and health (Webster-Stratton &

As a result of these problems in the mother, the
family members of the depressed mothers displayed a higher rate of aggressive behavior. Depressive symptoms contributed to the development and maintenance of depression, and the absence of positive reinforcement itself also caused social skill deficits which were strongly related to depression in the children (Hops et al., 1987). The children raised by the depressed mothers exhibited significantly low self-esteem, behavior problems and external locus control (Longfellow & Szpiro, 1983). The children of the mothers with depression reported less favorable views about the quality of their relationships with their mothers and were less likely to turn to their mothers for support (Longfellow & Szpiro, 1983).

They also had disturbances in attention, cognitive problem solving and social functioning. They had emotional problems (Billings & Moos, 1985; Weissman et al., 1987), displayed less need of closeness (Beardslee et al., 1983), and increased feelings of helplessness (Longfellow & Szpiro, 1983). Even the children with recovered mothers continued to exhibit more dysfunction than children of normal controls, especially in psychological symptoms and behavioral problems (Billings & Moos, 1985). The children's health problems were significantly related to the degree of
the mother's depression too. Initial health problems in the children were a strong predictor of later health problems, not only psychological but also physical.

Treatment

There has been a small but consistently growing research regarding the treatment of childhood depression. Depressive disorders were the most responsive to treatment among those with mental disorders. Advances in therapy have helped to alleviate and minimize the symptoms and enabled many children to lead normal lives. A variety of treatments was available and decisions regarding the choice of treatment depended upon the children's condition, diagnosis and personality. There were two major classes of treatment for depression: medication and psychotherapy. Under psychotherapy there were several treatments such as cognitive, behavioral-cognitive, short-term dynamic, interpersonal and family therapies.

Pharmacotherapy. First of all, pharmacotherapy was generally used for moderate to severe depression or in conjunction with other therapy. There were three major drugs used to treat affective disorders: tricyclic antidepressants, monoamine oxidase inhibitors (MAOI's) and lithium (Lobel & Hirschfeld, 1984; Rutter, 1986). The tricyclics alleviated such symptoms as loss
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of appetite and weight, depressed capacity to feel pleasure, loss of energy, psychomotor retardation, suicidal thoughts, patterns dominated by hopelessness and excessive guilt (Rutter, 1986; Sargent, 1986).

On the other hand, MAOI's were more likely to be used for increasing appetite, reducing excessive sleepiness and alleviating anxiety and phobia (Sargent, 1986; Lobel & Hirschfeld, 1984). One of the most effective tricyclic antidepressants for children was imipramine (IMI) (Kazdin, 1990). The use of IMI resulted in great improvements in neuropsychological functioning. It also showed improvements in a variety of externalizing and internalizing behaviors among children (Wilson & Station, cited in Kazdin, 1990). However, Ryan et al. cautioned that sex hormones might interfere with the antidepressant effects of IMI during adolescence (cited in Kazdin, 1990).

Lastly, lithium was generally most effective in decreasing the frequency and severity of manic-depressive cycles, especially those who had a family history of mania (Sargent, 1986). At least 70% of the manic-depressive patients maintained on lithium stopped or reduced episodes of manic depressive symptoms or had shorter and less severe ones (Sargent, 1986).

Even though these drugs cured or alleviated the
symptoms of depression, medication did not alter characteristic patterns, nor did it change the ability to solve life problems. It only brought individuals to the level of functioning they had had before the onset of depression. With medication several considerations must be borne in mind. It was absolutely necessary to give the treating physicians a complete history of all other drugs having been taken, including alcohol (Sargent, 1986) as well as the medical history of the children. To begin with, the guidelines for administration of medications to children should be given to the parents of the children. It also was essential to make the parents aware of the side effects of the medication because long-term medication might affect the children's growth, intelligence, and nonsymptomatic behaviors (Kazdin, 1990).

Psychotherapy. There were several therapies available for the children in psychotherapies: cognitive, cognitive-behavioral, short-term dynamic interpersonal and family. The cognitive therapy was an integral part of the treatment program which was based on the assumption that the children with depression tended to think negatively about themselves, the world and the future, and that these negative and distorted thought patterns led to depressive feelings (Seligman,
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1984; Kendall et al., 1983; Rutter, 1986). The emphasis was on the depressed children's learning to correct their distorted thought-patterns by focusing on current happenings in the children's life as material for the discussion (Sargent, 1986).

There were a few general rules that were followed when teaching them to children (Stark, 1990). First, the therapists and the children tried to keep away from children's maladaptive cognitive structures. Secondly, the children were tested to see if they were ready to change the maladaptive cognitions. Thirdly, the children were taught to identify their own maladaptive thoughts and beliefs and then to restructure them. Fourthly, the children learned a new, more adaptive way of constructing their perception of the world. Next, they were taught to change behavior strategically in a way that directly restructured the premises underlying the cognitions. Finally, core cognitive structures became the focus of change in the children's daily lives.

The cognitive therapy consisted in several subtypes of procedures. Above all, a cognitive restructuring procedure was designed to change the children's thinking and premises, assumptions and attitudes underlying the children's thoughts which
caused maladaptive cognitive structures (Stark, 1990). In this procedure the children were asked to identify their negative thoughts and cognitive structures. One of the most commonly used techniques for identifying their problems was self-monitoring. By using self-monitoring techniques, the children wrote out their maladaptive behavior, a change in mood and the occurrence of a specific event as well as of thought.

Another subtype of cognitive therapy was problem-solving training. This procedure assumed that the children with depression failed to control their behavior because they did not employ effective problem-solving skills (Beck & Young, 1985). There were several steps in this training (Stark, 1990). The first step of the training was to recognize the children's own problem or bad feelings. The second step was to find possible solutions for the problem they faced. During the third step, the children were taught to put their energy and attention on solving problems. In the fourth step, the therapist taught the children to predict the possible outcomes of each proposed solution and let them select and enact one of their possible solutions. The problem-solving steps helped the children develop in identifying, talking about and solving their problems. Stark, Reynolds and
Kaslow (1987) reported that problem-solving training was effective, especially for moderately depressed children. The children in their study participated in more activities.

The last subtype of cognitive therapy was self-instructional training that emphasized helping children internalize a set of self-statements (Beck & Young, 1985; Stark, 1990). The self-instructional training could be employed by using games, such as Chinese checkers or Othello (Kendall, 1981). There were several steps in the sequence. First of all, the therapist showed the use of the self-instruction and let the children observe the therapists' modeling. In the second step, the children were asked to perform the task while instructing themselves out loud. During the third step, the therapist whispered the self-guiding directions while completing the task, and then the children were asked to whisper their own self-guiding directions while working on their task. Finally, the therapist asked the children to complete the task by using covert self-instructions independently. After the children mastered the steps and skills, they were encouraged to use them in their daily life situations.

Cognitive-behavioral therapy assumed that the depressive behaviors resulted from either too little...
positive reinforcement or too much punishment (Clarizio, 1985; Beck & Young, 1985). The therapist selected from a variety of behavioral techniques those which could help children cope more effectively with situational and personal problems and modify automatic thoughts (Clarizio, 1985; Beck & Young, 1985; Haley, 1987). The most commonly used cognitive behavioral techniques included scheduling activities that consisted of pleasure exercises, cognitive rehearsal, self-reliance training, role playing and diversion techniques (Beck & Young, 1985; Stark, 1990).

The scheduling of activities was frequently used in the early stages of the therapy course to counteract loss of motivation, hopelessness, and excessive rumination. Usually therapists used an activity schedule for planning activities hour-by-hour, day-by-day (Beck & Young, 1985; Stark, 1990). This technique helped the children obtain more pleasure and a greater sense of accomplishment from activities on a daily basis.

Another technique used in cognitive therapy was cognitive rehearsal. The children were taught to imagine each step involved in the accomplishment of a particular task. This technique was very effective with those who had difficulty carrying out a task and
concentrating on performance. The imagery used guided the children to identify obstacles that gave them difficulty in a particular task or in a situation (Beck & Young, 1985; McLean, 1982; Stark, 1990).

Self-reliance training was very helpful for the children who were dependent upon others to take care of most of their daily needs (Beck & Young, 1985). This training helped the children learn how to take care of themselves. Therefore, activities were routine ones such as showering, making their beds, cleaning their rooms and doing homework.

Another technique was role playing which was the most often used in cognitive therapy. It was used through homework assignments and guided the children in participating and attending to new cognitive responses in problematic situations. The role-playing could be used as part of assertiveness training and was often accompanied by modeling and coaching. This technique was very helpful to the children in observing another person's viewpoint of their behavior. Lastly therapists introduced diversion techniques to assist the children in learning to reduce the intensity of painful memories and emotions. The children with depression could learn to change negative thinking to positive through physical activity, social contact,
work, play and imagery (Beck & Young, 1985).

Short-term dynamic psychotherapy was based on the premise that the predisposition and origin of depressive disorders stemmed from disappointment with parents or significant others in early developmental stages (Lobel & Hirschfeld, 1984; Strupp, Sandell, Waterhouse, O'Malley, & Anderson, 1982). These early experiences influenced the children's life and caused pervasive ambivalence toward these relationships and impaired current relationships with others. The therapy emphasized changing or modifying in current life the depressed children's maladaptive behavior in dealing with others which was rooted in early significant relationships (Strupp et al., 1982; Mills, Bauer, & Miars, 1989). The children were taught to identify their maladaptive behavior through observation of their own behaviors. They eventually learned the patterns of their inappropriate behaviors.

The role of the therapist was very important in this therapy. The therapist developed a viable interpersonal relationship between the depressed children and himself/herself. The therapist not only helped these children explore feelings toward the therapist but also provided sympathetic understanding and emotional support (Bergner, 1988; Strupp et al.,
The development of trusting, friendly feelings toward the therapist was very important in furthering motivation as well as in transference (Mills et al., 1989). Unless the depressed children could make effective use of a good relationship, a serious contraindication for dynamic therapy could occur.

Another crucial element in this model was transference in which the depressed children in treatment transferred perception and feelings about important childhood figures onto the therapist and the therapy sessions (Strupp et al., 1982). The here and now relationship was used immediately to correct depressive behaviors which were carried over from the past through pointing out the transferred perception (Lobel & Hirschfeld, 1984). Mills et al. (1989) recommended that transference of feelings should be dealt with quickly and energetically so that development of a more difficult and regressive transference could be prevented. Such on-the-spot learnings should connect the children's current-life situation with their experience in the transference and in their past life.

Interpersonal therapy was a brief, individual, weekly outpatient treatment and was usually employed for nonbipolar, nonpsychotic depressed clients.
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(Rounsaville & Chevron, 1982). It was based on the assumption that depressive symptoms occurred in the context of disturbed personal and social relationships (Sargent, 1986). Thus the therapy dealt with disturbances in functioning between the depressed children and others in their daily life environment and current life situation (Sargent, 1986; Rounsaville & Chevron, 1982) and attempted to resolve the current problems the children had been facing (Lobel & Hirschfeld, 1984).

Focusing on current issues, the therapist helped the children understand their illness, their feelings and how interpersonal problems and conflicts related to their depression. Through discussion, the therapist encouraged the development of changes in the children's behavior and social skills. He/she helped the depressed children deal with the connection between important events associated with depression.

Family therapy was considered very important, since a majority of depressed youngsters came from families with depressed parents and/or from disturbed families. This model assumed that the children began receiving messages, and encoded and stored them into cognitive structure from the moment of birth (Stark, 1990). The children who grew up in a dysfunctional
family environment developed cognitive structure through their experiences with the perceived world, which was very different from the way it really was. With these assumptions the family therapy focused on changing interactions and verbal and nonverbal communication within families that led to and maintained the children's maladaptive behavior as well as distorted cognition about themselves and the world (Stark, 1990).

There were several suggestions for developing a good family therapy. First was that the children should be empowered as full participants in the therapeutic process. Generally speaking, young children were deprived of a share of direct power commensurate with their ability to contribute to the family decisions that affected them (Guerney & Guerney, 1987). Secondly, the therapist should give parents opportunities to express and resolve their own problems, attitudes and inhibitions relating to the children. Thirdly, the therapist should help the families identify possible precipitating stresses relevant to the current episode and possible stresses both within and outside of the families. Lastly, the therapist focused on working to change unspoken rules that hampered family communications and interactions.
With these considerations, the family's interactional behaviors and verbal and nonverbal communications were observed. The activity level of the families and the parents' child-rearing styles were also important information for the therapy. A variety of techniques have been employed for family therapy. The techniques used should be ones that allow the young depressed children ample opportunity to reduce internal conflicts and depressive symptoms and develop social controls with peers, parents and others in general (Guerney & Guerney, 1987). Problem solving skills, social interaction skills and activity scheduling have been very powerful not only in preventing but also in increasing social relationship (Stark, 1990).

The therapist promoted the patterns of verbal and nonverbal interactions among family members and minimized current and future stresses through coaching, modeling, and providing feedback on new appropriate behaviors of family members. However, the most important factor to be kept in mind was the willingness of the parents to succeed. Therefore, the parents' cooperation was an essential key for family therapy. The therapist needed to tailor the program to the family's situation and needs.
In general, the treatments of psychotherapy were only useful for the children who were able to talk rationally, but were not useful for the mute or those who showed psychotic symptoms. Therefore, they were generally recommended by clinicians for those who had mild to moderate depressive symptoms, and those who had long-standing behavioral problems (Lobel & Hirschfeld, 1984). The treatment was chosen according to the children's diagnosis and a combination of these techniques could be used.

Class Implications

Signs of depression. As noted, depression had a great impact on the children's daily lives in many ways. The children with depression suffered physically, mentally and academically. Teachers who spent time interacting with the children in school had a great responsibility in helping them because the teachers were in excellent positions to observe the student's behaviors and to teach them. There were many ways that the teachers helped the children who were suffering from depression. First of all, the teachers identified the symptoms of depression.

There were many indicators that suggested the signs of depressive feelings. Most children experienced some ups and downs. However, a marked
negative mood shift that persisted for weeks was a sign of depression (Herskowitz, 1990). The children who had depressive feelings often displayed sadness, tiredness, physical complaints and sleeping problems (Leftkowitz & Tesiny, 1985). The behaviors exhibited by the depressed children might be related to the developmental level of the children. Kovacs and Paulanishers (cited in Bauer, 1987) reported that younger children demonstrated great disruptions in the class, unhappiness, irritability and soberness, and were more self-deprecating, while older children displayed disobedience, oppositional behavior, complaints of physical pains, sadness, apathy and helplessness (cited in Bauer, 1987; Kazdin, 1990).

Moreover, the depressed children put forth less effort than the children who were not depressed, especially in reading and mathematics (Leftkowitz & Tesiny, 1985). These children also exhibited inability in thinking and had difficulty in concentrating on tasks. They frequently expressed a feeling of being burdened and often submitted incomplete assignments (Bauer, 1987; Herskowitz, 1990). Self-expression activities such as art and creative writing provided excellent opportunity for teachers to hear about and see their feelings. In social interaction, the
Depressed children lost enthusiasm for playing, had a limited number of play activities and complained of being bored for a disproportionate amount of time (Downing, 1988; Romney, 1986). In severe cases, the children did not show any interest in activities at all and passively gazed at whatever happened around them. They complained of not having friends and demonstrated social withdrawal behaviorally by refusing to initiate or engage in play with peers.

In addition, the children who had enjoyed school suddenly exhibited school phobia which was often a symptom of childhood depression. In extreme cases, the children wished to die or to kill themselves. Some older children had thought out detailed plans on how they would cause their own deaths (Lobel & Hirschfeld, 1984). They acted out their depression through substance abuse, running away, petty crimes and aggressive behaviors (Leftkowitz & Tesiny, 1985).

Considerations for Working with Depressed Children. After recognizing the symptoms of depression, there were several things the teachers could do. Above all, the teachers should not ask how the children were feeling. They should ignore the droopy behaviors. Instead they should have paid attention to the children's positive behavior and
discussed more positive topics with the children (Hirschfeld, 1984). Whenever the children raised their hands, the teachers needed to acknowledge it quickly. The teachers privately talked to the children about the impact of saying "I don't know" or "I cannot" in their performance (Romney, 1986). They needed to avoid overemphasizing the importance of success or being perfect (Gold, 1987).

While the children are suspected of suffering from depression, the teachers need to talk with the children's parents about the children's behavior at home. The teachers should share changes in children's behavior noticed in the class. They should ask the parents whether the children have difficulty in sleeping or whether they have noticed changes in appetite or weight. If any changes were noticed by the parents, the teachers could suggest that the parents take their children to the doctor. Most of the time the parents are reluctant to accept that their children are having depression. If so, the teachers need to talk with the principal, school guidance counselor or social worker about the children who are suffering from depression.

Fortunately, if the parents are willing to cooperate with the school, the teachers can inform the
parents about how to deal with their children's depression. They can ask the school counselor to educate not only parents but also the school staff regarding depression and appropriate adult responses to depressed children. When the school offers meetings for the parents of depressed children, small-groups should be used so that parents can support one another and share ways of dealing with their children's depressed behaviors or feelings (Downing, 1988).

Another consideration for working with depressed children is medication. If children are under medication, the teachers should be aware of the side effects of the drugs that the children are taking and communicate to the parents as well as to the school nurse their observations noticed in class of the children's behavior which result from the side effects of the drugs. Full participation and cooperation with other professionals as well as with the parents is essential for the children's maximum improvement. Working with depressed children should be based on the strengths and competencies of the children and their families (Bauer, 1987).

Intervention skills. Several strategies which the teachers employed were suggested for helping the children overcome their depressive feelings. The
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teachers taught skills that the children could use when the droopy times appeared, for instance, self-management skills. The children were trained to change their negative thoughts and feelings to positive ones by redirecting their thoughts to pleasant experiences by using deliberate internal affirmations (Downing, 1988). The use of self-programming was a powerful technique for changing their own thinking patterns. For example, self-talk induced relaxation and reduced anxiety when employing new skills in school.

Another coping skill for managing depression was to teach the children to use their natural ability to daydream and fantasize in a positive way as well as when and how to use certain daydreams effectively. At the same time the teachers had to teach them to distinguish reality from fantasy (Bauer, 1987). A simple system of biofeedback was a very powerful strategy with which the children could control their own body movements and feelings. For instance, by counting the rate of their pulse or other's, the children learned how to control their bodies and discovered the changes in body movements when they felt depressed or happy.

Moreover, the teachers could assign a special job or responsibility to the children in school and/or
suggest that the parents give chores to the children at home. By doing a special job, they improved their self-esteem and participated in more activities (Romney, 1986). Positive reinforcement was very helpful in improving the children's self-perception. Positive reinforcement was given whenever the children completed their assignment and an appropriate behavior. However, the positive comment focused on providing attention and positive interaction as a consequence of appropriate behavior (Bauer, 1987).

When grouping activities or study groups, the depressed children should be assigned to work in small groups in order to get them involved in the activities as well as to increase the opportunity for participation. The children could also be involved in peer tutoring in study groups. Increasing the activity level for the children was another way to help them. When the children were allowed to select games they liked, they were more likely to participate in and enjoy them. Also, when the activities were fun, the response of the children would be more immediate and effective (Brazelton, cited in Downing, 1988).

Although these implications for intervention seem to be relatively simple and straightforward to implement, they require skills and practice to be able
to be used successfully and effectively. The teachers need to adjust strategies based on the children's strengths as well as weaknesses.
Conclusion

Most Koreans are still unfamiliar with childhood depression. However in North America since the 1970's many researchers have explored childhood depression with growing acceptance of the idea that affective disorders do occur in children. Even though the debate regarding treatment, etiology and symptoms of childhood depression has continued, the majority of investigators have found evidence that depression in children is not identical with that of adults.

The depressive etiologies of childhood depression were addressed with attention to the affective phenomenology of depression. The prevalence of childhood depression was examined in terms of developmental psychopathology focusing on pubertal states and age because age and puberty have major modifying effects on most psychobiological markers of depressive illness in children.

This paper has dealt with the cognitive features of childhood depression focusing on self-perception, attributional styles, cognitive distortion, social interactions, guilt and suicidal behavior. The consistent findings suggested that depressed children made more internal, stable and global attributions for
failure, and more external, unstable and specific attributions for success as compared to the nondepressed children. Further, the children who showed feelings of hopelessness, distorted self-perception and lack of social skills were more likely to attempt or commit suicide, even though there was no clear relationship between depression and suicidal behavior.

Home environment and mothers' depression as risk factors for depression in children were dealt with by focusing on approaches to affective illness with respect to genetic and environmental components. Families of the depressed children were less democratic in decision making, and displayed less cohesion and more conflict. The children of depressed mothers were more likely to be diagnosed as having affective disorders than those of well mothers. They showed a lack of care that created a psychopathological vulnerability in the children. The mixture of vulnerability in the children and risk factors in family context extended the children's susceptibility to depression.

Treatment approaches included antidepressant medications, cognitive training, short-term dynamic psychotherapy and family and interpersonal therapies.
Antidepressant medications should be used with psychotherapy because of potential side effects. Psychotherapies emphasized developing cognitive and social skills in which most depressed children were lacking. Family therapy is considered very important, since the depressed children were more likely to come from homes with depressed mothers than children without such a diagnosis.

Schools were found to be considerably unique places of help for children who are suffering from depression. Most depressed children had low achievement in academic areas and a difficulty in getting along with their peers in class. Teachers are very important for helping or incorporating intervention as well as treatment.

Limitations and Future Considerations

There are several limitations and suggestions for future research. Most of the studies in childhood depression regarding etiologies, treatment alternatives and symptoms have been based largely on examining the literature concerning depression in adults and extending these to children. Extrapolation of concepts and methods from adults to childhood disorders does not take into account the identification of the boundaries of continuity of dysfunction across the developmental
spectrum. Therefore, there is a great need to define a clear criteria for childhood depression because the current diagnostic criteria are not an aid in pointing the way for identifying developmental differences. It is necessary to consider some of the obvious unique characteristics of children that do not derive from extrapolation from adult literatures.

In addition, it is essential to consider the differences between children and adults in relation to potential avenues for treatment. There are several reasons that treatment for children should be investigated apart from that for adults. Firstly, maintenance of a positive therapeutic relationship may be difficult because many depressed children have difficulties in social interactions that had preceded the current depressive episode.

Secondly, some of the younger children may not be mature enough to describe their problems. Thirdly, a distinguishing feature of children is their living situation and the role of their parents in their daily lives. Because of the home environment and of the potential influence that parents can exert over their children, family therapy should be given great consideration in the treatment of childhood depression.

Another finding is that depressed children meet
criteria for more than one disorder. Depressed children have often been misdiagnosed as having a conduct disorder or other disorders. Feinberg et al. reported that 7% of inpatient children with a manic depressive disorder and 11% of those with dysthymic disorder were diagnosed as conduct disorders (cited in Cole & Carpentieri, 1990). However, only a few studies have explored the difference between depressed and conduct disordered children or the variables contributing to the relationship between depression and conduct disorder.

Surprisingly, children with depression have been misdiagnosed or met other disorders such as attention deficit, anxiety disorder, hyperactivity or autism. The correlation of depression with these kinds of disorders stimulates many critical questions that have potential relevance for assessment, classification, etiology and treatment. Therefore, further work will be critical for examining the overlap and relation of these dysfunctions with depression in children.

Lastly, this paper was written based on the studies investigated in North America and New Zealand. When Koreans read this paper as a resource for dealing with childhood depression, they need to take into account the differences in cultural backgrounds, such
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as family structure, values, communication patterns
between children and parents and asymmetrical
interpersonal relationships.
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