CHAPTER III

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Present conveys its meaning is terms of past. In fact, there is nothing new except in the context of old. Every new thing is learnt with reference to the old. It is universally acknowledged fact that effective research cannot be accomplished without critically studying what already exists in relation to it in the form of general literature and specific studies. Best (1983) considered the survey of related literature as an important pre-requisite to actual planning and execution of any research project. It helps to eliminate the duplication of what has been done and provides useful hypotheses and helpful suggestions for significant investigations. Citing studies that show substantial agreement and those seem to present conflicting conclusions help to sharpen and define understanding of existing knowledge in the problem area, provides a background for the research project, and makes the reader aware of the situation of the issue.

In the present chapter, an attempt has been made to present a brief review of those studies which have some relation with the present investigation. The studies reviewed here are directly or indirectly related to the variables of present investigation. Depression as observed in adults, though reported in children, was not recognized as a separate diagnostic entity in children till around 1970. However, the last two decades have witnessed a burgeoning interest in Childhood Depression because the Psychoanalytic theory basis, that depression in children did not occur due to lack of a well internalized superego, lost credibility and depression in childhood was found to occur and it was later accepted as a distinct entity. Review of related studies has been presented under the following headings: -
3.1 Childhood Depression

Until the late 1960s to early 1970s, it was thought that children could not experience depression. This was based on the psychoanalytic assumption that depression can not exist until the onset of adolescence (genital stage) and the full development of the superego (Maag & Forness, 1991). In the early 1970s, the theory of “masked childhood depression” was postulated (Fuller, 1992; Morrow, 1987; Patros & Shamoo, 1989), which stated that the symptoms of depression was covered up by the symptoms of other behavior disorders such as learning disabilities, somatic complaints, conduct disorders, hyperactivity, enuresis, boredom, restlessness, fatigue, and problems with concentration, which made it difficult to diagnose childhood depression correctly (Morrow, 1987). The masked depression theory is now being disputed by researchers (Maag & Forness, 1991). The growing consensus today is that childhood depression and adult depression are parallel in their symptoms (Kazdin, 1990; Reynolds, 1986). The diagnostic criteria for both adult and childhood depression are appropriate for both disorders (Brumback et al, 1980; Leon et al, 1980; Maag & Forness 1991; Moyal, 1977).

We shall take a closer look at the development of the concept & its further modifications under the following headings.

3.1.1 Development of the concept

Historically, sadness or despondency in children was recognized in the 17th century and was reported by Robert Burton, in his work “Anatomy of Melancholy” in which he recorded sadness in children of
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Suicide & Melancholia was reported in children by the 19th century and in early part of the 20th century. Krapelin (1921) reported Manic Depressive Psychoses in children. Krapelin reported that in a sample of 900 patients, 0.4% had an episode of Manic Depressive Psychoses before the age of ten years. Barret (1931) supported this view & reported 5% incidence of 1st episode of Manic Depressive illness before the age of 12 years, in a sample of 100 patients in the age range of 0-20 years. But this claim was contested by Bradley (1937) who felt that true depression does not occur in childhood and that manic-depressive episode is rare & of questionable existence before puberty.

Levy (1937) noted that depression in infancy is an effect of deprivation. He studied a group of children who in their earliest years had received little or no maternal love & found their affect to be shallow & that they shared various neurotic symptoms. Levy described them as suffering from affect hunger due to deficient social relationships and they showed persistent relationship difficulties such as delinquent behavior. Goldfarb (1943) and Spitz (1945) described a concept known as 'Hospitalism' which holds that children brought up in hospitals and institutions and deprived of emotional contact with a mother or mother-substitute in early lives are rendered liable to an enormous range of abnormal reactions like failure to gain weight, sleeplessness, apathy, listlessness, unsocial behavior, depression, aggression, insecurity in adapting to environment and persistent infections. But it was only in 1946 that a definite expression “analytic depression” was described by Spitz and Wolf (1946) in the infants and young toddlers in the nursery. These infants and small children were separated from maternal care after 6 months of age and they manifested expressionless eyes, sad faces, social withdrawal, tearfulness, insomnia, weight loss and retardation of development & most of them screamed when an adult tried to make contact. 19 out of 123 infants showed this reaction when separated from mother for 3-4 months and the syndrome disappeared if
the mother-child relationship was restored within about 3 months. This severe depression was interpreted as a reaction to the loss of a love object (mother) & occurred with greater security and frequency where mother-infant relationship was good. Spitz’s observation of excessive rocking, fecal play and other non-oral auto-eroticism in institutionalized infants has been alluded to the above. The criticisms of Spitz’s study are few. But Kanner (1948) felt that full fledged depression as seen in adults was very rare in children.

Meanwhile, Campbell (1952) studied 18 children (11 girls and 7 boys) with manic-depressive psychoses over a period of 2-6 years and emphasized the frequency and importance as well as familial tendency and reversible nature of this psychosis in children. At the same time, Hall (1952) studies 1000 children and found 6 cases of affective illness of whom only 2 were manic depressives and the others were reactive depressions. The earliest depressive phase was noticed by Schachter (1952) at the age of 2 years. A corresponding study by Despert (1952) noted suicide rates in children aged 4-14 years and reported higher incidence of successful suicide among boys than girls & among whites than in colored children. There were other studies also during this period which recorded the occurrence of effective disorders in children. Bierman et al (1958) wrote a paper about a 6 year old boy with poliomyelitis in which a clinical description of affective depression, after the illness, is recorded. Anthony and Scott (1966) had also suggested 10 criteria for diagnosis of Manic-depressive Psychosis in childhood and yet only 3 cases out of 28 were diagnosed and even they fulfilled five of the criteria.

Till this time, depression in children was either thought to be non-existent or presenting in varying symptomatology or to be present as “Masked” Depression. Poznanski and Zrull (1970) reviewed 14 cases with depressive symptoms over a 4-year period follow-up till adulthood and
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gave the ideas that affective depression is seen clinically in children. In
the review of 14 cases, the expression of an affective state of chronic
sadness or unhappiness was essential for inclusion in the study. Other
depressive symptomatologies seen were excessive crying, withdrawal and
disturbed self-image by the child. The authors then re-evaluated 10
cases after 6-1/2 years at adulthood and concluded that this group
tended to resemble adult depressives; supporting the idea that
depression in childhood may persist and appear in its adult form. It was
also evident that these young people had spontaneous remissions from
depression and neither broken homes nor parental loss was predictive of
depression. All the patients had inadequate peer relationship and
dependency was prominent as in adult depression. Hence, this study
gave a direct co-relation of depressive symptomatology in children with
Adult Depression.

But a clear-cut definition of depression in children was still not
clear and there was much confusion in diagnosing depression in
children because of a lack of agreement on childhood depression and
childhood itself. Attempts were then started to define childhood
depression could not be ascertained without a proper definition of the
reported the rate of pure depression to be as low as 0.1 %. They
identified 3 groups of disturbed children-conduct disorder, emotional
disorder and a mixed group of above two. The disturbed ones had more
depressive symptoms than non-disturbed ones. Cytryn and Mcknew
(1972) indicated that depressive symptoms especially sad affect are
common in children. However, they are of short duration, most of the
time and do not interfere with the child’s functioning. In those cases
where it is severe, it does not usually manifest itself in a clearly
recognizable form but rather presents as a masked depressive reaction of
childhood. Such children may show a variety of emotional disorders,
among them, hyperactivity, aggressive behavior, psychosomatic
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illnesses, hypochondriasis and delinquency. In such cases, the underlying depression is largely inferred from a periodic display of purely depressive picture and from depressive themes on projective techniques such as Rorschach and Thematic Apperception Test (TAT).

Cytryn and Mcknew (1972) also felt that in addition to children with masked depression, there exists a group of latency-age children who present a clearly identifiable depressive syndrome. This syndrome includes a persistent sad affect, social withdrawal, hopelessness, psychomotor retardation, anxiety, school and social failure, sleep and feeding disturbances, suicidal ideas and threats but rarely attempts. It usually lasts two or three months before medical help is sought. They classified childhood depression into three distinct categories -(1) Masked Depression is the commonly appearing in children whose personality and family, display severe psychopathology (2) Acute Depression, in which children are fairly well-adjusted prior to traumatic events precipitating depression and there may be mild psychopathology in the family (3) chronically depressed children who have a history of marginal premorbid social adjustment, depression and repeated separation from important adults and at least one parent having history of depression.

3.1.2 Social Aspects of Childhood Depression

The social aspects of childhood depression have been studied by some authors. Bruhn (1962) laid emphasis on the role of broken homes among attempted suicides and psychiatric out-patients and hence highlighted the relationship between parental loss and adult depression. Greer (1964) studied the relationship between parental loss & attempted suicide and augmented Bruhn's view that there exists a relationship between parental death and attempted suicide and that the controls from a similar population show much less frequency of suicide. Sandler and Joffe (1965) in their article from Hampstead clinic gave a theoretical discussion of depression in children. They considered depression as an
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affective reaction, analogous to the effect of anxiety, without tying it to a specific diagnosis. They commented that there was a tendency for the depressive reaction to occur in most children but the degree with which it manifested itself varied enormously in intensity and duration.

The separation of the mother as a determinant of depressive symptoms as given by Spitz and Wolf in 1946 was confirmed by other studies also (Bowlby, 1969). He further described three stages of the child’s response to the mother’s absence and described them as Protest, which is characterized by acute distress, angry outbursts and attempts to bring about restitution. Despair, which is associated with quietude, inaction, tearfulness, sadness and a state of mourning. Detachment, which is characterized by gradual resignation and loss, with efforts to bring about an adaptation to the changed environment.

Depression in childhood has also been postulated to be due to stressful event occurrence in most instances. In a study, conducted on recently bereaved children, Weller et al (1981) gave the view that recently bereaved children endorse the depressive symptoms after the death of a parent. 37% of such children met DSM-III-R criteria for major depressive episode but the depressive symptoms were less than depressed pre-pubertal children. Hence, the role of life events in the onset of depression is significant.

Linn (1989) research suggests that depression exists in children and adolescents and is manifested in the younger population much the same way that it is in the adult population. Investigators have hypothesized that social skill deficits are causal factors in the development of depression. Although, there have been few systematic studies of social skills deficits in depressed children, a relationship has been demonstrated between childhood depression and poor social functioning. The aim of the study was twofold: (1) to determine whether or not depressed children have more social skill deficits than
nondepressed children, (2) given the presence of social skill deficits, to delineate the nature of the deficits. More specifically, given that depressed children have significantly more social skills deficits than nondepressed children; this study was designed to determine whether the deficits were related to content knowledge of social skills, the cognitive component of social skills, and/or physiological response to social situations. The study employed a multimethod assessment of depression as well as a multimethod assessment of social skills in depressed and nondepressed pre- and early-adolescents. The study incorporated the use of self-report measures as well as a teacher rating scale in data collection. Findings demonstrated significant differences between the groups in: (1) appropriate and inappropriate social skills, (2) content knowledge of social skills, (3) positive and negative self-statements, and (4) physiological arousal in social situations. Results of this study could have implications for assessment and treatment of depression in children. Training for the remediation of deficits in social skills could be included in a childhood depression treatment program. Such training could be tailored to conform to the specific needs of the individuals based upon the particular deficits which might be revealed by assessment.

Crook (1994) has suggested that both social skills deficits and maladaptive family relationships are associated with childhood depression. Two theoretical models have been advanced which represent competing explanations of the relationship between social functioning and depression. Lewinsohn’s behavioral model of depression suggests that depression is a result of social skill deficits, while Coyne’s interpersonal model of depression postulates that the negative interaction patterns characteristic of the depressed person develop after the onset of depression. Family relationship variables also have been consistently linked with childhood depression. A number of theorists have implicated the role of family in the development of depression. In
addition, research has shown that there does indeed appear to be a relationship between negative family environment and childhood depression.

However, a number of theorists have recently criticized current models of depression as being too linear and simplistic in nature. These theorists are increasingly calling for an integrated model of depression. This study was designed to test two models which examine the relationship between family environment, social skills and depression. Subjects consisted of 133 children ranging in age from 9.5 to 14.75 years. All children were screened using two measures: self-report, paper and pencil tests. Their level of depressive symptomatology was assessed with a well-respected clinical interview. The children then completed a self-report measure of their social skill functioning and a measure of their perceived family environments. Results of a series of regression analyses indicated that family environment variables are consistently predictive of depression during childhood. However, some family variables are more predictive of social skills than others, and these results differ depending on gender and age. Only inappropriate and impulsive/recalcitrant social skills are predictive of depression during childhood. These results are integrated and discussed in terms of their relations to the theoretical formulation of Lewinsohn and Coyne.

A number of studies have also shown that ongoing depression is associated with social support, negative cognitions and social adversity. Depressed individuals have greater difficulties in interpersonal interaction (Brugha, 1995; Upmanyu and Dhingra, 1992; Coyne 1976; Weissman and Paykel, 1974), less gratifying social contacts (Costello, 1982; Roy, 1978) and a weak social support system (Andrew et al, 1978). They also manifest a variety of negative cognitive patterns (Upmanyu and Reen, 1991; Teasdale, 1988; Lewinsohn et al; 1981; Seligman et al; 1979; Beck, 1967).
Recent studies of depressive disorder and symptomatology have identified salient psychosocial risk factors. Two broad non-demographic factors, gender and age, have been widely studied. Recent studies have reported that adolescence females are at significantly greater risk than males for depression or depressive symptomatology (Garrison et al, 1989; Reinzberg et al, 1989; Kashani et al, 1987; Kandel and Davis, 1982). However, there is mixed evidence about the relationship between age and depression in children and adolescents (Fleming and Offord, 1990; Kaplan et al, 1984).

The sex difference emerges in early adolescence and continues until late middle age (Burke, et al 1990). Cross sectional evidence shows that prior to puberty, depressive symptoms and rate of depression generally tend to be higher in boys than in girls (Nolen Hoeksema et al, 1991; Costello et al, 1988; Pearce, 1978). In adolescence, however a trend emerges showing preponderance for depression or depressive symptoms in girls (Angold and Rutter, 1992; Mc Gee et al, 1990; Kandel and Davis, 1982).

3.1.3 Criteria for diagnosis of Depression

Weinberg et al (1973) gave specific criteria for diagnosis of childhood Depression which was indicated by presence of two or more of the following 8 symptoms. (1) Agitation (2) Sleep disturbance (3) Diminished socialization (4) Change in attitude towards school (5) Somatic complaints (6) Change in school performance (7) Loss of usual energy (8) Unusual change in appetite or weight. Using these, he diagnosed 63% of the patients who were referred to an educational diagnostic centre for learning and behavior problems. 19 were treated on anti –depressant medication and were found to be markedly improved than the non- treated ones after 3-7 months. Appositive family history of an affective condition was present in 40 out of 45 depressed children. Depressed children had a high incidence of hyperactivity, school phobia,
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enuresis and other developmental behavior problems occurring during the depressive phase.

In another research, Cytryn and Me Knew (1974) attempted to conceptualize a pattern of defense against depressive process that changes with age. They enumerated several forces which oppose and promote these defensive operations resulting in there levels of which the depressive process manifests itself as fantasy, verbalization, mood and behaviors. The variability of the depressive process manifesting itself throughout the various phases of the life cycle has been attributed to the shifting balance of these three forces (1) Fantasy as manifestation of depressive process, is demonstrated in dreams on spontaneous play or elicited by the use of projective testes where the depressive themes are mistreatment, thwarting, blame or criticism, loss and abandonment, personal injury, death or suicide verbalization as spontaneous or elicited verbal content, talk of hopelessness, helplessness, guilt, of being unattractive, worthless or unloved and suicidal preoccupation (3) Mood and Behaviors by manifestations of depressive affect that can be noticed without verbal exchange. These manifestations include psychomotor retardation, sadness, crying, disturbance in appetite and sleep as also signs of masked depression such as hyperactivity, aggressiveness, school failure, delinquency and psychosomatic symptoms. Cytryn and Mcknew tried to explain the patterns of defenses that help children to avoid experiencing or expressing depressive affect, at each level. In depressive fantasies, the defenses are denial, projection, introjections, acting out and avoidance. Depressive fantasy is the most effective of all. Depressed verbalization is less effective and the defenses are dissociation of affect and reaction formation. In the manifested depressive mood and behavior, defence mechanisms seem to fail as in chronic and in some acute depressive reactions.
Glaser, 1967; Cytryn and McKnew, 1974 have maintained the existence of “masked depression”; these clinicians believe that depression in children is “masked” by symptoms that are not typically associated with the problem in adults; such symptoms may include hyperactivity, aggressiveness, delinquency, and school failure.

In reviewing the literature on childhood depression, Kovacs and Beck (1977) maintain that childhood depression is demonstrated by behavioral changes that are similar in type to those manifested in adult depression. All of the studies agree that depressed children show some type of negative cognitive change, most of the studies describe attitudinal motivational changes as well as disturbances in vegetative (such as, sleep and appetite) and psychomotor (for example, activity) functions. The studies do not, however, uniformly consider a report of “feeling sad” as the primary symptom of childhood depression.

On the basis of the symptoms mentioned researcher made observations to familiarize herself with manifestations of symptoms.

3.1.4 Genetic or Familial aspects

The influences of parents and environment at home have been important factors. Children who are unwanted by their parents and who are given little affection are likely to develop hostile behavior patterns. The children of parents who are more punitive towards them are found to be more depressive (Bandura, 1971).

Beardslee et al (1983) assessed the validity of the diagnosis of depression in nine children and adolescents as a part of study of offspring’s of parents with affective disorders. The authors concluded that these nine children were suffering from affective disorders because disruptions in multiple domains of functioning accompanied the major depression and hence seriousness of depression in children of parents who had affective disorders was highlighted.
It has been suggested that the rate of affective disorder in children doubles if one parent is depressed and quadruples if both parents are depressed (Puig-Antich, 1984). The familial aspects of depressive disorders in childhood also were subsequently examined.

Professional counselors in the elementary setting must also consider the depressed child’s home life and family system. Parents of depressed children are often more overprotective, more likely to have communication difficulties in the family, and more apt to undermine children’s learning than parents of nondepressed children (Magnussen, 1991). These parents are also less aware of their children’s feelings. The few studies that have been conducted on the relationship between family interaction patterns and depression in children portray these families as having chaotic, rejecting, and having hostile interaction patterns (Dadds et al, 1992; Magnussen, 1991; Sternberg et al, 1993). Families with at least one depressed parent have less cohesion and expressiveness, more conflict, less emphasis on the development of independence, and religious values than families with nondepressed parents (Billings & Moos, 1983).

In an investigation of depression as a generational phenomenon, researchers (Whitbeck et al, 1992) found that a history of rejection by the parents increased the likelihood of depressed affect in the children. The presence of depressed affect, in turn, the increased the likelihood of the rejecting parenting behaviors. The children of depressed parents experienced higher levels of helplessness and depression because of the rejecting behaviors of the parents. Additionally, the parents of depressed children are more likely, than parents of nondepressed children, to attend to their children’s failure rather than success on a structured task (Cole & Rehm, 1986). Also, parents of depressed children tend to allow the children to miss more school than parents of children without depressive symptoms (Magnussen, 1991).
When compared with nondepressed peers, depressed children perceive their families as much less supportive, more placid, and disengaged from outside involvement (Billings & Moos, 1983; Stark et al, 1990). Also, depressed children are more likely to report that they are allowed less involvement in the decision-making, and have more intense feelings of helplessness (Seligman and Peterson (1984); Stark et al, 1990). Families of depressed children report higher levels of conflict, within the family system than families with nondepressed children (Sternberg et al, 1993). Obviously, when families do not engage in the outside activities, they are deprived of positive distractions from their daily problems. Family members are forced to remain in contact with one another which increase the probability of conflict. Depressed children internalize this conflict which reinforces their feelings of despair and helplessness. It is not at all surprising that children in abusive homes are more likely to report depressive symptoms than children in no abusive families (Sternberg et al, 1993). Abused children feel more sad and unwanted, and less healthy then their nonabused peers.

Childhood psychiatric disorders and psychiatric symptoms especially have been found to be associated with depression in adulthood (Caspi et al, 1996, Harrington et al, 1993, Rogers, 1990). Many of the earlier studies have focused on the effects of childhood separation. Parental divorce—but perhaps not parental death—has been found to have an association with later depression in adulthood (Parker, 1992; Tennant, 1988). It has seen emphasized that the separation itself may not be significant (Rutter, 1994). Overall, individuals with a history of depression report their parents as being less caring and more protective than do controls (Mackinnon et al, 1993).

Renouf and Kovacs (1993) in their study of concordance between mother’s reports and children’s self reports of depressive symptoms gave the concept that depressed mother’s tend to overate their children’s
symptomatology as compared with the children's reports. Hence, the level of maternal depression as well as the young patient's age need to be closely monitored when assessing on self report and parental report of children's symptoms.

According to a New Columbia study, nearly 60 percent of children whose parents and grandparents suffered from depression have a psychiatric disorder before they reach their early teens. Columbia University Medical centre (CUMC) and the New York State Psychiatric institute (NYSP) have conducted the study. This is more than double the number of children (approx 28 percent) who develop such disorders with no family history of depression. (Times of Chandigarh, January 17, 2005).

Offspring of parents who suffered from depression face an increased risk themselves for depression, anxiety and drug dependence that extends well into adulthood, according to Weissman of Columbia University in New York City and colleagues. While children of depressed parents are known to be at greater risk of depression and anxiety early on, there has been little research on how they fare as adults. They report in the American Journal of Psychiatry on a 20-year's follow-up study comparing 101 people who had at least one parents with major depressive disorder and 50 whose parents were free of major depression. Participants were 35 years old, on average, at the time of follow-up. Offspring of depressed parents were three times as likely to have anxiety disorder, major depression or substance dependence, the researches found, and they were also at greater risk of social impairment on the job or in family life. (The Tribune, Chandigarh, June 7, 2006)
3.1.5 Abuse and Neglect

Results of a pair of case studies completed Kashani and colleagues (Kashani & Carlson, 1987; Kashani et al, 1984) on depressed preschoolers clearly implicated extreme family chaos, parental psychopathology, abuse, neglect, and substance abuse in their families. Recent research also indicates a relation between abuse and elevated levels of depressive symptoms (Toth et al, 1992), and when abuse is combined with parental psychopathology, children are at an especially high risk for developing depressive symptoms. Although this more recent research implies a relation between child maltreatment and depressive disorders, it does not firmly implicate maltreatment as a cause.

Cicchetti (1995), using a developmental framework, reported findings from a number of studies examining the effects of child abuse and neglect. Among some of the more salient findings are that physically abused infants are more likely to demonstrate high levels of negative affect and a paucity of positive affect. Maltreated toddlers also were found to be more angry, frustrated, and noncompliant than were no maltreated children, and, as preschoolers, these children were rated as more hyperactive, distractible, and lacking in self-control. In kindergarten, maltreated children were rated as more inattentive, aggressive, and overactive by teachers. Studies also indicate that maltreated children experience heightened levels of physical and verbal aggression in peer interactions reviewed by him. Across the investigations reviewed by him, physical abuse was linked with higher levels of childhood depressive symptomatology, as well as higher rates of ADHD, oppositional and defiant disorder.

Virginia Tech University witnessed a homicide in which 32 people were killed in the massacre and later he killed himself. The perpetrator of crime was Cho Seung Hui, a guy doing majors in English at that time. According to his teachers, talking to him was like talking to a hole. They
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took him to be a shy person. Before the massacre, he came in limelight when a female student reported that Cho had made annoying contact with her through phone and in person. His play works in his drama class were violent, obsessive, and focussed on sexual abuse. These acts spoke of his troubled state of mind. What is that makes individual members of a usually empathetic species turn rogue? In many ways his profile matched with a "narcissist" (Kluger, 2007).

3.1.6 Suicidal tendencies in children

There is not much written on suicide in children, though the phenomenon was reported as early as in the 19th century. Klein (1948) and Bender (1953) gave concept that child reacts to an unbearable situation with an attempt to escape. The unbearable situation could be deprivation of love or child’s perception of insufficient love. This provoked aggressive tendencies directed against those who denied love. Under the influence of feelings of guilt, these tendencies were turned against self. Suicide in children may, hence, constitute a method to get greater love or reenact a union with the loved object (always one of the parents). Kovacs et al (1992) studied suicidal ideation and rates of suicide among children aged 8-13 years at presentation and inclusion in the study and found that 66% of the subjects evidenced suicidal ideation and 9% already attempted suicide. The rate of ideation remained fairly stable over time whereas the rate of attempts reached 24% by 17 year of age. Major depressive and dysthymic disorder were more related to significantly higher rates of suicide than adjustment disorder with depressed mood and non-depressed disorder. The rates of suicide were increased by presence of affective disorder, conduct disorders or substance-abuse disorders. In a similar study, Rao et al (1992) studied a sample of subjects having major depressive disorder, mixed anxiety states and normal controls and reported that the onset of first of first depressive episode in the subjects was around puberty but the suicide
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did not occur until adolescence or early adulthood. At least five of the seven subjects had recurrent depressive symptoms and were clinically depressed at the time of death. Hence, it is concluded that major depressive disorder in childhood has significant mortality by suicide.

It is due to this aspect, depression that it needs to be taken care of with utmost urgency.

3.1.7 School-Aged Years and Depression

The bulk of the search on childhood depression has focused on the school-aged population. As previously discussed, the consensus is that depression in this period parallels depression in the adult population. While most researches as well as the DSM-III-R acknowledge age-specific differences, few studies have directly addressed the developmental issues. In selecting studies for discussion here; researcher has chosen those which have attempted to do so.

Carlson and Kashani (1988) compared the symptom patterns across development and frequency of depressive symptoms in three studies of four clinic referred age groups: preschoolers, prepubertal children, adolescents and adults. Although they acknowledge the difficulties in comparing across studies, the authors chose the particular studies on the basis of their similarity in methodology. Some symptoms which increased with age included anhedonia, diurnal variation and psychomotor retardation. Those which decreased with age included depressed appearance and somatic complaints. Fatigue, agitation and anorexia were less frequent among prepubertal children and adolescents than they were in the preschool and adult groups. Symptoms such as depressed mood, diminished ability to concentrate, sleep disturbance, and suicidal ideation were consistent across the life span measured.

Some studies have attempted to examine developmental changes within the prepubertal period. For example, three patterns of depression
were identified in a group of six to thirteen year olds (McConville et al., 1973). Symptoms in the six to eight year old group were characterized as the "affectual" type and included dysphoric mood and feelings of loneliness, helplessness and loss. The symptoms in the eight to ten year old group were described as the "self-esteem" type. These included hopelessness and negative self-esteem. The symptomatology in the ten to thirteen year old group was characterized as the "guilt" type.

It has been suggested that the shift from the affectual type to the self-esteem type is due to the ability of the older groups to verbalize their feelings and thoughts about themselves and is a function of their developing cognitive structures. More specifically, children at this point in development are beginning to perceive internationality in their own behavior as well as in the behavior of others. They are also beginning to misattribute blame which in depressed children, might lead to unwarranted self-blame and guilt (McConville et al., 1973; Bemporad and Wilson, 1978).

On the other hand, young children do not seem to have the cognitive capacity to engage in self denigration by internalizing failure experiences. In a study of the effects of failure on the self-evaluations of children six to eleven years old (Ruble et al., 1976), it was found that failure feedback affected the self-evaluations of the older children (ages eight to eleven) but not the younger children. Additionally, children were given information on the ease with which others completed the task. This affected the self evaluations of the older but not the younger children, suggesting that young children may not engage in self denigration since they are not likely to evaluate themselves negatively (Glasberg and Aboud, 1980). Furthermore, they found that although both kindergarten and second grade children reported disliking a sad other, only second grade children were able to extend this negative evaluation to themselves. Kindergarten children were unable to evaluate
themselves as negatively as they did a sad other. Although young school-age children are cognitively unable to engage in self-denigration, they can exhibit dysphoric mood. It was found (McConville et al, 1973) that six to eight year old children were able to behaviorally express long periods of sadness but without the accompanying prolonged beliefs that they were bad or inferior. In this period, sadness can be sustained and is usually in response to an external situation. Furthermore, it is seen in overt rather than verbal behavior (Bemporad and Wilson, 1978). Two more recent studies, (Garber, 1984; Kovacs and Paulauskas, 1984), attempted to overcome the problems of these earlier studies in that they utilized more well-defined criteria and standardized assessment methods. However, their findings are quite contradictory. In Garber's study of seven to thirteen year old clinic-referred females, there was an increase in frequency of depressive syndrome and of individual depressive symptoms. Those symptoms that were found to increase with age were appetite disturbances, hyperactivity, pervasive loss of interest, capacity to have fun, guilt, hopelessness, irritability, fatigue, and problems at school, low self esteem, difficulty concentrating, and depressed feelings. Those symptoms which decreased with age (among the depressed children only) were crying and morbid ideation.

While Garber's results are consistent with the findings of previous studies and with that predicted by developmental changes in cognitive and socioemotional capacities, Kovacs and Paulauskas (1984) were contradictory and counter theoretical. In direct opposition to earlier findings, behavior problems and somatic complaints were more evident among the older children in their sample. With regard to other depressive symptoms, the development findings were inconsistent, varying with the particular statistical method employed. Furthermore, in contrast to developmental expectations, younger children were found to have the more chronic depressions.
3.1.8 Studies on childhood depression in India

The literature available on childhood depression in India is very little. The work on child psychiatry in India started around 1960, mainly being centered on neurotic disorders. In a study conducted in a Child Guidance Clinic, neurotic disorders were investigated and reported to be 3.7% in 592 patients.

Raju et al (1969), Rao (1970) studied psychological problems in the inmates of orphanages, beggar homes, etc. but did not list depressive symptoms as a major problem. Manchanda and Manchanda (1978) conducted a study on neurotic disorders in children with the main emphasis on epidemiological aspects. They diagnosed 49 children, up to the age of 12 years, coming to Pediatrics inpatient department and Child Guidance Clinic, to be suffering from a neurotic disorders during a period of 11 months and found that incidence of neuroses in pediatrics inpatient was 1.1% and 8.2% in child guidance clinic. They found the incidence to be higher in females and that none of the subjects was below 6 years and also that most of the children belonged to urban areas. According to this study, hysteria was the commonest diagnostic group (71.4%) followed by Anxiety (16.3%), Depression (6.1%) and Phobia (4.1%).

Nandi et al (1978) in their analysis of suicide in West Bengal reported that 10-15% were below 18 years of age. Chacko (1980) reported a prevalence of 7.8% of ‘masked depression’ in children at Vellore. The prevalence of neurotic disorders from the child guidance clinic at NIMHANS, Bangalore was found to be around 2% during the year 1980-85 (Prakash, 1985). Another study from Bangalore has reported 9.2% of the children attending the clinic in 1984 as having depression as a major or significant feature (Srinath and Bavle, 1985).

Malhotra and Chakraborti (1992) conducted a study on children who attended the child psychiatric clinic from January 1984 to February
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1988 and included children with the primary diagnosis of depression based on ICD-9 diagnosis in the study. The study reported 1.2% prevalence of depression in the clinic. The study also showed a male preponderance among the subjects while the main symptoms shown in the study were sadness, weeping spells, poor appetite, somatic symptoms, withdrawal and disinterest being most common. The picture also resembled that of adult major depression with its core features of sadness, anhedonia, retardation and disturbed biological function. Family history of major depression was common. The subjects responded well to anti-depressant treatment and the majority recovered in 5-7 months.

Malhotra et al (1992) studied the extent and nature of stress associated with psychiatric disorders in children as compared to normal children including both qualitative and quantitative assessments. The study included children of both sexes, ranging between the age range of 4-14 years, attending the child Guidance clinic of Post-Graduate Institute of Medical Education and Research, Chandigarh. Children suffering from various psychiatric disorders and mental retardation were included. A control group was taken from siblings of patients attending the pediatrics out-patient department with minor ailments. The study concluded that role of life-events in the psychiatrically sick children was significant as is evident from the higher stress score by the sick group. Also it was noted that though sick children of all ages scored high on stress-score yet the score was higher in younger children indicating that stress has greater role in causation and precipitation of psychiatric illness especially in younger children. The sex of the child was not found to be significant in psychiatric disorder causation. It was also postulated that the nature of stress may have an impact on the diagnosis of sick children. Hence, these studies have shed some light on the various aspects of childhood depression in India.
But, in general, the field of childhood depression lacks much information and a lot remains to be done to probe this disorder in Indian children, as is evident from the scant data available till date.

3.2 DEPRESSION AND CLASSROOM BEHAVIOR

Differences occur in behavior patterns of children with depression, whether it is more or less in the classroom.

Many researchers indicated that in school settings, the more depressed a child is, the more helpless she or he feels and the more pessimistic she or he is in explaining classroom events (Leon et al, 1980; Nolen et al, 1992). Children with depression in school settings considered themselves to be less socially competent, and they spent more time alone than in the social company of their peers at school (Altmann and Gotlib, 1988). They are usually quiet and withdrawn, and it is easy for them to get lost and fall through the cracks in educational institutions (Leon et al., 1980; Maag & Forness, 1991; Quiggle et al, 1992).

Nardone (1992) conducted a study to learn more about the school experience of depressed children. Four dysthymic fifth grade students were observed in their special education classroom, and three of them were also observed in a day-treatment programme to learn about them and their perceptions of their school experience. Findings revealed a pervasive pattern of limited expression of feelings and questionable integration of their social skills curriculum into their lives. The conditions under which they lived outside of school raised questions as to whether they were appropriately labeled emotionally disturbed and whether it is desirable to require a diagnostic label before providing special services. The following recommendations were offered. Dysthymic students should be thought, whenever possible, in the regular classroom so that they benefit from appropriate modeling and are provided enhanced opportunity to develop social skills by interacting with non-
handicapped peers. Depressed children may benefit from programs featuring more opportunity to make choices. Finally, it is possible that appropriate services can be delivered without resorting to cabling with its danger of stigmatization & stereotyping.

Russell and Russell (1996) investigated the relationships between children's level of depression, their perceptions of their classroom social climate, and their perceptions of their families functioning. The three self-report instruments employed were the Reynolds Child Depression Scale (RCDS), the relationship dimension of the Classroom Environment Scale (CES), and the Family Adaptability and Cohesion Evaluation Scale III (FACES-III). Children in the third through sixth grades (n=113) who had been referred for counseling services, in ten different elementary schools, were involved in this co-relational investigation. The results indicate significant correlations between depression and family cohesion, family adaptability, the total score on family functioning, classroom involvement, classroom affiliation, and the relationships dimension of classroom social climate. Implications of these findings for school counselors include the importance of providing comprehensive treatment for the depressed child through family counseling and classroom-based interventions, in addition to traditional individual or small group counseling.

3.3 CHILDHOOD DEPRESSION AND ACADEMIC ACHIEVEMENT

School is an important arena for social and emotional development; however, it can also be a source of negative life events.

In its mild form, depression is probably the most common psychological disturbance during adolescence; all adolescents suffer at least mild depression at one time or other early adolescents are more apt to exhibit the following triad of symptoms: fatigue, hypochondria, and concentration difficulty (Weiner, 1980). This may effect their academic achievement.
In a study of 153 children, 53 of whom were diagnosed in their schools as having a learning disability, it was found that depression, rather than learning disability, was the major factor contributing to poor academics (Colbert et al, 1982).

In a study (Klein et al, 1988), the children of depressed parents had more overall social impairment than did the children of control parents. In another study (Weissman, 1988) they had poor functioning in school, including more special classes for math and attention problems. This poorer school functioning was not explained by lower IQ scores, since there was no significant difference in IQ scores between the two groups of children.

Dotan (1991) conducted a study to investigate the relationship between childhood depression and school achievement and with a group of children who scored high on the depression measures used, to compare the groups of high and low achievers in an attempt to identify variables associated with the difference between them. The results were related to the theoretical models developed to explain childhood depression and examined in turn for evidence in support for one or more of them. Using scores on the Child Depression Inventory, the peer Nomination scale for depression and teacher rating, 32 students. From grades 3rd, 4th & 5th were selected to participate in control group. Using the scores on the California Tests of Basic Skills two sub groups were formed in each of the depressed and control samples. Those who scored high constituted the high achieving groups and those who scored low constituted the low achievers groups. These four groups were contrasted on measures of cognitive functioning, attributional style, temperament scores, a behavior rating scale and the no. of days absent and/or tardy since the beginning of the year. The results showed that there were significant difference between the depressed and control groups on most of the measures used. Low school achievement as measured by scores on the California Tests of Basic Achievement was present in 68% of the
depressed sample, but in only 27% of the control sample. Results on a two factor ANOVA revealed that the differences between the four groups on the cognitive and achievement variables were associated with the achievement level factor. Most of the measures of behavioral and emotional functioning and the temperament trait of mood are associated with the factor of depression/non depression. The temperament trait of mood also showed a significant interaction between the two main effects (depression control and low/high achievement). The relationship between an early tendency to moodiness and depression in childhood as well as the possible effect of moodiness on academic achievement was discussed and suggested for future research.

Hamilton et al (1997) studied 49 children with either depression or schizophrenia, or no clinical diagnosis, to see if differences existed in their social, academic and/or behavioral functioning. In addition, they investigated the influence of transactional family behavior on child competence in these domains. Statistical analyses showed that the children with depression and their non-clinical cohort functioned comparably in academic performance. No impaired cognitive functioning was evidenced by the students who were depressed. However, a significant difference was noted in the social domain, with the depressed children demonstrating poorer social functioning than their non-clinical peers. No distinctions could be made between the children with depression the children with schizophrenia in this domain. This finding is important, when we consider that the problem only compounds as the child reaches adolescence and adulthood. It is important to note, however, that the children who participated in this study were inpatients and that the severity of their psychiatric illness may not allow for generalization to children with depression in the community. In other words, although a child may experience depression, s/he will not necessarily have dysfunctional interpersonal interactions.
The depressive symptoms, life events, and explanatory styles of 168 school children were measured five times during the course of 1 year. Measures of school achievements were obtained once during the year. Depressive symptoms and explanatory styles were found to be quite stable over the year. As predicted by the reformed learned helplessness theory, explanatory style both correlated with concurrent levels of depression and school achievement and predicted later changes in depression during the year. Depression also predicted later explanatory styles. The implications of these results for intervention with children with depressive symptoms or school achievements problems are discussed. (http://www.ppc.sas.upenn.edu/cvabs.htm as seen on 24.04.2007)

Poor academic achievement and beliefs about academic ability, coupled with depression, result in poor school engagement, enhanced perceptions of school-related stress and increased problem behaviors (Bandura et al, 1999; Rudolph et al, 2001).

Upadhayay (2007) conducted a study on 115 children to examine the effects of depression on academic achievement. Results of this study reveal that those students who are depressed have low academic achievement. The author used Kovacs Children’s Depression Inventory (CDI) to identify children with depression.

Interviews with children in school settings also gave a similar picture of depressive feelings and there were equality common in boys and girls. As children are much more involved in learning (whether at home or in the school), any difficulty related to learning process is highly depressing for them because their social emotional and familial relationship are largely entangled with their competence in school.
3.4 PLAY THERAPY AS A REMEDIAL TECHNIQUE

It can be difficult at times to understand how young children feel. They may not express themselves in the same manner as others. When people hear that someone is "depressed", they automatically assume that the person walks around looking sad, they may sleep a lot, cry etc. But depression in younger children can be displayed in a very different manner. When children encounter stressful points in their lives, they often do not have the necessary skills to deal with their problems. They are not able to express their feelings in an appropriate way, and the feelings come out in other forms. Play therapy can be used with children who are suffering from depression. Since young children cannot sit down and talk clearly about their feelings, a play therapist is trained specifically in how to help children in the play setting. The therapist observes and interacts while the child "plays freely".

Emotional growth in a play therapy relationship parallels the normal emotional development in the early year of life in a family relationship (Moustakas, 1955). By exploring and expressing feelings and attitudes through the medium of play, the child gains a sense of inner relaxation, insight, and a sense of personal adequacy and worth.

One of the primary objectives of play therapy is to help children develop a sense of personal significance and adequacy. Young children do not usually possess the necessary verbal skills to fully express problems directly even when they feel free to do so (Carlton & Moore, 1966). Instead of using abstract words, they use play as a natural means of communication. According to Landreth (1982) "Play is to the child, what verbalization is to the adult."

Child-centered play therapy has also been demonstrated to be effective correcting speech problems (Axline & Rogers, 1945; Dupent et al, 1953), improving social and emotional adjustment (Axline, 1948; Cox, 1953; Dorfman, 1958; Moustakas, 1951), and helping children accept their sex (Guerney, 1983a).
Guerney (1983) suggests that the opportunity in play therapy to fantasize, to practice behavior, and to experience successes not possible in real life seems to promote more nature adaptive and seems to assist in cognitive development.

3.4.1 The Language of Play

Axline (1947) viewed play as a process in which the child plays out feelings, thus bringing the feelings to the surface, getting them out in the open, facing them, and learning to either control them or abandon them. It would seem then that play allows children to express themselves in a way that reduces tension and anxiety, and thus allows them to gain control of their lives.

The elementary school counselor uses play therapy with children because play is the child’s symbolic language of self-expression and for children to play out their experiences and feelings is the most natural, dynamic, and self-healing process in which children can engage. Play is serious business (White, 1960) and a process through which children build up their confidence in dealing with their environment. Self-directed play provides children with an opportunity to be fully themselves (Bruner, 1986). In play therapy nothing is held back; all parts of the self are experienced because self-directed play is safe. Only through engaging in the process of play in an accepting, caring relationship can children express and use the totality of their personalities.

Because children’s language development lags behind their cognitive development, they communicate their awareness of what is happening in their world through their play. The use of toys enables them to transfer anxieties, fears, fantasies, and guilt to objects rather than people. In the process, children are safe from their own feelings and reactions because play enables children to distance themselves from traumatic events and experiences. Therefore, children are not overwhelmed by their own actions because the act takes place in fantasy. By acting out through play a frightening or traumatic experience
or situation symbolically, and perhaps changing or reversing the outcome in the play activity, children move toward an inner resolution, and then they are better able to cope with or adjust to problems.

In a relationship characterized by understanding and acceptance, the play process also allows children to consider new possibilities not possible in reality, thus greatly expanding the expression of self. In the safety of the play therapy experience, children explore the unfamiliar and develop a knowing that is both experiential-feeling and cognitive. It can then be said that through the process of play therapy, the unfamiliar becomes familiar, and children express outwardly through play what has taken place inwardly. A major function of play in play therapy is the changing of what may be unmanageable in reality to manageable situations through symbolic representation, which provides children opportunities for learning to cope by engaging in self-directed exploration.

Various forms of play are useful in child psychotherapy. Even simple practice play (e.g., bouncing a ball) can help a child relaxed and comfortable with the therapist. In addition, game with rules (e.g., checkers) can be used to teach a child about formal play (e.g., Gardner, 1993a). Symbolic or pretend play, however, especially important for psychotherapy, because such play expresses children's experiences beyond their limited capacity to verbally explain themselves. Symbolic play entails engaging in one activity with one object for the purpose of representing a different activity and a different object. Symbolic play can involve toys (e.g., dolls or action figures) or sociodramatic scenes in which children join together to enact stories. Symbolic play represents and communicates children's personal view points about real events as well as their wishes, fears and other personal reactions to those events (e.g., Bretherton, 1989; Ciotto & Madonna, 1996; Johnson et al, 1997; Schaefer, 1993). Infect, researches find that children are especially likely to symbolically enact events and wishes that have aroused their anxiety.
as well as their wishes (Watson, 1994). Symbolic play is "often so revealing of the child’s otherwise hidden wishes that it can open the inner world of the child to the therapist" (Coppolillo, 1987). Moreover, some authors propose that children can construct new ways of coping with the dilemmas when they miniaturize or "model" dilemmas symbolically (Erikson, 1964, Watson, 1994).

Materials should be sufficiently varied to encourage enacting diverse themes and personal issues. Unstructured materials include items such as sand, water, and clay; they are intended to allow maximum freedom of self-expression. Structured materials include items such as cars, puppets, and dolls. Therapists often introduce such toys to elicit play about particular themes that deal with feelings, attitudes and conflicts in family or peer relationships (Johnson et al, 1997), e.g. therapists often introduce two doll houses into the playroom for children who are adjusting to having two homes after adoption or divorce (e.g., Kuhli, 1993). Similarly, toy medical equipment might be introduced to children who are facing a medical procedure (Oremland, 1993). Instead of focusing on toys, many therapists have adopted the "mutual storytelling" technique that was introduced by Gardner (1971, 1993b). The therapist begins to tell a story that raises a therapeutic issue; the client finishes the story while the therapist suggests adaptive outcomes. The mutual storytelling technique (Gardner, 1971; Gardner, 1986) can be easily and effectively used to intervene with children during a suicidal crisis. Mutual storytelling is a powerful technique when used with children who are old enough (at least 5 years) and verbally comfortable enough to engage in storytelling (Gardner, 1986). It would be most appropriate for use with children between the ages of 9 and 14. Of crucial importance to its effectiveness is the relationship between child and counselor. Before the counselor can understand the child’s metaphors and use those metaphors effectively in the retelling, the counselor must take adequate time and care in becoming acquainted

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with the child and in developing a democratic, trusting relationship (Gardner, 1971).

Storytelling is an ancient tradition of imparting, indirectly, important messages about how to behave cooperatively within a social context. In using storytelling as a technique, the counselor makes creative and efficient use of the child’s ability to communicate and learn metaphorically. First, the counselor asks the child to tell a self-created story about anything the child chooses. While listening to the story, the counselor analyzes its metaphors and their psychological meaning to the child. The counselor responds with a story that is similar to the child’s story, but the ending represents a healthier resolution than does the ending in the child’s story. In the retelling, the counselor uses the same characters in a similar setting as the child’s. In the counselor’s story, however, the characters solve their problems and conflicts in healthier, more adaptive ways. The counselor uses the retelling as a way of communicating to the child, through the use of the child’s own metaphors, new ways of coping in the world.

Finger Painting: Finger painting is a form of projective play and is viewed within the context of the therapeutic situation. It is introduced to the client by describing the process but without suggesting color or themes. Finger paints and paper are made available with directions of “paint a picture of something important to you, or of a dream, or of your family doing something together” While the painting is being completed, the counselor remains in the room with an attitude of creative objectivity, taking note of the client’s behaviors as well as the content of the productions. The counselor observes how the client applies himself or herself, the rate and rhythm of the work, colors used, types of lines, and so forth. When the picture is complete, the client is first asked to tell a story of the painting and then to discuss if anything in the painting reminds him or her of something in real life. The pictorial productions and fantasies the clients create about themselves are characteristic for
them and undergo relatively minor modification with the passing of time (Arlow & Kadis, 1993).

The consistent use of finger painting has proved invaluable in treating a child with behavior problems and neuroses (Arlow & Kadis, 1993). In the therapeutic setting, it allows observation of personality and motor skills. It facilitates the emergence of the child’s fantasies and inner world, and acts both as evidence of ego strength and as an evaluative measure of progress.

3.4.2 Play therapy and Depression

Oualline (1975) investigated the effect of short-term nondirective play therapy on preschool deaf children with behavioral problems. It was found that children who experienced the short term therapy intervention score higher in mature behavior patterns. No statistically significant change was noted in the area of personality adjustment and manifest behavior following the short-term intervention between the experimental and control groups.

Perry (1988) investigated the diagnostic value of children's play by exploring whether or not play behaviors of maladjusted children can be discriminated from play behaviors of adjusted children. Analysis indicated that play behaviors of maladjusted children significantly expressed more play disruptions, negative self-disclosing statements, dysphoric feelings, and conflictual play themes.

Barlow et al (1985) reported on the case of a 4-year-old child whose emotional reactions were so severe that she had, over a period of several months, pulled all her hair out and was completely bald. By the end of the eighth play therapy session, previously reported behavioral symptoms had disappeared and her hair had grown back, a dramatic picture of the effectiveness of child-centered play therapy. They experienced dramatic changes in the behaviors of traumatized and emotionally disturbed children by the fifth and sixth sessions of play therapy. In one case, the mother of a 5-year-old boy who was reacting to
his parent’s divorce reported dramatic changes in her son’s behavior (i.e., less aggressive and angry) by the sixth session. In another case, a 6-year-old boy who had spent 2 years denying the permanency of his grandfather’s death was able to express awareness and acceptance of his grandfather’s death during the fifth play therapy session.

Oe (1989) compared the initial session play therapy behaviors of maladjusted and adjusted children to investigate the value of children’s play for diagnostic purposes. Results indicated a significant difference in the following areas for maladjusted children: (1) more self-accepting and nonacceptance of environment behaviors and (2) more intense dramatic or role behavior and acceptance of environment. Additionally, specific gender differences were noted between maladjusted and adjusted children.

Brennan (1990) investigated the effectiveness of implementing Parent Adaptive Doll Play in helping children ages three through six-years of age cope with stress as a result of parental separation/divorce. Brennan discussed that each parent in the experimental group reported improvement in the child’s behavior and success in implementing the technique. No statistically significant differences were found on the Parental Attitude Scale results or between the groups in any specific area of child behavior.

Kao and Landreth (1997) investigated the effects of child-centered play therapy as a play therapy training model that can be used for beginning play therapy students. The effects of child-centered play therapy were examined to see if improvement in the following areas would occur: positive attitudes and beliefs towards children, knowledge of child-centered play therapy, and confidence in implementing child-centered play therapy skills, and tolerance levels. Furthermore, reducing the dominance tendencies in trainees was also examined. The findings revealed a significant change in every area for the play therapy trainees in the experimental group except for the tolerance level.
Kot et al (1999) examined the effectiveness of using intensive play therapy as a treatment method for child witnesses of domestic violence. Research findings indicated a significant improvement in both the self-concepts and play behaviors of physical proximity and play themes for the children in the experimental group as compared to children in the control group. Results also showed a significant reduction in both the externalizing behavioral problems and total behavior problems manifested for the children in the experimental group.

McGuire (2000) examined the effectiveness of child-centered group play therapy in the following areas with kindergarten child experiencing adjustment difficulties: reducing behavior problems, enhancing emotional and behavioral adjustment to school, improving self-concept, increasing self-control, and decreasing parental stress. Although no statistically significant change was indicated, positive trends in the area of children’s behavior, self-control, and self-concept were observed for children in the experimental group.

Giordano (2000) examined the effectiveness of using a child-centered self-reflective play therapy supervision model to facilitate change in Master’s level play therapists in the areas of child-centered attitude, knowledge of child-centered play therapy, change in skill utilization, and confidence in implementing the skills. A significant increase was gained for the play therapy supervisees in the experimental group in both the quality of verbal responses and the ability to implement certain play therapy skills.

Lind et al (2001) examined the effectiveness of intensive sibling group play therapy with child witnesses of domestic violence in improving self-concept, reducing internalizing and externalizing behavior problems, and reducing overall behavior problems. Statistical significance was found in all areas for children in the experimental group as compared to children in the control group. The study also compared the effectiveness of intensive sibling group play therapy and intensive
individual play therapy. Results indicated that both modalities were equally effective treatment interventions for child witnesses of domestic violence.

Jones and Landreth (2002) examined the effectiveness of intensive individual play therapy as a viable treatment intervention for children diagnosed with insulin-dependent diabetes mellitus. A significant improvement was reported for the children in the experimental group in adapting to their diabetes. Additionally, improvements were reported in both adherence behaviors and behavioral difficulties for the children in the experimental group as compared to children in the control group.

Hoffman (2004) contributed knowledge to the extent to which play therapy with adults can cultivate emotional expressiveness. There were a total of eight participants. A questionnaire was administered to the eight participants to collect data pertinent to the degree to which they express themselves emotionally and their desire to be more emotionally expressive. The participants engaged in a series of play therapy activities using the Bag of Feelings. Three licensed psychologists served as transcribers and raters and determined whether adults who engage in play therapy experienced an increase in emotional expression. If two out of three of the raters agreed, their conclusions were considered valid. The results of the study revealed that participants who described themselves as generally emotionally expressive exhibited a low degree of expression of the emotions of anger and shame; conversely, participants who described themselves as generally non expressive exhibited a high degree of expression for the emotions of enjoyment, happiness, surprise, sadness, and anger. In addition, the study showed that some emotions are expressed more frequently than others. Finally, play therapy contributed to great emotional expression for some emotions and proved to be valuable for adults. Play therapy helped the participants become more adaptable and flexible and in the moment of the play therapy sessions and overall more expressive of some emotions as a result of the
play therapy activities. A final conclusion could be based on the idea of neuroplasticity, or continual changes in the brain as a result of experience either by fresh connections between or generation of new neurons and the influence of practice on these changes. In this study, the play therapy sessions gave participants the opportunity to experience fresh connections and more emotional expressiveness. Additional opportunities to practice and to repeat experiences could result in greater emotional expressiveness.

3.4.3 Play Therapy and Classroom Behavior

Play therapy in a school setting has been found to be particularly helpful in promoting children’s emotional adjustment. Bills (1950) investigated the effects of nondirective play therapy on poorly adjusted slow readers and found that after six individual and three group play therapy sessions, students in the play therapy group showed significant gains in their reading ability when compared to a control group.

Professional counselors working with elementary children are in a position to observe and recognize the signs and symptoms of depression in children, and to provide appropriate comprehensive treatment. To maximize the effectiveness of the therapeutic treatment, in addition to providing individual or small group counseling or play therapy for children suffering from depression, the school counselor may need to consult or counsel with the depressed child’s two major life systems: the family and the classroom. Childhood depression is a complex, multifaceted disorder that affects many school-age children, their families, and their classrooms.

Griffiths (1971) found that participants in play therapy exhibit higher self-concept scores than do those who do not participate, concluding that play therapy has a positive effect on the self-concept of children who are low achievers in reading.

Gaulden (1975) examined whether a developmental play therapy group would decrease disruptive behaviors, increase self-concepts, and
improve attitude toward school for disadvantaged primary grade school children who are exhibiting problematic behaviors in the classroom. Although none of the hypotheses were confirmed, the data did indicate that the play group did reduce overall disruptive behavior in the classroom.

Barrett (1975) examined the effects of play therapy on the adjustment of socially and psychologically maladjusted children across six variables: personal adjustment, social adjustment, self-concept, school-related self-concept, inferred self-concept as rated by the parent, and behavioral maturity as rated by the teacher. A significant improvement was made by the children in the experimental group in the area of social adjustment.

Carns (1979) examined the effects of long-term play therapy on the following: social contacts, self-esteem, level of academic functioning, school-related behavior problems, attitude toward school, and family relations. Several significant results were observed in the experimental group.

Beezeley (1988) found that hyperactive or hyperaggressive children who remained in play therapy for at least one year showed significant gains in their ability to trust adults, delay gratification and verbalize feelings. Schaefer and O’Connor (1983) reported that out of twenty-five children they treated, with the exception of one psychotic boy, all had improved in areas of behavioral symptom control, social relationships, school performance and self esteem, if they remained in weekly therapy for at least one year. In their study parents, foster parents, teachers and the therapists judged the children.

Jones (1992) gave a residential school based play therapy program for children with emotional and behavior problems. In India, Raman (1995) studied play intervention in children with emotional disorder and compared that with behavioral intervention and found that both were equally effective.
Raman and Kapur (1999) conducted an exploratory study of the impact of non-directive play therapy on emotionally disturbed children. The study involved ten children between the ages of 5 and 6, diagnosed as having 'Emotional disorder' according to ICD-9 criteria. Five children underwent play therapy and the other five served as controls. Baseline assessment consisted of the teachers rating on the Rutter's A&B scales and Raven's controlled projection Test (RCPT). The children in study group underwent 15 sessions of non-directive play therapy and the other five served as control. Baseline assessment consisted of the teacher rating on the Rutter's A&B scales and Raven's Controlled Projection Test (RCPT). The children in the study group underwent 15 sessions of non-directive play therapy individually. All the ten children were administered the RCPT again at the end of this period. The teachers repeated the ratings on the Rutter's B scale for all the ten children. The children in study group showed a statistically significant reduction in Rutter's Child Behaviour Questionnaire scores as compared to the control group. Qualitative analysis of the RCPT responses and of the play sessions was undertaken.

Brandt (1999) researched the effectiveness of play therapy as a viable treatment intervention for children experiencing emotional and behavioral problems. Significant improvement on internalizing behavior problems, as well as overall reduction in parenting stress and externalizing behavior problems as compared to the control group.

Rennie (2000) investigated the effectiveness of individual child-centered play therapy as a treatment intervention for kindergarten children experiencing adjustment difficulties. A comparison was also looked at between the effectiveness of individual child-centered therapy and child-centered group play therapy. Results indicated a significant reduction in total behavior problems and in externalizing behavior problems for the children in the experimental group. Additionally, based on the comparison of the two play therapy treatment interventions,
individual play therapy was found to be significantly more effective than group play therapy in helping children behave in class.

3.4.4 Play Therapy and Academic Achievement

Bills (1950) demonstrated that children with learning disabilities improved significantly in reading ability following six sessions of individual non-directive play therapy.

Dorfman (1951) developed a system of coding play session behaviors, which yielded a three stage process from the “child being reticent” to “testing limits” to “attempted relationship with the therapist.

Herd (1969) investigated the effect of play therapy for the following: improved personality adjustment, mature and desirable behavior patterns, interpersonal relationship, and adequate use of intellectual capacities. Results indicated that the children in the play therapy group did score higher in the area of more adequate use of intellectual capacities. However, no statistical differences were indicated in the other areas between the experimental and control group.

Moustakas (1973) has done the most continuous investigation of process. He described six stages ranging from undifferentiated expression to clear negative and positive feelings. There are many cases and experimental studies reported which document the success of non-directive play therapy with children of every possible category except autistic and schizophrenic children. Children with intellectual impairments and physical handicaps have shown considerable improvement with non-directive play therapy (Guerney, 1979).

Child-centered play therapy has also been demonstrated to be effective in ameliorating elective mutism (Barlow et al, 1986), increasing academic performance in learning-disabled children (Axline, 1949; Guerney, 1983b), correcting speech problems (Axline & Rogers, 1945; Dupent et al, 1953), improving social and emotional adjustment (Axline, 1948; Cox, 1953; Dorfman, 1958; Moustakas, 1951), and helping children accept their sex (Guerney, 1983a).
If emotional needs of disadvantaged learners are not met, they will probably be unprepared to learn to read and may not benefit from instruction. Many reading problems stem from emotional immaturity brought about by unmet needs may result in children feeling helpless and unable to measure up academically and socially. Simple remediation in academic areas is not enough to overcome children’s negative self concepts academically, particularly in reading (Dreikers, 1954; Strother & Barlow, 1985).

Crow (1989) Achievement in most academic areas depends on reading. This study examines the relationship between play therapy and reading. Twenty-four first graders from two North Louisiana schools, who were repeating first grade and who had scored lowest on the Gates MacGinite Reading Test (GMRT) and the Stanford Reading Achievement Text the previous year, participated in this study. Researchers divided the children into an experimental group and a control group. Those in the former cluster received one 30-minute individual play therapy session each week for 10 weeks. The play therapist followed the principles of Child-Centered Play Therapy and tracked the children's play, reflected their feelings, and set limits if necessary. The GMRT, the Piers-Harris Children’s Self-Concept Scale, and the Intellectual Achievement Responsibility (IAR) questionnaire were administered to all children one week prior to the play therapy sessions and one week after the sessions' conclusion. Results indicated that children who received play therapy scored significantly higher on the self-concept inventory than children in the control group. However, children who received play therapy did not achieve notably higher mean scores on the IAR (locus of control) and the GMRT. Likewise, play therapy did not appear to increase students' measured reading ability.

Shashi et al (2001) evaluate the efficacy of play therapy and family counseling in emotionally disturbed school going children. The sample consisted of ten children in the age range of 5-10 years with five children
each in the study group and control group. Children in the study group were seen on alternate days for ten individual sessions of play therapy. Statistically significant difference was seen in pre and post scores of Children’s Behavior Questionnaire (A&B), Developmental Psychopathology Checklist, Child Behavior Checklist and Symptom Rating Checklist in the study group indicating better scholastic performance and symptom reduction then the control group. Qualitative analysis of play sessions revealed increased verbalization, acting out of conflicts and fears, anger towards significant others and subsequent resolution of the same by employing improved coping strategies and creating a positive attitude towards significant others, as the sessions progressed. Parents and teachers also reported improvement in the problem behavior. Children were more interactive, taking responsibility for household chores and improvement in academic performance.

On the basis of above studies, the researcher arrived at the following hypotheses:

1. There will be a significant improvement in depression among children after play therapy in experimental group.
2. There will be a significant improvement in classroom behavior of children after play therapy in experimental group.
3. There will be a significant improvement in academic achievement of children after play therapy in experimental group.