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RELATIONSHIP BETWEEN PARENTAL DEPRESSION AND ADOLESCENT'S ABILITY  
TO COPE WITH TRAUMA

GABRIELLE STRATT JANNEY  
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Reviewed and approved\* by the following:

Dr. Elizabeth J. Susman  
Professor, Biobehavioral Health  
Thesis Supervisor

Dr. Lori A. Francis  
Assistant Professor, Biobehavioral Health  
Honors Adviser

\*Signatures on file in the Schreyer Honor College.

**ABSTRACT**

The present study is an analysis of symptoms of depression in children who have endured trauma. Parental depression was used as a moderator of exposure to trauma and depression. The hypothesis was that children who endure trauma and have parents who are depressed will have less support and therefore cope differently resulting in depression. Childhood depression was measured using Diagnostic Interview Schedule-IV (DISC-IV); trauma was reported using KIDS-SAVE; parental depression symptoms were measured using Brief Symptom Inventory (BSI) as the moderator. Although the regression analysis did not support the hypothesis using parental depression as a moderator, the association was significant between both parental depression and presence of trauma in explaining variation in childhood depression.

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## INTRODUCTION

Studies have suggested that families that include a parent with depression impose a risk for poor mental health for the children of that household (Harold, Rice, Hay, Bolvin, & Thapar, 2010; Abela, Zinck, Kryger, Zilber, & Hankin, 2009; Schermerhorn, D'Onofrio, Turkheimer, Ganiban, & Spotts, 2010). Mental health problems among adolescents also tend to be concentrated in minority groups including low-income families and single-parent families. It is important to look into the implications of parental depression on adolescent depression because depression in adolescents may lead to poor school performance. With inhibited school performance, the adolescent will likely lose earnings in the future and could influence cycles of depression in generations to come. Further, adolescent depression poses a risk for dangerous behaviors such as risky sexual behaviors and alcohol and drug abuse (Schumaker, Coffey, & Stasiewicz, 2006). On the societal level it is advantageous to prevent adolescent depression because of the medical costs ensued. Data from 1985 estimated that the cost for medical care for mental health problems for children under the age of 15 was 2 billion dollars per year. For those younger than 19 the cost increased exponentially to a range as high as 20 billion a year (Glied & Pine, 2002). With billions of dollars spent on mental health care in the adolescent population alone, it is important to identify events that lead to mental health disorders and possible protective factors.

### *Adolescent trauma:*

Adolescent trauma can lead to a variety of disorders later in life. Experiencing trauma at a young age is associated with a variety of stress disorders including severe cases of posttraumatic stress disorder (Schumaker, Coffey, & Stasiewicz, 2006). Adolescents who have undergone

trauma(s) at a young age are at an increased chance for developing stress disorders and also becoming alcohol and drug dependent later in life. There is evidence that enduring trauma at a younger age is associated with more severe psychological disorders than enduring trauma at a later age (Schumaker, Coffey, & Stasiewicz, 2006). These data suggest that early onset of trauma is negatively correlated with the ability to cope with the stressors of that trauma. Results of the study showed that psychological symptoms that have been previously defined in relation to trauma were more pronounced among individuals with earlier onset of trauma than those with later onset. Early onset of trauma can lead to the comorbidity of disorders as severe as posttraumatic stress disorder and alcohol dependency (Schumaker, Coffey, & Stasiewicz, 2006). With early onset of trauma showing clear implication for psychological disorder it is important to assess which aspects of trauma are most likely to lead to the development of these disorders.

There are many aspects of adolescent trauma to consider in addition to early onset of trauma. Although most studies focus on response to a single trauma, it is important to assess the detrimental effects of multiple traumas. It is also important to assess the different psychological symptoms that are present in adolescents who go through the same or similar traumas. Krupnick et al. (2004) found significant differences between college women who experiences multiple traumas and ongoing traumas compared to a singular trauma. The study looked at the confounding effects of women who endured traumas including sexual and physical assault. The results show that the women who experience no trauma have insignificant health outcomes, followed by the group with a singular trauma. The group of women who reported multiple traumas had the highest reporting of mental health problems (Krupnick, Green, Stockton, Goodman, & Corcoran, 2004). Although the data did not support the hypothesis that there would be major differences in psychological outcomes by those experiencing different traumas, the

hypothesis should not be discounted.

*Relationship between parental and adolescent depression:*

It is important to consider both genetic and environmental influences between parental and adolescent depression. In Harold and colleagues (Harold, Rice, Hay, Bolvin, & Thapar, 2010) there was significant associations between both mother's and father's depression and child depression. These correlations carried through to antisocial behavior in the parents and the children. By looking at both genetically related and genetically unrelated parent/ child relationships, the study is able to show that environmental factors are at play. Although, genetically related mother and father dyads did have more significant correlations on their child's psychopathology there were still significant results for genetically unrelated mothers and their children. Parental hostility was positively correlated for antisocial behavior for both mothers and fathers. Conversely, parental warmth is inversely correlated to antisocial behavior in children (Harold, Rice, Hay, Bolvin, & Thapar, 2010). This study shows significance in parental behavior and the reflection that it has on the behavior and psychopathology in their offspring.

Parental depression can also lead to negative attachment cognitions in children and adolescents. Fluctuation of children's attachment and depression mirrored that of their parents (Abela, Zinck, Kryger, Zilber, & Hankin, 2009). Children who exhibit high levels of negative attachment reported higher levels of depressive symptoms when their parents were also experiencing high levels of depressive symptoms. When the parent's symptoms subsided, the children's depressive symptoms lessened (Abela, Zinck, Kryger, Zilber, & Hankin, 2009). Implications of the study are that parental depressive symptoms appear to effect their child or



adolescent's attachment that in turn has a negative effect on the child's psychopathology.

Parental depression can lead to parenting styles that are correlated with adolescent depression. It is not surprising that a depressed parent will have a different parenting style than a non-depressed parent and therefore affect their child's psychopathology. In a study assessing family psychopathology and parent-child relations, family psychopathology was elevated in families of depressed adolescents whose mothers were also depressed (Schermerhorn, D'Onofrio, Turkheimer, Ganiban, & Spotts, 2010). Siblings of the depressed adolescents were more likely to experience a depressive disorder and fathers in the same group were more likely to report a history of substance abuse. Focusing on depressed mothers and their parenting styles, the authors suggested that non-depressed mothers are likely to be more overprotective of their depressed child with more energy to expend on their child's health. On the contrary, depressed mothers are less preoccupied with the needs of their depressed child and more concerned with their own health. With a mother's inability to cope with her own stress, they are more likely to withdraw from their own child and without the support the child's depressive symptoms may be enhanced.

Even among parents who do not report depressive symptoms, parenting styles can be a protective or risk factor for adolescent depression. Responsiveness of a parent can be a protective factor in both girls and boys (Piko, & Balazs, 2010). For boys, a mother's behaviors have more of an impact than that of the father's while for girls both parents impact their psychopathology. Authoritative parenting style was correlated with lower depression rates in both girls and boys. A prevailing trend showed that the opposite sex parents had the largest impact on depressive symptoms. The study also has significant data showing that negative family interactions can serve as a risk factor for depression in the adolescent (Piko, & Balazs, 2010).

Without a parent's depression as a factor in a child's psychopathology, parent-child interactions are still important for a child's mental health.

Open communication in the relationship between a parent and adolescent is also key in the prevention of depression and risky behavior. Communication between an adolescent and parent is the primary indicator of the quality of the relationship (Riesch, Anderson, Pridham, Lutz, & Becker, 2010). Adolescents with less open communication with their parents report less satisfactory relationships and have been reported to show poorer coping skills and academic difficulties when transitioning into adolescence. Little communication in an adolescent-parent relationship can also lead to the development of depression and suicidal proneness. Adolescents who report a satisfactory relationship with open communication are also less likely to engage in risky sexual behaviors as well as alcohol and drug use (Riesch, Anderson, Pridham, Lutz, & Becker, 2010). With communication reported as an important factor in a child's mental health, it is important to assess how a parent's mental health will impact communication.

### *Hypothesis*

With adolescent trauma and parental depression showing strong indication that each is a risk for adolescent depression, the hypothesis is that adolescents who endure trauma(s) and have parents who report depressive symptoms will be less capable of coping than adolescents with non-depressed parents. When an adolescent endures a trauma and a parent is unable to aid in coping with the trauma due to their own depression, the adolescent may not be as capable at coping with the trauma on their own as they would be able to with a mentally healthy parent. Therefore, the prediction is that adolescents who endure trauma(s) and have a depressed parent will report more symptoms of depression than children with mentally healthy parents.

## METHODS

### *Sample*

*(The following description is reproduced with permission from E.J. Susman.)*

Participants were 135 healthy children and adolescents and a parent or caregiver (88.2% mother, 9.6% father and 1.5% grandmother). Girls were age 8, 10 or 12 years (N=69, M = 10.06 years, SD = 1.64) and boys were age 9, 11, or 13 years (N = 66, M = 10.94 years, SD = 1.61). The age difference was designed to include boys and girls at similar stages of pubertal development since girls mature earlier than boys. Day-in-menstrual cycle was controlled as the girls were assessed between day five to nine of their cycle. The racial/ ethnic composition of the adolescents appears in Table 1 along with demographic characteristics of the sample.

Table 1: Means and Standard Deviations for Demographic Variables

	<b>Girls (69)</b>	<b>Boys (66)</b>
	<b>Mean (SD)</b>	<b>Mean (SD)</b>
Age	10.06 (1.644)	10.94 (1.607)
Family SES	46.2(10.6)	47.2(10.6)
Race	Count(%)	Count(%)
White	62 (89.9)	59 (89.4)
African American	2 (2.9)	1 (1.5)
Hispanic White/Latino	3 (4.3)	2 (3.0)
Asian	1 (1.4)	1 (1.5)
Korean		1 (1.5)
White, Part Thai (Asian)		1 (1.5)
White, Arab, Black		1 (1.5)
White & African American	1 (1.4)	

The study was approved by an Institutional Review Board and all procedures were carried out with the adequate understanding and written consent or assent of the parents and adolescents. Parents signed a written consent for themselves and their adolescents. Adolescents signed an assent form.

The recruitment strategy consisted of obtaining a list of children's names from designated ZIP codes from the American Student List (ASL), a commercial enterprise that provided names, addresses, ages and phone numbers of school age children. The comprehensive list of names was generated by ASL from ZIP codes supplied by the investigator. The ZIP codes were chosen to include low-income neighborhoods from the county in which the research lab was located and adjacent counties that had easy accessibility to the lab. A letter was mailed to the families on the list. The parents either called the lab to ask about the study or families were telephoned to inquire if the adolescent was interested in participating in the study.

The sample was heterogeneous with regard to occupational status and the employment and education of the participants was representative of the counties from which the sample was drawn. Eligibility criteria were boys age 9-, 11-, or 13-years; girls age 8-, 10-, or 12-years; not on medications that would interfere with hormone levels (e.g. oral steroids); and free from chronic physical (e.g. diabetes) or serious mental health problems. Names were chosen at random from the list until all names were exhausted. Eighty-five children were enrolled from the ASL list. The remaining participants were obtained from flyers distributed throughout the community and from parental telephone response to e-mails distributed to non-faculty, staff at a large university (E.J. Susman et al., 2010, p.5).

*Child Depression:*

Diagnostic Interview Schedule for Children (DISC-IV) (parent). The DISC-IV is a structured interview used to assess symptoms of psychiatric disorders in children and adolescents in accordance with DSM-IV criteria (APA, 2000; Shaffer et al., 2000). The DISC is a pre-constructed, computerized interview. Due to a higher correlation of parent scores across time, parent reports of DISC-IV symptoms are used in the current analysis. (Piacentini et al., 1999).

*Parent Depression:*

Brief Symptom Inventory (BSI). The BSI is designed as a self-reported survey of psychological symptom patterns in both adolescents and adults. The BSI is a shortened version of the SCL-R-90 (Derogatis, 1993). The BSI was shortened from its original form through a selection process that identified the highest loading items for each symptom dimension. The current model uses 53 items consisting of nine symptom dimensions including somatization, anxiety, hostility, phobic anxiety, paranoid ideation, interpersonal sensitivity, psychoticism, and depression. To measure levels of symptom severity three global devices of distress were included: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. For the current study, the items used to identify depression were used. These items include questions 9, 16, 17, 18, 35, and 50 from the BSI questionnaire. The questions for each dimension are mixed within the BSI so that participants cannot identify which disorder matches the item (Derogatis, 1993).

*Child's Exposure to Trauma: KID-SAVE:*

The KID-SAVE is a 45-item questionnaire including scales for frequency and impact. Each item is rated for frequency on a 3-point scale: 0= Never, 1=Sometimes, 2= A lot. Frequency is accompanied by a 3-point impact scale: 0= Not at all upsetting, 1= Somewhat upsetting, 2= Very upsetting. The 3-point scale for impact is matched with faces to describe the feeling: smiling, frowning, and very upset. Items in the KID-SAVE are based on events the child had witnessed, events the child had heard about, and events directed at the child. The three different types of items were separated throughout the questionnaire and put into three categories: Indirect Violence, Traumatic Violence, and Physical/Verbal abuse. Indirect violence includes witnessing less severe interpersonal violence or hearing about violent events (16 items). Traumatic Violence includes witnessing a shooting or murder, or being the victim of an assault with a deadly weapon (12 items). Physical/Verbal Abuse includes hitting among peers, and grown-ups hitting/screaming at child (6 items). Items are shown in Table 2 (Flowers et al., 2000). For the purpose of this study, the Physical/Verbal Abuse items were used in the analysis for describing trauma.

Table 2: Physical/Verbal Abuse items from KID-SAVE

Physical/Verbal Abuse	
25.	I have been badly hurt.
28.	Someone my age hits me.
36.	Grown-ups scream at me at home.
38.	Someone has threatened to beat me up.
40.	Grown-ups hit me at home.
45.	I have seen someone get badly hurt.

## RESULTS

### *Analysis*

#### *Descriptive Statistics and Pearson's Correlation*

Descriptive information and Pearson's correlations for all variables appear in Table 3. Correlations were done for Parent Depression, Child Depression, and items from KID-SAVE. There was no significant correlation between Parent Depression and frequency of Physical/Verbal Abuse. The items from KID-SAVE all show a significant positive correlation with increased Childhood Depression (Trauma Frequency, Trauma Impact, Indirect Frequency, Indirect Impact, and Physical/Verbal Abuse Frequency ( $p < .01$ )) (Physical/ Verbal Abuse Frequency ( $p < .05$ )) (Table 3).

Table 3. Descriptive Statistics and Pearson Correlation Analysis: Parent Depression, Child Depression, and KIDS-SAVE variables.

	Child Depression	Parent Depression	Trauma Freq	Trauma Impact	Indirect Freq	Indirect Impact	P/V Freq	P/V Impact	Age
Parent Depression	.20*	..							
Trauma Freq	.25**	-.01	..						
Trauma Impact	.25**	-.01	1.0**	..					
Indirect Freq	.35**	.03	.45**	.45**	..				
Indirect Impact	.27**	.11	.39**	.39**	.75**	..			
P/V Freq	.27**	.05	.27**	.27**	.54**	.32**	..		
P/V Impact	.21*	.13	.13	.13	.42**	.37**	.85**	..	
Age	-.12	.08	.077	-.18*	-.04	-.12	-.22*	-.26**	..
	<i>M</i> = 5.13 <i>SD</i> = 4.66	<i>M</i> = .23 <i>SD</i> = .39	<i>M</i> = .93 <i>SD</i> = 1.42	<i>M</i> = .86 <i>SD</i> = 1.14	<i>M</i> = 1.80 <i>SD</i> = 2.45	<i>M</i> = 2.50 <i>SD</i> = 2.38	<i>M</i> = .10 <i>SD</i> = .69	<i>M</i> = .06 <i>SD</i> = .44	

*Note.* P/V= physical/verbal, Trauma=traumatic, Freq=frequency. \*  $p < .05$ ; \*\*  $p < .01$ ; *M* = Mean; *SD* = Standard Deviation; Pearson Correlation Coefficients; Parent Depression is from BSI (Derogatis, 1993); Child Depression is from DISC-IV (APA, 2000; Shaffer et al., 2000), Trauma Frequency, Trauma Impact, Indirect Frequency, Indirect Impact, Physical/Verbal Frequency, and Physical/Verbal Impact are from items in the KIDS-SAVE questionnaire (Flowers et al., 2000).



*Hypothesis Testing*

Hypothesis testing focused on the relationship between Parental Depression, Physical/Verbal Abuse Frequency, and Child's Depression. A multiple linear regression model tested the association between both parental depression and childhood depression and frequency of physical/verbal abuse and childhood depression. The F statistics, betas, and p-values are presented for the three models in Table 4. Model 1 shows no significance in a child's age or sex determining symptoms of depression. Significance found in Model 2 ( $p < .01$ ) for variation in a child's depression outcomes for both the presence of a parent's depression symptoms ( $p < .05$ ) and Frequency of Physical/Verbal Abuse ( $p < .01$ ). Significance found in Model 3 but no significance found when using parent's depression as a moderator.

Table 4. Regression of Child's Depression on Age, Sex, Parent Depression and Physical/Verbal Frequency and the interaction of Parent Depression and Physical/Verbal Frequency

Variable	B	SE	$\beta$	F	R <sup>2</sup>	$\Delta R^2$
Model 1						
Age (years)	.25	.94	.03			
Child's Sex	-.26	.28	-.09			
Full Model				.62	.01	.01
Model 2						
Parent's Depression	2.25	1.09	.19*			
Physical and Verbal Frequency	1.11	.39	.27**			
Full Model				3.70**	.12	.11
Model 3						
Parent's Depression	1.78	1.49	.15			
Physical and Verbal Frequency	1.00	.46	.24*			
Parent's Depression by P/V Frequency Interaction	.49	1.06	.07			
Full Model				2.98*	.12	.002

*Note.* P/V= physical/verbal. \* $p < .05$ . \*\*  $p < .01$ ; Depression is from BSI (Derogatis, 1993); Child Depression is from DISC-IV (APA, 2000; Shaffer et al., 2000), Trauma Frequency, Trauma Impact, Indirect Frequency, Indirect Impact, Physical/Verbal Frequency, and Physical/Verbal Impact are from the KIDS-SAVE questionnaire (Flowers et al., 2000).

### *Regression Models*

Model 1. There was no significance in Model 1 for the association of age or sex in the variation of child's depression (Table 4).

Model 2. Significance was found in the overall model assessing the association between Parental Depression and Physical/Verbal Abuse Frequency in the variation of Childhood Depression. ( $F=3.70$ ,  $df=4,109$ ,  $p<.01$ ). Presence of parental depression shows a significant association with variation in a child's depression having controlled for frequency of physical/verbal abuse ( $\beta =.19$ ,  $p<.05$ ). Frequency of physical/verbal abuse also shows significant

association in the variation of a child's depression having controlled for parent's depression ( $\beta=.27, p<.01$ ). (Table 4)

Model 3. With both parental depression and physical/verbal abuse showing significance for variation in childhood depression, parental depression was tested as a moderator between physical/verbal abuse and child depression. This model included the interaction term of parental depression by physical/verbal abuse. The overall model was significant. ( $F=2.98, df=5,108, p<.05$ ) The moderating effect of parental depression on the association between presence of physical/verbal abuse and childhood depression was not significant. (Table 4)

Based on results of the linear regression analysis, Model 2 is accepted as the best model for explaining the association between parental depression and childhood depression as well as frequency of physical/verbal abuse and childhood depression. The hypothesis that parental depression will have a moderating effect between physical/verbal abuse and childhood depression is rejected based on the results in Model 3. (Table 4)

## **DISCUSSION**

The purpose of the current study was to identify whether children who endure trauma(s) and have parents who report depressive symptoms will in turn report symptoms of depression. The goal was to find the parent's roll in helping a child cope with trauma, hypothesizing that parents who are mentally stable will be able to help their child cope with the trauma and in turn decrease the chance of the child developing depression. Three measures were used to represent child depression, parental depression, and trauma: DISC-IV, BSI, and KID-SAVE respectively. (Refer to methods).

Both a simple correlation and linear regression were used to analyze the data. The correlations between frequency of physical and verbal abuse and parent depression were not significant. For both parent depression and frequency of physical/verbal abuse, significance was found in the correlation with childhood depression. The regression analysis showed that both parental depression and frequency of seeing and/or hearing verbal and/or physical abuse explained the variation between children without or little depressive symptoms and children who reported having more depression symptoms.

The first model in the regression analysis accounted for age and sex. When accounting for both of these variables, the model is not significant which suggests that age and sex are not a discriminating factor for predicting childhood depression in this sample. The second model included parent's depression and frequency of physical/verbal abuse. This model showed that both a parent's depression and the frequency of physical/verbal abuse independently account for variation in a child's report of symptoms of depression. To take the analysis further, in the third model, parent's depression was used as a moderator suggesting that a parent's depression can predict variation in a child's symptoms of depression having reported physical/verbal abuse. The overall model still shows significance but parent depression did not have a moderating effect on the child's depression. This suggests that there is no significant change in a child's depression when they endured physical/verbal abuse frequently and also have parents who are depressed.

Although the third model was not significant, the second model indicates that both variables are related to a child's mental health. The lack of variation in the two models does not provide enough information to support that there is no significance in having a parent's depression as a moderator between physical/verbal abuse and a child's outcome of depression, it

merely suggests that there is not enough variation between the scores in the two models to support the hypothesis in this sample.

The significance in the second model shows that parental depression is related to the variation between children and depression. In the present study, only one parent was required to accompany their child and 88.2% of the parents were represented by mothers. According to the significant findings in Harold et al. (2010), the mothers will have a significant effect on their child's depression if they also show symptoms of depression.

### *Future Research*

Similar to the findings of Schumaker et al. (2006), experience with trauma at an early age is a risk factor for depression. Therefore, it is important to help a child cope with a trauma close to its occurrence to prevent the development of symptoms or keep symptoms from carrying on into later life. It has been found that children who have depression often become depressed adults (Schumaker, Coffey, & Stasiewicz, 2006).

Significance found in the regression analysis, that frequency of verbal and physical abuse can be attributed to symptoms of depression, mirrors the findings of Krupnick et al. (2004) that the frequency of a trauma will have a negative impact on an individual's mental health. With the present analysis and information found in the Krupnick et al. (2004) study, it would be beneficial to expand the scope of the population sample to see if significance is found in other populations. The findings of this study, along with information in the Krupnick et al. (2004) and Schumaker et al. (2006) study suggest that enduring trauma at a young age as well as the frequency of trauma can lead to increased risk of depression at a later age.

Since both parental depression and frequency of physical/verbal abuse have an effect on a child's depression separately, it is important to identify the type of physical or verbal trauma that the child endured. The KID-SAVE measure for physical and verbal abuse can include verbal or physical abuse among peers, among adults, or abuse directed from an adult to the child. For the current study, the interest was in the presence of trauma(s) and the effects on a child's mental health, which was sufficiently covered in the frequency measures of the KID-SAVE. For future studies, it would be beneficial to separate the specific items of physical and verbal abuse to determine which type has the most profound impact on a child's psychopathology.

The KID-SAVE measure does have a question related to the impact of physical and verbal abuse but the specific items are lumped into one variable. Without separating the items, there is no way of knowing what specific events caused depression in the children. For example, a child in school may see bullying on a daily basis and therefore report a high number of verbal/physical abuses. This event may not have as big of an impact on the child if he/she was specifically reporting being physically abused by a parent. In a study of children and parental abuse, children who reported physical abuse by their parents were more likely at risk for developing clinical depression compared to children who did not endure physical abuse (Sternberg et al., 1993). The literature has focused mainly on the mental effects of the victims of peer bullying, however witnessing peer bullying may have been less explored. Children who are bullied frequently report poor mental health (Rigby, 2000). Further, Rigby (2000) reported that children who endure frequent bullying and report having little social support are at a higher risk for depression compared to those who perceive having more social support. With peer bullying having a psychological effect in the child and adolescent population, separating the questions and

determining the effects of indirect and direct peer conflict on a child can be an important direction to pursue in the future.

### *Limitations*

There are a few limitations within the study. The sample was collected to assess relations between hormones and aggressive behavior and depression during puberty. Although the KID-SAVE and BSI were collected and relevant to the current study, the sample was not collected specifically to explore the effects of trauma and depression. Therefore, the sample has little variation among race and SES that may have implications for the type of abuse a child encounters (Table 1). For future studies, a more heterogeneous sample should be included so variables such as race, SES, and religion can be controlled for in the analysis.

Due to the lack of variability in the sample, not all aspects of the KID-SAVE variable were explored in this report. Since the first two variables dealt mainly with items asking about violence relating to guns, shootings, etc., there were fewer responses from the sample. Literature has reported that living in a community with a high rate of violence can be related to poor patterns of behavior in a child's behavior (Linares et al., 2001). Expanding the sample based on certain demographics will allow for a discussion in extreme violence and how the presence of those traumatic events can affect a child's mental health.

Childhood depression was measured using an interview (DISC-IV) completed by the child's parent. Parents may be reluctant to report symptoms of depression in their child. Parents may also not be completely aware of their child's symptoms. Results in Moretti et al. (1985) suggest that children ages 8-17 years are capable of reporting personal symptoms of depression. Further, the report also found that a parent's report of their own depression has an effect on how

they report symptoms of depression in their child (Moretti et al., 1985). For future studies in this area, it could be beneficial to use a measure that gets a direct account from the child of depression symptoms.



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## ACADEMIC VITA

### **Gabrielle S. Janney**

458 E. College Ave. Apt # 602

State College, PA 16801

[Gsj819@gmail.com](mailto:Gsj819@gmail.com)

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### **EDUCATION:**

Candidate for Bachelor of Science in Bio Behavioral Health

Minors in Human Development and Family Studies; Deafness and Hearing Studies

- Focus on adolescent/child behavior and language development

Dean's List: 2008, 2009, 2010, 2011

### **RESEARCH EXPERIENCE:**

**Schreyer Honors College, University Park, PA**

**Independent Student Investigator**

**August 2010-April 2012**

- Honor's thesis: "Relationship between parental depression and adolescent's ability to cope with trauma"
- Complete IRB approval for social sciences research

**Infant Temperament Lab, University Park, PA**

**Student Research Assistant**

**Fall 2009- Spring 2011**

- Observe teaching relationships and develop skills to code verbal and non-verbal behavior of observed children
- Assist in creating methods/behavioral codes for measuring emotion in 2-5 year olds; increased reliability among researchers from 60% to 80%

**Prevention and Methodologies Lab, University Park, PA**

**Student Research Assistant**

**June 2011-Present**

- Administer surveys for 10 patients seeking group therapy
- Analyze progression of relationships between group leaders and patients as well as patient to patient relationships

**Breast Cancer Support-Group Project, University Park, PA**

**Student Research Assistant**

**September 2010-December 2010**

- Develop code book to analyze data collected from a sample of support groups among women suffering from breast cancer

### **COMMUNITY INVOLVEMENT:**

**Morale Committee for Penn State IFC/Panhellenic Dance Marathon**

**Team Mentor; Dancer Liaison; Intra-Committee Liaison**

**September 2010- Present**

- Support dancers and families of the Four Diamond Fund during THON weekend

**Lion Line, University Park, PA**

**October 2008-May 2009**

- Communication skills used to raise money for Penn State academics

**Private Homes, Delaware County, PA**

**Babysitter/ Tutor**

**Fall 2005- Present**

- Administer lesson plans and tutor children through summer school work in math, reading comprehension, and specialized subject areas
- Develop personalized teaching techniques based on student's strengths and weaknesses

**Main Line Reform Temple, Wynnewood, PA**

**Camp Counselor**

**June 2000-August 2009**

- Create activities and lesson plans appropriate for different co-ed age groups
- Coordinate with peers and parents to execute activities and lesson plans