

2002

# Preventing childhood depression by building resiliency in children

Sarah Carroll  
*University of Northern Iowa*

Copyright ©2002 Sarah Carroll

Follow this and additional works at: <https://scholarworks.uni.edu/grp>

 Part of the [Child Psychology Commons](#), [Counseling Commons](#), and the [Education Commons](#)

*Let us know how access to this document benefits you*

---

## Recommended Citation

Carroll, Sarah, "Preventing childhood depression by building resiliency in children" (2002). *Graduate Research Papers*. 486.  
<https://scholarworks.uni.edu/grp/486>

This Open Access Graduate Research Paper is brought to you for free and open access by the Graduate College at UNI ScholarWorks. It has been accepted for inclusion in Graduate Research Papers by an authorized administrator of UNI ScholarWorks. For more information, please contact [scholarworks@uni.edu](mailto:scholarworks@uni.edu).

---

# Preventing childhood depression by building resiliency in children

## **Abstract**

This review of literature is a report of the success of programs designed to prevent childhood depression by building resiliency. Research results indicate that prevention programs focused on teaching children and parents coping skills, changing negative thought patterns, social problem solving, teaching the symptoms of childhood depression and how to discuss it with children, and fostering resiliency have reduced the incidence of depression in children (Comer, 1985; Gladstone & Beardslee, 2000; Seligman, 1995).

Additional research needs to address the following questions: a) How does building resilience differ for children from diverse cultural and socioeconomic backgrounds? b) . What are the best ways to identify children who are at risk for depression? c) Is the developmental timing of resiliency programs critical? d) Do the effects of resiliency last into adulthood? e) What are the most important components of a prevention program? f) How can we best evaluate program effectiveness? g) What are the basic skills needed to implement a prevention program? h) Are schools willing to provide resiliency programs for children at risk for childhood depression?

PREVENTING CHILDHOOD DEPRESSION BY  
BUILDING RESILIENCY IN CHILDREN

A Research Paper  
In Partial Fulfillment  
of the Requirements of the Degree  
Masters of Arts

Sarah Carroll  
University of Northern Iowa  
January 2002

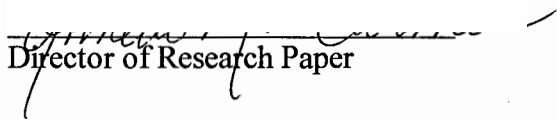
This Research Paper by: Sarah Carroll

Entitled: Preventing Childhood Depression By Building Resiliency in Children

has been approved as meeting the  
research paper requirement for the Degree of

*Master of Arts in Education: Educational Psychology*

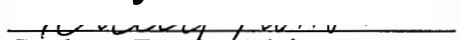
Annette M. Carmer

  
Director of Research Paper


Melissa L. Heston

  
Co-Reader of Research Paper

Barry J. Wilson

  
Graduate Faculty Advisor

Barry J. Wilson

  
Head, Department of Educational  
Psychology & Foundations

2-15-02

Date Approved

## ABSTRACT

This review of literature is a report of the success of programs designed to prevent childhood depression by building resiliency. Research results indicate that prevention programs focused on teaching children and parents coping skills, changing negative thought patterns, social problem solving, teaching the symptoms of childhood depression and how to discuss it with children, and fostering resiliency have reduced the incidence of depression in children (Comer, 1985; Gladstone & Beardslee, 2000; Seligman, 1995). Additional research needs to address the following questions: a) How does building resilience differ for children from diverse cultural and socioeconomic backgrounds? b) What are the best ways to identify children who are at risk for depression? c) Is the developmental timing of resiliency programs critical? d) Do the effects of resiliency last into adulthood? e) What are the most important components of a prevention program? f) How can we best evaluate program effectiveness? g) What are the basic skills needed to implement a prevention program? h) Are schools willing to provide resiliency programs for children at risk for childhood depression?

## TABLE OF CONTENTS

CHAPTER	PAGE
I. INTRODUCTION .....	1
Statement of Problem.....	1
Purpose of Review .....	2
Search Methods.....	2
Overview.....	3
Important Terms.....	3
II. REVIEW OF THE LITERATURE .....	5
Classification.....	5
Prevalence .....	6
Theoretical Models .....	8
Symptoms .....	10
Cognitive.....	10
Emotional.....	12
Motivational.....	13
Physical .....	15
Risk Factors .....	15
Family Factors .....	16
Life Events.....	18
Disabilities .....	19
Emotional Regulation .....	20

Effects of Childhood Depression .....	23
Social Impacts .....	23
Academic Impacts .....	24
Suicide .....	25
Future Depression .....	26
Resilience .....	26
Characteristics of Resilient Children .....	27
Optimism .....	28
Prevention of Childhood Depression .....	29
The Role of Schools .....	29
Types of Prevention .....	30
Prevention Through Emotional Regulation .....	31
Fostering Resilience .....	32
Fostering Resilience in the Classroom .....	32
Resilience Education .....	34
Fostering Resilience at Home .....	34
Prevention Programs .....	35
Yale-New Haven Primary Prevention Project .....	35
Penn Prevention Project .....	37
Prevention Intervention Project .....	40
Critique of Research .....	42
III. SUMMARY/CONCLUSION .....	44

Summary of Findings.....44

Remaining Research Questions .....45

Implications for School Psychologists.....46

REFERENCES .....47



## CHAPTER 1

### INTRODUCTION

#### Statement of Problem

Childhood depression is affecting a large number of children (Stark, 1990).

Prevalence rates between 5 and 15% are commonly reported and are cause for concern because depression can negatively impact child development (Chess & Hertzig, 1989). Accordingly, researchers have focused on factors that put a child at risk for depression. Factors that appear to have the most influence include specific family variables, history of prior depressive symptoms, significant life events, and the presence of a disability (Cytryn & McKnew, 1998; Fassler & Dumas, 1997; Magnussen, 1991; Stark, 1990). Knowledge of risk factors has allowed researchers to shift from an emphasis on intervention to prevention. Some researchers have investigated the use of resilience-building programs to prevent childhood depression in at risk populations (Comer, 1985; Gladstone & Beardslee, 2000; Seligman, 1995). This literature review is a report of the effectiveness of such programs.

The review also provides answers to the following additional questions about childhood depression. How are children classified as depressed? What are the symptoms of childhood depression? Which factors put children at risk and which protect them from depression? What are the negative effects of depression on a child's life? Lastly, what are some specific programs and of what do they consist that have been used to build resilience?

## Purpose of Review

The purpose of this paper is to review the literature published after 1985 on childhood depression and the prevention of the disorder. The review examines important issues related to childhood depression such as theoretical models and symptoms. Risk factors and protective factors are explored.

The review also looks at the concept of resiliency and how resilience building has been used in the prevention of childhood depression. The review includes an analysis of the current research on prevention. Areas that have not been thoroughly explored are summarized.

## Search Methods

The literature review was completed using the following steps. First, a computer search for books published after 1990 on childhood depression at the Rod Library on the University of Northern Iowa Campus was conducted. Books were examined for topics related to the prevention of childhood depression and prevention through resiliency. Second, a search was conducted using ERIC, PsychINFO, and Educational Digest databases. Search terms included childhood depression, resiliency, prevention, and emotional regulation. Articles were selected if they appeared to provide relevant information on the topic and were published after 1985. Additional articles were selected from the reference sections of key books and articles. A professor who teaches a course on risk and resiliency was contacted for additional resources and they were obtained, also.

## Overview

The literature review begins with a summary of research on the classification and prevalence of childhood depression. The symptoms of childhood depression are then examined in detail. Theoretical perspectives on depression are described. Factors that put a child at risk for depression are explored, as well as the various effects of depression on a child's life.

Emotional regulation and the role of resilience in depression are described. Research on how childhood depression can be prevented, in particular through building resilience in children, is presented. Specifically, three longitudinal primary prevention studies are critiqued. A summary of the literature with implications for school psychologists and additional research questions are presented.

## Important Terms

### Attributions

“A person's beliefs about causes of outcomes and how these beliefs influence expectations and behavior” (Alderman, 1999, p. 23).

### Childhood Depression

An episode of depression meeting American Psychological Association criteria that takes place prior to the age of 18 years.

### Emotional Regulation

An attempt to influence which emotions one has and how these emotions are expressed (Gross & Muñoz, 1995).

### Optimism

“A positive explanatory style” (Seligman, 1995, p. 52).

### Resilience Education

“The development of decision making and affective skills within each person and connectedness between people in the context of a healthy democratic learning community” (Brown, D’Emidio & Benard, 2001, p. 28).

### Resiliency

“A child’s inner strength to deal competently and successfully, day after day, with the demands he or she encounters” (Brooks & Goldstein, 2001, p. 1).

## CHAPTER 2

### REVIEW OF THE LITERATURE

Childhood depression was not recognized as a distinct illness until approximately 1970 (Cytryn & McKnew, 1998). Prior to this time childhood depression was often ignored or treated as a behavior disorder. The 1970's brought greater attention to psychiatric disorders in children and childhood depression began to be examined (Kazdin, 1990). Childhood depression is a relatively new disorder and research is needed to better understand its causes and treatment. The following sections contain information on the research that has already been completed.

#### Classification

The American Psychological Association (APA) does not have separate diagnostic criteria for childhood depression. Instead, the adult criteria for depression are applied to children. There are three types of depression that can be present: a) Major Depressive Disorder, single episode, b) Major Depressive Disorder, recurrent, and c) Dysthymic Disorder (APA, 1994). The Diagnostic and Statistical Manual IV (DSM IV) lists several indicators of depressive illness in children. They are unhappiness, sadness, hopelessness, loss of appetite, disturbance of sleep, slowness of movement or agitation, loss of pleasure, loss of energy, low self-esteem, decreased concentration, and suicidal thoughts and actions (APA, 1994). At least five of these characteristics must be present for a child to be diagnosed with major depression (Cytryn & McKnew, 1998).

Cytryn and McKnew (1998) developed an alternative classification process for childhood depression because they believe that childhood depression is uniquely different

from adult depression. Their classification system identifies depression as acute, chronic, or masked. Acute and chronic depression are similar in that they both include symptoms such as impairment of scholastic and social adjustment; disturbances of sleep and eating; feelings of despair, helplessness, and hopelessness; retardation of movement, and occasional suicidal thoughts or attempts. The distinction between the two is that the chronic form does not have a known precipitating cause, lasts for a longer period of time, involves a history of marginal social and emotional adjustment, and often occurs when the child has experienced previous depressive episodes or has a family member with a depressive illness.

Masked depression is a form of depression characterized by acting out behaviors, often antisocial acts. This form of depression is not well supported by research. It is controversial, although many claim to see instances of masked depression in their work with children.

#### Prevalence

Childhood depression is affecting a large number of children (Stark, 1990). The age of the onset is earlier than it has been in the past (Seligman, 1990). This may be due to increase recognition of depressive symptoms in children and increased reporting of those symptoms. Estimates of the prevalence of childhood depression in school-age children differ due to the variety of instruments used to assess depression, age of children studied, and the different populations studied. Lefkowitz and Tesiny (1980) assessed 3000 third, fourth, and fifth grade children without disabilities and found a prevalence rate of 5.2%. Another study of 3000 children ages 12 to 14 found a 9% prevalence rate

(Seligman, 1995). Based on 26 studies of the prevalence of depression in children Angold (1989) found rates of between 5 and 15% to be the most common.

In adolescence the rates of depression increase and change from approximately equal numbers of boys and girls who are depressed to a greater incidence of depression in girls (Cytryn & McKnew, 1998; Kazdin, 1990). The rates move closer to equal following adolescence. A study by Cohen et al. (1993) illustrates some of these trends. Prevalence rates of depression in 776 children were 2.3% female and 1.8% male for ages 10 to 13 years, 7.6% female and 1.6% male for ages 14 to 16 years, and 2.7% both for males and females aged 17 to 20 years. These results illustrate the increase of depression in females during this period of development.

Some researchers argue that the reported gender difference in prevalence rates during adolescence may not be an accurate depiction of the actual situation (Fassler & Dumas, 1997). Adolescent boys with depression often exhibit aggressive, acting out behavior. Fassler and Dumas (1997) suggest that this behavior is a symptom of depression that is not identified and the boys are disciplined for their behavior. Since the boys are not identified as depressed, the prevalence rates are skewed and indicate fewer depressed adolescent boys than actually exist.

Rates of depression in children with learning disabilities have been found to be between 20% and 50% (Stark, 1990). Rates up to 60% have been reported for children in psychiatric hospitals (Stark, 1990).

These high prevalence rates call for more research on childhood depression. School psychologists, counselors, teachers, and special educators are likely to encounter

children who are depressed. In fact, in a survey of school psychologists, 82% indicated that referrals for childhood depression were “not a rare occurrence” (Clarizio & Payette, 1990, p. 59). Educators are encountering depression in children and must understand the disorder. One way to develop an increased understanding of childhood depression is to study the theoretical models that have been used to explain its development.

### Theoretical Models

Several theoretical models have been used to explain childhood depression. It is important to understand these models because the treatment or preventative approaches are based on them. Kazdin (1990) identified two general theoretical models, biological and psychosocial. Biological models are based on an understanding of genetic influences and neurotransmitter levels as causes for depression (Kazdin, 1990). For example, the individual who is depressed may have a deficit, excess, or levels of one or more neurotransmitters not of balance. Psychosocial theories emphasize intrapsychic processes, cognitive processes, and interpersonal relations as causes of depression (Kazdin, 1990).

James (1992) described several theories that can be used to explain depression including psychoanalytic theory, cognitive theory, learning theory, and social cognitive theory. The central principles of each theory are described in one or two sentences. Psychoanalytic theory believes that a fixation in the oral or anal phase of psychosocial development causes an individual to feel sexually inadequate (James, 1992). These feelings of inadequacy then become anger. The anger is directed inward and leads to the manifestation of depressive symptoms.



Cognitive theory assumes “depression is due to illogical and distorted thinking which causes the patient to look at the world, himself, and his future in negative terms” (James, 1992, p. 18). There are three main components of cognitive theory: cognitive triad, cognitive errors, and cognitive schemata (Harrington, Wood, & Verduyn, 1998). The cognitive triad consists of the individual’s view of the self, the future, and the world. Cognitive errors are cognitive distortions that a depressed individual makes. While all of us make cognitive errors, a depressed individual makes even more. Lastly, cognitive schemata are the patterns of thinking that govern how a situation is interpreted.

Researchers such as Lewinshon and Seligman have used learning theory to explain childhood depression. Lewinshon (1974) suggested that depression is due to the inability to behave in ways that will lead to positive reinforcement. Without positive reinforcement the individual’s positive behaviors are extinguished and depression results because of a lack of pleasant experiences.

Seligman (1975) believes that individuals develop a sense of “learned helplessness” when they feel they do not have the ability to exert control in their environment. Learned helplessness can then lead to depression. Seligman later revised his position to include the role of the negative attributions for positive and negative events as causes of depression (Reinechk, Daltilio, & Freeman, 1996).

The assumptions of social cognitive theory yield yet another explanation of why children become depressed. Specifically, depression develops when social relationships are disrupted at a severe level and if the individual is particularly vulnerable (James, 1992). This theory base also considers the difficulties that individuals who are depressed

often have with social skills and problem solving (Rehm & Sharp, 1996). Each theory offers a slightly different perspective on the development of depression and should be considered as educators identify the symptoms of depression in children.

## Symptoms

### *Cognitive Symptoms*

Stark (1990) identified six major cognitive symptoms of childhood depression: negative self-evaluations, guilt, hopelessness, difficulty concentrating, indecisiveness, and morbid ideation. Negative self-evaluations are one of the most common symptoms of childhood depression. Children who evaluate themselves negatively perceive themselves to be inadequate. Children with depression believe that their performance is unacceptable and these ideas persist even if others encourage them otherwise (Stark, 1990). Kendall, Stark, and Adam (1990) investigated the evaluations made by 38 children in third, fourth, and fifth grade in terms of reading standards they set. Half were depressed and half were not. The standards developed by the two groups were not significantly different. However, children who were depressed evaluated themselves significantly more negatively.

Guilt is another important symptom of childhood depression. A meta-analysis of 28 studies, involving 7,500 subjects, found that children with high levels of depressive symptoms held attributions for negative outcomes that were internal, stable, and global (Gladstone & Kaslow, 1995). In other words, the students believed that negative events were caused by a factor within themselves, could not be changed, and were not due to a specific situation. The same children had attributions for positive outcomes that were

external, unstable, and specific meaning that causes were caused by others, could change, and were due to a specific situation. Students who have stable and internal explanations for negative situations are more likely to develop learned helplessness (Alderman, 1999). They believe that no matter what strategy they use they will fail. Therefore, they give up and do not try helpful strategies.

Stark (1990) explained that children with depression often feel a sense of hopelessness. They do not believe that the future will improve and often fear that it will become worse. Children with depression fail to see solutions to problems and are not hopeful that problem solving will result in a successful outcome. Garber, Braafladt, and Zeman (1991) examined the problem solving strategies of 30 children ages 8 to 17 years half of whom suffered from depression. Results indicated that children without depression were more likely to use problem-focused and active distraction strategies whereas children with depression chose active avoidance or negative behavior strategies. They also found that the children with depression had significantly lower expectations about the efficacy of their strategies for altering their negative mood than did the nondepressed children.

Over half of all children with depression have difficulty concentrating (Stark, 1990). Decreased concentration limits the child's ability to acquire new skills and information. Combined with a lack of motivation and a sense of hopelessness, children can experience difficulties both in school and at home.

Stark (1990) identified children with depression as indecisive. They have difficulty seeing the probability of success and therefore struggle when they must make

decisions because they are unable to choose the alternative (Stark, 1990). Stark believes this slows children down greatly, causes them to accomplish less, and impacts their learning negatively.

The last cognitive symptom of childhood depression is morbid ideation and refers to a preoccupation with death (Stark, 1990). This preoccupation may direct the student's attention away from school and friends. Morbid ideation also is a risk factor for suicide.

### *Emotional Symptoms*

Stark (1990) identified six major emotional symptoms of childhood depression. First, dysphoric mood is the sad mood many people associate with depression. It is important to note that this symptom is not present in all children. Some children who are depressed do not appear sad and this can cause confusion for individuals who are not familiar with childhood depression. Graves and Lahey (1982) found that negative affect, also known as dysphoric mood, resulted in decreased learning in preschool children.

The second symptom is an angry or irritable mood. Children with depression may become angry instead of sad. Quiggle, Graber, Panak and Dodge (1992) found a hostile attributional bias was characteristic of children with depression. This angry mood can lead to difficulties in school as children participate in increased conflicts with teachers and peers.

The third emotional symptom identified by Stark is anhedonia, the loss of the pleasure response (1990). Children with depression may become bored, uninterested, and suffer from a lack of motivation due to this symptom. The children are difficult to

motivate because they do not obtain pleasure from successful performance or the rewards teachers often give.

The last four emotional symptoms are weepiness, loss of mirth response, feeling unloved, and self-pity (Stark, 1990). Again, these symptoms influence a child's school and home life by decreasing the child's motivation and ability to focus on a task.

### *Motivational Symptoms*

A survey of school psychologists identified motivational factors, including lack of interest, concentration, and productivity, as a significant expression of childhood depression (Clarizio & Payette, 1990). After reviewing research in the field, Stark (1990) identified three major motivational symptoms, social withdrawal, suicidal ideation, and decreased academic performance.

Social withdrawal is defined as a "decrease in the frequency of contact and depth of involvement with other children and adults" (Stark, 1990, p. 16). Shah and Morgan (1996) found teachers' ratings of social competence of children who were depressed to be significantly lower than their peers. Levendosky, Okun, and Parker (1995) found depression to predict both teacher and parent ratings of lower social competence, parents' ratings of increased peer rejection, children's ratings of lower social competence, and children's ratings of their lack of ability to use social problem solving in comparison to their peers. Altmann and Gotlib (1988) conducted an observational study of 40 children. Half were depressed and half were not. Results indicated that children who were depressed spent significantly more time alone and had significantly higher frequencies of negative interactions with their peers than children who were not depressed.

Results suggested that children who are depressed not only suffer from internal conflicts but also are subject to increased difficulties in peer relationships (Altmann and Gotlib, 1988; Levendosky, Okun, and Parker, 1995). For example, Alderman (1999) stresses the importance of membership in learning. Successful experiences are one of the key elements needed to develop membership. The difficulties in peer relations children with depression experience make it difficult for them to have the successful experiences needed and therefore decrease their likelihood of feeling like a member of the school community.

Decreased academic performance often occurs when children suffer from depression because they are unmotivated to learn (Stark, 1990). Children with depression often hold beliefs such as, "I can't do that," "I'm not as smart as the other kids," and "It's too hard" (Stark, 1990, p. 18-19). These beliefs are closely connected to the negative self-evaluations that were previously discussed. These children also often suffer from fatigue and are apathetic. They do not obtain pleasure from school so academic success is no longer important (Seligman, 1995). The lack of motivation is made even worse by difficulties with concentration and being irritable (Stark, 1990). Children with depression may also withdraw, which can negatively impact their academic performance (Seligman, 1995).

Suicidal ideations, the third motivational symptom identified by Stark (1990), may also affect motivation because the child sees no reason to complete his or her schoolwork and has no desire to try to learn new things. A sense of hopelessness can

develop as the child wishes that he or she was dead and has difficulty seeing a reason to go on.

### *Physical Symptoms*

Stark (1990) identified five physical symptoms of childhood depression including fatigue, change in weight/appetite, aches and pains, sleep disturbances, and psychomotor retardation. The child's ability to pay attention may be impacted by these symptoms. Psychomotor retardation can present difficulties with motor skills such as learning to write and cause the child to fall behind his or her peers in terms of academic achievement. The speed at which the child executes tasks and follows directions may also be affected.

Overall, children with depression may experience many symptoms that can impact their education. Educators must find ways to help children who are depressed in the classroom so that their learning does not suffer greatly. An important element in helping children is having knowledge of which factors put children at increased risk for childhood depression. Identifying children with particular risk factors allows prevention efforts to be targeted specifically at the children who need them most. This results in more time efficient and cost effective prevention programs.

### *Risk Factors*

Researchers have determined several factors that increase a child's risk of developing childhood depression. Risk factors that appear to have the most influence include specific family factors, prior history of depression, significant life events, presence of a disability, and inability to regulate emotions. The presence of risk factors

does not determine that a child will develop depression. Rather, the knowledge of risk factors can prompt educators to provide prevention programs for children who may be especially at risk.

### *Family Factors*

Family factors appear to place children at the greatest risk for depression. Cytryn and McKnew (1998) found that children who had a close relative who experienced depression had a 25 to 30% occurrence of childhood depression. The incidence increased to 70% when both parents had an affective disorder. Another study of 26 families, half of whom had a parent with depression and half of whom did not, found similar results (Cytryn & McKnew, 1998). Of the 13 families in which one of the parents was depressed, 11 had one or more children who suffered from depression. This differed significantly from families without parental depression in which only three were dealing with a child who had depression. Fassler and Dumas (1997) found that children were 13 times more likely to suffer from depression if their parents experienced depression before puberty. Reasons for increased prevalence appear to be both genetic and environmental.

Fassler and Dumas (1997) investigated a genetic link and found that children whose birth parents suffered from depression were still at greater risk even if they were adopted at birth by nondepressed parents. This study suggested that depression, or at least a predisposition for depression, is genetically based.

A depressed parent may also increase environmental risks. Research by Jaenicke et al. (1987) indicated that children of mothers who had major affective disorders had more negative self-concepts, less positive self-schemas, and a more negative attributional



style than children whose mothers were not depressed. Kovacs (1997) described behavior of depressed parents as less responsive and affectionate and more contingent, hostile, and critical. Children in these homes became self-critical and had problems with emotional regulation. Radke-Yarrow et al. (1990) found depressed mothers displayed significantly more negatively toned affect in their attributions to their toddlers, especially regarding their emotions, than parents who were not depressed. A follow-up study four years later showed that this behavior by the mothers with depression predicted psychopathology, including depression, and difficulties with social competence for their children (Radke-Yarrow, Richards & Wilson, 1988). Results suggests parental characteristics increase a child's risk for depression.

Magnussen also looked into the topic of children whose parents were depressed. His research examined 186 outpatient children of depressed parents and found that their parents were more overprotective, had communication problems, and were more likely to undermine their children's learning (Magnussen, 1991). Examination of mother-child dyads found that mothers who were depressed responded to their children's negative affect with more directiveness, fewer supportive statements, and less on-task problem solving behavior (Garber, Braafladt & Zeman, 1991). Children who have a parent who is depressed also have been found to have an increased risk for developing insecure attachments, similar to children who were maltreated (Cicchetti, Ganiban & Barnett, 1991). Research results highlight the importance of including parents in efforts aimed at preventing childhood depression. Changes in parenting could greatly reduce the child's risk of developing depression.

Family factors are an issue in childhood depression even if the child's parent has not experienced a depressive episode. Stark (1990) studied families who had children that were depressed. He found that these families allowed children minimum input in child rearing. The children who were depressed characterized their families as less cohesive, more conflictual, and less open to any form of expression. Stark found that families of children who were depressed had lower levels of social, recreational and intellectual/cultural activity. Depreciation or rejection by parents or loved ones also has been found to put children at an increased risk for childhood depression (Cytryn & McKnew, 1998). Examination of these characteristics helps us to understand family situations that may put a child at risk for depression. However, more investigation is needed. Since many of the studies have been done in families in which the child was already depressed, it is not known if depression arose from the family situation or if the family situation arose from the depression.

### *Life Events*

Stressful life events also can increase children's risk for developing depression. A sudden loss of something the child was attached to has been found to trigger depression (Cytryn & McKnew, 1998; Fassler & Dumas, 1997). The loss can occur through a death, divorce, or a move. The stress of poverty has been found to increase a child's risk (Cytryn & McKnew, 1998). Fassler and Dumas identified several life events that put a child at increased risk for depression (1997). They include death of a parent; losses linked to parental divorce; death of a sibling; changes in neighborhood, school, and finances; and disasters. Illness in the family also can increase the risk of depression

because it often consumes a great deal of the family's time and attention. An accumulation of several stressors is especially likely to cause problems (Mrazek & Haggerty, 1994).

Child abuse also puts a child at risk for depression. Children who are abused are faced with a high tension levels, their needs are neglected, and they often blame themselves for the abuse (Fassler & Dumas, 1997). Parental drug and alcohol abuse lead to problems because there is increased chance of child abuse and the expectations that parents have for children often are not consistent (Fassler & Dumas, 1997).

### *Disabilities*

Yet another risk factor for childhood depression is the presence of a disability. Cytryn and McKnew (1998) identified increased risk when a child has a physical disability. In addition, they found attention deficit hyperactivity disorder could put children at risk for depression because they feel worthless, helpless, isolated, and unable to exert control in their lives. Learning disabilities that are not detected may lead to depression (Fassler & Dumas, 1997). Disorders such as anxiety disorders, eating disorders, and learning disabilities often coexist with childhood depression (Fassler & Dumas, 1997).

Another factor that has been linked to increased risk of childhood depression is a previous episode of depression. Lewinshon followed 1,500 children for 10 years who experienced an episode of depression prior to age 18 years (as cited in Fassler & Dumas, 1997). He found that 44% experienced another depressive episode before the age of 24 years. This rate of depression is much higher than the prevalence rates of 5 to 15% that

have been reported in general population prevalence studies (Angold, 1989). This high reoccurrence percentage urges educators to pay close attention to children who have previously suffered from depression.

In addition to the above risk factors, there are additional factors that increase a child's risk for developing childhood depression. Robinson, Garber, and Hilsman (1995) studied 371 sixth grade students transitioning into the seventh grade. They found that maladaptive attributional style and perceived low self-worth predicted depressive symptoms in the students. Others have found that poor social skills put children at a greater risk for childhood depression (Fassler & Dumas, 1997).

Nolen-Hoeksema, Seligman, and Girgus (1992) identified a connection between age and specific risk factors. They found, in early childhood, negative events significantly predicted depressive symptoms; while in later childhood, both pessimistic explanatory style and negative events were significant predictors. Knowledge of the factors that put a child at risk for depression is valuable to educators and parents who wish to prevent it from developing. Prevention efforts should also consider the use of emotional regulation strategies.

### Emotional Regulation

Emotional regulation has been found to play an important role in childhood depression. Many believe that helping children to better regulate their emotions is key to preventing childhood depression. Therefore, it is important to understand what emotional regulation is, how it is related to depression, and how it develops.

Emotional regulation has been defined many ways. One simple definition by Gross and Muñoz (1995) is that emotional regulation is an attempt to influence which emotions we have and how these emotions are expressed. Kovacs (1997) offers a more formal definition. “Emotional regulation is the process whereby emotional arousal is redirected, controlled or modified to enable adaptive functioning and some balance is maintained between negative, positive, and neutral emotions” (p. 292). We have all observed differences in how children handle emotional experiences. Some children may cry or become angry but soon move on to other things. Other children have a great deal of difficulty moving beyond the crying or angry stage. Researchers believe that the inability to regulate emotions effectively may put children at a greater risk for depression (Gross & Muñoz, 1995; Kovacs, 1997; Stark et al. 2000).

Characteristics of individuals who have problems with emotional regulation include having difficulty altering a negative mood once they are in it, using fewer pleasant activities to deal with emotions, and not expecting emotional regulation strategies to work (Stark et al., 2000). These individuals also may use strategies that increase their amount of distress. For example, Garber, Braafladt, and Zeman (1991) found that girls with poor regulatory behavior avoided direct problem solving. Boys with poor regulatory behavior acted in aggressive ways.

Gross and Muñoz (1995) theorized that major depressive disorder involves “a dysregulation of emotions in which the frequency, intensity, and duration of negative emotions, especially sadness, are increased, and those of positive emotions, such as interest and enjoyment, are decreased” (p. 157). This continued and significant sadness

indicates that the child has not been able to effectively regulate his or her emotions (Kovacs, 1997). Currently, it is not known if difficulties with emotional regulation precede depression or are caused by its symptoms (Stark et al., 2000). It may be that children who experience depression had difficulties with emotional regulation prior to the depressive episode and the depression increased the emotional dysregulation. The importance of emotional regulation in depression urges us to closely examine the development of emotional regulation.

Stark et al. synthesized current research on the typical development of emotional regulation into four major steps (2000). First, the child progresses from other-regulation to self-regulation. Infants move from relying on others to control their level of arousal to behaviors, such as eye closing or distraction, which they do on their own. Second, the child's emotional regulation repertoire expands as they grow older. Language development in early childhood allows the child to ask a caregiver for help with emotional regulation and they slowly begin to add emotional regulation strategies. Third, there is a shift from behavioral emotional regulation strategies to cognitive regulation strategies. School-age children increasingly use cognitive strategies such as "thinking happy thoughts." Lastly, there is an increased emphasis on situational characteristics. Older children are able to match the appropriate emotional regulation strategy with a particular situation.

Kovacs (2000) reported that mothers with affective disorders may disrupt this process by showing more negative affect, responding less sensitively, criticizing the child, and providing less encouragement. By being aware and responsive to their child's

needs, parents show the children they can turn to them as a strategy for emotional regulation (Kovacs, 1997). Children whose parents suffer from an affective disorder may be at even greater risk because this responsive behavior is less likely to occur. The identification of risk factors, including the inability to regulate emotions, becomes important when we examine the effects of depression on a child's life.

### Effects of Childhood Depression

Childhood depression negatively affects the lives of children who experience it in many ways. The disorder affects the child both socially and academically. It also can lead to suicide. It is important to understand these effects on children and why prevention programs are critically important.

#### *Social Impact*

Childhood depression is linked to numerous social problems. Kovacs (1997) stated that children suffering from depression often have impaired functioning in both peer and family relationships. Psychosocial deficits and significant interpersonal problems are of great concern because they can continue for years, even after the child no longer exhibits symptoms of depression. The disruption in the child's social development due to the depressive episode often causes the child to fall behind his or her peers socially. Consider the following example given by Kovacs (1997), "If a 10-year-old child has a 1-year episode of depression, upon recovery at the age of 11 this child will have missed a significant interval of peer relationships during which social skills are modeled, tested, and consolidated" (p. 289).

Social problems also occur within the child's family. Childhood depression can disrupt the attachment bond between parent and child (Kovacs, 1997). This is thought to occur because children who are depressed are less likely to give positive feedback to their parents. Lack of feedback leads to parents giving less positive feedback to their child and soon a negative cycle has begun.

### *Academic Impact*

Childhood depression can have a strong negative impact on a child's academic performance. Stark and Livingston et al. (1990) found that children with depression scored significantly lower on the math and social studies sections of the California Achievement Test than did children who were not depressed. These children also had significantly lower overall grade point averages and lower grades in science, physical education, and language.

Many have questioned whether these achievement differences are due to children with depression having a lower IQ. Kovacs and Goldston (1982) found that during a major depressive episode children had lower nonverbal performance on an intelligence test as compared to when they were not in the episode. However, most research has not found a link between childhood depression and changes in measured IQ (Stark, 1990). Children who are depressed also have increased behavior problems and may have difficulties with teachers. Fortunately, it appears that these difficulties are resolved after the child has recovered from the depression (Kovacs, 1997).



## *Suicide*

A life threatening effect of childhood depression is suicidal ideation. Suicide is currently the third leading cause of death for 15 to 24 year-olds and the sixth leading cause of death for 5 to 14 year-olds (Dubuque, 1998). Risk factors for suicide overlap to a great extent with factors related to depression (Fassler & Dumas, 1997). Emotional risk factors of suicide include previous suicide attempts, hopelessness, eating disorders, substance abuse, and psychosis. Environmental risk factors for suicide include family history of suicide, stressful life events, significant loss or separation, physical abuse, poor academic performance, poor peer relationship/isolation, family conflict or discord, and hearing about other suicides. The similarities between risk factors for depression and suicide have led several researchers to investigate possible relationships.

Brent et al. (1993) conducted a study to determine the risk factors for adolescent suicide. They compared 67 suicide victims to 67 control participants who were demographically matched. Results showed that the most significant psychiatric risk factor was major affective disorder. Depression was present for 82% of the suicide victims and 31% of those who were depressed had been depressed for less than three months. This study illustrates the relationship between depression and suicide and suggests that depression does not have to be present for a lengthy amount of time before suicides occur. Another study found that one third of children with major depression and/or dysthymia were at risk for a suicide attempt before the age of 17 years (Kovacs, 1997). Similar results by Ryan and associates found that 25 to 37% of depressed children

and adolescents had attempted suicide. These findings show that depression must be taken seriously.

### *Future Depression*

Children who have a depressive episode are at risk for later depressive episodes. Kovacs (1997) reported that 80% of children with dysthymia and 50% with major depression experience at least one more depressive episode by the time they are 17 years old. A five-year longitudinal study investigated this phenomenon (Nolen-Hoeksema, Seligman, & Girgus, 1992).

Results showed that explanatory styles of children with depression remained pessimistic following remission of depression. Researchers believe that this puts children who have suffered from depression at increased risk for another episode. Fortunately, there are protective factors that can help reduce the chances of a child developing depression. One of the most significant protective factors is resilience.

### The Role of Resilience

Resilience can play an important role in understanding and preventing childhood depression. Brooks and Goldstein (2001) define resilience as a child's "inner strength to deal competently and successfully, day after day, with the demands he or she encounters" (p. 1). Resilience involves the ability to deal with stress and pressure; the capacity to cope and feel confident; the ability to handle disappointments, adversity, and trauma; and the skill of developing goals. Resilience also includes coping with challenges, relating with others, and treating both the self and others with respect.

### *Characteristics of Resilient Children*

Resilient children are hopeful, have high self-worth, feel special and appreciated, develop realistic goals and expectations, solve problems, and make decisions (Brooks & Goldstein, 2001). They have productive coping strategies, are aware of their weaknesses and talents, and have effective interpersonal skills. Resilient children are more likely to view their mistakes as challenges and focus their energy on parts of their lives that they can control. Resilient children also seek out assistance and nurturance in an appropriate manner.

Cytryn and McKnew (1998) found that children who were resilient were able to function well even in the face of risk factors. They divided the protective factors that resilient children possessed into two groups, inherited characteristics and support systems. Inherited characteristics of the child included qualities such as above average intelligence, easy temperament, quality interpersonal relationships, a strong sense of self, and a clear understanding of their parent's affective disorder if one was present.

The second group of factors involved the child's support system. Resilient children had strong support systems both inside and outside of the family. Few studies have been done on the importance of support systems in the prevention of childhood depression. However, support systems and adult depression have been studied and offer insights on the topic. Brown and Harris (1989) studied inner city women in London who had lost a parent in childhood. They found that those women with a good supportive relationship did not develop depression while those without a strong relationship did develop the disorder. Resiliency information provides insight into factors that help

protect a child from depression. This knowledge can be used to help develop resilience in children and prevent depression.

### *Optimism*

Optimism is another characteristic that is closely related to resiliency and can help protect against childhood depression. Seligman (1995) followed 400 children, starting at the age of eight years, for a period of five years. He found that more than 25% were depressed at any one time and approximately 25% experienced at least one severe major depressive episode. One of the most important findings of this longitudinal study was that children who were pessimistic were significantly more likely to develop depression than children who were optimistic. Also, once children experienced a depressive episode they became more pessimistic. These findings prompt a greater look at the role of optimism in depression.

Optimism is defined as a “positive explanatory style” and is very similar to attributions (Seligman, 1995, p. 27). Three important types of explanation must be examined: permanence, pervasiveness, and personal. Permanence involves whether children believe that the causes of bad events are temporary or permanent. Pervasiveness is whether children believe the event is specific or global. Lastly, personal involves whether the children place internal blame on themselves or external blame on other people or circumstances. We want children to avoid pessimistic general self-blame, which sees causes as permanent, pervasive, and internal and is often the case in childhood depression. Instead, Seligman (1995) believes children should have “healthy optimistic behavioral self-blame” which sees causes as temporary, specific, and internal. He

believes that the development of “optimistic behavioral self-blame” should decrease a child’s risk of depression and be included in prevention programs.

### Prevention of Childhood Depression

Knowledge regarding symptoms of childhood depression, risk factors, and the protective factors of resilience and optimism can be used to develop prevention programs. Preventing childhood depression is an issue of national concern. Funding for research on the prevention of mental disorders almost doubled between 1987 and 1994 (Cytryn & McKnew, 1998). Educating the public is very important and publications such as “The Prevention of Mental Disorders, Alcohol and Other Drug Use in Children and Adolescents” by the American Academy of Child Psychiatry can serve as important tools (Cytryn & McKnew, 1998).

#### *The Role of Schools*

Schools can play an important role in the prevention of childhood depression. Children spend a large part of their day in schools and school personnel have an influence on their lives. Schools can provide a network of people to foster healthy coping mechanisms in children and help children feel comfortable at school (Miezitis et al., 1992). Strong social support networks have been found to prevent depression for adults and are likely beneficial for children as well (Willis, 1996). Children who are at risk for depression need mentors, “adults who model appropriate behavior, coach it, and reinforce such behavior in others, and schools are one place where they should meet” (Bullough, 2001, p. 111). Mentors can help children think through problems, which improves the child’s problem solving capabilities and competence. They also can provide children

with challenging opportunities and support. Another benefit of schools is parents are often willing to participate in activities which they believe will help their child to be more successful, such as a depression prevention program (Miezitis et al., 1992). This is especially true in the younger grades.

Unfortunately, there are factors that may make prevention efforts in schools difficult. Attitudes of educators may limit the school's ability to help children (Miezitis et al., 1992). Many people blame mental illness on the child's parents and do not feel that it is the school's place to get involved. Research also has indicated that educators have a tendency to react more negatively to children who are depressed. This may influence their eagerness to help children at risk for depression. Attitudes and behaviors such as these may lead to resistance and difficulties when implementing a prevention program in the schools.

#### *Types of Prevention*

Caplan developed three types of prevention: primary, secondary, and tertiary. Primary prevention involves services provided to the total staff and students and sharing of information about issues and resources (Miezitis et al., 1992). Secondary prevention involves early intervention with children who show some initial symptoms or proneness to childhood depression (Rehm & Sharp, 1996). Tertiary prevention includes crisis intervention services for staff and students who are experiencing difficulties in school (Miezitis et al., 1992).

Research on depression has shifted from tertiary treatment to primary prevention (Gladstone & Beardslee, 2000). Comer stated the aim of primary prevention is to

“reduce the incidence of psychological disorders in the population thus reducing the need for more costly and labor intensive secondary and tertiary efforts such as psychotherapy, hospitalizations, and residential treatment” (1985, p. 154). The prevention focus also has changed from the general unselected population to a target population of at-risk children. These changes are important to keep in mind as we examine programs to prevent childhood depression.

### *Prevention through Emotional Regulation*

As was discussed earlier, emotional regulation plays an important role in childhood depression. Children who learn to regulate their emotions are less likely to become depressed than children who cannot regulate their emotions (Gross & Muñoz, 1995). Therefore, one way to prevent childhood depression is to help children learn to regulate their emotions.

Gross and Muñoz (1995) identified several skills children need to develop in order to have better emotional regulation. Children need to be able to identify which environments trigger their depressive states. They then need to understand that their interpretation of the event can change how they react. Children must then learn how they can regulate their emotions when they are aroused and what alternative ways to express emotions can be used. Explicit teaching and later prompting of these skills may be needed with some children in order to increase their resilience (Garber, Braafladt & Zeman, 1991).

## Fostering Resilience

### *Fostering Resilience In the Classroom*

A survey of 66 certified school psychologists from two north central states found that only 14% of school psychologists' recommendations for children with depression were directed at resiliency building activities such as changing classroom climate, developing social skills, and teaching problem solving strategies (Clarizio & Payette, 1990). Knowledge appears to be needed on how depression can be prevented in children who are at risk. Brooks and Goldstein (2001) described eight recommendations for teachers to implement in their classrooms to prevent depression by building resilience in children.

The first recommendation is to practice empathy (Brooks & Goldstein, 2001). Dubuque (1998) encouraged teachers to demonstrate good listening skills and give children a "feeling vocabulary." Teachers can be good role models and build children's self-esteem by focusing on intrinsic goodness, efforts, and intentions. The second recommendation is to change the negative scripts of both teachers and students (Brooks & Goldstein, 2001). For example, instead of seeing a student as lazy, a teacher looks deeper for alternative explanation that is more helpful for both the student and the teacher. Seligman (1995) offers a detailed plan for changing negative scripts.

The third recommendation is educators make all students feel welcome and appreciated (Brooks & Goldstein, 2001). Children with depression report less friendship and connectedness with classmates and teachers, less participation in school and academic activities, and less involvement in classroom social relationships (Russell &



Russell, 1996). Connectedness and the depth and consistency of relationships are key factors in building resilience (Brown et al., 2001; Bullough, 2001). Children who lack a sense of belonging often experience many difficulties and teachers can find ways to help students become more involved in classroom projects, activities, and relationships (Russell & Russell, 1996).

The fourth recommendation is that teachers develop realistic expectations and make accommodations for students when needed (Brooks & Goldstein, 2001). Unrealistic expectations only add to the sense of inadequacy that is already present in children with depression. Discussing the role of mistakes in the learning process is the fifth recommendation of Brooks and Goldstein (2001). Teachers can use classroom discussions to talk about coping skills related to academic and social issues (Miezitis et al., 1992).

The sixth recommendation is to develop responsibility and compassion in the classroom and the seventh is to teach students how to solve problems and make decisions (Brooks & Goldstein, 2001). Seligman (1995) encourages educators to teach students strategies for handling interpersonal conflicts and solving social problems. These skills will be beneficial for all students regardless of whether or not they are at risk for depression.

The final recommendation of Brooks and Goldstein (2001) is to use discipline to promote self-discipline. Teachers can let students be involved in developing classroom rules and consequences, thus giving the students a sense of ownership and responsibility. Another way to approach this task is by offering self-control sessions on topics including

self-monitoring, self-evaluation, and self-reinforcement (Russell & Russell, 1996).

Those lessons can then be referred to later when discipline is needed.

### *Resilience Education*

The concept of “resilience education” has come about through increased knowledge of the role of resilience in children who are at risk for school difficulties. Resilience education is the “development of decision making and affective skills within each person and connectedness between people in the context of a healthy democratic learning community” (Brown, D’Emidio & Benard, 2001, p.28). There are five key principles of resilience education. First, educators use strategies that engage students’ intrinsic motivations. Second, educators allow young people to safely experiment with decision-making. Third, educators help to create life goals that the child believes in. Fourth, educators create a “healthy, democratic educational community.” And lastly, educators encourage the exploration of emotions related to the adversity that young people face.

### *Fostering Resilience at Home*

An important component of fostering resilience is to teach parents the strategies that can be used to build resilience in their children. This information can be given by classroom teachers or through workshops designed for parents and presented by school psychologists and counselors. There are several strategies that parents can use to foster resiliency. Jazen and Saklofske (1991) recommended that parents give frequent genuine praise, maintain stability, keep routines, teach their child to relax, be supportive and

reassuring, encourage discussion of angry feelings, urge children to participate in activities, and be aware of suicidal warning signs.

Fassler and Dumas (1997) suggest that parents follow six essential principles when striving to raise resilient children. They are to provide love and support for the child and encourage self-awareness. Parents are to establish predictability, availability, and security through clear guidelines and a unified message. They can foster open and honest communication and have a constructive and balanced approach to discipline. Parents are instructed to let their children experience life and nurture their talents. Lastly, parents are to enhance self-esteem through such actions as celebrating successes, not making approval contingent on success, modeling good coping strategies, and interpreting experiences positively. Educators can help to bring this information to all parents, especially those with children at risk for depression. Building resilience at home can help to prevent childhood depression.

### Prevention Programs

The following sections will examine three unique primary prevention programs that are based on current information about childhood depression. Each of the programs has some research support, including longitudinal data. Longitudinal programs were chosen in order to determine if prevention efforts has long-term effectiveness.

#### *Yale-New Haven Primary Prevention Project*

An early study conducted at Martin Luther King Jr. Elementary School in New Haven sought to improve the outcomes of children who were judged to be at risk for difficulties in school (Comer, 1985). The program “focused on creating a desirable

climate or social environment in schools through the application of mental health principles in a way that effects a coordinated management, curriculum and staff development program, and teaching learning process” (p. 155). Participants in the study were from an elementary school that was 99% Black. Half of the children in the school received Aid for Families with Dependent Children. At baseline children were 19 and 18 months below grade level in reading and math, respectively. Frequent and severe behavior problems occurred in the school. These factors put the students at risk for problems in school and mental illness, including childhood depression.

There were four key elements of the project (Comer, 1985). First, there was a representative governance and management group who met regularly to identify problems and opportunities relating to the school’s climate and academic program. Second, parent participation on several levels was used. Third, a mental health program was carried out by a team of mental health professionals who provided direct services to the students. Lastly, there was an academic program that focused on curriculum and staff development. Teachers were taught how to facilitate the social, psychological, cognitive, speech, and language development of their students. Results of the study indicated the program was effective (Comer, 1985). In follow-up three years later, researchers found that the school had excellent attendance, no serious behavior problems, low staff turnover, high parent participation, and appropriate grade level scores in reading and math.

Researchers also followed 16 school students who had attended King Elementary to their receiving middle school (Comer, 1985). The 16 students were compared to

matched students who attended other elementary schools. Students who participated in the prevention program outperformed the matched students in all nine subtests of the Iowa Test of Basic Skills. The 16 King students also rated themselves as having significantly better overall social competence. These increased capabilities, especially social competence, made the children more resilient and therefore less likely to experience depression.

### *Penn Prevention Project*

Jaycox, Reivich, Gillham, and Seligman (1994) developed the Penn Prevention Program. Unlike the Yale-New Haven Primary Prevention Program, this program was specifically designed to prevent childhood depression. Fifth and sixth grade students were identified as at risk for depression using the Children's Depression Inventory and the Child's Perception Questionnaire. Children who were either experiencing parental conflict or depressive symptoms (sum of z-scores on Children's Depression Inventory and Child's Perception Questionnaire  $> 0.50$ ) were included in the study and divided into two groups. The first group was the coping skills group ( $n=69$ ) and the second was the control wait-list group ( $n=23$ ) who would receive the coping skills classes in one year (Seligman, 1995). There was also a second control group ( $n=50$ ) in a neighboring district matched on income, educational level, and racial profile.

The coping skills group received direct training on coping with family conflict and other stressors from an advanced doctoral clinical psychology student (Jaycox, Reivich, Gillham, & Seligman, 1994). Students participated in a 12 week, 24 hour program designed not to feel or sound like school (Seligman, 1995). This was important

because many of the children had negative school experiences. The program used comic strips, role-playing, games, discussions, and videos to teach the important concepts that researchers believed would facilitate the development of resilience. Characters such as Hopeful Holly, Gloomy Greg, Say-It-Straight Samantha, Bully Brenda, and Pushover Pete were used to teach the children about changing negative thoughts, coping with problems, and building assertiveness skills.

The program had two main components, cognitive and social problem solving (Seligman, 1995). Cognitive therapy techniques were used to teach the children the four basic skills of optimism. First, the children learned to recognize their thoughts when they felt the worst. Second, they learned to evaluate those thoughts. Third, the students generated more accurate explanations and used them to challenge their automatic thoughts. Lastly, students learned the skill of decatastrophizing, not always thinking in terms of the worst-case scenario.

The Penn Prevention Program used Ellis' ABC Model to teach children to examine their explanations to see if they are permanent or temporary, pervasive or specific, and personal or impersonal (Seligman, 1995). Researchers expanded the model to include the letters D and E as well. In this model A stands for the adversity or negative event, B stands for the child's beliefs and interpretations about the adversity, and C stands for the consequences based on those beliefs. D stands for disputation and is the stage in which the child makes an argument to counter their initial beliefs. E stands for energization, which is the emotional and behavioral consequence of the disputation.

Through fun interactive activities students played the role of detectives and investigated the accuracy of their thoughts.

The social problem-solving component of the program sought to teach the children how to handle interpersonal conflicts and solve social problems (Seligman, 1995). This is especially important because children who are depressed often fall into the role of bully or victim. The children were taught problem solving in five steps. Steps included slowing down, perspective taking, goal setting, choosing a path, and evaluating using the question "how did it go?"

Initial effects showed a significant decrease in depressive symptoms. Prior to the coping skills class (treatment condition), 24% of the students in both the prevention and the control group had moderate to severe depressive symptoms (score above 15 on Children's Depression Inventory) (Seligman, 1995). Immediately after the coping skills class, the prevention group symptoms were reduced to 13%. The control group remained constant at 24%.

Long-term results were investigated two years later. Seligman (1995) found that 22% of the children in the coping skills class (treatment condition) reported moderate to severe depressive symptoms and 44% of the control group reported the symptoms. Results reflected predicted natural increase in symptoms during adolescence. Children in the prevention group also were less likely to explain bad events pessimistically. Some particularly interesting results were that the treatment effects were stronger for children experiencing more parental conflict at home and more depressive symptoms (Jaycox,

Reivich, Gillham, & Seligman, 1994). One drawback of the study was that there was not a placebo group.

This study is exciting because it suggests that teaching children skills that will make them more resilient and optimistic can prevent childhood depression, not only immediately following treatment but in the future as well. Since it typically is not feasible to have clinical psychologists lead sessions, Seligman (1995) expressed the need to train school psychologists, counselors, teachers, and parents to teach these skills to children.

#### *Prevention Intervention Project*

Gladstone and Beardslee (2000) developed the Prevention Intervention Project to decrease the incidence of childhood depression. Goals were to decrease the impact of family and marital risk factors, increase resilience related behaviors and attitudes through enhanced parental and family functioning, and prevent the onset of depression or related psychopathology. The project also sought to be developmentally appropriate, use a family-centered perspective, develop interventions that could be used by a variety of disciplines, and strengthen the role of parents to better deal with challenges and avoid depression.

The Prevention Intervention Project used two conditions with 100 middle class families. Each included at least one parent who had recently suffered from an affective disorder episode (Gladstone & Beardslee, 2000). The clinician-facilitated condition consisted of six to ten sessions of separate meetings for parents and children, family meetings, and telephone contacts. Refresher sessions at six and nine month intervals



were conducted. Lecture conditions involved two meetings in a group format without the children present.

Both of the interventions focused on helping parents deal with misunderstanding, guilt, and blame (Gladstone & Beardslee, 2000). Both provided information on resilient characteristics and strengths and how to encourage the development of resilience.

Interventions encouraged parents to discuss their affective disorder with their child and gave them information on childhood depression.

Results showed both initial and sustained effects three years later (Gladstone & Beardslee, 2000). Parents in both of the conditions reported improved communication about depression between the children, spouses, and family. Parents also reported less feelings of guilt and children's increased understanding of the illness. The clinician-facilitated group reported a greater number of overall changes than the lecture group including improved communication and increased illness understanding (Beardslee et al., 1997).

Gladstone and Beardslee (2000) developed the Family Communication, Openness, Resiliency, and Empowerment (FamilyCORE) Program. FamilyCORE followed a similar format to the Prevention Intervention Project. However, changes were made in order to better identify with the 16 families with diverse backgrounds from an urban neighborhood in Boston. Results showed once again that both interventions were helpful and there was less of a difference between the groups than in the Prevention Intervention Project. Participants reported increased focus on their children and fewer

depressive symptoms. One concern with both of these studies was that there was not a control group.

### Critique of Research

Currently, there is very limited research on the prevention of childhood depression. Prevention programming for depression is relatively new. Past research focused more on intervention than prevention. There is very little information on building resiliency in children in order to prevent childhood depression. The topic of resiliency is gaining popularity among educators and psychologists and more research on this issue would be beneficial.

There are weaknesses in research on the prevention of childhood depression. First, few of the studies involve control groups that allow us to see how children would have turned out without the prevention efforts. Instead of denying at-risk children access to the prevention program, random sampling could be used in order to compare the two groups. A placebo group, which was not present in any of the studies, would also provide needed information regarding the success of the programs. Placebo groups could show whether the actual prevention program was successful or if students were simply benefiting from increased attention. Second, the majority of the studies appear to be targeted at approximately the same age group, upper elementary and middle school. It would be interesting to find out if prevention programs showed similar results with lower elementary or high school children. Third, a majority of the studies use parental reporting, which is not always a reliable form of measurement, especially when the reporting parent has an affective disorder (Beardslee et al., 2000). More objective

assessment tools are needed. Lastly, research must be conducted on prevention programs that could realistically be used in schools. This means that programs should be researched that would be feasible in terms of time, funding, and trained personnel available in school districts.

Currently, the number of longitudinal studies is very limited. Aside from the three that were discussed, many programs are only evaluated in terms of short-term prevention. Research also needs to be conducted on students from all cultural and economic groups in order to find out what efforts are successful for all students. These changes improve the validity of the research base.

## CHAPTER 3

### SUMMARY/CONCLUSION

#### Summary of Findings

Childhood depression is affecting a large number of children (Seligman, 1995). Children with the disorder present cognitive, emotional, motivational, and physical symptoms that interfere with their optimal growth and development. Researchers have determined several factors that increase children's risk for depression including family factors, prior history of depression, significant life events, and the presence of a disability.

Childhood depression negatively impacts the lives of children who suffer from it in many ways. The disorder influences the child both socially and academically. It can lead to future episodes of depression and put the child at increased risk for suicide. Emotional regulation has been found to play an important role in childhood depression. Many believe that helping children to better regulate their emotions is key to preventing childhood depression.

Resilience also can play a very important role in the understanding and prevention of childhood depression. Resilience involves the ability to deal with stress and pressure, the capacity to cope and feel confident, the ability to handle disappointments, the skill of developing goals, and the ability to relate with others. Optimism is an important characteristic in children that is closely related to resiliency and can help protect children against depression.

Knowledge regarding symptoms of childhood depression, risk factors, and the protective factors of resilience and optimism can be used to develop school programs aimed at preventing children from developing depression. There are several strategies that educators and parents can use to build resilience in children as well as programs that have been shown to be successful at preventing childhood depression. Three of those programs are the Yale-New Haven Primary Prevention Project, the Penn Prevention Project, and the Prevention Intervention Project. Increased research on programs such as these is needed.

Current research indicates that increasing resiliency characteristics can prevent childhood depression. Programs aimed at teaching children and parents coping skills, how to change negative thoughts, assertiveness, social problem solving, the symptoms of childhood depression and how to discuss it with children, and how to foster resiliency traits and provide a supportive environment have reduced the instance of depression in children determined to be at risk (Comer, 1985; Seligman, 1995; Gladstone & Beardslee, 2000).

### Remaining Research Questions

This review of literature has provided information on many aspects of childhood depression and how it can be prevented. There are numerous questions that remain unanswered. Does building resiliency work for children from a variety of cultural and socioeconomic backgrounds? What are the best ways to identify children who are at risk for depression? Is the developmental timing of resiliency programs critical? Do the effects of resiliency last into adulthood? What are the most important components of a

prevention program? How can we best evaluate program effectiveness? What are the basic skills needed to implement a prevention program? Are schools interested and willing to provide resiliency programs for children at risk for childhood depression?

The last question is the one that is especially intriguing. In order for any program to be successful, a group of people need to be devoted to finding funding, identifying the children, leading the program, and explaining its importance to the rest of the school community. Research needs to be conducted to determine if individuals, such as school administrators, school psychologists, and school counselors, feel that this type of program is needed and are willing to take on the responsibilities involved in its implementation.

#### Implications for School Psychologists

This review of the literature on childhood depression has important implications for all educators, including school psychologists. Childhood depression is a disorder that needs to be addressed in schools. School psychologists are in an excellent position to screen for the risk factors of childhood depression and create prevention programs to build children's resilience. They can also educate teachers and parents through inservices, presentations, and handouts. Action must be taken to prevent children from experiencing childhood depression. Research suggests that it can be done and school psychologists must take a leading role in making it happen.

## REFERENCES

- Alderman, M. K. (1999). *Motivation for achievement: Possibilities for teaching and learning*. Mahwah: Lawrence Erlbaum.
- Altmann, E. O. & Gotlib, I. H. (1988). The social behavior of depressed children: An observational study. *Journal of Abnormal Child Psychology*, 16(1), 29-44.
- American Psychological Association. (1994). *Diagnostic and statistical manual of mental disorders (4<sup>th</sup> ed.)*, Washington, D.C.
- Angold, A. (1989). Child and adolescent depression II: Research in clinical populations. In S. Chess & M. Hertzog (Eds.), *Annual Progress in child psychiatry and child development* (pp. 355-384). New York: Brunner/Mazel.
- Beardslee, W., Versage, E., Wright, E., Salt, P., Rothberg, P., Drezner, K. & Gladstone, T. (1997). Examination of preventive interventions for families with depression: Evidence of change. *Development and Psychopathology*, 9, 109-130.
- Brent, D., Perper, J., Moritz, G., Allman, C., Friend, A., Roth, C. et al. (1993). Psychiatric risk factors for adolescent suicide: A case-control study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32(3), 521-529.
- Brooks, R. & Goldstein, S. (2001). *Raising resilient children: Fostering strength, hope, and optimism in your child*. Lincolnwood: Contemporary.
- Brown, G. & Harris, T. (1989). *Life events and illness*. New York: Guilford.
- Brown, J., D'Emidio, M. & Benard. (2001). *Resilience Education*. Thousand Oaks: Corwin.
- Bullough, R. (2001). *Uncertain lives: Children of promise, teachers of hope*. New York: Teachers College.
- Cicchetti, D., Ganiban, J. & Barnett, D. (1991). Contributions from the study of high-risk populations to understanding the development of emotional regulation. In J. Garber & K. Dodge (Eds.), *The development of emotional regulation* (pp. 15-48). Cambridge: Cambridge University.
- Clarizio, H. F. & Payette, K. (1990). A survey of school psychologists' perspectives and practices with childhood depression. *Psychology in the Schools*, 27(1), 57-63.

- Cohen, P., Cohen, J., Kasen, S., Velez, C., Hartmark, C., Johnson, J. et al. (1993). An epidemiological study of disorders in late childhood and adolescence-Age and gender specific prevalence. *Journal of Child Psychology and Psychiatry*, 34(6), 851-867.
- Comer, J. (1985). The Yale-New Haven primary prevention project: A follow up study. *Journal of the American Academy of Child Psychiatry*, 24(2), 154-160.
- Cytryn, L. & McKnew, D. (1998). *Growing up sad*. New York: W.W. Norton.
- Dubuque, S. E. (1998). Fighting childhood depression. *The Education Digest*, 63, 65-69.
- Fassler, D. & Dumas, L. (1997). *"Help me, I'm sad" Recognizing, treating, and preventing childhood and adolescent depression*. New York: Penguin.
- Garber, J., Braafladt, N. & Zeman, J. (1991). The development of sad affect: An information-processing perspective. In J. Garber & K. Dodge (Eds.), *The development of emotional regulation* (pp. 208-242). Cambridge: Cambridge University.
- Gladstone, T. & Beardslee, W. (2000). The prevention of depression in at-risk adolescents: Current and future directions. *Journal of Cognitive Psychotherapy: An International Quarterly*, 14(1), 9-23.
- Gladstone, T. & Kaslow, N. J. (1995). Depression and attributions in children and adolescents: A meta-analytic review. *Journal of Abnormal Child Psychology*, 23(5), 597-606.
- Graves, K. J. & Lahey, B. B. (1982). The effects of induced affective states on letter discrimination in disadvantaged preschool children. *Journal of Applied Developmental Psychology*, 3, 149-154.
- Gross, J. & Muñoz, R. (1995). Emotional regulation and mental health. *Clinical Psychology: Science and Practice*, 2(2), 151-164.
- Harrington, R., Wood, A. & Verduyn, C. (1998). Clinically depressed adolescents. In P. Graham (Ed.), *Cognitive-behaviour therapy for children and families* (pp. 156-192). Cambridge: Cambridge.
- Jaenicke, C., Hammen, C., Zupan, B., Hiroto, D., Gordon, D., Adrian, C. et al. (1987). Cognitive vulnerability in children at risk for depression. *Journal of Abnormal Child Psychology*, 15(4), 559-572.



- James, J. (1992). Depression in children and adolescents: An overview. In S. Mieztis (Ed.), *Creating alternatives to depression in our schools: Assessment, intervention and prevention* (9-29). Seattle: Hogrefe & Huber.
- Jaycox, L., Reivich, K., Gillham, J. & Seligman, M. (1994). Prevention of depressive symptoms in school children. *Behavior Research and Therapy*, 32(8), 801-816.
- Jazen, H. & Saklofske, D. (1991). Children and depression. *School Psychology Review*, 20(1), 140-142.
- Kazdin, A. (1990). Childhood depression. *Journal of Child Psychology and Psychiatry*, 31(1), 121-160.
- Kendall, P. C., Stark, K. D., & Adam, T. (1990). Cognitive deficit or cognitive distortion of childhood depression. *Journal of Abnormal Child Psychology*, 18(3), 255-270.
- Kovacs, M. (1997). Depressive disorders in childhood: An impressionistic landscape. *Journal of Child Psychology and Psychiatry*, 38(3), 287-298.
- Kovacs, M & Goldston, D. (1982). Cognitive and social cognitive development of depressed children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(3), 388-392.
- Lefkowitz, M. & Tesiny, E. (1980). Assessment of childhood depression. *Journal of Consulting and Clinical Psychology*, 48, 43-50.
- Levendosky, A. A., Okun, A., & Parker, J. (1995). Depression and maltreatment as predictors of social competence and social problem solving skills in school-age children. *Child Abuse and Neglect*, 19(10), 1183-1195.
- Lewinshon, P. (1974). *The psychology of depression*. Washington, DC: Winston.
- Magnussen, M. (1991). Characteristics of depressed and non-depressed children and their parents. *Child Psychiatry and Human Development*, 21(3), 185-191.
- Mieztis, S., Cole, E., Heath, N., James, J., Matiss, I. & Vella, D. (1992). Towards prevention of depression in our schools. In S. Mieztis (Ed.), *Creating alternatives to depression in our schools: Assessment, intervention and prevention* (pp. 9-29). Seattle: Hogrefe & Huber.
- Mrazek, P. & Haggerty, R. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy.

Nolen-Hoeksema, S., Seligman, P. & Girgus, J. (1992). Predictors and consequences of childhood depressive symptoms: A 5-year longitudinal study. *Journal of Abnormal Psychology, 101*(3), 405-422.

Quiggle, N. L., Graber, J., Panak, W. F., & Dodge, K. A. (1992). Social information processing in aggressive and depressed children. *Child Development, 63*(5), 1305-1320.

Radke-Yarrow, M., Belmont, B., Nottelmann, E. & Bottomly, L. (1990). Young children's self-conceptions: Origins in the natural discourse of depressed and normal mothers and their children. In D. Cicchetti & M. Beeghly (Eds.), *The self in transition: Infancy to childhood* (pp. 345-361). Chicago: University of Chicago.

Radke-Yarrow, M., Richters, J. & Wilson, W. (1988). Child development in a network of relationships. In R. Hinde & J. Stevenson-Hinde (Eds.), *Individuals in a network of relationships* (pp. 48-67). Cambridge: Cambridge University.

Rehm, L. & Sharp, R. (1996). Strategies for childhood depression. In M. Reinech, F. Daltilio & A. Freeman (Eds.), *Cognitive therapy with children and adolescents: A casebook for clinical practice* (pp. 109-123). New York: Guilford.

Robinson, N., Garber, J. & Hilsman, R. (1995). Cognitions and stress: Direct and moderating effects on depressive versus externalizing symptoms during the junior high school transition. *Journal of Abnormal Psychology, 104*(3), 453-463.

Russell, T. T., & Russell, D. K. (1996). *The relationship between childhood depression, perceptions of family functioning and perceptions of classroom social climate: Implications for school counselors*. Retrieved October 10, 2001 from <http://orders.edrs.com/members/sp.cfm?AN=ED396197>

Shah, F. & Morgan, S. (1996). Teachers' ratings of social competence of children with high versus low levels of depressive symptoms. *Journal of School Psychology, 34*(4), 337-349.

Seligman, M. (1975). *Helplessness: On depression, development, and death*. San Francisco: W.H. Freeman and Co.

Seligman, M. (1995). *The optimistic child*. Boston: Houghton Mifflin.

Stark, K. (1990). *Childhood depression*. New York: Guilford.

Stark, K., Sander, J., Yancy, M., Bronik, M. & Hoke, J. (2000). Treatment of depression in childhood and adolescence: Cognitive-behavioral procedures for the