Kevin was in third grade when he entered the school psychologist’s office and asked to talk to her about his feelings. He indicated that other children didn’t like to play with him and that he felt very lonely. When asked about his mood, Kevin said he was fine and smiled throughout the interview. Kevin reported that the other children did not choose him to play on teams and that he had no one to play with during recess. When asked what he did during recess, Kevin reported that he just walked around or talked to the teacher on recess duty. He also told the therapist that he began having these problems in second grade and that he had had friends before that time.

Kevin came to the office several times to talk about his concerns but was very guarded when asked about what was happening at home. When asked to draw pictures of his family, the pictures were generally of smiling stick figures holding hands and walking together. After a few sessions, he was again asked to draw a picture of his family doing something together. This time he drew a picture of his father lying on a couch watching TV with beer bottles next to the couch and his mother and he in the kitchen eating dinner. The faces on all the figures were smiling but Kevin’s picture showed smiling with tears on his cheeks. When asked to explain the picture, Kevin said, “That’s just what we do at night.” He continued to smile throughout the interviews and subsequent meetings.

After a month of sessions, Kevin’s mother came for a meeting. When she was shown the pictures, she broke into tears and began talking about her husband’s withdrawal from the family, his drinking, and her feelings of social isolation. She shared that she had thought Kevin was doing well as he told her all was fine except his lack of friends. She reported that approximately 18 months earlier her husband had been fired from his position as a mid-level manager. After that time he had taken a series of positions that were below his previous level of education. Kevin’s father had begun drinking heavily every night and withdrawing more and more from his family.

We talked about depression and dysthymia and how Kevin was likely trying to protect her and take care of her. It was also likely that he was
feeling a sense of loss of his father’s love and attention. The sadness was also noted by his teacher and was beginning to impact his learning. He appeared to be tired a great deal of the time and did not seem to be interested in activities in which other children participated. Kevin was showing indications of depression that were beginning to influence not only his social relationships but also his academic progress.

A first look at Kevin would make one think he was a happy child with few difficulties. Only after talking to him did it become readily apparent that he was sad and feeling very isolated not just from his friends but also from his father. It required several more meetings with Kevin and more family meetings for his father to agree to family counseling in order to assist with these difficulties.

Internalizing Disorders

Internalizing disorders are those where the child experiences a mood disorder that impacts his/her functioning. These have been defined by DSM IV TR (APA, 1997) as including major depression, dysthymia, bipolar disorder, and anxiety disorders. Each of these is a disorder of affect and for children depression and anxiety can appear remarkably similar in nature (Semrud-Clikeman et al., 2003). In many cases the term “mood disorder” may more accurately capture the difficulties the child is experiencing.

In the case of bipolar disorder, obsessive compulsive disorder (OCD), and social anxiety, characteristics differ and it is important to evaluate the difficulties the child is experiencing. While Kevin’s difficulties were mostly depression related, he did experience anxiety when asked to attempt new tasks and meet new people. This chapter will discuss depression, bipolar disorder, anxiety, and OCD separately for diagnostic purposes followed by a discussion of social impairment found with each of these diagnoses. In some cases, social competence studies in depression and anxiety overlap and may be discussed together as appropriate.

Depression

Conceptions about depression in children have changed over the years initially in the 1970s it was believed that children could not experience depression. The current view of depression in children is that it is a syndrome that can be present at an early age and which is able to be diagnosed (Bell-Dolan et al., 1993). Interpersonal theories of depression stress the role of impaired relationships with others as well as a tendency to provoke negative interactions with peers and caretakers (Joiner & Coyne, 1999). Social behaviors that, in particular, define depression include poor eye contact, lack of social reciprocity, lack of social conversation, and a sense of disconnectedness in conversation (Segrin & Abramson, 1994). These behaviors serve to isolate the child even more and to increase the tendency to withdraw from interpersonal contact as such contact becomes more and more unreinforcing (Gable & Shean, 2000).