Order Number 9030112

Depression and children/adolescents: Behavioral correlates of a mood disorder in hospitalized youth

Byrns, Judy Elaine, Ph.D.

The University of Nebraska - Lincoln, 1990

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

DEPRESSION AND CHILDREN/ADOLESCENTS: BEHAVIORAL CORRELATES OF A MOOD DISORDER IN HOSPITALIZED YOUTH

by

Judy E. Byrns

A DISSERTATION

Presented to the Faculty of
The Graduate College in the University of Nebraska
in Partial Fulfillment of Requirements
For the Degree of Doctor of Philosophy

Major: Psychology

Under the Supervision of Professor John Berman

Lincoln, Nebraska

May, 1990

DISSERTATION TITLE

Depression and Children/Adolescents: Behavioral Correlates of a Mood Disorder in Hospitalized Youth

BY

Judy Elaine Dannehl Byrns

SUPERVISORY COMMITTEE:

	APPROVED	DATE
Signature	John J. Berman	5/7/90
Typed Name	John Berman, Ph. D.	
Signature	James K. Cole	5/07/90
Typed Name	James K. Cole, Ph.D.	
Signature	P. Clayton Rivers	5/07/90
Typed Name	P. Clayton Rivers, Ph. D.	
Signature	Calvin Garbin	5-07-90
Typed Name	Calvin Garbin, Ph.D.	
Signature	Jane Clare Conoley	5/07/90
Typed Name	Jane Conoley, Ph. D.	
Signature		
Typed Name		

GRADUATE COLLEGE
UNIVERSITY OF NEBRASKA

DEPRESSION AND CHILDREN/ADOLESCENTS: BEHAVIORAL CORRELATES OF A MOOD DISORDER IN HOSPITALIZED YOUTH

Judy E. Byrns, Ph.D.

University of Nebraska, 1990

Advisor: John Berman, Ph.D.

Depression is a mood disorder that has been recognized in adults, with a variety of etiologies and subtypes. The past twenty years have seen a preponderance of literature which applies the same etiologies and subtypes to children and adolescents. Most of the same adult criteria are currently used to diagnose depression in children and adolescents. Because relatively few children and adolescents can recognize and report the existence of depression to doctors, one of the criteria for the identification of the disorder is that the child "looks depressed". This criteria has not been clearly defined, especially in terms of observable behaviors, but the common assumption seems to be that lack of eye contact and smiling along with tearfulness are the defining observable behaviors. The present study investigated such behaviors among children and adolescents who had been hospitalized for emotional and behavioral problems (not including drug and alcohol abuse) and found that it is possible to discriminate between depressed and nondepressed children and adolescents by slow or absent gross body movements, appetite and sleep disturbance, and school refusal. The commonly assumed

behaviors were not able to discriminate between depressed and nondepressed children and adolescents. Other correlations were obtained which suggest that anxiety may coexist with depression and that the patients themselves are better able to identify their mood disorder than are their parents. No gender differences were obtained. A description of a checklist for observing depressive behaviors in children and adolescents, along with implementation procedures, is presented.

ACKNOWLEDGEMENTS

Mayhaps the precise composition of this section will be the hardest. Herein must contain the Truth according to Judy. I cite no one but myself. Now is when I acknowledge ((a.) to recognize as a fact or as one's own, to confess (b.) to express thanks for (c.) to give validity) my dissertation. Some of you know the whole story of this struggle. All of you are deeply held in gratitude.

To my committee members, the first and foremost thank you. Your guidance in this final project was excellent. Scotty, from the day you telephoned me in Kearney, Nebraska to offer a position in the new field of Rural Psychology to your new job in Virginia, you have provided the role model for assertive and caring power-holding. You have been a worthy ally. John, your ability to step in and provide guidance for a semi-completed project was impressive. You seemed to resist the urge to "start over", allowing and assisting me to focus my writing in a professional manner. With the exception of my guru in Kentucky, you were the best teacher I ever had (and I have had more excellent teachers than anyone I know). Jim, my genuine fondness for the minifield of neuropsychology comes from you. I have always appreciated your gentle support and wisdom. Your explanation of reciprocity is the core of my superb clinical skills. Cal, your sincerity and humor made the scariest

part into a most satisfying part. The ability to manipulate machines and mathematics is a joyous feeling - and when it WORKS, well. You know what I mean. Jane, your prompt and precise feedback was most helpful in providing direction. I always felt that you understood and approved of my research. Mary, your willingness to assist me with the initiation of the project, to guide the proposal stage, was so stalwart.

To the staff and patients at BMU; Tom, Ronn, Mickie, Kathy, Diane, Kay, Harvey, the Techs, the nurses, and to Carey and Tina - you all helped to make this huge project possible, with the most empirically sound techniques. I could never have finished without you.

To Harvey, who exemplifies the entire profession of psychiatric nursing, all my love.

To Beth, your skills with the 'puter and the 'phone made some of the work painless and your wit/love/strength will always remind me of my best work. Motherhood was raised to a pinnacle because you grew up so beautifully. To Jason, your brilliance has kept my mind ever-expanding and without my "computer support team", I would have been lost in hi-tech dust. Your portrayal of "a depressed male adolescent" is rivaled only by Dustin Hoffman in "Rain Man".

The decision to become a doctor was made ten years ago. It has been a time of personal and professional growth seldom experienced by midwestern, midaged women. I owe a great deal to the women who helped me. To Debrah, who

provided co-parenting and stress reduction; to Barbara, who provided such beauty and class; to Natalie, who named the struggle and always encouraged; to Theo, you are the role model I still need; to Jocelyn, you helped me be a part of the best family in Lincoln; and to Pat, you helped me stay open and honest.

To the Hobo, you gave me the music, the tears, the memories, and the sacrifice which will forever surround my work.

To my family of origin - Mom, Daddy, Jerry, Dan, Kurt, Matt, and Bill - this is all for you - to all of you I offer my most humble expression of thanks.

To Pat -thank you, dear one. You gave me the strength, the courage. But we both know that you just helped me to find my own - and then to trust myself. The strength and the courage were there for me and within me all the time, just not easily acknowledged. And so I finally acknowledge. I confess. I validate. I am woman. I am doctor.

IN MEMORY OF

Grace Mueller Bean

Jones

TABLE OF CONTENTS

CHAPTER FOUR: RESULTS

CHAPTER FIVE: DISCUSSION

Chapter One: Introduction

There still exists controversy regarding the various criteria for diagnosis of depression in children and adolescents, as well as the many aspects of etiologies and treatments of childhood depression. Many professionals and lay persons working with children and adolescents, in education, medicine, parenthood, and other overlapping fields, will have the opportunity in their daily interactions to wonder about the possibility of a treatable depression as the underlying cause for behavior problems. In order to treat depression, one must first accurately diagnose the condition. Although much research has been done in the past 10 years about childhood depression, there are still several methods or sets of criteria used to obtain a diagnosis of depression. The current study will provide observational data and empirical analysis to further clarify one of the main concepts or criterion in the proper assessment of childhood depression.

In this first chapter an overview of the issues concerning the diagnosis of depression in children and adolescents is presented. The problem to be examined in the present research is clearly identified. A review of the literature, with historical background as well as definitional and theoretical focus, is provided in Chapter Two. Six hypotheses, to be tested in this research, are specified following the literature review. The methodology

is described in Chapter Three, as an empirical design to analyze a large set of observational data in light of the hypotheses in this study. The results are provided in Chapter Four and a discussion of the relationship of the results to the problem, based on the specified hypotheses, is contained in Chapter Five.

Overview of Present Study

Fifty years ago children who were "seen and not heard" were considered well-disciplined. Today many parents as well as professionals are suspicious of quiet children because a lack of social interaction may be symptomatic of a mood disorder. Depression is a treatable disorder and most children and adolescents rely on the adults in their lives to initiate such treatment. A variety of problems, including many behavioral problems such as physical aggression or a reluctance or refusal to attend school, may be attributed to depression; and yet it is not a precise and easily-identifiable disorder. Children and adolescents come to the attention of teachers, law enforcement members, social service workers, physicians, and mental health professionals for a variety of concerns which may or may not include the suspicion of depression. Child psychiatrists report that depression is never diagnosed in many children who are seen by psychiatrists because of other problems (Rosenstock, Kraft, Rosenstock, Mendell, & Stubblefield,

1986). They stress the need to recognize its symptoms so as not to miss the concomitant depression.

Current practice among clinical pyschologists and psychiatrists dictates a set of criteria, contained in the Diagnostic and Statistical Manual-Third Edition-Revised, by which the diagnosis of childhood depression is made (see Appendix A for DSM-III-R diagnostic criteria). One of the standard criterion is that the child should look depressed. This criterion is found in all of the currently accepted diagnostic lists used in research and practice (see Appendix A for lists). No further definition of this depressed look is offered, probably because this seems obvious or self-evident. Everybody knows what "looks depressed" means. However, one could doubt this basic assumption because it is subjective and because many cases of childhood depression seem to be missed.

Two problems are clear when considering the difficulty of diagnosing depression in children and adolescents based on a "look". The problem in testing the common assumption is to determine if there indeed exists observable behaviors which are related to the diagnosis of depression in children and adolescents. These behaviors must be clearly defined so that the presence or absence of the behaviors can be directly observed. A related problem is to determine if the observable behaviors can be differentiated from other problem behaviors exhibited by children and adolescents.

Anxiety and anger have often been correlated with child and adolescent depression (Eason, Finch, Brasted, & Saylor, 1985; Harris & Howard, 1987).

The purpose of this research is to develop a reliable method for discriminating between depressed and normal behaviors which might be observable in children and adolescents who are experiencing problems in living as described by their parents and teachers. Because one of the basic criteria for assessing depression in children and adolescents is a look of depression, further reliable and valid description of this look is needed. The reliable assessment of depression is the first step toward developing a treatment plan which has a goal of decreasing the experience of depression.

Chapter Two: Review of the Literature

This chapter is a review of the literature as it relates to the concepts and issues contained in the broad area of child and adolescent depression. It is divided into eight sections. First, a comparison of depression in adults and children is discussed as a basis for the overall study. Second, depression as a syndrome in children and adolescents is discussed with a particular focus on the historical progression of this relatively new and still controversial syndrome. Third, an overview of several theories of child and adolescent depression is presented, with an attempt to explain the possibility of interactions and interrelatedness among the theories. The fourth section contains another perspective of child and adolescent depression with the focus on seven subtypes or models of depression which either are or have been used in clinical practice. The fifth section defines the current widely-accepted concept of child and adolescent depression and considers the criteria which are used to diagnose this disorder. The sixth section contains a more specific discussion concerning possible observable behaviors of depression, because it is this diagnostic criterion which remains to be scientifically researched. The seventh section offers a discussion of assessment as it relates to the other diagnostic criteria of depression. Multiple methods are described. The final section contains a summary of the literature and rationale

for the present research, with six specific hypotheses stated.

A Comparison of Depression in Adults and Children

Depression is a mood or affective disorder experienced by thousands of the adult population at any given time. Current estimates place the figure at approximately 20% for a lifetime expectancy to experience an affective disorder (Gotlib & Colby, 1987). The experience of depression has been related to job inefficiency, social withdrawal, family dysfunction, and suicide (Dohrenwend & Dohrenwend, 1976; Lazarus & Folkman, 1984; Padfield, 1976; Rounsaville, 1978). All of these consequences take a toll on the lives of individuals and families, both economically and in terms of meaningful and fulfilling living situations (Dolinsky, 1982; Russell, 1978; Weeks & Drengacz, 1982). Individuals suffering from some form of depression rarely do so without affecting the lives of others, either by being unable to perform their normal activities, to interact positively with family or friends, or by taking the time of professional service providers in the quest for relief from this mood disorder (Millman, Huber, & Diggins, 1982). The experience of depression in one person can result in a sense of helplessness and confusion in that person's loved ones, who wish for some expression of happiness that is often not forthcoming (Russell, 1978).

Perhaps our society has overrated the "pursuit of happiness", but it does seem to be a motivating force for many, and the sense of unhappiness will send people searching for relief. Depression seems to be a subjective experience, perhaps different for each individual, but generally agreed to be a nondesirable state of emotional discomfort (Arieti & Bemporad, 1980; Kaslow, Rehm, & Siegel, 1984). It is also agreed that depression is costly to individuals and to society, so that efforts to alleviate this condition are supported (Harder, Strauss, Kokes, Ritzler, & Gift, 1980; Millman, Huber, & Diggins, 1982; Padfield, 1976; Rounsaville, 1978).

In recent years, the condition of depression has been explored in more depth and with more attention to various subtypes and populations. There has been extensive work with depressed adults as to understanding, classification, and treatment of depressive states (Beck, 1974; Liberman & Raskin, 1971; Wolpe, 1979).

The current understanding of adult depression is that depression is a syndrome which can be diagnosed using a standard set of criteria. A syndrome is a collection of feelings and behaviors as experienced by human beings. Psychologists and psychiatrists use the Diagnostic and Statistical Manual - Third Edition - Revised (DSM-III-R) to diagnose the depressive syndrome. The DSM-III-R (APA, 1987) describes depression as a mood disorder or mood syndrome.

Depression is a group of "mood and associated symptoms that occur together for a minimal duration of time" (p. 213). By definition, this syndrome excludes feelings that have an organic or psychotic basis.

The feeling or emotion that is most often associated with depression is one of dysphoria (i.e., a sense of ill-being or dissatisfaction), although this is not a necessary requirement for the diagnosis of depression (Yapko, 1988). One can be depressed without feeling dysphoric because this feeling may be outside of the individual's conscious awareness. Yapko (1988) describes associated dimensions of depression which may exist within or without awareness and which are amenable to treatment. These dimensions, which have numerous components, are (a) an individual's thought patterns, (b) situational responses, (c) physical conditions, (d) relationship patterns, and (e) historical factors. He states that depression is "a warning signal that at some level a change is needed in order to build or restore a healthy balance..." (p. 72).

The Harvard Medical School published an update on the nature and causes of depression. The rates of incidence were reported to be difficult to determine with precise accuracy due to the varying definitions and diagnostic criteria used in recent studies. A common current estimate is that 2-3% of men and 4-9% of women are suffering from major depression at any given time (Harvard Medical School