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Prevalence of depression among adolescent males in residential treatment

Keri Nicole Chavez
Alexa Joy Perez

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PREVALENCE OF DEPRESSION AMONG ADOLESCENT MALES
IN RESIDENTIAL TREATMENT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Keri Nicole Chavez
Alexa Joy Perez
June 2006
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ABSTRACT

The following study looked at the prevalence of depression among males in a residential group home setting. The study used a quantitative research design. The Beck Depression Inventory was administered to fifty adolescent males ranging in age from twelve to eighteen. The participants were sampled at a group home facility in Yucaipa, California. A bivariate analysis was used in order to test the data. The study hypothesized that there was going to be a significant relationship between depression and male adolescents, who received less family support and fewer family visitations.
ACKNOWLEDGMENTS

I would like to acknowledge my family. I could not have come this far without their support. I am grateful for my parent’s constant encouragement and understanding. I am grateful for my sisters who were supportive and patient with me through these past three years. I am grateful for my nieces and nephews who brought me sanity and happiness during those days when I was not sure how much more I could take. Lastly, I would like to thank Michael, who was so patient and supportive during these past three years and I will always be grateful for that.

Keri Nicole Chavez

I would like to thank my family for all of their encouragement, support, and patience as I pursued my degree. To my co-workers and friends, thanks for supplementing my education with your knowledge, consultation, and feedback. You took time from your lives, books from your collections, and examples from your practice to facilitate my education. Finally I want to thank Nicholas, my husband. Your patience and forgiving nature are little miracles in my life and are likely responsible for my ability to satisfy the requirements of my degree. I love you all and appreciate all you have done to support me in this process.

Alexa Joy Perez
DEDICATION

I would like to dedicate this thesis to "La Familia". As the baby of the group you guys became my second family and I am blessed to have made such good friends. We have shared so many memories with each other and I am certain that there will be more to come. Without you all, this journey in my life would not have been the same. I am a better person because of you guys, as well as a better Social Worker. I promise to never forget you guys and to cherish these past three years forever. I love you all, and look forward to our future endeavors.

Keri Nicole Chavez

"La Familia" what a team we are. All of our late nights, long papers, group projects, and flubbed video outtakes brought us together to complete our journey. The inside jokes, end of quarter celebrations, and friendships developed kept us sane. Without each other we may have completed the degree but we would not have ended up as the individuals we will now be as we go out to practice as social workers. We will make change, promote justice, and above all, know the importance of human relationships. I am grateful for each of you and our experiences over the last three years. I love you all.

Alexa Joy Perez
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CHAPTER ONE
INTRODUCTION

Problem Statement

The problem that this study addressed was the prevalence of depression in adolescent males in a group home setting. Depression among adolescents has been studied extensively in recent years, but few studies have looked at the population of adolescents residing in group homes. One study reported, "to date, research into prevention of depression in young people is in its infancy" (Spence, Sheffield, & Donovan, 2003, p. 3). Further findings state, "research at this point suggests the general lack of evidence regarding the effectiveness of treatment with adolescents" (Gorske, Srebalus, & Walls, 2003, p. 59).

This study looked at depression in adolescent males placed in residential group homes. There is a need for this information because more and more young men are being placed in group homes. Johnson, Wise, and Smith (2000) stated that "...so many children have these difficulties in this environment, but we are continually surprised at the magnitude" (p. 59). An understanding of treatment for these adolescents is necessary because they are not your
typical adolescent. This is further supported by Kovacs (1989) in his finding that adolescents have "...more limited life experience, fewer problem solving alternatives and age-related aspects of information processing that may affect cognitive and attributional styles" (p. 214). Experiences like going to the prom, learning how to drive a car, developing friendships and graduating from high school are often stripped from these adolescent males when they enter into placement. Kovacs stated, "there is now compelling evidence from a diversity of studies that...adolescents do experience depression" (Kovacs, 1989, p. 209).

This study targeted the male adolescent population due to the fact that the coping style, "...most related to men...[is] suppression" (Rim, 1990, p. 976). Suppression of feelings and fears by males can result in outward actions, which often reveal themselves in physical aggression. Often times these behaviors are internalized and experienced as depressive symptoms. Freedoms and rights are taken away and these children become forced to follow the rules of their environment. It may be that it is these events, plus the separation from family and friends that increase the prevalence of depression in this population.
Johnson et al. (2000) found that family discord and poor family support are identifiable risk factors for depression in adolescence. Life events that lead adolescents to separation from their family and to be placed in a group home setting may be antecedents to depression as, “...first on-set depressions are more strongly linked to antecedent life-stress” (Post, as cited in Monroe, Rohde, Seeley, & Lewinsohn, 1999, p. 606). Life stress of these adolescents can impede their day-to-day functioning thus leading them to require ways in which to cope. Rim explains, “an individual may adopt certain ways of defending as an...attempt to deal with problems and difficulties and these ways may be referred to as coping styles” (Rim, 1990, p. 973). It is essential for these youth to experience warmth and guidance to develop appropriate coping mechanisms. Spence et al. (2003) found, “proactive variables [such as] family and peer support, coping skills, positive self-esteem, interpersonal, problem-solving skills and positive problem solving” (p. 3). These skills need to be instilled in these adolescent males in order to teach them better coping skills. Involvement with the judicial or child welfare system coupled with being taken away from social support
may be the life stressors that are associated with teenage boys becoming depressed.

There are a number of individuals, groups and organizations that are concerned with this topic. Social work, psychology and the medical field have all published articles discussing the topic of depression as it relates to adolescents. Residential treatment centers and their clients are concerned because updated information will allow for improved treatment and better-trained staff. It is suggested that, "child-care workers rank amongst the lowest paid in the country which contributes to increased staff turnover and increased child-staff ratio" (Scrivo, 1998, p. 1). There are concerns raised by parents, foster parents and other support systems of adolescents due to vested interest in their children. It is appropriate that while their children are living in the group home they want the best treatment for their child. Department of Children Services (DCS) also has concerns because there is a need for safe and secure placements to receive those adolescents that are taken into custody. DCS line workers need to ensure that the child's needs are being met while in residential placement. It is the goal of social workers to serve disenfranchised populations and provide special attention, in order that their needs be met; for this
reason adolescents in group homes are of particular concern. Finally, the National Mental Health Association is concerned about this population and its rate of depression, because as more adolescents are placed in-group homes, areas of mental health and placement need to be monitored and addressed appropriately. The attention provided by these agencies may allow for funding that can be made available for new programs and, "...effective treatment that are suitable for children and adolescents" (Kovacs, 1989, p. 209).

Purpose of the Study

The purpose of this study was to determine whether there is an elevated level of depression among adolescent males in a group home placement, in order to raise awareness and create better programming and services. It was important for this issue to be addressed because of the risk of depression becoming more prevalent in the future. This study was able to demonstrate that there was a high prevalence of depression among adolescent males in-group homes. These numbers can prepare the field in areas of prevention, treatment and awareness. Therapy in the form of prevention and awareness are offered to the male adolescent. Awareness taught to the staff and
adolescents in support groups in order to provide youth with an all-encompassing support circle. The support and therapy would be utilized to teach the adolescents how to develop coping skills.

By bringing the problem to the attention of the social work field this population may be better served. Those adolescents who are in placements and suffer depressive symptoms may receive more effective treatment. It could be the simple gesture of support that could prevent a client from being diagnosed with clinical depression. The findings of this study have brought awareness regarding adolescent depression, an area where social workers are needed for support. This study will further help the social work profession develop new treatment models and alternatives to placement based on the findings.

The clients addressed in this study were male adolescents between the ages of thirteen and eighteen. Previous research (Rim, 1990) has demonstrated that males may have more difficulty with coping skills and may therefore experience depression during this time in their lives. This is supported in that, "there is increasing evidence of the importance of the interaction between...internalizing problems of anxiety and
depression” (Loeber, Russo, Stouthamer-Loeber, & Lahey, 1994, p. 616).

The population surveyed was from different ethnic backgrounds and have been assigned to a residential placement facility, located in Yucaipa, California, by the court system of California. The minors have violated terms of their probation and have been offered the opportunity to complete their juvenile sentence at the facility. It is postulated that these young men have had difficulties coping and therefore their anger has turned outward in physical behavior or inward as depressive symptoms. The facility provides a structured environment for these youth while allowing more freedom, treatment, and responsibilities. The responsibilities that the client gains in residential treatment, results in him acquiring skills to transition into the public more smoothly compared to the traditional juvenile hall setting.

The agency from which this study collected its data from is Trinity Children and Family Services, a non-profit organization that was founded in 1960. The facility, located in Yucaipa where this study was centered, was the first residential facility for run-away boys and it has now grown to several facilities throughout the state and nation. Trinity Children and Family Services today
specialize in foster care, residential care and elderly care. Trinity, Yucaipa offers the population served, adolescent males, one-on-one contact with counseling and treatment staff. The facility offers substance abuse counseling, anger management counseling and daily peer centered groups. They also provide the residents with an off site psychiatrist and contracted therapists who come in through out the week to provide treatment.

Although there are many therapeutic outlets provided to the clients this study attempted to determine if depression was a prevalent issue among this population. The current therapy structure of this program is geared toward family reunification and monitoring whether the youth is performing the terms of probation. If depression is prevalent among this population therapy offered should be geared towards teaching the youth coping skills and providing an outlet for these young men to be able to work through their problems.

A quantitative study was used to sample this population. The Beck Depression Inventory was administered to fifty randomly selected male adolescents at Trinity Children and Family Services, Yucaipa. Stinton (2004) describes the, "Beck Depression Inventory is a 21 self-report rating inventory measuring characteristics
attitudes and symptoms of depression” (para. 1). The rationale for administering this questionnaire was that it was well tested for reliability and validity and decreased the chances of harm to the client. The questionnaire interprets “sadness, pessimism, fatigability, loss of appetite” (Stinton, 2004, para. 5). The survey questions are phrased in the present tense and therefore should not provoke images from past events that may cause distress to participants. Furthermore research finds, “...the Beck Depression Inventory is a valid screening tool for adolescent depression in a clinical setting, regardless of the presence of comorbid conditions” (Bennett, Ambrosini, Bianchi, Barnett, Metz, & Rabinovich, 1997, p. 127). The surveys were administered individually to participants in the facility’s training room in order to provide confidentiality. The test took approximately ten minutes each and participants were compensated with an ice cream bar.

Significance of the Project for Social Work

The study was necessary in order to address an existing population that is lacking attention. The code of ethics supports this in that, “the primary mission of the social work profession is to enhance human well-being and
help meet the basic human needs of all people..." (National Association of Social Workers [NASW], 1999, p. 1). The social work profession recognizes that adolescents with depression are a growing population and that there is a need for continued research. Furthermore, "children in-group homes are an at risk population of significant proportions" (Johnson & Leopard, 1996, p. 43). All adolescents experiencing depressive symptoms are not fortunate enough to live at home with the support of their parents. Social workers need to address the population of adolescents in residential environments in order to be prepared and knowledgeable when providing services to these youth.

The results of this study provided data that can contribute to existing findings. Social work practice may benefit from this study’s findings because many social workers are in the field of mental health and child welfare. Social work practice can also benefit from this study because it may provide additional resources for reference when working with adolescent youth in residential treatment. Other benefits to social work are in recognizing that there may be a problem and then providing a limb for other similar studies to branch off. Social work policy may benefit because calling attention
to and labeling depression in adolescents in residential treatment can create interest in policies and grants that can be developed in order to provide better treatment programs and continue future research.

Phases of the generalist model that will be contributed to due to the results of the study are assessment, planning and termination. Assessment has been affected because it has been discovered that new assessment tools need to be developed and implemented at the treatment facility as part of the in-take process, in order to provide an accurate diagnosis and individually designed treatment programs. Therefore, planning will follow as a result of the individual’s assessment. The adolescent needs to be enrolled in therapy that will work to enhance their coping skills, rather than substance abuse counseling. Planning also plays a part in regards to the family and developing their role in the therapy process. Termination is affected due to the whole of the treatment program. Part of the graduation process includes therapy thus enhancing family or other support systems that can be educated on how to cope better and continue treatment once the adolescent has returned home.

Adolescent depression is a fairly new topic. For years children and adolescence were seen as being
incapable of experiencing depression. With an increased awareness of depressive symptoms in adolescents other arenas of adolescent depression need to be addressed. This study has decided to ask the question, what is the extent of depression among adolescent males living in-group homes?
CHAPTER TWO
LITERATURE REVIEW

Introduction

The adolescent years are a time of tremendous growth and change. Research in this area is on the rise and has been for the last fifteen years (Zaslow & Takanishi, 1993). New areas of research have included development, advocating for healthy decision-making, promoting resilience and identifying risk factors as well as supports for teenagers. Of particular interest are the maladaptive behavior patterns of adolescents and associated psychopathology. Until, the past ten to fifteen years, depression in childhood and adolescence was not considered due to lack of ego development among these age groups. Another reason for this belief was that adolescence is viewed as a tumultuous time, which often results in depressive symptoms that are not clinically significant (Gizynski & Shapiro, 1990; Robertson & Simons, 1989).

Theories Guiding Conceptualization

During this time of growth and change adolescents have the task of defining themselves. Erickson's eight stages of development include a stage entirely developed
to this age group. Identity versus role confusion is the stage where adolescents are faced with the task of determining who they are,

...Identity formation employs a process of simultaneous reflection and observation, a process taking place on all levels of mental functioning, by which the individual judges himself in the light of what he perceives to be the way in which others judge him in comparison to themselves and to a typology significant to them; while he judges their way of judging them in the light of how he perceives himself in comparison to them and to the types that have become relevant to him. This process is, luckily, and necessarily, for the most part unconscious except where inner conditions and outer circumstances combine to aggravate a painful, or elated, 'identity-consciousness'.

(Erikson, 1968, pp. 22-23)

Since this time can be, not only, mentally, but emotionally trying there are particular concerns regarding suicide at this stage of life. Kirk (1993), Lefrancois (1999), and Santrock (1999) (as cited in Zastrow & Kirst-Ashman, 2001) discuss three main areas that, when
problematic, may result in suicidal ideation or attempts: "increased stress, family issues, and psychological variables (particularly depression)" (Zastrow, & Kirst-Ashman, 2001, p. 293). Similar risk factors for suicidal ideation and attempts in adolescents have been corroborated which include: "...family history of depression, and stressful events," (Johnson et al., 2000, p. 47).

The National Association of Social Work (NASW), requires that social workers hold themselves ethically responsible, "...to enhance human well-being..." (NASW, 1999, p. 1). Due to the difficulties associated with adolescent development and increased stressors that can be associated with residential treatment looking at this population is important for the emotional and mental well being of this population. Research suggests, "children in group homes are an ‘at risk’ population of significant proportions" (Johnson & Leopard, 1996, p. 43).

Depression Scales

Depression scales have existed for quite some time for adults, but with the new trend in testing youth these measures have needed modification and reliability testing. Current research focuses on the reliability and validity
of different measures administered to adolescents to
determine depressive symptoms. These scales include:
Children’s Depression Inventory (CDI), Beck Depression
Inventory (BDI), Depression Self-Rating Scale (DSRS), and
the Center for Epidemiological Studies-Depression Scale
(CES-D). Timbremont, Braet, and Dreesen (2004) found the
CDI to be reliable but not a detector of diagnosable
mental illness. This study found that interviews using
criteria from the DSM-IV were also successful at
supplementing their research scores. The CES-D was found
to vary little in both validity and reliability from
adults to children in a study conducted by Roberts,
describes the BDI as a self-rating scale depression. The
BDI has also been examined for its reliability and
validity when administered to adolescents, “results
indicate that the BDI is a valid screening tool for
adolescent depression...” (Bennett et al., 1997, p. 127).
In their study, Osman, Kopper, Barrios, Gutierrez, and
Bagge (2004) found that the BDI was both a valid and
reliable measure for obtaining depression scores in youth.
Factors of Depression

Many different factors have been determined to increase depressive symptoms in adolescents. Most prevalent is low self-esteem. Also found to be associated are inadequate social skills, poor self-control, and high expectations of self (Kovacs, 1989; Lewinsohn, Gotlib, & Seeley, 1997; Carbonell, Reinherz, & Giancona, 1998; Reinherz, Giaconia, Hauf, Wasserman, & Silverman, 1999). Adolescents with depressive symptoms often have poor interpersonal skills and problems with boundary violations. In a study by Hintikka et al. (2003) of adolescents diagnosed with either major depressive disorder or conduct disorder, the adolescents with major depressive disorder diagnoses came into inpatient treatment with higher rates of suicidal ideation and attempts. Those diagnosed with major depressive disorder were also found to have more hospitalizations and increased incidences of self-destructive behavior. This draws particular concern for adolescents diagnosed with major depressive disorder.

all determined sexual abuse to be a particular detriment in the depressive symptoms of adolescent males. Major depressive disorder in adolescence has also been found to be associated with the loss of an individual important to the adolescent or the result of a break up of a relationship (Monroe et al., 1999).

Much attention in recent research has focused on gender differences among those with depressive symptoms. Culbertson (1997) indicates that women have a 2:1 prevalence rate of depression as compared to men. Among early adolescents however, depressive symptoms are prevalent in both males and females, but are associated with different factors. In a study conducted by Leadbeater, Blatt, and Quinlen (1995) the CES-D was divided into interpersonal and self-critical factors of depression. In this study, females were found to have significant impairment in the interpersonal items and internalizing factors, while males were found to have the most difficulty in the self-critical factors and often exhibited externalizing behaviors. This also concurs with findings that show marked increase in behavioral acting out among adolescent males and associated symptoms (Lindeman, Harakka, & Keltikangas-Javinen, 1997; Loeber et al., 1994).
In Cohen et al. (1993) studies of major depressive disorder show that both boys and girls report similar symptoms although boys at this age were found to get more mental health treatment due to their externalizing behaviors, I.E.: behavioral acting out.

As adolescents develop, their rates of depressive symptoms diverge, particularly in females post puberty, where the reported rate of depressive symptoms increased significantly over their male counterparts according to the same study conducted by Cohen et al. (1993). In a study of adolescents in residential treatment, gender was found to be a significant factor placing adolescent females at greater risk for depressive symptoms (Li, Johnson, & Leopard, 2001).

Call for Change

The need to conduct further research to determine the rates of depressive symptoms among adolescents in residential treatment is necessary in order to focus attention on the need for an increase in mental health services. As suggested by, Leichtman, Leichtman, Barber, and Neese (2001) these mental health services may include increased family therapy, coping skills for living in the community and general mental health support. Cognitive
therapy has been evidenced as having a significant impact when used to address problem areas with depressed teens (Carbonall, Reinherz, & Gianconia, 2002). Coping skills have also been addressed in recent research and are found to assist in increased success when dealing with life situations. These findings, discussed in Pearlin and Schooler's 1978 study, state that those with difficulty implementing or having a deficit of coping skills were more often placed in situations with an increased need for coping skills. Suppression, replacement and reversal, were found to be the most frequently used coping mechanisms for men in Rim's (1990), study of coping.

Finally, effectiveness of residential treatment needs to be evaluated as well as alternatives to residential treatment in treating depressive symptoms in adolescents. Smollan and Condelli (1990) indicate residential treatment has been shown to be emotionally and fiscally expensive to adolescents and society. While Leichtman et al. (2001) found that adolescents improved from short-term residential treatment. Smollan and Condelli (1999), indicate that adolescents often have multiple residential placements, on average four per youth. Adolescents placed in residential treatment are found to have increased rates of depression as compared to their non-placed counter
parts. Pumariega, Johnson, and Sheridan (1995) found a depression prevalence of 51.7% among adolescents in residential treatment. Raynor and Manderino (1988) found 63% of nineteen adolescents reported depressive symptoms, of which fourteen were males.

Also of concern is that the caretakers of these children are, "...among the lowest paid in the country, which contributes to high staff turn over and high child staff ratios" (Scrivo, 1998, p. 1). This disruption of services in the continuum of care can result in increased loss and less support for these youth.

It is essential to indicate methods to reduce prevent and treat depressive symptoms in adolescents. Carbonall et al. (2002) found protective factors for adolescents diagnosed with major depressive disorder to include family cohesion, and positive self-image, as well as increased interpersonal skills. Social support has been determined important in reducing risk of depressive symptoms in adolescence but not all social support is received equally by each gender group. Female adolescents have been found to obtain more support from their friends than do male adolescents who were found to obtain more support form their families (Colarossi & Eccles, 2003). In the same study adolescent males with depressive symptoms identified
their fathers as being a primary support and females with depressive symptoms sought their mothers as primary support. This is especially important when looking at youth placed in residential treatment centers because familial support is often restricted or nonexistent. Leichtman et al. (2001), suggest that increased attention and inclusiveness in treatment is particularly important for those adolescents in short-term residential treatment, in order that they be successful once returned to in-home placement. A study conducted in 2003 by Gorske et al.; found that treatment outcomes for youth in residential placement were most successful with family involvement and a multiple treatment modalities.

Spence et al. (2003), conducted a study that found cognitive-behavioral interventions to be successful in reducing depressive symptoms and increasing problem solving skills of participants, these results however were not found to be applicable to long term change.

Summary

The literature important to the project was presented in Chapter Two. In the past ten to fifteen years, research has determined that youth are in fact susceptible to depression and associated symptoms. Many tools have been
developed to test for these symptoms and determine contributing factors. Different skills to address these symptoms have also been developed and tested for effectiveness. This study will apply the aforementioned information to adolescent males in residential treatment to determine if depression is a factor affecting these youth in order that treatment modalities are developed as needed.
CHAPTER THREE

METHODS

Introduction

The following chapter will cover the methods of this study. The chapter will describe the study design and what the sample population looked like. It will also explain how the study collected data and the instrument that was administered to each participant. The last part of the chapter will focus on the procedures, protection of human subjects and the data analysis of this study.

Study Design

The purpose of this study was to explore what the prevalence was of depression among adolescent males in a residential setting. The research design for this study was quantitative. A quantitative research design was the best approach for this study due to the fact that it focused on depression. A qualitative approach would have been too invasive and therefore, a quantitative method created less of a chance that excessive negative feelings may surface. The study determined whether there was a high prevalence of depression among males in a group home environment. One of the limitations of this study was that the quantitative instrument may not have determined the
exact level of depression in the participant. This study looked at, what is the prevalence of depression among adolescent males in residential treatment?

Sampling

The sample for the study consisted of fifty-four adolescent males. The criteria for sample inclusion were as follows: they had to be males between the ages of twelve and eighteen and residing in a group home. The study had decided to use this sample due to the lack of research on this population. These young men have had limited and traumatic life experiences and lack coping skills, which may help explain the cause of depression in this population. An approval from Trinity Children and Family Services, Yucaipa had been provided for this study to pull the sample population from their facility.

Data Collection and Instruments

The data was collected from the sample, using the Beck Depression Inventory. The independent variables for this study were the length of time in the group home, the level of support from the family and the number of visitations the client received from family or other support systems. The dependent variable, the study will measure, is depression.
The strengths of this data collection method were that having the participant fill out a questionnaire rather than interviewing them would have likely caused less harm to the participant. The questionnaire to be used was also reliable in testing for depression and therefore targeted and provided the correct data that was needed for this study. Limitations may have included difficulty for participants when reading the survey, which was estimated to be at the fifth grade reading level. Another limitation was the possibility that repressed feelings could surface, causing undo stress to the participant.

The instrument that was used to test depression was purchased from the publisher. The Beck Depression Inventory is a 21-item self-report-rating questionnaire. The questions are summed according to the number assigned to them. For example question one has four different responses to choose from. Each response is given a number 0-3. It is these numbers that are totaled up. After the numbers are summed the ranges for depression are as follows, 05-09 ups and downs are considered normal, 10-18 mild to moderate depression, 19-29 moderate to severe depression, 30-63 severe depression. Scores below 4 are considered to denote denial of depression, faking of responses and below usual scores for normal (Stinton,
The internal consistency ranges from .73 to .92, with a mean of .86 and a retest reliability of .46 to .86 (Stinton, 2004).

Procedures

There are sixty-six clients that reside in the facility. This study sampled those that were willing to participate in the study. Those clients that did not want to participate were still given an ice cream bar at completion of the recreation session. The potential participants for the study were given an option to participate during their recreation time. The individual conducting the survey made an announcement about the study prior to the beginning of their recreation time. Completing the questionnaire was an additional activity to choose from during the recreation session. Due to the confidentiality of these adolescents an individual that worked for the company, but not at the facility administered the instrument. These researches trained the individual in how to proficiently administer the instrument. The participant marked an assent form before beginning and was given explanation as to the purpose of the study. Consents for each individual in the facility were obtained from an appropriate guardian prior to
administering the instrument to the participants. The individual, who was collecting the data, along with the participant were in a private training room and the test took approximately ten minutes to administer. The participant was then debriefed and provided with a list of resources on the campus that could have been referred to as needed. There was a licensed Marriage and Family Therapist, as well as a licensed clinical director on grounds during the testing. Each participant was compensated with an ice cream bar.

Protection of Human Subjects

Each client at the facility was given the choice on whether they wanted to participate in the study or engage in another recreational activity. If they chose to participate they would take a number and engage in another activity until their number was called for their turn to complete the survey. The researcher called each participant by number when they pulled that individual for the test. The person, who administered the test works for the company, but not for this particular agency and therefore did not have any ties or dual relationships with the participants. Before the instrument was administered an assent form was given to the individual and they were
instructed to sign with a mark, in place of their name. After the instrument was administered the participant was given a debriefing statement. There was a licensed therapist on grounds during the test. Each survey upon completion remained locked in a file cabinet owned by the researchers.

Data Analysis

This study used a bivariate analysis to analyze its data. This study assessed levels of depression among male adolescents living in a group home setting. This study also looked at frequencies among age, ethnicity, and number of family visits, levels of support and length of time at the group home.

Summary

This chapter examined the methods of this study. The study design, sampling, and data analysis were each discussed in depth. The importance of the method by which information is obtained is necessary in order to prevent harm and misrepresentation to the participant.
CHAPTER FOUR

RESULTS

Introduction

The purpose of this chapter is to discuss the findings of the study, regarding depression amongst adolescent males with depression residing in a residential treatment facility. Demographic information is presented as well as cross tabulations of the four independent variables: ethnicity, age, length in placement, and familial involvement and the dependent variable: Beck Depression Inventory (BDI) scores, are presented to provide information regarding the population studied. Bivariate analysis is also utilized to present overall depression ratings of respondents and information regarding, BDI question 9, which assess for suicidal ideation/attempts.

Presentation of the Findings

Table 1. Depression Scores of Respondents

<table>
<thead>
<tr>
<th>Total respondents (n = 54)</th>
<th>Depression within normal limits</th>
<th>Moderate to severe depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>68.6%</td>
<td>31.4%</td>
</tr>
</tbody>
</table>

Almost 69% of youth surveyed were found to have depression within normal limits and 31.4% of youth
surveyed were found to have depression in the moderate to severe range according to the Beck Depression Inventory (BDI).

Table 2. Ethnicity and Depression Scores

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total percentage of population</th>
<th>Depression score in moderate to severe range</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>16.7%</td>
<td>44%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>Black</td>
<td>27.8%</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>5.6%</td>
<td>0%</td>
</tr>
</tbody>
</table>

In the moderate to severe range White adolescent males scored highest with 44% indicating scores of 19 or higher. Next were Hispanic males at 33% of the population tested scoring in that range, 20% of Black adolescent males also scored in the moderate to severe range, and no one of the other ethnicity category scored 19 or higher.

Table 3. Age and Depression Scores of Participants

<table>
<thead>
<tr>
<th>Age range (in years)</th>
<th>Number of participants in age range</th>
<th>Percentage with depression score in moderate to severe range</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-15</td>
<td>23</td>
<td>30.4%</td>
</tr>
<tr>
<td>16-18</td>
<td>31</td>
<td>32.2%</td>
</tr>
</tbody>
</table>
Of the total population in the age range 12-15, 30.4% scored in the moderate to severe range for depression according to the Beck Depression Inventory. Of the total population in the age range 16-18, 32.2% scored in the moderate to severe range for depression according to the Beck Depression Inventory.

Table 4. Length in Placement in Relation to Depression Scores

<table>
<thead>
<tr>
<th>Length in placement (in months)</th>
<th>Percentage of population</th>
<th>Percentage with depression score in severe range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>7.4%</td>
<td>0</td>
</tr>
<tr>
<td>3-6</td>
<td>42.6%</td>
<td>8.6%</td>
</tr>
<tr>
<td>7-9</td>
<td>16.7%</td>
<td>0</td>
</tr>
<tr>
<td>10-12</td>
<td>5.6%</td>
<td>0</td>
</tr>
<tr>
<td>13-15</td>
<td>5.6%</td>
<td>66.6%</td>
</tr>
<tr>
<td>16-18</td>
<td>3.7%</td>
<td>0</td>
</tr>
<tr>
<td>19+</td>
<td>18.5%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Nearly 43% of the population studied has been placed between 3-6 months in the residential treatment facility. Of those placed 3-6 months only 8.6% scored in the severe range.
Table 5. Parental Involvement in Treatment

<table>
<thead>
<tr>
<th>Frequency of family visits</th>
<th>Percentage of total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1x per week</td>
<td>35.2%</td>
</tr>
<tr>
<td>2x per month</td>
<td>18.5%</td>
</tr>
<tr>
<td>1x per month</td>
<td>27.8%</td>
</tr>
<tr>
<td>1x per 2 months</td>
<td>1.9%</td>
</tr>
<tr>
<td>1x per 3 months</td>
<td>5.6%</td>
</tr>
<tr>
<td>1x per 6 months</td>
<td>3.7%</td>
</tr>
<tr>
<td>Never</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

Close to 82% of the adolescents that participated had family visits at least one time per month. The remaining respondents had visits from family only every other month or fewer (18.6%).

Table 6. Percentages of Beck Depression Inventory Question 9 in relation to Suicidal Ideation

<table>
<thead>
<tr>
<th>BDI #9</th>
<th>Number scoring in range</th>
<th>Percentage in scoring range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 I don’t have any thoughts of killing myself.</td>
<td>47</td>
<td>87%</td>
</tr>
<tr>
<td>1 I have thoughts of killing myself, but I would not carry them out.</td>
<td>7</td>
<td>13%</td>
</tr>
<tr>
<td>2 I would like to kill myself.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 I would kill myself if I had the chance.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100%</td>
</tr>
</tbody>
</table>
Of the total population 87% answered, "I don’t have thoughts of killing myself". The remaining 13% answered, "I have thoughts of killing myself, but I would not carry them out".

Summary

Chapter Four reviewed the results of the project and detailed the statistical information compiled from data collected. Approximately 3/4 of respondents were determined to have depression scores within normal limits per the Beck Depression Inventory.
CHAPTER FIVE
DISCUSSION

Introduction

The following chapter will present discussion of findings of this study. This chapter will also discuss the limitations of the study and their influence on the data outcomes. Thus the chapter will conclude with recommendations for future social work research, practice, and policy in relation to adolescent males in residential group home facilities.

Discussion

The study sampled a population 54 male adolescent boys, who resided in a residential treatment facility. The majority of the population we sampled was Hispanic males between the ages of fifteen and seventeen. There was an under representation of White, Black, and other ethnicity respondents. Based on the total number of youth surveyed 68.6% were found to have depression with in normal limits and 31.4% of the youth surveyed were found to have depression in the moderate to severe range according to the Beck Depression Inventory. Among these totals White males were the group that scored highest in the moderate to severe in depression with a total of 44%. Hispanics
were second in this category with a total of 33%, while the Black population had a total of 20% in this category. This finding is not consistent with the research discussed in an article that looked at gender differences, ethnicity, social economic status, and social support in relation to depressive symptoms in adolescents. The article found that "...both African American and White adolescents obtained lower levels of depressive symptoms than did adolescents in all other ethnic groups," (Schraedley et al., 1998, p. 102). In the present study Whites and Hispanics were the two ethnicities with the highest level of severe to moderate depression. A possible reason for this is that Hispanics were the majority of the population tested with 50% being Hispanic male adolescents. This discrepancy between ethnicities may have skewed the data. Another possible reason for this finding may be due to the availability of medication to the clients. The majority of the clients taking psychotropic medication at the time of the study were Black. With the assistance of the medication may have decreased the symptoms of depression resulting in the lower Beck Depression Inventory scores.

The present study found that there was no difference in age groups in regards to depression. Thirty point four
percent of the twelve to fifteen year old male adolescents sampled were in the moderate to severe range on the Beck Depression Inventory. Thirty-two point two percent of the sixteen to eighteen year old male adolescents scored in the moderate to severe range. A study that looked at disorders in relation to age and gender specific prevalence found that depression "...remained approximately level throughout the adolescent years for boys" (Cohen et al., 1993 p. 857). In the study the prevalence of depression was 8% at ages ten to thirteen, 8% at ages fourteen to sixteen and 1.1% at ages seventeen to twenty (Cohen et al., 1993 p. 855). The evidence discussed above supports the findings of this study. Age was not a determining factor of depression. Some of the possible reasons for this finding could be due to the fact that all of the individuals sampled are separated from their families, some of them have substance abuse problems and most are diagnosed with conduct disorder or intermittent explosive disorder, as described by the Diagnostic and Statistical Manual IV. A combination of factors such as the ones mentioned above can be a catalyst for depression. Discovering that depression is significant across all ages is not surprising because depression does not discriminate according to age.
Many of the respondents studied, 42.6%, had already been placed at the residential facility for the previous three to six months. Of the 42.6%, 8.6% scored in the severe range. This finding is supported by the results found in an article by Jacqueline Smollar and Larry Condelli. This article found that many "...adolescents in the system tend to average 4 placements before they exit the system" (Smollar, & Condelli, 1990, p. 5). The placement history of clients often shows multiple placement failures and returns to juvenile hall. The failures often mean that the client will be spending more time separated from their family. The absence of family and teenage experiences may be a catalyst for depression and a result for the number of clients that scored moderate to severe depression in this study.

This study asked the population sampled how much family contact they had? The study hypothesized that the more family support the individual had then the less likelihood of significant depression. Of the study's total population 81.5% had visits with their family or got to go home at least one time per month. The significance of family involvement is made evident in an article that focused on youth depression in the family context. The article found that when parents were included in their
child’s treatment process that the treatment program was just as effective, if not more than, when working with the adolescent on their own. In another article that looked at social support of adolescents with depression found that “...5% of adolescents with high levels of social support and 9% of adolescents with moderate levels of social support were classified in the high depression group...” (Schraedley et al., 1998, p. 102). The findings of the study support the hypothesis that depression levels will decrease with the increase of family involvement. The high level of family involvement at Trinity Yucaipa may be a correlate to the lower levels of depression.

Although there were a number of individuals that scored moderate to severe depression, none of them admitted to attempting suicide. A staggering 87% of the population stated that they do not have thoughts of suicide, while the other 13% answered that they have thoughts of suicide but would not carry them out. A possible reasoning for these results is that the individual has become institutionalized and is aware of the consequences that follow when they say that they have suicidal thoughts. Many of the clients have been to multiple placements with multiple treatment modalities. In an article discussed earlier, by Jacqueline Smollar and
Larry Condelli, they mentioned that "...large numbers of adolescents in the foster care system will, at some time during their tenure, be placed in a mental health treatment center simply because there are no other placements available" (Smollar & Condelli, 1990, p. 5).

With the early introduction to mental health settings many of these adolescents have witnessed the results of 5585. Due to the fact that the majority of the population studied is not suffering from severe mental health issues the involuntary, locked setting may be overwhelming to the young teenage boys. They may hide their suicidal ideation for fear of being 5585’d and removed from the facility.

Limitations

After completing this research project the researches found that the instrument that was used to test the population may have been difficult to understand. English was a second language for some of the participants. This was a limitation for this study because the instrument was only administered in English. Although this instrument is found to be reliable and valid, some of the participants sampled had difficulties comprehending what the question was asking of them. This also presented a limitation
because respondents had to ask the proctor for assistance and this may have skewed their answers.

Another limitation was the sample size the study pulled from. The sample size was sixty-six and only 54 questionnaires were collected. The small sample size may have influenced the research findings. The combination of the small sample size and the lack of a culturally diverse population may have had an effect on the results of this study. Due to the fact that the study did not compare the results with that of another residential facility our numbers are limited to the current residential facility and therefore may have difficulties being generalized.

Recommendations for Social Work Practice, Policy and Research

Based on the above mentioned limitations the researchers suggest that the staff and professionals at Trinity-Yucaipa should be aware of the diverse population of clients they serve and provide services that are going to meet the needs of this population. The researchers also find that based on these limitations the staff and professionals should receive culture diversity and sensitivity training in order to meet the needs of the clients' better, while respecting their cultural differences.
Furthermore in regards to the limitations of the study the researchers find that it is important to use a large sample population in order to substantiate the significant findings of the study. The researchers also find that it is important when administering an inventory to a diverse population to have a proctor that can interrupt the instrument or an instrument that is in the individual's native language as well as reading comprehension level.

Conclusions

The proceeding chapter described what the researchers found in their research at Trinity Yucaipa residential treatment facility. The study found that Whites scored highest in the moderate to severe range of depression. The study also found that there was no difference in regards to depression in relation to age. The study found that time in placement and the amount of family involvement had an impact on the level of depression of the adolescent. The study also found that a small portion of the population sampled did have thoughts of suicide but reported that they would not follow through with attempts. Although there were some limitations that were encountered in the study the findings were significant for
Trinity-Yucaipa and they will play a future role in program development and implementation.
APPENDIX A

QUESTIONNAIRE
Name: ___________________ Marital Status: _____ Age: ____ Sex: __________
Occupation: __________________ Education: __________________

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2 or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

<table>
<thead>
<tr>
<th>1</th>
<th>I do not feel sad.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I feel sad.</td>
</tr>
<tr>
<td>1</td>
<td>I am sad all the time and I can't snap out of it.</td>
</tr>
<tr>
<td>2</td>
<td>I am so sad or unhappy that I can't stand it.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>I am not particularly discouraged about the future.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I feel discouraged about the future.</td>
</tr>
<tr>
<td>1</td>
<td>I feel I have nothing to look forward to.</td>
</tr>
<tr>
<td>2</td>
<td>I feel that the future is hopeless and that things cannot improve.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>I do not feel like a failure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I feel I have failed more than the average person.</td>
</tr>
<tr>
<td>1</td>
<td>As I look back on my life, all I can see is a lot of failures.</td>
</tr>
<tr>
<td>2</td>
<td>I feel I am a complete failure as a person.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>I get as much satisfaction out of things as I used to.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I don't enjoy things the way I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I don't get real satisfaction out of anything anymore.</td>
</tr>
<tr>
<td>2</td>
<td>I am dissatisfied or bored with everything.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>I don't feel particularly guilty.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I feel guilty a good part of the time.</td>
</tr>
<tr>
<td>1</td>
<td>I feel quite guilty most of the time.</td>
</tr>
<tr>
<td>2</td>
<td>I feel guilty all of the time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6</th>
<th>I don't feel I am being punished.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I feel I may be punished.</td>
</tr>
<tr>
<td>1</td>
<td>I expect to be punished.</td>
</tr>
<tr>
<td>2</td>
<td>I feel I am being punished.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7</th>
<th>I don't feel disappointed in myself.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am disappointed in myself.</td>
</tr>
<tr>
<td>1</td>
<td>I am disgusted with myself.</td>
</tr>
<tr>
<td>2</td>
<td>I hate myself.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
<th>I don't feel I am any worse than anybody else.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am critical of myself for my weaknesses or mistakes.</td>
</tr>
<tr>
<td>1</td>
<td>I blame myself all the time for my faults.</td>
</tr>
<tr>
<td>2</td>
<td>I blame myself for everything bad that happens.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9</th>
<th>I don't have any thoughts of killing myself.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I have thoughts of killing myself, but I would not carry them out.</td>
</tr>
<tr>
<td>1</td>
<td>I would like to kill myself.</td>
</tr>
<tr>
<td>2</td>
<td>I would kill myself if I had the chance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10</th>
<th>I don't cry any more than usual.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I cry more than I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I cry all the time now.</td>
</tr>
<tr>
<td>2</td>
<td>I used to be able to cry, but now I can't cry even though I want to.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11</th>
<th>I am no more irritated now than I was.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I get annoyed or irritated more easily than I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I feel irritated all the time now.</td>
</tr>
<tr>
<td>2</td>
<td>I don't get irritated at all by the things that used to irritate me.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12</th>
<th>I have not lost interest in other people.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I am less interested in other people than I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I have lost most of my interest in other people.</td>
</tr>
<tr>
<td>2</td>
<td>I have lost all of my interest in other people.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13</th>
<th>I make decisions about as well as I ever could.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I put off making decisions more than I used to.</td>
</tr>
<tr>
<td>1</td>
<td>I have greater difficulty in making decisions than before.</td>
</tr>
<tr>
<td>2</td>
<td>I can't make decisions at all anymore.</td>
</tr>
<tr>
<td>Question</td>
<td>Score</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>I don't feel I look any worse than I used to.</td>
<td>0</td>
</tr>
<tr>
<td>I am worried that I am looking old or unattractive.</td>
<td>0</td>
</tr>
<tr>
<td>I feel that there are permanent changes in my appearance that make me</td>
<td>0</td>
</tr>
<tr>
<td>look unattractive.</td>
<td></td>
</tr>
<tr>
<td>I believe that I look ugly.</td>
<td>0</td>
</tr>
<tr>
<td>I can work about as well as before.</td>
<td>0</td>
</tr>
<tr>
<td>It takes an extra effort to get started at doing something.</td>
<td>0</td>
</tr>
<tr>
<td>I have to push myself very hard to do anything.</td>
<td>0</td>
</tr>
<tr>
<td>I can't do any work at all.</td>
<td>0</td>
</tr>
<tr>
<td>I can sleep as well as usual.</td>
<td>0</td>
</tr>
<tr>
<td>I don't sleep as well as I used to.</td>
<td>0</td>
</tr>
<tr>
<td>I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.</td>
<td>0</td>
</tr>
<tr>
<td>I wake up several hours earlier than I used to and cannot get back to sleep.</td>
<td>0</td>
</tr>
<tr>
<td>I don't get more tired than usual.</td>
<td>0</td>
</tr>
<tr>
<td>I get tired more easily than I used to.</td>
<td>0</td>
</tr>
<tr>
<td>I get tired from doing almost anything.</td>
<td>0</td>
</tr>
<tr>
<td>I am too tired to do anything.</td>
<td>0</td>
</tr>
<tr>
<td>My appetite is no worse than usual.</td>
<td>0</td>
</tr>
<tr>
<td>My appetite is not as good as it used to be.</td>
<td>0</td>
</tr>
<tr>
<td>My appetite is much worse now.</td>
<td>0</td>
</tr>
<tr>
<td>I have no appetite at all anymore.</td>
<td>0</td>
</tr>
<tr>
<td>I haven't lost much weight, if any, lately.</td>
<td>0</td>
</tr>
<tr>
<td>I have lost more than 5 pounds.</td>
<td>0</td>
</tr>
<tr>
<td>I have lost more than 10 pounds.</td>
<td>0</td>
</tr>
<tr>
<td>I have lost more than 15 pounds.</td>
<td>0</td>
</tr>
<tr>
<td>I am purposely trying to lose weight by eating less.</td>
<td>0</td>
</tr>
<tr>
<td>I am not more worried about my health than usual.</td>
<td>0</td>
</tr>
<tr>
<td>I am worried about physical problems such as aches and pains; or upset stomach; or constipation.</td>
<td>0</td>
</tr>
<tr>
<td>I am very worried about physical problems and it's hard to think of much else.</td>
<td>0</td>
</tr>
<tr>
<td>I am so worried about my physical problems that I cannot think about anything else.</td>
<td>0</td>
</tr>
<tr>
<td>I have not noticed any recent change in my interest in sex.</td>
<td>0</td>
</tr>
<tr>
<td>I am less interested in sex than I used to be.</td>
<td>0</td>
</tr>
<tr>
<td>I am much less interested in sex now.</td>
<td>0</td>
</tr>
<tr>
<td>I have lost interest in sex completely.</td>
<td>0</td>
</tr>
<tr>
<td>My appetite is no worse than usual.</td>
<td>0</td>
</tr>
<tr>
<td>My appetite is not as good as it used to be.</td>
<td>0</td>
</tr>
<tr>
<td>My appetite is much worse now.</td>
<td>0</td>
</tr>
<tr>
<td>I have no appetite at all anymore.</td>
<td>0</td>
</tr>
</tbody>
</table>
DEMOGRAPHICS

Age: ________________

Ethnicity: (Circle One)

White   Hispanic   Black   Asian   Other ________________

Number of Family Visits each Month ________________

Number of Months in Placement (Circle One)

0-2      13-15
3-6      16-18
7-9      19-+
10-12

48
APPENDIX C

INFORMED CONSENT
Informed Consent

The study for which you are consenting to allow __________________________ to participate in is going to test the participants for depression. This study is being conducted by Keri Chavez and Alexa Christensen, students at Cal State University San Bernardino under the supervision of Dr. Tom Davis, Assistant Professor of Social Work. The study has been approved by Institutional Review Board (IRB).

They will be asked to respond to 21 questions about depressive feelings. The questions should take about 10-15 minutes to complete. All of their responses will be held in the strictest of privacy by the researchers. Their name will not be used with their responses. All data will be reported in group form.

Their participation is voluntary. They are free not to answer any questions and to stop at any time during this study. When they have completed the survey they will receive a paper that will describe the study in more detail and where to go for questions. After they have completed the study the proctor will examine their score for question #9, which assess for suicidal ideation and will also tally the questionnaire incase of scores of 30 or above which denote major depression. If either of the aforementioned scores are found the proctor will notify the dorm therapist in order to intervene with thorough assessment and intervention as needed. They may also have an ice cream.
bar, along with other residents, who may or may not have participated.

If you have any questions or concerns about this study please feel free to contact Dr. Tom Davis at (909) 880-5000 ext. 3839.

By signing below I realize that I have been informed of and I understand what this study is about and I freely consent to this individual's participation. This study has no foreseeable risk or benefit for this particular child to participate at this time.

Signature: ____________________
Today's date: ________________
APPENDIX D

INFORMED ASSENT
Informed Assent

The study in which you are being asked to take part in is going to ask you questions about feelings and moods. This study is being conducted by Keri Chavez and Alexa Christensen, students at Cal State University San Bernardino.

You will be asked to answer 21 questions about feelings and moods. The questions should take about 10 to 15 minutes. All of your answers will be held in the strictest of privacy by the researchers. Your name will not be used with your answers.

Choosing to do this study is voluntary. You are free not to answer any questions and stop at any time during this study. When you are done, you will receive a paper that will describe the study in more detail and where to go for questions. You may also have an ice cream bar. In order to make sure that the results of the study are true, we ask that you do not talk about this study with other boys from your dorm. This study has no foreseeable risk or benefit for you to participate in at this time.

By placing a check mark in the box below, I realize that I have been told of and that I understand what this study is about and I freely choose to participate.

Place a check mark here

Today's date: ____________
APPENDIX E

DEBRIEFING STATEMENT
Debriefing Statement

The questions you have just answered were created to look at sadness. Sadness is a mood that affects many people. We want to know how sadness affects teenage boys in a group home.

Thank you for answering the questions and for not talking about the questions with the other boys in your dorm that may choose to answer the questions. If you have any questions about the study, please feel free to contact your dorm therapist. If you would like a copy of the group results of this study contact Trinity Yucaipa at the end of June of 2006.

If you have feelings you need to talk about more please see your dorm therapist.
REFERENCES


This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:
   Team Effort: Keri Chavez & Alexa Perez

2. Data Entry and Analysis:
   Team Effort: Keri Chavez & Alexa Perez

3. Writing Report and Presentation of Findings:
   a. Introduction and Literature
      Team Effort: Keri Chavez & Alexa Perez
   b. Methods
      Team Effort: Keri Chavez & Alexa Perez
   c. Results
      Team Effort: Keri Chavez & Alexa Perez
   d. Discussion
      Team Effort: Keri Chavez & Alexa Perez