University of Northern Iowa
UNI ScholarWorks

Graduate Research Papers | Student Work

1991

Childhood depression

Jonnie M. Webster
University of Northern Iowa

Let us know how access to this document benefits you

Copyright ©1991 Jonnie M. Webster
Follow this and additional works at: https://scholarworks.uni.edu/grp

 Part of the Education Commons

Recommended Citation

Webster, Jonnie M., "Childhood depression" (1991). *Graduate Research Papers*. 3577.
https://scholarworks.uni.edu/grp/3577

This Open Access Graduate Research Paper is brought to you for free and open access by the Student Work 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.

Offensive Materials Statement: Materials located in UNI ScholarWorks come from a broad range of sources and time periods. Some of these materials may contain offensive stereotypes, ideas, visuals, or language.

Childhood depression

Abstract

This paper will focus on a study of childhood depression using the following format. Childhood depression will be defined; characteri cs and symptoms will be discussed; an overview of theories about etiology will be presented; possible treatments will be reviewed; and practical applications and possible treatment as they relate to school counseling will also be included.

This open access graduate research paper is available at UNI ScholarWorks: https://scholarworks.uni.edu/grp/3577

CHILDHOOD DEPRESSION

A Research Paper

Presented to

The Department of Educational Administration

and Counseling

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Masters of Arts in Education

---

by

Jonnie M. Webster

December, 1991

This Research paper by: Jonnie M. Webster

Entitled: CHILDHOOD DEPRESSION

has been approved as meeting the research paper requirements for the degree of Master of Arts in Education.

Richard Strub

10-30-91
Date Approved

Adviser/Director of Research Paper

Annie M. Jones

10-30-91
Date Approved

Second reader of Research Paper

Dale R. Jackson

10/31/91
Date Received

Head, Department of Educational Administration and Counseling

In contrast to the wealth of knowledge about depression in adults, relatively little is known about depressive symptoms in childhood (Altmann & Gotlib, 1988). However, in a relatively short time, childhood depression has gone from being essentially overlooked, to it's existence being challenged and denied, to being accepted as a distinct clinical syndrome (Clarizio, 1989). According to Kazdin (1989), research on childhood depression has only begun to emerge on the scene within the last fifteen years. Having been once widely unrecognized (Poznanski, 1982), childhood depression has recently gained acceptance by mental health professionals.

This paper will focus on a study of childhood depression using the following format. Childhood depression will be defined; characteristics and symptoms will be discussed; an overview of theories about etiology will be presented; possible treatments will be reviewed; and practical applications and possible treatment as they relate to school counseling will also be included.

Definitions

According to the Diagnostic and Statistical Manual of Mental Disorders (1987), (DSM-III-R) depression is

part of a larger category referred to as mood rather than affective disorders. The criteria for major depression is presented in two parts, inclusive and exclusive .

Inclusive

Under inclusive, at least five of the nine symptoms have been present during the same two week period; at least one of the symptoms was either depressed mood, or loss of interest or pleasure. The nine symptoms are: (1) Depressed mood most of the day, nearly every day; (2) Loss of interest or pleasure in all or almost all activities nearly every day; (3) Significant weight loss or gain (more than 5% of body weight in a month); (4) Insomnia or hypersomnia nearly every day; (5) Psychomotor agitation or retardation nearly every day (in children under six, hypoactivity); (6) Fatigue or loss of energy nearly every day; (7) Feeling of worthlessness or excessive or inappropriate guilt; (8) Diminished ability to think or concentrate, or indecisiveness nearly every day; and (9) Thoughts that he or she would be better off dead or suicidal ideation.

Exclusive

Under exclusive criteria, the symptoms, according to DSM III (1987), are: (1) Organic etiology has been ruled out; (2) Not a normal reaction to the loss of a loved one; (3) At no time during the disturbance have there been hallucinations for as long as two weeks in the absence of prominent mood symptoms; and (4) Not superimposed on schizophrenia.

At this point, it is important to establish the distinction between depression as a symptom as opposed to depression as a syndrome. As a symptom, depression refers to sad affect and as such is a common experience of everyday life (Weiner, 1982). According to Weiner , depression is said to be a familiar psychological state that most people have experienced in response to such disappointments and frustrations as misplacing a valued possession, failure to achieve a desired goal, facing the break up of a close relationship, or loss of a loved one. Weiner further goes on to point out that all of these events normally leave a person feeling sad, apathetic or unwell. However, as a syndrome or disorder, depression refers to a group of symptoms that go together. For example, Weiner (1982), indicates that sadness may be partly due to a larger set of

problems that also include loss of interest in activities, feelings of worthlessness, sleep disturbance, change in appetite, and others. When episodes of depression become more profound and last longer than events would seem to justify, they constitute a pathological depressive reaction.

The fact that depression as a clinical syndrome can be diagnosed in children, adolescents, and adults does not mean that the manifestations of the disorder are necessarily identical. DSM-III-R (1987) has recognized that there may be associated features for different ages and developmental levels. However, at present, these differences are not well specified and are based on primarily clinical experience rather than solid empirical research (Mash & Barkley, 1989).

Characteristics and Symptoms

The clinical picture of depression in children has similar symptomatology to that of depression in adults. The form of expression differs and relates to the developmental level of the child (Kazdin, 1990). For example, Kazdin suggests that prepubertal children tends to show somewhat greater depressive appearance, somatic complaints, psychosomatic agitation, and hallucinations than did adolescents. In contrast,

adolescents showed greater anhedonia, hopelessness, hypersomia, weight change, and suicide attempts. Many of the characteristics of the depressed child were discussed under the definition portion of the paper. In this section of the paper a more detailed summary is being given to some of those symptoms previously mentioned.

Depressed Affect

A child with moderate or severe depression looks very unhappy. The distinction between an unhappy child and a depressed child can be made in part by determining the duration of the child's down-cast mood. If the down-cast mood persists more than a month, then it qualifies as a depressive syndrome. The mood should be observed by multiple sources, including, parents, teachers, counselors, and significant others involved in working with the child. One of the best sources would be the classroom teacher because she spends a sizable amount of time during the day with the child (Pozanski, 1982).

Anhedonia

Pozanski (1982), defines anhedonia as simply the ability to have fun. Having fun is an integral part of a child's life, and a necessary ingredient for learning

and playing. Occasional boredom is a fact of life, but being bored 50%-90% of the time suggests that the child has fewer interests.

Social Withdrawal

Investigations examining the phenomenon of childhood depression have demonstrated a possible relationship between depressive symptoms and reported dysfunctional social behavior(Altmann & Gotlib, 1988). Altmann and Gotlib further suggested that depressed children spent more time alone. When these same depressed children did show interest in others, they were more negative and aggressive than non-depressed children.

Impairment of School Work

The depressed child differs from the learning disabled child in that the depressed child has been able to perform in school prior to the depression, whereas the learning disabled child has not. Another factor that may influence or impair school work is the depressed child's lack of energy. One may see these children volunteering to take naps in the afternoon or feeling too tired to engage in activities children normally enjoy. School work may also be influenced by the fact that the depressed child is often hypoactive,

and oftentimes speech and language retardation is common (Poznanski, 1982).

Lasko (1986) estimates that the incidence of childhood depression vary widely. In this study , Lasko cited that reported frequency ranged from less than 2% to as many as 30% of school-aged children. The degree of variation or discrepancy was attributed to whether depression was defined as a symptom or as a syndrome. Many may experience the symptoms while few suffer from the syndrome. It has been suggested by Mash and Barkley (1989) that adult depression generally is more prevalent among women than among men. To date, research has found no sex differences in prevalence of depressive disorder in clinical and nonclinical samples of children (aged 6-12). However, Mash and Barkley suggest that among adolescents, the prevalence is greater in females than males.

Etiology

The causes of depression may be summarized under two headings, psychosocial, and biological models (Mash and Barkley, 1989).

Psychosocial Models

Three models or theories will be highlighted under the psychosocial model. They are the psychoanalytic,

behavioral, and cognitive models. The psychoanalytic models focus on intrapsychic influences. It has its beginnings with Freud's emphasis on unsatisfied libidinal strivings, particularly object loss e.g., a parent who fails to fulfill the child's needs (Mendelson, 1982). This model also states that the self criticism and self rejection of depressed persons are attributed to the battle of the ego and the superego which reflects these values (Mash and Barkley, 1989).

According to Clarizio (1985), the behavioral model focuses on learning, environmental consequences, and skills acquisition and deficits. The author further stated that symptoms of depression are considered to result from problems of interacting with the environment. It was further suggested by Nezu and Ronan (1985) that persons who are depressed, when compared to nondepressed persons, indicate deficits in generating alternative solutions to social problems, engaging in means-ends thinking and making decisions.

The cognitive model as it relates to etiology presents several different models, each emphasizing a specific view or position. One example of a cognitive model is Seligman's learned helpless model (Abramson,

et. al., 1978). This learned helplessness model suggests that depression results from peoples' experiences and expectations that their responses do not influence events in their lives. Another cognitive based position proposes that depression is related to deficits in interpersonal problem-solving skills (Nezu & Ronan, 1985). Nezu and Ronan further suggested that persons who are depressed, when compared to nondepressed persons, indicate deficits in generating alternative solutions to social problems, engaging in means-ends thinking and making decisions.

Biological Models

The biological models that will be discussed at this time include the biochemical and the genetic models. Under the biochemical model, Mash and Barkley (1989) suggest that a number of biochemical agents have been implicated in depression. They further imply that most of the research done in this area has focused on the identification of neurotransmitters that may in fact underlie depression. Mash and Barkley cited monomines as an example in which there is an imbalance of this transmitter and this causes depression.

Genetic models show indications that genetic influences in depressive disorders have been

physical symptoms considered to be consequences of these cognitions. Second, the therapist elicits thoughts, self-talk, and interpretations of upsetting events. Third, the therapist gathers from the client evidence for or against certain perceptions or interpretations. The therapist usually ends by setting up homework assignments to test out the validity of the perceptions or beliefs (DiGiuseppe & Bernard, 1983).

Family Therapy

At least two assumptions underlie family therapy. One is the belief that noxious family relationships cause affective problems in children. The other is the belief that the affective problems of any one member are determined and maintained by the problems of the relationship within the family. Family therapists advocate treating the mother, father, and children as a total unit (Clarizio, 1986).

Drug Therapy

Some clinicians strongly advocate using antidepressant medication in treating depressed children, whereas, others state flatly that drugs are of little benefit. When medication is used, to date, tricyclic antidepressants such as imipramine have been most widely studied and used for depression in children

(Mash & Barkley, 1989). Several studies have examined the effects of combined psychotherapy and medication. The combination of psychotherapy and medication has been shown to be more effective than either treatment alone (Klerman & Schechter, 1982).

Multimodal Therapy

Multimodal treatment addresses the various factors that contribute to the development and maintenance of depression in children-home, school, community, intrapsychic, physiological, and cognitive. In brief, multimodal therapy involves several methods, such as individual psychotherapy, academic remediation, and antidepressive drug therapy, depending on a comprehensive assessment of the child's problem (Clarizio, 1986). Clarizo explains that a counselor may want to consider using the multimodal treatment package when (a) the disorder has multiple roots; and (b) the depressed child has problems in more than one area.

Practical Applications and Interventions as They Relate to School Counseling

In the following discussion, four studies have been cited regarding the topic of childhood depression. The first two studies (Brown,et. al, 1988) and (Ney,

et. al., 1986) present information in reference to the connection of childhood depression to academics. The latter two (Stiles, and Kottman, 1990,) and (Downing, 1988) refer to interventions that school counselors can use to treat depressive symptoms expressed by school-aged children.

Childhood Depression and Academics

In a study that was done on depression in attention deficit-disordered (ADD) and normal children and parents of both groups (Brown, et. al., 1988), some interesting findings were discovered . This study revealed that one important cluster of symptoms characteristic of adult depression is cognitive impairment, including the ability to concentrate and sustain attention. According to this study, there is now evidence to show that depressed children show similar difficulties. Some of these cognitive deficits in children include having difficulties in problem solving on higher order cognitive tasks; poor academic performance; and inattention. These are all factors that influence a child's classroom performance. The study also indicated that ADD children and their parents reported higher levels of depression than did their normal counterparts.

Ney and others (1986) cited a study regarding depressed children showing symptoms of aggressive behavior and learning difficulties. They reported the importance for teachers and psychologists to distinguish between depressed children who have learning difficulties from those who have learning difficulties and are subsequently depressed. They found that learning difficulties in children may contribute to depression, and depression may result in school difficulties. The study also revealed that depressed children may need to remain active because they have not yet learned they can withdraw and survive without adult attention. Their activity may become aggressive when met by a lack of understanding and hostility from adults. The study reported finding a number of children who had been diagnosed by teachers as learning disabled. It was suggested by Ney et. al. that teachers may find it easier to diagnose and treat a learning disability because of their orientation, but, being labeled as learning disabled may compound the child's depression.

Interventions that can be used by School Counselors

According to a study that was done in regard to working with depressed children in a school setting,

mutual storytelling was used as a counseling intervention (Stiles, & Kottman, 1990). This study projects that given the increasing incidence of depression and suicidal behavior among children, it may be necessary for school counselors to acquire the skills to successfully intervene with sad or depressed children. Mutual storytelling in the context of play therapy, is one of the methods of working with children who are expressing difficulties. The authors warn that this technique should not be used as an intervention with children who demonstrate a high degree of lethality. These children should be referred for psychiatric evaluation and possible hospitalization.

The last study focused on the concept of significant others in a child's life who may be contributing to the maintenance of the depressed status of the child (Downing, J., 1988). In this study Downing (1988) discusses a concept or approach to counseling depressed children which incorporates a multifaceted system involving home, school, physician, and the child. The basic thrust of the intervention consist of an educational process for the child and the significant adults. Some specific components of the intervention are as follows: (1) Consistent monitoring;

(2) successful experiences (most important); (3) increased activity level; (4) positive support for the team; (5) limited inappropriate attention; (6) teaching the child coping or change skills; (7) productive use of guided fantasy and daydreams; (8) using simple biofeedback; and (9) using affirmations.

In conclusion, the term depression tends to bring to mind an image quite contrary to the picture that one normally has of children. The term childhood depression indeed sounds like a contradiction. However, childhood depression is a reality and may seriously effect many areas of the child's world. The review of literature referenced above indicates that depression, if not properly handled may have a negative influence on a child's academic and social environment. Sometimes the child has to deal with a combination of elements. The depressed child may have a learning disability, or parents who suffer from depression. Both of these may contribute to the child's own depression. I believe that teachers and school counselors are in key positions to observe and identify children suffering and dealing with depression. Such school personnel may also be able to intervene with these depressed children and help them return to a

fully functioning status. Perhaps the most compelling aspect of recent information about childhood depression is the positive prognosis when school personnel and parents work together. There is no limit to the creative ways counselors, teachers, parents, administrators, and children themselves can use behavioral, affective, and cognitive systems to assist the child in feeling better. The struggle to understand and to commit to devise feasible and workable techniques to deal with today's problem for today's child is indeed a challenge.

Bibliography

Abramson, L.Y., Seligman, M.E.P., & Teasdale, J.D. (1978). Learned helplessness in humans: Critique and reformulation. Journal of Abnormal Psychology, vol. 87, pp. 49-74.

Atmann, E.O. & Gotlib, I.H., (1988). The social behavior of depressed children: An observational study: Journal of Abnormal Psychology, vol. 16, pp. 29-44.

Brown, T.R., Borden, K.A., Clingerman, S.R., & Jenkins, P.B., (1988). Depression in attention deficit -disordered and normal children and their parents: Child Psychiatry and Human Development, vol. 18, pp. 119-132.

Clarizio, H.F. (1985). Cognitive - behavioral treatment of childhood depression. Psychology in the Schools, 22, pp, 308-322.

Clarizio, H.F. (1986). Treatment of childhood depression: The State of the art; Techniques, vol. 2, pp. 322-333.

Clarizio, H.F. (1989). Continuity in childhood depression: Adolescence, vol. XXIV (94), pp. 253-267.

Cole, D.A., & Rehm, L.P., (1986). Family interaction patterns and childhood depression. Journal of Abnormal Psychology, vol. 14, pp. 297- 314.

Diagnostic and Statistical Manual of Mental Disorders, 3rd ed., rev., by American Psychiatric Association, 1987, Washington, D.C.

DiGiuseppe, & Bernard, M. (1983). Principles of Assessment and Methods of Treatment with Children. In A Ellis & M. Bernard (Eds.), Rational Emotive Approaches to the Problems of Childhood, New York: Plenum.

Downing, Jerry (1988). Counseling interventions with depressed children: Elementary School Guidance and Counseling, vol. 23, pp. 231-237.

Kazdin, Alan, E. (1990). Childhood depression: Journal of Child Psychology and Psychiatry and Allied Discipline, vol. 31, pp. 21-160.

Klerman, G.L. & Schechter, G. (1982). Drugs and Psychotherapy. In E.S. Paykel (Ed.), Handbook of Affective Disorders (pp. 329-337). New York: Guildford press.

Lasko, C.A. (1986). Childhood depression: Questions and answers: Elementary School Counseling and Guidance, vol. 20, pp. 283- 288.

Mash, E.J. & Barkley, R.A., (1989). Childhood Depression. Treatment of childhood Disorders (135-164), New York: Guildford press.

Mendelson, M. (1982). Psychodynamics of Depression. In E.S. Paykel (Ed.), Handbook of Affective Disorders (pp. 162-174). New York: Guildford Press.

Ney, P., Colbert, P., Newman, B., & Young, J. (1986). Aggressive behavior and learning difficulties as symptoms of depression in children: Child Psychiatry and Human Development, vol. 17, pp. 3-14.

Nezu, A.M., & Ronan, G.F. (1985). Life stress, current problem-solving, and depressive symptom: An integrative model. Journal of Consulting and Clinical Psychology, 53, pp. 693-697.

Nurnberger, J.I., & Gershon, E.S. (1982). Genetics. In E.S. Paykel (Ed.), Handbook of Affective Disorders (pp.109-125). New York: Guildford press.

Pozanski, E.O. (1982). The Clinical phenomenology of childhood depression: American Journal of Orthopsychiatry, vol. 52, pp. 308-313.

Stiles, K., & Kottman, T. (1990). Mutual storytelling: An intervention for depressed and suicidal children: The School Counselor, vol. 37, pp.337-342.

Weiner, I.B. (1982). Affective Disorder: Depression and Mania. In Irving B. Weiner (ed.), Child and Adolescent Psychopathology (pp. 264-297), New York: Wiley Press.