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Depressive Symptomatology among High Risk African American Adolescent Males

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DEPRESSIVE SYMPTOMATOLOGY AMONG HIGH RISK AFRICAN AMERICAN ADOLESCENT MALES

DISSERTATION

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were considered to be at-risk of becoming contributors to major social problems. The data from this study we analyzed using the t-Test for independent samples. All the hypotheses were tested at the .05 alpha level.

From the data collected and analyzed, none of the independent variables was found to have a significant effect on the subjects' depression levels. Therefore family's income level, grade point average, number of expulsions from school, number of years residing in Houston, number of family members in the home, parents' level of education, number of female headed homes, number of single-parent homes, employment status of head of household, grade levels, the recipients of public assistance, grade levels, and the youngster's ages did not produce a significant effect on their depression level. The results from the investigation were generally found to be contrary to the findings of other investigators.

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DEDICATION

To my loving mother

Bertha Louise Goudeau-Geyen

CHAPTER 1

INTRODUCTION

Depressive illnesses are occurring more frequently among the childhood population than ever noted before in recent history. A number of cases are reported daily of young people who have become affected by some form of melancholia. Too, there is no one specific age group, sex, race, or socio-economic class which is the target of the depressive disorder. For any number of reasons, this disorder may beset any youngster. Therefore, it is very necessary to be aware of its pervasiveness, and to become cognizant of research and efforts made to cope with this illness.

There is now compelling evidence, gleaned from a plethora of studies, which indicates that school-aged children and adolescents do indeed experience depression. This depression may be defined as a painful emotion, a negative mood or an aggregate of negative moods that are associated with complaints such as hopelessness, worthlessness, suicidal wishes, and lethargy. Likewise, it may be a depressive syndrome with a characteristic symptom pattern and duration that impairs the person's functioning, or it could even meet other requirements for a diagnosis, (Kovacs, 1989). In any case, it is still considered a depressive illness.

Researchers have identified one particular area of interest as a result of studying depressive symptomatology among the childhood population. This area, as indicated in the literature, suggests that living

within adversed environmental conditions are related to depressive symptoms. Malmquist (1977) reported that some counter-productive behavior have particular psychodynamic and social meanings. He suggested that some researchers believed that such acting out behavior is a primary defense in a majority of depressive individuals. This action is often referred to as reaction depression, and occurs in response to chronic psychosocial distressors.

In a similar investigation, Mullins, Siegel, and Hodge (1985) discovered a significant relationship between depressive illnesses of this type symptomatology and factors related to external control. They also found that negative life events, a selected aspect of interpersonal problem-solving and innerpersonal problem-solving abilities, and a low socio-economic status were significantly related to depressive symptomatology. Research has also indicated that black youths who are most likely to develop this type symptomatology are those who have grown up in chaotic homes with disturbed or dysfunctional parents, where they have been subjected to parental deprivation or neglect, have experienced various forms of abuse and have been exposed to drugs and antisocial behavior (Lewis and Shanok, 1977; Offer, Marohn, and Ostrov, 1975).

In addition, Kovacs (1989) suggested that one of the features of a clinical picture among depressed youths was that many of them had multiple psychiatric diagnoses. She commonly referred to this as psychiatric comorbidity. Kovacs further indicated that the most prevalent comorbid condition among troubled youths included anxiety and conduct disorder. Offering some support of Kovacs' findings, the American Psychiatric Association (1987) has identified the presence of low self-esteem as an associated feature of Disruptive Behavior Disorder. Furthermore, the

Association's researchers indicated that symptoms of anxiety and depression were commonly found among children with Disruptive Behavior Disorders.

Statement of the Problem

Inasmuch as research has generally shown that the nature of depressive illness is very extensive among today's childhood population, it is the present researcher's purpose in this study to single out one group for investigation. Consequently, this investigator endeavored to answer the question: "Is living within adversed environmental conditions associated to a symptom of depression found in the high-risk African American adolescent male?"

For almost two centuries, poor children, often non-white and from other cultures, have been thought to pose a threat to the larger society because neither their parents nor existing community institutions could control their unacceptable behaviors. Too, fear of having to spend more for welfare payments drove public officials to compel attendance in schools as a solution to the problem of allowing children to be labeled "at risk." During these years, some poor children from various ethnic and racial backgrounds achieved well in school; however, there were then and are now many that do not succeed (Cuban, 1989).

Too, if one, considers the problems characterizing at-risk students today, he will discover that many children live in poverty and that even though their parents try hard to "make ends meet," the corrosive effects of long-term poverty can and does splinter families. Thus children in these families often lack nurturing care; they lie, steal, fight, and lead stunted lives. Without help, these youngsters will continue their

destructive paths of behavior into adulthood. So, then, if some parents cannot rear their children properly, the public schools must intervene to avert substantial future cost to society and to help each child become a productive citizen. Therefore, this description of at-risk children and their families should be quite familiar. After all, it is almost 200 years old and it remains today, as it was when it first appeared, a formula used by reformers to arouse the public to action (Cuban, 1989).

Consider the urban African American adolescent male who grows up within inner city boundaries and is faced with many challenging experiences. The latter are particularly acute when he lives under certain adverse circumstances such as low socio-economic conditions, poor academic performance, and single-parent homes where the father's whereabouts are unknown. In addition, there is usually a heavy drug and alcohol influence within the community. Likewise, crime, violence, and promiscuous sexual activity are often seen as commonplace throughout the atmosphere.

The value system of the family can be grossly conflictual within the home. This conflict may create a substantial amount of confusion and cognitive dissonance within a youngster's frame of thinking. In fact, there are numerous accounts of parents who do not condone drug peddling, yet they may provide subtle messages to the youngster which cause him to continue with his illegal activity. When such illicit behavior is engaged in, the family's income in all likelihood will increase, thereby enabling the family to have greater buying power. Even the parents of some of these young men may be themselves consuming drugs, thereby leading all onto a path of self-destruction. All of these things, of course, place a hardship on the African American adolescent male by

putting him in danger of becoming fatally injured, emotionally abused, or even killed.

Consequently, as a result of living within such conditions, the young African American male may begin to internalize the pressures from his society. This action could occur not only because of the lack of alternatives from which he has to choose for help, but also from just an overwhelming feeling of hopelessness and helplessness about his circumstantial situation. As a result, the youngster may begin to exhibit, in a maladaptive manner, his feelings of frustration and unhappiness. For the aforementioned and other reasons, the major question informing this investigation was: "Is living within adversed environmental conditions a symptom of depression found in the high risk African American adolescent male?"

In addition, the following sub-problems were investigated:

1. Did the family's level of income affect his level of depression?
2. Did his grade-point average affect his level of depression?
3. Did the number of times expelled from school affect his level of depression?
4. Did the number of years residing in the inner city area of Houston affect his level of depression?
5. Did the number of family members living within the household, affect his level of depression?
6. Did the parents' level of education affect his level of depression?
7. Did living in a female-headed home affect his level of depression?

8. Did living in a single-parent home affect his level of depression?
9. Did the employment status of the head of the house affect his level of depression?
10. Did his family as the recipients of public assistance affect his level of depression?
11. Did his grade level affect his level of depression?
12. Did his age affect his level of depression?

The Purpose of the Study

Across the country, minority children who are poor are usually undereducated in disproportionate numbers. Academically, such children may lag behind the national average by as much as two years. In large cities as many as 50 percent of minority children drop out of school. Consequently, the failure to educate these children makes harder the task of rectifying economic and social inequities. Therefore, unless schools can find a way to educate them and bring them into the mainstream, all of the problems associated with unemployment and alienation will continue to escalate (Comer, 1988). In particular, studies have shown that male children, comparatively, are given less nurturance by their parents, are treated more harshly by their teachers, are discriminated against more by employers, and are treated less favorably by nearly every other institution in American society. Thus it can be reasonably inferred that lower self-esteem is the inevitable outcome of these children's persistent differential and demeaning treatment. The links between low self-esteem, psychological disorder and behavioral dysfunction have been extensively documented in the social science literature. The complex interrelation-

ship among these three dimensions are of paramount importance in analyzing and understanding the psychological and behavioral problems of young black males (Gibbs, 1988).

Specifically, the purpose of this study was to determine whether living within adversed environmental condition and depression symptomatology could be significantly related. More specifically, the variables that were explored included: family income, grade-point averages, the number of expulsions from school, the number of years living in the inner city area of Houston, the number of family members living within the household, parents' level of education, number of female-headed homes, number of single-parent homes, head of home's employment status, recipients of public assistance, grade levels, and age.

Significance of the Study

Recent data from an Urban League Study revealed that many black males teenagers left school because of family economic problems, academic difficulties, or disciplinary problems, while black females often dropped out due to pregnancy (Williams 1982). More current figures from the Children's Defense Fund have indicated that black students were almost twice as likely as were white students to be suspended from public schools (9.9 versus 5.2 percent) and about 50 percent more likely to receive corporal punishment (7.0 versus 4.7 percent). From the total school population, the majority of youngsters who were suspended or physically punished were black males. Above all, black children and adolescents were also three times more likely than whites to be placed in classes for the educable mentally retarded (3.3 versus 1.0 percent) and

slightly more likely to be assigned to classes for the learning disabled (0.7 versus 0.6 percent) (Children's Defense Fund [1985]).

Parham and McDavis (1987) also reported that high rates of homicide, drug and alcohol abuse, and suicide among young Black men suggested that there may be a crisis in values among black male children. They advocated that mental health professionals and educators develop and implement more outreach programs and services. Also included was a recommendation for cooperation among churches and other organizations in the black community to promote these activities. Conceivably, the programs and services could include individual counseling, topical group discussion on relevant social issues, and seminars on careers of the future.

Congruent with the stated purpose of this investigation, the study itself should be significant for these reasons:

1. Assess depressive symptomatology among the African American adolescent male population.
2. Heighten the awareness of an aspect of childhood psychopathology from a cultural perspective for mental health professionals.
3. Use it as a screening device for those African American male teenagers with significant levels of depression.
4. Serve as a preventive measure in order to deter counterproductive behavior among African American male teenagers in the community.
5. Assist educators in providing scholastic, academic, and vocational direction to African American youngsters within the school system.

6. To make a contribution to the welfare and well being of African American youngsters as well as other children residing in the inner city areas.

Hypotheses

The following hypotheses were generated and tested in this study.

HO: There will be no statistically significant difference between the level of depression and adversed environmental conditions and the high-risk African American adolescent male.

HO_1: There will be no statistically significant difference between the level of depression and level of family's income and the African American high-risk adolescent male.

HO_2: There will be no statistically significant difference between the level of depression and grade point average and the African American high-risk adolescent male.

HO_3: There will be no statistically significant difference between the level of depression and the number of expulsions from school and the African American high-risk adolescent male.

HO_4: There will be no statistically significant difference between the level of depression and the number of years living in inner city area of Houston and the African American high-risk adolescent male.

HO_5: There will be no statistically significant difference between the level of depression and number of family members living within the household and the African American high-risk adolescent male.

HO_6: There will be no statistically significant difference between the level of depression and the parents' level of education and the African American high-risk adolescent male.

HO_7: There will be no statistically significant difference between the level of depression and the number of youngsters from female-headed homes and the African American high-risk adolescent male.

HO_8: There will be no statistically significant difference between the level of depression and the number of youngsters from single-parent homes and the African American high-risk adolescent male.

HO_9: There will be no statistically significant difference between the level of depression and the employment status of the head of household and the African American high-risk adolescent male.

HO_{10}: There will be no statistically significant difference between the level of depression and public assistance granted to the families of the African American high-risk adolescent male.

HO_{11}: There will be no statistically significant difference between the level of depression and the grade level of the African American high-risk adolescent male.

HO_{12}: There will be no statistically significant difference between the level of depression and the age of the African American high-risk adolescent male.

Assumptions

The research for this study was conducted based on several relevant assumptions. These primary assumptions were:

1. The instrument used was valid and reliable in terms of measuring the current level of depressive symptomatology.
2. The statistical test used was adequate in terms of producing the information desired.
3. The subjects were active participants and responded to questions without the influence of others during the assessment process.
4. The environment used to conduct the assessment was suitable and appropriate.

Limitations

Limitations were acknowledged for this study. Moreover, these specific limitations were:

1. The representative sample consisted of African American adolescent males who were participants in the Fifth Ward Enrichment Program.
2. The study was limited to a group of 33 African American adolescent male participants within the Fifth Ward Enrichment Program.

Definition of Terms

The following terms used in this research were operationally defined:

1. Acting Out Behavior - constitutes a child or adolescent as being "at risk." Normally it stems from a poor internal locus of control and an anxiety producing environment so that the person may exhibit counter productive behavior as a reaction.

2. Adolescents - are individuals whose ages range from 13 years to 17 years.
3. Adversive Environmental Conditions - those conditions that are considered unfavorable or harmful, such conditions can have a negative direct or indirect effect on a person's well being and livelihood.
4. Affective Illness - is a state in which a mood or feeling is abnormally depressed. It is often associated with behavioral and/or cognitive changes.
5. Children - are individuals whose ages range from birth to 12 years.
6. Childhood Population - refers to children and adolescents whose ages range from birth to 17 years.
7. Depression - is a normal human experience caused by a precipitating event. It may include feelings of guilt, worthlessness, hopelessness, frustration, irritability, aggression, and anxiety. This condition generally does not exceed two weeks in duration.
8. Depressive Disorder - is a pervasive condition of despondency, unresponsiveness, and a loss of motivation, motor and mental inhibition with depressed ideas and definite somatic disorders.
9. Depressive Symptomatology - refers to characteristics of depression.
10. High-Risk Adolescent - an individual with a history of minor anti-social, counterproductive behavior within the school and community. This individual exhibits substantial potential for severe problematic behavior in the society.

Organization of the Study

This research study has been organized into five chapters. The first is Chapter 1. Next is Chapter 2, which provides a review of the related research literature. Chapter 3 offers a discussion of the design of the study. Chapter 4 includes data analysis and appropriate discussion. Finally, Chapter 5 includes the summary of the study, conclusions, implications of the investigation, and recommendations for further study.

CHAPTER 2

REVIEW OF RELATED LITERATURE

To ensure clarity, the following review of related literature and research has been organized under four major categories. The categories include: (1) The concept of childhood depression, (2) The symptoms of childhood depression, (3) The causes of childhood depression, and (4) The treatments for childhood depression.

The Concept of Childhood Depression

Depression among children and among adolescents continues as a major mental health issue throughout America. In fact, it appears that more and more young people are being admitted to psychiatric hospitals, are being assigned to day-treatment psychological intervention centers, and are being seen in out-patient offices of mental health professionals who are trained to provide remedy for individuals with the diagnosis of depressive disorders.

Several studies have shown that as early as elementary school, black males report more psychological symptoms and display more behavioral problems than do black females (Children's Defense Fund, 1986). As they progress through adolescence and on into adulthood, black males appear to be more unable than black females to deal with problems in their families, in their schools, and in their communities. The high rates of

behavioral and learning disorders reported by schools, the number of incidents of emotional disturbances among juvenile delinquents, and the numerous inpatient and outpatient psychiatric treatment cases among the black male group all attest to the black males' coping inabilities (Myers and King, 1983).

Depression itself is not a tangible. The characteristics of depression may only be observed in certain kinds of behaviors that are exhibited, or through the communication of specific emotions. Therefore, researchers and practitioners can only make their judgment about depression based upon certain designated observable characteristics and expressions of the individual. Even in cases where there is a prevailing abnormal behavior evident, an element of depression is usually apparent.

Flach and Draghi (1975) discussed the concept of retarded depression. Their study identified a depressive illness in which sadness and marked mental and motor retardation were outstanding. They also indicated that patients had difficulty in understanding questions which too often had to be repeated. These patients were also slow in responding and many times appeared perplexed and confused. Indecisiveness and inactivity interfered with their social activity. Furthermore, their research suggested that, even eating became an effort for these individuals.

Somewhat consonant with Flach and Draghi's study, the American Psychiatric Association (1987) indicated that age-specific features in prepubertal children with a major Depressive Episode included somatic complaints, and psychomotor agitation; and mood-congruent hallucinations (usually only a single voice talking to the child) were particularly frequent. The Association's researchers also suggested that with the

adolescent population, negative or antisocial behavior and the use of alcohol or illicit drugs may also be present. All of this justifies the additional diagnosis of Oppositional Defiant Disorder, Conduct Disorder, or Psychoactive Substance Abuse or Dependence.

Similarly, The American Psychiatric Association (1987) specified that the adolescent-aged youngsters might experience feelings of wanting to leave home or of not being understood and approved of. Other feelings commonly observed were restlessness, grouchiness, and aggression. Sulkiness, a reluctance to cooperate in a family venture, and withdrawal from social activities were also frequent. School difficulties were likely to be common for the depressed adolescent. Likewise, there also were inattentiveness to personal appearance and increasing emotionality, with particular sensitivity to rejection in love relationships. A major Depressive Episode normally occurs during the late twenties; however, it has been noted to occur at any given age, including infancy.

Two basic, fundamental elements of the affective disorders have been identified by the American Psychiatric Association (1987). They consist of the manic episodes and the depressive episodes or syndromes. Each of these disorders are characterized by a core of symptoms which may be the result of a variety of causes.

First of all, a manic episode is depicted by an expansive, elevated or irritable mood. It is portrayed by such associated symptoms as high levels of distractibility, flight of ideas, hyperactivity, inflated self-esteem, decreased need for sleep, and loud, rapid speech. A manic episode may typically last from a few days to a couple of months. Due to impaired judgment, a manic episode is often accompanied by legal and

financial problems and is thus commonly associated with the person's substance abuse (American Psychiatric Association, 1987).

On the other hand, the depressive episode involves a dysphoric mood (usually depression) or a loss of pleasure. The youngster's interests in usual activities are often accompanied by such symptoms as disturbances in sleep and appetite, psychomotor agitation or retardation, decreased energy, feelings of worthlessness, and quiet, impaired concentration and thoughts of suicide. Associated features of the depressive episode vary, depending on the person's age. Such features include a display of separation anxiety portrayed by prepubertal children, antisocial behavior exhibited by adolescent boys, and, with elderly people, disorientation and memory loss (American Psychiatric Association, 1987).

The course of both manic and depressive episodes may last for a varying amount of time. A cluster may be separated by several years of normal functioning, or the episodes may occur one event after another. It is estimated that a moderate-to-small percent of cases involves a chronic course (American Psychiatric Association, 1987).

Based upon differences in symptomatology, several researchers have distinguished between bipolar and unipolar depression. Bipolar depression is represented by detachment, preoccupation, reduced interaction with others, lethargy, and an increase in sleep. Bipolar episodes also alternate between periods of mania which are depicted by hyperactivity, elation, irritability, and excessive talking. Furthermore, bipolar episodes may be associated with higher frequencies of affective disorders in family members at an earlier onset than that of unipolar episodes. By contrast, the unipolar episode is characterized by agitation, anxiety,

overt expression of anger, somatic complaints, insomnia (American Psychiatric Association, 1987).

The Diagnostic and Statistical Manual of Mental Disorders -- Revised (American Psychiatric Association, 1987) has adapted an approach to affective disorders that can be described in terms of bipolar and unipolar depression.

DSM-III-R AFFECTIVE DISORDERS - BIPOLAR AND UNIPOLAR DEPRESSION

	Bipolar Disorders	Unipolar Disorders
Major Affective Disorder	Bipolar Disorders	Major Depression
Other Specifies Affective Disorders	Cyclothymic Disorder	Dysthymic Disorder
Atypical Affective Disorders	Atypical Bipolar Disorders	Atypical Depression

Another approach to classifying the concept of depression is based upon its etiology and the description of depression as being either endogenous or exogenous. Endogenous depression is thought to be caused by internal processes, such as genetic or biochemical ones. The exogenous depression is believed to be related to a recent loss, stress or external events. The research indicates that endogenous depression is more likely to be displayed among older people. The younger individuals more commonly exhibit exogenous depression. Furthermore, the endogenous person typically display a stable, non-neurotic premobid personality than does a person suffering from exogenous depression (Kaplan and Sadock, 1981).

A number of methods have been used to label depression. However, for the purpose of this research project, depression was explored at three different stages of severity: mild, moderate, and severe. Mild depression is the first of this group to be discussed.

Mild depression is probably the most common and is the least severe of the three categories. It is normally brief and does not seriously interfere with daily activities. Certain events such as holidays, a relocation to a different home, enrollment in a new school, the anniversary date of a traumatic event, boredom and even frustration can produce brief feelings of despondency. Inescapable, subtle reminders such as old songs, certain scenarios, and even particular physical characteristics of an individual can induce temporary feelings of depression.

Rutter, Izard, and Read (1986) described mild depression exhibited by children as sadness or depressed affect as a single symptom. It is a subjective state experienced by most people at various points in their lives, and yet by itself, it is not necessarily pathological. This type of depression is also referred to as Reactive Depression. And again, it is caused by external psychogenic factors. In her research, Wetzel (1984) referred to such life factors as exogenous in nature. In contrast to this, she identified internal causes of depression as being endogenous.

Reactive depression, which may be considered synonymous with mild depression, is usually short in duration and lacks marked signs of physical retardation. These signs are fundamentally not different from a reaction to life's situations (Flach and Draghi, 1975), and individuals with this type of depression usually respond positively to medication, support, and understanding (Wetzel, 1984).

This literature review also includes those studies focusing on moderate depression. This second stage of severity is referred to as moderate depression. Moderate depression is similar to mild depression, except that the emotional experience is longer in duration and is greater in intensity. Children who exhibit moderate depressive symptoms may or may not be aware of what they are undergoing. Quite often, they do not always know and understand how to react to their feelings of despondency. For the most part, children just realize that what they are experiencing is not a comfortable feeling.

Older children and adolescents may develop maladaptive methods of responding to the symptoms, due primarily to their lack of insight and their poor judgment. Because of this shortcoming, the youngster may cause danger to himself as well as to others. In many cases, these young people may turn to their peers instead of to responsible adults for guidance. As a result, this type of resource may be detrimental, for it is not a viable option for relieving feelings of unhappiness. Rutter, Izard, and Read (1986) indicated that this form of depression among children is considered a syndrome. It implies more than an isolated dysphoric mood, and it occurs in combination with other symptoms to form a symptom-complex. Likewise, Wetzel (1984) described moderate depression as neurotic depression. She suggested that neurotic depression was free from bizarre symptoms and that a youngster was able to maintain apparent contact with reality, despite depressive symptomatology.

Again, in 1987, the American Psychiatric Association characterized moderate depression as Dysthymia or Depressive Neuroses. The researchers proposed that the essential feature of this disorder was a chronic disturbance of mood involving a depressed mood (or a possible irritable

mood with children or adolescents). This disturbance of mood lasted for most of the day, more days than not, and for at least two years (one year for children and adolescents).

Finally, this literature review addresses severe depression, which is a type that is the most pathological form of depression. Severe depression occurs when the youngster loses touch with the reality of his environment; and it may be characterized by prolonged changes in the youngsters common behavior. There are times when other mental disorders, such as schizophrenia, alcoholism, and drug addiction may be related to and impact on the severely depressed youngster. In addition, manic-depressive illnesses are also considered a form of severe depression, which takes place as the child moves from extreme highs of motivation, enthusiasm, and jubilation to deep lows of despondencey and apathy. Psychotic episodes usually manifest severe depression, together with visual or auditory hallucinations and delusions of something that is impossible to be true. Even in less obvious cases, loss of contact with reality is evident (Wetzel, 1984).

Furthermore, the American Psychiatric Association (1987) focused on the Major Depression Syndrome. The researchers explained that the essential features of a Major Depressive Episode were either a depressed mood (or possibly, in children or adolescents, an irritable mood), or loss of interest or pleasure in all, or a almost all activities, and associated symptoms for a period of at least two weeks. The symptoms represented a change from previous functioning and were relatively persistent; that is, they occurred for most of the day, nearly everyday, during a two-week period.

The Symptoms of Childhood Depression

There is a wide range of symptoms which a youngster may exhibit during the course of a depressive episode. Some of the symptoms are marked by noticeable and overt changes in his behavior and attitude. Others may be centered in complaints of physical ailments which have no organic origin. The child may even express an evident deference in his feelings and perception toward life. The case notwithstanding, depression can certainly impact the lifestyle of a youngster.

The most obvious signs of the depressive disorder among the childhood population have been researched. These are presented in the Diagnosis and Statistical Manual of Mental Disorders -- Revised (American Psychiatric Association, 1987). The signs include:

(1) A depressed or irritable mood in children and adolescents, most of the day, nearly everyday, as indicted either by subjective account or observation;

(2) Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly everyday, as indicated either by subjective account or observation by others of apathy most of the time;

(3) Significant weight loss, when not dieting, weight gain, or decrease or increase in appetite nearly everyday;

(4) Insomnia or hypersomnia nearly everyday;

(5) Psychomotor agitation or retardation nearly everyday;

(6) Fatigue or loss of energy nearly everyday;

(7) Feelings of worthlessness or excessive or inappropriate quietness;

The Symptoms of Childhood Depression

There is a wide range of symptoms which a youngster may exhibit during the course of a depressive episode. Some of the symptoms are marked by noticeable and overt changes in his behavior and attitude. Others may be centered in complaints of physical ailments which have no organic origin. The child may even express an evident deference in his feelings and perception toward life. The case notwithstanding, depression can certainly impact the lifestyle of a youngster.

The most obvious signs of the depressive disorder among the childhood population have been researched. These are presented in the Diagnosis and Statistical Manual of Mental Disorders -- Revised (American Psychiatric Association, 1987). The signs include:

(1) A depressed or irritable mood in children and adolescents, most of the day, nearly everyday, as indicted either by subjective account or observation;

(2) Markedly diminished interest or pleasure in all or almost all activities most of the day, nearly everyday, as indicated either by subjective account or observation by others of apathy most of the time;

(3) Significant weight loss, when not dieting, weight gain, or decrease or increase in appetite nearly everyday;

(4) Insomnia or hypersomnia nearly everyday;

(5) Psychomotor agitation or retardation nearly everyday;

(6) Fatigue or loss of energy nearly everyday;

(7) Feelings of worthlessness or excessive or inappropriate quietness;

(8) Diminished ability to think or concentrate, or indecisiveness nearly everyday; and

(9) Recurrent thoughts of death.

At least five of the nine symptoms must be evident and they must exceed a two-week duration before the child can meet the criteria of depressive disorder in the DSMIII-R (American Psychiatric Association, 1987). Because of their lack of emotional maturity and their limited understanding of the experienced sensations, some young people do not always possess the best insight and judgment as they relate to depressive feelings. In essence, they may develop maladaptive methods of reacting to the entire notion of despondency.

Noshpitz (1979) suggested that during latency, the child who is depressed shows the feelings of inferiority. He is stamped as the under-achiever, the slow learner, and the youngster with learning disabilities. For this reason, the child feels inferior and obtains no validation of his worth from either family or peers. Incidentally, according to Vincenzi (1987), depression has a direct relation to learning problems for children in school. In his study, Vincenzi examined the relationship between depression and reading achievement, using two diverse groups of 39 black urban sixth-grade children. Using the Children's Depression Inventory, he discovered that the level of depression was significantly related to current reading level, grade-point averages, and reading achievement. The results of his study indicated that significant correlations existed between depression score and reading level, depression and reading achievement, and depression and grade-point averages. The data showed that depression was negatively associated with reading ability of groups within each school.

Somewhat similar to Vincenzi's study, Shure and Spivach (1982) argued that urban school children could suffer from increased maladjustment as they move through the early grades. They further concluded that one way to promote mental health in children was to build their cognitive strengths, which, in turn, will allow them to better cope with frustration and conflict and will reduce the risk of depression.

Similarly Vincenzi (1987) in his study reported that the theory associated with Shure and Spivach's concept implied that depressed children generated less effective means in problem-solving situations than did non-depressed children. Thus the reduced problem-solving ability does not allow them to deal effectively with life's perplexing situations. This lack, of course, stifles the depressed child's ability to learn.

In many instances, depression may be hidden or "masked" by children or expressed covertly. Rosenstock, Kraft, Rosenstock, and Mendell (1986) indicated that the common elements in masked depression were feelings of losing face, a low self-esteem, a lack of relationships and of ambition. Rosenstock and his colleagues suggested that some youngsters who experience masked depression attempted to act out their frustration and feelings of impotency; on the other hand, others tried to assuage their pains by taking drugs. The researchers also opined that children who appeared to be paragons of good behavior, might actually be living in a fantasy world. Finally, the researchers reported that even somatic problems could be representative of the concept of masked depression.

In support of these findings, Knope (1984) discovered that depressive symptoms among children might also be masked by apathy, social withdrawal, and somatic complaints, such as headaches or abdominal pain.

He reported that even a display of aggressive behavior, for instance, vandalism, sexual acting out, or truancy, especially in older children, might be masked. Knope also found a significant relationship of poor appetite, weight loss, and disturbed sleep patterns among the children surveyed.

In a related study, Noshpitz (1979) noted that through empirical observation, depressed children, who suffered losses, who feared abandonment, and who craved unequivocally to be nurtured and protected in their feelings of infantile helplessness, were not always "nice kids." On the contrary, he suggested that they may be aggressive and hateful children. In fact, many delinquents functioned from a position of emotional depression, and a number of them were more agitated, restless, sad, and lonely than they were jazzed up or cunning.

There is general agreement among researchers and practitioners in the field that depression does occur in children before puberty and that dysphoria is a major characteristic of the disorder (Kestenbaum and Williams, 1988). As early as six months of age, infants have been found to possess depressive symptomatology. Spitz and Wolf (1946) documented the responses of six-month-old children who were removed from their mothers. In their research, they noted that the infants in this situation seemed sad, weepy, and apathetic. Spitz and Wolf indicated that the babies appeared to lose interest in their surroundings, moved slowly, and possessed irregular eating and sleeping habits. Spitz and Wolf (1946) thus described the syndrome as "anaclictic depression" and believed that the most significant characteristics were sadness, withdrawal, and lethargy. They also noted that these symptoms closely resembled the depressive symptoms observed in adults.

A summary of the clinical representation of the dysphoric infant would include sad faces, listlessness, a lack of responsiveness to the environment, and, possibly, disturbances in eating and sleeping. The interpretation of this state is that the infant is withdrawing from a world made painful by the absence of the mother (Kestenbaum and Williams, 1988).

However, probably the most significant symptom noted among depressed children is suicide. According to Noshpitz (1979), many depressed children, express suicidal ideations and wishes, both consciously as well as on a fantasy level. However, he indicated that under the age of 14 suicide attempts, and suicidal gestures were very rare among this age group of children.

Further, he reported that the occasional suicidal attempts in the 14 and below age group were mostly attributable to impulsive-angered children, those who had a low level of frustration tolerance that usually came from chaotic, disturbed, multi-problem families. In contrast to those actual successful suicidal attempts which were more common among boys, suicidal gestures were found to be more prevalent among girls.

The U.S. Department of Health and Human Services (1983) noted that the possibility of suicide was the most serious complication of the depressive disorders. Feelings of worthlessness can quietly overcome the person, and he feels unfit to live. Sometimes these feelings remain just as thoughts, and at other times they lead to suicidal attempts.

To be sure, not all of those suffering from depressive disorders attempt suicide, nor do all of those who attempt suicide suffer from depressive disorder. It has been estimated, however, that 15 percent of

depressed persons eventually commit suicide. Other studies have indicated that the person hospitalized for depression at sometime in his life was about 30 times more likely to commit suicide than was the non-depressed person, with the greater risk occurring during or immediately following hospitalization (U.S. Department of Health and Human Services, 1983).

Likewise, research has revealed that the likelihood of suicide increases with advancing age. In recent years, however, there have been alarming increases in suicide among young adults. Moreover, approximately twice as many women as men suffer from depressive disorders, and hence nearly twice as many women attempt suicide. Like the rate among the youngsters, three times more men than women complete the suicide attempt (U.S. Department of Health and Human Services, 1989).

The Causes of Childhood Depression

The causes of depression among the childhood population may vary. However, Mullins, Siegel, and Hodge (1985) discovered in an investigation of 135 students in a coed, mid-western city school that the level of self-reported depressive symptoms in non-referred children was significantly related to an external locus of control, to negative life events, to a selected aspect of interpersonal problem-solving abilities in general, and to a low socio-economic status. They also found that of all the variables considered, the external locus of control emerged as the most significant variable, accounting for the variance in depression among the children whom they evaluated.

In addition to the data presented by Mullins and colleagues, the American Psychiatric Association (1987) has also indicated, as a result

of their research, that chronic physical illness and psychoactive substance dependence, particularly alcohol and cocaine dependency, are apparent predispositions to the development of a major depressive episode. Frequently, a major depressive episode follows psychosocial stressors, particularly the death of a loved one, marital separation, or divorce. More specifically, with children and adolescents, predisposing factors to depression can be the presence of attention-deficit Hyperactivity Disorder, Conduct Disorder, Mental Retardation, a severe Specific Developmental Disorder or an inadequate, disorganized, rejecting, and chaotic home environment.

Interestingly enough, the primary causes for depression are multiple and few may thus be understood. However, the most basic cause, according to Noshpitz (1979), is the failure to develop skills and competencies that buffer the self from sadness-discouragement of one's own hostility (anger, disgust, and contempt) and shame.

Depression may therefore be present as a symptom associated with some other disorder, for example, as an acute grief reaction to the loss of a loved one, as a temporary state of developmental crisis, or as a separate psychotic condition. In reference to a temporary state of development, Rosenstock, Kraft, Rosenstock, Mendall, and Stubblefield (1986) suggested that the school environment was often responsible for exacerbating depression in certain children. They indicted that whenever the child and school were mismatched, a stressful situation resulted. Hence, this often created hidden depression.

The researchers cited four specific underlying reasons for school related depression. These reasons were:

a) children's sense of captivity at school; that is, the law requires children to attend school until they are 16 years of age;

b) the erosion of the teacher-child relationship;

c) competition from other children within the school environment; and

d) an overall adjustment to the school environment.

Studies in the literature have indicated two theoretical foundations for the etiology of depression. These foundations includes a physiological concept which contains genetic and biochemical sub-components and a psychological concept that covers the sub-components of psychoanalysis, cognition, and learning.

In short, the genetic theory suggests there is a higher incidence of affective disorders among relatives than there is in the general population. For example, the concordance rates among relatives were higher for bipolar depression than for those relatives with unipolar depression (Kallman, 1953; Rosenthal, 1971; and Wenokur, 1969). Furthermore, another researcher has offered two major biochemical theories which propose to explain the causes for depression. One is the Catedrolamine Hypothesis, which states that low levels of catecholanines, especially norepinephrine produces depression, while an increased level has become associated with mania. The second theory suggests that depression is caused by low levels of serotonin. Both norepinephrine and serotonin are involved in producing affective disorders. The researcher also noted that a low level of serotonin produces a predisposition for an affective

disorder and that certain levels of norepinephrine will determine the disorder's direction (Prange, 1974).

The second foundation making up this category involves the psychological dimension. According to the psychoanalytic theory, depression is represented by hostility or aggression toward others, hostility that is turned inwardly. The theory also indicates that depression results from a significant loss of an actual love object, or a symbolic loss. Incidentally, Beck (1976) contended that depression was due to an individual's illogical inner statements (schemata) related to a person's own perception of his environment. The schemata associated with depression are characterized by the following:

a) arbitrary inference (a conclusion made in the absence of sufficient evidence);

b) selective abstraction (a conclusion is made on the basis of any one element of a situation);

c) over generalization;

d) magnification; and

e) minimization.

Finally, from a psychological perspective, the behaviorists have suggested two learning theories. The first of these notes that depression results from a reduction in reinforcement and activity. Lewinsolm (1974) indicated that a feeling of depression and of related symptoms was elicited by a lack of reinforcement. The reduced reinforcement, in turn resulted in decreased activity which provided even less opportunity for reinforcement.

Another learning theory contends that depression is due to learned helplessness (Seligman, 1975). According to this theory, depression

results when an individual believes that he has little or no control over important life events. Seligman's theory was derived from his arrival studies wherein dogs were first exposed to conditions from which they were not able to escape elective shock. The dogs were subsequently placed in a box where shock could be avoided by their jumping over a hurdle. Dogs that were initially subjected to the inescapable shock condition were unable to learn the simple task of jumping the hurdle in order to avoid shock and thus displayed a variety of behaviors that Seligman defined (1975) as "learned helplessness." Based upon these studies, Seligman (1975) described several similarities between learned helplessness and exogenous depression, which included:

a) a lower initiation of voluntary responses such as passivity, social withdrawal, and reduced activity;

b) a negative cognitive set and the inability to learn new responses which could produce relief;

c) dissipation of symptoms over time;

d) lack of aggressive behavior;

e) loss of appetite and sexual energy; and

f) depletion of norepinephrine.

In 1971, Wiener discussed the concept of attribution, which is related to Seligman's theory. Wiener proposed that this phenomenon was the manner in which a person attributed failures and was how he determined the subsequent effects of those failings. Wiener also suggested that the depression resulted from the person's attributing negative outcomes to his personal, global and stable individual characteristics.

The Treatment for Childhood Depression

The eclectic treatment modalities for those children with affective disorders are primarily determined by the severity of their psychopathology. Treatment may range from weekly counseling sessions with a mental health professional to alterations made in the living environment to an extended stay in a psychiatric hospital or mental institution. The basic formality for psychological care provided to these youngsters involves active participation in counseling or psychotherapy, possibly a change within the home and family structure and/or usage of psychoactive drugs.

Moreover, the rational approach to the treatment of reactive depression is the alleviation of influences that have set the stage for depression and of those that perpetuate it. Careful diagnostic evaluation of the child and family will most often elucidate those influences. Appropriate intervention at the individual's family, school, and/or community level becomes then the desired manner of dealing with the condition. In the direct treatment of the child, attention to impaired self-esteem is of paramount importance. When the child's coping mechanisms are inadequate, or when environmental influences are overwhelming, placement of the child in a neutral or therapeutic setting is often necessary (Wiener, 1977).

On the other hand, medication therapy for the treatment of childhood depression is probably more pronounced in Europe than in America, where the treatment has been chiefly through the process of environmental manipulation and psychotherapy (Wiener, 1977). This type of medication therapy may only be prescribed by a licensed physician, particularly one who has specialized training in psychiatry. The mood-altering drugs that

are used for the treatment of depression among the childhood population include:

1) Tricyclic Derivative Antidepressants;

2) Monoamine Oxidase Inhibitor Antidepressants;

3) Central Nervous System Stimulants; and

4) Lithium Salts

Tricyclic Derivative Antidepressants are comprised of imipramine, desipramine, amitriptyline nortriptyline and protriptylene (Berkow, 1982). The tricyclic antidepressant drugs will elevate mood and reduce tension and anxiety. The drugs also sedate, decrease suicidal preoccupation, rumination, or retardation, and improve appetite and sleep patterns (Denber, 1977).

The Monoamine Oxidase Inhibitors Antidepressants (MAOIs) include hydrayine derivatives, iproniazid, phenelzine, nealamide, insocarboxazid, nonhydrazine compounds tranylcypromine and paragyline (Berkow, 1982). The Monoamine Oxidase Inhibitors are primarily effective with phobic and hysterically depressed patients (Denber, 1979).

According to Goldsmith (1979) the MAOIs are not considered to be as effective as are the tricyclics in relieving depression. He pointed out that some studies had indicated they were just a little better than placebos. Conversely, there may be certain types of depressions for which they prove most beneficial. Goldsmith also reported that MAOIs had been used effectively in depressions in which the the patient was severely retarded in his activity. MAOIs have also been used successfully in the treatment of phobias and anxieties. Too, the drugs are also effective for use with patients who have disabling obsessions.

The Central Nervous System Stimulants are amphetanines, dextro-amphetamines, methamphetamines, methylphenidates, penolines, and deanals (Wiener, 1977). According to Wiener (1977), these stimulants produce an euphoric effect in adolescents and in adults. They have been utilized for short-term depression with adults. However, they are rarely used for the treatment of depression among adolescents, due to their negative side effects. Furthermore, Wiener indicated that due to the of rebound depression, the use of the drug may become hazardous. For the most part, CNS stimulants were not viewed as the treatment of choice for depression among the childhood population.

Lithium Salts focus primarily around lithium carbonate (Wiener, 1977). Lithium is used in the treatment of manic-depressive psychosis. However, it is most successfully used to prevent episodes of mania. Lithium is less consistently useful in the prevention of depression, but seems to be effective in some patients with recurring endogenous depression. Lithium is also being tried in other emotional illnesses in which there are a wide range of mood swings. And it has been used successfully on patients with schizo-affective, schizophrenic and manic-depressive behaviors. This medication may be of value in other types of schizophrenia, when it is combined with a standard anti-psychotic drug. Lithium has also been tried, with varying degrees of success, on patients with alcoholism, heroin addiction, behavior disorders, tardive dyskinesia, and other psychiatric illnesses (Goldsmith, 1977).

Certainly, medication therapy is not the sole treatment for depression among children. It may be used temporarily in order to stabilize a young person's depressive condition. Equally as important as the use of medication is an effective measure which is taught to the individual to

be used for coping with depressive symptomatology. This procedure can be accomplished through various forms of psychotherapy and counseling.

Through the processes of a guided verbal exchange, behavioral interventions, and psychotherapeutic activities, a youngster may explore his complicated and unresolved feelings. It is believed that through these psychotherapeutic exercises, the child can begin to examine much more clearly what he is actually internalizing. Subsequently, the youngster can adapt and develop an effective method to deal with his psychopathology.

For the treatment of depression disorders among children and adolescents, the mode of operation for counseling, psychotherapy, and other forms of treatment may be conducted in different modalities. Trad (1987) discussed "Interpersonal Psychotherapy." He indicated that this model was based on the hypothesis that depression evolved from a defect in interpersonal relationship.

More specifically, this psychoanalytic interpersonal therapy suggests that a breakdown has occurred in the primary interpersonal interaction, which is mostly centered around the mother and child (Trad, 1987). This idea, of course, represents the matrix from which depressive symptomatology arises. Trad (1987) also indicated that interpersonal therapy was often brief, lasting only 12 to 16 weeks. Moreover, it focused on restructuring the individual's prevailing interpersonal functioning. In his research, Trad described yet another form of treatment for depressive children. This model he called "Developmental Guidance and Support," and said that it may be used in two different situations. In the first situation, parents are assessed to determine their possession of competent nurturing skills; yet neonatal complications, or infant

illness/hospitalization have somehow stressed their capacities as parents. The second form of thought suggests that although both infant and parents manifest severe emotional impairment, the parents' innate capacities may be too limited for them to benefit from the intensive analysis posed by a psychotherapeutic model. Therefore, such treatment emphasizes providing support to strengthen those capacities that do exist, while at the same time providing information about the infant's growing needs.

This particular model of treatment has also proven beneficial, not only with infants, but also in an upscaled version. For example, it has been found to be helpful with the treatment of older children and young adolescents. Currently, it is referred to as a form of parent education and is utilized in many mental health centers and schools within inner-city, urbanized areas of living. Modification of this treatment model also offered substantial relief to the parents of those children who lived within the lower socio-economic class.

Another form of treatment for depression is called behavioral therapy. Behavioral therapy is based primarily upon the behavioralistic school of thought, which simply suggests that depressive symptoms are pathologically learned as a coping mechanism. After being taught effective coping mechanisms, an individual may be able to adjust to life in an adaptable fashion.

Whitehead (1979) discussed four major objectives of the behavioral approach to treatment. He contended that:

. Depressive behavior, per se, constitutes the disorder and can be modified by the manipulation of reinforcers;

. There exists a decrement of positive reinforcement that can be manipulated and increased;

. The decreased sense of control over one's life, as well as the person's sense of helplessness, can be extinguished through selective positive and negative reinforcement; and

. Negative viewpoints should be replaced with positive viewpoints.

This suggested approach to the treatment of depression emphasizes the concept of the "here-and-now" practice.

An additional approach to the psychotherapeutic treatment of depression among the childhood population is cognitive therapy. Beck (1976, 1973) developed a method that focused on the thought processes, or cognitives, that are present in all psychotherapeutic approaches. Furthermore, Wolman (1983) indicated that this treatment was predicated on the theory that overwhelming stress, either specific or nonspecific, in combination with idiosyncratic thought patterns, preceded depressive states. The treatment modality thus attempted to alter maladaptive cognitives.

There are a number of different treatment methods that exist within the overall categories of psychotherapy and counseling. However, Trad (1987) had suggested the psychoanalytic psychotherapy as one of the most effective forms of treatment. He indicated, though, that psychoanalytic psychotherapy with children was a much less intensive version than adult psychoanalysis. This therapy provided for a more insight-directed treatment which sought major changes beyond those of just symptom reduction.

In view of the educational process as an area of intervention, those children who are unable to achieve in school will begin to see academic success as unattainable. They will therefore protect themselves and guard their tender egos by deciding school is not important. Many seek a

sense of adequacy, by belonging to and identifying with non-mainstream groups that do not value academic achievement. Such children are at risk for dropping out, for teenage pregnancy, for drug abuse and for crime (Comer, 1988).

At Yale University's Child Study Center, Comer (1988) has started an intervention project at two inner-city schools in New Haven, Connecticut. The program focuses on development and learning by building supportive bonds that draw together children, parents, and school. This program was created because Comer found that interactions among parents, staff and students revealed a basic problem underlying the schools' dismal academic and disciplinary records. Comer contended that there was a socio-cultural misalignment between home and school. As a means of supporting the holistic treatment approach to depressive symptomatology from a psychoeducational perspective, the philosophy was centered in the notion that a youngster developed strong emotional bonds to his or her immediate caretaker, a fact which enabled the caretaker to foster the individual's academic and psychological growth as well as his overall development. In this case, the primary caretaker beyond the home was the elementary school teacher.

Moreover, Comer (1988) also opined that the attitudes, values, and behaviors of the family and its social network strongly affect such development. Thus, he suggested that a child whose development meshed with the mainstream values encountered at school would be prepared to achieve at the level of his or her ability. The meshing of home and school fosters further development, so when a child's social skills that are developed at home are considered appropriate by the teacher, these skills tend to elicit positive reactions from the teacher. Too, a bond

develops between the child and the teacher, who can now actively join in supporting the overall development of the child.

Earlier, Marlowe (1978) concluded, after working with 12 academically low-achieving seventh-grade black males students who reportedly exhibited a high rate of inappropriate classroom behavior, that the teacher approval within the classroom could be most effective in changing the students' behavior. He noted in his study that, the teacher was able to reduce inappropriate behaviors among the three counseling groups that were assessed. The positive reinforcement of appropriate behavior from the teacher was significantly more effective than was client-centered counseling conducted by a counselor. The method used only reaffirmed the importance of a healthy child-teacher relationship.

Above all, it should be noted that a child from a poor marginal family is likely, in many cases, to enter a school without adequate preparation. The child may arrive at school without ever having learned such social skills as negotiation and compromise. This same child, who is expected to read at school, may come from a home where no one reads, or may never have heard a parent read him a bedtime story (Comer 1988).

Finally the process of family therapy offers the entire family a method of dealing with a depressed child within the household. With this modality of therapy, the parents and other family members' behaviors can be altered or modified to become an integral part of the treatment, thereby optimizing family functioning. Trad (1987) also indicated that parental discussion, counseling, reattunement, and re-education are often useful methods for initiating the ameliorative efforts of treatment. Family therapy can provide the psychotherapist or counselor with a wealth of new data for devising interactive strategies for intervention.

Therefore, theoretically, the emphasis of family therapy is placed upon family interactions which can be traced to the adoption of a general systems theory. Moreover, the general systems theory proposes that the actions of interacting components can be best understood by examining those components within the context (Goldenberg and Goldenberg, 1985).

The general systems theory is also responsible for generating two major family therapeutic concepts. The first of these is homeostasis, which is the tendency of a family to act in a way that maintains the family's equilibrium or status quo. The other is the "identified patient," which includes the family member whose symptoms help monitor the the family's homeostasis (Goldenberg and Goldenberg, 1985). Nevertheless, family therapy should not be considered an isolated technique for treatment, but collective effort by all members to resolve internal family conflict. According to Goldenberg and Goldenberg (1985), family therapy is an attempt to alleviate the current interlocking emotional problems within a family system by helping its members change the family's dysfunctional transactional patterns by working together.

In summary, the review of related literature was comprised of four major parts. The parts included: (1) The concept of childhood depression, (2) The symptoms of childhood depression, (3) The causes of childhood depression, and (4) The treatment for childhood depression.

First, the concept of childhood depression provided an account of the nature of depression among the childhood population. Generally, it dealt with such factors as the definitions and types of depression that were suggested by various theorists and researchers. Furthermore, it separated the concept of depression into three subsections; mild, moderate, and severe to offer clarity and greater understanding.

The second category dwelled upon the symptoms of depression among the childhood population. In addition, a number characteristics were cited as signs of depressive symptomatology. This category also provided various theories and focused upon the criteria which constitutes the diagnosis of depression. Such criteria was based upon researched data provided by the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders-Revised (1987). Above all, this section noted that various forms acting out behavior was seen as the most prevalent symptom of depression among the childhood population.

In category three, the causes of childhood depression were discussed. This proportion beared a close resembles to the section on symptoms of depression. The literature from this part focused upon the causes that are identified with children who are depressed. Environmental circumstances played a significant role from this section of the study. Several theorists, researched in the proportion, placed great emphases on the adversive atmosphere as contributing to depression among children. Others argued that heredity was a primary principal component to the development and maintenance of depression among children.

The final section concentrated on the remedy of childhood depression. It suggested different treatment methodologies that were postulated by researchers in the field. A heavy emphasis was placed on the different kinds of counseling and psychotherapy modalities which may range from individual sessions, to family conferences, to extended visits in mental institutions. Even school based intervention programs were found to be a beneficial form of treatment. And finally, there was significant weight given to medication therapy and its reaction for helping children with childhood depression.

CHAPTER 3

DESIGN OF THE STUDY

The purpose of this investigation was to determine if living within adversed environmental conditions was related to symptoms of depression found in the high-risk African American adolescent male. This present chapter consists of seven sections:

1. Type of Design;
2. Population;
3. Profile of Demographic Data;
4. Sampling Procedure;
5. Data-Gathering Instrument ;
6. Data-Collection Procedure;
7. Statistical Analysis.

Type of Design

The researcher used a single-variable design for analysis in this study. For the purpose of this investigation, the following served as independent variables: level of family income, grade-point averages, number of expulsions from school, number of years residing in Houston, number of family members in the home, parents' level of education, number of single-parent homes, grade levels, the number of female-headed homes, the number of recipients on public assistance, and ages of the subjects.

The depression level of the subjects was the dependent variable. According to Kerlinger (1986), this design is used to measure the effect of the independent variable on the dependent variable.

Population

The Fifth Ward Enrichment Program is a non-profit organization which is part of the Urban Affairs Corporation Project that was established in 1984. The program was set up to empower high-risk inner-city Black youth to achieve responsible adulthood. During its initial phase in the 1984-85 school year, the Fifth Ward Enrichment Program was implemented and housed at E.O. Smith Middle School. The program was designed to involve young men ages eleven to fourteen. The boys were primarily from single, female-headed households and were at-risk of becoming contributors to such major social problems as school dropouts, criminal offenders and teen fathers. The primary objective of the program was to redirect the youngster's energies into constructive, socially desirable and developmentally appropriate behaviors.

From 1985 to 1987 the Fifth Ward Enrichment Program continued to grow and develop. It underwent assessment and reevaluation to better serve the needs of the young black males of the community. After the school year 1987-1988, the Fifth Ward Enrichment Program expanded to include not only those from E.O. Smith, but also youngsters who attended Fleming Middle School and Langston and Crawford Elementary Schools. The expansion of the program allowed staff members to serve many children who were in need of the services offered. Prior to this time, several youngsters had signed a waiting list for the program.

The young men were identified by their respective schools as being at high risk of becoming contributors to major social problems. These participants were referred for the program services, based on one or more indicators of counterproductive behavior, such as poor academic performance, truancy, criminal justice contacts, alcohol and drug use, disruptive school or home behavior, and emotional and psychological problems. For the purpose of this study, only those boys who were participants in the program attended either E.O. Smith or Lamar Fleming Middle schools. This group comprised the total population.

Profile of Demographic Data

The profile presents the distribution sample of African American adolescent males whose families level of income was $8,000 or less and African American adolescent males whose families level of income was $8,001 or more. Table 1 shows that 75.8% of the sample were African American adolescent males whose families level of income was $8,000 or less and 24.2% of the sample were African American adolescent males whose families level of income was $8,001.

TABLE 1

Distribution Sample of Family's Level of Income

Family's Level of Income	Number of Subjects	Percentage
$8,000 or less	25	75.8
$8,001 or more	8	24.2

The profile presents the distribution sample of African American adolescent males who had a 1.9 or less grade-point average and African American adolescent males who had a 2.0 or above grade-point average. Table 2 shows that 57.6% of the sample were African American adolescent males who had a 1.9 or less grade-point average; 42.4% of the sample were African American adolescent males who had a 2.0 or above grade-point average.

TABLE 2

Distribution Sample of
Grade Point Averages

Grade Point Average	Number of Subjects	Percentage
1.9 or less	19	57.6
2.0 or above	14	42.4

The profile presents the distribution sample of African American adolescent males with one or fewer expulsions from school, and African American adolescent males with two or more expulsions from school. Table 3 shows that 45.5% of the sample were African American adolescent males with one or less expulsion from school, and 54.5% of the sample were African American adolescent males with two or more expulsions from school.

TABLE 3

Distribution Sample of the Number of School Expulsions

Number of Expulsions	Number of Subjects	Percentage
1 or less	15	45.5
2 or more	18	54.5

The profile presents the distribution sample of African American adolescent males who have resided in the inner city area of Houston for 12 years or less and of African American adolescent males who have resided in the inner city area of Houston for 13 years or more. Table 4 shows that 21.2% of the sample were African American adolescent males who had resided in the inner city area of Houston for 12 years or less; and 78.8% of the sample were African American adolescent males who have resided in the inner city area of Houston for 13 years or more.

TABLE 4

Distribution Sample of the Number of Years Living in Houston

Number of Years	Number of Subjects	Percentage
12 years of less	7	21.2
13 years or more	26	78.8

The profile presents the distribution samples of African American adolescent males who have lived in homes with three or fewer family members and of African American adolescent males who have lived in homes with four or more family members. Table 5 shows that 36.4% of the sample were African American adolescent males who had lived in homes with three or fewer family members, and 63.6% of the sample were African American adolescent males who lived in homes with four or more family members.

TABLE 5

Distribution Sample of the Number of Family Member Within the House

Number of Family Members	Number of Subjects	Percentage
3 or less	12	36.4
4 or more	21	63.6

The profile presents the distribution sample of African American adolescent males whose parent received a high school diploma and African American adolescent males whose parent did not receive a high school diploma. Table 6 shows that 54.5% of the sample were African American adolescent males whose parents had received a high school diploma, and 45.5% of the sample were African American adolescent males whose parent did not receive a high school diploma.

TABLE 6

Distribution Sample of Parents with High School Diplomas

High School Diploma	Number of Subjects	Percentage
Yes	18	54.4
No	15	45.5

The profile presents the distribution sample of African American adolescent males who resided in female-headed households and African American adolescent males who did not reside in female-headed households. Table 7 shows that 78.8% of the sample were African American adolescent males who resided in female-headed households, and 21.2% of the sample were African American adolescent males who did not reside in female-headed households.

TABLE 7

Distribution Sample of Female Headed Households

Female Headed Households	Number of Subjects	Percentage
Yes	26	78.8
No	7	21.2

The profile presents the distribution sample of African American adolescent males who resided in single-parent homes and African American adolescent males who did not reside in single-parent homes. Table 8 shows that 78.8% of the sample were African American adolescent males who

resided in single-parent homes, and 21.2% were African American adolescent males who did not reside in single-parent homes.

TABLE 8

Distribution Sample of
Single-Parent Homes

Single Parent Homes	Number of Subjects	Percentage
Yes	26	78.8
No	7	21.2

The profile presents a sample distribution of African American adolescent males who resided in homes in which the head of the household was employed and African American adolescent males who resided in home in which the head of household was not employed. Table 9 shows that 39.4% of the sample were African American adolescent males who resided in homes in which the head of household was employed, and 60.6% were African American adolescent males who resided in homes in which the head of household was not employed.

TABLE 9

Distribution Sample of Employment
Status of Head of Household

Employment Status	Number of Subjects	Percentage
Yes	13	39.4
No	20	60.6

The profile presents a sample distribution of African American adolescent males whose families were granted public assistance and African American adolescent males whose families were not granted public assistance. Table 10 shows that 75.8% of the sample were African American adolescent males whose families were granted public assistance, and 24.2% of the sample were African American adolescent males whose families were not granted public assistance.

TABLE 10

Distribution Sample of Public Assistance Granted

Public Assistance Granted	Number of Subjects	Percentage
Yes	25	75.8
No	8	24.2

The profile presents a sample distribution of African American adolescent males who were in grade seven and below and African American adolescent males who were in grade eight and above. Table 11 shows that 60.6% of the sample were African American adolescent males who were in grade seven and below, and 39.4% of the sample were African American adolescent males who were in grade eight and above.

TABLE 11

Distribution Sample
by Grade

Grade	Number of Subjects	Percentage
Grade 7 and below	20	60.6
Grade 8 and above	13	39.4

The profile presents a sample distribution of African American adolescent males who were 13 years of age and less and of African American adolescent males who were 14 years and more. Table 12 shows that 33.3% of the sample were African American adolescent males who were 13 years of age and less and 66.7% of the sample were African American adolescent males who were 14 years of age and more.

TABLE 12

Distribution Sample
of Age

Age	Number of Subjects	Percentage
13 or less	11	33.3
14 or more	22	66.7

Sampling Procedure

The total population of 71 African American adolescent males were enrolled in the Fifth Ward Enrichment Program, at the time the data was collected. Attendance to the after school program was described as in-

consistent and erratic among subjects. Therefore, it was rarely observed that the entire 71 subjects participated on a given day.

The sample for this investigation consisted of 33 African American adolescent males labelled as high-risk who were participants in the Fifth Ward Enrichment Program. The sample was obtained through a process of random sampling, thereby given each subject for the population equal chance of being chosen.

Instrumentation

The purpose of the investigation was to determine if living within adversed environmental conditions was associated with symptoms of depression among high risk African American males. The investigator explored the variables to see if there were any statistically significant differences between them and the subjects' current levels of depression. Recent research has indicated that commonly used measures of depression differed significantly in assessments as regards functions of ethnicity, age, and sex. Researchers have urged that measures be developed with greater cross-cultural appropriateness (Dube, Kunar and Dube, 1982; Marsella, Sattorier, Jablensky, and Fenton 1985; and Miao 1981).

Therefore, the instrument used in this study was Reynolds Adolescent Depression Scale. It is a self-reported measure designed to assess depressive symptomatology in adolescents ages 13 through 18. According to Reynolds (1987), the scale is specifically designed to be used in assessing clinically relevant levels of depressive symptomatology in individual adolescents. It may also be used as a screening measure for the identification of depression in school-based and clinical populations.

The scale lends itself to research on depression, related constructs, and is used for evaluation of treatment outcomes. The scale can be administered individually or in a group. Although the age range of the scale is 13 through 18 years of age, it can be administered to persons outside this range who are in junior or senior high school settings. Finally, the Reynolds scale can also be administered orally to reading disabled adolescents.

The scale itself is a 30-item, four-point Likert-type response format. Reynolds (1987) indicated that the initial field-testing of the scale taken place in the spring of 1981 at a urban and suburban high school in the Midwestern region of the United States. Too, the reliability of the scale has been evaluated, using Cronbach's coefficient alpha, an index of internal consistency reliability, as well as test re-test reliability.

Reynolds (1987) reported that the computation of Cronbach's coefficient alpha was conducted for reliability. He indicated that an internal consistency reliability coefficient by grades were uniformly high and ranged for .909 to .939 with a total sample of .922. In addition to alpha reliabilities reported, the split-half reliability was computed using odd-even items forms and correcting for scale length with the Spearman-Brown correction formula was utilized. For the total standardization sample, the split-half reliability coefficient was .91.

Finally, validity has been examined from a number of perspectives: correlations with other self-report measures of depression; correlations with clinical interviews for depression, utilizing the Hamilton Depression Rating Scale; correlations with related constructs, such as anxiety, self-esteem, loneliness, learned helplessness, suicidal idealism, and

hopelessness ; and multivariate investigations that include factor analysis procedures (Reynolds, 1987).

The scores on the Reynolds Adolescent Scale ranged from a minimum of points 30 to a maximum of 120 points. According to Reynolds (1987) a score of 77 or above on the scale has been determined to delineate a possible level of symptom endorsement associated with clinical depression.

Statistical Analysis

A parametric statistical technique was appropriate for this investigation for such a procedure allows the research to make assumptions about the population's means and variances. The specific statistical procedure utilized was the t-test for independent samples to determine if there were significant differences. The independent samples were those that were randomly formed; and, more specifically, the samples were developed without any type of matching.

According to Gay (1987), the t-test is used to determine whether two means are significantly different at a selected probability level. He noted that t-test is designed to compare the actual mean difference observed with the difference expected by chance. In particular, the t-test for independent samples is the one that is randomly formed without any type of matching. The subjects of one group are not related to members of the other group in any systematic way other than that they are selected from the sample population. Thus, t-test for independent samples is used to determine whether there is probably a significant difference between the means of two independent samples.

In this investigation, the t-test was used to determine whether the two means were significantly different at the .05 percent probability level. Inasmuch as the sample consisted of more than 30 subjects, the analysis had a non-pooled variance. The standard error of difference was the standard deviation among the sample that displayed the difference between the two means.

Data-Collection

With the informed consent of the Program Director and the Staff of the Fifth Ward Enrichment Program, the Reynolds Adolescent Depression Scale was administered to the subjects. First, data were collected after formal school hours during the fall of 1989. A special group of Black adolescent males was actively involved in the Fifth Ward Enrichment Program. These subjects were enrolled in either E.O. Smith Middle School or Lamar Fleming Middle School. Moreover, subjects were identified by numbers in order to maintain confidentiality.

The subjects from both schools were assessed within five days of each other, under very similar conditions and circumstances. The scale was administered in a group setting and did not exceed 20 minutes in duration. Due to some of the subjects' limited reading abilities, the subjects were asked to read the questions silently, while the researcher read the questions aloud. According to Reynolds (1987) this was a permissible assessment procedure. The demographic data on each subject were collected from records housed within the headquarters of the Fifth Ward Enrichment Program. This information was also obtained during the five-

day assessment period. The subjects' records were also identified by numbers to protect their identity.

CHAPTER 4

DATA ANALYSIS

The purpose of this investigation was to determine the effects of specific demographic variables on the level of depression experienced by youngsters involved in the Fifth Ward Enrichment Program. Specifically, the researcher was concerned with the effects of high risk African American adolescent males' family's income level, grade-point average, number of expulsions from school, number of years residing in Houston, number of family members in the home, parents' level of education, number of female-headed homes, number of single-parent homes, employment status of the head of household, recipients of public assistance, grade levels, and the youngsters' ages on their current levels of depression.

The t-test for independent samples was employed in treatment of data. The hypotheses were tested at the .05 level. Since the sample consisted of more than 30 subjects, the analysis had a non-pooled variance. The standard error of difference was the standard deviation among the sample that displayed the difference between the two means.

Examination of Hypotheses

The following hypotheses were tested:

HO_1: There will be no statistically significant difference between the mean depression scores of African American adolescent

males whose family's income is $8,000 or less and African American adolescent males whose family income is $8,001 or more.

Reported in Table 13 is the summary of the mean differences between the depression scores of African American adolescent males whose family income was $8,000 or less and the depression scores of African American adolescent males whose family income was $8,001 or more. The mean depression score for the African American adolescent male's family income of $8,000 or less was 56.16 and the African American adolescent male's family income of $8,001 or more was 58.00. The differences between the two means were not significant ($t = -0.43$, $df = 31$, $p > .05$). Therefore, hypothesis one was not rejected.

TABLE 13

The t-Test for mean differences between the depression scores of African American adolescent males with a family income of $8,000 or less and the depression scores of African American adolescent males with a family income of $8,001 or more

Statistics	$8,000 or Less		$8,001 or More
mean	56.16		58.00
STD-DEV	12.69		9.68
SE diff	2.54		3.42
mean diff		-1.84	
df		31	
t-ratio		-0.43	

Critical value = 0.672

HO_2: There will be no statistically significant difference between the mean depression scores of African American adolescent males who had a 1.9 or less grade-point average and African American adolescent males who had a 2.0 or above grade-point average.

Shown in Table 14 is the summary of the mean differences between the depression scores of African American adolescent males with a 1.9 or less grade-point average and African American adolescent males with 2.0 or above grade-point average. The mean depression score for African American adolescent males with a 1.9 or less grade-point average was 57.58, and the mean depression score for African American adolescent males with a 2.0 or above grade-point average was 55.29. The differences between the two means were not significant ($t = 0.54$, $df = 31$, $p > .05$). Thus, hypothesis two was supported.

TABLE 14

The t-Test for mean differences between the depression scores of African American adolescent males with a 1.9 or less grade-point average and African American adolescent males with a 2.0 or more grade-point average

Statistics	1.9 or Less Grade Point Average		2.0 or Above Grade Point Average
mean	57.58		55.29
STD-DEV	12.30		11.68
SE diff	2.82		3.12
mean diff		2.19	
df		31	
t-ratio		0.54	

Critical value = 0.590

HO_3: There will be no statistically significant difference between the mean depression scores of African American adolescent males with one or less expulsions from school and African American adolescent males with two or more expulsions from school.

Indicated in Table 15 is the summary of the mean differences between the depression scores of African American adolescent males with one or fewer expulsions from school and the depression scores of African American adolescent males with two or more expulsions from school. The mean depression score for African American adolescent males with one or less expulsions from school was 56.27, and the mean depression score for African American adolescent males with two or more expulsions was 56.89. The difference between the two means was not significant ($t = -0.15$, $df = 31$, $p > .051$). Consequently, hypothesis three was not rejected.

TABLE 15

The t-Test for mean differences between the depression scores of African American adolescent males with one or less expulsions and African American adolescent males with two or more expulsions

Statistics	One or Less Expulsion		Two or More Expulsions
mean	56.27		56.89
STD-DEV	12.44		11.81
SE diff	3.21		2.78
mean diff		-.62	
df		31	
t-ratio		-0.15	

Critical value = 0.885

HO_4: There will be no statistically significant difference between the mean depression scores of African American adolescent males who have resided in the inner city area of Houston for 12 years or less and of African American adolescent males who have resided in the inner city area of Houston for 13 years or more.

Revealed in Table 16 is the summary of the mean differences between the depression scores of African American adolescent males residing in the inner city area of Houston for 12 years or less and African American adolescent males residing in the inner city area of Houston for 13 years or more. The mean depression score for African American adolescent males residing in the inner city area for 12 years or less was 54.71, and the mean depression score for African American adolescent males residing in the inner city area for 13 years or more was 57.12. The differences between the two means were not significant ($t = -0.40$, $df = 31$, $p > .05$). Consequently, hypothesis four was retained.

TABLE 16

The t-Test for mean differences between the depression scores of African American adolescent males residing in the inner city area of Houston for 12 years or less and African American adolescent males residing in the inner city area of Houston for 13 years or more

Statistics	Twelve Years or Less		Thirteen Years or More
mean	54.71		57.12
STD-DEV	14.77		11.31
SE diff	5.58		2.22
mean diff		-2.41	
df		31	
t-ratio		-0.40	

Critical value = 0.700

HO_5: There will be no statistically significant difference between the mean depression scores of African American adolescent males residing in a household with three or fewer family members and African American adolescent males residing in a household with four or more family members.

Indicated in Table 17 is the summary of the mean differences between the depression scores of African American adolescent males residing in a household with three or fewer family members and African American adolescent males residing in a household with four or more family members. The mean depression score for African American adolescent males residing with three or fewer family members was 59.17, and the mean depression score for African American adolescent males residing with four or more family members was 55.14. The differences between the two means were not

significant (t = 0.95, df = 31, p> .05). Consequently, hypothesis five was not rejected.

TABLE 17

The t-Test for mean differences between the depression scores of African American adolescent males residing in a household with three or fewer family members and African American adolescent males residing in a household with four or more family members

Statistics	Three or Less Family Members		Four or More Family Members
mean	59.17		55.14
STD-DEV	11.42		12.21
SE diff	3.30		2.66
mean diff		4.03	
df		31	
t-ratio		0.95	

Critical value = 0.352

HO_6: There will be no statistically significant difference between the mean depression scores of African American adolescent males whose parents received a high school diploma and African American adolescent males whose parents did not receive a high school diploma.

Shown in Table 18 is the summary of the mean differences between the depression scores of African American adolescent males whose parents received a high school diploma and depression scores of African American adolescent males whose parents did not receive a high school diploma. The mean depression score for African American adolescent

males whose parents received a diploma was 54.89, and the mean depression score for African American adolescent males whose parents did not receive a diploma was 58.67. The differences between the two means were not significant ($t = -0.92$, $df = 31$, $p > .05$). Thus, hypothesis six was retained.

TABLE 18

The t-Test for mean differences between the depression scores of African American adolescent males' parents with a high school diploma and African American adolescent males' parents without a high school diploma

Statistics	High School Diploma		Without A High School Diploma
mean	54.89		58.67
STD-DEV	12.82		10.79
SE diff	3.02		2.79
mean diff		-3.78	
df		31	
t-ratio		-0.92	

Critical value = 0.365

HO_7: There will be no statistically significant difference between the mean depression scores of African American adolescent males residing in a living arrangement headed by a female and African American adolescent males residing in a living arrangement not headed by a female.

Reported in Table 19 is the summary of the mean differences between the depression scores of African American adolescent males residing in a living arrangement headed by a female and depression scores of African American adolescent males residing in a living

arrangement not headed by a female. The mean depression score of African American adolescent males residing in a female-headed household was 56.69, and the mean depression score of African American adolescent males not residing in a female-headed household was 56.29. The differences between the two means were not significant ($t = 0.09$, $df = 31$, $p > .05$). Thus, hypothesis seven was not rejected.

TABLE 19

The t-Test for mean differences between the depression scores of African American adolescent males residing in a living arrangement headed by a female and African American adolescent males residing in a living arrangement not headed by a female

Statistics	Headed by A Female		Not Headed by A Female
mean	56.69		56.29
STD-DEV	12.44		10.56
SE diff	2.44		3.99
mean diff		.40	
df		31	
t-ratio		0.09	

Critical value = 0.932

HO_8: There will be no statistically significant difference between the mean depression scores of African American adolescent males residing in a single-parent home and African American adolescent males residing in a two-parent home.

Revealed in Table 20 is the summary of the mean difference between the depression scores of African American adolescent males residing in a single-parent home and the depression scores of African American adolescent males residing in a two-parent home. The mean depression score for children residing in a single-parent living arrangement was 57.46, and

the mean depression score for African American adolescent males residing in a two-parent was 53.43. The difference between the two means were not significant ($t = 0.93$, $df = 31$, $p > .05$). Therefore, hypothesis eight was supported.

TABLE 20

The t-Test for mean differences between the depression scores of African American adolescent males residing in a single-parent home and African American adolescent males residing in a two-parent home

Statistics	Single-Parent Home		Two-Parent Home
mean	57.46		53.43
STD-DEV	12.50		9.52
SE diff	2.45		3.60
mean diff		4.03	
df		31	
t-ratio		0.93	

Critical value = 0.372

HO_9: There will be no statistically significant difference between the mean depression scores of African American adolescent males who reside in a living arrangement in which the head of household is employed and African American adolescent males who reside in a living arrangement in which the head of household is not employed.

Reported in Table 21 is the summary of the mean difference between the depression scores of African American adolescent males residing in a living arrangement in which the head of the household is employed and

depression scores of African American adolescent males residing in a living arrangement in which the head of the household is not employed. The mean depression score for African American adolescent males residing in a living arrangement in which the head of household is employed was 57.54, and the mean depression score for African American adolescent males residing in a living arrangement in which the head of household is not employed was 56.00. The differences between the two means were not significant ($t = 0.33$, $df = 31$, $p > .05$). Therefore, hypothesis nine was not rejected.

TABLE 21

The t-Test for mean differences between the depression scores of African American adolescent males residing in a living arrangement in which the head of household is employed and African American adolescent males residing in a living arrangement in which the head of household is not employed

Statistics	Head of House-hold is Employed		Head of House hold is not Employed
mean	57.54		56.00
STD-DEV	14.70		10.08
SE diff	4.08		2.25
mean diff		1.54	
df		31	
t-ratio		0.33	

Critical value = 0.745

HO_{10}: There will be no statistically significant difference between the mean depression scores of African American adolescent males who receive public assistance and African American adolescent males who do not receive public assistance.

Revealed in Table 22 is the summary of the mean differences between the depression scores of African American adolescent males who receive

public assistance and African American adolescent males who do not receive public assistance. The mean depression score for African American adolescent males receiving public assistance was 57.08, and the mean depression score for African American adolescent males not receiving public assistance was 55.13. The difference between the two means were not significant ($t = 0.44$, $df = 31$, $p > .05$). Consequently, hypothesis ten was sustained.

TABLE 22

The t-Test for mean differences between depression scores of African American adolescent males receiving public assistance and African American adolescent males not receiving public assistance

Statistics	Public Assistance		No Public Assistance
mean	57.08		55.13
STD-DEV	12.54		10.32
SE diff	2.51		3.65
mean diff		1.75	
df		31	
t-ratio		0.44	

Critical value = 0.665

HO_{11}: There will be no statistically significant difference between the mean depression scores of African American adolescent males in grade seven or below and African American adolescent males in grade eight or above.

Indicated in Table 23 is the summary of the mean differences between the depression scores of African American adolescent males who are in the

seventh grade or below and depression scores of African American adolescent males who are in the eighth grade or above. The mean depression score for African American adolescent males in the seventh grade or below was 56.80, and the mean depression score for African American adolescent males in the eight grade or above was 56.31. The differences between the two means were not significant ($t = 0.13$, $df = 31$, $p>.05$). Hypothesis eleven was supported.

TABLE 23

The t-Test for mean differences between the depression scores of African American adolescent males in grades seven or below and for African American adolescent males in grade eight or above

Statistics	Grade 7 or Below		Grade 8 or Above
mean	56.80		56.31
STD-DEV	13.80		8.76
SE diff	3.09		2.43
mean diff		.49	
df		31	
t-ratio		0.13	

Critical value = 0.901

HO_{12}: There will be no statistically significant difference between the mean depression scores of African American adolescent males who are 13 or less years of age and African American adolescent males who are 14 or more years of age.

Shown in Table 24 is the summary of the mean differences between the depression scores of African American adolescent males who are 13 or less years of age and depression scores for African American adolescent males

who are 14 or more years of age. The mean depression score for African American adolescent males 13 or less years of age was 56.27, and the mean depression score for African American adolescent males 14 or more years of age was 56.77. The differences between the two means were not significant ($t = -0.10$, $df = 31$, $p>.05$). Therefore, hypothesis twelve was not rejected.

TABLE 24

The t-Test for mean differences between the depression scores of African American adolescent males 13 or less years of age and African American adolescent males 14 or more years of age

Statistics	Thirteen or Less		Fourteen or More
mean	56.27		56.77
STD-DEV	15.93		9.76
SE diff	4.80		2.08
mean diff		-.50	
df		31	
t-ratio		-0.10	

Critical value = 0.925

TABLE 25

Summary of Hypotheses Tested

Hypotheses	mean Difference	df	t-ratio	Hypothesis/ Supported Non-supported
HO_1: There will be no statistically significant differences between the mean depression scores of black adolescent males whose family income is $8,000 or less and those whose family income is $8,001 or more.	-1.84	31	-0.43	supported
HO_2: There will be no statistically significant differences between the mean depression scores of black adolescent males who had a 1.9 or less grade-point average and those who had a 2.0 or above grade-point average.	2.19	31	0.54	supported
HO_3: There will be no statistically significant differences between the mean depression scores of black adolescent males with one or less expulsion from school and those with two or more expulsions from school.	-.62	31	-0.15	supported
HO_4: There will be no statistically significant differences between the mean depression scores of black adolescent males who have resided in the inner city area of Houston for 12 years or less and those who have resided in the inner city area of Houston for 13 years or more.	-2.41	31	-0.40	supported

Summary of Hypotheses Tested Continued

Hypotheses	mean Difference	df	t-ratio	Hypothesis/ Supported Non-supported
HO_5: There will be no statistically significant differences between the mean depression scores of black adolescent males residing in a household with three or less family members and those residing in a household with four or more family members.	4.03	31	0.95	supported
HO_6: There will be no statistically significant differences between the mean depression scores of black adolescent males whose parents received a high school diploma and those whose parents did not receive a high school diploma.	-3.78	31	-0.92	supported
HO_7: There will be no statistically significant differences between the mean depression scores of black adolescent males residing in a living arrangement headed by a female and those residing in a living arrangement not headed by a female.	.40	31	0.09	supported
HO_8: There will be no statistically significant differences between the mean depression scores of black adolescent males residing in a single-parent home and those residing in a two-parent home.	4.03	31	0.93	supported

Summary of Hypotheses Tested Continued

Hypotheses	mean Difference	df	t-ratio	Hypothesis/ Supported Non-supported
HO_9: There will be no statistically significant differences between the mean depression scores of black adolescent males who are residing in living arrangement in which the head of household is employed and those who are residing in a living arrangement in which the head of household is not employed.	1.54	31	0.33	supported
HO_{10}: There will be no statistically significant differences between the mean depression scores of black adolescent males who receive public assistance and those who did not receive public assistance.	1.75	31	0.44	supported
HO_{11}: There will be no statistically significant differences between the mean depression scores of black adolescent males in grade seven or below and those in grade eight or above.	.49	31	0.13	supported
HO_{12}: There will be no statistically significant differences between the mean depression scores of black adolescent males who are 13 or less years of age and those who are 14 or more years of age.	-.50	31	-0.10	supported

CHAPTER 5

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

This study was designed to ascertain if residing within adversed living conditions and depression symptomatology were significantly related. The study focused on the variables and on the level of depression among African American adolescent males involved in the Fifth Ward Enrichment program. More specifically, the study explored the independent effect of the following variables: family's income level, grade-point average, number of expulsions from school, number of years residing in Houston, number of family members in the home, parents' level of education, number of female headed homes, number of single-parent homes, employment status of head of household, grade levels, the recipients of public assistance, grade levels, and the youngsters' ages on their current level of depression.

Using the assessment instrument and information gathered from the records, data were collected from 33 African American adolescent males enrolled in the Fifth Ward Enrichment Program. The young men were administered the Reynolds Adolescent Depression Scale. These youngsters were considered to be at-risk of becoming contributors to major social problems. The data from this study were analyzed using the t-test for independent samples. The hypotheses were tested at the .05 alpha level.

Summary of the Findings

The following findings were obtained from the analysis of the data generated in this investigation:

1. The level of income of the African American adolescent males' families did not produce a significant effect on their depression level.
2. The grade-point averages of African American adolescent males did not produce a significant effect on their depression levels.
3. The number of times African American adolescent males had been expelled from school did not produce a significant effect on their depression levels.
4. The number of years African American adolescent males had resided in the inner city area of Houston did not produce a significant effect on their depression levels.
5. The number of family members living within the household of African American adolescent males did not produce a significant effect on their depression levels.
6. Black adolescent males' parents' level of education did not produce a significant effect on their depression levels.
7. The female-headed household of African American adolescent males did not produce a significant effect on their depression levels.
8. The single-parent homes of African American adolescent males did not produce a significant effect on their depression levels.
9. The employment status of the head of household of African American adolescent males did not produce a significant effect on their depression levels.

10. The African American adolescent males' family being recipients of public assistance did not produce a significant effect on their depression levels.
11. The grade level of African American adolescent males did not produce a significant effect on their depression levels.
12. The age of African American adolescent males did not produce a significant effect on their depression levels.

Conclusions

The following conclusions were drawn from the findings of this study:

1. The income level of the family did not have a significant influence the depression level of African American adolescent males.
2. African American adolescent males who had a low grade-point average had a similar depression levels similar to those of African American adolescent males who had an average or above-average grade-point average.
3. The number of expulsions from school did not influence the depression levels of African American adolescent males.
4. African American adolescent males who had resided in a metropolitan area for 12 years or less had depression levels similar to those of African American adolescent males who had resided in a metropolitan area for 13 years or more.
5. The number of members in a family did not influence the depression levels of African American adolescent males.
6. African American adolescent males whose parents did not receive a high school diploma had similar depression levels as did

African American adolescent males who parents did receive a high school diploma.

7. Female headed households had no more influence on African American adolescent males' depression level than did male-headed households.
8. African American adolescent males who resided in single-parent living arrangements had depression levels similar to those of African American adolescent males who resided in two-parent living arrangements.
9. African American adolescent males whose families received public assistance had a similar depression levels similar to those African American adolescent males whose families did not receive public assistance.
10. African American adolescent males who resided in a living arrangement where the head of the household was working had depression levels similar to those of African American adolescent males who resided in a living arrangement where the head of the household was not employed.
11. The grade levels of African American adolescent males did not influence their depression levels.
12. African American adolescent males who were 13 years of age or less had a depression levels similar to African American adolescent males who were 14 or more years of age.

Discussion

The researcher of this study endeavored to ascertain whether living within adversive environmental conditions was related to symptoms of

depression as found in the high-risk African American adolescent male. The researcher examined 12 variables to find out if there was an effect on the subjects' levels of depression. The variables investigated included: family's level of income, grade-point average, number expulsions from school, number of years residing in the inner city area of Houston, number of family members within the household, parents' level of education, female-headed homes, single-parent houses, employment status of heads of household, recipients of public assistance, grade-level, and age. These variables were all tested at the .05, and none were found to be significant. Overall, these results were generally found to be contrary to the findings researched in the literature review.

Therefore, it may be speculated that such differences can be attributed to a number of causes. However, for the purpose of this study, the researcher suggested that participants in the investigation may have learned to adapt effectively to their environment. Notable, this phenomena may be an indication of intelligent and rational thinking. Ironically these subjects may not view their unfavorable circumstances as impacting issues. Consequently, what may be considered adversive for some youngsters may not necessarily be considered the same for others. For example, studies have shown that black male children comparatively, are given less nurturance by their parents, are treated more harshly by their teachers, and are discriminated against more by employers and are treated less favorably by nearly every other institution in American society (Gibbs, 1988).

By gaining a greater awareness of this concept, the young African American male grows up in an atmosphere with selective survival skills. This occurrence often becomes just a matter of maintaining an existence.

So often the use of such survival methods may be considered unacceptable by the dominant society. Several studies have shown that as early as elementary school, the black male is reported as having more psychological symptoms and displays more behavioral problems than do black females (Children's Defense Fund, 1986).

Furthermore, recent research findings suggested that as the black male progress from childhood through adolescence and onto adulthood he appears to be more unable than the black female to deal with problems in their families, schools and communities. This of course is evident by the high rate of behavioral and learning disorders reported by schools, the number of incidents of emotional distance among juvenile delinquents and the numerous inpatient and outpatient psychiatric treatment cases among the black male group (Myers and King, 1983).

Societal deprivation and the lack of exposure to living conditions other than those within the immediate environment are considered elements that brought about results contradictory to the material located in the literature review. In light of this, there is still a need to develop more research findings on the human nature of the African American male child. Recent data from an Urban League study revealed that many black male teenagers left school because of family and economic problems, academic difficulties or discipline issues, while black females often quit school due to pregnancy (Williams, 1982). More current figures from the Children's Defense Fund (1985) have indicated that black students were almost twice as likely as were white students to be suspended from public schools and about 50 percent more likely to receive corporal punishment. From the total school population, the majority of youngsters who were suspended or physically punished were black male children.

Another concept acknowledged as part of the opposing findings included that of the sample size. The researcher suggested that a larger sample may have provided additional data on the nature and extent of childhood depression among African American males. Methodologically speaking, the greater the sample size the more accurate the generalizations. Gay (1987) indicated that if the sample is too small, the results of the study may not be generalizable to the population. The results may hold only for the sample and may not be the same results that would have obtained if the entire population had been used. If the sample is not large enough, the wrong decision may be made concerning the validity of the hypothesis. A sample which is too small can affect the generalizing ability of the study regardless of how well it is selected.

Finally, Reynolds (1987) reported that based upon his standardization sample, of two, 460 adolescents, the racial composition consisted of 75.8 percent white, 20.6 percent black and 3.6 percent other minorities. A review of his normative data indicated there may not have been a large enough number of blacks within the sample to provide relevant data on African American subjects as it relates to the concept of depression.

Furthermore, the normative data reported that Reynolds sample consisted of subjects who attended schools located in an urban/suburban community in the Midwestern portion of the United States. The sample had substantial variability in number of wage earners, and nearly 20 percent were living with only one parent; therefore, socio-economic status was estimated by summing the occupation values of both parents.

Recommendations for the Field of Guidance, Counseling and Psychology

The following recommendations are suggested for educators and mental health professionals to consider regarding childhood depression as well as other related emotional, behavioral, and psychological disorders of African American children.

1. Professionals in the field should be aware that depression is a mental health problem which affects the lives of many children from all walks of life. A concerted effort should be made by educational institutions and mental health establishments to develop programs as well as strategies to identify African American children who may have depressive symptoms. Early detection of these issues could enable educators and mental health professionals to implement proper, more effective treatment solutions which may minimize the onset of more serious problems found among African American children, problems such as alcoholism, drug abuse, suicide, teenage pregnancy, robbery and truancy from school.

   For example, in 1988, Comer started an intervention program at two inner-city schools in New Haven, Connecticut. This program focused on development and learning by building supportive bonds that draw together children, parents and school.

   This program was created because of the lack of interaction among parents, school personnel, and students which revealed a basic problem underlying the school's dismal academic and disciplinary records. Comer summarized that there was a profound socio-cultural misalignment between home and school among his population. Such a program and like many others similar to it

serves as a bridge to gap the distance between home and school. Furthermore, it provided a preventive method and deterrent to counter productive behavior among the youth in that community (Comer, 1988).

2. It would be beneficial for professionals in the field of guidance, counseling and psychology to organize and launch a national effort focusing on childhood depression among African American children for the purpose of establishing sound criteria for the implementation of guidelines to address this alarming social issue. For a national organization to accept the leadership role in this endeavor would provide impetus for counseling programs in American colleges and universities to offer quality education and training of individuals who would detect and treat this phenomenon. Only through a broad role by practitioners in the field of guidance, counseling and psychology and their clientele can depression among African American children as well as other related psychological, behavioral and emotional illnesses be prevented or at least treated.
3. Educational institutions and mental health agencies should equip their professional staff to deal with childhood depression from a multi-cultural perspective. An understanding as well as a knowledge regarding depression could provide personnel with the requisites to identify and the treat all minorities as well as African American youngsters with this problem. The professional staff members should be aware of the factors that can lead to depression. By knowing and understanding these factors, such individuals can educate other school personnel, staff members in

mental health centers, and concerned citizens regarding this social problem. Consequently, by providing workshops, seminars and other outreach programs for concerned persons, the educators and mental health professionals could develop a better teacher-child relationship, a strong school environment to enhance the academic standards of the institution, foster family cohesiveness, and curtail hostile and inappropriate behavioral problems.

4. Educators and mental health professionals should be responsible for providing support and understanding to the African American child and to the family who are faced with childhood depression. A lack of understanding between the aforementioned parties could propel this dilemma into a much more serious problem.

Wiener (1977) noted that a rational approach to the treatment of reactive depression is the alleviation of influences that have set the stage for depression and of those that perpetuate it. Careful diagnostic evaluation of the child and family will most often elucidate those influences. Appropriate intervention at the individual's family, school, and/or community level becomes then the desire manner of dealing with the conditions.

In the direct treatment of the child, attention to impaired self-esteem is of paramount importance. When the child's copying mechanisms are inadequate, or when environmental influences are overwhelming, placement of the child in a neutral or therapeutic setting is often necessary (Wiener, 1977).

Recommendations for Further Research

In order to extend the findings of this study, the investigator recommends that:

1. A follow-up study using a larger sample size be conducted. Such a study, if conducted, would provide additional data on the nature and extent of childhood depression among high risk African American adolescent males.
2. A study to be conducted that would examine the effects of various counseling procedures on childhood depression among African American children.
3. A study to be conducted to measure the predictability of psychological and social variables, separate and combined, on childhood depression from a cultural perspective.
4. A study to be conducted to compare and contrast childhood depression among Caucasian and African American children.
5. A study to be conducted to determine if similar social, economical, and psychological factors may have an effect on other minority adolescent males.
6. A study to compare the findings of subjects in this group with other African American adolescent males who reside in different areas of this city.
7. A follow-up investigation with the same subjects be conducted.

APPENDICES

APPENDIX A

Reynolds Adolescent Depression Scale

R.A.D.S.

Name _____

Age _____ *Grade* _____

Sex _____ *Date* _____

ABOUT MYSELF

RADS Form HS

by William M. Reynolds

Directions

On the back of this page are a number of sentences that people use to describe their feelings. You will be reading each sentence and deciding how often you feel the way the sentence describes. There are no right or wrong answers. Just remember to answer the way you really feel.

PSYCHOLOGICAL ASSESSMENT RESOURCES, INC.
P.O. Box 998 / Odessa, Florida 33556

9 8 7 6 5 4 3 2 1 Printed in U.S.A.

This form is printed in blue ink on white paper. Any other version is unauthorized.

Directions

Listed below are some sentences about how you feel. Read each sentence and decide how often *you* feel this way. Decide if you feel this way: almost never, hardly ever, sometimes, or most of the time. Fill in the circle under the answer that best describes how you really feel. Remember, there are no right or wrong answers. Just choose the answer that tells how you usually feel.

	ALMOST NEVER	HARDLY EVER	SOME-TIMES	MOST OF THE TIME
1. I feel happy	○	○	○	○
2. I worry about school	○	○	○	○
3. I feel lonely	○	○	○	○
4. I feel my parents don't like me	○	○	○	○
5. I feel important	○	○	○	○
6. I feel like hiding from people	○	○	○	○
7. I feel sad	○	○	○	○
8. I feel like crying	○	○	○	○
9. I feel that no one cares about me	○	○	○	○
10. I feel like having fun with other students	○	○	○	○
11. I feel sick	○	○	○	○
12. I feel loved	○	○	○	○
13. I feel like running away	○	○	○	○
14. I feel like hurting myself	○	○	○	○
15. I feel that other students don't like me	○	○	○	○
16. I feel upset	○	○	○	○
17. I feel life is unfair	○	○	○	○
18. I feel tired	○	○	○	○
19. I feel I am bad	○	○	○	○
20. I feel I am no good	○	○	○	○
21. I feel sorry for myself	○	○	○	○
22. I feel mad about things	○	○	○	○
23. I feel like talking to other students	○	○	○	○
24. I have trouble sleeping	○	○	○	○
25. I feel like having fun	○	○	○	○
26. I feel worried	○	○	○	○
27. I get stomachaches	○	○	○	○
28. I feel bored	○	○	○	○
29. I like eating meals	○	○	○	○
30. I feel like nothing I do helps any more	○	○	○	○

RS	
TOTAL %	
_____ %	

CI	

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