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Identifying Depressed Children: A Qualitative Analysis

of Child and Parent Responses to Depression Screening and Assessment

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Identifying Depressed Children: A Qualitative Analysis of Child and Parent Responses to Depression Screening and Assessment

by

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Dedication

To my husband James, for his love and support

throughout this long journey,

and to my children Julia and Aaron,

for their celebration of each step along the way

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Identifying Depressed Children: A Qualitative Analysis

of Child and Parent Responses to Depression Screening and Assessment

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This qualitative interview study explored the responses of child participants and their primary caregivers to the experience of completing a multi-stage screening process designed to identify depressed youth. Participants were sixteen girls ages 9 to 11 and caregivers of twelve of the girls. The child participants selected for this study were those who reported symptoms of a depressive disorder at the initial stages of screening without receiving diagnosis of a depressive disorder at the final stage of screening. Qualitative interviews were completed separately with child participants and their caregivers using a semi-structured interview format. A grounded theory approach was used to analyze interview transcripts and generate an integrated explanation of child and caregiver responses to depression screening and assessment (Strauss & Corbin, 1998). Results of this study indicate that depression screening and assessment serves the function of

creating a forum for the child perspective by raising the child's emotional state and concerns to the attention of both the child and the parent.

The child participants in this study reported experiencing emotional distress or a sense of burden prior to the first stage of screening. A process of reflecting on their emotions, beliefs, and stressors began as child participants completed screening questionnaires, followed by a sense of relief or improved mood in response to talking with interviewers during a brief interview.

The forum for the child perspective expanded as parents received interviewer feedback about child emotions and concerns and began to assess the information in light of their own observations and situational factors. The extent to which parent and child maintained the forum for the child perspective through sustained communication about the child's emotions and concerns influenced the type and intensity of interventions subsequently introduced by parents.

The chief means through which depression screening affected the child participants was through enhancing their understanding of themselves, promoting positive coping processes, facilitating parent/child communication, and influencing parent perceptions and the parenting agenda.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

Introduction

Untreated depression can disrupt a child's social and cognitive development (Kovacs, 1996; Puig-Antich, Kaufman, Ryan, & Williamson, 1993), yet less than half of depressed children and adolescents are diagnosed and treated (Simon & VonKorff, 1995). The low rates of treatment may be due in part to the difficulty in identifying children who are depressed. Many depressed children do not engage in behaviors that draw attention to themselves, and adults often attribute symptoms of depression in children to other causes, such as a phase that will be "outgrown" (Kovacs, 1989).

Screening children for depression using brief questionnaires of depressive symptoms is one method for preliminary identification of children who may be depressed that has been used in primary care settings and in schools. In depression treatment studies, multi-stage screening using repeated administration of questionnaires and diagnostic interviews, for example, is a typical process for identifying study participants (Kendall, Cantwell, & Kazdin, 1989; Timbremont, Braet, & Dreesen, 2004). Little research has examined, however, the responses of children and their parents to depression screening and assessment.

Participants for this study were drawn from pre-adolescent girls screened for a cognitive behavioral depression intervention study conducted through the University of Texas (the "Action Study") (*see* Stark, Hargrave, Sander, Custer, Schnoebelen, Simpson, & Molnar, 2006). A multi-stage screening process using self-report questionnaires, a brief

symptom interview, and an in-depth diagnostic interview was implemented to identify participants for the Action Study. The impetus for the current study derived from anecdotal evidence suggesting that the participant screening process may have unintended intervention effects. The reports of changes in child mood and of parent-introduced interventions were intriguing, but data were insufficient to determine if such changes were fleeting placebo effects or more long-term changes in response to the screening process. In addition, it was unknown which aspects of screening and assessment might promote change, or which subgroup of participants was responsive to the process. Potential intervention effects of depression screening are of particular interest because screening school children for depression has been proposed as a first-line intervention strategy for use in schools (Department of Health and Human Services, New Freedom Commission on Mental Health, 2003; Shaffer, et al., 2004).

Conducting research with children requires considerable contact between researchers and the parents of child participants as one means of safe-guarding the well-being of the child participants. Researchers must continually provide parents with feedback about a child's symptoms and seek informed consent from parents for the child's continued participation. In the Action Study, contact between researchers and parents occurred as children moved through the multi-stage screening process. The goals of this study were to identify responses of both child and parent to the screening and assessment experiences. Depression screening instruments and feedback to parents are not intended as interventions, and a high score on a self-report measure is not conclusive evidence that a child is depressed (Sitarenios & Kovacs, 1999). However, anecdotal

reports have raised the question of possible intervention effects resulting from the process of screening and assessment.

Much of the research on depression in youth, including studies examining the efficacy of interventions and screening, has focused on adolescents of high school age, approximately age 14 and up (Asarnow, Jaycox, & Thompson, 2001; Compton, Burns, Egger, & Robertson, 2002). Depression screening instruments have proven less reliable with younger age groups than with older adolescents (Lonigan, Hooe, David, & Kistner, 1999), but possible interactions between screening and levels of depression had not been explored. Due to the lack of extant research examining parent and child responses to depression screening and assessment, and recent public policy initiatives aimed at promoting more widespread use of screening instruments, understanding how children and parents experience participation in screening and assessment has implications for research and policy.

Because the goal of this study was to explore the effects of an assessment process, it was not possible to approach these questions from a traditional quantitative stance. Instead, a qualitative method was employed in this study to explore the depression screening and assessment processes. Theoretical perspectives such as family systems theory (Broderick, 1993; Cox & Paley, 1997) and therapeutic assessment (Finn, 2005) were reviewed as possible viewpoints for understanding a family's response to depression screening. However, this study did not seek to find support for a particular theory. Rather, a grounded theory approach of qualitative analysis (Strauss & Corbin, 1998) was utilized to allow for the development of a theory based on the data collected.

This study found that depression screening and assessment serves the function of creating a forum for the child perspective by raising the child's emotional state and concerns to the attention of both the child and the parent. The child participants in this study reported experiencing emotional distress or a sense of burden prior to the first stage of screening. A process of reflecting on their emotions, beliefs, and stressors began as child participants completed screening questionnaires, followed by a sense of relief and/or improved mood in response to talking with interviewers during a brief interview.

During the assessment process, the forum for the child perspective expands as parents receive interviewer feedback about child emotions and concerns and begin to assess the information in light of their own observations and situational factors. The extent to which parent and child maintain the forum for the child perspective through sustained communication about the child's emotions and concerns influences the type and intensity of interventions subsequently introduced by parents.

The chief means through which depression screening has the potential to affect the child participants is by enhancing self-understanding, promoting positive coping processes, facilitating parent/child communication, and influencing parent perceptions and the parenting agenda.

CHAPTER TWO

Review of Literature

Depression in Children

Prevalence

The occurrence of depression in children has been recognized by the scientific community only since the 1970s (Cantwell, 1985; Puig-Antich, 1982). We have learned in the intervening decades that depression in children is a problem of significant proportions. In a 6-month period, 6% of 9-to 17-year-olds in the U.S. experience depression (Shaffer, Fisher, & Dulkan, 1996). Epidemiological studies indicate that approximately 2.5 % of children and 8.3% of adolescents in the U.S. are depressed (Birmaher, Ryan, Williamson, Brent, & Kaufman, 1996). Longitudinal studies indicate the cumulative prevalence of depression in adolescence to be 20% by age 18 (Birmaher, et al., 1996).

Outcomes of Child Depression

The duration and consequences of childhood depression can be considerable. Childhood depression is associated with more persistent, recurrent, and severe episodes of depression through adolescence and adulthood (Kovacs, Akiskal, Gatsonis, & Parrone, 1994; Puig-Antich, 1986; Weissman, Wolk, & Goldstein, 1999). An episode of major depression in children and adolescents typically lasts from 7 to 9 months (Birmaher, et al., 1996), while dysthymia lasts an average of about 4 years (Kovacs et al., 1994). A low grade, chronic depression (as in dysthymia) that occurs at a young age is a significant risk factor for an episode of major depression. Kovacs and colleagues (1994) found the cumulative probability of an episode of major depression in dysthymic children to be

81% by nine years following the dysthymia diagnosis. (Kovacs, et al., 1994). In addition, depression appears to be occurring at younger ages today than in the past (Klerman & Weissman, 1989; Lewinsohn, Rohde, Seeley, & Fischer, 1993).

Depressed children and adolescents are more likely than adults diagnosed with depression to have co-morbid disorders, most often anxiety or externalizing disorders. Based on prior studies, Kovacs & Devlin (1998) calculated an average co-occurrence of depression with an anxiety disorder to be approximately 41%, and an average co-occurrence of depression with a conduct disorder to be 16% (Kovacs & Devlin, 1998). Regardless of whether or not one disorder leads to another or two disorders overlap in terms of the psychological processes involved in their pathology, those with co-morbid diagnoses are usually impaired to a greater degree than those with a single diagnosis (Asarnow, 1988).

The neuroscience research of recent years is producing evidence that early experiences can influence brain development in children (Shonkoff & Phillips, 2000). Thus, early onset depression may have far reaching effects by affecting neurological development (Charney & Nestler, 2005; Stein & Kendall, 2003).

Untreated depression can disrupt a child's social, emotional, and cognitive development (Kovacs, 1996; Puig-Antich, et al., 1993) and result in interpersonal/psychosocial deficits that continue after the depression abates (Gotlib, Lewinsohn, Seeley, Rohde, & Redner, 1993; Kandel & Davies, 1986; Nolen-Hoeksema, Girgus & Seligman, 1992; Rao, et al., 1995). More specifically, depression in children and adolescents can result in diminished school performance, social withdrawal, a pessimistic outlook, increased physical illness, increased risk of school dropout, and

increased risk of suicide (Cole, Martin, Powers, & Truglio, 1996; Gotlib, et al., 1993; Kovacs, 1996; Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2003; Nolen-Hoeksema, et al., 1992; Puig-Antich, et al., 1993; Thompson, Mazza, Herting, Randell, & Eggert, 2005).

Diagnosing Depression in Children

Symptoms of Depression in Children

Despite the prevalence and adverse outcomes associated with depression in youth, estimates are that less than half or even less than 75% of depressed children and adolescents are diagnosed and treated (Simon & VonKorff, 1995; Ringel & Sturm, 2001; Wells, Kataoka, & Asarnow, 2001). One of the barriers to providing help to depressed youth is the difficulty parents, teachers, and healthcare providers have in recognizing depression in children and adolescents. The clinical presentation of depression varies across the different stages of development and therefore may be difficult to identify. Depression in children may be characterized by irritability, temper tantrums, and misbehavior rather than by displays of sadness (Birmaher, et al., 1996). In addition, depression in children may involve fewer symptoms in total than depression in older age groups (Weiss & Weisz, 1988). Adolescents report more sleep and appetite disturbances, delusions, and suicidal ideation than younger children. However, adolescents still exhibit more behavioral problems and less vegetative symptoms than adults. (Ryan, Puig-Antich, & Ambrosini, et al., 1987).

What Adults See

The subjective symptoms of depression, such as sadness and guilt, often go unrecognized by adults (Kazdin & Petti, 1983; Kashani, Orvaschel, Burk, & Reid, 1985;

Kovacs, Crouse-Novak, Paulauskas, Pollock, & Finkelstein, 1984). Symptoms may be incorrectly attributed to temperament (e.g. – social withdrawal interpreted as shyness). Parents may see symptoms as a "stage" the child will outgrow or may see symptoms as developmentally appropriate (e.g. – characterizing irritability as moodiness due to "hormones" or as expected rebelliousness of adolescence. Some research suggests that parents and teachers are aware of the symptoms of depression in children. They do not, however, recognize that the symptoms amount to a depressive disorder, nor do they seek help for their children (Puura, et al., 1998). In a large sample of Finnish children, Puura, et al., found that parents who sought psychiatric help for their children reported symptoms in their children that might be irritating (e.g., disobedience) or of great concern (e.g., encopresis). Puura and colleagues (1998) pose the question, "How can we reach and help those children who are depressed but not annoying enough to get anyone to help them?" (p. 584). They suggest using a self-report questionnaire of depressive symptoms "as part of any regular check-up for schoolchildren" and using the self-report as "a basis for starting discussion with the parents about the problems expressed by the child" (Puura, et al., 1998, p. 584).

Depression Screening

Uses of Self-Report Measures of Depression

Questionnaires to screen for depressive symptoms have been used by primary care physicians and researchers to identify children who may be depressed and require further assessment. Self-report measures are also used for screening populations who are "at risk" for depression to identify those who need treatment; as measures of treatment progress (Corney & Simpson, 2005); and as measures of severity (Rogers, Adler,

Bungay, & Wilson, 2005). In the research context, self-report measures of depressive symptoms are typically used in the first stage of a multi-gate screening process to identify participants for intervention studies (Kendall, et al., 1989; Timbremont, et al., 2004).

Advantages of Screening Measures

The chief advantage of using screening questionnaires is that they preclude the need for more time consuming and expensive assessments such as interviews with each individual to be assessed. Self-report questionnaires are valuable as a relatively quick and easy first step to bring persons experiencing depressive symptoms to the attention of those who can help them.

Children's Depression Inventory

The Children's Depression Inventory (CDI; Kovacs, 1981) is one of the most commonly used depression screening measures for youth ages 7 to 17 (Kovacs, 1985, 1992). It is also one of the screening measures used to identify participants for the Action Study. Considerable research has examined the psychometric properties and use of the CDI (Hodges & Craighead, 1990; Saylor, Finch, Spirito, & Bennett, 1984; Timbremont, et al., 2004). The depression scale from the Beck Youth Inventory (Beck, Beck & Jolley, 2001; BDI-Y) is a much more recently published instrument with a much smaller research base. Thus, the issues of false positives, cut-off scores, and testing effects will be discussed as they pertain to the CDI.

False Positives and Cut-Off Scores.

One of the difficulties with depression screening questionnaires for children and adolescents is that they result in a fairly low level of specificity. That is, a fair number of "positives" on a screener will in fact have a disorder other than depression or no disorder

at all upon further assessment. It has been suggested that self-report measures such as the CDI "assess negative affectivity in general rather than depression in particular" (Timbremont, et al., citing Joiner, Catanzaro, & Laurent, 1996, and Stark & Laurent, 2001, p. 150). Examinations of the discriminant validity of the CDI have yielded mixed results. Several studies have demonstrated that the CDI differentiates youth receiving clinical treatment from those who are not (Carey, Gresham, Ruggiero, Faulstich, & Enyart, 1987; Saylor, et al., 1984). In some studies, CDI scores have not differed significantly among children and adolescents diagnosed with depression, anxiety, and externalizing disorders (Carey, et al., 1987; Hodges, 1990). However, in a recent analysis, the CDI did serve to discriminate among those diagnoses (Timbremont, et al., 2004).

Administrators of screeners must strike a balance in establishing cut-off scores between sensitivity for detecting depression when it is present and specificity, that is, the avoidance of false positives. Following recommendations of the author of the CDI, cut-off scores for the CDI have ranged from 13 to 19 depending on the population being screened. Kovacs suggests a cut-off score of 13 when the instrument is used with clinical populations (Kovacs, 1992). In non-clinical samples, the cut-off score has typically been 19 (Stark, Humphrey, Laurent, Livingston, & Christopher, 1993; Stark & Laurent, 2001). A recent study to establish the optimal cut-off score for the CDI indicated that a cut-off score of 16 or above maximizes the sensitivity and specificity of the CDI such that 86.3% of cases are accurately classified (Timbremont, et al., 2004). In that study, a cut-off score of 16 resulted in 16.2% false positives among those classified as depressed. In keeping

with the findings of Timbremont, et al., (2004), the Action Study uses a cut-off score of 16, which is one standard deviation above the mean.

Although screening measures such as the Children's Depression Inventory have demonstrated acceptable specificity (Craighead, Smucker, Craighead, & Ilardi, 1998; Kovacs, 1992; Timbremont, et al., 2004), a substantial number of the false-positives from a screening may have another mental disorder, such as anxiety or PTSD (Leon, 1999; Klinkman, 1998). Others may "occupy a clinical middle ground between clearly depressed and clearly nondepressed patients" (Klinkman, 1998, p. 1).

A recent taxonometric analysis concluded that depression is dimensional in both children and adolescents, rather than categorical in nature. In other words, the analysis indicated that the latent variable, depression, is a "naturally occurring type," in both groups, rather than a variable consisting of categories (e.g. – emotional depression vs. endogenous depression). These researchers propose that what researchers typically construe as more severe forms of depression may be viewed best as the extreme end of a continuum of depressive experiences (Hankin, Fraley, Lahey, & Waldman, 2005). In keeping with this view, the false positives generated by self-report questionnaires may include individuals who are in the "middle ground" between depressed and not depressed.

One of the goals of this study was to gain a better understanding of the participants who appear to be false-positives in the Action Study. That is, the aim was to uncover some of the processes at work when a child scores high on a screening measure but later receives no diagnosis. My conjecture was that some of those who appear to be false positives are actually accurate positives who change during the screening process.

However, participants may score high on self-report measures of depression for several other reasons. As discussed previously, elevated scores on self-report measures of depression may occur in the presence of disorders other than depression (Gotlib, Lewinsohn, & Seeley, 1995). In addition, the false positive participants on a depression screening measure may be at risk for developing depression or other disorders, rather than being clinically depressed. Gotlib, et al., (1995) found that adolescents who were false positives on a measure of depression were twice as likely as true-negative participants to develop a psychological disorder in the following year. Nearly one fourth of the false positive participants met the diagnostic criteria for a disorder one year later (Gotlib, et al., 1995). One of the tasks necessary for carrying out this study was to distinguish participants who were depressed at initial screening (and improved) from participants who were not depressed at screening.

In an analysis comparing symptomatology and psychosocial functioning of the true-positives and false-positives among adolescents screened for depression, Gotlib, et al., (1995) found that after controlling for level of depression on the screening measures, the two groups differed significantly only on suicidal ideation. In other words, participants who were false-positives on the screening measure were quite similar to the depressed (true-positive) participants on most measures of psychosocial functioning, but the depressed participants reported a significantly higher amount of suicidal ideation. Suicidal ideation, then, may be one symptom that is particularly useful in differentiating the depressed and non-depressed high scorers on a screening measure.

Children's Depression Inventory – Testing Effects.

Longitudinal studies using the CDI to assess depression in children have shown a decrease in mean CDI scores over successive administrations, while cross-sectional studies of depression have not shown a decrease in depression with age (Twenge & Nolen-Hoeksema, 2002). As an example, one study used administrations of the CDI at intervals of 2 weeks for a period of 6 weeks. The mean score at the first administration was 10.10, as compared to the final mean score of 8.57. Sharpe and Gilbert (1998) have suggested that a drop in scores on self-report measures of depression could occur for several reasons, including social desirability, boredom, decreased test anxiety, and the introduction of coping mechanisms. Sharpe and Gilbert (1998) proposed that completing the self-report measures caused participants to realize they were depressed, which prompted them to employ coping strategies to improve their mood. A meta-analysis of studies that used the CDI conducted by Twenge and Nolen-Hoeksema (2002) confirmed a testing effect for the CDI, and they argued for habituation as the most likely cause of the decreasing scores. They found that scores decrease 0.08 standard deviations from the first administration of the CDI to the second administration. Thus, while a testing effect is to be expected with the CDI, the effect is quite small from the first to second administrations.

Screening Adolescents

Screening to Detect Suicide Risk.

Suicide prevention has been one of the main goals in screening adolescents for depression and suicidal ideation. Research has focused on developing questionnaires that accurately detect adolescents at risk for suicide (Shaffer, et al., 2004; Thompson &

Eggert, 1999) and on the efficacy of screening as a means of reducing suicide rates in a student population (Shaffer, et al., 2004). The studies of suicide risk questionnaires have demonstrated that such questionnaires "compare favorably" with depression screening measures while providing a stronger association with specific suicide risks, namely mood or substance use disorder accompanied by suicidal ideation or previous attempt (Shaffer, et al., 1999). Although not all adolescents who are at risk for suicide suffer from a mental disorder, it is estimated that 90% of those who commit suicide are suffering from a mental disorder, most often depression (Brent, Perper, & Goldstein, et al., 1988; Shafii, Steltz-Lenarsky, Derrick, Beckner, & Whittinghill, 1988). Depression screeners tend to have better test-retest reliability and lower rates of false positives, but they are less sensitive to detecting suicide risk (at least in the case of the BDI-Y). Both types of questionnaires have proven effective in identifying adolescents for their respective purposes (Beck, et al., 2001; Shaffer, et al., 2004; Thompson & Eggert, 1999). Adolescent suicide rates have declined in recent years (NCHS, 2001), possibly because more depressed adolescents are being treated with antidepressant medication (Olfson, Shaffer, Marcus, & Greenberg, 2003; Shaffer, et al., 2004). Should that, in fact, be the case, Shaffer and colleagues conclude that "screening teens for untreated mood disorders should be an important component of any suicide prevention program" (Shaffer, et al., 2004, p. 1).

Screenings in Schools.

School based screenings have proven effective for identifying adolescents who are depressed or at risk for suicide (Reynolds, 1991; Shaffer & Craft, 1999; Thompson & Eggert, 1999). One of the drawbacks of school-wide multi-stage screening and

assessment is the burden and expense involved in providing further assessment for those who score above the specified cut-off score on the self-report measure being used. Such screenings typically produce a larger number of false positives (though few false negatives). As many as 25 to 50% of the adolescents who require additional assessment may be false positives and not depressed (Thompson & Eggert, 1999). An obstacle to the widespread use of screening in schools may be administrators, since they rate large scale screening as less acceptable than curriculum based programs and staff training (Gould, Greenberg, Velting, & Shaffer, 2003; Miller, Eckert, & DuPaul, 1999).

Public Policy

U. S. Preventive Services Task Force.

Although a few empirical studies have suggested screening adolescents for depression may be beneficial, the practice remains open to question (Reynolds, 1991; Shaffer & Craft, 1999; Thompson & Eggert, 1999). The U.S. Preventive Services Task Force ("Task Force"), an independent task force created by the Agency for Healthcare Research and Quality of the U. S. Department of Health and Human Services, publishes recommendations directed toward physicians as to various aspects of patient care. The Task Force currently recommends screening adults for depression "in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up" (United States Preventive Services Task Force [USPSTF], 2002, p. 121). The Task Force cited fourteen studies that investigated the effectiveness of screening adults for depression in primary care settings. Based on those studies the Task Force concluded that screening improves a primary care physician's accurate identification/recognition of depressed patients and improves patient outcomes, particularly when treatment advice

and follow-up care are provided. The Task Force noted that effective follow-up care in the studies reviewed included physician and/or patient education, case management of mental health care, and telephone follow-up.

The Task Force cited "insufficient evidence to recommend for or against routine screening of children or adolescents for depression" (USPSTF, 2002, p. 121). The Task Force concluded that the existing studies suggest that screening tests "perform reasonably well in adolescents;" however, the task force noted that depression screening has not been studied in clinical pediatric settings (USPSTF, 2002, p. 122). The Task Force listed the lower prognostic merit of screeners in children and adolescents as an additional rationale for the position. Thus, while routine screening for depression is recommended for adult patients in primary care settings, the recommendation has not been extended to children and adolescents due to the lack of research with those populations.

The Task Force listed a number of potentially harmful effects of screening, namely, false positive results, the need to allocate resources for further assessment, and adverse effects for patients incorrectly identified as depressed. However, the Task Force noted that existing research has not provided empirical information about possible harmful outcomes of depression screening.

American Academy of Pediatrics and American Medical Association.

The American Academy of Pediatrics (AAP) and the American Medical Association have recommendations regarding the screening of adolescents for depression, although they have not published recommendations pertaining to children. The AAP recommends verbal screening for depression throughout adolescence. The AMA recommends screening adolescents for depression when risk factors such as family

problems or drug/alcohol use are present. (American Medical Association Guidelines for Adolescent Preventive Services, Recommendation 20, 2001).

New Freedom Commission on Mental Health.

Despite the more conservative positions of these professional associations with regard to routine depression screening, the New Freedom Commission on Mental Health strongly supported screening in its final report and recommendations to Congress as one means of addressing mental health concerns/crisis (DHHS, New Freedom Commission on Mental Health, 2003). The New Freedom Commission on Mental Health was created for the purpose of evaluating the mental health needs and services in the U.S. and making policy recommendations for improving the access to and quality of mental health care. The commission likened mental health screening to the vision and hearing screenings children receive at school. Members of the commission who addressed Congress in 2004 and 2005 spoke in favor of more routine screening in both schools and primary care settings. Several arguments in favor of conducting screenings in schools were presented in testimony before Congress, including that schools are where the children and adolescents are, and that schools typically have some mental health services or providers on site that students can seek out independently.

American Psychological Association and the National Association of School Psychologists.

The American Psychological Association (APA) and the National Association of School Psychologists (NASP) have not published position statements or recommendations regarding depression screening. Nevertheless, both organizations have contributed support for the initiatives proposed by the New Freedom Commission on

Mental Health. The APA submitted a letter of support for several recommendations of the Commission, including the recommendation for increased mental health screening in primary care settings for patients of all ages (Honaker, APA, 2003; APA, 2005). The National Association of School Psychologists (NASP) called for member advocacy action to oppose legislation that would effectively limit mental health screening. Surprisingly, mental health screening has been the subject of some legislative controversy stemming from misunderstanding of proposals put forth by the President's New Freedom Commission on Mental Health. In the Fall of 2004, legislation was introduced to deny federal funds for mental health screening in schools based on the misapprehension that screening would be conducted without parental consent. The proposed legislation was sidelined when documentation showed the Commission was proposing voluntary screening with parental consent (NASP Legislative Update, April 13, 2005).

Interventions for Depression in Children

In considering the means by which the depression screening and assessment process might have intervention effects, it is helpful to review the interventions that research has shown to be promising for treating depression in children. The effectiveness of several treatments is supported by research, but the studies have not been replicated. To be considered "efficacious" or "possibly efficacious" treatments must demonstrate success in a randomized clinical trial conducted with sound methodology that has been replicated (Chambless & Hollon, 1998).

Several interventions have obtained positive results with depressed children and/or adolescents, including cognitive-behavioral therapy, family therapy, and

interpersonal therapy (Asarnow, et al., 2001; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000; Rosello & Bernal, 1999).

Cognitive Behavioral Therapy

The cognitive theory of depression is based on the premise that negative interpretations of events increase vulnerability to depression. Negative interpretations can lead to feelings of depression and counter-productive behaviors, such as social withdrawal (Asarnow, et al., 2001). Thus, cognitive behavioral therapy is directed at specific deficits, cognitive distortions, maladaptive cognitions and behaviors, and social and interpersonal problem solving with the goal of improving client skills.

Compton, Burns, Egger, and Robertson (2002) reviewed the research focused on intervention studies conducted exclusively with children ages 6 through 12. They identified six well-designed studies of cognitive-behavioral interventions with children in that age range: Kahn, Kehle, Jenson, and Clark (1990); Stark, Reynolds, and Kaslow (1987); Liddle and Spence (1990); Vostanis, Feehan, Grattan, and Bickerton (1996); Jaycox, Reivich, Gillham, & Seligman (1994); Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux (1997). These studies shared many key elements, including cognitive restructuring, social and interpersonal problem-solving skills, decision-making skills, relaxation training, and coping strategies. In addition, these studies employed similar techniques for intervention, such as psychoeducation, discussion, modeling, role-playing, self-monitoring, corrective feedback, reinforcement of adaptive responses, and homework assignments.

Compton and colleagues cautiously concluded that "cognitive-behavioral interventions may be efficacious in reducing symptoms of depression among children

when compared with no-treatment or wait-list controls" (Compton, et al., p. 5). Since the studies have not been independently replicated, however, they do not yet meet the criteria as "efficacious" or "possibly efficacious" (Compton, et al, 2002). They also stated that depressed children appear to "respond similarly to most active interventions, including cognitive behavioral therapy, attention-placebo, and nonspecific supportive interventions" (Compton, et al., p. 5 – 6).

A number of other studies have also provided support for using cognitive behavioral therapy with adolescents (Brent, et al., 1997; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Kaufman, Rohde, Seeley, Clarke, & Stice, 2005; Lewinsohn, Clarke, Hops, & Andrews, 1990; Reinecke, Ryan, & DuBois, 1998; Reynolds & Coats, 1986; Weisz, Weiss, Han, Granger, & Morton, 1995; Wood, Harrington, & Moore, 1996).

Due to the limited amount of research on interventions targeting childhood depression, studies in which participants covered a greater age range or were adolescents are included in the remainder of this discussion for the purpose of broadening the scope of possible explanations for effects of depression screening and assessment.

The efficacy of cognitive behavioral therapy for children and adolescents has been compared to other therapies, including relaxation training, non-directive supportive therapy, self-modeling, and life skills therapy. Interestingly all of the alternative therapies proved to be effective in reducing symptoms of depression in youth, an indication that "non-specific therapeutic effects" are involved in the process of change (Kaufman, et al., 2005). In some studies, the alternative treatments appeared to be as effective as cognitive behavioral therapy (Liddle & Spence, 1990; Stark et al., 1987). In

other instances the participants receiving cognitive behavioral therapy reached normal range by the end of the intervention at twice the rate of those receiving other treatments (Kahn et al., 1990) or showed cognitive changes that could be attributed specifically to cognitive behavioral therapy (Kaufman, et al., 2005).

The existing research on cognitive behavioral interventions suggests a couple of possibilities to consider regarding parent and child responses to depression screening and assessment. In providing parents with information about their child's symptoms, the process of providing that feedback sometimes takes on an element of psychoeducation. As the researcher informs the parent of the symptoms being experienced by the child and conveys that these are symptoms of depression, parents may reach a new understanding of the child and the child's problems. The new information may reframe a child's irritating "moodiness" as depression and prompt parents to respond to the child differently.

Another point of interest is the apparent effectiveness of alternative treatments (e.g.—relaxation training, nonfocused supportive therapy) that is documented in the cognitive behavioral therapy research (Kahn et al., 1990; Liddle & Spence, 1990; Stark et al., 1987; Vostanis et al., 1996). This could suggest that some children who are experiencing depression are highly responsive to intervention. Perhaps some children experience much relief when their parents are made aware that there is a problem, a result that is compounded by actions or changes implemented by the parents. Depression screening and assessment might spark environmental changes that bring about therapeutic effects in some children.

Interpersonal Therapy

Interpersonal therapy for depression is based on the premise that depression occurs as a result of problems in interpersonal relationships (Klerman, Weissman, Rounsaville, and Chevron, 1995; Rossello & Bernal, 1999). Thus, the therapy is centered on current interpersonal conflicts. Current problems, important interpersonal relationships, developing social skills and communication strategies, and problem solving around difficult situations are the focus of therapy. The goals of the therapy are to decrease depressive symptoms and improve interpersonal functioning. Preliminary intervention studies of interpersonal therapy with adolescents have proven effective (Mufson & Fairbanks, 1996; Mufson, Moreau, Weismann, Wickramaratne, Martin, & Samoliov, 1994; Santor & Kusumakar, 2001). In a study with Puerto Rican adolescents comparing the efficacy of cognitive behavioral therapy with interpersonal therapy, both treatments were effective (Rosello & Bernal, 1999). In addition to improving symptoms of depression, the therapy led to improved self-concept and social adjustment for participants (Rosello & Bernal, 1999).

The usefulness of interpersonal therapy for younger children has not been empirically examined at this point, nor have the relative contributions of components of the therapy been studied. However, this therapy may inform our understanding of depression screening and assessment through its focus on interpersonal communication. Participants in depression screening and assessment could acquire a new strategy for dealing with their feelings or interpersonal problems, namely direct discussion about those topics with someone else. The brief symptom interview and the diagnostic interview are sometimes the first occasions that a child has discussed their depression or

personal circumstances related to the depression. Those interview conversations could serve to break the ice of silence surrounding the imperceptibly depressed child, prompting the child to try discussing feelings or problems with a friend or family member.

Family Therapy

Family therapy for childhood depression is another method of intervention under investigation (Brent, Holder, Kolko, Birmaher, Baugher, Roth, & Johnson, 1997; Kolko, et al., 2000). Parent and family variables such as parenting style/discipline, family conflict, and low family cohesion influence symptoms and severity of depression in children (Chiarello & Orvaschel, 1995; Colder, Lochman, & Wells, 1997; Cummings, Keller, & Davies, 2005; Frank & Jackson, 1996; McGinn, Cukor, & Sanderson, 2005; Nomura, Wickramaratne, Warner, Mufson, & Weissman, 2002). Thus, these concerns are targeted in family therapy.

Systemic-behavioral family therapy has been shown to benefit depressed adolescents by promoting change to general family functioning and parent-child relationships, and reducing family conflict (Kolko, et al., 2000). The therapy combines functional family therapy (Alexander & Parsons, 1982) with a problem-solving model developed by Robin and Foster (1989). In the first phase of treatment, the therapist provides reframing statements to clarify the family's concerns and highlight problem behaviors. In the second phase, the therapy focuses on parenting and developmental considerations, family communication, and problem-solving skills (Kolko, et al., 2000).

The outcomes of the Kolko, et al., study comparing cognitive-behavioral family therapy, systemic-behavioral family therapy, and non-directive supportive therapy are not

straightforward. The cognitive therapy led to greater improvement in depressive symptoms than did the family therapy or the supportive therapy immediately following treatment. In addition, while family therapy improved family functioning, cognitive therapy demonstrated a greater effect on family functioning immediately after treatment. At the two-year follow-up, however, family therapy was found to have a more positive effect on family functioning than cognitive therapy or supportive therapy, while the groups did not differ on measures of depression (Kolko, et al., 2000). Although this family therapy was beneficial to the adolescents in the study, the researchers suggest that family interventions may be more effective with younger depressed children (Kolko, et al., 2000).

Brief psychoeducational interventions for parents of depressed youth have shown promise as one component of an intervention (Brent, Poling, McKain, and Baugher (1993). Parents have rated brief psychoeducational interventions as worthwhile (Brent, et al., 1993), and such interventions are associated with greater reductions in depressive symptoms in children (Brent, et al., 1993).

In the Action Study, the information imparted by researchers to parents about their children during the depression screening and assessment process could produce a therapeutic effect by intervening in the family system. Again, problematic symptoms and behaviors the parent has observed in the child may be reframed as depression in need of treatment. The altered parent and child perceptions could lead to changes in parent/child interactions and family problem solving to reduce stress on the child. Because there is evidence that family interventions are particularly useful with younger children (Barrett,

Dadds, & Rapee, 1996; Harrington, et al., 1998), feedback that a child may be depressed may have stronger impact on the family system than might be expected with adolescents.

Another model of family therapy has shown promise in work with depressed adolescents (Diamond, Siqueland, & Diamond, 2003). Diamond and colleagues found preliminary empirical support for an attachment-based family therapy for adolescents. In developing the intervention, they drew from interpersonal models of depression (Joiner & Coyne, 1999), particularly Attachment Theory (Bowlby, 1969), and Contextual Family Therapy (Boszormenyi-Nagy & Sparks, 1984) with clinical procedures based on Structural Family Therapy (Minuchin, 1974), Multidimensional Family Therapy (Liddle, 1999), and emotionally focused therapy (Greenberg & Johnson, 1988).

The attachment based family therapy focuses on rebuilding an appropriate attachment for the developmental stage. For adolescents, a secure attachment is based on open communication, accessible caregivers, and trust that the caregivers will provide help when needed (Diamond et al., 2003, citing Ainsworth, 1989 and Kobak, Sudler, & Gamble, 1991). These researchers report that when the attachment relationship between parents and adolescents breaks down, typically around the adolescent's attempt to negotiate independence while maintaining connection, negative outcomes may include conflict, depression, and a breakdown in communication. In addition, adolescents may "protect parents from angry or sad feelings, worrying that it would over-burden them and lead to further rejection" (Diamond, et al., 2003; Diamond & Siqueland, 1998). In the Action Study, the researchers sometimes hear similar comments from some of the girls during screening and assessment. The girls say things such as, "I don't tell my mother things" or "I don't want her to worry about me."

The attachment-based family therapy aims to create considerable change in the family by promoting relational reframing, building alliances with the adolescent and parent, repairing the parent/child attachment, and promoting the adolescent's competency. The strategies for repairing the attachment focus on discussions about specific instances in which the adolescent felt rejected, ignored, or hurt by the parents. The adolescent is helped to identify and articulate those experiences and communicate about them directly. Through these conversations, the adolescent is encouraged to actively participate in the relationship and toward a more coherent understanding of the past conflicts. The parents may gain an increased level of tolerance for adolescent autonomy and dealing directly with conflict. The intent is to rebuild trust among family members.

While depression screening and assessment in the Action Study involves only brief contacts and simply feedback to parents (not therapy), the process could encourage family change in some similar ways. The research assistant who has contact with the family spends an average of 60 to 90 minutes in conversation with the child and parent individually. In that time, the research assistant forms relationships with both of them, then, through feedback to the parent about the child's symptoms, can become a bridge in a parent/child relationship marked by disengagement, withdrawal, or limited communication. In the younger age group (i.e. – preadolescents), where a higher level of parent involvement is appropriate, screening and assessment could lead to improved parent/child communication and attachment. Anecdotal evidence from the Action Study gives some support to this notion. One girl interviewed for the Action Study who maintained a surly, disdainful attitude throughout the brief screening interview,

responded with anger at the notion of telling her mother of her self-harm behavior and depression. However, after discussions with the research assistant and the school counselor and agreeing to tell her mother, the girl's affect visibly lightened and she seemed relieved. Knowing that some communication with her mother would occur seemed to transform this girl from a surly adolescent to a hopeful twelve-year-old girl.

An additional speculation about the processes at work when screening and assessment appear to be therapeutic comes from research on the "significant moments" in family therapy for childhood depression (Campbell, et al., 2003). In a qualitative analysis of therapists conducting systemic family therapy, one theme of significance identified in the study was "hearing the child's voice" (Campbell, et al., 2003, p. 430). The researchers reported that they were "struck by the power which the parent or parents' story had in influencing the way things were seen in the family" (Campbell, et al., p. 430). As a result, the researchers "attached great significance to those times when the child was heard in a different way and therefore created the potential for new beliefs about the family or the sources of depression" (Campbell, et al., p. 430). Similarly, by providing feedback to parents following screening and interviewing, the researcher may be providing a voice for the child that brings about change in the family's story.

Brief Interventions

Interpersonal therapy as developed by Klerman and colleagues (described above) was adapted for use with adolescents and intended as a time-limited therapy (Weissman, 1998). The interpersonal intervention studies cited above all consisted of therapy sessions once a week for about 12 weeks. Though time-limited in nature, it is, nevertheless, a substantial intervention. A literature search for brief interventions

primarily yields studies designed to facilitate change in problematic health behaviors. Brief interventions have produced positive outcomes in promoting reduced alcohol consumption in college students and adults (Marlatt & Baer, 1998; Borsari & Carey, 2000), promoting reduced drug use in young substance abusers (Breslin, Li, Jarvie, Tupker, & Ittig-Deland, 2002), and reducing relapse in smoking cessation programs (Fiore, et al., 1996). In these studies, the "brief" interventions ranged from two assessments with two feedback sessions (Marlatt & Baer, 1998) to four sessions (Breslin, et al., 2002).

Other brief interventions aimed at preventing or ameliorating psychological symptoms have shown promise. Trials of brief interventions (less than 12 sessions) for preventing depression in older populations have proven effective in preliminary trials (Boyer, Novella, Morrone, Jolly, & Blanchard, 2004). Kazak and colleagues implemented a four session, one-day intervention to treat posttraumatic stress symptoms for adolescent survivors of childhood cancer and their families. The intervention integrated cognitive-behavioral and family approaches and successfully reduced physiological arousal in the adolescents and intrusive thoughts experienced by their fathers (Kazak, et al., 2004). In addition, a brief intervention for preadolescent children with social phobia proved effective in reducing social anxiety and related symptoms, including depressive symptoms as measured by the Children's Depression Inventory (Gallagher, Rabian, & McCloskey, 2004). The eight to eleven year-old participants in the social phobia study received an assessment, an individual/parent session, and three intervention sessions of approximately three hours. Accordingly, the participants probably had about 11 hours of contact with the administrators of the intervention study.

In contrast, families participating in the Action Study have only about 30 minutes of contact with a research assistant prior to the KSADS interview. The parent and child KSADS interviews and parent feedback give the family an additional 2½ to 4 hours of contact with researchers, significantly less than the brief interventions described.

"Ultra-brief" therapy is a term that has been suggested to describe therapies designed to include only six sessions or less (Shapiro, et al., 2003). Two and four hour cognitive-behavioral interventions have demonstrated improvement in symptoms of depression and anxiety among a group of chronically ill patients (Kunik, et al., 2001) and anxiety symptoms in participants with panic disorder (Newman, Kenardy, Herman, & Taylor, 1997).

The definition of "brief therapy" depends in large measure on the treatment orientation of the therapist (Shapiro, et al., 2003). Psychodynamic psychotherapy has typically been considered a long-term intervention, such that brief psychotherapy is considered to be about 25 sessions (Shapiro, et al., 2003). In an effort to determine how much therapy is enough, several analyses have been carried out that examined the rates of improvement of clients receiving psychotherapy. In an analysis of data from nearly 2500 patients, Howard, Kopta, Krause, Merton, & Orlinsky (1986) found that approximately 50% of clients had measurably improved after 8 sessions, and 75% of clients had improved after 25 sessions. A more recent analysis provided similar results. Hansen, Lambert, and Forman (2002) reported that between 13 and 18 sessions of therapy were necessary for 50% of patients to substantially improve. In "carefully controlled and implemented treatments," between 58% and 68% of clients improve in about 13 sessions (Hansen, et al., 2002). But about 35% of clients improved after only 3 sessions (Given,

2002). As a practical matter, aside from clinical trials, the national average number of therapy sessions per client is less than five, which is inadequate for most clients (Hansen, Lambert, & Forman, 2002). Nevertheless, the statistic has implications for efficacy and efficiency of interventions attempted.

The research on brief interventions and improvement rates in psychotherapy suggests that brief interventions have the potential to be very helpful to some adult and adolescent clients. The effectiveness of brief interventions with children has not been clearly established. Even so, the possibility is suggested that conceivably some children experience depression screening and assessment as an intervention.

Therapeutic Assessment

Finn and Tonsanger (1992) have developed a therapeutic model of assessment that "strives to maximize the interventional aspects of assessment for clients (and their families)" (Finn & Tonsanger, 1992, p. 5). Finn and Tonsanger state that the focus of the assessment is broadened from just the test measures to include "such aspects as the client-assessor relationship, the context of the assessee's difficulties, and the clinicians' own countertransference" (Finn & Tonsanger, 1992, p.5). A number of client benefits have been noted from the sharing of test feedback, including benefits for therapy, such as facilitating the development of the therapeutic alliance (Allen, 1981). More immediate client benefits have been documented including increased self-esteem, hope, and self-awareness, and reduced symptoms and feelings of isolation (Finn & Butcher, 1991).

The goal of a therapeutic assessment is to provide the client with new experiences or new information about himself that helps him make changes is his life. Thus, a therapeutic assessment emphasizes empathy with the client, working collaboratively, and

sharing the results with the client. The process is collaborative and egalitarian (Finn & Tonsanger, 1997). Even relatively brief assessments can have a therapeutic effect. In a key study, Finn and Tonsanger (1992) had college students complete an interview and a personality measure (the Minnesota Multiphasic Personality Inventory-2, MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), then receive a one-hour feedback session conducted in a collaborative manner. A control group completed an interview, the MMPI-2, and received one-hour of supportive, non-directive therapy. In comparison with the control group, the participants who received feedback showed a significant decline in symptoms, increase in self-esteem, and increase in hopefulness, effects that were maintained at 2-week follow-up (Finn & Tonsanger, 1992). In a replication and extension of that research, Newman and Greenway (1997) found similar results and demonstrated that the therapeutic effect was a result of receiving the feedback, not a result of completing the MMPI-2.

Finn and Tonsanger (1997) suggest several possible theoretical concepts that may explain the efficacy of therapeutic assessment. Therapeutic assessment may offer "self-verification" and help relieve anxiety a person feels about his own self-concept, an idea based on Kohut's (1977) notion of "disintegration anxiety" (Finn & Tonsanger, 1997). The assessment can offer confirmation for self-schemas that have come in to question when experiences have challenged existing beliefs. Based on object-relations theory (Fairbairn, 1995), Finn & Tonsanger suggest therapeutic assessment leads to "self-enhancement" by helping clients reframe negative beliefs about themselves (e.g., reframing laziness as low energy due to depression). Another theoretical perspective offered as an explanation for therapeutic assessment is Bandura's (1994) theory of self-

efficacy and the needs for mastery and control. The new information gleaned from a therapeutic assessment can help clients understand themselves and past experiences in new ways and lead to better problem solving in the future (Finn & Tonsanger, 1997).

Therapeutic assessment has been referred to as a "treatment microcosm" (Allen, 1981, p. 251; Kubiszyn, et al., 2000, p. 11). Therapeutic assessments have been successfully used in marital therapy (Dorr, 1981); to develop empathy among parents and educators for children with learning and behavioral problems (Pollak, 1988); to build a therapeutic alliance (Ackerman, Hilsenroth, Baity, & Blagys, 2000); and to bring about acceptance of treatment for eating disorders (Michel, 2002). In a very moving case example, Michel describes an anorexic young woman in denial about the severity of her eating disorder. Through a therapeutic assessment, the young woman was able to recognize conflicts between her beliefs and her behavior, and her parents were able to recognize the need for inpatient treatment and family therapy (Michel, 2002). Michel noted that receiving confirmatory information about previously known or suspected ideas about the client and family relationships had a self-verifying effect for both the client and the family (Michel, 2002).

The therapeutic assessment model presents a promising explanation for intervention effects that occur with depression screening and assessment. Some therapeutic assessments entail about as much therapist/client contact as occurs in depression screening and assessment (about 3 or 4 hours). The processes are analogous in that they both involve evaluation and feedback regarding the results. In the case of children, therapeutic assessment and depression assessment both entail feedback to the parents, creating the potential for change in the family. When a child in the Action Study

has her depression openly acknowledged for the first time, the experience may be self-verifying and lead to positive changes. Similar effects could occur in the family. For participants who complete the diagnostic interview and feedback, this explanation appears quite plausible. The more intriguing question is what happens to promote change following the brief symptom interview.

Unexpected/Unintended Intervention Phenomena

Placebo Effects

To establish the efficacy of a medication in medical research, the effects of a medicine are contrasted with the effects of taking a non-therapeutic or inert substance, in other words, a placebo. In psychotherapy research, placebo groups typically receive a non-theoretically based supportive therapy, attention, life skills training, or tutoring, to name a few examples. Intervention effects that occur in response to the placebo condition in psychotherapy are also referred to as non-specific therapeutic factors/effects or common factors (Lambert, 2005). Common factors are "those dimensions of the treatment setting (therapist, therapy, client) that are not specific to any particular technique" (Lambert, 2005, p. 856). The research on common factors in psychotherapy has focused on "causal mechanisms such as expectations for improvement, therapist confidence, and a therapeutic relationship that is characterized by trust, warmth, understanding, acceptance, kindness, and human wisdom" (Lambert, 2005, p. 856).

Various researchers have categorized common factors in various ways. One frequently cited categorization is that made by Miller, Duncan, and Hubble (1999). They extended the meaning of common factors to include client, relationship, placebo, and technique. Subsequent research established percentages of influence these factors have in

the therapeutic process, as follows: client (40%); relationship (30%); placebo (15%); and technique (15%) (Assay & Lambert, 1999). Although the relative percentage of influence accorded to technique is fairly low, some have argued that a therapist's technique influences the other three factors (Castelnuovo, Faccio, Molinari, Nardone, & Salvini, 2004). Grencavage and Norcross (1990) reviewed fifty publications discussing common factors and coded them to generate a comprehensive list of commonalities. They produced a list of 35 commonalities that could be divided into the following five categories: client characteristics, therapist qualities, change processes, treatment structures, and relationship elements (Grencavage & Norcross, 1990, as cited by Castelnuovo, et al., 2004).

Psychotherapy research comparing no-treatment control groups, to placebo groups and active treatment groups consistently shows that placebo groups yield significant effects but do not help participants as much as active treatments (Lambert, 2005). Meta-analyses by Lipsey and Wilson (1993) and Grissom (1996) found support for the reliable superior effects of active, theory driven treatments. Lambert (2005) reports that these studies found average effect sizes for the placebo groups to be .44 and .48 respectively. Lambert states that these effect sizes "suggest that the placebo patient will move to the 60th percentile of no-treatment controls, while the average psychotherapy patient moves to the 80th percentile" (Lambert, 2005, p. 858). With the question of placebo vs. therapy somewhat resolved, research studies have turned to the comparison of different therapies and comparison of different components of therapies. At present, the debate continues over whether or not all therapies are equally effective (the so-called "Dodo bird verdict") (Hunsley & Di Giulio, 2002; Lambert, 2005).

Research comparing various components of therapies (e.g. – behavioral vs. cognitive) has shown little difference in effects of various components (Lambert, 2005; Lambert & Ogles, 2004).

The facets of the screening and assessment processes that are shared by psychotherapies may be responsible for changes observed in some participants. In particular the warmth and empathy offered by research assistants together with hope and expectancy of change may lead to decrease in symptoms. These kinds of common factors may be amplified when a participant has more extensive contact with researchers during the screening process. Increased researcher/participant contact occurs when a participant endorses suicidal ideation on questionnaires or in interviews. In such instances, the research process must be set aside while risk is assessed and safety is assured. Addressing suicidality may entail longer conversations with researchers during brief symptom interviews or diagnostic interviews, or both, completing a safety contract, and a conversation with the school counselor to solidify plans for seeking help if the child feels unsafe. In addition, researchers are likely to have longer conversations with parents to appropriately address the child's suicidal feelings and safety concerns. There have been instances in the Action Study of participants who are emotional, endorse suicidality and considerable symptoms in the brief symptom interview, who then present as not depressed in the diagnostic interview. Warm and empathic research assistants who have been certain of the participants' depression on the prior occasion are mystified by the sudden change. Taking the Action Study as a whole, it may be worthwhile to consider that the screening process may have excluded those participants who are particularly responsive to common factors of therapy.

It seems fairly straightforward to conclude that study participants who go through the screening and intervention phases of the study are exposed to common therapeutic factors by virtue of their contact with research assistants. It seems plausible, however, to conjecture that more is at work than only common factors when there is evidence that parents of participants use the information provided in feedback to change their actions and/or their child's environment. One could argue that feedback to parents is one of the common factors when conducting research with children. However, the research methods of screening and assessment and the specificity of feedback to the parents are not typical of a naturalistic practice. For that reason, it would be useful to have an understanding of the extent to which depression screening and assessment influences participants and their families. The findings of this study may suggest that in the Action Study we are observing a pre-treatment brief therapeutic assessment, followed by a comparison of the waitlist control with the active intervention groups.

Sudden Gains

Early treatment response, pre-treatment response, and sudden gains in treatment have been studied to increase understanding of the efficacy of therapy and the mechanisms of change. The aim is to pinpoint the stages in therapy when substantial gains are made in hopes of identifying the therapeutic mechanisms at work. Ilardi and Craighead (1994) called attention to the time course of participant response when they pointed out that 60 to 70% of symptom reduction in most cognitive behavioral therapy studies occurs in the first four weeks of therapy. Therefore, early response in cognitive behavioral studies often occurs prior to the introduction of specific cognitive behavioral

strategies. This suggests that early treatment response is a result of common therapeutic factors rather than specific techniques (Lambert, 2005).

In contrast, Tang and DeRubeis (1999) and Tang, DeRubeis, Beberman, and Pham (2005) presented research indicating that cognitive changes in participants were observed in the cognitive behavioral therapy session immediately preceding sudden therapeutic gains. Other investigations, though, have shown sudden gains in cognitive behavioral therapy without documented cognitive changes (Morgen, Roberts, & Ciesla, 2005). Sudden gains occur in therapies other than cognitive behavioral therapy, including supportive-expressive therapy (Tang, Luborsky, & Andrusyna, 2002); systemic behavioral family therapy, and nondirective supportive therapy, although cognitive behavioral therapy results in fewer reversals of sudden gains (Gaynor, Weersing, Kolko, Birmaher, Heo, & Brent, 2003).

Early responders in the studies cited ranged from 17% of participants (Stiles, et al., 2003) to 55% of participants (Gaynor, et al., 2003). Participants who experience sudden improvement early in treatment usually maintain those gains over time, improve more than other participants, and have a higher recovery rate (Tang, et al., 2005; Morgen, et al., 2005; Stiles, et al., 2003). The mechanism responsible for early treatment response is as yet unknown. Lambert suggests two possible explanations for the phenomena. First, he suggests, "Early responders to psychotherapy may be more resilient, better prepared, more motivated, and thus more receptive to therapeutic influences of any kind" (Lambert, p. 865). Second, he suggests that a "better fit" between client and therapist may be the causative factor behind early treatment response (Lambert, p. 865). It seems reasonable to speculate that if participants do improve during depression screening and

assessment, they are probably more resilient and experiencing fewer symptoms of depression (e.g. – fewer of the physical symptoms of depression).

In a study of adolescents receiving therapy for depression, pre-treatment gains and subsequent sudden gains were considered separately (Gaynor, et al., 2003). Twenty-eight percent of the adolescents experienced pre-treatment gains and another 39% experienced sudden gains within treatment. Fifty-five percent of the total number of participants maintained their gains over the course of treatment. Eighty-five percent of sudden gains occur by the fifth session, and 100% have occurred by the tenth session. Pre-treatment and sudden gains occurred across all three treatment conditions: cognitive-behavioral therapy, strategic behavioral family therapy, and non-directive supportive therapy. The non-directive supportive therapy was intended as a non-specific therapeutic factors control group, but it produced better outcomes than the strategic behavioral family therapy group. Both pre-treatment and within treatment gains were linked to superior therapeutic outcomes. Gaynor and colleagues suggest, "…the first level of care for depressed teens may be the presentation of a credible treatment rationale with a set of associated therapeutic procedures, independent of any specific orientation" (Gaynor, et al., 2003). For adolescents who did not experience a sudden gain, cognitive-behavioral therapy produced significantly better outcomes.

In this study, it will be interesting to see if any of the participants describe cognitive changes that they attribute to participation in screening and assessment. For instance, do they have a different view of themselves as a result of having their symptoms characterized as depression? And if they do describe cognitive changes, do they attribute them to contact with researchers or to changes in relation to their parents?

Models of Depression with Implications for Screening and Assessment

Several theoretical models of depression may offer insight into the depression screening and assessment processes. The cognitive models of depression are based on the theory that depression occurs as a result of faulty information processing. From this perspective, depression occurs not as a result of negative life events, but as a result of how they are cognitively interpreted (Ingram & Kendall, 1986; Beck, 1967). Beck's model of depression posits that cognitive errors in processing information create a vulnerability to depression when stressful events occur. Beck proposed that a negative self-schema and a negative cognitive triad consisting of dysfunctional thoughts about the self, the world, and the future lead to depression (Beck, Rush, Shaw, & Emery, 1979). This explanation for depression has been supported by research with adolescents and children (Epkins, 2000; Lewinsohn, Joiner, Rohde, 2001).

A depressed child might have a negative core belief of worthlessness, a distorted perception that no one cares about her, and little hope that the future will be better. If this child were interviewed in the course of depression screening, she might find her distorted perception challenged when faced with an empathic interviewer and parental concern following the interview. Her negative views of the future could be altered by the prospect of therapy to address her problems and by an improved state of relationship with her parents. Although a negative core belief would not be altered by such a brief contact, a positive interaction with an interviewer could promote more positive self-perceptions. If, during the course of an interview, the child expresses suicidal ideation, the therapist might find it necessary to take a crisis intervention tack and actively work to challenge the child's negative thoughts and dysfunctional beliefs with the intention of promoting

hopefulness. In these ways, depression screening and assessment could influence some of the cognitions that are sustaining the depression.

Another cognitive theory of depression, the reformulated helplessness theory, is worth considering. This theory was developed from the basis of Seligman's learned helplessness theory. Seligman demonstrated that helplessness can be learned when a person continually faces an insurmountable problem. Eventually, the individual stops trying (Seligman, 1975). Abramson, Seligman, and Teasdale (1978) expanded on this theory, proposing that the ways a person explains and attributes causes of negative events can lead to depression. In particular, individuals who view the causes of negative events as internal (caused by themselves), global (generalizing across domains), and stable (unchangeable) are at increased risk of depression. Several studies have found support for this model of depression in children and adolescents (Nolen-Hoeksema, et al., 1992; Robinson, Garber, and Hilsman, 1995).

A child's experiences during the depression screening and assessment process could affect her attributions about specific negative events. For instance, during a diagnostic interview, the interviewer's empathic and perhaps unexpected response could cause the child to question her attributions for an event such as her parents' divorce, struggling in a school subject, or even attributions about being depressed. She may begin to realize her parents' divorce is not her fault. She may, in telling the interviewer about how things go at school, realize there is only one class in which she struggles, or she may realize, through the experience of talking with the interviewer, that there are things she can do to improve her mood.

A related theory, the hopelessness theory of depression (Abramson et al., 1989), proposed that depression is promoted by the tendency: to view the causes of negative events as global and stable; to view negative events as having disastrous consequences; and to view the self as flawed. Again the experience of talking with an empathic, rational interviewer may lead to revised perspectives about negative events, so that causes are not viewed as global or stable, consequences are evaluated more realistically, and feelings about the self are more positive. Simply by asking follow-up questions, an interviewer may inadvertently call distorted attributions into question. For example, interviewers often ask about what kinds of things cause a child to feel sad and how long those sad feelings last as a way of assessing the severity of depression. A child might talk about becoming upset due to conflicts with a particular friend. To get an idea of the scope of the problem, the interviewer might ask if the child has other friends, and whether or not distressing conflicts occur with them. A child's attributions about events and herself may become less negative as she relays information about the totality of circumstances to an interviewer. She may gain a new appreciation for the fact that perhaps she is not so flawed (since she does have other friends) and that outcomes of conflict with one friend are not as catastrophic as she thought (she does have someone else to play with).

A social learning theory of depression offers another perspective (Lewinsohn, Hoberman, Teri, & Hautzinger, 1985). According to this theory, individuals who are depressed experience an environment lacking in positive reinforcement or, in other words, an absence of enjoyment. The unrewarding environment may be initially triggered by a negative life event, however, poor social skills of the depressed person play a role in perpetuating the depression as ineffective social skills lead to less

rewarding interactions with others. In addition, the opportunities for positive interactions are missed as the depressed person sometimes fails to respond at all.

A significant change in reinforcement from the environment is one possible explanation for a rapid change in mood that seems to occur for some depressed children identified through screening. Perhaps parents, upon learning their child is depressed, devote more time and attention to the child and arrange more enjoyable activities in hopes of helping the child's mood. Attention and affection from a parent is likely a very rewarding experience for most children. Risk factors such as poor social skills or negative cognitions would remain unless the parent is successful in maintaining the increased contact and it leads to improvement in the other areas.

Family Systems Theory and Child Depression

According to the family systems approach, a child's depression may be viewed as serving a purpose in the family, an indication the family is not functioning effectively, or the result of intergenerational transmission of depression (Crethar, Snow, & Carlson, 2004). Depression in children is associated with maladaptive family functioning (Kaslow, Deering, & Ash, 1996; Kaslow, Rehm, Pollack, & Siegel, 1990). When the child becomes depressed, the negative, self-focused attitudes and behaviors associated with the depression tend to elicit more reactive responses from other family members. Eventually, the more negative patterns of interaction are incorporated into the family's homeostatic functioning. Some of the goals in systemic family therapy may include improving interactional patterns among family members, working with family dynamics that occur with the symptoms, and adjusting family boundaries (Crethar, et al., 2004; Cotrell & Boston, 2002).

While depression screening and assessment bears little resemblance to family therapy, more general principles of family systems add insight to the process. The family can be viewed as a self-regulating system that continually receives information from the outside world, from the family's past, and from its members. The family makes use of the incoming information to maintain progress toward family goals. Like every system, the family has guidelines for regulating the degree to which relationships between the family and the environment are open (Broderick, 1993). Some families more readily accept information from outside sources. News that a child is depressed may be given considerable weight by some families, and used as a basis for evaluating existing family processes. The family (in particular the executive subsystem of the family) may recognize a "discrepancy between its goals and its current trajectory toward those goals" Broderick, 1993, p. 44). As a result, the family may make decisions that lead to changes in the family's functioning and the child's functioning. Stated another way, news that a child is depressed may be accepted by family members as a signal that existing patterns must be changed, triggering a process of "adaptive self-organization," (i.e. – reorganization) (Cox & Paley, 1997, p. 251).

Parent Response to Child Diagnosis

Several types of responses are seen in parents when their child is diagnosed with a physical or mental illness. Parents may have an emotional response to a child's diagnosis characterized by feelings such as sadness, shock, denial, fear, self-blame, guilt or confusion or a physiological reaction (e.g. – crying) (Heiman, 2002; Kawanishi, 2005). Parents sometimes experience those types of emotions, even when the potential problem being raised is identified by a screening measure that has a high number of false positives

(Kurtzer-White and Luterman, 2003). After the initial emotional response, parents may appraise the situation to try to understand its cause (Kawanishi, 2005; Woolfson, 2004). Responses to a diagnosis range from flexible adaptation and mobilization to freezing in various degrees of rigid, ineffective reactions, or even denial. Many parents discuss a new diagnosis with other family members or friends and are strongly affected by that person's response (Heiman, 2002). In addition, they may cope by obtaining various services or supports for the child (Heiman, 2002).

A number of factors could influence the way parents respond to information about their child's depression. Responses may differ depending on whether or not the diagnosis is expected, the cognitive appraisal a family makes of a diagnosis, or the explanation the family constructs for the problem (Heiman, 2002; Kawanishi, 2005; Woolfson, 2004). A parent's pre-existing attitude toward the school is likely to affect a parent's decision to discuss a child's depression with a teacher or school counselor (Arnold, Michael, Hosley, & Miller, 1994).

The referenced studies examined the parent responses to diagnoses of schizophrenia, intellectual disability, physical disability, learning disability, and hearing loss. No research was identified that explores the response of parents to a diagnosis of depression in their child. The episodic nature of depression may elicit different reactions from parents than those that have been found in response to diagnosis with chronic or life threatening conditions (e.g. – cancer, mental retardation, hearing loss). It is also possible that parents underestimate (or overestimate) the seriousness of diagnosis of a depressive disorder at a young age.

The intense grief response that has been observed in parents of children diagnosed with a severe illness or disability (Kurtzer-White & Luterman, 2003) probably goes beyond the reaction parents experience when a child is diagnosed with depression. Some similarities may occur, however, particularly in the way parents of the severely ill or disabled child seek information about the disorder and seek resources to remediate the problem. In addition, mothers of children diagnosed with hearing loss experience considerable guilt feelings related to the cause of the hearing loss, and it seems reasonable to speculate that some parents would experience guilt related to the cause of depression in their children (Kurtzer-White & Luterman, 2003).

Parent Processes: Meta-Parenting

A more general review of the parenting literature produced means of considering the ways parents may negotiate the screening feedback and parenting problems in general. Meta-parenting is a construct for understanding parent cognitive processes. Meta-parenting occurs in the "deliberate cognitions" of the parent involving considerations about the child outside of an ongoing parent-child interaction (Hawk & Holden, 2006). Put most simply meta-parenting refers to the thoughts parents have about their children and about parenting. The construct brings together cognitive processes of parenting, including processes of assessing, reflecting, and problem solving. When engaging in these cognitive processes, parents are actively evaluating childrearing concerns, examining their own parenting behaviors and beliefs, and re-examining their past behaviors and their child's past behaviors in light of new information. A parent is engaged in meta-parenting when he or she consciously identifies a child-rearing problem, plans and implements a solution, and evaluates the outcome.

A parent's tendency to engage in cognitive processes of meta-parenting provides a useful framework for considering the ways that parents may respond to feedback following screening and assessment. Parents' may engage in cognitive process of assessing the child's situation and the screening information, reflecting on past beliefs and events, and engaging in problem solving. Meta-parenting may be a particularly useful parenting framework for reference in connection with this exploratory study since the theory encompasses both parent beliefs and behaviors. Screening and assessment involve feedback from outside the family, and meta-parenting may provide a basis for considering how parents respond to the information.

Statement of the Problem

Screening children for depression using self-report measures of depressive symptoms is a means of preliminary identification of children who may be depressed that has been used in primary care settings, in schools, and in the context of depression research. Those who score above a specified cut-off score on a self-report measure are referred for additional assessment and, if necessary, treatment. Anecdotal evidence from an ongoing treatment study for pre-adolescent girls (the Action Study) suggests that the screening and assessment process may have intervention effects for some families. No research has been conducted to determine how this might occur, although a review of literature including literature regarding interventions for depression, theories of depression, family systems theory, brief interventions, therapeutic assessment, and common therapeutic factors offers some possibilities. More generally, very little is known about how child participants and their parents respond to the processes of

screening, assessment, and diagnosis of depression. Based on the literature review, the research study will be organized around the following questions:

1. How do children react to the depression screening and assessment processes? During screening and assessment, do some depressed children experience improvement in depressive symptoms? If so, does something about the screening process help them to improve?
2. How do parents respond when they are informed their child may be depressed? What actions do they take?
3. What factors influence a parent's response to the news that his or her child is or may be depressed? How do parents who intervene to help their depressed child interpret the diagnosis and what coping or problem solving strategies do they employ?

CHAPTER THREE

Methodology

Qualitative Research

This study explored child and parent reactions to child depression screening and assessment. Data were collected through semi-structured interviews with children and their parents and analyzed using the grounded theory method of qualitative analysis.

Screening children for the presence of depressive symptoms is a commonly employed procedure for researchers seeking to identify depressed children. In addition, screening youth for depression and other suicide risk factors is increasingly used as a first step in suicide prevention measures, yet little research has attempted to discover how participating in depression screening and assessment influences children and their parents. Qualitative methods can be used to "uncover the nature of persons' experiences with a phenomena" and can give "intricate details of phenomena that are difficult to convey with quantitative methods" (Strauss & Corbin, 1990, p. 19).

Qualitative research is particularly appropriate for understanding participants' experiences and the meaning they ascribe to events, situations, and their own actions, where "meaning" may be broadly understood to include cognitions, emotions, and intentions (Maxwell, 1996). The goal of a qualitative study is not only to discover events and behavior that occur, but also to learn how participants make sense of events and how their understandings influence their behavior (Maxwell, 1996, p. 17). Qualitative research is also well suited to understanding the "process by which events and actions take place," information that may remain unexplored with other research methods (Maxwell, 1996). By interviewing children and their parents about their experiences with

depression screening and assessment, it was possible to learn about the process from their points of view and hear how they made sense of it and responded to it. Using a grounded theory approach permits the researcher to develop hypotheses and build theory based on the data as it emerges, rather than limiting the analysis to preconceived ideas of the phenomena (Strauss & Corbin, 1990). Using this approach allowed me to generate a theory of child and parent responses to depression screening and assessment.

Grounded Theory

The grounded theory method of qualitative analysis was initially developed by Glaser and Strauss (1967) to address the need for, among other things, a means of understanding complex human processes of perception, action, and interaction, and the need for "making comparisons between data to identify, develop, and relate concepts" (Strauss & Corbin, 1998). Interviews and observations are the most commonly used methods of collecting qualitative data, but other sources of information may be used, such as documents, books, or videotapes (Strauss & Corbin, 1990; 1998).

The goal of the grounded theory method of data analysis is to "build theory" through "theoretically informed interpretations" (Strauss & Corbin, 1990, p. 22). The researcher analyzes the data to identify concepts and relations between concepts to develop a theory grounded in the data.

Qualitative research involves a flexible, interactive process of inquiry and analysis. Data are initially collected to explore a phenomena or broadly defined research question. Hypotheses are developed and tested as data are collected, and new ideas are incorporated with subsequent data collection. The researcher does not set out to prove a particular hypothesis, but "actively forms questions, seeks data, asks new questions based

on the data, and interacts with the data by checking out hunches and formulating concepts" (Webster-Stratton & Spitzer, 1996, p. 7). Through this inductive process, new theories can be developed.

As data are collected, they are analyzed. A detailed process of open coding is used to identify small units of data, or codes, that constitute discrete ideas or concepts. In the next step, axial coding, the initial codes are compared and contrasted then organized into categories based on similarities. As data collection continues, the researcher considers the emergent categories in an ongoing process of comparing across categories and across informants to verify categories and identify relations among categories. Finally, the researcher undertakes selective coding to organize the data into higher order categories, develops explanations for relations among categories, identifies a core category, and develops a theory (Webster-Stratton & Spitzer, 1996). Via these procedures, "the theory emerges from the data and remains grounded in the data, hence the term 'grounded theory'" (Webster-Stratton & Spitzer, 1996, p. 7).

Research Questions

In a grounded theory study, it is typical to begin with a broad research question focused on action or process (Strauss and Corbin, 1990). In this study, the broadly defined research question was: What reactions do child participants and their parents have to depression screening and assessment? The goal was to learn about depression screening and assessment from the points of view of the child participants and their parents.

Due to the exploratory nature of this study, an initial pilot of the study was conducted with one girl and her mother to refine the hypotheses and provide direction for

the additional interviews. She and her mother were interviewed individually in a semi-structured, flexible interview initiated with open-ended questions about the screening process. The interview was further developed and refined based on the data and experience gained from the first two interviews of the data collection phase. Interviews for this study were guided by several general questions.

1. How do children react to the depression screening and assessment processes? During screening and assessment, do some depressed children experience improvement in depressive symptoms? If so, does something about the screening process help them to improve?

2. How do parents respond when they are informed their child may be depressed? What actions do they take?

3. What factors influence a parent's response to the news that his or her child is or may be depressed? How do parents who intervene to help their depressed child interpret the diagnosis and what coping or problem solving strategies do they employ?

Participants

Number of Participants

Qualitative interviews were completed with sixteen girls and with twelve parents. Inherent in the process of qualitative research is the researcher as the instrument.

Researcher as Instrument

Ideally, all interviews are conducted by one researcher to make best use of the interviewer's subtle perceptions, emotional responses, and emerging issues for comparison across participants and interviews, experiences that are difficult to share with another interviewer. Therefore, for this study, I was the interviewer for all child and

parent participants who were English speaking. Eight of the child participants reported that Spanish was the primary language in the home. Among these families, one parent was bilingual and agreed to complete the interview in English. Due to concerns that the flow of communication would be hampered if interviews were conducted through a translator, a bilingual graduate student colleague was recruited and trained to conduct the remaining interviews. She completed interviews with three of the parents. The other four parents never made themselves available for the parent interview, despite repeated contacts and granting permission for their daughters to participate. A review of the home ownership data gathered regarding the study participants suggests that those parents who did not complete the qualitative interview are among those with less economic resources. Perhaps completing an interview such as this was a low priority, where unrelated to specific and immediate concerns about their child and in the face of other more pressing demands. Three of the parents who did not complete qualitative interviews for this study had completed all or part of KSADS interviews during screening/assessment.

Child Participants

Fourteen of the child participants were elementary school students: 7 fourth graders and 7 fifth graders. Two participants were sixth grade middle school students. Child participants ranged in age from 9 years, 5 months, to 11 years, 8 months, with an average age of 10 years, 3 months. They are socio-demographically diverse. Race/ethnicity data collected from parents indicated that eleven of the child participants were Hispanic (no other ethnic data indicated), two were African-American, two were White Non-Hispanic, and one was biracial African-American and Hispanic.

Family Structure

Twelve of the girls live with both parents, one lives with her mother and step-father, two have divorced parents and live in the household headed by their single mothers, and one other lives with her single/widowed mother following her father's death. The three girl's whose parents are divorced have ongoing contact with their fathers. Four of the households currently include extended family members who are aunts, uncles, cousins, and nieces/nephews to the child participants in this study.

Parent Participants

With one exception, all of the parents interviewed for this study were mothers. Four mothers are fulltime homemakers, five work part time, and seven work fulltime. Their years of education range from 3 years to 16 years (college graduate), with an average of 12.5 years of education. Similarly, fathers education ranged from 5 years to 16 years with an average of 12.5. Parent occupations included janitor, crossing guard, pharmacist, construction worker, police officer, and corporate manager. A listing of parent occupation and education is provided in Table 1.

The mother of one child participant [17] requested that she and the father be interviewed jointly, in the same manner that they had completed the KSADS Interview. Of the 12 parents/parent-pairs interviewed, 10 had completed parent KSADS, while two had not.

The families live in a variety of housing arrangements, such as renting apartments, houses, or mobile homes, or owning their own mobile homes and single family homes. The value of homes owned ranges from $43,000 to $211,000 according to the public tax records in the counties in which participants reside. The median home

value in the Austin, Texas, metropolitan area is $204,000 (OnBoard LLC, 2007). Eight of the families either rent their homes or own homes valued at less than half of the median home value. A listing of participant socio-demographic and economic information is included as Table 1.

Table 1
Participant Socio-Demographic & Economic Data

ID #	Child Name	Family Members	Race/ Ethnicity	Home Ownership/ Assessed Value	Parent Occupation/ Parent Education
1*	Penny	5	White	Owner, single family home $211,000	Mother: Beautician (part time); Technical School Father: Building Contractor; Some College
2	Mara	4	White	Owner, single family home $192,000	Mother: Secretary (part time) Some College Father: Welder Some College
3	Sabrina	2	African-American	Renter, Apartment	Mother: Licensed Voc. Nurse; Some College Father: deceased
4	Jeanette	4	Hispanic*	Owner, mobile home $75,000	Mother: Homemaker; Some High School Father: Construction Worker; Some High School
5	Patrice	8, E	Hispanic*	Renter, mobile home	Mother: Homemaker; High School Graduate Father: Construction / Painter; High School Graduate
6	Lauren	3	African-American/ Hispanic	Owner, single family home $148,000	Mother: Corporate Manager; College Graduate Father: Police Officer, Some College
7	Madison	5	Hispanic	Owner, single family home $118,000	Mother: Homemaker; Some College Father: Shift work, food processing; High School Graduate
8	Nina	6	Hispanic*	Owner, single family home $98,000	Mother: Janitor; Fifth Grade Father: Construction; Fifth Grade
9	Sadie	5, E	White	Renting, apartment	Mother: Pharmacist, College Degree.

10	Meliah	5, E	African-American	Owner, single family home $181,000	Mother: Corporate Sales Representative, College Degree. Father: Employed, Some College
11	Ilse	7	Hispanic*	Renter, single family home	Mother: Crossing Guard; Third Grade Step-father: Plumber, Some College
12	Kamryn	6	Hispanic*	Owner, mobile home $43,000	Mother: Homemaker, High School Graduate Father: High School Graduate Assembly Line
13	Violet	5	Hispanic*	Renter, apartment	Mother: Part Time Employment; Some College Father: Janitor, High School Degree.
14	Janine	8	Hispanic*	Owner, single family home $143,000	Mother: Medical Assistant; Some College Father: Employed
15	Ariel	4	Hispanic*	Renter, quadplex unit	Mother: Part time employment Father: Employed
16	Tory	4	Hispanic	Owner, single family home $167,000	Mother: Corporate Manager, College degree.
17	Angela	4	Hispanic	Owner, single family home $192,000	Mother: School Cafeteria Food Service, High School Graduate Father: Employed; College Graduate

Note. *Spanish is the primary language spoken in the home; E=Extended family member(s) in the home.

Child Participant Screening and Assessment Data

The screening measures and DSM Interviews completed by the child participants suggested a range of symptom severity was present upon screening. Fourteen of the child participants completed both the CDI and BDI-Y as their initial screening measures. Of the participants who were screened using both measures, four produced elevated scores on both measures. Eight of the participants scored above the screening cutoff score on the CDI only, and three participants (two of whom completed the BDI-Y only) scored above the cutoff on the BDI-Y only. Excluding the pilot participant, CDI scores ranged from 15 to 38, and BDI-Y scores ranged from 16 to 43. The average of the CDI scores

was 19.17, and the average of the BDI-Y scores was 26. The duration of symptoms reported in the DSM Interviews ranged from three years to two weeks. Eleven girls reported symptoms consistent with a major depressive disorder, one reported symptoms consistent with an adjustment disorder with depressed mood, two reported symptoms consistent with dysthymia, and two reported symptoms consistent with a depressive disorder, not otherwise specified. Symptoms of anxiety were noted for two participants following the DSM Interview. Five participants endorsed some suicidal ideation during the DSM Interview. Upon the KSADS interview, participants were assigned diagnoses of major depressive disorder in partial remission (one participant) and attention deficit/hyperactivity disorder (two participants). The remaining 13 participants were given no diagnosis. Participant screening and assessment information is set forth in Table 2.

Table 2
Participant Screening/Assessment Information

#	Grade	CDI Score	BYI Score	DSM Score	Duration of Symptoms	DSM Int. Symptoms Consistent with:	KSADS Diagnosis
1*	4	**29**	**34**	12 SI SC=yes	3 years	MDD Possible GAD	MDD & GAD (T1) MDD in Partial Remission (T2)
2	5	**38**	**41**	11 SI SC=yes	2 years	MDD	No Diagnosis
3	4	**29**	**43**	11 SI SC=yes	3 years	MDD	No Diagnosis
4	6	**25**	24	11	8 months	MDD	MDD partial remission
5	6	15	**34**	11	6 months	MDD Possible anxiety	No Diagnosis
6	4	**16**	16	5	1 month	MDD Possible anxiety	No Diagnosis

#	Grade	CDI Score	BYI Score	DSM Score	Duration of Symptoms	DSM Int. Symptoms Consistent with:	KSADS Diagnosis
7	4	**24**	**25**	4 SI, SC=no	Unknown	DD NOS	No Diagnosis
8	5	**17**	19	6 SI, SC=no	6 weeks	MDD	No Diagnosis
9	4	**18**	18	7	2 weeks	Adjustment Disorder with Depressed Mood	ADHD
10	5	13	**28**	6 SH SC=yes	1 year	MDD	ADHD
11	5	**30**	18	6	2 years	MDD	No Diagnosis
12	5	**25**	**28**	7	6 weeks	MDD	No Diagnosis
13	5	15**	N/A	10	2 weeks	MDD	No Diagnosis
14	5	**19**	20	7 SI past year SC=no	7 months (per KSADS)	MDD	No Diagnosis
15	4	**22**	N/A	9	1 year	Dysthymia	No Diagnosis
16	4	**16**	21	6	2 years	MDD	No Diagnosis
17	4	15	**31**	3 SI SC = no	1 month	Depressive Disorder NOS	No Diagnosis
Average:		19.17	26	7.5	10.6 months		MDD/partial rem. = 1 ADHD = 2 No Diagnosis = 13

Note. *Pilot Participant (active participant from Action minimum contact control condition), excluded from averages and totals. **Advanced from CDI to DSM Interview based on school counselor request; data not included in Action Study analyses. SI = Suicidal Ideation; SH = Self-Harm; SC = Safety Contract; MDD = Major Depressive Disorder; GAD = Generlized Anxiety Disorder; DD NOS = Depressive Disorder Not Otherwise Specified; BDI-Y screening cutoff score = 25 or above (in bold); CDI screening cutoff score = 16 or above (in bold).

Instruments

Questionnaires and symptom interviews collected in connection with the depression treatment study were incorporated as additional sources of data for this study, together with interviewer research notes. The two questionnaires used in the Action

Study for initial screening of potential participants were the Children's Depression Inventory (Kovacs, 1981; CDI), and the Beck Youth Inventory, Depression Scale (Beck, Beck, & Jolly, 2001; BDI-Y).

Children's Depression Inventory

The CDI is one of the most widely used self-report measures of depressive symptoms in children and adolescents. It includes items to measure emotional, cognitive, psychomotor, and motivational symptoms of depression in youth ages 7 to 17 (Shaver & Brennan, 1991). For each item, the measure presents participants with three sentences that describe varying levels of a given symptom, and participants are asked to indicate which sentence best describes the way they have been feeling for the past two weeks. Item choices are scored from 0 to 2, with higher scores indicating higher levels of depressive symptoms. Total scores of 19 or above indicate a significant level of depression (Kovacs, 1983). For screening purposes, a cut-off score of 16 or above has the highest total predictive value; that is, the specificity and sensitivity of the instrument are maximized (Timbremont, et al., 2004). The CDI has demonstrated good test-retest reliability and internal consistency (Craighead, et al., 1998; Finch, Saylor, Edwards, & McIntosh, 1987; Kovacs, 1992). Studies evaluating the discriminant validity of the CDI have produced conflicting results. Some studies have found that the CDI discriminates depressive disorders from other diagnoses while others have not (Carey, et al., 1987; Timbremont, et al., 2002). Timbremont, et al. (2002), found that overall, more than 86% of participants could be correctly classified as depressed or not depressed based on CDI score. However, only about 67% of participants with elevated CDI scores were correctly classified (Timbremont, et al., 2002).

Beck Youth Inventory – Depression Scale

The BDI-Y is one scale from the Beck Youth Inventories of Emotional and Social Impairment (BYI) developed by Beck, Beck, & Jolly (2001) and appropriate for children ages 7 to 14. The complete BYI consists of five self-report inventories for assessing anxiety, anger, depression, disruptive behavior, and self-concept that can be used individually or in concert. The BDI-Y includes 20 items written as statements about the self. The participant rates the frequency with which the statement has been true for her in the past two weeks: never, sometimes, often, or always. The responses are scored from 0 to 3, with higher scores representing greater degrees of disturbance. For expediency, raw scores are used in the Action Study. For screening purposes, a cut-off score of 25 or greater was used to identify participants who may be depressed. Initial calculations based on the standardization sample indicate the BDI-Y has acceptable internal consistency and test-retest reliability (Beck, Beck & Jolly, 2001; Bose-Deakins & Floyd, 2004). Discriminant validity of the BDI-Y has not been demonstrated. In a factor analysis of all five Beck Youth Inventories, all of the anxiety and depression items plus most of the anger items loaded on one factor (Steer, Kumar, Beck, & Beck, 2005). However, other analyses revealed that children diagnosed with a mood disorder did score statistically significantly higher on the BDI-Y than children with diagnoses of anxiety, attention deficit, and disruptive behavior disorders (Steer, Kumar, Beck, & Beck, 2005).

DSM Symptom Interview

The DSM Interview is a brief interview of depressive symptoms based on diagnostic criteria of the *DSM-IV*. It is an extension of the Carlson-Swanson-Taylor Interview with Children for DSM ADHD/ODD/CD Diagnoses. Participants are asked

whether each of the symptoms has been a problem for them for most days of the previous two weeks. A copy of the DSM Interview record form is attached as Appendix A. The DSM Interview was used in the multi-stage screening process to eliminate participants from the screening process for whom depression could be ruled out. Participants were screened out at this stage if it became clear that they did not understand the questions of the screening questionnaires due to reading/language issues, if another disorder was clearly primary (such as anxiety or recent grief not preceded by depression), or if the participant was just having a bad day (an anomaly in the past two weeks). The DSM interviewer indicated symptom presence, whether the cluster of symptoms was consistent with a depressive disorder, the symptom duration, and noted any significant stressors shared by the child. Inter-rater reliability of the DSM Interviews has been assessed in the past using 20% of the interviews, resulting in a high correlation between raters on the depressive symptom score (r = .91) (Graves, 2006).

KSADS Interview

A semi-structured clinical interview, the Schedule for Affective Disorders and Schizophrenia for School Age Children-Present Episode Version (KSADS) (Puig-Antich & Ryan, 1986); was used as the chief measure of symptom severity and diagnostic tool in the Action Study. The KSADS was developed as a measure of the presence and severity of symptoms of DSM-IV, Axis I disorders, including depression (Puig-Antich & Ryan, 1986). The interview assesses the greatest severity of symptoms during the past twelve months along with severity over the past seven days on a five to eight point rating scale. The KSADS is a reliable diagnostic instrument for use with children (Ambrosini, Metz, Pabricki, & Lee, 1989). High inter-rater reliability for mood disorders (Last & Strauss,

1990) has been demonstrated with the KSADS, together with satisfactory internal consistency and test-retest reliability (Ambrosini, et al, 1989; Apter, Orvaschel, Laseg, Moses, & Tyano, 1989).

Procedures

Participant Selection Process

Participating Schools.

The Action Study drew its participants from two suburban school districts in central Texas. Both school districts are in ethnically and economically diverse communities. Fourth through seventh grade girls ages 9 to 13 in the two districts were screened as potential participants for the Action Study. Participants for this qualitative study were identified following screenings conducted at five elementary schools and one middle school during the Fall of 2006. Participants for this study were identified and recruited from each of the schools.

Selection Criteria.

Participants interviewed for this study were those who reported symptoms consistent with presence of a depressive disorder at the DSM Interview but who did not report a diagnosable depressive disorder during the KSADS interview. These participants may have received a diagnosis of another psychological disorder other than depression or no diagnosis at all as a result of the KSADS. Participants who were diagnosed with generalized anxiety disorder or oppositional defiant disorder were not considered potential participants due to possible overlap in symptoms of those disorders and depressive disorders (e.g., irritability) (Carey, et al., 1987; Stark & Laurent, 2001). Participants diagnosed with attention deficit/hyperactivity disorder (ADHD) were

considered appropriate for this study provided that symptoms reported at the DSM Interview were consistent with a depressive disorder.

Multi-Stage Assessment

Permission forms for the Action Study (approved by the University's Institutional Review Board for research with human subjects) were distributed to 942 girls in the targeted grades to take home to their parents. Teachers monitored the distribution and return of the permission forms. A copy of the permission form for screening is attached at Appendix B. Consent forms were returned by 670 girls. Of the 670 forms returned, 425 indicated parental agreement (i.e., "Yes") for screening and advanced to the first stage of screening.

Stage 1 – Screening Questionnaires.

A multi-stage assessment procedure was used for the Action Study as recommended by Kendall, et al., (1989). In a multi-stage screening process, successive assessment processes serve to screen out or remove from the subject pool all but those who are depressed. In School District No. 1, participants completed the CDI as the initial screening measure. Girls who scored at or above the clinical cut-off score of 16 proceeded to the next stage of assessment. In School District No. 2, participants completed both the CDI and BDI-Y at initial screening. Girls who scored at or above the clinical cut-off score on either measure, 16 on the CDI or 25 on the BDI-Y, proceeded to the next stage of assessment. Screening measures were completed by a total of 422 participants at this stage. A total of 114 participants scored above the cut-off score on a least one measure and advanced to Stage 2 of screening.

Stage 2 – DSM Interview.

A brief individual interview was conducted with each participant who scored at or above the cut-off score on a screening measure. Thirty-five girls who were clearly not depressed were ruled out at this stage. Seventy-nine participants were invited for a complete diagnostic interview. The DSM Interviewer contacted the girl's parents by telephone as soon as possible following the DSM Interview, usually on the same day. Parents were given feedback regarding their daughter's elevated questionnaire scores and symptoms. To standardize parent feedback at this stage, DSM Interviewers were asked to follow a prepared script, to the extent possible, in the conversations with parents. A copy of the DSM interview script is attached as Appendix D. The intervention was described to parents and a verbal request was made for permission to interview the daughter. The written consent form was given to the daughter to deliver to her parents and return to researchers via the school counselor.

Stage 3 – KSADS Interview.

Upon receiving written parental consent, the KSADS, a semi-structured diagnostic interview, was administered to both the child and one of her parents as the final step of the depression assessment process for the Action Study. Of the 79 participants invited for the KSADS Interview, 65 provided consent. Following parent and child interviews, summary ratings for symptoms were calculated based on parent and child symptom reports. Supervision was available to interviewers as they completed summary ratings and assigned diagnoses. Thirty-two girls who received primary diagnosis of a depressive disorder at this stage were invited to participate in the Action Study. Parents were given feedback about their daughter's symptoms following the

KSADS interview. For girls who received diagnoses other than depression, letters were sent to the parents confirming the feedback conversation, again noting the daughter's symptoms and referring the family to mental health providers in the community.

Identification of Potential Participants for the Qualitative Study

To identify potential participants for this qualitative study, I reviewed the diagnostic information for the 33 girls who did not receive primary diagnosis of a depressive disorder following KSADS. Of these girls, one received parent consent for the KSADS but chose to stop participation without completing the interview, while another dropped out after completing the KSADS. Eight had diagnoses deemed incompatible with the goals of this study, including post traumatic stress disorder, oppositional defiant disorder, and generalized anxiety disorder and/or were referred for additional evaluation. Two others moved to different school districts following screening. One girl was excluded based on the diagnostic interviewer's report that cognitive ability (corroborated by parent input) was too low for effective interviewing and participation in the Action Study. Finally, one girl who did not receive diagnosis of a depressive disorder but had residual symptoms of depression was included in an active treatment group in response to a request by the school counselor. Although her data was not used in connection with the Action Study, her continued participation in the primary study excluded her from this investigation.

The remaining 19 girls and their caregivers were invited to be interviewed for this study. Of those, 16 agreed to complete the interviews. Issues of communication and circumstance were barriers in obtaining participation from the other three families. Parents of two who declined participation were non-English speaking. One parent spoke

Vietnamese, did not have a telephone, and did not have a bilingual family member other than the child in the home. Another parent was Spanish speaking and had recently had a baby. Parents of the third child could not be reached by phone and did not respond to a permission form sent home with the daughter on two occasions.

Collecting the Data

Once the potential participants were identified, their parents were contacted by telephone. The research was described as a study aimed at learning more about parents' and children's experiences of participation in depression screening and assessment, and parental agreement for participation in the study was requested. Consent forms (attached as Appendix B) were provided and reviewed with the parent prior to the parent and child interviews. The child participants were presented with an assent for participation allowing them to agree to or decline participation prior to their interviews (attached as Appendix C).

Ethical Considerations

Research with children must be conducted with special care and attention to ethics to safeguard this vulnerable population. Particular attention must be paid to obtaining informed consent, protecting children's privacy, and protecting children from harm.

Safety Procedures

The Action Study provided an extensive set of safety procedures to address the safety concerns that arise when dealing with depressed youth. All of the participants in present study continued to be subject to the protections afforded participants in the Action Study because they were identified through procedures of that study. Following screening, none of the participants in the present study had need of the safety measures

set forth for the Action Study, therefore, the procedures are not set forth in detail here. Parents had the option of contacting me for information or referrals if concerns arose with their child following my interview of the child.

Confidentiality

In the Action Study, privacy of participants was protected by the use of subject numbers for participants rather than names. In this study, participants were assigned pseudonyms and new subject numbers (unconnected with subject numbers and data from the Action Study) for use in the written documentation of interviews and analysis. The limitations of confidentiality were explained to participants when they completed the assent form for the study. In keeping with the policies of the Action Study, the child was informed that general information about a child's functioning would be shared with parents. In one instance, with the child's permission, the parent was given additional feedback about the child's symptoms following the qualitative interview.

Qualitative Interview

A flexible, semi-structured interview format was employed to obtain information from participants. The interview guides presented below were based on a review of the literature regarding interventions for depression in children, depression screening, and parent and family factors related to child depression.

Interview Development

Prior to data collection, the interview was piloted with a participant identified from an earlier screening (Fall 2005), who had been through the minimum contact control condition of the Action Study and shown significant improvement by the end of the waiting period. She was a 9 year old fourth grader at another elementary school in

School District No. 2. She and her mother were interviewed regarding their experiences in the Spring 2006 with the purpose of refining hypotheses and testing the focus of inquiry. The interview was further refined in the first two pairs of interviews conducted in the data collection phase of the study. Concepts introduced in each interview were used to inform and direct subsequent interviews.

For the pilot and initial interviews, the parents were interviewed first so that the child could be asked about her responses to actions the parent reported having taken. The ordering of parent and child interviews was re-evaluated following those interviews and weighed against the necessity of completing the interviews in a timely fashion. Once permission for interviews was received, completing child interviews could be done quickly, since child interviews were conducted at school. Completing parent interviews sometimes involved more difficulty due to parent schedules and availability. The few additional questions generated by completing parent interviews first did not yield considerable information, and, thus, ten of the subsequent parent interviews were completed after the child interviews.

Child Interview

The child interview began with an explanation of the nature and topic of the study and answering any questions. To build rapport, the child was asked about her interests and hobbies, and other topics such as favorite subjects at school, friends, and family. Since the goal of the study was to find out about participants' experiences of the screening and assessment process, I began by reminding the child about the steps of screening/assessment so she might better understand my questions. I presented blank copies of the questionnaires completed at screening, and provided verbal reminders of the

brief interview (DSM Interview), the phone call we made to her parents, and the long interview (KSADS Interview). To elucidate participant responses to specific aspects of the screening and assessment processes, I found that it worked best to go through the screening procedures one at a time, first asking a very general, exploratory question about what it was like to complete that step and what they remembered about it. My goal in responding was to encourage participants to elaborate (e.g., "Tell me more about that." "What was that like for you?"). A guide with sample questions is provided in Table 3.

Table 3.
Child Interview Guide

Topic	Description	Example Questions
Experience of Screening/Assessment.	Child is asked to describe the experience of participating in screening and assessment.	Tell me what it was like for you to do the questionnaires and talk to the UT Action people in the interviews.
Questionnaire Experience	Child is asked to describe her experience in completing the self-report measures.	What was it like to answer all those questions about how you had been feeling?
DSM Interview Experience.	Child is asked to describe her thoughts, feelings, and reactions to the DSM Interview.	I don't know what it's like to be a kid and answer questions from an Action person. Tell me what it was like to talk with the Action interviewer that day.
Response to First Parent Feedback.	Child is asked to describe her response to the first feedback to parents that she seems to be experiencing "distress."	What did you think about the Action person calling your mom or dad?
Parent/Child Communication	Child is asked to describe conversations with parent following the DSM Interview.	What did your mom/dad say to you after the short interview? What did you tell your mom/dad?
KSADs Interview Experience.	Child is asked to describe her experience with the diagnostic interview.	Tell me what it was like to talk to the Action person in the long interview.

Parent/Child Communication	Ask the child to describe conversations with parent following the KSADS Interview.	What did your mom/dad say to you after the long interview? What else did your parent do?
Mood Change.	Child is asked to her mood at screening and at interview and what (if anything) changed.	How were you feeling the day we first talked with you? How were you feeling the day of the long interview?

Parent Interview.

After establishing rapport and explaining the nature and the topic of the study, a general question about their response to their first contact with the Action Study following the first stage of the screening process was used to initiate the interviews with parents. The parent was initially asked what stood out in her mind about having her child participate in the depression screening and assessment, and what it was like to receive feedback from researchers. Topics were covered as participants introduced them and participants were encouraged to elaborate. Sample questions are shown in Table 4.

Table 4.
Parent Interview Guide

Topic	Description	Example Questions
Parent Perceptions of the Child's Mood.	Is the parent's perception of the child's mood consistent with the Action information?	How did you think your daughter was doing when we first called you? How is she doing now?
Parent Response to Feedback.	Parent is asked to describe the experience of receiving information that his/her child is distressed.	What was it like for you when we called to tell you she seemed stressed/sad?
Parent/Child Communication & Parent Actions	What messages did the parent give following feedback?	What did you say to your daughter after we called? What did you do?
Parent Reactions to the KSADs Interview.	Parent is asked to describe the experience of completing the parent portion of the diagnostic interview.	What was it like for you to answer the questions about your daughter in the long interview?

Parent/Child Communication & Parent Actions	What messages did the parent give following feedback?	What did you say to your daughter after we called? What did you do?
Parent's Use of Resources	Parent is asked to describe what he/she does to deal with child-rearing concerns.	Tell me about the things you do to manage parenting problems.

Analysis of Data

Interviews were transcribed and analyzed for emergent themes and examined for the interrelations among themes in the grounded theory approach to qualitative analysis. In keeping with the procedures of the grounded theory method, data collection was alternated with data analysis so that concepts emerging in the analysis could be verified in subsequent interviews. Interviews were recorded, transcribed, and analyzed. The analysis consisted of open coding, notes and memos, axial coding, and selective coding. Open coding was completed on the first three interviews and preliminary categories were identified. Because all of the participants in this study completed the screening process within a four week period, completing the interviews while the experience was fresh in the minds of participants (particularly the child participants) was a challenge. I generated notes and memos following the subsequent interviews as a way of tracking the new concepts, comments, questions, and reactions generated for comparison with past interviews and refining future interviews. I interviewed two child participants and one parent a second time to gain additional information from them as the categories and themes developed.

The grounded theory method of analysis is also called the "constant comparative method of analysis," as it requires constant comparison across data items, concepts, categories, and data sources (Glaser & Strauss, 1967, pp. 101-116). In open coding,

transcripts were broken down into small units of data, or codes, that constitute discrete ideas or events. Concept labels were generated for codes in the first step of abstraction. As patterns in the data were identified, similar items were grouped together in categories (axial coding) based on similarities identified through constant comparison across categories and across interviews.

In axial coding, categories were created based on the conditions preceding events, the context in which experiences occurred, the strategies used to manage the situation, and the consequences that resulted (Strauss & Corbin, 1990). Links among categories were provisionally suggested with relational statements explaining connections among categories. Relational statements were subject to verification based on additional data and continuing analyses.

In the next phase of data analysis, selective coding, the goal was to identify higher order categories and a core category or "basic social psychological problem" (McCann & Clark, 2003). Connections among categories were identified and categories were refined. Once the core category was conceptualized, analysis focused on developing a theory to integrate the core category with underlying categories and subcategories. The core category is the central theme that explains much of the variability within underlying categories and makes sense of the data as a whole (Strauss & Corbin, 1998).

Validity

In qualitative research, rival hypotheses or alternative explanations for the phenomena observed are the threats to validity that must be addressed (Maxwell, 1996). The chief means of dealing with threats to validity in qualitative research is to collect evidence to render the alternative hypotheses implausible (Maxwell, 1996).

The reliability and validity of qualitative research is evaluated in terms of its trustworthiness on the basis of its credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). The credibility of a study refers to the certainty with which the findings can be viewed as accurate. The transferability of a study is the degree to which it is specific to a certain context rather than generalizable. The dependability of a study is a reflection of the reliability of the researcher's coding, and confirmability signifies the ability of a reviewer to inspect and re-check the procedures of data collection and data analysis.

The trustworthiness of this study was addressed by collecting data from various sources: child participants and their parents, questionnaires, researcher notes, and diagnostic interviews. In addition, within interviews, participants were asked to provide feedback to the researcher on the accuracy of categories and relationships generated in preliminary and ongoing data analysis. Their comments were incorporated to confirm categories and provide direction for analysis.

A particular concern for the validity of this study was the initial documentation of emotional symptoms in the child participants. In order to draw meaningful conclusions about the processes at work between the DSM Interview and the KSADS Interview, I felt that having participants confirm their emotional states at those times, to the best of their recollections, would be useful information. In order to address this concern, DSM Interviewers who conducted brief interviews with participants at the initial screening were requested to note whether or not the depressive symptoms documented in the DSM Interview were consistent with a depressive disorder. Data from the screening instruments and DSM Interview record form were compiled and are presented in Table 2.

A sample of integrated participant data including interviewer notes is provided in Appendix E. A summary of child and parent recollections of mood is provided in Appendix F.

CHAPTER FOUR

Results: Creating a Forum for the Child Perspective

The outcome of this study is a model of child and parent responses to child depression screening and assessment, as initiated in the school setting for research purposes. The processes revealed by the analysis showed that depression screening and assessment serves the function of creating a forum for the child perspective. This forum is created as the child's emotional state and concerns are brought to the attention of both the child and the parent. The child participants in this study report experiencing emotional distress or a sense of burden prior to the first stage of screening. The forum for the child perspective is created with in the child as she begins a process of reflecting on her emotions, beliefs, and stressors as she completes screening questionnaires and a brief interview. Many child participants feel a sense of relief or improved mood in response to talking with interviewers during a brief interview.

The forum for the child perspective is expanded as parents receive interviewer feedback about child emotions and concerns and begin to assess the information in light of their own observations and situational factors. The extent to which parent and child maintain the forum for the child perspective through sustained communication about the child's emotions and concerns influences the type and intensity of interventions subsequently introduced by parents.

This chapter contains a description of the background from which I approached this research and the process of development of the theoretical model. A detailed discussion and illustration of components of the model is set forth in subsequent chapters.

Quotations from the interviews are included to demonstrate the connections among abstract components of the model and individual experiences. Participant transcripts are referenced by number in brackets following quotations.

The Researcher's View Point and Biases

While it is not advisable to "take the reader on a tour of your changing perspectives on your topic," I am inclined to offer a description of experiences and knowledge from which I began this research to provide the reader with an additional information for evaluating the trustworthiness of the study (Bogdan & Biklen, p. 186).

My experiences with the Action Study over the past five years have influenced my beliefs about childhood depression and provided insights into child and parent perceptions of child depression. My role as a diagnostic interviewer has given me a strong basis in differential diagnosis. Thus, I have been accustomed to working with diagnostic categories and case conceptualizations. I have also had considerable experience in the challenges of eliciting diagnostic information from young clients/participants, including their difficulties in reporting time frames that cover weeks and months or just one day. I have interviewed the same child at different intervals during their participation in the Action Study, and I have seen them report little of their initial depression as time and their own emotional state distance them from the past. I have seen parents who were "in tune" with their daughters and widely disparate reports from parent and child.

My experience as a parent has been helpful in the past in diagnostic interviews with parents as a basis for empathy with parents, and that proved to be the case in these interviews as well. I know from first hand experience how difficult parenting can be, and

I found I could readily appreciate their insights and points of view as parents experiencing the screening/assessment process. On a personal level, the themes that emerged from this study (from both the child and parent participants) have influenced my priorities and strategies as a parent.

Development of the Model

One of the challenges for me in completing this research was to, as best I could, understand what was going on for the child participants at the time of the screening/DSM Interview and at the time of the KSADS Interview. Categorizing them according to their symptoms during the process seemed an important aspect for predicting how their experiences would generalize to others undergoing similar experiences in the future. I wanted to understand 'Who are these girls?' and 'What is going on here?' I felt I needed to verify, to some extent, their emotional state at the time of screening to improve the credibility of the data. While I considered and reconsidered the meaning of anxiety vs. depression and sub-clinical vs. false positive as I collected my early data, the themes and processes that would emerge were not readily apparent. My impression of two of the first three girls I interviewed was that mixed anxiety and depression had contributed to their high screening scores. Upon reflection about those early interviews, I realized that those two child participants had appeared anxious, and I had responded to their anxiety during the interview (despite my best efforts to put both them and myself at ease). Possible anxiety had been noted in the DSM Interview of one of the girls, but not the other. Chronicling my responses to the participants served as a source of data in that regard, which could be checked against themes emerging in the transcripts.

I struggled to determine how I could check child participants' recollections of mood in a time efficient and meaningful way as part of my qualitative interview. For the mood question, I adopted a simple method (suggested as a technique for use in diagnostic interviewing by Nadine Kaslow), of asking the girls to choose which face drawing best represented them on the day we (the Action team) first met them, at the KSADS interview, and on the day I met with them: the smiley face, the flat face, or the unhappy face (i.e. – ☺, 😐, or ☹). I added that question to my interview, and proceeded with data collection. As I became more immersed in the data and gained understanding of the meaning my participants ascribed to the events about which I was asking, my preconceived concerns about "diagnosis" and "depression" faded from the forefront.

The diversity of responses and experiences meant that the overall theme that would explain the outcomes following screening was not immediately apparent. As I compared the information from later interviews with earlier interviews, however, responses that had seemed like inconsistencies proved to be dimensions of categories. Inconsistencies within parent interviews came together as a category in of themselves. I had expected to omit from my data any participants I determined had not been depressed at the screening. However, the data did not provide a basis for such a distinction. The data instead demonstrated that the same dimensional processes of responding to screening/assessment are at work for children (and their parents) regardless of the diagnosis, if any, that is assigned. Including all of the interviews in the analysis provided a theoretical sampling across a greater range of experiences within the same model.

Open Coding

One of the critical concepts that emerged early on and became an organizing contextual condition within the analysis of the child interviews was the sense of carrying a *burden* and a nearly uniform (across interviews) sense of *relief* they felt from completing questionnaires and talking with Action interviewers. As Penny said, "It kind of felt good to get it off of my chest, because I didn't really want to tell anybody, but once I did it felt good because it was all a secret" [1]. The concepts of *emotional distress/burden* and *relief* were useful for understanding the experience of child participants. Several described the experience of talking with Action interviewers as "getting it off my chest" [1, 12] or of a weight "lifting off my shoulders" [4]. Others talked about how it felt good to talk and express feelings [1, 2, 7, 12, 14, 16] , saying things such as "some of the things I've been keeping a secret, and I feel good to get out now" [2]. In all, fifteen of seventeen child participants in this study described feelings of relief from talking with Action interviewers. Accompanying the relief was a new tendency to talk with parents or others about problems, according to many child participants [1, 2, 4, 12, 16, 17], and improved mood [1, 4, 5, 6, 7, 8, 11, 12, 16, 17] . Thus, communication with interviewers served to *facilitate child coping* with emotions, providing relief and improved mood for many and improved long-term coping for some.

Often, but not always, child *emotional distress/burden* appeared to be associated with some particular, ongoing stressor such as sibling conflict or parent divorce. To standardize post DSM interview feedback, relaying the major source of stress to parents was written in to the feedback script, since on many occasions it becomes natural to provide that feedback and parents sometimes request it. Thus, a relaying of *child*

concerns was built into the feedback and emerged in the data for this study in interviews with both parents and children.

Axial Coding

One of the challenges of this research was the need to collect data specific to the steps of the screening/assessment process in order to generate a meaningful understanding of participant responses to each step. By carefully questioning the participants as to their experiences at each step along the screening/assessment progress, I was able to collect data pertinent to each step. I believe this was an important aspect of this research, but it complicated data analysis somewhat, as I had three parties (child, parent, interviewer(s)) and five assessment stages (questionnaires, DSM interview or feedback, post DSM parent/child interaction, KSADS interview and feedback, and post KSADS parent/child interaction) to cover for each interviewee. As concepts and categories were identified, I found it useful to question or consider "what type of process is this" and "where did it originate?" I found that many categories pertained to intra-personal experiences, characteristics, and processes for parent and child and grouped them accordingly, such that intra-personal child categories for *perceptions/beliefs*, *behaviors*, and *coping* were identified. Similar intra-personal categories were identified for parents: *emotional factors, cognitive processes, beliefs, personal resources, and problem solving.* Concepts specific to the research processes were also grouped together generating categories for *questionnaires*, *permission forms*, *interview questions, and interviewer*.

Links among categories were suggested with relational statements to explain connections among categories and verified based on additional data and continuing

analyses. Relations among the intra-personal categories were often easily apparent in the interview data. For instance, a parent might evaluate (in a *cognitive process)* the post DSM interview feedback and determine it indicates a problem, regardless of what further information researchers provide later. Awareness of the new concern may lead to an *emotional* response such as worry. The parent may learn specific concerns the child has from the feedback or from the child through *parent/child communication*. The *belief* that a problem exists is likely to lead to *problem solving* within the contexts of *parent resources* (e.g., time) and *family resources* (e.g., money).

Relational statements exploring changes in parent *beliefs*, particularly *parent perceptions of the child,* as a result of parent/child communications and researcher/parent communications during screening and assessment highlighted the key role such changes sometimes play in responses to screening/assessment as parents engage in *problem solving*. Similarly, child participants reported changes in *beliefs* about themselves and understanding of their feelings in response to questionnaires and interviews. Potential for changes in a child's *understanding of self* and a parent's *perceptions of the child,* therefore, were identified as two other critical categories for understanding responses to depression screening and assessment.

During axial coding, the preceding conditions, context, strategies, and consequences related to parent/child communication were identified. The complexity of the parent/child communications during screening/assessment showed that for many child participants, the outcome of screening/assessment was related to the intervening actions and interactions in communication with parents following the DSM interview. In describing the conversation with her mother the day of the DSM interview and feedback,

Kamryn (a fifth grader who speaks Spanish at home) reported, "She asked me what I told ya'll, and I wanted to tell her; I told her, and she['s] awful good at helping me, and my problems have been helped" [12]. In contrast, mother of another child said, "...[Mara] was all excited, she was like, 'I might qualify for the Action program' like she'd just made the student council or something…..and here I am, my face just drops, and I was like, 'Oh no' [P2] . Relational statements explaining the connections among categories within parent/child communication and with other categories showed that *parent/child communication* was a critical category in understanding responses to depression screening and assessment.

Selective Coding

During the selective coding process, I endeavored to understand the data in terms of higher order categories. I found it useful to focus on the categories that produced participants' reports of change during screening and assessment in order to come up with a basic social psychological problem that conceptualized the process with greater dimension than 'depression screening and assessment.' Since I had identified processes grounded in the data that centered in the child, in the parent, and between them, I strove to articulate the unifying theme that encompassed them all. *Parent/child communication* and child *coping* processes, categories that emerged early on, were clearly critical to the model but not broad enough to encompass the data. From the parent perspective, "balancing individual and family needs,' captured much of the parent process, but not the child processes. Emerging from the language in the interviews themselves, I proposed an analogy with "providing a jump start" as a core theme for the processes sparked by depression screening and assessment. However, that theme did not capture the

complexity of the processes at work. By reviewing my research memos and relationships among categories, I discerned the concept of "creating a forum for the child perspective" which permeated the data.

As I identified the patterns and relationships among processes, I constructed diagrams to conceptually represent the model. I tested the data against the model on a case by case basis, making revisions as necessary.

Overview of the Model (Storyline)

Depression screening and assessment serves the function of creating a forum for the child perspective by raising emotional issues and child concerns to the attention of both child and parent for consideration and providing opportunities for their discussion with interviewers. The forum may continue in communications initiated by the child or by the parent. A variety of possible consequences result including changed child or parent beliefs, feelings of relief, improved mood, reduced report of emotional symptoms, improved child coping, increased parent/child communication, and interventions introduced by the parent.

Child participants in depression screening and assessment who score high on questionnaires and receive preliminary diagnosis of a disorder based on a brief interview report experiencing *emotional distress* and/or a sense of *burden* during the screening. Most report a sense of *relief* or *improved mood* in response to talking with interviewers about their emotions and concerns. Many of these child participants who screen out at the stage of the diagnostic interview appear to benefit from a latent resilience or *resourcefulness* that contributes to their ability to maximize the potential of the

screening/assessment process for themselves as they make use of the opportunities to talk with interviewers, generalize the experience to future *coping*, and engage in *self-advocacy* with parents around the issues raised.

Some children reflect on their *beliefs* about themselves as a result of completing questionnaires and interviews. Others are reminded of *concerns* that trouble them. In these ways they enter into the forum for consideration and discussion of their emotions and concerns. *Interviewer* comments, *characteristics*, and *questions* also influence child *beliefs* and *emotions*.

Even the signing of *permission forms* serves to re-emphasize the child perspectives as they prompt the parent and child to communicate about whether or not the next interview will be completed.

For the parent, a complex set of processes follows notification of the DSM interview outcome. They have a variety of *emotional* responses to the information as shaped by their beliefs. Parents take in the information received in post-DSM feedback and evaluate it in the context of all they know about their child. Thus they engage in *cognitive processes* that influence their *beliefs* about whether or not a problem exists. Parents then engage in *problem solving* to addresses the problems they and/or their children have defined. Their own *personal resources* and *family factors* influence the types of interventions parents undertake. Concerned parents may intervene in ways that affect *family factors* when they perceive a problem of high priority and they have sufficient *resources* to make meaningful changes. *Interviewer* comments sometimes change parent *perceptions of the child*, resulting in additional parent *problem solving*. In this group of participants, parent interventions over the long-term included reducing work

hours by one parent and obtaining private counseling services for her two youngest children by another parent. Where sufficient *time* is allowed, parent interventions can result in significant improvement even in a child experiencing significant *emotional distress* (i.e. – severe depression and anxiety).

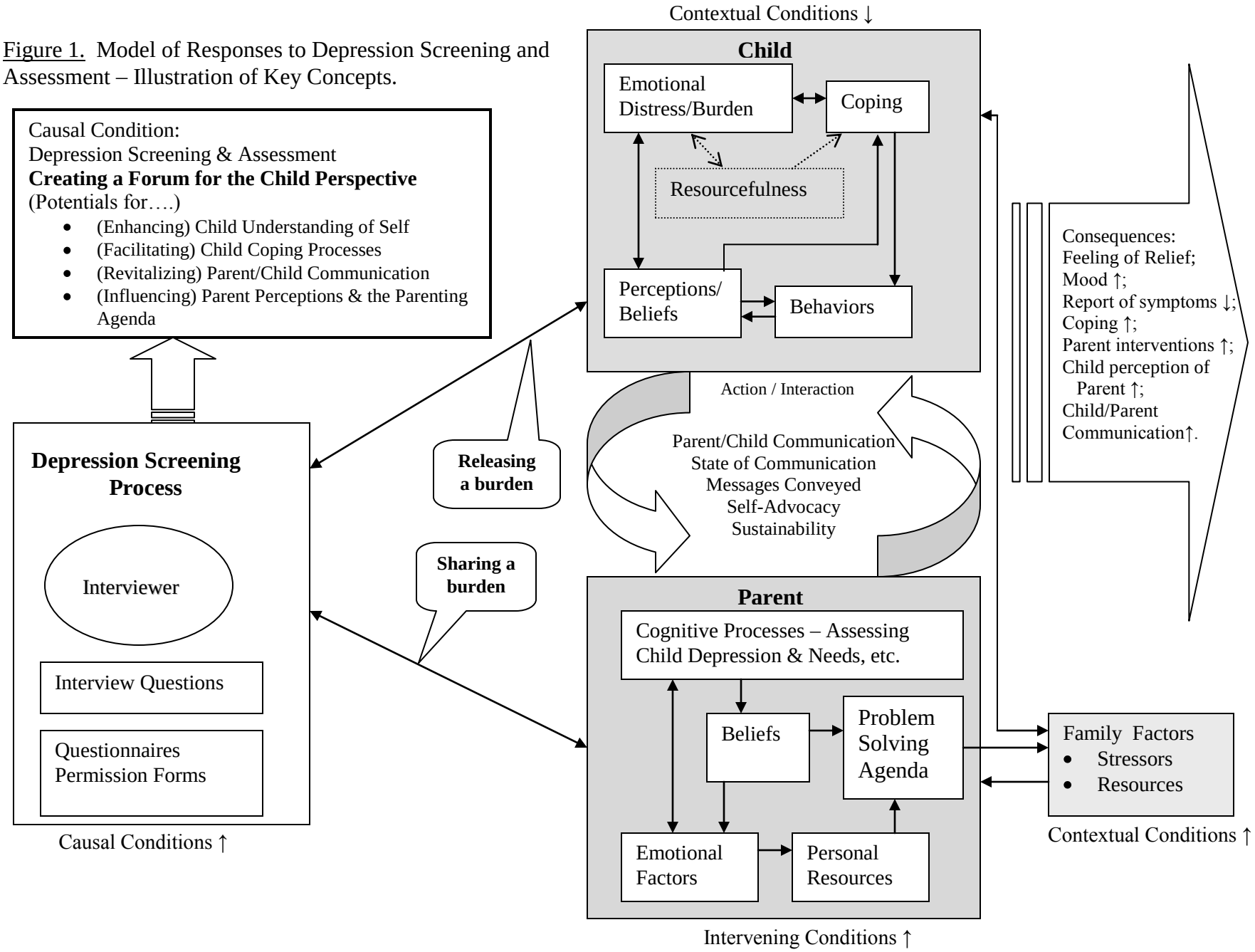
Parent/child communication during the screening/assessment process is influenced by the pre-existing condition of *parent/child communication* patterns. For instance, child comments that illustrate a *negative* or *positive* state of *parent child communication,* generally, appear to be related to the outcome of parent/child communications following screening. Whether or not parents typically use parent/child communication as *problem solving* strategy also appears to influence the outcome of screening. *Child concerns* raised in the conversations subsequent to interviewer feedback together with *parent messages* recalled by children also appear to play a role in the outcomes of screening/assessment. (The parent who communicates, "Talk to me" elicits a much different response than the parent who communicates "Oh no.") On a dimensional level, the *sustainability* of parent/child conversations following screening/assessment feedback (i.e., sustainability of the forum for the child perspective) seems to be a predictor of the outcome for the child. Where the child is not comfortable in talking with the parent and communication breaks down, the parent is less able to respond to child concerns.

Depression screening and assessment appears to be a serendipitous opening of Pandora's box. It sets the stage, or *creates a forum,* for the *child perspective,* including child emotions and child concerns. The degree of change for child participants depends on the success of the child and/or the parent in maintaining the forum for the child

perspective, either through intra-personal child processes, interpersonal parent/child communication, or through parent interventions.

The chief means through which depression screening/assessment has the potential to affect the child participants is by enhancing their understanding of themselves, improving child coping strategies, facilitating parent/child communication; and influencing parent perceptions and the parenting agenda. Examples from this data show that optimal outcomes can bring about remission of depression when the child and/or the parent succeed in maintaining the forum for the newly identified or emphasized child perspectives. A problematic outcome may result when the parent/child interactions following DSM feedback involve initial parent expression of considerable anxiety followed by a breakdown in parent/child communication about the screening as the child refuses to discuss it. Thus, the concept of a forum for the child perspective is broad in its implication that we have introduced a topic for debate, internally, within child and parent, as well as between them. What they make of it largely depends on factors they bring to the process individually and in relationship to one another. An illustration of the major concepts and processes involved in response to depression screening and assessment is provided in the diagram of the model in Figure1. Due to the number and complexity of processes involved, this figure represents a summary overview of the model. More detailed depictions of component processes are provided in subsequent chapters.

Figure 1. Model of Responses to Depression Screening and Assessment – Illustration of Key Concepts.



CHAPTER FIVE

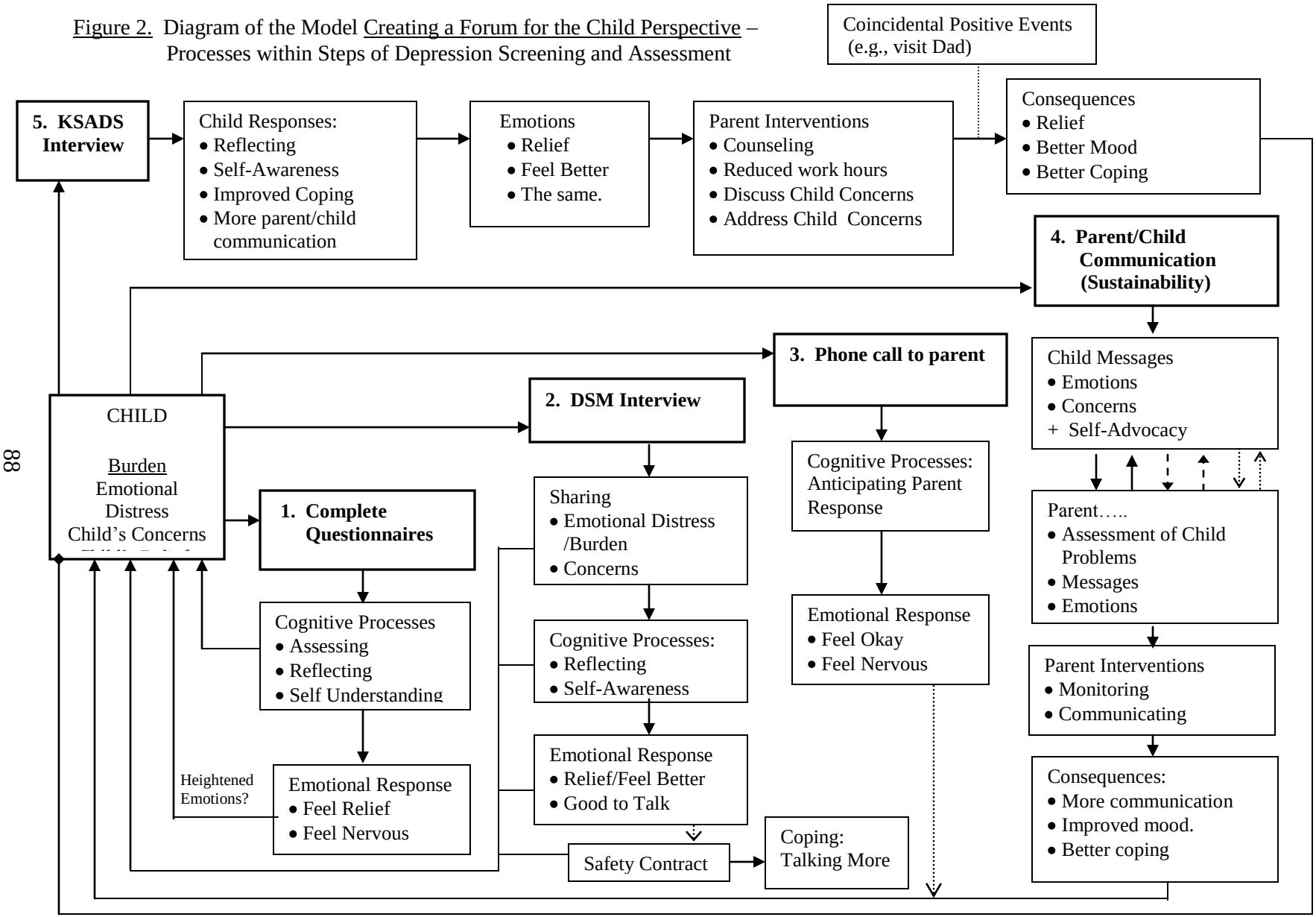
Discussion and Illustration: Components of the Model

The theoretical model derived from this study has four major component areas: experiences of the child; experiences of the parent; parent/child communication; and parent problem solving. These components of the model are discussed in subsequent chapters. Discussions of contextual conditions related to the model and the range of outcomes are also provided. This chapter is devoted to a discussion of contextual conditions for the model and components centered in the child's experience.

Relating the Processes to the Steps of Screening/Assessment

Because one of the goals of this study was to identify and explore aspects of the screening and assessment processes that promote change, the data were collected and analyzed pertinent to each step of screening and assessment. The discussions that follow illustrate the model and relate the model to specific aspects of the screening/assessment process whenever possible. A diagram depicting components of the model within the steps of the screening/assessment process in which they occur is provided in Figure 2. While the result is rather dense and does not give adequate emphasis to some of the major components of the theoretical model (e.g., parent/child communication), it provides an additional point of view for consideration of the discussion that follows. Constructed as a combined iterative/stepwise model, the diagram illustrates the sequence of potentials for change within the child presented by depression screening and assessment.

Figure 2. Diagram of the Model Creating a Forum for the Child Perspective – Processes within Steps of Depression Screening and Assessment



Contextual Conditions

In order to understand the experiences of the participants in this study, it is useful to understand characteristics of this group of children and their parents that serve as contextual conditions. The participants were recruited for this study because they screened high on the questionnaires, reported symptoms consistent with diagnosis of depressive disorder in the DSM Interview, but were not diagnosed with a depressive disorder following the KSADS interview.

Family Factors

A review of the SES data suggests that many of these families have stable living situations, in that parents of 10 of the 16 child participants are homeowners. In addition, every family reported at least one employed parent in the home. The child participants brought up stressors and concerns (i.e., parent's divorce, family conflict, etc.), but none brought up difficulties related to abuse, neglect, or severe psychological trauma. Nationally, 23% of children under the age of eighteen have parents who are divorced. Among children included in this study, only 17% of parents are divorced at present. The three child participants whose parents are divorced continue to have contact with and maintain a relationship with their fathers. Although some participants brought up problems related to members of their extended family, most of the parents and children reported extended family members as resources in their lives. Four families reported members of the extended family living in the home. Family homeownership, adequate family functioning (absence of reports of abuse and neglect), less than typical divorce

rate, on-going relationships with non-custodial parents, and relationships with the extended family are positive family factors that form the context for the child participants of this study.

Child Factors

Child Cognitive Factors

Only three of the sixteen child participants in this study had a history of academic difficulties. Overall, they appeared to be a group of typically developing children, cognitively and academically, based on parent report and informal observation. The extent to which some child participants were able to reflect on their thoughts, feelings, and behaviors in response to the screening and assessment experiences suggests that adequate child cognitive abilities play a role in a child's capacity to benefit from the process and may be a contextual condition for the processes identified in this study.

Child Symptoms

Depressive Symptoms.

All of the child participants endorsed symptoms consistent with diagnosis of a depressive disorder at the DSM Interview. For participants who were diagnosed with attention deficit/hyperactivity disorder or who appeared to experience subclinical levels of anxiety, a review of their symptoms as reported in the DSM Interview showed that all had symptoms specific to depression, such as sadness, suicidal ideation, and anhedonia.

Subclinical Anxiety.

The evidence of subclinical anxiety in some of the child participants emerged from the data. Those participants who had appeared anxious at the beginning of the qualitative interview were the same participants who reported feeling "nervous" or

"worried" throughout the screening/assessment process. They were the participants who were nervous in response to the questionnaires and nervous or worried during the DSM Interview, though they still might feel relief as a result of the DSM Interview. The participants described anxious emotional responses to most steps, despite also reporting benefits. In all, the transcripts of eight girls suggested they were experiencing subclinical anxiety characterized by a tendency to react with anxiety to new situations [2, 3, 5, 6, 11, 13, 15, 17]. For these girls, the KSADS interview might be "weird" or "scary" due to the novel situation. As one child said, "It was kind of scary…'cause I thought I was going to get in trouble…my teacher asked me to come outside, and…then when I went in there it was fine" [17].

All of the girls in whom I noted these consistent reports of anxiety in response to screening/assessment reported symptoms in their DSM Interviews which are specific to depression, rather than anxiety. The discriminatory symptoms included sadness, anhedonia, suicidal ideation, guilt, and negative self-esteem. I concluded that these eight girls had been experiencing mixed symptoms of depression and anxiety at the time of the DSM Interview. Three of these girls completed safety contracts as a precautionary measure due to reported suicidal ideation [2, 3, 17]. As a group, they reported relief from the DSM Interview [2, 3, 11, 17], positive benefit from parent communication or interventions [6, 13, 15], and relief from the KSADS Interview [3, 5, 13].

The presence of symptoms of both anxiety and depression may in part explain the presence of quite high questionnaire scores and the later KSADS finding of no diagnosis. Perhaps the combination of symptoms of anxiety and depression produces an acute distress in some participants that is relieved by the opportunity to talk to interviewers

and/or parents. At screening, this group of girls had the four highest BDI-Y scores of my sample and the three highest CDI scores in my sample.

Coping Abilities

Most of the child participants in this study could readily answer a question about how they coped with bad moods prior to their experience with depression screening/assessment [2, 3, 4, 6, 7, 9, 10, 12, 14, 15, 16, 17]. They named positive ways of comforting themselves, such as lying down with a teddy bear or going to their rooms to "calm down;" ways of distracting themselves by listening to music, watching TV, finding someone to play with, or trying to "think of something else" [17]. Some means of coping, such as taking a nap [2, 9] or eating a snack alone [12] appeared to indicate withdrawal, but overall they had some strategies for coping. The strategy that appeared to be missing from their repertoire was the strategy of talking with someone. It was not mentioned as a strategy used by any of these participants as a coping strategy prior to screening/assessment.

Resourcefulness

In considering why some children seem to benefit from depression screening and assessment, I noted that my participants demonstrated a latent resilience, which I chose to call resourcefulness, that appeared to be activated by the screening process. This resourcefulness was evidenced by some participants in their newfound plan to use talking as a coping strategy [2, 3, 4, 12, 16, 17] and by some participants' use of the experience as a basis for self-advocacy in communication with their parents [4, 6, 7, 9, 16]. Because of the effects of other factors (e.g., the pre-existing parent child relationships, subclinical child anxiety, parent emotional response to DSM Interview feedback, and parent

interventions) and perhaps because this group represents a truncated range (due to commonalities among them that cause them to "screen out"), connections between child resourcefulness and positive family factors and child factors are not clear cut. However, it seems likely that a connection exists. The resourcefulness I identified in the participants emerges within the context of some generally positive family and child factors that are worth noting.

Components from the Child's Experience

Initiating the Forum: Child Responses to Questionnaires

Depression Screening and Assessment creates a forum for the perspectives of it's child participants through processes triggered within the child and within the family. The forum is introduced in the first stage of screening, the completing of the CDI and/or BDI-Y self-report measures. Child participants reported varying responses to the questionnaires, including cognitive and emotional responses. Emotional responses varied dimensionally from positive to negative. Several reported feeling good or feeling relief while completing the questionnaires [12, 16, 17]. Kamryn explained, "I felt good, because I never really told people what I felt like…it was like taking everything off my chest."

Others experienced neutral [3, 9, 10, 15, 17] or even negative emotions [6, 11, 13] in response to the questionnaires. Meliah demonstrated a neutral response to the questionnaires, saying it was "nothing much; they just asked me about my life" [10]. Those who experienced negative emotions were typically nervous about the process, as illustrated by Violet's comment, "I was nervous because I didn't know which one I was going to answer" [13]. The questionnaires may be especially stressful for the girls who

are still developing their English literacy skills, even if help with reading and translating the questionnaires is provided. In the school in which the bilingual school counselor was an active participant in the screenings, she read the questionnaires to some of the girls and translated as necessary. One child said she felt "sad" when filling out the questionnaires, and explained that it was "difficult," saying, "I don't know how to read English," and went on to say that the counselor had read the questionnaires to the girls from her class. She said that she had understood the questions, but felt nervous about answering them even when she understood them [11].

The screening questionnaires appear to trigger cognitive processes of assessing (i.e., interpreting) and reflecting in the child participants. In assessing the questionnaires, Mara said, "I was like, what does this have to do with anything?" in reaction to the questionnaire item about frequency of stomach aches [2]. Another child commented that the format of the CDI questions was "weird" [13], and another said she thought, "Why are they asking me this?" [5]. The questionnaires prompt some child participants to reflect or "think back" [2, 4, 6, 16] on their emotions, behaviors, and stresses in their lives. In talking about the questionnaires, Tory described her thoughts:

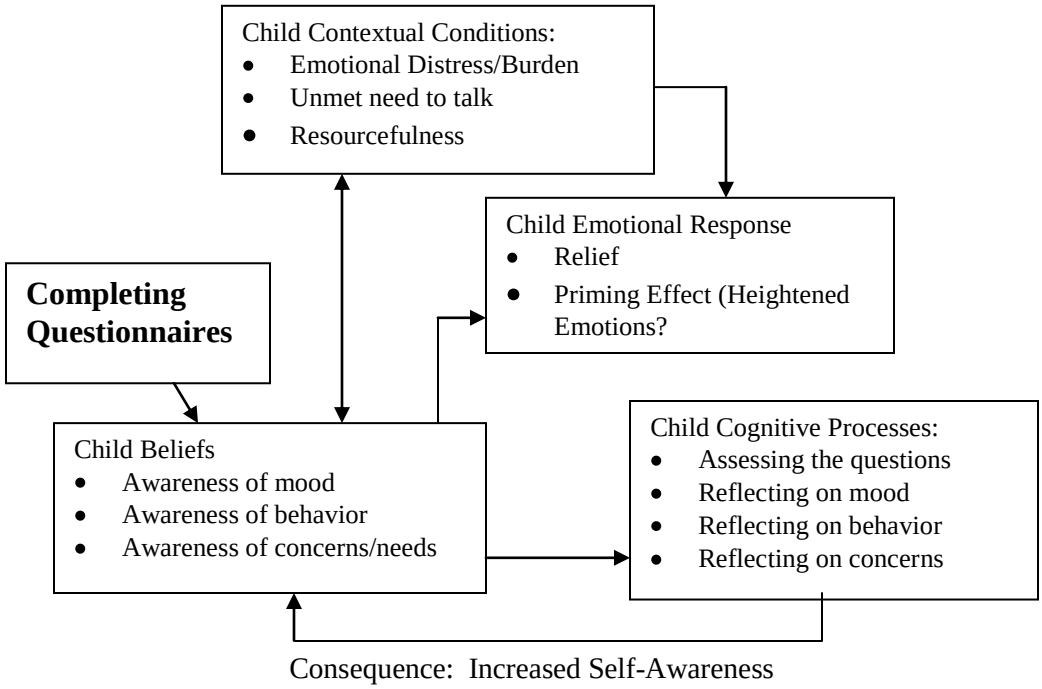
> I think they [questionnaires] actually helped me to see what I actually did. Once like I finished this paper I looked over it and actually read what I did….I kind of saw what I had been acting like…… to, like, see if I was mean to my brother or something [16].

Another child said the questionnaires caused her to think about her emotions, saying she thought about "what kind of person I am, like, since everything changes…if my friends move out of town, or my sister moves [to college]….how my life has changed ever since" [6]. Similarly, Jeannette reflected on her experiences and emotions, saying, "It reminded me of all the things that would happen to me, and how I was feeling…whenever I get

mad at my dad when he…cheats on my mom" [4]. One child indicated that she thought about her parents' reactions at this early stage of screening, saying her parents would "probably get pissed that I feel bad, when I do" [5].

In summary, for some child participants, completing the questionnaires appears to be a significant experience involving emotional and cognitive processes. The feelings of relief begin for some participants when they complete the questionnaires [12, 16, 17] and others reflect on thoughts, feelings, and experiences in ways that suggest a process of self examination and increased self understanding [2, 4, 5, 6, 16]. The experience of completing questionnaires is anxiety provoking for those who tend to be anxious [2, 3, 5, 6, 11, 13] and can prove especially stressful for a child who both tends to be anxious and does not read English [11]. A depiction of child responses to questionnaires is provided in Figure 3.

Figure 3. Model of Child Responses to Questionnaires:
Creating a Forum for the Child Perspective – Within the Child



Child Interview Experiences

Child participants in this study received a brief interview (DSM Interview) following the questionnaires and a KSADS Interview approximately one week later. The themes and concepts that emerged regarding these interview experiences indicated that the interviews are characterized by the same general properties.

Interviewer Characteristics

Interviewer characteristics were mentioned by several participants, although not to the degree expected. It may be that due to the age of these young respondents they had difficulty articulating aspects of the interviewer that were helpful. One girl said, "I felt good from that person," but she was unable to elaborate [7]. Due to the overall positive terms in which they talk about the DSM Interview experience, it seems likely that adequate interviewer warmth and empathy were contextual conditions (or causal conditions) for the experience. The child participants do contrast the experience of talking with interviewers to the experience of talking with their mothers. Sadie said she felt better "being able to talk to other people about it….besides just my mom; cause sometimes if I tell my mom something, she'll get really upset, and start yelling at me and be like 'why did you tell them this' and 'you can't do that,' 'well I don't care' and stuff like that" [9]. Similarly, Mara said, "I just don't like to tell [my mom] about a lot of things; I don't know why" [2]. Other's indicated that it felt good to talk with someone. Tory explained, "I felt good that I'm actually talking to somebody at least….I don't want to be one of those bad kids who kill people who they are mad at…I don't want to be that person" [16]. Knowing that the interviewer would maintain confidentiality was mentioned by one child. She said, "What made me feel happy was that I got to express

my feelings….without embarrassing myself…because I knew no one else would hear it, cause they would keep it to theirselves" [17].

Overall, child participants described an appreciation for the confidentiality, acceptance, and calm response interviewers provided and some contrasted it with experiences of talking with their parents. The strong positive emotional response many participants described to the DSM Interview and statements by some participants suggests that adequate interviewer characteristics are a necessary condition for the process.

Need to Talk

Having a desire to talk about feelings and problems and lacking the opportunity appears to be a contextual condition for the experiences these child participants reported. For example, Angela described her experience, "I wanted to share my feelings with someone, but I didn't know who to [talk to]" [17]. For some participants, a lack of time to talk with parents preceded screening and assessment. Lauren's mother was aware that she was having difficulty adjusting to her older sister's move to college, but Lauren said, "….usually we didn't talk about it, we would just talk about what my dad did at work and what my mom did in work, what I did in school" [6]. Mara's statement,"We don't really get to talk," referring to herself and her mother seemed to capture the experience of several participants who said they felt they did not have enough of their mother's time and attention prior to the screening [2, 6, 7, 9, 10, 13]. Thus, and unmet <u>need to talk</u> appears to be an additional contextual condition that may contribute to the salience of the screening/assessment process for these girls.

Sharing a Burden

Most of the child participants reported feeling better from talking with interviewers at the DSM Interview stage of screening [2, 4, 7, 8, 9, 11, 12, 14, 16, 17]. They sometimes talked in terms of "secrets" or "getting it off my chest" [2, 8, 12]. Although not all child participants recalled discussing concerns or stressors during the interviews in addition to their feelings, a review of the DSM Interview forms showed that all participants named at least one concern in addition to mood. I conceptualized the content of interviews as sharing a burden due to the description of the experience provided by participants, namely the feeling of a weight being lifted. Eleven of the sixteen child participants reported that they felt better after talking with interviewers in the DSM Interview. Similar feelings were reported by three other child participants following the KSADS interview. The presence of subclinical anxiety and reports of nervousness during the DSM Interview appeared delay their positive response to interview experiences until the KSADS. Some children named more than one concern. The consequence of sharing the burden was conceptualized as relief. The concerns they named included severe mood symptoms and self-harm behaviors, as well as academic problems, interpersonal conflicts, and interpersonal losses. Although as psychologists, we would call these concerns stressors, the concept of a child concern seemed to better capture the process of both child and parent participants' experiences with the stressor information in screening and assessment. For instance, parents were often aware of stressors, but unaware of the extent of child emotional responses to the stressors. Speaking in terms of the child's concerns reflects that the information gleaned from the interviews is from the child's perspective. For instance, a mother may know her child

misses her deceased father, but underestimates the effects of that loss because she knows her daughter can barely remember her father at this point [3]. Thus, the child's concern (continued feelings of loss for her father) is the new information highlighted during screening and assessment. Examples of child concerns are listed in Table 5.

Table 5
Examples of Child Concerns.

Interpersonal	
Conflicts	*Losses*
Peer Conflict	Father's Death
Parent Marital Conflict	Sister Moved to College
Sibling Conflict	Parent's Divorce
Family Conflict – Extended Family	Need More Time with Mom/Dad
Negative Parent/Child Interaction	Friend Has Cancer
Conflict with Extended Care "Teacher"	Recent Move/Katrina Evacuation
	Friend Moved Away
Mood Stress	Academic
Severe Sadness	Difficulty with Math
Self-Harm Ideation or Behavior	Difficulty with Reading

The majority of concerns named by these participants were interpersonal in nature, and involved either conflict or loss. These interpersonal concerns vary dimensionally as to duration, from time limited to chronic. Many of these children named significant losses that had become chronic stressors, such as father's death or parent's divorce. In fact, most of the stressors they named appeared to be chronic in nature. The presence of emotional distress and concerns (i.e., burdens experienced by the child participants) are contextual conditions for the depression screening/assessment process described in this study.

The type(s) of concerns reported by child participants seemed to have little relation to most other categories identified in the analysis. The concern initially raised by the child appears to have less impact on parent reaction and parent problem solving than

the way the "problem" is defined by the parent and child together. There is some evidence in the data that parents may less receptive to concerns raised by the child when those concerns are dissatisfaction with the parent/child relationship or sibling relationships, particularly in the absence of another major stressor [2, 3, 7, 9]. However, these were cases in which parent/child communication was strained during screening/assessment, and lack of parent responsiveness may have been related to unsuccessful communication attempts in some cases [2, 3].

Safety Contract

Six of the girls endorsed some level of suicidal ideation or self-harm behavior in the DSM Interview. The research protocol safety procedures were followed at that point, and assessment of intent and risk was undertaken by the interviewer and may have included consultation with supervisors and/or the school counselor. Four of the girls who participated in this study completed written safety contracts on which they would have been required to list the adults they would talk with if they felt unsafe. Three of these girls were among those who said or demonstrated in the qualitative interview their intention to talk with adults as a way of managing their feelings in the future. The safety assessment likely led to increased interview time and procedures (i.e., completing the safety contract, possibly meeting with school counselor). The safety contract is a written plan for coping, a plan which these girls professed intent to follow in more general circumstances of emotional distress rather than only upon suicidal ideation or self-harm ideation. The outcome for these girls suggests that completing the safety contract (within the context of the therapeutic experience of the DSM Interview) helps them internalize talking as a means of coping with emotions.

Angela said that after the screening/assessment experience that included completing a safety contract, she has relied more on her mother when she is upset. She said in the past if she was sad or upset, "I would just go home and I would try to think about something else," whereas now, she said, "If I feel sad or upset, I'll tell my mom and she'll calm me down" [17]. She indicated that the screening experience helped her become more comfortable talking about emotions. She said, "I think it's because it helped me express my feelings more. Because I used to be really shy and I really didn't like playing around anyone; and now I'm just happy" [17]. She described a shift in her thinking in response to situations where she feels mad or sad, times that in the past had sometimes led to suicidal ideation. Rather than getting caught up in the emotional response to her mistakes, she said, "What usually I think is like, 'Oh, I should have done this instead of that,' but maybe it will change in the future if that happens again; I can do *that* instead of what I did…..like if I hit my brother 'cause I was really mad" [17].

Cognitive Processes

Although the emotional response to the interviews seemed to be the most significant aspect of the experience for the child participants, they also engaged in cognitive processes of reflecting on their feelings and behaviors. For Jeannette, the DSM Interview led to the realization that she wanted to talk about her feelings, "It made me….more like I wanted to tell my mom, like how I felt, like more than what I had already told her" [4]. Similarly, Tory realized, "…..I do want to talk more" [16]. Others engaged in reflecting on their feelings in processes akin to those described in response to the questionnaires. For example, Patrice said, "Some of [the questions] I really had to think about" [5]. Lauren was comparing her DSM interview responses to

the questionnaires as she answered the questions, "…I was wondering if I answered the questions wrong kind of, like if I answered something else from the person, and then the sheet [questionnaire], like different answers" [6].

DSM vs. KSADS Interview Experiences

Girls who reported feeling much better after the DSM Interview said that the KSADS interview was not as useful since they were feeling better by the time they completed the KSADS interview. One attributed it largely to the conversations she had with her mother during the interim [12], while the other attributed her improved mood largely to the experience of talking with the DSM interviewer [11]. Many girls who felt better following the DSM Interview reported similar feelings following the KSADS Interview [2, 3, 4, 7, 8, 14, 16, 17]. Several who described feeling "nervous" in response to the DSM Interview said they felt "good" from the KSADS Interview [3, 5, 13]. Those with symptoms are a diagnosis of ADHD [7, 9, 10, per KSADS; 15, per physician diagnosis following screening] generally described the experience of the KSADS in neutral terms, except to say that it was "boring" [7, 9, 10, 15]. For Jeannette, who had felt better after the DSM Interview but not talked openly about her concerns (home situation), the KSADS interview was a very positive experience. She said, "I felt more like something kind of lifted off my shoulders…I had to get it out, but I didn't know who to get it out with, and I guess I got it out with ya'll" [4].

New Insights

Interviewer comments and questions were validating or helpful for several girls. Patrice remembered telling the interviewer about a situation with one of her friends and recalled, "She said I was a really good friend…and I, like, I don't know, I felt really

good" [5]. The interviewer's questions about symptoms prompted two girls to reflect on their behaviors. Violet realized that her lack of communication with friends sometimes contributed to her bad moods. She said she realized in the KSADS Interview "that it's better to tell [your friends] what's going on than keep it a secret" [13]. Tory realized that by skipping breakfast she had been eating less since her parents' divorce. She gained a new understanding of her role in conflicts with her brother as she answered questions about the times she is in bad moods. She explained, "I found out that most of the things I do, I'm like either being mean to my brother, or like teasing him or something; and then I always get in trouble…and it's my fault…" [16]. Tory said she found a comment the interviewer made to be helpful. "She said, 'Maybe you should talk to your mom and ask her some questions'….and I did and [my mom] helped me understand part of the divorce' [16]. Although new insights as a result of the KSADS were only mentioned by a few child participants, they seemed to be a significant part of the experience when they occurred.

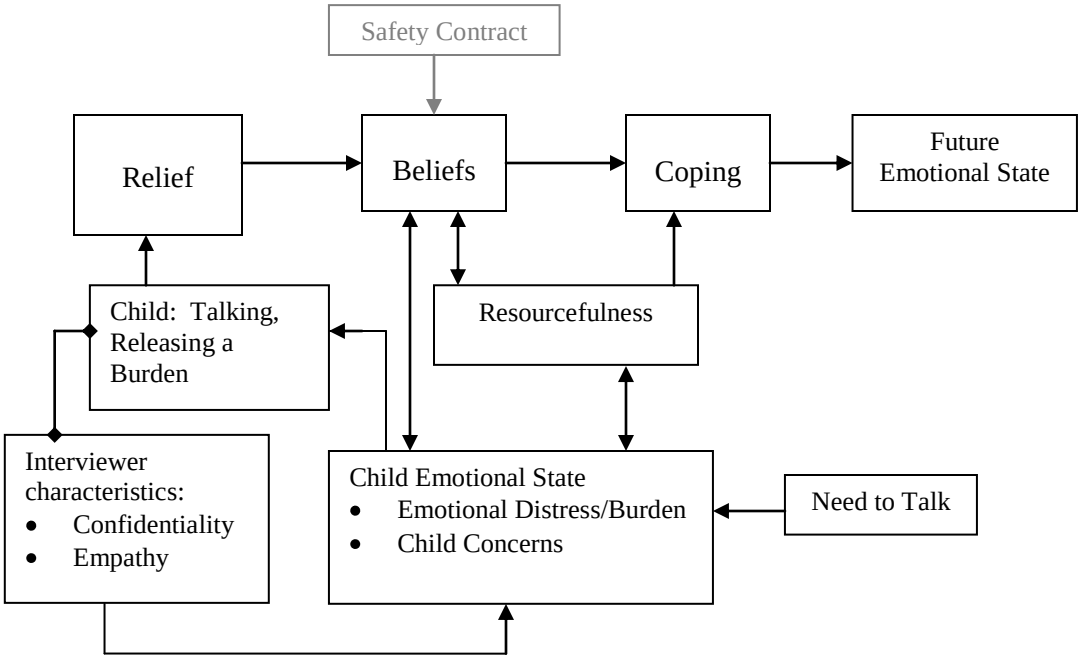
Summary: Components of the Child Interview Experience

In summary, the interviews involve a significant feeling of relief for many of the child participants in this study (14/16). A sense of relief reported following the DSM Interview is typically accompanied by a recollection of improving mood that occurs between the DSM Interview and the KSADS Interview (9/16). (One participant who reported relief without a recollection of improved mood recalled being "happy" on both interview occasions, despite quite high scores on screening measures.)

The interviews occur within the context of child participants who are burdened by emotional distress and specific concerns (stressors) that are sometimes coupled with an

unmet need to talk. The experience of an interview becomes a causal condition for relief as the interview experience expands the forum for the child perspective that was begun as an internal process for some participants with the questionnaires. In the interviews, they find a forum for discussion of emotional distress/burdens and concerns. Interviewer characteristics such as acceptance appear to facilitate the process, though these young participants had difficulty articulating their responses to interviewers. Cognitive processes play a role in the experience as participants reflect on their feelings and behaviors, in some instances leading to a realization that they want to talk more about their feelings. The signing of a safety contract in the context of the brief interview may be effective in promoting the using of talking about feelings and problems as a way of coping in the long term. The key concepts involved in the child's experience of the interviews are depicted in Figure 4.

Figure 4. Model of DSM and KSADS Interview Processes (Child Participants).



Child Response to Knowledge of Post DSM Interview Feedback

Reactions in child participants response to being informed of the procedure for post DSM Interview feedback seemed to be largely determined by the existing state of parent/child communication. Where parent/child communication was at a low level according to the child report, child worries about the feedback appeared to be amplified [2, 3, 5, 6, 9]. Lauren explained:

> Well, I felt like my mom was going to say, 'you felt this way?' 'You felt that way?' 'You felt kind of different than the other girls?' And [I was thinking] like, 'Oh, I wonder what my mom's going to say, what are they going to call her to tell her about….what's the note going to say…I'm wondering' [6].

Patrice, a sixth grader, said simply, "I thought I was in trouble," whereas Sadie was "kind of nervous that ya'll was gonna tell her everything I said…." [5, 9]. In contrast,

even participants who expressed nervous reactions during other parts of the screening process indicated little concern about the post DSM feedback if they reported a high or positive level of parent/child communication [13, 15, 17]. Violet said, "She always asks me what I did in class today, so it was okay." In all, nine of these sixteen participants indicated they were comfortable with DSM Interviewers providing feedback to their mothers [4, 7, 10, 12, 13, 14, 15, 16, 17]. The concept of parent/child communication is discussed further below.

CHAPTER SIX

Components from the Parent's Experience

Components of the model creating a forum for the child perspective emerged from the parents' descriptions of their responses to interviews, interview feedback, and their means of making sense of the experience. The screening and assessment experience for parents was marked by three events: feedback from the DSM Interview, parent/child communication following the DSM Interview feedback, and the parent KSADS Interview/feedback. The DSM Interview feedback appears to spark emotional responses and cognitive processes that may continue throughout the assessment/screening process and beyond. The two occasions that involve contact with researchers appear to be characterized by fairly distinct responses, therefore, they are discussed separately.

Parent Response to DSM Interview Feedback

Following the DSM Interview, parents were contacted by telephone for feedback and to request permission for the KSADS interview. The forum for the child perspective, thus, was expanded once again, this time to include the parent. The initial parent responses were exemplified by internal emotional and cognitive processes.

Emotional Response

The parents' emotional responses to the DSM Interview feedback were categorized as positive (not concerned), neutral (surprised), and concerned. Concerned responses varied dimensionally as to intensity and were typical or intense.

Positive Emotional Response.

Only one mother reported a positive emotional response to the DSM Interview feedback, saying that she "felt comfortable with the situation" and was not "concerned" that her daughter was depressed [9]. Her positive emotional response was appeared to be closely linked with her beliefs about what her daughter needed, her confidence in her assessment of how her daughter was doing, and her assessment of situational factors. In the case of this family, Sadie had changed schools only two weeks prior to the screening, and her mother felt she was "transitioning" [9]. In addition, she saw the screening as meeting a need for her daughter, "I know she needs someone to talk to….It's always nice to have somebody that you can talk to if you can't talk to your parents" [9]. She talked about concerns that she has for her daughter, but explained that she had "no concerns about her well-being" in terms of depression. This mother's positive emotional response to the screening appeared to result from her positive assessment of her child's overall emotional state, her belief that her daughter was simply going through an adjustment, and her assessment of the screening as meeting a need for her daughter. Her cognitive process of assessing the situation resulted in a positive emotional response.

Neutral and Concerned Emotional Responses.

Most parents report feeling surprised (a neutral response) [3, 6] or concerned following the DSM Interview feedback [7, 10, 11, 14, 15, 16, 17]. Said Tory's mother, "I was concerned….but I was glad that somebody had identified something that I need to take care of" [16]. Her response indicated a typical level of intensity.

Intense Emotional Responses.

Two of the mothers talked about intense emotional responses to the DSM Interview feedback. Janine's mother said, "It made me cry, because she put on the [note] after the ticket [traffic ticket for not wearing seatbelts], she told me [wrote] she want to die, because for her fault they got a ticket" [14]. Mara's mother also had a strong emotional reaction to the feedback, saying, "It made me nervous and sad and depressed…..I guess I started thinking, 'What have I done wrong? Or is there something I could have done,' you know, 'Is it something that I did bad?' or whatever" [2]. Mara's mother seemed to assess the information that her daughter was experiencing emotional distress and find fault with herself, a belief that resulted in guilt and self-blame in her immediate response.

Interaction of Emotions and Cognitive Processes

Whereas most mothers engaged in a process of assessing the DSM feedback in terms of what they knew about their daughters' mood and situation, Mara's mother, Lisa, was overwhelmed. She received the news of the request for the KSADS interview from her daughter after school, prior to the phone call from the DSM Interviewer, as was the case with several of these participants. This is the mother who described her reaction to her daughter's statement of possibly qualifying for Action as "…..and here I am, my face just drops and I was like, "Oh no" [2]. She indicated that she tried to modulate her reaction after her initial response, because she didn't want her daughter "to think it was a bad thing," but her attempt to discuss the DSM Interview with Mara later that day was met with resistance.

In Mara's case, several factors appear to have contributed to her mother's difficulty in processing the information, including Lisa's internal emotional state, that is, her admitted tendency to "worry" or be anxious, the unexpectedness of the news, and the type of concerns Mara shared in the DSM Interview. Mara's concerns included sibling conflict and a need for more of her mother's attention at home. Although some other parents were able to respond productively to these kinds of concerns [5, 7, 9, 10], parents may find it easier to make sense of the screening information when the child's experience includes stressors more readily identified by the parent, such as a recent move [9] or Hurricane Katrina evacuee status [10].

Lisa's emotional response, which was related to her pre-existing emotional state (grouped together in the model as emotional factors), negatively affected both her communication (parent/child communication) with Mara about Mara's concerns and her ability to engage in problem solving to address those concerns. Because the parent/child communication process was adversely impacted when Mara refused later to discuss her concerns, Lisa's ability to gain input from her daughter later to fully assess the situation was limited. Instead, she waited for the KSADS interview and feedback to help her make sense of the situation.

Parents who were concerned by the DSM Interview feedback and had emotional responses of a typical level of intensity were the greatest number of parents [7, 10, 11, 13, 15, 16, 17]. Parents from this group engaged in the most active problem solving and introduced the highest intensity interventions following screening/assessment.

Parent Cognitive Processes

In discussing their reactions to the screening/assessment process, parents described cognitive processes which were conceptualized as assessing, reflecting, and problem solving. Nearly all parents engaged in their own assessment of the situation following DSM Interview feedback, including consideration of the child's mood, family stressors, and child concerns. Some parents reflected on past family stressors, the new information presented from child concerns, their experiences with their as children in relation to their own parents, and their past interactions with the child. Parent processes of assessing, reflecting, and problem solving are significant components of the model for continuing or attenuating the forum for the child perspective. Parent problem solving following screening was undertaken by many parents to address the problems defined through their own assessment and in communication with their daughters.

Parent Cognitive Process: Assessing

Parent Assessment of Child Depression

Most of the parents interviewed considered their observations of their child's mood as a first step in assessing the information provided following the DSM Interview/feedback. Several mothers commented that their daughters have labile moods, describing depressed moods that last for brief periods of time [2, 3, 7]. Mara's mother said, "It may take an hour, or it may take a couple of hours, but within the day, she's over it….she doesn't mope around and get depressed for long periods of time" [2]. Similarly, Madison's mother said,

> "She….can have a good day one day, and the next day, everything is just too overwhelming for her….It changes…within 15 minutes…she can run to her room, and she's mad at the world and 15 minutes later she comes back and she's a different person, you know?" [7]

Some of the parent's frustration in dealing with child moods was evident in the response of Stephanie's mother to question, 'Do you think your daughter was sad?' She said, I do *think!* I mean every damn day she might be down, but, I mean, most of the time she's a pretty happy kid" [3]. These mothers considered the fairly short amounts of time their daughters experienced observable moodiness as typical for a child. Parents also considered their own knowledge of depression and situational factors. Several mothers attributed their daughter's high questionnaire scores to recent (or fairly recent) events/stressors such as parents' divorce, father's death, a recent move, extended family members moving into the home, sister's move to college, terminal cancer diagnosis of the child's best friend, or a racist school environment [16, 3, 9, 14, 6, 17, 13].

In part based on the feedback provided following the KSADS Interview, most of the parents said their daughters were not depressed and had not been depressed at the outset of the screening process. Parents who experienced intense sadness or anxiety in response to the post DSM phone call readily accepted the news that there was no diagnosis. Several parents used the words "adjusting" or "transitioning" as they talked about their daughters and ongoing family situations [9, 14, 6]. Said Tory's mother, "I thought she might be stressed, but sad, no, unhappy, no" [16]. Meliah's mother determined that she had "just had a bad day" on the day of the screening [10]. Three parents used the words "sad" or "depressed" to describe their daughter's emotional state at the beginning of the screening process. Ilse's mother was not surprised by the DSM Interview feedback, saying, "She looked sad" [11]. Parents of the girl who is stressed by her friend's cancer diagnosis said that she was sometimes depressed because of it [17],

and the mother who perceives a racist school environment described her daughter as sometimes sad [13].

Most parents interviewed, regardless of how they eventually defined the issues, determined that the feedback and request for the diagnostic interview signaled a problem of some kind and set about solving it. For example, although Meliah's mother determined that Meliah had "just had a bad day," she was quite concerned about her and reduced her work hours following the screening in response to Meliah's concern about not having enough time with her. In the instances in which the parent decided to "wait and see" what the KSADS Interview showed, the parents introduced fewer and less intensive interventions [2, 6].

Parent Assessment of Child Concerns.

In addition to engaging in a process of assessing their child's mood and situation, parents assess child concerns raised in interview feedback and in conversations with the child following feedback. In this role, parents exercise considerable power in defining reality for their children. They stand in judgment of child concerns and determine their merit. Stephanie, for example, still feels sadness about the loss of her father from time to time, which her mother doesn't understand since "she can't really remember him anymore" [3]. Madison's concern was that her mother pays more attention to her younger brother and sister than to herself. Her mother's response (according to her mother) was, "It's not all about you…I have to take care of everybody else, too" [7]. She explained, "I've never done anything intentionally, you know, to make her feel left out." Nina was distressed about difficulties with a teacher in the after-school program. Her mother arranged a meeting to discuss and resolve the problems, much to Nina's relief [8].

The parent's ability to be responsive to child concerns depends on the parent's assessment that the child's perspective is valid.

Parent Cognitive Process: Reflecting

Parents reflect on past experiences in considering interview feedback, their child, and their priorities as parents. They mentioned reflecting on their experiences in parenting their older children, their experiences as a child, their experiences of family stressors, and managing competing needs of various family members [7, 9, 10, 12, 13, 14, 15, 16, 17]. Managing the competing needs of family members often presents a dilemma for these parents. While many of these parents seem to be aware of and reflect on competing needs, they struggle to manage them. The outcome often seems to be a denial or rejection of the child's emotions when those emotions relate to situations that can not be readily changed [5, 7, 9, 11, 14].

Parent Cognitive Process: Problem Solving

All parents interviewed engaged in problem solving in response to screening and assessment. Problem solving is discussed in detail in Chapter Nine.

Parent KSADS Experience

Several parents cited interviewer feedback following the KSADS that influenced their beliefs and strategies following the interview. Parents recalled interviewer comments about child concerns, insights on child behavior or parenting, and consistency of parent and child responses.

KSADS: Consistency of Parent/Child Responses

Parents felt validated when KSADS interviewers told them their responses matched their daughter's responses [2, 6, 9, 15, 17]. The consistency of responses

appeared to be reassuring to parents. For the parent who was very anxious following the DSM Interview feedback, the KSADS interview itself was anxiety provoking, but positive feedback about consistency and about her daughter's mood were a relief. Lisa said, "My first thought every time they gave me a question is, 'Oh, what did she say to this?' She had this to say about the consistency of their answers, "That made me feel good, that I answered the questions honestly and that they matched her answers" [2]. Other parents reported positive comments made by interviewers. Angela's father summed up the KSADS interview, "If anything, just a lot of it was a reaffirmation that we were on the right track and doing the things that we were doing to help her through this [friend's illness]" [17].

The often startling DSM Interview feedback is contrasted here with an often validating (among these parents, at least) experience of receiving KSADS Interview feedback. The screening/assessment feedback experience for parents differs from the recommended means for providing feedback for parents in a therapeutic assessment situation. In a therapeutic assessment, the parent is initially given feedback that is comfortable and consistent with pre-existing knowledge about the child, with difficult or new information provided later. In may be a mark of resilience in these parents, as a whole, that they are so well able to respond to startling new information about their child resulting from the DSM Interview feedback.

KSADS: New Insights

Two parents reported insights they had gained from the interviews about interacting with their daughters. Although these were uncommon in the group as a whole, in the instances in which these occurred, the parents indicated that the

understanding they had gained of their daughter through the interviewer's comments was affecting their parenting strategies in an ongoing way. Interviewer comments reframed the meaning of Madison's behavior for her mother. she did reconsider the meaning of some of Madison's behavior based on the interviewers comments:

> You know, how I told you how she can really just go from one extreme to the next. . . And she does it here at home, but she won't do it around her dad, you know? And. . .it's very rare that he raises his voice to them…When I had this interview, you know, and [the interviewer] said, 'It's good that she can vent that out, that she feels safe enough to. . . show her emotions and stuff at home. So I've kind of been trying to really think that… 'okay, she needs to be able to let it out and not hold it in, you know….it's okay if it has to be me, so. . . [7]

Madison's mother indicated that she has done more to "give her a chance to talk…but not… have an attitude…" [7]. In addition, the idea that Madison's "venting" was an indication of closeness has led her parents to increase the amount of time the children spend with their father [7]. Madison's mother seemed to be making sense of her experience as she discussed it with me in the qualitative interview.

Another parent found guidance in the interviewer's comments. Janine's mother said, "[The interviewer] told me, well, I'm doing right, I'm doing right; but I need to understand [Janine], too, I need to talk to her." She said she is encouraging her daughter to talk with her, "And I say, 'You need to tell me what you feel'" [14]. Although Janine and her mother had a difficult (strained) communication following the KSADS interview, her mother worked at understanding why her daughter had not talked with her about her feelings. She concluded that her daughter had not told her because she anticipated an unsympathetic reaction. Janine's mother was struggling with how to be responsive to Janine's feelings (a desire for her own room and space) when the family's situation would not allow it at present (older sister with three small children had moved in). The

interviewer's comment about the need for understanding was something she continued to consider.

KSADS: Information About Child Concerns

In some instances, the parent reported having a better understanding of the child's symptoms and concern's due to the feedback following the KSADS interviews [2, 9, 14, 16]. For instance, Sadie and her mother had not talked specifically about her concerns following the DSM Interview, but her mother heard Sadie's concerns from the KSADS interviewer. They had a productive (sustained) conversation following the KSADS feedback, in which Sadie's mother told her, "I'll do what I can" [9]. According to Sadie, her mother did not maintain the changes. That conversation, however, may have contributed to Sadie's ability to make sense of her emotions and the screening experience. In a situation such as Sadie's, marked by strained parent/child communication following the DSM Interview, the feedback provided from the KSADS interviewer may take on more importance in bridging the parent/child communication gap.

KSADS: Psychoeducational Aspects

Several mothers reported reflecting on the symptoms of depression due to the experience of answering the interview questions [2, 6, 10, 14, 16]. Tory's mother said, "The questions kind of pointed out things I needed to look out for, like was she depressed, was she unhappy…" [16]. For some parents, the KSADS interview provides an element of education about depression.

Summary

The DSM Interview and the KSADS Interview represent distinct events for parents. Most parents feel concerned by the DSM feedback and engage in a process of assessing the information in light of what they know about their daughters emotional states and situational factors. Subsequent communications with their daughters adds additional information for consideration. Most of the parents interviewed made a determination that the DSM Interview feedback signaled a problem (other than depression) prior to the KSADS interview. Parent emotional response to the DSM Interview feedback is related to the success of parent/child communications. The KSADS is a validating experience for some parents when the feedback affirms the consistency of their responses with their daughters. It also presents opportunities for reassurance and guidance as to parenting strategies and new insights into their daughters emotions and behaviors. Internal parent processes of parent emotions, cognitive processes, and responses to the KSADS interview experience are a significant components of the model.

CHAPTER SEVEN

Parent/Child Communication

Parent/child communication about child emotions and concerns following DSM Interview feedback emerged as a particularly dynamic factor influencing outcomes of depression screening and assessment. The extent to which parent and child were able to sustain communication was influenced by parent emotional response, the pre-existing state of parent/child communication, and parent time.

Existing State of Parent/Child Communication

The state of parent/child communication prior to screening appears to influence the extent to which parent/child communications following screening experiences and feedback are robust and sustainable.

Child Perceptions of Parent/Child Communication

Child perceptions of parent/child communication were categorized as positive [4, 7, 8, 10, 12, 13, 14, 15, 16, 17], ambivalent [5, 6, 11], and negative [2, 3, 9]. Jeannette's statement that "my mom knew that I was feeling that way…" indicated a positive state of communication with her mother [4]. Sadie's negative communications with her mother were evidenced by her statement "…sometimes if I tell my mom something, she'll get really upset, and start yelling…" [9]. An ambivalent state of parent/child communication was noted for those who gave both positive and negative comments about communicating with their parents, as Lauren did when she talked about her anxiety about the post DSM feedback to her mother, coupled with her report that she call her at work after school to read the note and KSADS permission form to her over the phone [6].

The girls whose early interview comments suggested an ambivalent or negative existing state of parent/child communication reported less discussion with their parents following the DSM Interview/feedback and the KSADS Interview/feedback. Thus, a pre-existing positive state parent/child communication appears to facilitate continuation of the forum for the child perspective that is introduced by depression screening and assessment.

Parent/Child Communication as a Parenting Strategy

Most of the mothers reported good existing communication with their daughters. Where the DSM feedback was not anticipated, these mothers were sometimes puzzled that they were unaware of their daughters emotions. When asked about her response to the DSM Interview feedback, one of the first things Madison's mother said was, "I thought we had good communication….." [7]. The parents' opinion of communication with their daughters seemed less useful than other aspects of parent/child communication that emerged from the interviews.

A consistent theme from most of these parents was their use of parent/child communication as a parenting strategy [7, 9, 10, 13, 14, 15, 16, 17] (8/12 interviewed). This theme emerged from one of the exploratory questions of the parent interview inquiring about the parents' typical parent problem solving resources and strategies and where they seek help and information. Though the question as I posed it tended to lead in other directions, this group of mothers was consistent, as illustrated from the excerpt below from one of the translated interviews:

> Interviewer: Generally, when you have some preoccupation [translated from Spanish "preoccupado"] with your daughter, what do you do? Talk with friends, family members, read books, magazines?
> Parent: First, I consult with my husband, and then I speak with her. Regularly I come to her to talk [15].

Another mother explained, “I'm always talking to her; I’d like to think that we always have open conversations about things, and every time I see her seem sad I pretty much try and encourage her to tell me about it…..I really don’t want her bottling things up….[16].” Only one of the parents who reported use of parent/child communication as a parenting strategy had a daughter who indicated a negative state of parent/child communication. The tendency of these parents to communicate with their child as a typical problem solving strategy may support a productive forum for the child perspective and thus increase the potential for change as a result.

Parent/Child Communication Following the DSM Interview/Feedback

Most parents and children reported discussions following the DSM Interview and feedback. These conversations were sometimes initiated by the child [5, 6, 11] but more often by the parent [3, 4, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17].

Child Recollections of Parent Messages

The child participants recalled their mothers asking them about the interview questions and about their feelings [3, 5, 6, 7, 8, 9, 12, 16, 17]. They remembered messages from their parents in conversations following the DSM Interview that provided reassurance, a directive to talk to mom, advice regarding child concerns, and empathy. For several girls who appeared to have subclinical levels of anxiety and anxiety about the feedback to their parents, the messages of reassurance from their mothers about the feedback and continued participation stayed in their minds, recalling “She said that it was fine” [11] and “She said it’s okay if they talk to me” [5]. Another girl said her mother told her “that she would love for me, for me to do questions [the KSADS Interview]….I was scared” [3]. In this way, the signing of permission forms for the KSADS Interview

becomes a transaction between parent and child around the acceptability of talking with others about problems. While the permission form is designed to provide permission for researchers to talk with the child participants, the children themselves also seem to take from the process a message of reassurance and permission to talk.

Some child participants remembered that their mother gave a directive to talk with her [2, 12]. "She said that…if I was sad or something that I should talk to her about it," a message that was new to Mara [2]. For Kamryn, her mother's directive to talk and the whole conversation with her mother following the DSM Interview was a turning point. Kamryn explained:

> She told me that if I never tell nobody, they will never know how I feel; and that's why from now on I keep on telling her what happens…Because I used to not talk to her that much but now I keep talking to her and she helps me…she tells me what I should do…..I used to not like my mom very much and now I think she's like the greatest mom I could ever have [12].

Kamryn reported that she has been talking more to her mother and that she feels much better. She said her mother, Elena, had also talked with her about her experiences with her own mother as a child, and how had also sometimes been angry with her own mother as a child. Kamryn seemed to feel closer to her mother and less isolated as a result. She said, "I always thought that I was the only one going through, it but I'm not, because she told me that she felt the same way about her [mother]" [12]. Kamryn's mother was successful in joining with her in the experience of being a child. Other's also talked about feeling better after talking with their mothers following the DSM Interview [4, 8, 14, 16] in response to a positive overall interaction, which was conceptualized as a parent message of empathy.

Some child participants recalled messages of advice in conversations following the DSM Interview and feedback related to handling the child concerns relayed by the child or in the feedback, including handling feelings [12], peer conflicts [14], and sibling conflicts [5]. "She talks to me, and she tells me 'what's wrong?,' and I tell her what happened, and she tries to give me, like, advice" [5]. This parent guidance was described in positive and helpful terms.

Based on parent recollections of conversations following the DSM Interviews/ feedback, it appears likely that parent/child conversations with similar themes occurred with additional child participants but were not recalled by the children.

Parent Recollections of Conversations Following DSM Interview and Feedback

The mothers interviewed reported talking with their daughters following the DSM Interview and Feedback [2, 3, 6, 7, 9. 10, 11, 13, 14, 15, 16, 17]. The parents interviewed indicated that these conversations were usually fairly brief, but sometimes were more extensive [14, 16] or occurred in a couple of brief conversations [2, 3, 6]. The parents reported questioning the child about the DSM Interview and about the child's or feelings [2, 6, 7, 11, 14, 15, 17]. Lisa, Mara's mother said, "I just asked her about it, you know, that 'I heard you talked to them' and…..'Are you okay, did something happen?' or…..stuff like that, just, you know, wanting to know if there's something I can do or anything…." [2]. Similarly, Stephanie's mother said, "I just went to her room and asked her how her day was at school, and I asked, 'did she want to talk to me about anything,' cause you know she can talk to me about anything…..and I just told her that someone from the school had called…" [3]. One mother interviewed gave their daughter the directive to talk. Janine's mother said she told her daughter, "You need to talk to me, and

you feeling like that, I can help you" [14]. A message of encouragement to talk was reported by several [13, 15, 16], as well, specifically encouraging their daughters to talk honestly in the upcoming KSADS Interview, "I said that it is good that she talked with them, the she tells the truth, more than anything, be serious, honest" [13]. Another mother said she told her daughter, "Whatever she was feeling, that she could talk to the counselors there…and if there was anything she needed to say, she was welcome to say it" [16]. Some parents indicated that they had conversations with their daughters about specific child concerns at that point, the stresses mentioned by the child or in feedback [3, 6, 9, 14, 16].

Sustainability of the Communication

The extent to which parent and child are successful in sustaining the communications that occur related to depression screening and assessment influences the outcomes for child participants. Although the success of sustaining communication varied dimensionally among the families in this study, the child participants consistently reported positive outcomes and messages from conversations with parents as a result of screening/assessment. Communications between parent and child ranged from strained to sustained. Because communication is a reciprocal process, it is difficult to sustain communication when one party is unable or unwilling to engage in discussion or responds to discussion attempts in a negative way. Strained communication following the DSM Interview and feedback was noted among some participants in the difficulties parent and child reported in maintaining discussions. For instance, Lauren called her mother at work after school and read her the letter requesting the KSADS interview:

> I read the note to her on the phone, I told her what it said, and then she said, 'I'll talk about it at home,' because she's always in meetings this whole past couple of

> weeks, so I really don't have, we really don't have the time to talk and have like a family conversation, cause sometimes my mom has to stay up, my dad has to leave early in the morning or at night, so we don't really get to get together like we used to do in the summer [6].

It appears Lauren's communication attempt was cut short because her mother was busy at work. Interestingly, this is the part that Lauren remembered well, whereas her mother recalled the conversation she (mother) had initiated at home later. Her mother recalled that conversation:

> I just asked Lauren…was there something that she was upset about today, and I said, 'What did you think about the interview?' and she was like, 'Well I don't know' and I was like 'okay' and I just wanted to wait to see what the second interview came up with…. she kept saying 'Oh I don't know mom, I don't know.' I was like, 'Well, they said that you seemed to be sadder than most, and she was like, 'Well I'm not getting a lot of sleep' [6].

Lauren's attempt to talk with her mother after school was cut short. Based on her mothers report, in seems that when the mother initiated a conversation later, Lauren was resistant to the discussion. Although Lauren's mother reported being surprised that her daughter had been identified by the screening as "sadder than most children," she also said, "But I have already kind of known that because she talks about it all the time" [6]. The concerns Lauren's reported in the DSM Interview were her sister going away to college and a close friend moving away. These were things that her mother said she knew about, but they did not discuss them following the DSM Interview. Difficulty sleeping was another symptom that Lauren had reported, and they focused on that in the problem solving they engaged in over the following weeks. Her mother said they were "working on no caffeine after 6:00" to help Lauren with falling asleep at night. She said, "And now she reminds me, because there are times when I forget, and she's like, 'Mom, I can't have caffeine, and I was like, 'Oh, yeah, I forgot' [6].

As neither party seemed very satisfied with the communications following the DSM Interview, I considered their communication to be strained. A positive aspect of their communication emerged with Lauren reminding her mother of the "no caffeine" rule. These reminders seem to be a small but significant way that she advocates for herself, as they call her busy mother's attention to her needs. With this self-advocacy she continues the forum her perspective as a child experiencing difficulties and needing parent support. Other examples of self-advocacy were noted in Jeannette's decision to talk with her mother more about her feelings, and Madison, Sadie, and Tory raising their concerns to their mothers in an ongoing series of conversations [4, 7, 9, 16].

Strained communication was previously described in the case of Mara and her mother Lisa, when Mara's news that she might qualify for Action was met with a negative/anxious response by Lisa. Lisa's attempt to talk with Mara later in the day was subsequently met with resistance, "She just said that ya'll would call me and talk to me about it" [2]. Mara reported that her mother let her know she should talk to her if she was sad, a new message for her, so there were productive aspects of the post DSM parent/child communications, despite it's strained quality.

In several other cases, the child was resistant to talking following the DSM Interview, according to the parent's report [3, 7, 14]. Janine's mother recalled the start of their conversation, "*Oh no, she's no[t] upset*, she told me, and I respond what they [interviewer] ask me…and final[ly] she say the truth about she [her] feelings [14]. Sadie's description of the conversation with her mother following the DSM Interview had the tone of an argument:

> She [mother] was like, 'So how long were you in the counselors officer?' I was like, 'Not long.' She was like, '*Really*.' I was like, 'Maybe it was long. It was

> probably just about 30 minutes.' And I was like, 'I don't know how long it was! I didn't take the time!' She's like, 'Alright, ok, alright' [9].

Strained conversation was characterized by brief or aborted conversation attempts, often marked by a child's reluctance to talk.

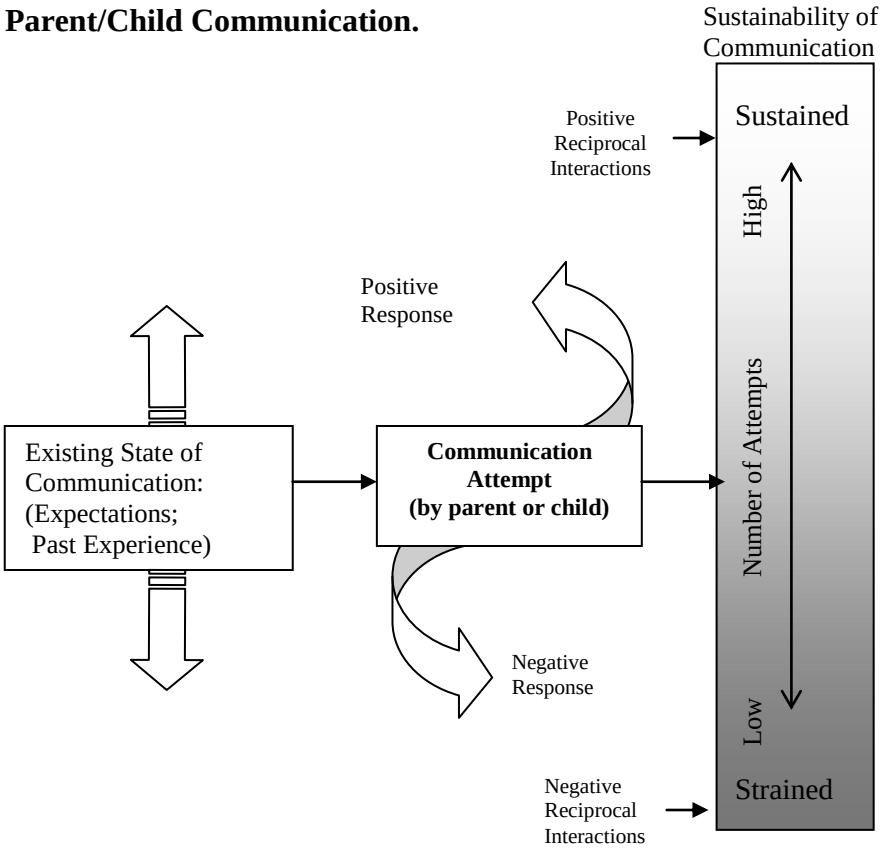
Sustained communication, characterized by a series of positive parent/child exchanges was dramatically evident in Kamryn's description of her conversation with her mother following the DSM Interview. When her mother asked her about the DSM Interview, Kamryn readily told her about it the interview and her feelings, explaining, "I wanted to tell her" [12]. Talking with her mother helped Kamryn feel better. Her mother said she should talk to her about her feelings and problems, so she has been talking to her more and apparently feeling closer to her mother. In addition, Kamryn reports that her attitude towards her mother has changed and that she is more compliant with her mother [12]. Positive sustained communication was evidenced by child reports of increased communication with their parents about their emotions and concerns that began following the DSM Interview [4, 8, 16, 17]. Parent reports of sustained communications following the DSM Interview were consistent with child reports of parent responsiveness to child concerns in three other instances [10, 13, 15].

Only limited communication occurred between parent and child following the DSM Interview in the remainder of the cases [5, 11]. Fathers of these two girls received the DSM Interview feedback, but the girls reported that they went to their mothers with the permission form for the KSADS. They reported more conversation with their mothers following the KSADS interview.

Robust, sustained parent/child communication following the DSM Interview appears to influence the child's ability to understand the screening/assessment

experience. Where the DSM Interview was followed by productive conversation and interaction with parents, child participants seemed to have made sense of the screening/assessment experience to a greater degree than other participants. They had greater certainty of how they felt before screening, how they felt after each step, and what had happened if their feelings had changed [4, 8, 10, 12, 13, 15, 16, 17]. With one exception [9], when parent/child communication was more limited [5, 11] or strained [2, 3, 6, 7, 14], the child participants seemed less confident in their explanations of the screening/assessment experience. An illustration of the parent/child communication process is shown in Figure 5.

Figure 5. Parent/Child Communication.



Contradictions of Parent Words and Actions

Verbally Rejects Child Concerns, Behaviorally Responds

In one instance, the strained parent/child communication did not match the parent's later positive response. Following the KSADS interview, Madison told her mother that she felt her mother favored her siblings and did not give her enough attention. Verbally, Madison's mother rejected those complaints (i.e., "It's not all about you…"). She continued to consider Madison's comments, however, and began to respond to Madison's complaints in a behavioral way. She said,

> I let her do some things…that I don't let the other ones [younger siblings] do; you know, just give her a little bit more older responsibility. Like when we go to the store…I have her hold my purse…or the phone…And for her that's like, 'Oh, ok, the other ones can't do this, so….' I'm trying to make myself more aware of that…trying to listen to her more [7].

In the qualitative interview with Madison (completed prior to the parent interview), she indicated that her mood had improved but she did not know why it had. The data of this study suggests that parent/child conversations about child's mood and concerns contributes to the child's understanding of her emotions and ability to make sense of the screening experience. In Madison's case, her parent was ultimately responsive to her concerns, but she did not discuss it with Madison later.

Responds Positively to Child Concerns Verbally, But Not With Actions

Sadie reported another set of circumstances. She indicated that after the KSADS interview, she talked with her mother about her concerns. She said she told her mother "that I miss my dad; I didn't tell her too much about wanting more attention, but I was like 'Can I get a little more attention?' and she's like, 'Sure, why didn't you just say so a long time ago;' I was like, 'Really!'" [9]. Sadie also asked her mother for more help in

dealing with her 3 year old sister. When asked if things had changed, though, Sadie said, "Mmm, a little bit; but after awhile, after I stopped doing the interviewing, she got the same again" [9]. She said she had been happier for awhile after the Action screening/assessment, which she attributed to getting to spend a weekend with her father and to talking with Action interviewers. She indicated the flat face as her mood for the day of the qualitative interview, however, she did not have the affect to match. She seemed more dissatisfied with her situation than depressed.

To summarize, for many of the families, the issues raised about the child's emotions and concerns (e.g., conflict with teacher, self-harm behavior, child reaction to family conflict with uncle, dissatisfaction with parent or sibling relationships, feelings about family situation) had not previously been discussed. The screening/assessment experience prompted parent/child conversations about the child's concerns and emotions (to varying degrees) in all of the families. The pre-existing state of parent/child communication influenced the extent to which parent and child were successful in sustaining discussions about child emotions and concerns following the DSM Interview feedback. Additionally, the child's ability to make sense of the depression screening experience appears to be related to the extent to which communication is sustained.

CHAPTER EIGHT

Parent Interventions

The parents in this study introduced a variety of interventions as a consequence of the screening/assessment process. This chapter will discuss the model of parent problem solving and the parent interventions that result.

Increased Communication

As a group, the parents interviewed put a higher priority on communicating with their daughters following DSM Interview feedback and the KSADS interview/feedback. Communication is the chief intervention parents can and do engage in the approximate one week time period between the DSM Interview and the KSADS interview. Communication appears to be higher on the parent (or child) agenda in some families long after the screening/assessment is over. A month after her KSADS Interview, Kamryn said, "I used to not talk to her [mom] that much; but now I keep talking to her, and she helps me" [12]. Although Kamryn's mother did not complete an interview for this study, the KSADS interviewer reported verbally that Kamryn's mother, Elena, used her own mother as a resource following the DSM Interview feedback. After receiving the feedback, Elena called her own mother and they talked about the history of their relationship and how they had managed conflicts over the years to arrive at a positive relationship. When Kamryn got home from school, Elena was ready to talk with her. According to the KSADS interviewer, Elena said she was talking more with both of her daughters about the give and take in their relationships. The conversation between Kamryn and Elena following the DSM feedback included Kamryn's father. He supported Elena's message that Kamryn should talk about her feelings. Thus, the

communications in Kamryn's family following the DSM feedback included Kamryn, Elena, Elena's mother, Kamryn's father, and Kamryn's sister.

Angela's parents expanded communication to include her teacher and the school counselor to help support her as she copes with her friend's illness. "We're keeping tight knit lines of communication with the counselor, the teacher, between us, and keeping it tight knit around, as she's working her way through this" [17]. For Janine and her mother, their communications after the interview feedback was initially difficult (with resistance from Janine), emotional, and intense. Her mother expressed determination in the qualitative interview, to continue increased communication: "When I talked to you [Action]…I come in more close; I close, but more close this past month, because after you talked to tell me she's no[t] feeling well, I feel worried" [14].

Problem Solving

The forum for the child perspective created during screening and assessment can lead to a considerable variety of interventions introduced by parents as they seek to address their child's concerns or solve the problem as they have defined it. The degree to which they introduce interventions in addition to increased communication appears to depend on several factors, including parent emotional factors, personal resources, family resources, the parent judgment (i.e., assessment) of whether or not a problem exists, and the level of the parents' concern. The families interviewed reported interventions instituted following the screening/assessment, even though there was no diagnosis of a depressive disorder for 15 out of 16 of these child participants (one was diagnosed with a depressive disorder in partial remission).

When types of parent interventions were grouped together, the following categories emerged: parent monitoring of mood, communication, time together, home environment, and accessing resources, as shown in Table 6.

Table 6
Parent Interventions

Monitoring Mood
Observing mood durations [2, 3, 7]

Asking the Child [2, 3, 15]

Communication (with)
Child [all]
Immediate Family (father, brother, sister) [2, 7, 10, 12, 13, 14, 15, 16, 17]
Extended Family (grandmother, aunt) [7, 12]
School Counselor [17]
Teacher [11, 17]
After School Teacher (regarding conflict) [8]
Friends, Co-Workers (ideas, advice, support) [2, 9, 16]

Accessing Resources
Counseling for child and sibling [16]
Tutors for English language acquisition and Math [13]

Time Together
Increased parent/child time & attention [7, 8, 10, 13, 14, 15,]

Increased parent/child activities [7, 8, 13, 14]

Home Environment
Mom reduced work hours [10]

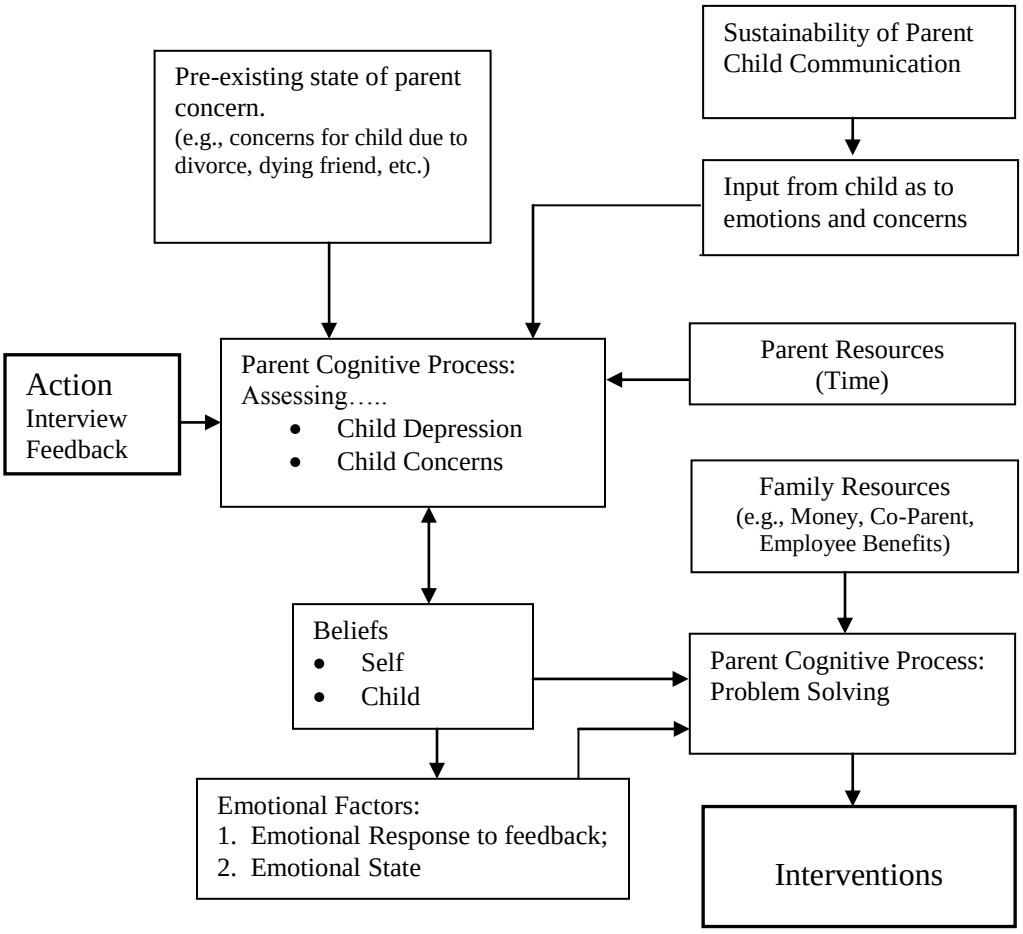
Intervene in sibling relationships [5, 7, 9]
No caffeine [6]
New breakfast foods [16]
More freedom for child [9]
More responsibility for child [7]

Changing parent/child interaction [7, 14]

Within and across categories, interventions vary dimensionally with regard to intensity, where intensity is considered the amount of time and effort required by the parent to carry out the intervention. For instance, obtaining counseling [16], engaging tutors [13], and reducing work hours [10] appear to be high intensity interventions. In contrast, parent monitoring of mood appears to be a low intensity intervention [2, 3]. As discussed previously, parent/child communication can vary considerably and be strained or sustained, and be "a little" helpful [3] to transforming [12]. The interventions are interesting in light of the fact that they were introduced for children who were not diagnosed with depression, a finding parents did not dispute. The type and intensity of

parent interventions introduced appear to be determined by an interplay of several factors: sustainability of parent/child communication, parent assessment of child's depression and concerns, parent emotional factors, pre-existing state of parent concern, and available resources. A depiction of the process is provided in Figure 6.

Figure 6. Model of Parent Problem Solving Process.



Some parent interventions seem to be an extension of successful sustained parent/ child communication. Where the parent and child report sustained (reciprocal) communication following interview feedback, the parent interventions appear to directly

address the child's concerns. For instance, Nina was concerned about ongoing difficulties with a teacher in her after-school program. Her mother arranged a meeting with that teacher to help her resolve the issues [8]. Meliah was missing her mother, who was working long hours. Her mother responded by significantly cutting back her work hours [10]. Tory wanted someone to talk to, so her mother arranged counseling [16].

Parent emotional factors can influence the degree to which interventions are introduced when an initial emotional response (accompanied by beliefs of guilt and self doubt in the parent) inhibits parent/child communication and results in a decision to "wait and see" what the KSADS shows [2]. More generally, when the parent/child communication process is strained following the feedback, the parent has less information on which to base a decision about whether or not there is a problem and what to do about it [2, 3, 6, 7, 9]. Parents who have limited time (a personal resource) and a fairly low level of concern (belief) about their daughters appear to devote less energy to assessing the situation or intervening [3, 6, 9].

In contrast, the interview feedback can coincide with an already heightened state of concern some parents have for their daughters due to situational factors. For instance, Angela's parents were concerned about her prior to screening because her best friend had recently been diagnosed with cancer. They arranged for her to meet with the school counselor, talked with her teacher, and worked together to increase communication and emotional support for Angela. Other parents who engaged in high intensity interventions were concerned about their daughter's well being due to the parents' divorce, due to parent perceptions of a racist school environment, and due to two moves following evacuation from New Orleans the prior year. These three parents evaluated their family

resources and outside resources for intervention options. Meliah's mother decided to reduce her work hours [10]. Violet's mother believed the school treated her daughter and other English language learners in a racist and discriminatory way. She felt that her daughter's adjustment at school would be helped if her English and other academic skills were improved. Violet's father was employed in a staff position at a local university. He engaged university students to work with Violet on her academics three days a week following the screening/assessment. Tory's mother described the high priority that she has given to helping her children adjust to their parents' divorce to years prior. She also described the criticism and "judgmental" attitude of her own mother and other relatives regarding the divorce. She took the screening feedback seriously and talked with her daughter about her concerns (i.e., not knowing when mom's boyfriend would be there; not eating breakfast; a wish to talk with someone). She then asked her other children if they had similar concerns. She arranged for counseling for Tory and her brother through her employee benefits.

To summarize, parent interventions following screening range from monitoring and slight increases in communication to interventions of considerable intensity. The type and intensity of interventions introduced is influenced by the degree of child input, the parents' decisions as to the degree of concern the feedback and the child's input warrant, pre-existing level of the parents' concern, parent time, and the resources available.

Summary of Results

Depression screening and assessment serves to create a forum for the child perspective by raising child emotions and concerns to the attention of both child and

parent. Changes may occur within the child, within the parent, in the content and quantity of parent/child communication, and subsequent to screening, through interventions introduced by the parent. Increased awareness of emotions and concerns begins for the child with completing screening questionnaires. Child participants experiencing emotional distress report relief upon talking with interviewers in a brief interview. The experience of talking with empathic interviewers seems to meet an unmet need to talk with an empathic adult for many of these children. Some report increased use of talking about feelings and problems as a coping strategy following screening.

Feedback regarding child symptoms and concerns provided to parents by interviewers (and sometimes by the child as well) serve to expand the forum for the child's perspective to the parents. Both child and parent participants report interviewer comments that lead to new ideas, beliefs, and strategies in parent/child relationships.

Parents assess the information received in feedback together with what they know about their child and family/child situational factors. Most parents talk with their child upon receiving the feedback following interviews. The characteristics of parent and child communication regarding child emotions and concerns appear to influence the type and intensity of interventions parents introduce. Parent interventions more directly address child concerns when parent and child are successful in sustaining a fluid communication and exchange of information. Other factors influencing parent problem solving and interventions are the preexisting level of concern, the parent's assessment of the child's depression and situation, the parent's emotional state, and available resources. Among the parents interviewed, those parents who had a high level of concern prior to the screening (due to individual situational concerns) introduced the most intense

interventions. Although most of these parents do not describe their child as "depressed," they talk with their child and engage in problem solving to address the problem as they have defined it.

When parent and child engage in sustained communication regarding the child's perspective, the child's understanding of herself appears to be enhanced. Parent/child communication may increase over the long term when the parent focuses on communication as an intervention. Several child and parent participants reported significant changes in parent/child interactions and communication that continued for weeks after the screening [4, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17]. This study shows that multi-stage depression screening and assessment can have long term intervention effects for some participants through enhanced parent/child communication, intra-personal changes in the child (emotions and beliefs), intra-personal changes in the parent (perceptions of the child), and through interventions introduced by the parent.

CHAPTER NINE

Discussion: Range of Consequences

Previous chapters have demonstrated the results of this study as a model for creating a forum for the child perspective. The following chapter discusses the range of experiences reported by the participants.

Therapeutic Benefits

When the data from the child participants are examined as a whole, most participants (14 of 16) described therapeutic benefits resulting from the screening and assessment experiences, particularly the interviews. The DSM Interview resulted in relief or feeling "good" for many girls (11 of 16). An additional three girls who had not reported such feelings reported relief and good feelings in response to the KSADS interview [3, 5, 13]. The experience of these three appeared to be tempered by the presence of subclinical anxiety that contributed to feeling "nervous" during the DSM Interview, thereby perhaps limiting the extent to which they could experience it in a positive way.

The two girls who did not describe therapeutic benefits from the screening and assessment experiences (i.e., questionnaires, interviews) did report positive parent/child communications and parent interventions following the DSM Interview and the KSADS interview [10, 15]. These two girls may share characteristics which affect their experience of screening and assessment. One of these girls received an ADHD diagnosis as a result of the KSADS [10], and the other received an ADHD diagnosis from her pediatrician in the interim between the KSADS and the qualitative interview [15]. Both

girls appeared to demonstrate less awareness and understanding of their emotions in their responses to the qualitative interview, suggesting perhaps a less advanced developmental level. Other participants reported positive parent interactions and interventions, but not to the exclusion of therapeutic benefits derived from the interviews.

As the prior report of results illustrates, depression screening and assessment brings child emotions and concerns into heightened focus for many child participants and their parents. While all participants interviewed for this study reported therapeutic benefits from screening experiences and/or parent/child interactions, they vary as to the number and intensity of therapeutic changes.

Potentials for Change

Optimal Consequences

In several instances, participants reported changes across all potential areas for change identified in this study. For instance, Tory reported positive emotions in response to the interviews, as well as arriving at new beliefs about herself as a result of the interviews. In addition, she realized that she wanted to talk with someone more about her feelings (a change in beliefs and coping intentions). Her mother talked with Tory about her feelings and concerns following feedback, and then opened the discussion to her brothers to find out if they had similar concerns. Her mother determined that Tory had a need that should be addressed (a new belief). Tory and her mother engaged in a series of conversations about her concerns, demonstrating increased use of communication to resolve problems and cope with emotions. She introduced the intervention of counseling for Tory and her brother. In the qualitative interview, Tory's mother expressed feelings of frustration that her daughter expressed complaints and "blamed" her for the divorce in light of the

considerable efforts she had put into easing the transition for her children. However, she was able to open herself to Tory's perspective and respond to her concerns. She opened the forum to Tory's brothers, seeking their perspectives as well. Based on a suggestion provided by one of Tory's brothers, the family devised a new way of handling the transfer to their father for visitation, decreasing the frequency of conflict between their parents. The changes precipitated by screening for Tory suggest she may experience benefits for an extended period of time. For Tory, a prediction of less risk of depression following screening appears reasonable.

Kamryn's story illustrates that renewed parent/child communication is an important intervention in itself. Although I did not obtain an interview from Kamryn's mother, Kamryn reported more positive feelings about herself and about her mother as a result of their conversations following the screening. In her case, the parent used her own mother as a resource for guidance in responding to Kamryn's feelings and concerns. Kamryn's father was present for the pivotal conversation between Kamryn and her mother, and verbally supported her mother's messages. Although additional interventions were not reported, Kamryn indicated that the changes within herself, the increased communication with her mother, and new ways of interacting with her mother were significant experiences for her. Thus, a prediction of reduced risk of depression following screening seems reasonable for Kamryn, as well.

Moderate Consequences

The expectation of a reduction in symptoms or reduced risk of depression following screening becomes less predictable when participants report change in fewer areas. For example, Madison reported positive feelings following the DSM Interview,

and she raised her concerns with her mother following the KSADS interview. Although communication about her concerns with her mother was conflictual, her mother began to respond to them behaviorally over the following weeks. Comments by the KSADS interviewer influenced her mother's perception of her behavior. Her mother described an ongoing process of trying to allow more communication of negative emotions from Madison, while requiring her to express those feelings in a respectful way. This outcome is quite positive, but not so definitive as the reports from Tory and Kamryn.

Modest Consequences (But Sufficient to Screen Out)

Mara's experience illustrates change in fewer domains following screening. She felt a great sense of relief from talking with interviewers and expressed an intent to talk more to handle feelings. However, she reported difficulty talking with her mother about her feelings, a circumstance that did not change with screening. Her mother's plan was to "keep an eye on her" [2]. Subclinical anxiety was noted in her descriptions of her responses to the screening events. Her risk for depression following screening may have been reduced if she carried out her intent to cope with problems by talking about them, but her risk may have changed little if she did not.

Parent Responsiveness

While parent responsiveness is an important component of the experience for most participants, a relatively modest level of responsiveness may sometimes be effective. In Jeanette's case, there seems to be a latent resilience or resourcefulness at work in her response to the screening process. The questionnaires reminded her of her feelings about an ongoing conflict in her home. Although she was aware that the program was for research purposes, she used the experience of having someone to talk

with to release some of her feelings of anger. As a result she was motivated to talk with her mother more about how she felt. By the KSADS interview, her mood had improved, but talking even more helped her to feel "like something kind of lifted off my shoulders." Eventually, discussion about the Action interview led to a sharing of her feelings with her father. The screening and assessment resulted in processes for Jeanette of reflection, feelings of release from negative emotions, increased coping through communication with her mother, increased communication with her father, and reduced symptoms. In addition, in the brief conversations about permission forms for this interview Jeanette reported that "[my mom] said it's okay to talk to ya'll." This comment was not recorded in the qualitative interview, as it preceded it; but, for a child who is lacking in confidants, obtaining permission from parents to talk about problems may promote communication as a coping strategy. In Jeanette's case, the screening seemed to prompt rapid improvement in an eight-month depression when she began talking more about her feelings. Her description of her parents' responses was that they "listened" [4].

In this instance, depression screening and assessment facilitated rapid improvement in a child with significant emotional burden who was willing to use the opportunities afforded by screening to reflect, to talk with interviewers, and to discover new ways of coping. Jeanette felt relief from talking, and that led her to talk more with her mother about her feelings. She indicated her emotional distress and depressive symptoms were diminished after talking about her feelings with interviewers and with her mother. She used her experiences with the interviews to create a forum for talking about her feelings with her mother and sharing them with her father. This ability to use the screening experience seems to indicate a latent resilience or resourcefulness that is

sparked by the process. In Jeanette's case, most of the change appeared to be within *her* and through communications initiated *by her* rather than through parent interventions, thus demonstrating that intra-personal child factors can lead to significant change when the child perceives adequate responsiveness on the part of the parents.

Based on this study, participants in depression screening and assessment has the potential to promote changes within the child, within the parent, in parent/child communication, and through parent interventions. The extent to which changes occur appears to depend on individual child and parent characteristics (e.g., presence of symptoms of anxiety), the pre-existing state of parent/child communication, pre-existing level of parent concern, and parent and family resources.

CHAPTER TEN

Discussion: Implications of the Model

This chapter discusses the implications of the model resulting from this study in terms of the extant literature, as well as implications for future research and practice. By reviewing the findings in comparison to the literature reviewed, the model can be considered within the context of existing theoretical and clinical perspectives. An additional area of focus that emerged from the data will also be discussed. The chapter concludes with a discussion of the implications of the model for multi-stage screening, assessment, and intervention.

The theoretical model developed from this study resulted in a "substantive theory" (Glaser & Strauss, 1998), that is, a theory based on data gathered from a particular group regarding a defined topic. In this instance, the model generated is relevant to pre-adolescent girls and their parent who participate in multi-stage screening and assessment of depression in a school setting for research purposes.

Comparison with Interventions

In reviewing the literature, I considered aspects of depression screening and assessment that may be similar to interventions or components of interventions found to be effective in treating symptoms of depression in children. Various aspects of screening/assessment are consistent with specific processes of a variety of therapies.

Common Therapeutic Factors

The feelings of relief and improved mood in response to interviews are consistent with research demonstrating the existence of common (or non-specific) therapeutic

effects. Several studies evaluating interventions for depressed children have shown that depressive symptoms in children are reduced in response to therapies with a theoretical basis as well as in response to alternative "placebo" therapies (Liddle & Spence, 1990; Kaufman, et al., 2005). Several participants commented positive characteristics of the interviewers, particularly their expectation or experience of a calm response from interviewers. These positive comments and the consistent reports of relief and improved mood in response to interviews (14/16) suggests common therapeutic factors (specific to interviewers) contribute to the therapeutic qualities of depression screening and assessment.

Interpersonal Therapy

Several participants reported leaving the brief interview with an intention to talk with their mothers about their feelings and concerns. This intention fits with the goal of improving interpersonal functioning consistent with interpersonal therapy (Rosello & Bernal, 1999). Having a positive experience discussing problems and feelings seems to facilitate acquisition and generalization of interpersonal communication as a strategy for dealing with problems.

Family Therapy

Systemic Family Therapy

Parenting and family communication are two of several focuses of systemic-behavioral family therapy (Kolko, et a., 2000). During the course of depression screening/assessment, parent feedback and parent interviews provide opportunities for (unintended) interventions. Only a few parents reported interviewer comments that reframed a child's behavior for the parent, but they were important messages for those

parents. The comments recalled were related to parent/child communication and continued to influence parenting for an extended period.

A qualitative analysis of systemic family therapists conducting systemic family therapy, identified a theme somewhat similar to the core theme of this study, creating a forum for the child perspective. The theme identified by Campbell and colleagues was "hearing the child's voice" (Campbell, et al., 2003, p. 430). They described occasions when the parents heard the child's voice or perspective in a new way as "significant moments" in therapy. In the present study, for families flexible enough to use the information, the feedback following interviews touches on a potential "significant moment" for hearing the child in a new way.

Family systems theory suggests that a parent would evaluate family processes in light of feedback that a child may be depressed. Upon determining that a problem exists, the information may trigger a process of adaptive re-organization, making changes in the family's functioning and the child's functioning (Cox & Paley, 1997). This explanation is consistent with parent responses to interview feedback.

Attachment Based Family Therapy

The attachment-based family therapy model developed by Diamond, Siqueland, & Diamond (2003) for use with adolescents is based on the theory that secure attachment during adolescence is based on open communication, accessibility of caregivers, and trust. These researchers suggest that in the struggle to maintain connection and negotiate independence, the attachment relationship and parent/child communication can break down. Just as Diamond, et al., described, participants in this study sometimes indicated they had not been revealing their thoughts and feelings to their parents. In fact, some

girls anticipated quite negative reactions from their parents following screening. The feedback to parents as to child symptoms and concerns often becomes a bridge in parent/child relationships marked by limited communication. Most child and parent participants described increased and improved communication as a result of the screening/assessment experience. In addition, some described increased feelings of closeness and attachment in the parent/child relationship [8, 10, 12, 13, 14]. The child initiated communications that I conceptualized as self-advocacy included communications with parents about past or on-going situations in which the child felt ignored or rejected by the parents. Child and parent interviews revealed efforts to revisit past issues and repair relationships, another goal common to attachment based family therapy.

Therapeutic Assessment

Depression screening and assessment might also be considered a brief, therapeutic assessment. Some participants report understanding themselves in new ways as result of completing questionnaires and talking with interviewers. Although this assessment process is not intended as an intervention, the child participants naturally respond to it as they focus on their thoughts and feelings as they complete questionnaires and answer interview questions. Through self-reflection, child participants provide feedback to themselves. Interviewers acknowledge their feelings and concerns in a way that is often a new experience. This process may be self-verifying as previously obscured thoughts and feelings are raised for overt consideration. Feedback to the parent also fits with a therapeutic assessment model as it can lead to changes in parent perceptions of the child, particularly as to whether or not there is a concern that needs to be addressed.

Of course, the assessment is therapeutic only if either through feedback or on their own the families are able to make sense of the information provided. My concern for Mara and her mother was that the explanation adopted by the mother (that there had been no problem) did not match Mara's experience. For that reason, I provided additional feedback to Mara's mother following the qualitative interview. Depression screening and assessment, therefore, has the potential to be a therapeutic experience, depending on what the parent and child make of the situation and information. Therapeutic assessment has been called a "treatment microcosm" (Kubiszyn, 2000). Because of the abbreviated nature of the assessment in a multi-stage screening process, it might be appropriate to consider it a micro therapeutic assessment.

Cognitive Behavioral Therapy

Although the number of participants in this study who had the experience of signing safety contracts was small, their responses suggest that signing safety contracts reinforced the idea of talking with others as a means of handling negative emotions. Signing the contract may be analogous to a cognitive/behavioral or psychoeducational process that puts a plan in place for solving the problem of intense emotions and emphasizes talking as a coping skills. The signing of the safety contract may facilitate acquisition of the skill, as it makes the process more concrete for these young participants.

Sudden Gains/Early Treatment Response

The participants in this study on the whole appeared to have positive family factors (intact families; ongoing relationships with non-custodial parents when divorce does occur, adequate parenting) and positive child factors (i.e., good cognitive abilities).

In addition, some child participants were resourceful in their ability to use the experiences afforded by screening and assessment and quickly appropriate communication as a desired means of coping. Parents likewise demonstrated flexibility in their marshalling of resources available to them. Research investigating sudden gains in treatment suggests those who are early responders to treatment are more resilient and probably experiencing fewer symptoms than those who are not early responders. The participants of this study appear to share those characteristics of latent resilience.

However, the array of therapeutic experiences participants derived from screening/assessment suggests that more is at work here than resilience. In research examining early treatment response in children and adolescents, it appears to be especially important to account for family based influences to treatment response. In particular, this study suggests that changes in parent/child communication (sparked by the screening/assessment process and initiated by either child or parent) play a role in rapid improvement in child symptoms. Research on early treatment gains in children without examining changes in parent/child communication and parent introduced interventions would be incomplete.

Response to Diagnosis

Responses of parents to the interview feedback were generally consistent with the research exploring parent responses to child diagnoses of physical or mental illness. Most parent interviewed for this study were able to respond to the DSM Interview feedback in responsive and flexible ways. When the parent has a strong emotional response to the situation, the parent may "freeze" and be less effective in responding. These parents engage in processes of cognitive appraisal to construct an explanation for

the problem, as do parent of children who receive a serious diagnosis (Heiman, 2002). In this instance, the child participants were not ultimately diagnosed with depression. While most parent defined the "problem" signaled by screening in ways other than "depression," many introduced interventions. The choice of avoiding the word "depression" suggests that depression is particularly threatening and that these parents were engaging in a bit of denial to avoid the word.

The findings of this study converge with prior research investigating the effectiveness of treatments of depression in youth. Family therapy interventions and therapeutic assessment are most analogous to the processes of depression screening and assessment. Research on parent responses to diagnosis of child illness demonstrate similar intra-personal parent processes in response to interview feedback, but that research does not account for parent/child interactions.

Emotional Openness

In conducting qualitative research, the literature review is put aside during data collection and analysis (Glaser, 1978). Following analysis, it is appropriate to return to the literature to investigate any key, as yet unexplored topics, that have emerged. In tihs study, I chose to explore parent/child communication more closely, as it appeared to be a key concept. I had noted in the data that the ability of parent and child to have a sustained conversation about child feelings and concerns seemed to depend on whether or not the parent was accepting of the child's negative emotions. In other words, where the parent rejected the child's expression of negative feelings or argued against them, the conversation usually broke down. I found in the literature the concept of emotional openness. Emotional openness between parent an child has been shown to improve a

child's ability to process and cope with traumatic disaster events (Lutz W., Hock, E.. & Kang, 2007). It is characterized by open communication about emotions by parent and in conversation with the adolescent. This construct fits with theories that hold positive coping is related to emotional well being. The results of this study suggest that the level of emotional openness in parent/child communications may work as a protective factor or as risk factor for child depression.

Multi-Stage Screening Process

This study has implications for the use of multi-stage screening methods for the purpose of identifying participants for depression intervention research. Since the DSM Interview seems to promote a response of relief and good feelings in most participants, use of such an interview should be used with the understanding that less severe cases and children with resilience will screen out. That may be a desirable circumstance, as response to treatment components can be tracked more reliably through participants experiencing greater severity of symptoms.

Study Limitations

While this study provides preliminary support for the potential positive intervention effects of depression screening and assessment, these results may be limited to similar situations in which a large team of assessment staff is available to conduct the screenings, interview the participants, and follow-up with parents. As a funded research project, the Action Study included a team of approximately 25 research assistants and two supervising psychologist available to participate in screening and assessment. The time and expense involved in administering and scoring several hundred screening questionnaires, conducting interviews, and providing parent feedback would be difficult to duplicate in a typical school setting by a school counselor or a school psychologist.

It must be noted that this study was limited to those participants who completed the screening/assessment process. Students who would have been included in the full screening process for the Action Study but dropped out either by their own choice or due to lack of parent consent were not interviewed for this study. Such students may be more vulnerable to possible negative effects from screening and assessment (e.g., if the process creates conflict with parents or if they are in emotional distress and parents respond negatively). A more complete understanding of the risks and benefits of depression screening and assessment could be gained if experiences of participants who chose to stop their participation in the process were known.

In addition, the demand characteristics of the interview process could have created some anxiety in the young participants. Some participants had difficulty answering open-ended questions or elaborating on responses. While even the brief interviews and responses generated valuable data, the developmental level of the child's verbal skills and the degree to which the child is aware of her thoughts and feelings may have influenced the data that emerged in the interviews.

there is some risk that participants

The timing of the data collection was another limitation of the study. Since the interviews were completed several weeks after screening/assessment, participant responses were retrospective accounts and may have been limited by the participants' ability to recall past thoughts and feelings.

The demographics of the participants limit the findings of this research as well. The average age of the participants was 10 years, 3 months. Very few of the older students screened for the Action Study met the criteria for this study. The intervention effects of depression screening and assessment in this relatively young sample may not generalize to older adolescents who may be experiencing more severe or chronic distress. While 11 of the 17 child participants were Hispanic, this is roughly proportional to the demographics of the student population of the schools in which the screenings took place.

Any cultural factors which may influence a family's experience of screening and assessment are unknown.

Conclusion

This study provided initial support for therapeutic effects of depression screening and assessment among pre-adolescent girls. The process created a forum for the child's expression of emotions and concerns and facilitates a process of emphasizing these to the parent. The chief means through which depression screening affected the child participants was through enhancing their understanding of themselves, promoting positive coping processes, facilitating parent/child communication, and influencing parent perceptions and the parenting agenda.

Appendices

Appendix A: DSM Interview Form

DSM-IV Symptom Interview for Children/Adolescents (D)

Interviewer Instructions: Use each symptom prompt (18 items) and determines whether a symptom is present or absent. **"Present" indicates that the symptom is distressing or clinically impairing** (similar to a rating of 3+ on the KSADS). Follow-up questions may be used as needed, questions do not need to be asked verbatim, but clearly mark the symptom as **present or absent** for each item, regardless of how many follow-up questions are used. Code a **symptom as present ONLY if it interferes or impairs** functioning of the child in some way, meaning it is more intense or frequent than the experiences of the child's peers, or beyond expected reaction to an event. If a child does not endorse any of the first 4 items, she will likely not continue to the KSADS**,** but ***please ask all items*** for data reasons and parent feedback.

This brief interview covers present symptoms of depressive disorders, and the purpose is to assess current functioning only, for the last two weeks, including today. A symptom is "present" if it is a problem for most days within the past 2 weeks. If a symptom was a big problem, but only for one day or a few days, that would likely be a temporary reaction and not truly a symptom.

INDICATE CLEARLY IF PRESENT OR ABSENT, NO "BETWEEN" MARKS.

Introduce yourself and say to the child/adolescent:
*"I'll be asking you some questions about your behavior and feelings over the **past two weeks**, including today. I will want to know if you have each experience, and if it is a **problem for you most days within the last two weeks.** There are no right or wrong answers, and you do not have to do this is you do not choose to participate. If you want to stop, we will stop if you say so. Your answers will be private, except I will need to tell another adult if I have any concerns about your safety, such as you feel like hurting yourself or someone else, or if someone is hurting you. If that happens, we'll work together to be sure you are safe. After we talk, I'll let your parent(s) know generally how you're doing, but not tell them exactly what you said. Do you have any questions?"*

COMPLETE A-E AT TIME OF INTERVIEW:

A. Participant ID# _____
B. Time (circle): (1) **Screening** (2) **Monitoring week#** _____ (3) other_____
C. Date:_____
D. School:_____
E. Interviewer:_____

Participant id#_____
Date: _____

ACTION PROJECT USE ONLY

Symptoms: Ask about symptoms being present most days for THE LAST TWO WEEKS, INCLUDING TODAY.	Symptom IS Present (√)	Symptom NOT Present (√)
1. Have you been feeling sad, unhappy, blue, or down in the dumps for a lot of the day?	❒	❒
2. Have you been feeling irritable, cranky, or easily annoyed for a lot of the day?	❒	❒
3. Have you been less interested in doing things like hobbies or sports?	❒	❒
4. Have you been enjoying hobbies or interests less than you did in the past?	❒	❒
5. Have you noticed a change in your appetite (eating more or less than usual)? Has your weight changed or do your clothes fit differently?	❒	❒
6. Have you had any trouble with your sleep, such as falling asleep, waking up at night, or waking too early?	❒	❒
7. Have you been having trouble with your sleep, in that you are sleeping a lot more than usual lately?	❒	❒
8. Do you feel like you still need sleep or rest, even if you got a full night's sleep?	❒	❒
9. Do you feel like you have no energy or not as much energy as usual?	❒	❒
10. Do you feel restless or fidgety, that you have a hard time sitting still?	❒	❒
11. Have you felt slowed down, like you are moving in slow motion or your movements are not as quick as usual?	❒	❒
12. Have you had trouble concentrating or paying attention, like your mind is "in a fog?" Or trouble making decisions?	❒	❒
13. Have you felt guilty about things lately?	❒	❒
14. Have you felt hopeless, like things won't work out for you, or that you will always feel bad?	❒	❒
15. Have you felt worthless, inadequate, or like you are no good lately?	❒	❒
16. Have you had thoughts of death or dying?	❒	❒
17. Have you had thoughts of wanting to hurt yourself? (or someone else?)	❒	❒
18. Have you done anything to hurt yourself, such as make a mark on your skin?	❒	❒
TOTAL "PRESENT" Items 1-18		

Revised 11/7/03 JBS

Participant id#_____

Date: _____

CONFIDENTIAL * ACTION PROJECT USE ONLY

When did these symptoms become a problem for you (onset)?_____

_____

_____

_____

Please immediately complete disposition below for all DSM screening interviews. You can ask the child for parent name and contact information.

Indicate disposition recommendation below (check one):

- ❒ Discontinue study participation, send letter to parents indicating no concerns.
- ❒ Contact parents for feedback and to invite for KSADS.
- ❒ Contact parents for feedback, discontinue study participation and not invite for KSADS.
- ❒ Contact parents to recommend immediate appointment with Dr. Custer or Dr. Hauser

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Parent name: _____ phone #_____

Child name: _____

Parent Contacted: (NO) or (YES) name of person who contact parents: _____

ACTION staff notes regarding contact:

Revised 11/7/03 JBS

Appendix B: Consent for Qualitative Interview

Informed Consent to Participate in Research
(Action Program Experience)

The University of Texas at Austin

You are being asked to participate in a research study. This form provides you with information about the study. The Principal Investigator (the person in charge of this research) or his/her representative will also describe this study to you and answer all of your questions. Please read the information below and ask questions about anything that you do not understand before deciding whether or not to participate. Your participation is entirely voluntary and you can refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

Title of Research Study:

Identifying Depressed Children: A Qualitative Analysis of Child and Parent Reactions to Depression Screening and Assessment

Principal Investigator, Faculty Sponsor, UT Affiliation, and Telephone Numbers:

Principal Investigator:
Deborah Giroux, M.A., Doctoral Candidate, School Psychology, University of Texas at Austin
Telephone Number: (512) 471-4407 or (512) 301-0373

Faculty Sponsor:
Kevin D. Stark, Ph.D., Professor of Educational Psychology, University of Texas at Austin
Telephone Number: (512) 471-4407

Funding Source:

Not applicable. Only personal funds are used.

What is the purpose of this study?

The purpose of this study is to learn about the experiences children and their parents have when they participate in depression screening and assessment by filling out questionnaires, completing diagnostic interviews, and talking with interviewers.

What will be done if you take part in this research study?

If you decide to participate and allow your daughter to participate, the primary investigator or another graduate student will interview your daughter at school, at home, or at another convenient location on one or two occasions. Each interview will last approximately 30 to 45 minutes. The interview questions will focus on (1) what completing the questionnaires and interviews was like for your daughter; (2) what completing the interviews was like for you; and (3) how the experiences affected your family. These interviews will be audio taped; however, all information that identifies you or your daughter will remain confidential and the audiotapes will be kept in a secure location and will be erased after they are transcribed or coded.

What are the possible discomforts and risks?

There are few identified risks involved in this study. Your daughter could disclose information during the interviews that affects her emotionally, or she may feel uncomfortable talking about her experience. Since the interview questions are not intended to cause discomfort, your daughter will not be required to answer any questions that she does not wish to answer. Your daughter will be provided with the option of taking breaks during the interview in order to avoid fatigue. Parents may contact the primary investigator in the days following the interviews with any questions or concerns.

What are the possible benefits to you or to others?

Your daughter may enjoy talking about her experiences. In addition, her participation in this study may help to improve the methods of identifying depressed/stressed children in the future.

If you choose to take part in this study, will it cost you anything?

There is no cost for participating in this study.

Will you receive compensation for your participation in this study?

There is no financial compensation for participating in this study.

What if you are injured because of the study?

There are no known physical risks associated with this study.

If you do not want to take part in this study, what other options are available to you?

Participation in this study is entirely voluntary. You are free to refuse to participate in this study or to allow your daughter to participate in this study. Your refusal will not influence current or future relationships with the University of Texas at Austin, the Pflugerville or Georgetown Independent School Districts, or the ACTION program.

How can you withdraw from this study and who should you call if you have questions?

If you wish to stop participation in this research study for any reason, you should contact Deborah Giroux at (512) 471-4407. You are free to withdraw your consent and stop participation in this research study at any time without penalty or loss of benefit for which you may be entitled. Throughout the study, the researchers will notify you of new information that may become available and that might affect your decision to remain in the study.

In addition, if you have questions about your rights as a research participant, please contact Lisa Leiden, Ph.D., Chair, the University of Texas at Austin Institutional Review Board for the Protection of Human Subjects, (512) 471-8871.

How will your privacy and the confidentiality of your research records be protected?

Authorized persons from the University of Texas at Austin and the Institutional Review Board have the legal right to review your research records and will protect the confidentiality of those

records to the extent permitted by law. If the results of this research are published or presented at scientific meetings, your and your daughter's identity will not be disclosed.

Interviews will be audio-taped and cassettes will be coded so that no personally identifying information is visible on them. Cassettes will be kept in a secure place and will be heard only for research purposes by the primary investigator and her associates. Cassettes will be erased after they are transcribed or coded.

Will the researchers benefit from your participation in this study?

No.

Signatures:

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

_____

Signature and printed name of person obtaining consent **Date**

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this from. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.

Printed Name of Participant **Date**

Signature of Participant **Date**
Phone Numbers: _____

Signature of Principal Investigator **Date**

Appendix C: Assent for Qualitative Interview

ACTION Program Experience
(Reactions to Questionnaires and Interviews)

I agree to be in a study about my experiences in completing questionnaires and interviews for the ACTION program. This study was explained to me by the researchers, my parent(s) or guardian(s). My parent(s) or guardian(s) have said that I could be in this study. The only people that will know that I am in this study are the people in charge of the study and my parent(s) or guardian(s). My name will not be shared with anyone outside of this study.

In this study, I will be asked questions about my experiences of completing questionnaires about my thoughts and feelings and about being interviewed for the ACTION program. I will be asked about what it was like to complete the questionnaires and interviews, what I liked, what I didn't like, and how it changed me or my family.

I understand that doing this interview does not change my participation in the ACTION program and that it is important for me to be honest. I understand that my specific responses will not be shared with anyone. I also understand that I do not have to answer any questions that I do not want to answer and that I can stop the interview at any time.

Signing my name to this form means that I have read this page or that it has been read to me and that I agree to participate in this study. I am indicating that I understand what will happen in this study.

_____

Signature of Student Date

_____

Signature of Researcher Date

Appendix D: Script for DSM Interview Feedback to Parents

POST-DSM PHONE CALL TO PARENTS:

Here is a guideline to follow in talking to parents after the DSM interview:

- I'm with the UT Action Project and we were at your daughter's school today to have the girls fill out questionnaires.
- Your daughter's questionnaire scores indicated that she is experiencing some distress.
- She reported :_____ (describe symptoms that came up in DSM).
- The main things that are bothering her are (why she's sad):_____.
- [Talk about safety concerns if necessary.]
- We would like to do a longer interview with her to find out more about how she's doing.
- We'll be having counseling groups for girls at the school, and the longer interview will help us figure out if she could be in the group.
    - If they ask for more info about the project: The Action Project is a research study that's testing the effectiveness of a counseling program for depressed girls your daughter's age. It's 20 sessions of group therapy done within the school day at times when the school says it's okay. In the groups, they work on things like problem solving skills and dealing with feelings. If we find in the longer interview that your daughter is having significant symptoms of depression, then she'll be eligible to be in the groups and we'll talk with you about that.
- Today, we'll send home a permission form with your daughter for the longer interview. If you give permission, we'll talk with your daughter again at school in the next few days, then call you to find out how she seems to you.
- You can sign the form and have your daughter turn it in to the counselor.
- Do you have any questions? There is also a phone number on the permission form we're sending home if you have any questions or concerns.

Appendix E: Example of Integration of Participant Data

4. Jeanette

Jeanette is a twelve-year-old sixth grader in middle school. She lives with her mother, father, and younger brother (age 9). Her father is employed in construction, and her mother is a homemaker. Public tax records indicate they are owners of their manufactured home. Spanish is the primary language in the home according to Jeanette. Her father is bilingual, and her mother is monolingual in Spanish. She is enrolled in general education classes and does not report any academic problems. She indicated she is comfortable speaking English and Spanish. She completed screening measures and interviews for the Action program in English without translation assistance.

She participated in an Action screening at her school in the Fall of 2006. On the questionnaires she completed for screening, she endorsed items indicating that she was experiencing sadness, hopelessness, negative self esteem, guilt, indecision, poor appetite, insomnia, withdrawal from others, irritability, and emptiness. These symptoms were confirmed in the DSM Interview following, and symptoms of anhedonia and psychomotor agitation/retardation were also noted. The interviewer determined that Jeanette had been having the symptoms for eight months (since January 2006) and the symptoms were consistent with diagnosis a depressive disorder. The interviewer indicated in research notes that Jeanette was sad about some issues at home but that Jeanette was "vague on the situation at home" [research notes 8/25/06, J. Herren].

Jeanette strongly requested that her mother be the parent contacted to receive feedback following the brief interview. A Spanish permission form for the diagnostic interview was sent home with Jeanette, and she was told that a bilingual research

assistant would call her mother in the next few days to give feedback and request permission. Research notes indicated the call was made two days later. The mother agreed to give permission for the interview and requested that the parent interview be conducted in person [research notes 8/27/06, M. Garcia].

When the child diagnostic interview was completed with Jeanette ten days after the screening, she only endorsed clinical levels of irritability (moderate), fatigue (mild), and psychomotor agitation (mild) for the past seven days. Her report of symptoms for the preceding months was recorded as severe for depression and irritability, with additional clinical symptoms of guilt, anhedonia, fatigue, difficulty concentrating, psychomotor agitation/retardation, insomnia, appetite disturbance, self-pity, and negative self-image. Following completion of the parent interview, she was given the diagnosis of major depressive disorder in partial remission.

The diagnostic interview with Jeanette's mother was partially completed three weeks after the screening. The Jeanette's mother also indicated that Jeanette had been experiencing significant symptoms of depression that had largely abated. The mother was quite distressed herself, and was unable to complete the interview at that time. A later attempt to complete the interview by telephone was also unsuccessful. The notes made by the bilingual interviewer following the first interview attempt with Jeanette's mother are reproduced below.

> Met mother at school on Friday the 15th at 1:30. Mom showed up with dad, but asked that he not be in the room for the interview. Mom started the interview by telling me about her husband, and how he had cheated on her. I listened to her as she tried to explain how it affected the child, but she could not get past the telling to answer the questions. I tried directing her on multiple occasions, but she kept elaborating on the situation. After about 75 minutes, she had only answered 23 (less than half) of the depression questions. At that point she started crying and continued to talk about what happened. It was clear she could not focus on the

> questions long enough to answer them. At that point I discontinued the interview because she was very upset.
>
> Basically the mother believes the daughter was very much affected by the episode. However, mom says she's been a lot better since the beginning of the screening process. Mom also reported that the girl no longer wants to participate in Action [research notes, 9/15/16, L. Ramirez].

Surprisingly, Jeanette was quite willing to complete an interview for this study, and her mother gave permission. She is an attractive girl with bright green eyes, wavy brown hair, and a direct gaze. In the qualitative interview, Jeanette reported that the questionnaires she completed at screening reminded her of things that had happened to her and how she was feeling. When asked about her reaction to the questionnaires, she said they reminded her of "whenever I get mad at my dad, when he, like, cheats on my mom," a situation that makes her feel "all frustrated and stuff." [4] She indicated that the brief interview "helped get everything out of me" and "release all my anger." [4] After the brief interview, she said she talked with her mom more about how she felt and that helped her feel better. She said, "…it made me like, more like I wanted to tell my mom, like how I felt, like more than what I had already told her." [4]

Jeanette's interview showed that she was already communicating with her mother about her feelings, but had very restrained communication with her father. When asked how she felt about us calling her mother after the brief interview, she said, "It was, it was ok, cause my mom knew that I was feeling that way; but, she says, cause my dad, he's like really tough, and if I tell him anything bad when he's in a bad mood, he'd probably like yell at me or something, or say something mean." She went on to describe a recent conversation with her mother about the Action interviews, a conversation that her father overheard. She indicated that conversation had given her an opportunity to share with

her father her emotional reactions to his behavior, as demonstrated by the following interview excerpt:

> C: My dad would get angry, and [say] 'like why'd you have to get in this program,' but like, two days ago, cause my mom was talking about it [the interview]….. and then my dad was like overhearing it, and said, 'What interview?,' and I was telling him the truth, and he got all serious. I don't know, I guess he felt guilty, about why.
> I: You told him the truth, what was the truth?
> C: That, 'cause the way he was acting, that was why I was like angry and stuff.
> I: Oh, and he didn't know that before?
> C: No.
> I: I see. So what was that like? What happened then?
> C: Mmm, well he got all serious, and then he like went to his room, and he didn't talk to me, like the rest of the night, 'cause it was like at night.
> I: So what did you think that meant, that he wasn't talking?
> C: That he was thinking about it and what he had done wrong.
> I: So what'd you think of that?
> C: I think it was something I had to say, for him to think.
> I: Say that again?
> C: Something I had to *say* for him to *think*.
> I: So your mom, and your dad and you were all talking together about that?
> C: No, me and my mom were talking about it, and he was overhearing it, and that's when that happened. [4]

Jeanette reported that by the time of the diagnostic interview, her mood had improved, but it was helped even more by the diagnostic interview. She said that afterward she "felt more like something kind of lifted off my shoulders."

Jeanette's mother did not complete an interview for this study. When she was contacted by phone to request the interview, her comments about Action were that "it helped" but she did not want to talk about it.

Appendix F: Child and Parent Recollections of Child Mood

	Child Recalls Mood – Screening			**Child Recalls Mood – KSADS**			**Mood At QI**	**Trend**	**Anxiety Noted in QI**	**Parent Report of Child's Mood at Screening**
1*	☹				😐☺		☺	Improving	✓	Sensitive/Sad
2			☺		😐☺		☺	No change	✓	Moody
3		😐			😐☺		😐	No change, but relief reported	✓	Moody
4	☹				😐		😐☺	Improving. MDD Partial Rem.		N/A
5	☹				😐☺		☺	Improving	✓	N/A
6		😐				☺	☺	Improving	✓	Adjusting
7		😐				☺	☺	Improving		Moody
8		😐			😐☺		☺	Improving		N/A
9		😐				☺	😐	No Change		Transitioning
10			☺		😐		☺	No Change		Parent Uncertain
11	☹					☺	☺	Improving	✓	Sad
12	☹					☺	☺	Improving		N/A
13			☺		😐		☺	No Change	✓	Sad/Stressed
14			☺			☺	☺	No Change		Sad
15			☺		😐☺		☺	No Change	✓	Sensitive
16		😐				☺	☺	Improving		Stressed
17		😐					☺	Improving	✓	Depressed

Note. QI = Qualitative Interview, 😐☺ = Child rates mood as "in between" the two symbols.

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