

## ***Depression and Childhood Illness***

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**ABSTRACT:** Childhood depression as a component of the impact of childhood illness or developmental impairment on the latency age child is studied in relation to three diagnostic groups: children with asthma, cancer, and psychiatric diagnoses of behavioral disorders. The study revealed a range of coping styles to deal with the anxiety, loss and feelings induced by the specific crises. The special dimensions of stress and coping adaptations affected the child's developing self concept, the separation individuation process and the child-parent relationships. Depressive symptoms were variously present within and between the three groups of children.

### **Introduction**

For a long time the prevailing clinical viewpoint was that children could not suffer from depression because they did not have sufficient superego development to internalize the self-criticism that was thought to be necessary for depression. In the last 15 years, however, researchers in child development have documented the existence of depression in infants and children. [Bowlby, J., 1980; Fraiberg, S., 1980] In addition, Cytryn and McKnew described masked depression in children which is typically expressed by acting out and aggression. [Cytryn, L. and McKnew, D., 1974] Furthermore, theoreticians like Anna Freud and Dorothy Burlingham have described the impact of loss and stress on the child at various phases of development and the potential interference of these crises with the mastery of developmental tasks. [Freud, 1966 and Freud and Burlingham, 1944]

This paper focuses on childhood depression particularly as a component of the impact of childhood illness or developmental impairment

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on the latency age child. The conceptual approach of this study drew heavily on the theoretical premises of A. Freud's concept of developmental lines, developmental adaptation models, [Sroufe, Rutter, 1984] and family functioning theory. The insights from this study regarding depressive symptomatology in children has implications for all children and families in situations of extraordinary stress from whatever causes.

The literature on childhood depression is only itself beginning to be developed both theoretically and descriptively. Indeed, DSM III 1980 does not have a diagnosis of depression until adolescence—although particular behavioral problems, vulnerabilities in ego functioning and low self-esteem are now being recognized as components of childhood depression. The Depression Rating Scale used in this study is one of the developing scientific efforts to assess symptomatic and internalized depressive features in children. [Poznanski, E. O., 1984]

This paper developed from a larger research project that studied both the effects of chronic medical illness and chronic psychiatric symptoms on the development of latency age children as well as the impact of these crises on families, particularly parental functioning. The child subjects were drawn from three diagnostic groups: children with asthma, cancer, and psychiatric diagnoses of behavioral disorders. The findings suggest there are a range of coping styles with which children deal with the anxiety, loss and feelings induced by these specific crises. The stress and coping adaptations take on special dimensions in each of these groups of children, affecting both the developing self concept and separation individuation process of all these children, and the child-parent relationships.

The inclusion of families added an important dimension to our understanding of the adaptations required of the family system and parents. This study suggested that the parents themselves deeply experience the developmental crises of their children. They face an important series of new burdens and subsequent parental adjustments as they try to help their children address developmental tasks while coping with their medical and psychological condition.

### **Illness as a Stress for the Child and Family**

A better understanding of the relationship between extraordinary stress, loss and depression would, we believe, greatly assist our capacity to help children with chronic illness and their families. When a

latency age child is diagnosed with a chronic illness, or has severe developmental problems, it invariably means certain stresses for both the child and his family. Each disease has its own unique patterns of symptoms and expected course. There are also wide individual psychological and health differences among the children and families. For instance, asthma can be mildly troublesome or life threatening, and some children can continue on a normal developmental path while others regress. Additionally some families cope with stress and uncertainty well and other families become disorganized in the face of the child's chronic illness (Pless, I.B., et al., 1972).

Despite differences, all chronic illnesses involve the child's experience of pain, disappointment, and physical distress, and compliance with a prescribed course of treatment, which may be uncomfortable and constrain his normal activities. [Stein, R. and D. Jessop, 1982] In addition, these constraints make the child different from peers, and being different creates difficulty for the child's self-esteem. The situation is particularly difficult because of the changing dynamics of the child-parent relationship.

Chronic illness in latency age children clearly impacts upon normal social, affective and cognitive development. This is ordinarily a time when the youngster's knowledge of the world and the people around him expands enormously, beyond the boundaries of his nuclear family.<sup>1</sup> His objects include schoolmates and neighborhood friends. He is busy learning all of the basic skills he will use in his lifetime. The psychological individuation from parents and his emerging autonomy become sturdier as his attachments to peers and teachers become important. [van Amerongen, 1979]

All chronic illnesses<sup>2</sup> disrupt school attendance to some extent, but not usually enough to qualify the child for special education programs, so that just keeping up with the progress of the class becomes an extra burden and a possible occasion for failure. Somehow the child must reconcile the two worlds of school and hospital or clinic, of normal developmental tasks and special problems because of illness.

At this point in a child's development, his identity or internalized perception of himself depends on the knowledge and physical competencies he masters. If his body is sick or weak, or causes him pain, he experiences it as an alien, untrustworthy part of himself. If he cannot negotiate relationships or control his feelings or concentrate, his

<sup>1</sup>The pronoun "him" refers to males and females for the context of this paper.

<sup>2</sup>"Illness" will be used to refer to medical illness and psychiatric diagnosis.

sense of failure is heightened. Because the illness is chronic, it becomes part of his identity. He may be too young to understand the etiology of the disease and instead have magical ideas that he is sick because he is bad. Regression is a very expectable consequence of being sick, and it is difficult for the child not to retreat from his own developing autonomy to the comforting circle of his mother's care.

A latency age child is also old enough to be aware of his special role in the family system. He knows that he is the occasion of increased anxiety on the part of his parents, that his illness causes some financial burdens, and that he might be a cause of some tension between his parents. He also knows that he probably consumes a disproportionate amount of the family's physical and emotional resources. He is likely to be favored and indulged, even infantilized, because of the limitations of his illness, and he's aware of his siblings' resentment and guilt.

The families of children with chronic illness or impairment must undertake arduous and long-term special responsibilities. Caretakers must cope with the unpredictability of the course of the disease and the constant anguish of watching a child suffer, having to protect him and seeing to it that the prescribed treatments are carried out. At the same time, they must encourage the child's normal development and individuation from them, all in the face of traumatic crises and hospitalizations. [Kaplan, D., et al., 1973; Koocher, P. and J. E. O'Malley, 1983]

Parents also worry about the fair distribution of family resources such as money, time, emotional and physical nurturance. Siblings are more likely to have adjustment, behavioral and academic problems than children with healthy brothers and sisters. They are also more likely to feel guilt, jealousy and resentment toward their ill sibling. (Drotar and Bush, 1985) Parents often have increased tension and disagreement between themselves, often about the care of the ill child, and sometimes the parents develop their own health problems as a consequence, such as extreme fatigue, headaches, insomnia, ulcers, eating disturbances. [Kalnins, 1983; Allen, Townley and Phelen, 1974]

Most chronic illnesses are costly to treat and mean a financial burden for the family, sometimes a crushing one. There also may be problems that develop in the relationship between the sick child and his primary caretaker. The diagnosis of a chronic illness, just as in mental retardation or birth defects, can be shattering for the parents' self-esteem and their perception of themselves as good parents. If the

disease has a demonstrable genetic etiology, such as cystic fibrosis, parents may feel they have given the child defective genes.

All of these stressors that we have noted are magnified when the child lives in a single parent family or even a reconstituted family. A single mother trying to earn a living and provide care for a chronically ill child is going to be pushed to the limits of her ability to cope. Even with remarriage, stepparents may be reluctant to assume a full share of the burden of caring for a child that is not biologically theirs.

In general, therefore, both the family and the child are at high risk for psychological and physical distress. Inasmuch as depression or grief is reactive to loss and uncertainty, these families and children are at risk for depressive symptomatology. Furthermore, it is noted that underlying depressive features or melancholia can be exacerbated in the face of extraordinary loss. [Rutter, et al., 1986]

#### *The Overall Study: Method and Findings*

As previously noted, the insights into manifestations of childhood depression emerged from a larger study of latency age children and their families coping with chronic illness and behavioral problems. This was a study of 60 children and their families from three clinics at the University of Michigan Medical Center: Pediatric Hematology, Asthma, and Child Psychiatry. Each group consisted of 20 children and their families. The research study arose from a desire to understand better the relationship between family functioning and the adaptation of children experiencing a developmental crisis.

The study protocols measured levels of family functioning, social support, caregiving burden, stressful life events and included a comprehensive assessment of the child's health and psychosocial development, as well as full demographic data. All of the children had recently been admitted to the hospital for evaluation and treatment planning and would eventually use the tertiary care hospital for acute care and follow-up treatment. The data were supplemented by open-ended interviews with a subset of families.<sup>3</sup>

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<sup>3</sup>The study variables employed were: the *Family Assessment Device* (Epstein, Baldwin and Bishop, 1983), the *Functional Status Measure* (Stein and Jessop, 1982), the *Child Behavior Checklist* (Achenbach and Edelbrock, 1983), the *Social Health Battery* (Brook, Ware, Davies-Avery, etc., 1979), and the *Recent Life Changes Questionnaire* (Rahe, 1974, as modified by McFarlane, et al., 1980), the *Clinician's Burden Index* (Stein and Jessop, 1982), and the *Childhood Depression Rating Scale* (Poznanski, 1984).

The ages of the children in the sample ranged from 4-13, with a mean age of 8.9 years. The children were 73% boys, which would be expected from what we know about the incidence of males with asthma and conduct disorders. The families in the sample were better off socioeconomically than a national sample would have been: 80% of parents were married; over 93% were white; 38% had graduated from college or had some college education; their mean income was \$26,186.00. One parent from each family, a primary nurse, and the children were interviewed and responded to the survey instruments.

The three groups of children and families faced significantly different problems: The children with asthma had a chronic respiratory disorder which had acute, sometimes life-threatening, flare-ups. They needed both acute care and a daily monitored regimen of care by their parents. The children from the hematology clinic were diagnosed as having leukemia and were treated with chemotherapy, and had periods of remission and renewed symptoms. Treatment had difficult side effects and normal periods of life were frequently interrupted by the illness and side effects of the treatment. The children diagnosed as having behavioral disorders had a mixed group of specific DSM III diagnosis, ranging from attention deficit and learning disorders, to oppositional and conduct disorders, and adjustment and major depressive disorders.

The overall analysis of the data showed some interesting differences and similarities between the groups. Table I presents the results of an analysis of variance of the study scale measures in five significant areas. On the whole, the asthma and cancer children were doing well in many areas and were closely matched in terms of the scores achieved in the various measures of school and social competency. However, the children with behavioral disorders achieved statistically significant lower scores (at the  $<.10$  level) in all social/developmental competency areas, as well as having increased behavioral problems. In terms of family functioning, the data showed a statistically significant difference between asthma and cancer families on the one hand, who exhibit higher rates of family functioning, and the families of children with behavioral disorders on the other.

Turning to our measures of perceived family burden, the analysis of variance indicates that the parental burden, perceived both by nurses and parents reveals statistically significant increasing levels of overall burden and stress as one moves to caring for children with asthma to cancer to behavioral problems. Interestingly, in terms of actual burden as measured by the medical scale alone, asthma families are rated as carrying the highest burden. Thus, the analysis of variance

seemed to imply that there were significant burden differences between the groups. In the broadest terms, it appeared that severe developmental problems were significantly more difficult for the child and family than problems of a primarily medical onset.

It seemed to us that a closer analysis of the data would be important in order to more fully understand the adaptations and coping mechanisms which the children and families made in handling the stress of illness and atypical development. In this respect, the Depression Rating Scale yielded the most important clinical insights and differences among the three groups. The analysis of the Depression Scale [Table I] showed the overall scores ascending from the cancer, to asthma, to behavioral disorder groups. The important insights, however, evolved from a close look at the patterns of the 19 discrete measures of this overall scale [Fig. 1]. Here it became evident that each of the groups of children had different levels of difficulty with school, peers, self-esteem, and feelings of physical and psychological well-being. A further statistical analysis of these measures produced a grouping of these individual dimensions into four different factors [Table 2] that were helpful in the analysis of child characteristics and family relationships. The next section of this paper describes the outcome of an analysis of the Depression Scale factors with specific child and family measures within each of the three groups of children and their families.

## **The Dynamics of Depression**

### *Children with Cancer*

Overall and comparatively speaking, the children diagnosed as having cancer had the least elevated depression scores despite the ominous prognosis of their disease [Table I]. The highest scores on the depression scale were in the spheres of fatigue, physical complaints, morbid ideation, weeping and slowed speech [Fig. 1]. However further analysis revealed, feelings and energy levels rose and fell relative to periods of general health. When general health was poor, the children became more depressed, and eating and energy levels were disturbed. Depression was inversely related to competence, and when depressed the children had significant setbacks in competence, in activities at school and in interpersonal functioning. There seemed to be a circular effect among illness, fatigue, competency and depressed feelings. As the children became more fatigued, they were less able to keep up with their "normal" work and play, and became reactively more depressed.

TABLE 1

Analysis of Variance

(Means of Summary Scores—by Illness Group)\*

Item	Mean Scores			F	p	ETA <sup>2</sup>
	Asthma	Cancer	Psych.			
A) Child Status Measures						
Activity Competency	41.82 <sup>a</sup>	39.57 <sup>ab</sup>	37.36 <sup>b</sup>	3.45	.042	.15
Social Competency	13.70 <sup>a</sup>	12.35 <sup>a</sup>	6.79 <sup>b</sup>	37.28	.0000	.57
School Competency	24.60 <sup>a</sup>	24.44 <sup>a</sup>	16.80 <sup>b</sup>	20.77	.0000	.46
Total Competency	83.60 <sup>a</sup>	80.06 <sup>a</sup>	55.47 <sup>b</sup>	46.99	.0000	.64
General Health	47.75 <sup>a</sup>	47.90 <sup>a</sup>	43.84 <sup>b</sup>	6.08	.0041	.18
Interpersonal Functioning	36.35 <sup>a</sup>	35.25 <sup>a</sup>	28.28 <sup>b</sup>	21.93	.0000	.44
Functional Status Total	68.80 <sup>a</sup>	68.25 <sup>a</sup>	59.11 <sup>b</sup>	17.60	.0000	.39
Behavioral Problems	147.40 <sup>a</sup>	146.90 <sup>a</sup>	205.85 <sup>b</sup>	50.14	.0000	.64
Child Depression Rating Score	27.80 <sup>a</sup>	26.11 <sup>a</sup>	34.35 <sup>b</sup>	3.97	.024	.12

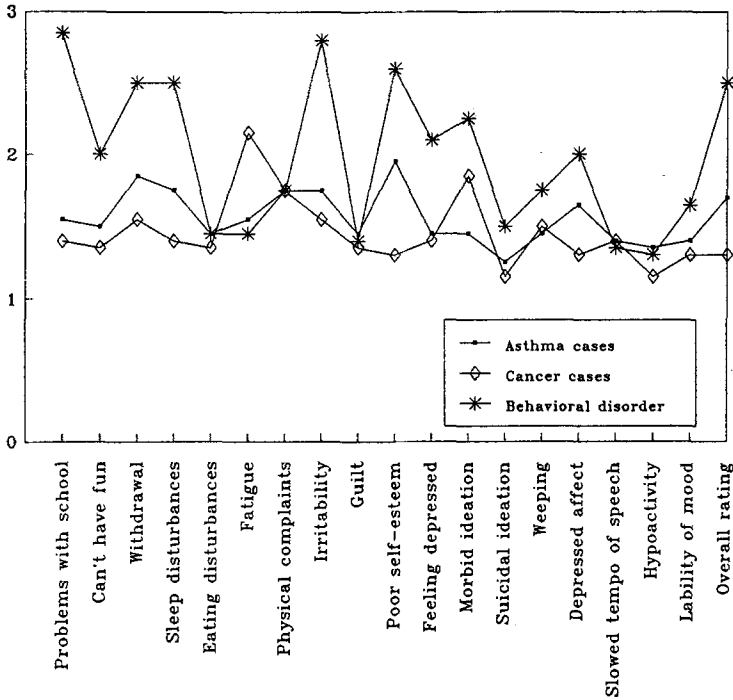


<b>B) Family Assessment Measures</b>						
Problem Solving	18.40 <sup>a</sup>	18.05 <sup>a</sup>	16.25 <sup>b</sup>	4.08	.022	.13
Communication	27.40 <sup>a</sup>	25.75 <sup>a</sup>	24.80 <sup>a</sup>	1.58	.215	.05
Roles	30.65 <sup>a</sup>	28.65 <sup>ab</sup>	26.85 <sup>b</sup>	3.06	.055	.10
Affective Responsiveness	19.45 <sup>a</sup>	18.50 <sup>a</sup>	17.85 <sup>a</sup>	1.34	.271	.04
Affective Involvement	21.25 <sup>a</sup>	19.65 <sup>ab</sup>	18.15 <sup>b</sup>	4.59	.014	.14
Behavior Control	31.20 <sup>a</sup>	28.45 <sup>a</sup>	28.90 <sup>b</sup>	3.57	.035	.11
General Functioning	38.75 <sup>a</sup>	37.05 <sup>a</sup>	33.45 <sup>b</sup>	4.14	.021	.13
<b>C) Burden of Caregiving Measures</b>						
Clinician's Measure of Overall Burden Index	114.75 <sup>a</sup>	105.95 <sup>b</sup>	99.35 <sup>c</sup>	38.46	.0000	.57
Burden for Any Family as assessed by nurse	4.75 <sup>a</sup>	8.85 <sup>b</sup>	8.30 <sup>b</sup>	29.33	.0000	.51
Burden for This Family as assessed by nurse	4.90 <sup>a</sup>	8.30 <sup>b</sup>	9.40 <sup>c</sup>	32.21	.0000	.53
Parent's Report of Burden	14.10 <sup>a</sup>	15.10 <sup>ab</sup>	15.68 <sup>b</sup>	2.94	.061	.09
<b>D) Social Health</b>						
Social Support	36.65 <sup>a</sup>	37.95 <sup>a</sup>	34.10 <sup>a</sup>	0.94	.396	.03
<b>E) Recent Life Changes</b>						
Life Events	10.50 <sup>a</sup>	11.25 <sup>a</sup>	12.05 <sup>a</sup>	0.13	.877	.005

\*Means which share a superscript do not differ at  $p < .10$ .

FIGURE 1

Depression Profiles in Asthma, Cancer, and Behavioral Disordered Children



There was also a statistically significant correlation between poorer family functioning and elevated child depression scores. In other words, poor family functioning was also a good predictor of elevated levels of depression in the child. The families that were open in communication and were responsive and warmly supportive seem to have buffered the child against fear of loss and abandonment. Family support seemed to help assuage fears that no one would be there to help them, and helped them believe that they were still valued and wanted. The competency and empathy of families were basic to these children's sense of security and psychological safety.

Some parents described a period after they received the diagnosis when they could not accept the seriousness of the child's disease, nor

TABLE 2

## 4 Factor Analysis of Child Depression Rating Scale

Functional Symptoms FACTOR I	Vegetative Symptoms FACTOR II	Internalized Symptoms FACTOR III	Fatigue FACTOR IV
1. Trouble w/ Schoolwork	1. Appetite— Eating	1. Guilt	1. Sleeping Dist.
2. Can't have fun	2. Physical Complaints	2. Morbid Ideation	2. Fatigue
3. Social Withdrawal	3. Weeping	3. Suicidal Ideation	
4. Irritability	4. Slow Speech	4. Depressed Affect	
5. Low Self- Esteem	5. Hypoactivity		
6. Feels Depressed			
7. Liability of Mood			
8. Overall Rating			

even comprehend the physician's communications. As a method of coping they denied that the child was so sick. They coped at first by mobilizing around the treatment needs and only gradually could express anticipatory grief or could even consider the possibility of the child's death. Frequently, it was the child himself who began to talk about these possibilities and opened a deeper level of feelings about himself with his parents. "Am I going to die and what happens?" was a very difficult question. If the child became sicker and remissions shorter, parents and children found it harder to maintain the denial. At this point communication and ability to talk about feelings were very important in buffering the child from severe depression.

The open-ended interviews revealed that there were previously un-

untapped strengths which helped many families. Capacity for trust, communication, adaptive responses to shouldering new levels of parental responsibilities, continuity of rituals, and availability of social support all helped. Large and well-integrated families provided a broader base of emotional support, both for the child and each other, and distributed some of the burden of caregiving more equitably.

The family was called upon to shore up the self-esteem of the child as he struggled with the effects of illness and treatment. For example, some parents mentioned that the child was very self-conscious about the changes in his physical appearance, such as weight loss or losing his hair. The children depended on their families for reassurance and acceptance, and were more comfortable and less anxious with family members than peers. It is encouraging that so many of the cancer families, despite the seriousness of the child's illness and the objective burden of providing treatment, continued to cope fairly well as a family.

The burden of caregiving increased with multiple factors and excessive burdens lowered family functioning. The factors that increased the family burden were degree of sickness of the child, increasing age of the child, financial stress, poor role division within the family, and poorer child functioning, including depressive symptoms. For at least one family, a divorced father felt responsible for his child's leukemia, fearing that the trauma had increased the vulnerability of his child.

Thus, in the families of children with cancer, the impact of the illness calls for special adaptation and new levels of parent-child relationships among parents, ill child and siblings. Siblings are directly and indirectly affected by the reorganization of the family in terms of both feeling states and roles. Families report anger, resentment, sadness and withdrawal amongst siblings as well as love and care for the ill child.

This study suggests that this diagnosis calls upon the families to think more consciously of sharing work and roles, solving family problems, and communicating about feelings which could otherwise be repressed or denied. The study revealed the need of parents themselves for support and attention, to sustain their own psychological and physical health. For the economically disadvantaged families, these resources were often difficult to procure.

### *Children with Asthma*

The depression rating score of children with asthma was somewhat higher than children with cancer [Table I], but more importantly the

pattern of the scores was quite different. The most elevated scores were in the areas of withdrawal, physical complaint, sleep disturbances, irritability, poor self-esteem, and depressed affect [Fig. 1]. Depression, however, was not a predictor of psychosocial or developmental problems in these children. There were no statistically significant correlations between Depression scores and child status measures.

For the family, the important issues for a child with asthma were the need to manage a potentially life-threatening attack and to help avoid such medical crises if at all possible. The burden of caregiving on the family was rated high by the physicians because of the need for continuous monitoring and treating of the medical condition. In terms of developmental issues, it has been suggested that children with asthma face special developmental problems regarding the risks of a life-threatening breathing disorder. The child and family do not know the precise triggers which may exacerbate an asthma attack, and the exact dynamics of this disease is poorly understood. It is generally accepted that emotional triggers may precipitate an attack as well as sensitive allergic responses and atypical immune reactions. The parent-child relationship as a factor in the exacerbation or control of the disease has been the subject of much research and much debate.

Yet, in this study, the families of the asthma children were better functioning in all spheres than the families of the other medical groups. They were better educated and had a higher average annual income. Moreover, unlike the other illness groups, there was no statistically significant correlation between poor family functioning and depression. In fact, the measured correlations were all positive, i.e. *the better* the family functioned the higher the depression score. One area approached statistical significance (at the 0.1 level), that is, the *more* the family was affectively responsive to the child, the greater the likelihood of child depression, particularly in spheres of overt signs of depression (eating, weeping, slowed behavior).

What insights can we derive from these findings, then, about the toll on developmental well-being on a child who suffers from asthma, and about his relationship to his family. If we look at the relatively higher depression scores of poor self-esteem, withdrawal, and depressed affect, we can hypothesize that the child is in fact experiencing some internalized feelings of self-doubt and self-vulnerability.

Theoretically, and clinically, it would seem that the special risks of a life-threatening breathing disorder bring the child and parent into a relationship that calls for proximal closeness, hypervigilance,

and uncertainty about safety in separation. The unpredictability of asthma attacks often causes mothers of those children to be excessive in their vigilance about the early indications of an attack, and careful about their child's response to multiple allergens, exertion, cold and nervous tension. Parents may be compelled to exert a great deal of control over the child's emotional outbursts as well as their own in order to protect him from an asthma attack. The child seems to internalize the parents' hypervigilance about their own state, and is more dependent on the parent for safety and relief than latency age children usually are.

This excessive "protective" parental involvement, and the child's conflict about separation, may explain the strongest correlation in the family-child data, that is, the relationship between high emotional responsivity on the part of the parent and higher depression score on the part of the child. This is consistent with the image much described in early studies of asthma [Koocher and O'Malley, 1983], of parents who are overly and intrusively concerned with the child's well-being. The most extreme treatment intervention to this "intrusiveness" prescribed was parentectomy, that is, separation of the parents and the child for a substantial period of time. [Robinson, 1972] Clearly, this extreme treatment approach implied a dynamic process among hypervigilance, overinvolvement, child conflict, and anxiety as a trigger to an asthmatic attack.

The asthma children in this research sample may have indeed been conflicted and depressed by the overinvolvement of their parents, but on the whole the parent-child relationship was not a factor in infantilizing these children or interrupting normal social and academic development. We can hypothesize, however, that these children do have a special developmental struggle in their drive to become self-sufficient and independent.

It would seem that children with asthma can become psychologically enmeshed in their disease as can their parents. One set of observable symptoms has been noted to be difficulties in expression of conflicted feelings. Both the expression and suppression of feelings can be very costly in terms of exacerbating the asthmatic condition and leading to feelings of helplessness in spheres of autonomy. Thus, the possibility of asthmatic attacks legitimates the overinvolvement of the parents, and the prolonged dependency of the child, and the condition of asthma can be used as a rationale for control on both sides of the parent/child relationship.

It is clear that sophisticated parent care is needed for asthmatic

children. For the sickest children, the disease requires both intensive home monitoring and care and a flexibility that allows for support of the child's normal latency age behavior.

There were asthma families in the sample who were experiencing more than average stress, and who were of great worry to the physician caregivers. The burden correlations revealed that for these families, family burden increased with degree and length of illness of the child and overall poorer child and family functioning. Frequently, parents suffered from extreme sleep deprivation, and parents blamed themselves for not having been attentive enough to early signs of an attack. Self blame sometimes turned to family friction, short tempers, uncertainty and exhaustion. Changes in job status and social isolation also were a result of increased need for home nursing care. Physicians and caregivers felt frustrated when the child's home care was less than optimal and resulted in frequent emergency visits, and identified these families as non-compliant. These families were seen as needing help, but the "nature" of the help needed was ill defined.

#### *Children with Behavioral Disorders*

These children were referred for a range of behavioral affective and socialization difficulties. An analysis of variance revealed there was a statistically significant difference between this group's highest overall score on the Depression Rating Scale and the scores of children with asthma and cancer. [Table I] Furthermore, they had a far greater degree of impairment in measures of school and social competency. The depression scores most highly elevated were significant problems at school, irritability, poor self-esteem, feeling depressed, morbid ideation, depressed affect, withdrawal and sleep disturbance. [Figure 1] A sub-analysis of the data revealed a surprising set of correlations. There was a positive correlation between various depression factors and activity and school competence. That is, for this group, the higher the factors such as fatigue and sleeping disturbance, the more competent the child was in activities. Significantly, these overtly depressed children seemed to be able to focus in an organized way on activities and tasks.

How can we explain these interesting and unexpected and counter-intuitive relationships? Ordinarily, activity competency in latency age children indicates a growing mastery of the world. It is possible that these children with more overt signs of depression are sufficiently in touch with their feelings, so that their energies are not used up in defending against anxiety and loss, but can be mobilized in

a more organized and purposeful way. On the other hand, for the children who are hyperactive and with major socialization problems, depression may be harder to detect without being clinically addressed, and the constant activity which hinders cognitive and motor organization may be a defense against feelings related to anxiety and loss. These hypotheses have important implications for research and diagnostic assessment and treatment planning.

The correlations between family functioning factors and depression scores made the dynamic picture even more complex. There were no overall statistically significant correlations between family functioning and depression, but a sub-analysis of the data gave some insights in two areas. The higher the families' affective responsiveness and affective involvement, the lower the vegetative signs of depression, i.e., the less symptoms of poor eating, physical complaint, weeping, slow speech and hypoactivity. On the other hand, there was some indication that, although not statistically significant, the greater behavioral control exerted by the parents, the greater the overall depression score.

For these children with behavioral disorders, the interviews with the families revealed histories of loss, stress, disorganization and perplexity about the child's disturbance. The families had high burden ratings, and this was correlated with stressful life events and poorer family functioning scores. Interestingly, the depressed quiet child was less of a burden than the hyperactive one. The clinical pictures of the children were not clear and the differential diagnosis in the hospital was important. Hospitalization was part of an effort to analyze the possible efficacy of drug treatment.

These complex results show the vulnerabilities of the development of the self and fragility of the ego of the children in this group. Furthermore, their coping attempts, with the frustrations of normal developmental tasks, are frequently maladaptive, resulting in self-destructive behavior, outward aggression and internalized depression. It is quite clear that it is hard to get a handle on the causes or treatment of the atypical development of these children.

The complexity of these children's problems is a great challenge to parents, doctors, social workers and teachers. One mother stated the uncertainty of the diagnosis and treatment when asked how she described to others why her son was hospitalized. She said quite in earnest, "I tell others he is here in the hospital for research!" In the interviews, the parents revealed that their commitment to their children's well-being was frequently a lonely experience, and different



from other ill children as they suffered rejection, incomplete services, and frequently blame for the status of their children. Furthermore, some of the children were on the verge of being out of control and a great risk to themselves and their families.

The study of children with behavioral disorders, although not definitive in any way, stresses the importance of a broad-based assessment of these children's capacities and vulnerabilities, as well as a dynamic understanding of organic, medical and familial factors that can explain their developmental status. Frequently, the impact of loss, of one kind or another, whether of objects or personal limitations, was undervalued and overlooked by the practitioners and families alike. While many of the children seemed tough and uncontrollable, the depression rating scale indicates a high level of anxiety, ego vulnerability, depression and limited coping mechanisms. It would seem that reaching these children's pain in the face of intransigent defenses to anxiety, fear and loss is very difficult. The study also reveals that these problems are exacerbated by vulnerable families, with less adaptive structures, increased burdens and stressful life event histories [Thompson, et al.].

## Summary

The literature on childhood depression speaks to the impact of stress, loss, and crisis on the developmental health of the child. The role of the family as a buffer between the child and the exigencies of life has been well documented. This study has looked at the crisis of chronic illness and psychiatric problems on latency age children. It focused particularly on the relationship between the particular parameters of the illness, the special tasks required of the child, the ability of the family to help, and the child's resultant expressions of anxiety, loss, and depression. The major treatment needs of the family revolve around helping them help their children return to continuing on the appropriate developmental track. Overall the study validated the importance of the family as a protective factor in helping children adapt to the stresses of the illness.

Families characterized by poor adaptive and coping styles, poverty or isolation were shown to be at even greater risk in the presence of a chronically ill child. Even well-functioning families had difficulties handling the impact of chronic disease. The children themselves varied in the strength they brought to the challenge of chronic disease.

This study has important implications for primary care interventions. A broad general assessment which focuses on child developmental well-being and family functioning is helpful in addressing the needs of the family. Proponents of such an assessment have referred to the impact of chronic illness as the "new morbidity," and have recognized the importance of such an assessment as a key guide to intervention. The broad-based assessment integrates social, psychological, effective and cognitive health factors of the child and also tries to understand the context of family dynamics which underlie the child's ability to proceed along the developmental track.

The study revealed that different illnesses can have differential impacts in relationship to developmental problems and depressive symptoms. The children with cancer, for example, experienced a grief reaction to functional losses related to the disease itself. These are a potential disruption of developmental progress. Their parents could and often did effectively provide emotional support and integration of care. These families could benefit from social and emotional support, within a developmental framework for their children.

The children with asthma made good developmental progress in most spheres, but were more at risk for internalized depression. For these children and their families, guidance and understanding of the child and family dynamics could be most helpful.

For the children with acting out disorders, the problems were more multileveled and complex. Depressive symptoms were frequently masked by aggressive acting out as a defense against helplessness, passivity, and despair. The study suggests that professional intervention should be focused on the underlying dynamics, rather than simply controlling problematic behavior. The families' vulnerabilities also require attention to needs for concrete supportive and psychiatric services.

The implications of this study call attention to the vulnerability of children who encounter a developmental disruption that strains their capacity to stay on the developmental track. The study, however, gives hope that parents can with help provide a sense of security and support to buffer the stress.

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