

Parent and Peer Attachment in Early Adolescent Depression

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Insecure attachment relations have been theorized to play a significant role in the development of depressogenic modes of adaptation and to thus form a vulnerability factor for the emergence of depressive disorder in children. This study examined security of parent and peer attachment among four groups of early adolescents: clinically depressed, nondepressed psychiatric controls, nonpsychiatric controls, and adolescents with resolved depression. Depressed adolescents reported significantly less secure parent attachment than either of the control groups, and less secure peer attachment than the nonpsychiatric control group. Attachment security of adolescents with resolved depression was on a par with the nonpsychiatric control group. Among all psychiatric patients, security of attachment to parents was negatively correlated with severity of depression according to interview and self-report ratings. Less secure attachment to parents, but generally not to peers, was also related to more maladaptive attributional styles, presence of separation anxiety disorder, and history of suicidal ideation.

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INTRODUCTION

Recent advances in the conceptualization and assessment of childhood depression has encouraged a proliferation of theoretical and empirical work on the subject. While the potential etiologic contribution of psychosocial factors has been acknowledged (e.g., Kashani et al., 1981; Poznanski, Krahenbuhl, & Zrull, 1976; Puig-Antich et al., 1985a, 1985b), there have been only a few efforts to study the role of interpersonal relations in the cause and course of childhood and adolescent depression. Understanding the nature of parent-depressed child relations would contribute to a more comprehensive theory of childhood depression (Burbach & Borduin, 1986). Other social influences such as peer relations must also be examined for their separate or interactive contributions to the risk of depressive disorder.

Attachment theory provides a valuable conceptual model for understanding the role parent-child relations play as a risk factor for depression (Bowby 1969/1982, 1973, 1980; Bretherton & Waters, 1985; Cicchetti & Schneider-Rosen, 1986; Cummings & Cichetti, 1990). Security in the parent-child relationship is regulated by patterns of the child's seeking and the parents' providing comfort, help, and protection. Experiences with attachment form the basis for the child's construction of representational models of the self and significant others in her/his world (Bowlby, 1969/1982, 1973; Bretherton & Waters, 1985), which are believed to influence later behavior. The child with a history of insecure attachment is more likely to become caught up in a cycle of selective perception of the world as unpredictable or threatening, and thus show less exploration, less competence, and greater helplessness. This, in turn, could lead to a greater likelihood of behaving in such a way as to increase the probability that experiences will be adverse.

Insecure attachment to parents is thus theorized to play a significant role in the development of depressogenic schemata and attributional styles. Such experience may impart cognitive biases that lead to interpreting later loss or disappointment as personal failure and to pessimism regarding the self's restoration abilities. Such hopelessness may be extended to life in general, with clinical depression setting in when the individual lacks or has lost the feelings of self-worth necessary to protect against such a generalization (Brown, 1982). Further, characteristics of the child with experiences of poor parent relations may contribute to a cycle of difficulties with peers, which may form a vulnerability factor for depression.

In nonclinical samples of older adolescents, self-report of attachment to parents is positively related to self-esteem and negatively related to endorsement of depression, anxiety and anger, and less adaptive (problem-solving) coping strategies (Armsden & Greenberg, 1987; Armsden, 1986). Adolescents' perceptions of their ability to be loved have been shown to be

positively related to parental acceptance, support, and nurturance and negatively related to emotional detachment from parents (Ryan & Lynch, 1989). Similar studies have not yet been reported using clinical samples.

Studies of parents of depressed children point to significant, often severe, deficiencies in parent-child relations. Cytryn and McKnew (1979) note the prevalence of parental deprecation and rejection in such families. Others have described the parents of clinically depressed children and early adolescents as rejecting and detached, a factor also related to depression at followup (Poznanski & Zrull, 1970), or as even abusive toward their children (Puig-Antich, Blau, Marx, Greenhill, & Chambers, 1978). Puig-Antich et al. (1985a, 1985b) reported that mother-depressed child relations tended to be less affectionate and lower in quality of communication when compared with relations between children who were normal or nondepressed psychiatric patients and their mothers. Among the community sample in the study by Kaslow, Rehm, & Siegel (1984), self-described depressed children perceived their parents as less available and less nurturing than did nondepressed children.

Little controlled study has been made of the peer relations of clinically depressed children or adolescents. Puig-Antich et al. (1985a, 1985b) have found evidence that prepubertal depressed children have poorer peer relations than normal and nondepressed psychiatric patients, with less skill at maintaining a best friend; such problems with peer relations were correlated with the extent of problems in the mother-child relationship.

In this paper we examine the security of self-reported parent and peer attachments in a sample of clinically depressed young adolescents and examine relationships between attachment and severity of depression. The design includes features often missing in previous studies on this subject (Burbach & Borduin, 1986): psychiatric as well as nonpsychiatric control groups, interrater reliabilities for diagnoses, sound psychometric properties of the parent-child relations measure, and clinical status of both child and parent.

METHOD

Clinical Sample

Subjects were recruited from the out- and inpatient psychiatric services of a children's hospital as part of a larger study of depression in children and adolescents which has been described in detail elsewhere (McCauley, Mitchell, Burke, & Moss, 1988; Mitchell, McCauley, Burke, & Moss, 1988). Children were first screened via the usual clinical intake procedures. Based

on this screening data, children between the ages of 7 and 17 with no known history of mental retardation, major medical disorder (e.g., seizure disorder, thyroid disease, diabetes), or substance dependence were asked to participate. Initially, subjects were recruited if their symptom presentation at intake included depressed mood, school refusal, or suicidal behavior. Subjects were then recruited from those patients presenting without depressive symptoms for the psychiatric control group.

The final clinical sample was made up of all subjects who completed the Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987). The IPPA was added to the initial study protocol after the first group of subjects had completed the evaluation and was administered only to children who were 10 years of age or older. This sample consisted of 29 children who met criteria for major depression at the time of the evaluation (Depressed), 12 who had had an episode of depression within 12 months but did not meet diagnostic criteria at the time of the evaluation (Depressed-resolved), and 14 children with other psychiatric disorders (Nondepressed). The psychiatric groups did not differ in terms of age or family's socioeconomic background. Subjects were predominantly Caucasian and came from families of middle to upper-middle ratings on the Hollingshead Index (Hollingshead, 1975). The children in the Depressed and Depressed-resolved groups were living with both natural parents (39% and 42%, respectively) or with their mothers in a single-parent or mother and stepfather home (50%, 42%). Seventy-nine percent of the Nondepressed psychiatric control children were living with their mothers in a single-parent or mother and stepfather home, while only 14% lived with both natural parents. No child had lost a parent due to death. Three children in the Depressed and two in the Depressed-resolved groups had been separated from their custodial parent for 6–10 months earlier in their childhood. Two of the Nondepressed psychiatric controls had also experienced shorter separations, 5 and 6 weeks, respectively.

Procedure and Instruments

Each child and parent completed the Schedule for Affective Disorders and Schizophrenia for School Age Children (KIDDIE-SADS; Puig-Antich & Chambers, 1978) diagnostic interview. Most parental interviews were done with mothers (91%) while 9% were done with the custodial parent who was a father or grandmother. Interviews were conducted by three experienced clinicians, one child psychologist, and two child psychiatrists. These three clinicians had completed a 1-week training program on the use of the KIDDIE-SADS interview. Interrater reliability was established in a series of

26 corated interviews, with 13 corated by Interviewers 1 and 2 and 13 corated by Interviewers 1 and 3. The first 13 of these interviews were pilot reliability interviews; the others were conducted with the first subjects to enter the study. The kappa statistic for interrater reliability of diagnosis of particular disorders between pairs of interviewers ranged from .50 (separation anxiety) to 1.00. The kappa for major depression was 1.00 for both pairs of interviewers.

From the interview data, Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978) and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980) criteria were used to determine diagnoses. To be included in the Depressed or Depressed-resolved groups, a child had to meet RDC criteria for a primary diagnosis of major depressive disorder currently or during the past 12 months. The Depressed-resolved group was made up of children currently seeking help because of initial, but not acute, depressive symptoms. In these cases, parents had delayed in seeking help, had been placed on a waiting list, or had initiated the request for treatment because of concern about recurrence. The Nondepressed psychiatric group was made up of children with the following diagnoses: conduct disorder ($n = 1$), attention deficit disorder with hyperactivity ($n = 1$), avoidant disorder ($n = 2$), overanxious disorder ($n = 4$), parent-child problems ($n = 3$), and adjustment disorder ($n = 3$). Many of the children in each group had concomitant secondary diagnoses, as commonly found in child psychiatric samples.

The children completed the IPPA (Armsden & Greenberg, 1987) as part of a larger battery of self-report scales (see McCauley et al., 1988) that included the Children's Hoplessness Scale (CHS; Beck, Weissman, Lester, & Trexler, 1974; Garber, 1981) and the Children's Depression Inventory (CDI; Kovacs, 1980/1981), which was used as an additional measure of depression.

The IPPA (Armsden & Greenberg, 1987) is a self-report instrument designed to assess the positive and negative affective/cognitive dimensions of adolescents' relationships with their parents and close friends—particularly how well these figures serve as sources of psychological security. The theoretical framework is attachment theory as originally formulated by Bowlby (1969/1982) and recently expanded by others (e.g., Bretherton & Waters, 1985). Three broad dimensions are assessed: degree of mutual trust, quality of communication, and extent of anger and alienation. The original version of the IPPA was used, which consists of 28 parent and 25 peer items. The instrument uses a 5-point Likert-scale response format, in which respondents indicate to what extent each statement is true for them (from *Almost never or never true* to *Almost always or always true*). Examples of Parent Attachment items are: "I can count on my parents when I need to get something off my chest"; "I feel it's no use letting my feelings show around my par-

ents"; "My parents trust my judgement." Examples of Peer Attachment items are: "I can tell my friends about my problems and troubles"; "My friends understand me"; "I feel alone or apart when I'm with my friends." Three-week test-retest reliabilities for a sample of twenty-seven 18- to 20-year olds were .93 and .86 for Parent and Peer Attachment scores, respectively. While the development samples were late adolescents, the IPPA has been used successfully in studies with adolescents as young as 12 (Armsden & Greenberg, 1988). To date, however, published IPPA scores for at least moderate-sized nonclinical samples of young adolescents are not available. Mean scores for Armsden and Greenberg's (1987) nonclinical sample of older adolescents were 60.7 ($SD = 16.2$) for Parent Attachment and 56.6 ($SD = 10.4$) for Peer Attachment. Parent attachment scores have been found to correlate with measures of family and social-self concept, loneliness, family functioning, and family coping, and discriminate delinquents from nondelinquents. Peer attachment has been found to be related to loneliness, social-self concept, and family functioning. Parent and Peer Attachment scores are associated with a number of personality variables, e.g., self-esteem positivity and stability, affective status, life satisfaction, and use of more adaptive coping strategies (see Armsden & Greenberg, 1988).

To assess parental psychiatric history, parents were interviewed at the time of entry into the study using the Schedule for Affective Disorders and Schizophrenia, Lifetime Versions (SADS-L; Endicott and Spitzer, 1978). SADS-L data were obtained on 95% of the mothers and 51% of the fathers. Since many fathers were unavailable for interview, we obtained data from the youths' mothers regarding fathers' psychiatric histories. A diagnosis for a disorder was not made unless the father had been treated for it or, in the case of antisocial personality disorder, there had been contact with the legal authorities. To analyze all fathers as a single group, the paternal diagnostic data on the "available" fathers were reduced to this abbreviated format, with the recognition that this approach probably underestimates paternal pathology. A detailed description of parental psychiatric assessment has been reported elsewhere (Mitchell, McCauley, Burke, Calderon, & Schloretdt, 1989).

The questionnaires and interviews were completed in one session. The interviewers were blind to the children's responses on the self-report questionnaires.

Nonclinical Sample

To include a control group of children without psychiatric disorders we utilized a nonclinical sample of children recruited as part of a study of the long-term impact of maternal chronic illness on family functioning (Lewis, Woods, & Ellison, 1983-1986). Because adolescents experience some degree

of family disruption resulting from maternal illness (Hirsch, Moos, & Reischl, 1985; Lewis, Hammond, Woods, & Armsden, 1990), this sample can be assumed to be dealing with greater than average stress on their relationships with parents. Fifty-two children (Maternal Illness Control), 13–14 years of age, were included from the 120 families who completed this study. Families were recruited after the mother had completed medical therapies and were experiencing no crises precipitated by mother's illness or treatment (average of 3 years postdiagnosis). Maternal disease types include nonmetastatic breast cancer, stable diabetes, and fibrocystic breast disease. Fifteen percent of mothers scored above the clinical cutoff on the Center for Epidemiological Studies-Depression Scale (Radloff, 1977). The data reported herein were collected during the study midpoint (third of five evaluations). The children completed the IPPA along with a battery of other self-report scales. Eighty-seven percent of mothers were married or living with a partner. The families were predominantly white and middle class, with household incomes averaging \$30,000–\$40,000 and median parent education at the level of high-school graduate.

RESULTS

Preliminary Analyses

Demographic Characteristics

Table I summarizes sample characteristics. Due to heterogeneous variances, multiple *t* tests were performed to compare sample differences in age, but no significant differences were found. No sample differences in gender were found, $\chi^2(3, N = 107) = 6.09, p < .11$. There were no differences in Hollingshead SES among the three psychiatric groups $F(2, 52) = .79, n.s.$; while Hollingshead SES was not available for the Maternal Illness Control sample, these families were also predominantly middle class. Parent and Peer

Table I. Group Demographic Characteristics

	Depressed (<i>n</i> = 29)	Depressed- resolved (<i>n</i> = 12)	Psychiatric controls (<i>n</i> = 14)	Maternal illness controls (<i>n</i> = 52)
Age				
<i>Mean</i>	13.79	13.00	13.43	13.31
<i>SD</i>	1.80	2.41	2.31	0.47
Females	72%	42%	43%	48%

Attachment scores were not found to be related to age, socioeconomic status, or gender (Pearson r and t tests, $p > .10$ for each).

To assess sample differences on acute depressive symptoms, the three clinical samples were compared on self-report of depression as measured by the Children's Depression Inventory. A one-way analysis of variance (ANOVA) revealed significant group differences, $F(2, 50) = 7.21, p < .002$, with *post hoc* Tukey paired comparisons indicating significant differences between the Depressed group and both the Depressed-resolved and Non-depressed psychiatric controls. Table II presents the mean CDI scores for all three clinical groups; no CDI scores were obtained in the nonclinical sample.

Primary Analyses

Attachment Security and Assessments of Depression

One-way ANOVAs comparing the four samples on attachment security revealed significant group differences for both parent attachment, $F(3, 103) = 7.02, p < .001$, and peer attachment, $F(3, 103) = 3.93, p < .01$ (Table III). Followup Tukey paired-comparison tests indicated that the Depressed group reported less secure parent attachment than the Non-depressed and the Maternal Illness groups at the $p < .05$ level. The Depressed group also experienced less secure peer attachment than the Maternal Illness Controls ($p < .05$), but were not significantly different from the other psychiatric groups on peer attachment. It should be noted that Depressed-resolved and nonpsychiatric controls had very similar means on both variables; the fact that the latter group differed significantly from the Depressed group and the former did not may reflect differences in sample size. A closer look at the distributions of attachment scores for these two groups, however, finds that, for the Depressed-resolved group, two clusters of parent attachment scores are apparent: cluster 1 ($n = 4$), $M = 25, SD = 6.6$; cluster 2 ($n = 8$), $M = 66, SD = 7.5$. Moreover, 50% of the nondepressed psychiatric controls were defined as extreme positive responders on the parent attachment measure (i.e., scored within one point of the most positive score possi-

Table II. Clinical Group Scores on the Children's Depression Inventory

	<i>Mean</i>	<i>SD</i>
Depressed	21.1	9.5
Depressed-resolved	11.9	7.8
Psychiatric controls	10.8	10.1

Table III. Group Means and Standard Deviations for Attachment Scores^a

	Depressed	Depressed-resolved	Psychiatric controls	Maternal illness controls
Parent attachment				
Mean	38.17 _a	52.67	65.29 _b	52.75 _b
SD	21.59	21.61	15.81	18.05
Peer attachment				
Mean	40.03 _a	51.25	45.43	51.63 _b
SD	18.97	13.09	12.00	14.03

^aNote: For each line, group with different subscripts (a or b) were significantly different at $p < .05$.

ble on at least one of the three subscales), compared with 27 percent of the Depressed and Depressed-resolved children.

As shown in Table IV, among all psychiatric patients, ratings of the severity of children's depressive symptomatology based on parent and child interviews yielded moderate and negative Pearson correlations with Parent Attachment Scores; higher association was found for the week of evaluation than for the episode as a whole. A correlation of similar magnitude was found between children's questionnaire report of depression (CDI) and the security of their parent attachment. Peer Attachment scores were modestly negatively related to CDI scores and child interview ratings for the week of evaluation, but were not related to parent interview depression ratings.

Further assessments of severity or subtype of depression were conducted, including analyses to evaluate impact of endogenous vs. nonendogenous subtype of depression and suppression or nonsuppression of cortisone in response to a dexamethasone challenge. Endogenous subtype and cortisone nonsup-

Table IV. Correlations Between Depression-Severity and Attachment-Security Scores

	Interview (KIDDIE-SADS)				Child Questionnaire (CDI)
	Whole episode		Week of evaluation		Week of evaluation
	Parent	Child	Parent	Child	Child
Parent attachment	-.37 ^{a,d}	-.50 ^{b,d}	-.43 ^{a,d}	-.56 ^{b,d}	-.53 ^{b,d}
Peer attachment	.06	-.09	-.04	-.30 ^{c,d}	-0.34 ^{c,d}

^a $p < .01$.

^b $p < .001$.

^c $p < .05$.

^dBonferroni correction requires $p = .005$.

pression are thought to be associated with more severe depression. No differences in Parent or Peer Attachment scores were obtained between Depressed and Depressed-resolved children classified as endogenously vs. nonendogenously depressed ($p > .40$ for each). The number of endogenously depressed children was too small to permit a separate examination of the Depressed and Depressed-resolved groups in this regard. Differences between cortisol suppressors and nonsuppressors on parent and peer attachment also did not reach significance.

Attachment Security and Other Depressive Phenomena

Information available from patients concerning attributional style, history of suicidal ideation, separation anxiety, and parent separation/divorce/death, as well as sense of hopelessness, were also examined in relation to security of attachment.

Comparisons among diagnostic groups on response to the Children's Attributional Styles Questionnaire have been previously reported (McCauley et al., 1988). To summarize these findings, the Depressed group endorsed a more depressive attributional style when compared to the Depressed-resolved and Nondepressed groups combined. Furthermore, the Depressed group more frequently attributed success to external, unstable, specific factors than the Depressed-resolved and Nondepressed groups; but no group differences were found in response to failure.

Table V shows Pearson correlation coefficients for the associations found between attachment security and attributional style among all psy-

Table V. Correlations Between Attachment-Security and Attributional-Style Scores

	Parent attachment	Peer attachment
CASQ scores ^a		
Positive-negative differ.	.53 ^{b,e}	.30
Composite positive	.53 ^{b,e}	.22
Composite negative	-.23	-.24
Stable positive	.49 ^{c,e}	.26
Stable negative	-.41 ^{c,e}	-.43 ^{c,e}
Global positive	.40 ^{d,e}	.11
Global negative	.08	-.08
Internal positive	.23	.06
Internal negative	-.03	.08

^aNote: CASQ = Children's Attributional Styles Questionnaire.

^b $p < .001$.

^c $p < .01$.

^d $p < .05$.

^eBonferroni correction requires $p = .002$.

chiatric subjects. Composite positive-negative difference scores, for which lower values indicate more depressogenic attributional style, were significantly positively related to parent attachment, but not related to peer attachment. Parent attachment was correlated more highly to positive than negative scores, and in the direction of less depressogenic cognition. For peer attachment, only stable negative scores were found to be significantly and negatively correlated.

Among all psychiatric patients, children with a history of suicidal ideation ($n = 19$) reported significantly less secure parent attachment than those with no such history ($M (SD) = 38.05 (20.9)$ vs. $53.6 (22.5)$; $t(53) = 2.49$, $p < .02$). Children with a concurrent diagnosis of separation anxiety disorder ($n = 17$) also experienced less secure parent attachment than those with so such history ($M (SD) = 39.9 (22.4)$ vs. $51.9 (22.6)$; $t(53) = 1.84$, $p < .07$). No differences were found between these groups on peer attachment ($p > .20$ for each). The greater the children's sense of hopelessness, the more insecure their parent attachment ($r = -.47$, $p < .001$) and, to a lesser degree, peer attachment ($r = -.34$, $p < .01$). Children with and without histories of parent separation/divorce/loss did not differ in their attachment scores ($p > .10$ for each).

Attachment Security and Parental Psychopathology

No association was found between parent or peer attachment security and parent history of any of the following: depressive or anxiety disorder, both depressive and anxiety disorders, suicide gesture or ideation ($p > .20$ for each). Severity scores of parent overall psychopathology were also not associated with security of attachment ($p > .20$ for each). In this sample, parent history of major or intermittent depression was also not found to be related to the presence of child depressive disorder in the previous year.

DISCUSSION

The findings reported above lend support to the hypothesis that security of attachment may be impaired in children with depressive disorders. The Depressed children endorsed less secure parental attachment than the Nondepressed psychiatric and the Nonpsychiatric controls. Furthermore, less secure attachment was associated with greater severity of depression as reflected in the severity index derived from the clinical interview (KIDDIE-SADS), the child's self-report on the Children's Depression Inventory and Hopelessness Scales, and severity of suicidal ideation. A number of issues must be taken into account when evaluating these data. First, the sample sizes are small and replication with larger samples is needed. Second, while on average adolescents with remitted depression reported security of parent attachment

on a level with the Nonpsychiatric controls, the distribution of scores shows that the Depressed-resolved group consisted of two distinct subgroups vis à vis relations with parents. While the numbers of children involved are small, it is possible that these two subgroups will evidence quite different clinical trajectories.

Third, it should be noted that the average parent-attachment score for the Nondepressed psychiatric controls was quite high, higher even than for the nonclinical sample in this study and in Armsden and Greenberg's (1987) report. While this finding may be an artifact secondary to small sample size, other factors may account for this finding. For example, for the Nondepressed psychiatric group, the rate of extreme positive responding on the parent attachment measure was twice the rate for Depressed and Nondepressed groups. Many of the Nondepressed psychiatric controls had anxiety or adjustment problems and it may be that these anxious or stressed children have developed unconscious representational models of their parental relations which promote anxiety, along with conscious representations with properties of idealization (Bowlby, 1973, 1980).

The associations found among security of parent attachment, attributional style, and presence of depressive disorders are consistent with a conceptual model linking insecure attachment with the manifestation of depression through the promotion of depressogenic cognitive schemata. Endorsement of less secure parental attachment may, however, reflect the cognitive distortions frequently associated with depression. Greater security of parental attachment, as reflected in the responses of the Depressed-resolved group, could represent a change in perception with improvement in clinical status. However, additional explanations are also plausible. The finding that parent attachment scores of the Depressed-resolved group distinctly clustered into low and high scores shows that a third of these adolescents viewed their relations with parents as relatively insecure. The Depressed-resolved patients may have experienced less severe depression or more secure prodromal parental attachments than the Depressed patients. It is also possible that the actual quality of parent-child interactions improved along with the clinical status of the child. While attachment is generally conceived of as reflecting long-term patterns of security in the relationship, there is evidence that significant events may improve or damage the quality of the parent-child attachment relationship (Vaughn, Egeland, Sroufe, & Waters, 1979; Ainsworth, 1982). Prospective, longitudinal study is necessary in order to clarify connections between current or past quality of attachments and the development and course of depressive disorder. As Cummings and Cicchetti (1990) have suggested, the conceptualization of the parent-child relationship may change with recovery for both parent and child. Puig-Antich et al. (1985b) observed that among children who remained depression-free for 4 months, the quali-

ty of the parent-child relationship had improved (including less maternal hostility) and parent-child togetherness had increased.

In general, the significant differences in security of attachment applied to parent, but not to peer, relations. The Depressed children did endorse a significantly less secure sense of attachment to peers than did the nonpsychiatric controls, but their scores were quite similar to the Nondepressed psychiatric controls (with, again, the Depressed-resolved having scores more in the normal range). This finding is consistent with the fact that difficulty with peer relationships is one of the most common features of children who are referred for psychological services. Anecdotal evidence from our clinical interviews suggests, however, that the nature of the depressed child's peer difficulties may be quite different than that seen in other disturbed children. Depressed children may have a history of more intact peer relationships that become impaired secondary to changes in the child's affective state. It appears as if the depressed children begin to perceive their peer relationships as less satisfactory or more rejecting and become more withdrawn secondary to changes in their perceptions or their internal mood state rather than experiencing frank peer rejection. It may also be that problems in peer relations emerge or become more apparent in early adolescence as increasingly sophisticated forms of interpersonal transactions are required to form and maintain adolescent friendships. Young adolescents become much more selective in their friendships and expect friends to be able to meet deeper psychological needs and to invest sustained commitment toward maintaining the relationship (Berndt, 1982; Selman, 1980; Youniss, 1980). The adolescent who earlier may have had an adequate number of playmates, or even one special friend, may suffer some rejection or feel alienated if she or he has difficulties around issues of trust, empathy, and dependency/autonomy.

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