CHAPTER I

INTRODUCTION

Although people often say that childhood is the happiest time of one’s life, this statement is not necessarily true. Yes, we did not have many responsibilities when we were children, but we did not have much freedom either. We may not have had job or financial worries, but how many of us stayed up in nights worrying about our grades? How many of us had nightmares that we had failed in our exams? How many of us were teased at school? How many of us were worried about peer acceptance or did things we did not really want to do because of peer pressure? Yes, childhood is great; as is every other stage in life, but it is certainly not worry-free! We all had our share of fights with friends, our share of sadness and shed tears more often that we can remember. No one, no matter how old, how rich or how successful, is immune to sadness. Everybody feels hurt at one or other point in life. And for this reason everyone is susceptible to depression.

1.1 DEPRESSION

Depression can refer to different characteristics as symptoms. Depression refers to sad effect and as such is a common experience in everyday life. As a syndrome it is referred to as a group of symptoms involving cognitive, psychomotor and negative manifestations. As a disorder, it has a characteristic clinical picture, natural history and biological correlates. Sadness or Dysphoric mood may be a part of larger set of cognitive, psychomotor and negative manifestations including loss of interest in activities, feeling of worthlessness, sleep disturbance, changes in appetite etc. Depression has been described as psychopathological feeling of sadness.
1.1.1 HISTORICAL PERSPECTIVE

The earliest references to the depressive symptoms are traced back to 'KAPHONMAD' an Indian equivalent of depression given in Ayurved also in the old testament story of King Saul as well as in Greek Literature given by Ajax's suicide in Homer's 'Iliad'. Around 400 B.C. Hippocrates used the term "Melancholia" and "Mania" to describe mental illness. In 30 A.D. Aulus Cornelius Celsus described melancholia to be caused by Black Bile, one of the four corporal Humors. The term continued to be used by other medical authors and in the 12th century, A.D., a Jewish-Physician Maimonides considered melancholia as a discrete disease entity. But the first classical treatise on depression "The Anatomy of Melancholy" was written in 1621 A.D. by Robert Burton, himself a sufferer as a morbid depression. In 1686 A.D Bonet described a mental illness; he called "Maniaco-Melancholia". Emil Krapelin, in 1921, described involutional depression and gradually after this, the term Melancholia began to be replaced by depression and further studies were conducted to explain the phenomenon. The classical symptoms of depression include the triad of reduced capacity to experience pleasure (anhedonia) reduced interest in the environment (withdrawal) and reduced energy (anergia) as well as Dysphoric or depressed mood. Other symptoms are reduced concentration and attention, reduced self esteem and self confidence, ideas of guilt, hopelessness, suicidal ideas, disturbed sleep and diminished appetite (ICD-10, 1993).

Ample attempts have been made to quantify and qualify the symptoms of depression among children. Children are known to be unable to express their feelings like adults, and due to which it is very difficult to quantify and qualify certain symptoms as diagnostic entity. Until 1960s there was a general lack of interest in affective disorders in children because such existing developmental perspectives were psychoanalytic. Developmental theory stated that the presence of an
internalized super-ego was essential to depressive illness occurrence. On this consideration, children could not have depressive illness because their internalized super-ego is absent or deficient and also due to presumption that children substitute for the loss of a loved object more easily than adults. Rochlin stated the psychoanalysts view unequivocably, “--------classical depression, a super-ego phenomenon, as we psychoanalytically understand the disorder, does not occur in childhood------”. Hence, inspite of the theoretical importance given to object loss in childhood in psychoanalytic theory and the presence of literature reporting depression like syndromes in infants, little interest was shown in this field.

But sadness or despondency was reported in children of over stern parents by Robert Burton in the 17th century in his book “Anatomy of Melancholy” and in the early 20th century, Krapelin reported the incidence of Manic-Depression episode in children below 10 years of age. It was only in the 1940s that further studies gave specific depressive symptoms as observed by Spitz and Wolf (1946) in the condition described as "Anaclitic Depression" syndrome in infants and toddlers, separated from their mother with expressionless eyes, social withdrawal, sad faces, fearfulness, weight loss and developmental retardation. A similar condition was described by Goldfarb (1943) and Spitz (1945) termed "Hospitalism" in older children brought up in institutions and deprived of emotional contact with a mother or mother subordinate. Even then, depression in children was not well accepted and clinicians in 1950s and 1960s regarded that depression as present in adults was virtually non-existent in children (Rie, 1966) or that it did not present classically but presented as “Masked” Depression (Glaser, 1967) or that "Depressive Equivalents in children included a wide variety of symptomatology i.e. psychosomatic symptoms, eating and sleeping disturbances, boredom, restlessness, learning disorders etc (Toolan, 1962).
Slowly, two schools of thought emerged, one which proposed that childhood depression has certain unique clinical features or symptoms which distinguish it from adult depression (Kovacs and Beck, 1977). The other group (Cytryn and Mc Knew, 1972) emphasized that an underlying depression was responsible for a wide range of behaviors with marked depression. These diverse behaviors including conduct disorders, school refusal, hyperkinesis, enuresis etc. However, a close inspection of children with these complaints often reveals a classical depressive syndrome (Carlson and Cantwell, 1980). It has been indicated that existence of depression in children is isomorphic with depression in adults. In 1970s depression in children was recognized as a discrete entity and it was suggested that the criteria used to diagnose depression in adults could be utilized in children. Hence, the 1970s witnessed a burgeoning interest in childhood depression.

The recognition of the syndrome, however, has not answered many questions leaving large gaps in our knowledge regarding it. The criterion for delineating childhood depression is not clearly defined and hence there is a wide variation in results of the various studies conducted. Lefkowitz and Burton (1978) indicated that normal children tend to have symptoms comparable to those described for depressed children. They stated that assessment instruments with adequate reliability and validity have not been developed, therefore preventing the longitudinal and cross-sectional research necessary for establishing norms for children of different ages. In this view, until adequate instruments and norms are developed, diagnosis appears to be premature and treatment, particularly medical treatment, possibly harmful.

The problem lies with choosing the type of diagnostic criteria for diagnosis. Two approaches are widely prevalent: one which uses unmodified adult criteria (DSM-III-R American Psychiatric Association,
1987) or Research Diagnostic Criteria (Spitzer et al., 1978) and the other which uses modified criteria e.g. Weinberg Criteria (Weinberg et al., 1973). These two approaches identify two different sets of children with depression; there being a very small overlap (Cantwell and Carlson, 1983). Kashani and Simmonds (1979) found that only 1.9 percent of a sample of seven to twelve year olds met the DSM-III diagnostic criteria for affective disorders, while sadness was reported in 17.4 percent of the children. No argument has been reached as yet as to which of these approaches is right in the sense that they identify a mere homogeneous group of patients with regard to natural history, family history, treatment etc. Hence the lack of uniform criteria for diagnosis of childhood depression poses a major problem in further study of the disorder.

The phenomenology of depression in children and adolescents in the western set up did not show significant differences in majority of depressive symptoms. However, pre-pubertal children showed greater depressed appearance, somatic complaints, psychomotor agitation, separation anxiety, phobias and hallucinations than adolescents. In addition, the children also exhibited three more symptoms, which are negative cognitions, appetite and weight changes and conduct disorders (Ryan et al., 1987).

Various studies have been conducted and most of them differ in their viewpoints of various aspects e.g. inclusion of sample. The term "childhood" has no well defined cut-off point and classically includes babies after the 1st year of life (infancy) till onset of adolescence (starting at puberty i.e. 11-13 years in girls and 13-17 years in boys). So various studies done on childhood depression have taken different age groups for study (Rutter et al. 1970 and Kovacs et al. 1984). Various tools have different inclusion ages as children's depression inventory (CDI by Kovacs 1985a) is designed for children in the age range of 7-17 years whereas Bellevue Index of Depression Modified is

5
used for the age range of 6-13 years and the Interview schedule for children (Kovacs, 1985b) is suitable for the age group 8-17 years.

In India, Rao (1970) studied psychological problems in the inmates of orphanages, beggar homes, etc. but did not list depressive symptoms as a major problem. Further, Manchanda and Manchanda (1978) and Chacko (1980) reported 6.1% and 7% cases of depression and masked depression respectively. Malhotra and Chakraborti (1992) who gave the conclusion that depression in children resembled depression in adults but this study was done retrospectively on children who attended the child psychiatric clinic from 1987-88. Early onset of depression in children and teens is increasingly common. Stresses of a growing divorce rate, rising academic expectations and social pressures may push more kids over the edge. Today, it is recognized world over that depression does exist among children and it can prove fatal if not treated early.

1.1.2 Symptoms of Depression

First, we should know that childhood depression may not take the form of "clinical" or adult depression in which the person becomes lethargic, unmotivated, and "down" or "blue" (although this form is often present in children, and becomes more common as youngsters enter adolescence). In identifying depression in children, it is important to avoid making the mistake of looking only for symptoms that characterize adult depression such as fatigue, suicidal fantasies, low self esteem, and social withdrawal. Depression in children is often "disguised" by "active" behavior such as irritability, temper tantrums, violence, risky actions, and/ or refusal to go to school. It is also important to note that sometimes something as simple as sleep deprivation due to staying up too late can mimic depression. If a better night time schedule and a nap or two usually clear things up, it wasn't true depression.
Introduction

Signs and symptoms can vary depending on the age, personality, and home situation of the children. Again, symptoms may vary from mild to profound. Typically, the indicators listed below are first thought by parents to be reflective of a physical condition or illness. They, then, visit the pediatrician who (hopefully) detects the condition (although many pediatricians are not knowledgeable in this area). To assist in identification, it is important that professionals working with children be alert for the following signs, often seemingly contradictory:

Feelings (as identified by verbalizations)
• Feeling sad (cries, pouts, looks sad or troubled)
• Feeling hopeless about the future (says that nothing s/he does will make a difference, not caring about outcomes)
• Feeling poorly about oneself and one's abilities (makes negative remarks about self, evaluates oneself poorly in contrast with others)
• Feeling responsible (blames self) for past events and negative outcomes in the present
• Feeling alone (expresses that no one likes him or her, says that no one understands)

Physical Symptoms
• Is lethargic, or conversely...highly active
• Fatigues easily, or conversely...rambunctious
• Becomes ill frequently
• Pretends to be ill

General Behavior
• Seems distracted; has trouble focusing and concentrating
• Emotional instability; the child angers with little provocation and/or cries easily
Introduction

- Fails to find happiness in activities that typically give children joy
- Frequently mentions unhappy thoughts and sad memories

Eating

- Loss of appetite
- Compulsive overeating

Appearance

- Obvious weight change (loss or gain)
- Looks to be very tired
- Has a sad appearance, or looks very tired and worn out

Sleep Patterns

- Engages in attention-seeking actions at bedtime
- Awakens more frequently during the night than was previously the case (insomnia)
- Experiences frequent nightmares and night terrors
- Slow to awaken and "get moving" in the morning
- Sleeps during the day even after a good night's rest (hypersomnia)

Relationships

- Excessive seeking of parental attention
- Lacks interest in friends' or family's activities
- Fights with friends and adults over trivial matters, irritable with others

School

- Avoids school or classes
- Diminished interest in school, schoolwork, or after-school activities
- Avoids socializing with friends or family; seeks isolation
1.1.3 Causes of Childhood Depression

Some causes of childhood depression seem obvious to us, but other times we are unable to discern a possible etiology. Certainly a long-term illness, an unhappy home situation, lack of social skill in interacting with others, and emotionally traumatic events can bring about depression. The various causes are sometimes categorized in the following manner:

1. Reactive - Depression as a response to environmental factors (family changes, death of a loved one, end of a relationship).
2. Endogenous - Depression due to biological or genetic factors (brain chemistry change, inherited predisposition to depression, trauma/injury to the brain).
3. Traumatic environments - Depression as a reaction to an emotionally overwhelming experience such as child abuse, harsh conflict, or real or imagined fears of physical or emotional harm.

The reasons students give for failure or the happening of a "bad" event is believed to determine whether they experience the helpless feelings that lead to depression. Three attributional spectra or continua are often considered by psychologist in their evaluation of children. These three are Internal, Stable and Global described in section 1.1.4.1.

Depressed students make more internal, stable, and specific attributions for failures, and more external, unstable, and global attributions for successes. They blame themselves for undesirable results, but fail to see the importance of their efforts in positive outcomes.
1.1.4 Theories of depression in children: cognitive, behavioral, and psychosocial

1.1.4.1 Cognitive theories

Cognitive models of depression are based on the notion that depression is not caused by bad or unfavorable events, but rather by negative thoughts or cognitions in explaining the bad events, the habitual ways we explain trouble to ourselves.

Cognitive theories include the 1) Cognitive distortion model (Beck, 1967; Kovacs and Beck, 1977) and 2) learned helplessness model (Seligman, 1974; Seligman et al, 1978), both of which share a common conceptual framework. When applied to children, these theories are most applicable from the age of eight on. By the late elementary school years, children are generally capable of the self-selection and the causal reasoning which are involved in cognitive theories.

Cognitive distortion model – feelings follow thoughts

Originally formulated in relation to adult depression, studies of children have also provided support for this model. Cognitive style, according to Beck, is rooted in unfavorable life experiences, which eventually result in a tendency to overreact to events, to notice only the unpleasant things, to make pessimistic generalizations about the future.

Any seeming loss, rejection, or disappointment can activate this thought pattern and set off a cycle of distorted thoughts about oneself, the world, and the future, as well as withdrawal and sadness.
Learned helplessness model – giving up

This model based on the premise that the way we explain things to ourselves about what happens to us affects our ability to cope and renders us vulnerable to depression. Originating in work with animals, the learned helplessness model has spurred much research on depression in humans. Cluster of deficits in motivation, learning, and emotional reactions was described as learned helplessness (Maier et al, 1969).

A helpless child sees problems as insurmountable; s/he feels ineffective and unable to influence the events in his/her life. S/he does not see a connection between what s/he does and what happens to his/her, either good or bad. When something bad does happen, this gives his/her further evidence that his/her efforts are useless. Therefore s/he learns to expect failure no matter what s/he does. And when s/he does meet with success, s/he attributes it to luck or other external causes.


Explanatory style

Accordingly to learned helplessness theory, three dimensions are critical in an explanatory style that predisposes an individual to depression: (Seligman et al, 1978)


**Introduction**

1) **Internal attributions:** Bad events are believed to be due to characteristic within the individual, such as worthlessness, incompetence, etc; self-esteem decreases as helplessness increases.

2) **Stable attributions:** Bad events are attributed to facts that persist over time; helplessness is expected to be permanent, so nothing one does can change it. The more stable the attribution, the more chronic the helplessness.

3) **Global attributions:** Bad events are attributed to causes that are present in a variety of situations, rather than in a specific situation. Helplessness is predicted to be pervasive. For example: lack of intelligence is more global than a specific lack of ability in math. The more global the attribution, the more the helplessness is apt to be generalized. The helpless person expects it to seep in everywhere.

To the degree that a child attributes bad events to internal, stable, and global causes, that child is increasingly likely to be helpless and depressed when a bad event does occur (Abramson et al., 1978). On the other hand, children who explain bad events in terms of external, unstable, and specific causes are not likely to become depressed. Numerous studies have shown a correlation between negative explanatory style and depressive symptoms in children, suggesting that this style is associated with depression. The strongest research support has been for the internal attribution concept (Peterson and Seligman, 1984). Criticisms have also been raised. Coyne and Gotlib (1983), reviewing the research on both the cognitive distortion and the learned helplessness models, conclude that neither model has an adequate empirical base and that neither explains the recovery of depressed persons. They believe that negative self reports would be better understood in relation to their environmental antecedents and consequences.
Introduction

Explanatory style and school achievement

Helpless children may also have problems in academic achievement behaviors; they tend to overestimate failure and underestimate success (Dweck, 1975; Dweck and Repucci, 1973). Studies have shown that the way children explained their performance to themselves influenced whether they gave up or persisted. The spontaneous remarks made by helpless children illustrate their negative explanatory style.

Children can learn a negative explanatory style from their parents, particularly the mother (Seligman and Peterson, 1984). When mother and child process information in the same negative style, they create a repetitive interpersonal cycle. The age of the child influences the degree to which the child is affected by the mother's explanatory style, with the preschool age being the most vulnerable.

Age and explanatory style

The age of the child must be considered in judging children's perceptions of the extent of their control. With increasing age and autonomy, however, stress situations are perceived to become more controllable.

Younger children are less susceptible to the sense of helplessness than older ones. Pride in accomplishment can be observed at an early age, as can the effects of failure. By the age of two, children show delight in success and in their own efficacy (Kagan, 1983); they also react with frustration and distress to failure. By the age of four, children seem to have an accurate sense of what they can and cannot do. However, even though young children are aware of their failures, they don't view failure as stable and lasting. Most young children don't make the connection between their abilities and their actual experiences of success and failure. Even when they do make
the connection, they don't generalize it to mean that they will fail in all situations.

In addition, young children generally tend to feel competent. They believe that high effort and high ability will result in success, whereas low ability and low effort will result in failure. Older children believe that high effort may compensate for lower ability (Rholes et al, 1980). Young children don't think much about the future or about distant consequences of their actions. Children as young as four or five are aware that other people are proud or ashamed of them, but it is not until they're about eight that they talk about being proud of themselves. In general, experiences of success and failure have a greater effect on the expectations of older children. Attributional patterns that promote helplessness are not characteristic of children before about 8 or 9 years.

Negative explanatory style- permanent or temporary?

Children whose depressions are largely reactions to environmental stress, such as separation or hospitalization, do not maintain a depressive explanatory style after the stress episode subsides (Asarnow and Bates, 1988). As children respond to positive environmental changes, their explanatory style changes and becomes more positive.

Not all children who have a negative explanatory style develop depression; only certain subgroups of depressive children use this style. It can, however, become solidified in children who experience serious, uncontrollable events that affect many areas of their lives over a long period of time.

Implications for treatment

According to cognitive theory the quality of children’s responses to failure or misfortunes is related to the causes by which they explain
events. The helpless child will interpret defeat as permanent, catastrophic, and evidence of personal shortcomings. The non-helpless child will interpret the same misfortune as temporary, under her control, and due to circumstance or bad luck. In treatment, therefore, learned strategies have to be unlearned. Children are taught techniques to help them change their thinking and their explanatory style, correct distorted beliefs, and to attribute their failure to factors over which they have control.

1.1.4.2 Behavioral Theories

Behaviorists as a rule do not consider the internal causes of behavior. They focus on understanding overt behavior in terms of the events that either precede or follow the behavior, that serve to reinforce it or extinguish it. From the behavioral point of view, changes in reinforcement – either in number or in kind – are seen as the causes of depression (Lewinsohn et al, 1976).

1) Depressed individuals receive less positive reinforcement. In a child’s life, there are numerous situations that could result in reinforcement changes; one important event involves the loss of a person who previously supplied the reinforcement – mother, father, or friend. Other stressful life events such as moving, death in the family, or divorce can all be viewed as situation which results in loss or reduction in sources of positive reinforcement.

2) Depressed individuals elicit fewer reinforcing behaviors from other people. Another important factor is the depressed child’s ability, or rather, lack of ability, to actively obtain reinforcements from other people. Some children, even at birth, have outgoing temperaments to which people are more likely to respond. In other cases a child’s behavior may not be pleasing to other people; he may be clingy, sullen, needy, whiny,
unresponsive, etc. Behaviorists translate the clinical features of depression into learning theory terms. Withdrawal is equated with avoidance behaviors. Self depreciation, crying, irritability and requests for help are seen as behaviors that help the child avoid unpleasant behaviors or to get attention.

If the disturbing behavior persists, it may cause others to avoid the child. He may not get the feedback from the variety of experiences he needs to develop social skills, and receives less positive reinforcement from his peers (Blechman et al, 1986; Kaslow et al, 1984).

3) Depressed individuals exercise fewer social skills. Many of us have seen a child with a dismal expression hovering on the fringes of a group in a playground, not knowing how to get involved. Although it is obvious that deficient social skills are also common in children with other types of psychiatric disorders, clinical observations show that depressed children are particularly impaired in their social skills. They are ill at ease with the ordinary give-and-take of social interactions. They are awkward in initiating or reciprocating social overtures. They often act impulsively, seemingly insensitive to the consequences of their actions.

Peers of depressed children view them as isolated and unsuccessful in actual social situations. Depressed children view themselves similarly, and are chosen less often than other children as play or workmates. They perform less well on tasks that require interpersonal problem solving. They expect to be unsuccessful; they set more stringent criteria for success and evaluate their own performance unfavorably (Blechman et al, 1986; Sacco and Graves, 1984).
Teachers don’t enjoy working with depressed children; they feel frustrated by them and keep a distance from them (Morris, 1980). A vicious cycle sets in; the depressed child withdraws, reduces his opportunities to be in social situations, and receives less positive reinforcement from his peers and teachers.

General treatment is carried out by manipulating reinforcements. Therapy programs range from improving problem-solving abilities, social skills and assertiveness training to increasing the depressed child’s involvement in rewarding activities.

1.1.4.3 Psychosocial Factors

Life events and stress

Each person’s life contains uncountable numbers of events of varying magnitude, duration, and particular meaning for the individual. Not all life events are stressful. Some, such as the death of a family member, are major, and can cause considerable upheaval. On the other hand, many events are relatively minor and exert relatively less impact (e.g., a child getting a poor grade). Life events affect human development in positive and negative ways, facilitating positive growth and adoption as well as contributing to illness and disturbance (Compas, 1987). Major life stressor that requires considerable readjustment may lead to reactive and other types of depression.

Numerous factors- the quality of early relationships, resources for coping both within the individual and within the family, age, temperament, frequency of stress, and social supports all affect the impact of the event. Recent research suggests that a gender difference may also be present; girls tend to rate events as more stressful than boys and report more major negative events and daily "hassles" or irritations than boys (Lawrence and Russ, 1985; Lewis et al, 1984; Burke and Weir, 1978).
There is reasonably strong evidence in adults that stressful life events play a significant role in the onset of depressive conditions and other disorders. Social class, for example, is significant; the rate of depression in the lower socioeconomic classes is significantly higher than in other classes (Brown and Harris, 1978). In contrast to the adult research, there is a paucity of evidence on the impact of stressful life events on psychiatric disorders in childhood. In spite of the considerable variability in measures used, studies do show a relationship between stressful life events and psychological or physical dysfunction in children and adolescents.

Stress has been broadly defined as a stimulus which exerts a demand and requires an adaptational response by the child. The child and the event reciprocally influence each other. Sources of stress during childhood and adolescence have been outlined by Compas (1987).

**Chronic stressors:** In triggering psychological distress, chronic stressors, including characteristics of the psychosocial environment e.g. socioeconomic status, parental alcoholism, marital discord, family violence, mother's physical or emotional illness, peer group relationship seem to be more significant than single major life events. Economic factors are critical; more mental illness occurs among poor people, who have to deal with poorer housing, clothing, and food in addition to the psychological stressors. Other chronic stressors may be:

a) Physical disabilities- children with illnesses which entail hospitalization, immobilization and/or pain often have at least one acute depressive episode. Children with chronic disabilities –paralysis, kidney disease, asthma, heart disease –tend to have one or many depressive episodes or a chronic protracted depression. The frequency depends on such factors as family background, personality, and
Introduction

biological makeup. When chronically ill children become depressed, they may give up and not take their medication. Children of parents with a chronic physical illness often suffer episodes of depression either because of losing the parent or because of identifying with the parent's reaction to the physical illness (Mcknew and Cytryn, 1973).

b) Learning disabilities- children identified as learning disabled have been found to have higher rates of depression than non-learning disabled children (Brumback et al, 1977; Stevenson and Romney, 1984). Depressed learning disabled children were found to have lower self-esteem than non-depressed learning disabled children. The personality traits which characterized the more depressed children were high anxiety, low ego strength, and over sensitivity.

It is sometimes difficult to differentiate between depression and learning disability. 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).

Abused children have been found to have higher rates of depressive symptoms, heightened externality, lowered self-esteem, and greater hopelessness about the future (Allen and Tarnowski, 1989).

Acute stressors:

a) may be specific events, the typical life transitions encountered by most children, such as change of school, etc., or a typical events, such as death or divorce,
b) may also refer to minor irritations of daily living which have a cumulative effect.

There are times during the life span when the frequency of acute stressors increases e.g. during adolescence many biological and social changes occur, including hormonal changes, school transitions, and different social expectations, all of which may contribute to the increased incidence of depression.

The single most important factor in acute depressive reactions is the sudden loss of a parent, which increased the likelihood that the child will be depressed by a factor of about 2 to 3 (Brown, 1977; Lloyd, 1980). Maternal loss has been shown to be more significant in later childhood. The child who loses either parent when he is 10 to 14 years is considered the most vulnerable for later depression.

Other types of single life events have been studied, several of which are summarized below:

1) Hospital admission – Studies were reviewed by Garmezy (1983) who concludes that hospital admission constitutes short-term distress and disorder in young children but that longer-lasting sequelae are unusual.

2) Birth of a sibling – More than half of forty-two-to-three year-olds became temporarily more tearful in reaction to the birth of a sibling; one-fourth had sleeping difficulties; more than half had toileting problems (Dunn et al, 1981). Changes in mother/child and family patterns of interaction were considered to be the critical factor.

3) Divorce – For each year during the period from 1972 to 1979, one million children below the age of 18 experienced family divorce (Wallerstein and Kelly, 1980). Although not all children
respond adversely, for some divorce can contribute to depression or to aggressive behavior.

Many researchers feel that event such as divorce, a loss, entering a new school, or similar experiences do not actually constitute discrete events, but really comprise a series of multiple events. In most cases, the negative event or events stress patterns of family interaction and relationships. The magnitude of the effect of stressful events depends on the coping resources within the child and the family.

1.1.5 Diagnostic Criteria for Major Depressive Episode

The American Psychiatric Association has established the diagnostic criteria for the evaluation of a major depressive episode, which are reproduced here. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either

(i) Depressed mood, or

(ii) Loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations). Depressed mood (can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated by subjective account or observation of others.

(iii) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective amount or observation of others), and apathy most of the time.

(iv) Significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a monthly), or decrease or
increase in appetite nearly everyday (in children, consider failure to make expected weight gains).

(v) Insomnia or hypersomnia nearly everyday.

(vi) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(vii) Fatigue or loss of energy nearly every day.

(viii) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(ix) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective amount or as observed by others).


1.1.6 Distinguishing Depression from other Disorders

The DSM-IV provides four disclaimers to the clinical diagnosis of depression. It is necessary to describe depression as a mood disorder, which differs from depression associated with other psychiatric or medical conditions. If any of the following four situations apply to a person, depression is not present (following from table of criteria for diagnosis):

1. It cannot be established that an organic factor initiated and maintained the disturbance.

2. The disturbance is not a normal reaction to the death of a loved one (uncomplicated bereavement).
3. At no time during the disturbance have there been delusions or hallucinations for as long as 2 weeks in the absence of prominent mood symptoms (i.e. before the mood symptoms develop or after they have remitted).

4. Not superimposed on schizophrenia, delusional disorder, or psychotic disorder (not otherwise specified). (Diagnostic and Statistical Manual of Mental Disorder, 4th ed. 1994. Washington. DC: APA). The diagnosis in children must consider the possibility of attention deficit disorder (ADD), which causes irritability and loss of concentration. These symptoms are often how children manifest depression.

Most youngsters (40% to 90%) with major depressive disorder have at least one comorbid disorder, and as many as 30% to 50% have two or more psychiatric disorders (Lewinsohn et al, 1999). The two most commonly diagnosed comorbid disorders are dysthymic disorder and anxiety disorder. Disruptive behavior disorders and substance abuse follow close behind in order of frequency of occurrence.

1.1.7 COMMON TREATMENT STRATEGIES

A large number of treatment strategies have been developed for ameliorating depression. Many of these approaches can be implemented individually or in, groups or in family therapy environment. Peer group approaches have been found to be effective for children. Play Therapy is appropriate with younger children.

- **Cognitive**

  Cognitive approaches utilize specific strategies that are designed to alter negatively based cognitions. Depressed patients are trained to recognize the connections between their thoughts, feelings and behavior to monitor their negative thoughts, to challenge their
negative interpretations and to focus on new behaviors outside treatment.

- **Behavioral**

  This approach is designed to increase pleasant activities, includes several components such as self-monitoring of activities and mood. Identifying positively reinforcing activities that are associated with positive feelings, increasing positive activities, and decreasing negative activities.

- **Social Skills**

  Social skills training consists of teaching children how to engage in several concrete behaviors with others. Initiating conversations, responding to others, refusing requests, making requests etc. Children are provided with instructions, modeling by an individual to peer group, opportunities for role-playing and feedback. The objective of this approach is to provide the child with an ability to obtain reinforcement from others.

- **Interpersonal**

  Interpersonal approaches focus on relationship, social adjustment and mastery of social roles. It usually includes non-judgmental exploration of feelings, elicitation and active questioning on the part of therapist.

- **Play Therapy**

  Play therapy is a therapeutic technique most often used when working with children. While a child may not be developmentally able to articulate their feelings, a therapist can help them express what’s going on through engaging them in play. The sessions take place in a room that is specially furnished with boys, games, and equipment a child can use as tools for the dramatic scenes they direct while working with the therapist. Through play therapy a
child can triumph over traumas or upsets that have threatened their well being. The present work aimed to study the effects of play therapy.

- **Medications**

Medication alone, or in combination with psychotherapy, has proven to be an effective treatment for a number of emotional, behavioral, and mental disorders. Competent therapy and counseling interventions may be more effective for children due to side effects of medications.

### 1.2 PLAY THERAPY AND ITS APPROACHES

Though play is a universal activity of childhood, many Indian parents and teachers view it as a purposeless and useless activity. However, it is one of the firmly established principles of psychology that play is very essential for the purpose of development of a child. Through play, children develop their intellectual, emotional, perceptual, motor and social skills. Psychologists and educators are now engaged in extensive research to uncover its full potential in normal child development apart from its growth-producing role. Play is also of therapeutic value to children with emotional and behavioral problems. Erikson (1963) states that, to "play it out" is the most natural self-healing process in children. There are many creative aspects of play. It releases tensions and pent-up emotions, allows for compensations in fantasy for loss, hurt or failure, facilitates self discovery of more adaptive behavior. It also promotes awareness of conflicts revealed only symbolically and offers the opportunity to educate children to alternate behaviors through role playing or story telling. Two figures stand out as major contributors to the early development of play therapy as a viable therapeutic technique with children: Melanine Klein and Anna Freud. Klein was the first therapist to use a carefully
planned playroom. She utilized a large number and variety of miniature figures, art materials, and kinesthetically stimulating toys (i.e., sand and water tables) to encourage children to generate meaningful play themes. In 1928, Anna Freud began to use play as a way of luring children into therapy. Non-directive or client centered play therapy was described first by Axline. The basic premise in this form of play therapy is that individuals have, within themselves, not only the ability to solve their own problems satisfactorily but also a growth impulse that makes mature behavior more satisfying than immature behavior. This form of therapy grants the individual the permissiveness to be himself/herself. Since play is the natural medium for self-expression, the child is given the opportunity to play out accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment and confusion. By playing out these feelings, the child brings them to the surface, gets them out in the open, faces them, learns to control them and abandon them. The therapist helps by not only providing toys and materials that elicit self-expression but by selecting or being a mirror to the feelings of the child and accepting the negative feelings of the child, so that the child can also accept them without feeling “abnormal” or “bad” because he or she has them.

Children lack the cognitive maturity to benefit from talking through their problems. Nor do adult controlled activities give children the feeling of empowerment they can achieve with the voluntary activity of play. In a play therapy session, the child is the director and rule maker. They create a world they can master, practice social skills, overcome frightening feelings and symbolically triumph over the upsets and traumas that have stolen their sense of well being.
The term ‘play therapy’ encompasses a wide variety of clinical techniques and therapeutic approaches. Despite the commonalities among many approaches to play therapy, significant differences in both goals and techniques exist. There are four major approaches to play therapy: Psychodynamic, Humanistic, Developmental, and Directive.

1.2.1 Psychodynamic Approach

The psychodynamic approach to child therapy represents the earliest conceptual model for how to conduct psychotherapy with young children. One of the central assumptions of the dynamic approach is that children’s play is an important form of communication. One of the therapist’s primary jobs within this approach is to offer interpretation about such behavior to the child. Interpretations are therapist’s comments designed to communicate to the child previously unrecognized (i.e., unconscious) relationship between thoughts, feelings, and behaviors or to increase a child’s understanding of the causes of such behaviors and feelings. The objective of interpretations is to increase the child’s understanding (i.e., insight), thereby increasing his or her control of behavior, emotions, and thoughts. Within this approach, children are given extensive freedom to choose how they will spend the therapy session (e.g., drawing, playing games, talking, using puppets). During the early phases of therapy, the therapist becomes a compliant player in the child’s activities and begins to comment on the metaphors that emerge during the child’s play. As such metaphors of past and present concerns of the child are “played out” in the child’s activities, the therapist’s acceptance and interpretations of the play allow the child to construct and try new solutions to his or her conflicts.
1.2.2 Humanistic Approach: client-centered play therapy

The client-centered approach to play therapy is characterized by the extensive freedom given to the child client to direct play activities and child-therapist interactions. Within this approach, the therapist believes that the child is his or her own best source of positive growth and that, given the opportunity to explore his or her own feelings in a safe, nurturing environment, the child will learn to meet biological, intrapersonal, and interpersonal needs in adaptive, self-realizing ways.

Carl Rogers developed this model based on his belief that the primary motivation for human beings is to grow toward self-direction and self-actualization by creating an optimal environment in which the therapist provides unconditional acceptance of the child and thereby reduces the conflict the child feels with the environment. Humanistic play therapy is conducted by regularly exposing the child to the warm, accepting nature of the therapist within the trust-promoting environment of the playroom.

1.2.3 Developmental Approach: Theraplay

Theraplay, developed by Ann Jernberg, is perhaps the most well-known of the developmentally oriented approaches to play therapy. Theraplay was developed for use with a wide range of child clients who experience difficulty in establishing and maintaining positive interpersonal relationships. The model is based on the assumption that healthy caretaker-child interactions in the first few years of life are critical for later mental health and put a positive impact on a child’s ability to experience satisfying personal relationships.

The therapist attempts to present activities that address four different types of early caretaker-child interactions: structuring, challenging, intruding and nurturing. Structuring interactions are designed to allow the therapist to set limits and provide an orderly
environment for the child. Challenge activities stimulate the child’s development and enhance achievement. Intrusive interactions discourage the child from withdrawing from the real world and retreating into a fantasy life. And finally, nurturing interactions are designed to meet a child’s need to be nourished, consoled and comforted.

Throughout Theraplay sessions, therapists maintain a positive and playful attitude. They model for the child client the enjoyment derived from normal childhood fun. They attempt to convey to the child that social interactions can be positive and pleasurable experiences. Frequently, therapist use touch as an important method for connecting and communicating with children. The act of touching is viewed as an important part of early caretaker interactions, and it is used frequently throughout all Theraplay activities.

1.2.4 Directive Approach: Cognitive–Behavioral Play Therapy

Cognitive–Behavioral play therapy combines more traditional play therapy techniques with behavioral and cognitive techniques. Such an approach has proven useful in developing children’s problem-solving and social skills and other cognitive and behavioral coping strategies.

In cognitive–behavioral play therapy, the therapist is more active than in traditional approaches to play therapy. Common behavioral techniques used in this approach include modeling, systematic reinforcement, shaping, and practice procedures, e.g. a therapist might use tokens and praise to gradually increase a shy child’s verbal interactions.

Cognitive procedures are more likely to focus on children’s thoughts, feelings and problem solving. The therapist, for example, may assist the child in thinking of alternative solutions to a problem or may help the child consider alternative
explanations for an event. Children may be taught to use coping self-statements to help them deal more effectively with stressful situations.

Children may also be encouraged to monitor their thoughts and feelings and engage in self-reinforcement for appropriate behavior. As with learning skills are developed through extensive modeling, shaping, practice and reinforcement.

Such an approach allows clear treatment objectives to be identified and specific procedures developed for achieving those objectives.

1.3 CLASSROOM BEHAVIOR

In order to manage classrooms effectively teachers must play a central role in defining expected students' behavior. This implies that teachers must have a clear idea of what behaviors are and are not appropriate in advance of instructions. However, identifying expectations for behavior is not a simple matter because of the complexity of elementary-school classroom. Children are engaged in learning many different subjects, often working in variety of formats including whole class, small groups, and individual seatwork. Within these formats different activities occur such as recitations, pupils' presentations, teacher presentations, and discussion. Children leave the classroom at various times to go to different instructional areas, lunch, recess, and so on. Most of these activities require different student behaviors. Thus, the teacher cannot depend on a few general expectations (e.g., respect others) to carry the day; students need to know what is expected of them in these different settings. Students need to know what to do when they first enter the classroom or teaching area. Some signal such as ringing the bell may be used to cue-in-seat behavior and cessation of talking. Students must be seated quietly during attendance. Expected student behavior
Introduction

frequently includes listening attentively when the teacher or a student speaks, raising one's hand and waiting to be recognized before speaking, and following directions. In small group activities students are allowed to talk to each other (e.g., to help, to socialize, to seek help) and in what manner (e.g., whisper or use classroom voices). Whenever students encounter difficulty with assignment, they can seek help from teacher. Students need to know how to use toilet facilities, get drinking water, find lost objects, store food or other items brought from home, and maintain their personal belongings. Students should raise their hand to ask and answer a question or seek assistance. Students should not speak out of turn at any time. There should be no talking when teacher is speaking. The teacher will dismiss students at the end of the class session. Students should not organize their classroom materials, not depart from their desks until directed by their teacher.

The areas outlined above besides some others encompass the major types of activities occurring in most elementary-school settings, and for which the teacher will need to have clear expectations for appropriate student behavior.

The process of identifying expectations is accompanied by the formulation of classroom procedures and routines to promote behavior in accordance with the expectations. Sometimes this process may be very direct. For example, if a teacher wants children to be seated quietly during attendance check, a workable procedure is to require that children be seated when the last morning bell rings and to refrain from speaking unless called upon. Other procedures may be more complex. For example, if children are expected to line up and pass through the halls in an orderly manner, a procedure to facilitate this behavior might include identifying a signal for lining up, how and when to leave seats (e.g., by rows or tables in a prespecified order), and appropriate behavior in line (e.g., hands off others, talk in
whispers only, walk rather than ran). The point of such procedures is not to regiment classroom life unduly, but rather to allow large numbers of children to coexist, move about, and do what is needed in order to preserve time and energy for accomplishing schools' primary goals. Failure to develop a workable set of procedures and routines will result in poor conditions for constructive use of time.

Behaviors of students in classroom are also influenced by other features, like child rearing, acceptance in class, friendships, obedience, and presence of hyperactivity, the perceptions that students and teachers have of others and what may have been designated overtly or covertly as appropriate or inappropriate behavior by teachers, students, or parents.

Many Student Variables Influence Class Room Behavior

Differences in behavior patterns, and consequently in student's roles occur between individuals who are more or less successful in class. In a detailed study of some or less successful in classrooms, Canning (1980) recorded that the high-achieving students raised their hands more often in response to a question, were called on more frequently to respond, and initiated more work related interactions with others than did their low achieving peers. They received less praise for correct answers; they were also subject to less criticism for incorrect answers than their low achieving classmates.

Moos (1978) reported that classrooms whose social environment was affiliation oriented were characterized by more student initiation and participation and interaction between students than was the case for control-oriented classrooms. Furthermore, the presence of the teacher, or the proximity of the teacher alters students' behavior patterns. The mobility of different teachers in various classrooms could account for some variations in students' behavior.
In addition, some of the strategies teachers use can affect students’ behavior patterns quite markedly. In particular, when teachers specify clear lesson goals for students, there are more on-task behavior by students and greater attention to class work (Suhunk and Gaa, 1981).

1.4 ACADEMIC ACHIEVEMENT

The prediction of academic achievement has assumed enormous importance in view of its practical use. It forms the main basis of admission and promotion in a class. It is also important for attaining a degree and getting a job. Success in life may have pervasive effect on student’s personality. As a young person improves his achievement, he develops his powers and his self-confidence increases, the way pupils apply themselves is an important factor in scholastic achievement. In addition, it helps the teachers to know whether teaching methods are effective or not and help them in bringing improvement accordingly. Academic achievement is the status of a person’s learning & his ability to apply what he has learnt. It means the extent to which teaching and study have resulted in mastery. It is the outcome of general & specific learning experiences. It refers to the knowledge attained & skills developed during their academic career in the subjects, which are assessed by the school authority with the help of achievement test, which may be either standardized or teacher made. In other words, academic achievement means the achievement of pupils in academic subjects such as reading, writing, history, etc. It is often referred to as the degree or level of success or proficiency attained in academic work.

1.4.1 School-Level Correlates of Achievement

Student academic performance is shaped by multiple factors, relating to the school, the teaching process, the students’ social and family background, and the community; and a school’s
reputation for academic performance can affect parents’ decisions, students’ behavior, and teachers’ attitudes and decisions. Student achievement is related to four types of factors: (a) students’ background, (b) organizational features of the school, (c) professional characteristics of the teachers, and (d) school behavior climate. While all these factors affect student’s academic success, they also interact with each other, and organizational characteristics and teacher choices can be affected by achievement at the school. We therefore, conceptualize the interrelationships among the five categories in a model as a web of interactions presented below (http://nces.ed.gov/pubs2000/2000303.pdf, dated 10.3.2006)

**Figure 1.1 Interrelations in various factors in academic achievement**

![Diagram showing interrelations in various factors in academic achievement](http://nces.ed.gov/pubs2000/2000303.pdf)
1.4.1.1 Student Background

Family background and socioeconomic status have consistently been shown to be related to student achievement (Coleman et al. 1966; Hanushek 1986). Previous studies called attention to students’ health and nutrition, the physical environment of their homes, their family structure (e.g. single-parent homes), the parenting styles, beliefs, and expectations of the students’ parents, and finally, their inherited intelligence. These studies lead us to expect that adverse background conditions (such as poverty and lack of parental involvement) lower student academic performance.

To maintain a distinction among diverse background issues, we focus on three types of background factors: (1) poverty, (2) English language proficiency, and (3) racial/ethnic minority status. Poverty is a major component of the effect of a student’s background on his or her academic achievement. Students are at a dramatically higher risk of academic failure when they come from a poor background, or from low SES families. Similarly, language is currently the focus of a heated debate in education circles, because there is evidence that lack of English proficiency puts students at a disadvantage when they are trying to learn not only how to read and write, but also how to solve mathematics and science problems. Last, racial/ethnic affiliation is repeatedly argued to be an important factor relating to academic performance.

1.4.1.2 School Organizational Features

Both objective features of a school’s organization, such as its class sizes, and subjective features, such as the level of cooperation among its staff, may be correlated with achievement. However, unlike the social background factors, these features are endogenous and to varying extents under control of the principals and teachers in the school. These characteristics may affect the overall goal attainment of
Introduction

the school, as indicated by the academic success of its students; and to some extent academic achievement can affect these characteristics. Four organizational features have been selected for inclusion in the model for this report: (1) school size, (2) average class size, (3) the teachers’ sense of influence over school affairs, and (4) the normative cohesion of the school’s staff. These four features, while sharing an organizational perspective that emphasizes a structural dimension and reflects on its impact on the operations of an organization, are quite distinct from each other. Each such feature represents a distinct dimension of organizational life: school size reflects the organization’s potential scope; class size reflects resources; teachers’ sense of influence represents the authority structure within the school; and the normative cohesion of the staff refers to the organizational culture.

(a) School size has been shown to have a significant effect on the school’s performance, yet the direction of the effect is inconsistent. Greater school size is shown to be associated with reduced academic engagement among eighth-grade students (Lee and Smith 1993), and at the high school level with lower student participation in school activities (Lee and Smith 1995), less satisfaction with school experiences and lower school attendance (Lindsay, 1982), and higher dropout rates (Pittman and Haughwout, 1987). Based on these research findings, many reforms call for dividing big schools into smaller subunits (e.g., Oxley 1994, Boyer 1995), in order to provide students with a more stable and supportive educational experience.

(b) In regards to class size, common sense suggests that it has an effect on students’ academic performance: It is now generally assumed that smaller classes, where greater attention is given to each student, foster academic Meta-analyses of existing studies (Glass et al, 1982), along with large-scale research projects based on experimental designs (Finn and Achilles 1990)
have confirmed the link between reduced class size and greater student learning, while Blatchford and Mortimore (1994) offer a number of possible explanations for these relationships between class size and student achievement.

(c) The third organizational characteristic refers to teachers' sense of influence. While teachers' sense of influence over their work environment is sometimes referred to as representing their efficacy, expectancy, and sense of control, this is an indication—albeit from the teachers' perspective—of the allocation of authority within the school.

(d) The fourth organizational factor whose correlation with achievement we investigated is the normative cohesion of the staff. This factor refers to the cultural solidarity among staff members in the school, or the collective norms that govern staff behavior in this organization. Cohesive interpersonal communication serves as an important foundation for consensus formation, social support, effective access to institutional resources, satisfaction, and eventually, enhanced performance.

1.4.1.3 Teachers' Qualifications

The third group of factors represents an attempt to take into account quality of teaching by measuring teachers' objective qualifications. Teachers' qualifications are calculated from a measure of years of teaching experience and the percentage of teachers who acquired a master's degree. This factor, while focusing on credentials and seniority, conveys a sense of the teachers' professional ability. More qualified teachers are more experienced, can better handle their students, colleagues, and their school system, and are more familiar with teaching practices and with the substantive material. Overall,
therefore, it is easier for experienced, qualified teachers to create a more effective learning experience for students.

1.4.1.4 School Climate

The various background, teacher, and organizational factors shape the climate of the school. School climate refers to the atmosphere of student behavior in the school and serves as a metaphor for the nature of school experience for students, teachers, and parents. Whereas some studies conceptualize such an atmosphere as it relates to learning, discipline, or expectations, and whereas previous studies of school climate called attention to a variety of attributes, such as teacher commitment and morale or the emphasis on academic goals and criteria, one focuses on behavior patterns. Specifically, one examines the prevalence of various student behavioral problems. Such behavioral problems refer to students’ respect for teachers and staff, peers, and property, disorderly and disruptive behavior, and substance abuse. By focusing on student behavior problems, one calls attention to the tone set by students themselves, and not by teachers, principals, parents, nor the policy guidelines. Thus, conceptualization of school climate is not merely a synonym for “better school”; it is not a personality trait of the school; and it is not a relationship-based assessment (Hoy and Hannum, 1997). Rather, this measure identifies behavioral patterns, while still regarding school climate as an organizational feature at the school level (Sirotkin, 1980). One also identifies specific behavioral tendencies in schools (e.g., violence, substance abuse), which reflect both the physical and psychological health of the school as an environment for learning. The general environment set in school touches upon the cultural resources, or support, available for students, and upon the impediments or disruptions to academic concentration. The school climate influences, therefore, how schools function as an educational environment for their students and as a workplace for their teachers. Arguably, providing a safe, orderly, peaceful, and “bully
proofed” school environment contributes to student academic success, while having multiple behavioral problems disrupts proper education. For the measurement of this factor, one relies on teachers’ identification of such problems as tardiness, absence, cuts, dropouts, apathy, verbal and physical conflicts, theft, vandalism, weapons, alcohol, and drug abuse. The perceived prevalence of these behavioral problems sets a discouraging atmosphere in schools, while in schools where such problems are minor or nonexistent; the culture sets a positive value and expectation to support learning and academic achievement.

In summary, this model is consistent with views that average student achievement in a school is affected by multiple factors that represent various facets of the education system and of the social environment within which education occurs.

1.5 RATIONALE OF THE STUDY

Despite a growing body of evidence to support the existence of depressive disorders in children and adolescents, it is only within the last two to three decades that these disorders have been formally recognized. The 20th century has been said to be the century of the child. During this period, several psychological and psychodynamic theories of development have focused attention on the importance of childhood, and on the child, in what he was rather than what he would become. The needs and the rights of children are relegated to lower levels of priority in most societies. The promotion of positive mental health and psycho-social development of children, which is so crucial to adult personality and mental health and to the character of the future society, is neglected during the most important phase of life when it is possible and fruitful to intervene.

A child at birth is totally dependent on adults for survival and then has to go through a prolonged period of dependency on his family. Since he, due to his immaturity and insufficient capacity, is unable to
speak for himself, it is the adults who should speak for the child. An infant is one who does not speak. In highly traditional authoritarian families, a child remains a child forever, who never knows as well as parents, and hence should not be allowed to speak. It is apparent when parents tell children: “Don’t ask questions, don’t talk at the table, speak only when you are spoken to”.

Teachers use this method to deal with children in classrooms. It is much easier to stop a child from talking than it is to encourage him to speak. If a child has to express what he thinks and feels, one must first create an atmosphere in which speaking is possible.

In fact, adults are too busy with themselves and parents have left the care of children to several extra-familial agencies, such as crèches, nurseries, servants, neighbors and older children. All the alternatives to a family system where parents, particularly biological parents, and children live together are far from satisfactory. The attitudes and morals that parents are expected to inculcate in their children, are left on backburners. This lack of interaction between child and parents has its own implications.

Today, we know that depression in children and adolescents exists and can be potentially lethal. In this world, millions of people under 18 years of age have depression. This situation of our future generation is very alarming. The growing demands of our society from children irritate and frustrate them. Also, they may become aggressive as part of their irritability.

Due to all these, poor school performance and failing grades, particularly in a child with previous good academic performance, is a common finding. Frequent absences from school and a history of running away from home are also seen. Suicidal thoughts and actual suicide attempts are seen in children as well as adolescents. Besides intellectual changes, such children also experience slowness of
thinking, difficulties generating alternative ideas for problems, decreases in concentration and problems with memory access and storage.

All these depressive symptoms are greatly affecting children's personality, behavioral patterns, and basic competencies that in turn affect classroom behavior and academic achievement. Aforesaid symptoms are likely to persist into adolescence and adulthood, which hamper good social learning. Viewing the seriousness of the problem; this is a great need to overcome depression at childhood stage, so that it may not hamper the progress of child in his future and he develops into a better individual. Unfortunately, we are too involved with the present and do not care to think about the future. Children should be seen as assets and a nation's wealth which should be protected, guarded and nurtured.

The present study is being conducted by researcher to examine the effects of depression on child's academic achievement and classroom behavior. Also treatment of play therapy will be administered to children with depression to examine whether depression, academic achievement and classroom behavior improve after such treatment. In light of present situation, importance of this study can't be overestimated.

1.6 STATEMENT OF THE PROBLEM

The problem is stated as under-
“Effect of play therapy on classroom behavior and academic achievement of 8-11 years old children with depression”.

1.7 DEFINITIONS OF KEY TERMS

1.7.1 Conceptual Definitions:-

- Depression: According to the New Penguin Encyclopedia (2003) A mental condition or state in which there are feelings of low
mood, despondence, self-criticizing and low esteem. It may be associated with a change (up or down) in appetite for sleep, food or sex. The term has been used in a variety of ways: in lay use, it may mean little more than common sadness, in psychiatric use, it may refer to specific conditions, such as melancholia or manic-depressive illness or be a factor in wide range of disorders. It can be measured by a variety of rating scales, and there are certain biological markers thought to distinguish between depressed and non-depressed individuals.

- **Play Therapy:** According to Encyclopedia of Psychology (2000) Play therapy as a therapeutic approach characterized by: (1) an ongoing relationship between a trained therapist and a child client who exhibits behavioral and/or emotional difficulties: and (2) the use of a variety of play-based activities designed to induce therapeutic change in the client.

- **Academic Achievement:** Mehta (1969) expressed the view that the word “performance” is a wider term, which includes both academic and co-curricular performance of individual. Academic achievement is included in performance of the individual.

  According to the Concise Dictionary of Education (1982), academic achievement means successful accomplishment or performance in particular subjects, areas or courses usually by reasons of skill, hard work and interest. Typically summarized in various types of grades, marks, scores or descriptive commentary.

  In New Webster’s dictionary and Thesaurus (1992), Achievement means to bring to a successful end or a performance.

- **Classroom Behavior:** Classroom behavior encompasses all the activities that take place in the classroom, verbal or non-verbal and whether on the part of student or teacher. In regular
classroom, numerous activities occur. Sometimes the teacher talks, sometimes he asks questions, sometimes he praises or accepts the student's ideas. Sometimes student puts questions and vice versa. Many activities are non-verbal too, such as nodding the head, writing on blackboard etc. Behavior can also vary according to intellectual perceptions, e.g. high or low level of thinking, concrete level or abstract level of thinking etc. So we can see behavior in classroom in different ways. All such occurrences, whether overt or covert, come under the term Classroom Behavior.

1.7.2 **Operational Definitions:**

- **Depression:** Children who score 16 or higher on CDI are considered children with depression, reflecting unusual levels of sadness, limited energy, and low self esteem.

- **Play therapy:** Play therapy is a therapeutic technique in which therapist engage children in play like finger painting, vegetable painting, making collages, bounces balls, mutual storytelling, games of imitative nature, dress up with newspapers, three legged race, lemon race, balloon blowing, catching others with closed eyes, dumbcherades and clay modeling, to overcome traumas in life.

- **Classroom Behavior:** Classroom Behavior encompasses all the activities that take place in the classroom, verbal or non-verbal on the part of student. A score on classroom behavior tool will be measurement of this.

- **Academic Achievement:** Academic achievement generally refers to the scores obtained by the children in their annual exams, class tests and unit tests.
1.8 OBJECTIVES

1. To identify children with depression.
2. To assess the classroom behaviors of children with depression.
3. To measure the academic achievement of children with depression.
4. To examine the effectiveness of play therapy to overcome depression among children.
5. To measure the effectiveness of play therapy on classroom behavior of children with depression.
6. To assess the effectiveness of play therapy on academic achievement of children with depression.

1.9 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.

1.10 DELIMITATIONS OF THE STUDY

1. The present study was limited to private schools.
2. Sample size was limited to seventy students.
3. The study was limited to geographical area of Patiala only.