

# 1

## Understanding Internalizing Problems

### *Depression and Anxiety in Children and Adolescents*

#### INTRODUCTION AND OVERVIEW

Depression, anxiety, and related “internalizing” problems of children and adolescents have been the focus of increased professional concern during the past two or three decades. During the majority of the 20th century, relatively little attention was given to these problems. In fact, until about the 1980s there was widespread professional denial that certain types of internalizing disorders, such as depression, could even exist in children. Fortunately, clinicians and researchers alike now understand that these problems are real, serious, complex, and most importantly, treatable and even preventable in many cases.

This class of problems and disorders, particularly depression and anxiety, is the focus of this handbook for school-based practitioners. Although there are several excellent scholarly books available in this area, there are surprisingly few practical guides available to assist in understanding, evaluating, and treating depression, anxiety, and related internalizing problems of children and youth. Even fewer available resources are designed specifically to be applicable to intervention in school settings. This book is specifically designed to be such a practical handbook. This introductory chapter is designed to provide a foundation for understanding internalizing problems in straightforward and practical terms.

The specific purpose of this introductory chapter is to help you develop a general understanding of depression, anxiety, and related internalizing disorders and problems, by

defining, describing, and analyzing this area in some detail, particularly as it relates to children and adolescents. The first sections of this chapter provide some very specific descriptions and definitions of internalizing problems and the four specific clusters of disorders, syndromes, and symptoms that I view as constituting this area. A brief overview of the major characteristics, prevalence rates, and related problems is provided for depression, anxiety, social withdrawal, and somatic or physical problems. Next, the issue of overlap and similarity among various internalizing symptoms is discussed. Finally, the information in this chapter is tied together by three case studies that help to set the stage for the development of interventions, which is the major focus of this book.

## WHAT ARE INTERNALIZING DISORDERS?

### Definition

Often misunderstood and frequently overlooked, internalizing disorders constitute a specific type of emotional and behavioral problem. In general terms, internalizing disorders consist of problems that are based on *overcontrolled* symptoms (Cicchetti & Toth, 1991; Merrell, 2007). The term “overcontrolled” is used to denote that these problems in part are manifest when individuals attempt to maintain inappropriate or maladaptive control or regulation of their internal emotional and cognitive state—in other words, the way they think about the way they feel. The term “internalizing” also indicates that these problems are developed and maintained to a great extent *within* the individual. For this reason, internalizing disorders have been referred to as *secret illnesses* (Reynolds, 1992), meaning that they are difficult to detect through external observation.

### Relation to Externalizing Disorders

Internalizing disorders contrast with *externalizing disorders* such as aggressive conduct problems, hyperactivity, antisocial behavior, and the like. In contrast to the overcontrolled and sometimes secret nature of internalizing problems, these externalizing problems are thought to result in part from *undercontrol* or poor self-regulation. In other words, children who exhibit serious conduct problems such as fighting, stealing, assaulting, threatening, and other behaviors tend to have serious difficulties in regulating their behaviors and emotional expressions. These problems are typically anything but secret, and they are generally easy to identify because they can be observed directly. Of course, although it has been well established that internalizing and externalizing disorders are indeed distinct domains, it is not unusual for children to exhibit *both* types of problems at the same time. In other words, a child or adolescent could be depressed and anxious, while at the same time engaging in hostile antisocial behaviors as a gang member. It is important to consider that the presence of depression, anxiety, or related internalizing problems does not necessarily mean that the existence of externalizing problems is not a possibility as well.

## Terminology: Symptoms, Syndromes, and Disorders

Several key terms have been introduced thus far or will be introduced later in this book. Specifically, the terms “symptom,” “syndrome,” and “disorder” are of interest and need to be fully understood to best comprehend the general area of internalizing disorders, especially as discussed in this book. These terms are sometimes used interchangeably, which can be confusing.

A *symptom* is a specific behavioral or emotional characteristic that is associated with particular types of problems or disorders. For example, depressed mood is a symptom of depression. In contrast, a *syndrome* is a collection of common symptoms. For example, the combination of depressed mood, sleep problems, fatigue, and feelings of low self-esteem would indicate depression as a syndrome. At this point, there are enough symptoms present to indicate a problem, and the affected person is in some distress. However, this problem or syndrome may not necessarily be formally diagnosable as a disorder. A *disorder* exists when a collection of symptoms or a syndrome meets specific diagnostic criteria, according to standard classification systems such as the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* and its later text revision (DSM-IV and DSM-IV-TR; American Psychiatric Association, 1994, 2000), or the Individuals with Disabilities Education Act (IDEA). For example, the syndrome of depression, as listed earlier, when accompanied by other symptoms, when exhibited over a common 2-week period, and when representing a change from previous functioning, would meet the criteria for *major depressive disorder* in DSM-IV. *A disorder always includes a syndrome and symptoms, and a syndrome always includes symptoms; however, symptoms do not always constitute a syndrome or disorder, and a syndrome is not always formally diagnosable as a disorder.* In this book, the general term “problem” is often used, instead of symptom, syndrome, or disorder. This term may indicate any or all of the three specific terms. An *internalizing problem* simply means an internalizing symptom, syndrome, or disorder that affects an individual to the point of causing distress.

For intervention purposes, it is usually not necessary to differentiate among the terms “symptom,” “syndrome,” and “disorder.” However, for conducting effective assessments and for communicating information regarding a student to other professionals, such differentiation may be very important.

## FOUR TYPES OF INTERNALIZING PROBLEMS

Although the symptoms of internalizing disorders are numerous and complex, researchers have shown that there are four main types of specific syndromes, disorders, or problem clusters within this general category (Merrell, 2007; Quay, 1986). These problems primarily include *depression, anxiety, social withdrawal, and somatic or physical problems*. Of course, depression and anxiety are the best known of the four types of internalizing problems and constitute the major focus of this book. However, to promote the complete understanding of internalizing disorders of children and youth, these four types are described briefly in this section.

## Depression

### *Characteristics*

Probably the most recognized and best understood of the internalizing problems, depression in both children and adults is primarily characterized by the following symptoms (see Table 1.1): depressed mood or excessive sadness; loss of interest in activities; sleeping problems (either sleeping too much or not enough); psychomotor retardation or slowing of physical movement (or in some cases, physical agitation); fatigue or lack of energy; feelings of worthlessness or excessive guilt; difficulty in thinking, concentrating, or making decisions; and a preoccupation with death. With adults, loss of weight is often associated with depression, but with children and adolescents, this symptom is sometimes manifest as a failure to make expected weight gains. The preoccupation with death that is often seen with adults and older children may not be seen in young children, for whom the concept of death is often too vague and abstract. Two additional symptoms often characterize the presentation of depression in children and adolescents: *irritability* and *complaints about physical symptoms*, such as stomach pain, headaches, and so forth. Of course, not all of these symptoms need be present for significant depression to exist. The general criterion for a diagnosis of depression is that at least five of these symptoms are present most of the time for the same 2-week period, and at least one of the symptoms is depressed mood or loss of interest. Therefore, in considering the existence of depression that is serious enough to constitute a problem or disorder, remember that at least one of the first two primary symptoms (depressed mood or excessive sadness, loss of interest in activities) must be present. Also consider that the younger the child, the more likely it is that loss of interest rather than depressed mood will be present.

**TABLE 1.1. Main Characteristics of Depression in Children and Adolescents**

- 
- Depressed mood or excessive sadness
  - Loss of interest in activities
  - Failure to make expected weight gains
  - Sleep problems
  - Psychomotor retardation (or agitation)
  - Fatigue or lack of energy
  - Feelings of worthlessness or excessive guilt
  - Difficulty thinking or making decisions
  - Preoccupation with death
  - Irritability
  - Physical or somatic complaints
- 

*Note.* The two items above the dashed line indicate essential characteristics of depression: At least one of the two characteristics must be present for the condition to be considered as major depressive disorder or “clinical depression.”

## Prevalence

It is difficult to estimate with much certainty how many children and adolescents suffer from depression. The few large-scale studies that have been conducted to determine the proportions of the population that suffer from psychological or psychiatric disorders have often overlooked youths. Of the even fewer studies that have focused on children and adolescents, most have been designed to identify those individuals who exhibit symptoms to a great enough extent that they are diagnosed with a specific disorder, according to a formal criterion such as the DSM-IV. Such studies do not usually take into account cases in which there are enough symptoms present that the person is in significant distress and may benefit from intervention, but not enough symptoms present to be formally diagnosed with a disorder. Again, this type of symptom presentation is referred to as a *syndrome*.

Despite the limitations in our understanding of how many children suffer from depression, there are some general estimates that we can use as a guideline. I have previously reviewed the available studies on depression in children and adolescents (Merrell, 1999), and concluded that 4–6% would be a very conservative estimate of the percentage of children who suffer from the symptoms of depression at any time to a great enough extent to constitute a syndrome or disorder, and would benefit from further assessment and intervention. In practical terms, this estimate represents at least one or two students out of a classroom of 30. In reality, the percentage of young people who experience depression to a great enough degree that it is negatively impacting their lives may be higher than my conservative estimate. My colleague John Seeley and his associates at the Oregon Research Institute have, for the past several years, gathered impressive data through their Oregon Adolescent Depression Project (OADP; see Seeley, Rohde, Lewinsohn, & Clarke, 2002 for more detail) that has examined the “lifetime” prevalence rather than the “point prevalence” of depression in young people. “Lifetime” prevalence indicates how many have experienced major depression at some point in their lives thus far rather than at one particular point in time. Their alarming results indicate that by age 18, about 1 in 5 boys and 1 in 3 girls will have experienced at least one episode of major depression!

Girls clearly seem to report the presence of depression to a greater extent than boys. During and after adolescence (by ages 13–14), this difference between the sexes becomes particularly noticeable, as the OADP data indicate, with nearly twice as many girls as boys experiencing the symptoms of depression at a significant level. Before adolescence, there is more similarity in reported levels of depression, but even then, girls seem to report somewhat more symptoms than boys. There are many potential explanations for this gender difference, some of which are explored in Chapter 2.

## Disorders That Include Depression as a Major Feature

When we think of serious or “clinical” cases of depression, we are usually thinking in terms of what DSM-IV and DSM-IV-TR refer to as *major depressive disorder*, or a *major depressive episode*. However, it is important to recognize that several other mood or adjustment disorders include depression as a major feature. Table 1.2 includes a list of disorders from DSM-IV in which depression is a key element of the symptom presentation. Although

**TABLE 1.2. DSM-IV Disorders with Depression as a Major Feature**

- 
- Major depressive disorder
  - Dysthymic disorder
  - Depressive disorder, not otherwise specified
  - Bipolar disorders
  - Cyclothymic disorder
  - Mood disorder due to medical condition or substance abuse
  - Adjustment disorder with depressed mood
- 

these classification categories were developed primarily from research with adults, they may also apply to children and adolescents in many cases.

*Dysthymic disorder* (or dysthymia) is a condition in which an individual has exhibited mild or moderate symptoms of depression for a long period of time (at least 2 years for adults, at least 1 year for children and adolescents). In this case, depression is less a temporary state and has become a more stable trait. In effect, being depressed becomes part of one's personality or general way of being. *Depressive disorder, not otherwise specified* is a general classification category used to diagnose depression when it is serious enough to interfere with one's life functioning but is not clearly diagnosable as one of the other disorders in Table 1.2. *Bipolar disorders* (commonly referred to as *manic–depression*) include serious levels of depression, or major depressive episodes, that alternate with *manic or hypomanic episodes*, which are periods of time when one feels a great deal of energy, invincibility, exhilaration, and a flood of ideas, all of which may lead to poor decision making. Bipolar disorders may include depression as the predominant symptom and occasionally alternate with manic episodes, or the reverse situation may be true. *Cyclothymia* has some similarity to bipolar disorders but lacks the intense severity of symptoms and tends to be longer lasting (at least 1 year). Individuals with cyclothymia tend to experience unpleasant mood swings that may alternate with varying degrees of depression, energy and exhilaration, and agitation or irritability. Parents of children and youth who exhibit cyclothymia tend to feel that their child is on an “emotional roller coaster” that seldom stops or ends. *Mood disorders due to medical condition or substance abuse* occur when individuals manifest significant symptoms of depression (or other mood problems) as a result of medical conditions (such as hypothyroidism—an underactive thyroid gland) or substance abuse (such as abuse of alcohol, barbiturates, or other depressants). Finally, *adjustment disorder with depressed mood* is a presentation of depressive symptoms that accompanies serious and long-lasting (6 months or longer) problems in adjusting to a major life event, such as a move, death of a loved one, or significant change in circumstances.

More specifics regarding depression in children and youth are discussed in Chapter 2, and some of the major issues presented in this section are summarized in Table 1.3. The mental health and human behavior professions have made a great deal of progress in understanding childhood depression in recent years. As unbelievable as it may seem to those professionals who received their training in the past two decades, it was not many

**TABLE 1.3. Important Points in Understanding Depression in Children and Youth**

- 
- Includes several possible symptoms, but *depressed mood or loss of interest is a hallmark characteristic*.
  - May sometimes be differentiated from adult presentation of depression by *irritability, physical complaints, and lack of making expected weight gains*.
  - *Approximately 4–6% of children and youth may exhibit depression as a syndrome or disorder*.
  - Girls tend to exhibit more symptoms than boys, particularly after onset of adolescence.
  - May be exhibited in several other mood or adjustment disorders besides major depressive disorder.
- 

years ago that the existence of depression during childhood was seriously questioned in some circles. Today, it is generally understood that childhood depression does indeed exist and, fortunately, we are now much better equipped to provide effective assessment and intervention techniques. However, there is still much to learn about this perplexing problem and how best to deal with it.

## Anxiety

### *Characteristics*

Anxiety disorders are an extremely broad category of problems, and the specific symptoms involved may vary considerably from one type of anxiety disorder to another. However, anxiety disorders do share some common elements. First, these disorders tend to involve three areas of symptoms: *subjective feelings* (such as discomfort, fear, or dread), *overt behaviors* (such as avoidance and withdrawal), and *physiological responses* (such as sweating, nausea, shaking, and general arousal). This particular way of explaining the presentation of anxiety symptoms has been referred to as the *tripartite model* because of the three main routes that are involved. Some of the more common presentations of anxiety symptoms (see Table 1.4) include negative and unrealistic thoughts, misinterpretation of symptoms and events, panic attacks, obsessions or compulsive behavior, physiological arousal, oversensitivity to physical cues, fears or anxiety regarding specific situations or events, and excessive worry in general.

Two other terms are closely related to anxiety: *fears* and *phobias*. There is actually a great deal of similarity in the meaning of these terms but important differences as well. Fears are usually considered to differ from anxiety because fears involve *specific reactions to very specific situations* (such as a perceived threat), whereas anxiety usually involves a more *general type of reaction* (such as apprehension or discomfort) to a more *vague situation or stimulus*. Phobias are similar to fears in that they involve a reaction to a specific threat, but they differ because they are more intense, persistent, and maladaptive. For example, being accosted by a couple of large, tough bullies after school would be a good

**TABLE 1.4. Major Characteristics of Anxiety Disorders in Children and Youth**

- 
- Negative and unrealistic thoughts
  - Misinterpretation of symptoms and events
  - Panic attacks
  - Obsessions and/or compulsive behavior
  - Physiological arousal
  - Hypersensitivity to physical cues
  - Fears and anxieties regarding specific situations or events
  - Excessive worries in general
- 

reason for a student to show a fear response, but developing a debilitating fear of birds, bugs, or drinking from open cups is less understandable and more maladaptive.

### *Prevalence*

Because anxiety is such a broad category, and because so many of its characteristics are common, it has been quite difficult to develop an accurate estimate of how many children and youth have anxiety disorders. The problem is further compounded by the same complications that have made it difficult to develop a good estimate of depression among children and youth. However, it is known that anxiety symptoms are quite common, and that anxiety disorders are not uncommon. In fact, anxiety disorders may be the largest category of internalizing disorders. It has been estimated that anxiety problems constitute about 8% or less of referrals to clinicians or of behavioral–emotional problems among the general child population (Morris & Kratochwill, 1998). However, the percentage of children and youth who have diagnosable anxiety disorders is probably somewhat less than this figure, perhaps somewhere in the range of 3–4%, even though a very large percentage of young people will experience at least some symptoms of fears and worries. Although the evidence is not nearly as convincing or dramatic as is the evidence for depression, girls may have a somewhat higher risk than boys for developing anxiety disorders or problems.

### *Disorders That Include Anxiety as a Major Feature*

As Table 1.5 indicates, there are a large number of diagnosable disorders in the DSM system that include at least some anxiety symptoms as a key feature. Some of these disorders, such as *obsessive–compulsive disorder*, are a bit peripheral to the aims of this book, whereas others, such as phobias, may be very specific to particular children and their circumstances. A couple of these disorders are particularly important when working with children. *Separation disorder*, a condition in which one shows excessive and continued dis-



**TABLE 1.5. DSM-IV Disorders with Anxiety as a Major Feature**

- 
- Separation disorder
  - Panic disorders
  - Agoraphobia
  - Specific phobias
  - Social phobia
  - Obsessive–compulsive disorder
  - Posttraumatic stress disorder
  - Acute stress disorder
  - Generalized anxiety disorder (overanxious disorder)
  - Anxiety disorder due to medical condition or substance inducement
- 

stress when separated from a parent or primary caregiver, is particularly common in younger children. Often related to separation disorder is a problem commonly referred to as *school phobia* (or more generally, school avoidance behavior), in which children exhibit unusual fear, anxiety, and panic symptoms in response to going to school. *Generalized anxiety disorder* (formerly referred to as *overanxious disorder of childhood*) is a broad category indicating severe anxiety symptoms that are not necessarily tied to specific events or situations. A child or youth with this disorder will typically show significant “free-floating” anxiety characteristics across a variety of situations and across time. The particular symptoms that may be seen with generalized anxiety disorder include restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbances. Obviously, some of these characteristics are quite similar to what might be exhibited with depression. And like depression, anxiety symptoms may also be caused by medical conditions or substance abuse. For example, use of amphetamines and marijuana may provoke general anxiety symptoms.

As is true with depression, for diagnostic purposes (but not necessarily for intervention purposes), it is important to understand the difference between anxiety symptoms, syndromes, and disorders. As has already been mentioned, anxiety symptoms are very common among children and youth but in most cases do not cause any significant or lasting problems. When symptoms of anxiety are abundant and severe enough to cause such problems, we would say that an anxiety syndrome is present. If the characteristics of an anxiety syndrome meet specific diagnostic criteria, say, from DSM-IV, then one would also have an anxiety disorder. However, one of the main points of this book is that the overlap between depression, anxiety, and other internalizing problems is so great that it is not unusual for someone to have a combination of co-occurring symptoms that may not be diagnosable as a specific disorder in DSM-IV, but for all practical purposes constitutes a “general internalizing disorder.”

## Social Withdrawal

### *Characteristics*

Social withdrawal is usually not thought of as a specific type of internalizing problem or disorder but is generally considered to be something that often goes along with or is a part of these problems, specifically, depression and anxiety. However, some of the previous research on classification has shown that social withdrawal is often identified as a specific cluster of internalizing problems (Caldarella & Merrell, 1997; Quay, 1986). Social withdrawal usually includes several key characteristics (see Table 1.6). Children and youth who are socially withdrawn actively avoid the companionship of others. They may lack responsiveness to the social initiations of other children and have behavioral deficits in the particular skills required to make and keep friends. Social withdrawal may be a temporary characteristic or be a long-term concern or trait. For example, a youth with a former pattern of many social interactions may withdraw from the companionship of his or her friends during a bout of severe depression and return to the pattern of frequent social interaction at a later time. Or a child may have a long-standing pattern of social withdrawal because of excessive shyness and social immaturity. In some cases, a socially withdrawn student may actually have reasonably good social skills but avoid getting involved in social interactions because of an unrealistically negative view or anxiousness regarding his or her social ability. For example, a student who consistently thinks, “*I am such an idiot when I try to talk to other people,*” may actively avoid getting involved with others, even though he or she might like to and may actually have the skills to do it effectively.

### *Prevalence*

Because social withdrawal is not traditionally thought of as a specific disorder, it is impossible to estimate the percentage of children and youth who have significant problems in this area. However, this is not a rare problem, and many children exhibit and suffer from the characteristics of social withdrawal.

**TABLE 1.6. Major Characteristics of Social Withdrawal in Children and Youth**

- 
- Not usually considered a separate disorder, but is a main component of several disorders.
  - May involve unrealistic self-appraisal of social performance.
  - May involve a lack of interest in social interaction.
  - May be complicated by excessive fear.
  - May involve a deficit in *social approach behaviors*.
-

## Somatic Problems

### *Characteristics*

Somatic problems, by definition, are complaints of *physical* discomfort, pain, or illness that have no known medical, organic, or physical basis. It is presumed that such symptoms are caused by emotional distress and are *psychological rather than physical in origin*. However, it is important to realize that just because a somatic symptom may have no known medical or physical cause does not mean that the discomfort is not very real to the person who is experiencing it, just as real as if the cause were an injury, infection, or structural problem. It is also important to consider that we must always emphasize the word “known” when we say that a somatic symptom has no known medical or physical basis. It is quite possible that there may be an injury, infection, structural problem, or allergic reaction of some kind that is causing the physical discomfort, but it simply is not detectable within the limits of current medical assessment technology.

Like social withdrawal, somatic problems are usually viewed as an ancillary part of internalizing problems such as depression and anxiety rather than a separate internalizing syndrome or disorder. But as with social withdrawal, the classification research has often shown somatic problems to be a unique component of the broad domain of internalizing problems. Because they are not usually viewed as a distinct disorder, exact prevalence data are difficult to find. However, it is widely understood that somatic problems are extremely common in children and youth.

The most common somatic complaints of children and youth (see Table 1.7) seem to be *stomachaches, pains, or nausea; headache; pain in the eyes; pain in the limbs or joints; tingling sensations or numbness in the extremities; skin rashes or itching; and breathing problems* (shortness of breath, asthma-type symptoms, or hyperventilation). It is not uncommon for children who exhibit somatic problems to report feeling dizzy or faint. In some cases, somatic complaints may be inconvenient and uncomfortable but not debilitating. In other cases, the severity with which these symptoms are experienced results in a major obstacle to adaptive functioning in life. It has been theorized that many individuals with significant and long-lasting somatic problems may have an *oversensitivity to physiological cues*; that is, they have a heightened ability or tendency to focus on and become aware of physiological sensations that many persons would not be aware of or simply pass off as being unimportant. Obviously, the way one thinks about such unpleasant sensations plays an important role in how distracting and problematic they may be.

**TABLE 1.7. Major Characteristics of Somatic Problems in Children and Youth**

- 
- Often a key component of depression and anxiety disorders.
  - May involve *oversensitivity to physiological cues*.
  - Common complaints in children include *stomachache or nausea, headache, pain in eyes, pain in limbs or joints, tingling sensations or numbness*.
-

## OVERLAP OF INTERNALIZING PROBLEMS

It has long been known that internalizing problems—whether they be symptoms, syndromes, or disorders—have a strong tendency to *overlap or occur together*. In the medical field, the term “comorbid” indicates the simultaneous existence of two separate disease processes, each having a separate pattern of development. For example, one could at the same time have a sinus infection and a skin rash; the two conditions exist in the same person and at the same time, but might be presumed to be unrelated in terms of their causes. In psychology, the term “comorbidity” has been used to indicate similar relationships. For example, a child could exhibit depression and panic attacks at the same time.

The use of the term “comorbidity” to describe the relationship among various internalizing or other psychosocial problems is perhaps unfortunate and misleading. This term implies that the two problems have separately occurring processes of development and maintenance. However, in reality, it is understood that internalizing problems, like many psychological disorders, may exist in a kind of symbiotic relationship; that is, they may nurture and sustain each other, and may have developed through similar events, predispositions, and patterns of responding. In our example of depression and panic disorder co-occurring, for example, it is entirely possible and perhaps likely that the expression and worsening of one of the symptoms increases the probability for the other symptom to occur, and increases the intensity of the problem once it has been expressed.

Regardless of the language used to describe this phenomenon, it is widely known that depression, anxiety, social withdrawal, and somatic complaints often co-occur. In some cases, the symptoms are the same. For example, irritability, fatigue, difficulty concentrating, and sleep problems are key diagnostic features of both major depressive disorder and generalized anxiety disorder in DSM-IV. Also, children with significant depression and those with significant anxiety may both develop somatic problems such as stomach pain, headaches, and so forth. Additionally, social withdrawal may be both a cause and effect of depression and is in many cases also linked with anxiety disorders. This similarity among core symptoms has made it difficult for researchers statistically to separate internalizing problems in the manner that they are distinguished in DSM-IV.

The overlap or co-occurrence of internalizing problems is not limited only to symptoms shared by depression and anxiety, or common consequences of the two problems. In fact, it is known that in a surprisingly large number of cases—as many as one out of three—anxiety and depressive disorders are formally diagnosed in the same individual at the same time. This fact should not be surprising given that several of the symptoms are the same. You will also note in later chapters of this book—those that focus exclusively on intervention—that some of the effective interventions for one internalizing problem are also effective for others, such as relaxation training, social skills training, and cognitive restructuring. However, in some cases, very specific and somewhat narrow intervention strategies may be effective for one type of internalizing problem but not for related types of internalizing problems. As is shown in Chapter 2 in the discussion of development of internalizing problems, much is still unknown regarding the similar or separate processes of internalizing problems.

## STUDENTS WITH INTERNALIZING PROBLEMS: FOUR VIGNETTES

In this section, four vignettes are presented. These true stories (with names and certain other facts changed to ensure confidentiality) are all from my own experience as a psychologist and educator. Any other practitioner or educator of at-risk students has or will have many similar stories. These stories are not unusual or remarkable; they are quite commonplace. They all differ according to the situation, the background, the details, and the outcome, but they share a common thread. Each of the three children or adolescents in the first three vignettes was suffering greatly from depression, anxiety, and related symptoms of *internalizing disorders*, such as social withdrawal and physical symptoms. The fourth vignette involves a teacher who incorporated effective practices into her classroom routine to help several of her students whom she considered internalizers, and to promote the mental health of all of her students. These case studies are presented to illustrate the challenges and complexities of internalizing disorders, along with the exciting possibilities available to school-based practitioners for helping troubled students.

### Emma

Emma was 8 years old and in second grade when her mother brought her in to the university training clinic where I supervised the work of graduate students. Our intake meeting revealed a family history of severe depression, and Emma seemed destined to continue this history with a vengeance. A precocious girl, Emma had verbal and cognitive skills more like those of a fifth grader than a second grader. But she also talked frequently of wanting to die. She had difficulty sleeping at night because of feelings of anxiety, hopelessness, and panic. She had to be physically removed from her bed in the morning and literally taken to school. Although she had previously been a gregarious girl, Emma's peer relations had deteriorated significantly that year, and most other kids actively avoided her. At school and at home, Emma would engage in "crying fits" that sometimes lasted for an hour or more. From my point of view Emma had many things going for her, but she seemed convinced otherwise, and her self-esteem and desire to engage in life had plummeted to an alarmingly low level.

Emma's father—convinced that counseling was futile—maintained that "drugs are the only thing that work." But Emma's mother first wanted to give counseling a try. After a careful intake assessment, we designed a basic treatment plan that focused on behavioral and cognitive change strategies, as well as emotional education. Individual counseling sessions would be carried out by a second-year graduate student working under my supervision. This student was highly competent but voiced doubts that such a serious case of depression could be treated adequately without first making a referral to explore the use of antidepressant medication. We all agreed to implement the individual counseling plan with frequent ongoing progress monitoring in place and then reevaluate our progress after four sessions.

The following 10 weeks were nothing short of amazing. Following a carefully developed treatment plan that included 1 hour per week of individual counseling, follow-up

meetings, phone checks with Emma's parents, and weekly data collection to gauge progress (what we now refer to as the "response to intervention" method), we observed a steady improvement over the first 4 weeks, to the point that our concerns about Emma being a danger to herself, and the possibility of considering medication evaluation or even hospitalization, diminished and then vanished. By 7 weeks into the intervention, it was hardly noticeable—across settings—that Emma was depressed, anxious, or had any social concerns. By 9 weeks into the intervention, all of our indicators showed that Emma was not only functioning normally in all respects but that she was also thriving. During the 10th session, when termination of counseling was being considered, the student therapist asked Emma why she thought she was doing so much better. Emma replied, "I think I'm doing better because I think about my problems in a different way than I used to, and I do different things than I used to, and then I usually feel okay even if things aren't going okay." Follow-up meetings at 2 and 4 months after the termination of individual counseling sessions showed us that Emma had maintained all, or almost all, of the progress she had made during treatment.

## Brandon

Brandon was 17 years old and beginning his senior year in high school when I began to work with him through my consulting contract with a very small rural school district. He had been a concern of the high school staff since his first year there, but these concerns had increased substantially over time. Brandon had become heavily involved in the local drug culture and was currently serving probation for an incident that resulted in arrest and 1 week in a juvenile detention facility. According to school board policy, any illegal drug use at school would result in an automatic expulsion, as well as a call to the local sheriff's department. It seemed likely to many staff members that this result was inevitable for Brandon. He had formerly been a B student, but his grades had plummeted dramatically, and he was in serious danger of not earning enough credits to graduate from high school that year. Brandon's English teacher had been alarmed by the overtly suicidal content of his essays and journal entries. Brandon had told more than one peer and teacher that he thought constantly of dying, and that he might even try to take his own life.

Brandon agreed to meet with me one time, with no obligation to continue in counseling. Although he refused to make eye contact with me for the first 30 minutes of our meeting, by the end of an hour, we had established reasonably good rapport, and he agreed to see me one more time. That "one more time" turned into Brandon's agreement to have weekly sessions with me and to make an effort to get better. And getting better was not easy in this case. Brandon was living, as he described it, "in a black hole." Every day was a struggle for him to go on, as he had very little energy and seldom desired to go on. Hardly a day went by that his thoughts were not preoccupied with death, dying, and feeling alienated "from the entire universe." He was also angry and resentful and seemed to have a unique talent for simultaneously getting teachers in his corner pulling for him and getting them so angry that they wanted him out of their classes.

Progress, not easy in this case, did emerge, although not nearly as dramatically or quickly as we had hoped. I had decided to go with an intervention plan that focused on

identifying and disputing irrational and unrealistic thoughts, coupled with lots of modeling and role playing on more productive ways to think and react. My plan also included a heavy emphasis on having him keep daily journals, confronting him when necessary, and helping him explore his feelings and goals about his life in general. Week to week, there would be some progress, but it was often followed by regression and falling into old habits. There was the Friday night at 11:30 when I received a call at home from Brandon, who said he was at a phone booth “a long way from here,” during a suicidal urge that was so serious I had to call the sheriff’s office for possible backup support. After Brandon terminated our conversation abruptly, I was not sure where he was and wondered if I would be reading about him in the paper the next day. There were also the times when his descriptions to me of his involvement in the drug culture pushed my desire to keep confidentiality to the very limits of law and ethics.

But progress did occur. Within a few weeks, Brandon and I both began to notice an upturn in the way he was feeling, accompanied by a downturn in his school problems. Brandon began to incorporate the strategies he learned in our sessions into his everyday challenges and gradually noticed how much they helped. Within about 4 months, it was clear that his depression, though not gone, was at least at a manageable level, and our more serious concerns diminished. At our termination session, 1 week before he graduated from high school, Brandon spoke with enthusiasm and confidence about what he would do in the future if and when the depression and suicidal thoughts returned.

## Jamie

A highly athletic and physically strong seventh-grade boy, Jamie seemed to be perpetually consumed in a chain reaction of anger and rage. He and his older brother, when they were younger, had been seriously physically abused by their father, a man for whom violence was the first approach to solving problems and conflicts. For the past 6 years, Jamie’s mother had been divorced from his father, after years of domestic abuse and brutal control. A gentle and well-meaning woman, Jamie’s mother was simply overwhelmed with parenting two sons who seemed to perpetuate their father’s disrespect toward this woman, which they had witnessed as young boys. Her view was that the best way to get Jamie’s behavior under control was weekly karate lessons, to teach him self-discipline.

At school, Jamie was in a self-contained classroom for students with behavioral disorders because of his generally out-of-control behavior and extreme aggressiveness. On the surface, Jamie seemed to be a vicious, even dangerous boy, with an extremely serious case of conduct disorder. And his overt behavior at school only emphasized this one-dimensional view of him. He frequently assaulted other students, threatened teachers, and exploded in uncontrollable episodes of rage. On one occasion, he caused another student to break a leg by deliberately shaking him off a 20-foot-high climbing rope in the gymnasium. Another time, he spit in the vice principal’s face while he was being confronted for fighting, in full view of 10 or so other students.

But underlying Jamie’s overt aggression, anger, and antisocial behavior was another dimension, one that few people saw or understood. He often seemed to sink into a state of despair and hopelessness, sometimes refusing to remove his head from his desktop for an

hour or two at a time. His journal entries revealed a scared and confused boy who, because of his own hostility and anger, exhibited a desire to die, perhaps violently, to end the perpetual torment he felt. Paradoxically to some, he was also consumed by fears and anxieties, and frequently awoke during the night in a sweaty state of panic. My own efforts to work with Jamie individually were uniformly unsuccessful and humbling to me, causing me to doubt my own skill as a clinician. Referral to a psychiatrist resulted in two or three medication trials that tended to make him drowsy and “spaced out” but did not improve any of the major symptoms. The only person who seemed to make any impact with Jamie was his special education teacher, a remarkable veteran educator in her 60s. This slightly built woman was barely 5 feet tall but showed no fear toward Jamie, even when he was confronting her during an explosion of rage. Through individual attention, group affective exercises, and interpersonal educational techniques, she had a knack for helping Jamie express his feelings, redirect his anger, and regain composure and calm when he was most upset. Although this was not a case in which we saw a quick turnaround, the progress that this teacher made with Jamie was remarkable and certainly helped to keep him in school many times when suspension or even expulsion might have otherwise been a certain outcome.

### Janice: A Teacher’s Story

I met Janice, an experienced elementary school teacher, in the course of conducting research on the effectiveness of the Strong Kids social and emotional learning (SEL) curriculum (discussed in detail in Chapter 4), authored by me and some of my associates. She participated in training on how to use Strong Kids in her classroom at the start of the school year, and we established a plan to consult with her on implementation, observe her teaching the lessons, and conduct pre- and posttest evaluations of her students’ social and emotional knowledge and symptoms.

Janice approached the task of using Strong Kids with her fifth-grade students with great enthusiasm, not only delivering the lessons as prescribed, but finding additional ways of incorporating the SEL concepts into her weekly classroom routine. During a couple of visits to her classroom, I was impressed by her skill and her ability to engage students in the curriculum. I was also delighted to see that she was incorporating key components of the emotional learning, cognitive restructuring, interpersonal problem solving, and conflict resolution aspects of the curriculum into her work with the students throughout the week, and not just promoting it within the designated curriculum time. Although her classroom was overly crowded (38 students), the students responded exceedingly well to her. There was nothing to tip me off to the fact that she had several students who struggling with fairly significant depression, anxiety, and related problems. At least 6 of the 38, based on our pretesting data and her own description of these kids, seemed to have problem symptoms at a level that clearly was a concern.

As the weeks progressed, Janice became a real expert on delivering Strong Kids and incorporating the wellness-promoting routines into her daily classroom life. She was not just focusing on those six students for whom she had significant concerns, but on promoting the mental health and wellness of *all* of her students. After the 12th week of interven-



tion, our posttesting results confirmed that her students in general showed significant gains in knowledge regarding critical SEL concepts, and that several of the students were reporting lower levels of emotional distress than they were prior to the start of the program. In particular, 4 of the 6 students identified as a concern demonstrated problem symptom reduction, and all 6 of them showed significant increases in their social and emotional knowledge. Janice now champions the use of SEL in elementary schools, and makes Strong Kids part of her ongoing teaching routine. Aside from our brief pre- and posttest data, Janice reports that she actually sees her students using the skills they learned in Strong Kids as they negotiate the social and emotional challenges of life within her classroom setting.

### The Common Thread

These four vignettes share some common threads. First, it is important to note that symptoms of depression, anxiety, and other internalizing problems, although clearly present and prevalent, are often intermixed with other problems. Particularly in the cases of Brandon and Jamie, treatment of their internalizing problems had to take place within the context of many other problems, such as substance abuse, aggression, and overt hostility. Second, these cases illustrate how challenging, even daunting, treatment of children and youth with serious internalizing problems can be. With each vignette, there were some initially good reasons for hesitation, even skepticism, regarding how well the intervention might be expected to go. Third, and most importantly, these vignettes all show that the common intervention techniques illustrated in this book have tremendous potential for improving the lives of students who are experiencing internalizing problems or other social and emotional difficulties. Although there will not always be a happy ending, you should proceed through this book encouraged that the intervention techniques that are available to you offer *real possibilities*.

## CONCLUDING COMMENTS

A great deal of progress has been made during the past two or three decades in our understanding of depression, anxiety, and related internalizing problems of children and youth. Now that we have clearly defined the general concept of internalizing disorders, there is a relatively good understanding of the components and symptoms of these disorders. Defining and describing clearly the overlap of internalizing symptoms, syndromes, and disorders has been an important recent development. Despite the impressive progress in this area, we still have a long way to go. One issue that still needs some definitive clarification is the incidence and prevalence of the various internalizing disorders. At the present time, we can only estimate or approximate the percentages of children and youth who suffer from these problems. Additional comprehensive prevalence studies would be very useful in this regard. Another issue that is still not well understood is the overlap or co-occurrence of internalizing symptoms and disorders. Sometimes, classifications or diag-

nostic labels such as “depression” or “anxiety” simply do not provide an accurate description of the problem, or do not fit particular children who experience many distressing symptoms, but not enough in any one category to justify a formal diagnosis.

This introductory chapter provides an initial foundation for understanding internalizing problems but is certainly not exhaustive or all-encompassing. Additional, helpful details for understanding this area are presented in Chapter 2, which provides additional practical insight into understanding internalizing problems, particularly regarding how these problems develop and emerge in children, what factors may cause or influence them, and the consequences to which they tend to lead. Additionally, Chapter 2 provides some practical guidelines for sorting out internalizing disorders from other common behavioral and emotional problems of children and youth.