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Elementary school teachers' recognition of depression in children

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ELEMENTARY SCHOOL TEACHERS' RECOGNITION
OF DEPRESSION IN CHILDREN

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
Mixel Ventura

and
Emelinda Figueroa

June 1998
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Approved by:

Dr. Lucy Cardona, Project Advisor, Social Work
Dr. Rosemary McCaslin, Chair of Research Sequence, Social Work
Dr. Craig Borba, Director of Pupil Personnel
ABSTRACT

The incidence of childhood depression is a growing problem in the United States. This study evaluated elementary school teachers' knowledge about childhood depression. Further, it sought to determine a relationship between elementary school teachers' knowledge of depression in children and their detection and consequent referral of depressed children for services. Data were gathered by use of a questionnaire which was administered to six of the thirteen schools within a school district in the Coachella Valley of Southern California. The participants included two elementary school teachers from each grade, first through fifth, from four elementary schools, and three teachers from each of the aforementioned grades from two of the largest schools of this school district. Teachers from five of the schools, including the two largest, were randomly selected by one of the researchers; however, the principal from one of the participating schools chose to personally randomly select the teachers who participated in our study. The findings suggest that training may be a factor in teachers' ability to recognize the symptoms of childhood depression and then to refer to the appropriate resources. Nevertheless, a need exists for further research in this area.
ACKNOWLEDGEMENTS

Throughout our journey into the realm of research, we have come into contact with various individuals who have been instrumental along the way. We would like to acknowledge Professor Lucy Cardona for her continual guidance and assistance throughout the research process. Her feedback and suggestions kept us focused, and her reassurance and enthusiasm kept us energized. We would also like to acknowledge Professor Morley Glicken for his helpful feedback and assistance. Additionally, an individual who was instrumental in facilitating our research project and who must be acknowledged is Dr. Craig Borba. Though we only had one meeting with him, Professor Conrad Shayo generously shared his time and expertise with us, allowing us to see the light at the end of the tunnel. Finally, the authors are indebted to all the teachers who participated, both formally and informally, in this research study. Our sincere gratitude goes out to each of them, for without them, this project could not have been possible.
DEDICATIONS

To my husband, Shahriyar, for his continual patience, love, encouragement, and support during my academic endeavor; and to my parents, Martha and Emil, for their love, guidance, and encouragement throughout my life.

To my husband, Nelson, for all of his support, love, encouragement, and patience; to my children, Rolando, Jacob, and Melanie, for their understanding during all those times when mom couldn't be there to spend time with them; and to the rest of my family for their unrelenting support.
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This project was a team effort such that the authors collaborated throughout the project. In certain circumstances, the authors divided the work and each author undertook a specific task. These tasks were assigned as follows:

1. Data Collection:
   Team effort: Emelinda Figueroa & Mixel Ventura

2. Data Entry and Analysis:
   Data Entry: Emelinda Figueroa
   Analysis: Mixel Ventura & Emelinda Figueroa

3. Writing report:
   Compilation of report: Mixel Ventura

4. Presentation of Findings:
   A. Introduction and Literature Review:
      Team Effort: Mixel Ventura & Emelinda Figueroa

   B. Methods:
      Team Effort: Mixel Ventura & Emelinda Figueroa

   C. Results:
      Team Effort: Mixel Ventura & Emelinda Figueroa

   D. Discussion:
      Team Effort: Mixel Ventura & Emelinda Figueroa
CHAPTER ONE: INTRODUCTION

Problem Statement

Currently, the impact of depression in children is beginning to receive much attention. However, the prevalence of childhood depression has not been adequately studied despite the fact that the number of children who experience depression is thought by some to be growing (Harrington, Bredenkamp, Groothues, Rutter, Fudge, and Pickles, 1994; and Kelly, 1991). Werthamer-Larsson (1994) estimated that 15% of the child population were in need of mental health services. Further, according to Allen-Meares (1995) and Kelly (1991), it is estimated that in the United States about 7.5 to 9.5 million youths suffer from an emotional or mental health disorder; yet, less than 20 percent receive treatment. According to Barker (1996), mental disorder is defined as "Impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes: biological, chemical, physiological, genetic, psychological, or social. Mental disorders are extremely variable in duration, severity, and
prognosis, depending on the type of affliction. The major forms of mental disorder include mood disorders, psychosis, personality disorders, organic mental disorders, and anxiety disorder" (p.231).

Lamentably, the prevalence of depression in children and adolescents is between three to over six million in the United States (Shamoo and Patros, 1990). More specifically, depression in prepubertal children in the general community is about two percent; however, exact data about the number of children with depression are not readily available (Kelly, 1991; Kauffman, 1993; Maag and Forness, 1991). To further elucidate the prevalence of childhood depression, Mash and Barkley (1996) gathered data on several epidemiological studies of child and adolescent depression. The findings reported by these authors in some ways support the above data; in other ways the findings exceed the two percent rate. For example, in one of the authors' reported studies, the Ontario Child Health Study, conducted by Offord, et al. (1987), 3,294 children between the ages of four through sixteen were studied. The method used was to administer child, parent, and teacher questionnaires by
interviewers. The results of this study found a 5.5% rate of major depression and dysthymia. Mash and Barkley (1996) also reported the findings of the Puerto Rico Child Epidemiologic Study conducted by Bird et al. (1988) which studied a sample of 386 children ages four through sixteen, and in which child and parent interviews were conducted by a psychiatrist. This study found a 5.9% rate of major depression or dysthymia. Yet another study reported by Mash and Barkley (1996), the Pittsburgh HMO Study conducted by Costello et al. (1988), studied a sample of 300 children between the ages of seven through eleven. This study conducted child and parent interviews and found that 0.4% of the sample had major depression and 1.3% had dysthymia. Although these rates seem to be low, this might be due to the study having been conducted at one point in time without any follow-up in order to check for possible changes as was done in the study reported by Mash and Barkley (1996) conducted by Anderson, et al., (1987); and McGee et al., (1990) which reported similar findings. For example, their study was conducted on a sample of 925 children age 11, and consisted of the child being interviewed by a psychiatrist,
and parents and teachers completing questionnaires. The results suggested that 0.5% of the children had major depression and 0.4% had dysthymia at age 11. At follow-up, however, these rates had increased to 2.5% of the sample reporting major depression and 1.5% reporting dysthymia at the age of 15. These increases suggest the importance of tracking children who present with depressive symptoms in order to intervene as early as possible and to treat the depression, thereby preventing the exacerbation of symptomology.

The challenge of identifying and determining childhood depression is partly due to the lack of recognition of the existence of depression in children up until the past fifteen years (Harrington, Bredenkamp, Groothues, Rutter, Fudge, and Pickles, 1994). To be sure, discrepancies between various theories regarding the existence of depression in children have existed for several decades. Though theories such as anaclitic depression and depressive position were discussed during the mid 1940s, Josephson and Porter (1979) also report theorists who refute this notion
such as Mahler who suggests that infants or older children lack a sufficiently mature personality structure and, thus, are unable to experience depression in the same way that it is experienced by adults. Similarly, psychoanalytical theorists proposed that depression was not thought to exist in prepubertal children due to their undeveloped superego such that aggression was not able to be inwardly directed at the self; thus only recently has depression been studied as it is manifested in children (Bleiberg, 1991; Kauffman, 1993; Mash and Barkley, 1996).

Generally, teachers are not required to take advanced courses in psychology. Thus, another challenge in identifying childhood depression may be due to a lack of diagnostic criteria and appropriate assessment instruments with which teachers are trained to administer (Kauffman, 1993). Although various diagnostic instruments exist which can assist in identifying symptoms of depression, teachers must first become skilled at detecting the symptoms of depression in order to refer children for the appropriate diagnostic tests (Kauffman, 1993). Compounding to this problem is the fact that controversial characteristics of
childhood depression exist (Kauffman, 1993; Mash and Barkley, 1996; Shamoo and Petros, 1990). To illustrate, depression in children may be expressed both internally, by exhibiting quiet or withdrawn behaviors, or externally in the form of irritable and restless behaviors; as a result, these contrasting behaviors may cause teachers to overlook or mislabel children who may actually be depressed (Black, 1996). Therefore, teachers' inability to accurately identify symptoms of depression may have long-term consequences for the child.

In considering the problem of childhood depression, it is essential that one look at the potential for suicide in children who suffer from depression. Alarmingly, one major implication of childhood depression is that it is a leading cause of suicide (Shamoo and Petros, 1990; Bleiberg, 1991; Harrington, Bredenkamp, Groothues, Rutter, Fudge, and Pickles, 1994). Kelly (1991) has stated that the prevalence of suicide in elementary school-age children is difficult to determine particularly because "...the National Center for Health Statistics does not classify suicide as a cause of death for children who are less than 10 years old;
therefore, youngsters who are 9 years of age or younger and who commit suicide are not even counted in the suicide statistics" (p. 546). Although fairly recent, it was not until 1986 that statistics were available for youth who had committed suicide. Kelly (1991) cited the Centers for Disease Control report which stated that suicide is the third leading cause of fatal injuries in children. Specifically, in 1986 of the 2,151 youths who committed suicide, 255 were for children between the ages of five to fourteen years old. Contrary to previous beliefs, the author confirms that prepubertal children, in fact, do commit suicide.

Suicidal behavior among children and adolescents currently is becoming the primary mental health issue in America (Shamoo and Petros, 1990). In 1993, of all the leading causes of death among five to fourteen year-olds in the United States, suicide was the fourth leading cause totaling nine percent of the population in this age group and it was the third leading cause of death among 15 to 24 year-olds with a total of 13.5% (U.S. Bureau of the Census, 1996). Deplorably, the incidence of completed suicides
"...have increased from 4.5 per 100,000 in 1950 to 13.2 per 100,000 in 1990 in the 15-to 24-year-old age group" (Woods, Lin, Middleman, Beckford, Chase, and DuRant, 1997, p.791).

Other ramifications of childhood depression are its impact on the child later in life resulting in major depression, academic difficulties, and interpersonal impairments (Kauffman, 1993; Mash and Barkley, 1996). It is suggested by Allen-Meares (1995) that by detecting childhood depression, teachers can serve to reduce the emotional vulnerability of children and, thus, the long-term effects of depression. Effective screening for depression requires that one be able to identify symptoms of depression that are not obvious, yet do so with sufficient accuracy. Unfortunately, many schools currently do not have a systematic method of screening children (Kauffman, 1993). Interestingly, enough concern about this problem has prompted legislative mandates for the provision of early screening, despite limited information about the nature of the disorder, procedures for its detection, ways to correct the problem, or effects on children not receiving treatment (Kauffman, 1993).
Problem Focus

This study evaluated elementary school teachers' knowledge about childhood depression. In addition, it sought to determine a relationship between elementary school teachers' knowledge of depression in children and teachers' detection and consequent referral of depressed children for mental health services. This exploratory study used the post-positivist paradigm to determine if such a relationship exists. It has been proposed by the psychosocial theory of development that children between the ages of 6-12 have as one of their developmental tasks that of self-evaluation, and that the central process for this age group is education (Newman & Newman, 1991). Because of the task of self-evaluation for this age group and the consequent possibility to internalize negative thoughts and feelings, it is critical to identify depression in children. With this in mind, and for the purpose of this study, elementary school children were defined as children between the ages of 6 and 12 inclusive.

Children are in a precarious position to request assistance when experiencing mental health problems such as
depression. First, children do not possess the cognitive ability to fully understand that they have a problem, and, second, they are dependent on adults, either parents, teachers, or others, to possess knowledge about their dilemmas and to assist them when such difficulties arise. As Stranger and Lewis (1993) have suggested, this reliance on adults for referral for services is very different than the process of self-referral for adults.

This study proposed that teachers who have had more training in child psychology or related courses are more likely than those without such training to identify depression in children and, consequently, to refer children for adequate services. Thus, if early intervention can take place, the depressed child's quality of life may be improved and other negative consequences may be prevented.

As Mash and Barkley (1996) have noted, several theoretical models of childhood depression exist. Briefly illustrated, one theory of childhood depression is the Genetic model which suggests that depression may be an inherited illness. A second theory is the Biological model which proposes that an abnormality in the circadian rhythm
causes depression. Another theory is the Cognitive model which stresses that negative or maladaptive beliefs play a role in the origin of depression. Additionally, the Behavioral/Interpersonal model suggests that skill deficits, such as an inability to elicit positive reinforcement, lead to depression; whereas, the interpersonal component posits that by reacting to interpersonal problems, one invariably adds to the problem resulting in depression. Moreover, Family theories, too, have been presented as a cause for depression by suggesting that a family's strained or conflictual interrelationship contributes to a child's lack of socioemotional adjustment. Finally, the Environmental model poses that depression is a response to environmental stressors.

Depression in children, as defined by the Diagnostic and Statistical Manual, fourth edition (DSM-IV), may present as the following symptoms: Depressed mood, an irritable or cranky mood instead of a sad or dejected mood, decreased interest or pleasure in usual activities, changes in appetite or weight patterns, changes in sleep patterns, loss of energy or tiredness, impaired ability to think,
concentrate, or make decisions, low self-esteem, poor social skills, pessimism, and recurrent thoughts of death or suicide (American Psychiatric Association, 1994). Thus, an abrupt drop in grades may represent poor concentration in children due to depression. Furthermore, social withdrawal, too, may be indicative of depression. Due to the nature of childhood depression, consequently, it may be difficult to detect because depression may be manifested in several ways. For instance, Borchardt and Meller (1996) proposed that depression in children may be expressed as externalized symptoms such as irritable mood, physical aggression, temper outbursts, and/or distractibility. However, for some children depression is internalized. Bell-Dolan, Foster, and Christopher (1995) studied internalizing problems in young girls as it related to girls' peer relations and discovered that for some girls, depression was demonstrated in the form of social withdrawal, isolation, and/or anxiety.

Although depression exists in children (Shamoo and Petros, 1990), it is not as readily detected in children as it is in adults. This is due to the nebulous nature of the symptoms exhibited by children. For instance, Mash and
Barkley (1996) suggest three issues which are important to address with regard to childhood depression. First, the authors state that depression in youngsters meets the same criteria as depression in adults. Next, depression in children often is overlooked because what catches the attention of adults is usually externalized behavior, thus, leaving the child with internalized symptoms undetected or lacking assessment. Finally, the authors suggest that an erroneous belief in "masked" depression surfaced due to the high level of comorbidity, especially involving disruptive disorders, with which depression in children is experienced. In other words, because depression often coexists with other disorders, its manifestation is confused due to the symptoms from other disorders overlapping with the symptoms of depression. As such, difficulties arise as to a clear presentation of childhood depression.
CHAPTER TWO: LITERATURE REVIEW

Detection Literature

Review of the literature, unfortunately, revealed very little research on teachers' ability to detect childhood depression. However, some studies have been conducted which examined childhood depression and its manifestations. To illustrate, Epkins (1995) elaborated on this point in her study which explored both community-based and inpatient-facility teachers' ratings of children's depression, anxiety, and aggression using parallel rating scales. The 83 subjects were between the ages of eight to twelve years-old and had been continuously hospitalized at an inpatient psychiatric hospital. Of this sample of children, 79% had two or more diagnoses. Several tools were used in this study in order to present greater accuracy in the assessment of informant correspondence. These tools were the Children's Depression Inventory (CDI), Revised Children's Manifest Anxiety Scale (RCMAS), Aggression Inventory (AI), Self Rating Form (SRF), and Teacher Rating Form (TRF). The results of this study suggest statistically significant
convergent and discriminant validity for measures of depression, anxiety, and aggression each of the respondents. It was noted that while studies have been conducted to assess externalizing disorders in children, only a few studies have explored the role of teachers in assessing children’s internalizing disorders. In addition, because teachers have the opportunity to observe children during social interactions with their peers, within structured and unstructured arenas, and for an extended length of time, Epkins suggests that teachers are in a unique position to evaluate the severity of children’s internalizing and externalizing behaviors.

Similarly, Werthamer-Larsson (1994) conducted a study in which literature on school-based services was critically analyzed. The findings of this study supported the previous study in suggesting that schools, and particularly teachers’ ratings, are important in identifying children with mental health problems. Because school-based services are delivered on a continuum according to service intensity, the study maintained that services which seek to alleviate problems for high-risk children are often awarded first
priority. Unfortunately, early-intervention services such as those focused on children with mental health problems are usually considered to be at a lower intensity, and, thus, do not receive as much attention. Additionally, Duchnowski (1994) confirmed that most public schools do not offer services for children who have serious mental health needs.

Another study conducted by Maag, Rutherford, and Parks (1988) assessed teachers', guidance counselors', and special education teachers' ability to identify depression. In this study the researchers used a questionnaire-interview format which asked open-ended questions in order to determine the respondents' comprehension of depression in adolescents. The questions requested that the participants list any behavioral manifestations, warning signs, and possible causes which might signal to them that an adolescent is possibly depressed. Additionally, participants were asked to identify resources which they would use to help their depressed students. The findings suggested that school counselors possessed the most knowledge about adolescent depression. However, teachers, too, possessed some ability to recognize important characteristics. Ironically,
although counselors have greater skills for identifying depressed students, teachers are usually the first to recognize students' problems. This is so because of the differing environments in which each participant works. Since teachers see students behaving in the structured environment of the classroom, they are able to assess students' behaviors and any changes, thereof. Whereas the counselors are limited to the office setting such that they are limited to the behaviors with which the students present at that time. The implications proposed by the authors of this study are that teachers would benefit from further training to recognize students with depression, and counselors also would benefit from increasing the amount of time spent in the classrooms. Overall, this asserts the need for collaborative efforts among various professionals in order to help students with depression.

Screening for Depression by Teachers and Other Professionals

In their study of the linkages between depression and social functioning, Bell-Dolan, Reaven, and Peterson (1993) suggest the existence of six social-functioning factors which forecast depression. These factors consist of social
withdrawal, social activity, negative social behavior, self-rated social competence, other-rated social competence, and accuracy of self-evaluated social competence. The authors found a consistent pattern showing that high ratings of negative social behaviors such as aggression and poor social-support, as well as social withdrawal, and social competence were critical predictors of depression. The authors of this study (i.e. authors of this study) suggest the need for interventions which teach alternatives to these behaviors. It is with this in mind that this research project intends to identify ways in which teachers identify depression and refer children for necessary assistance.

Epkins and Meyers (1994) conducted a study which focused on assessing childhood depression, anxiety, and aggression. The authors gathered information using self-, parent-, peer-, and teacher-reported measures. The subjects consisted of 102 children, both girls and boys, who ranged in age from eight to eleven years old. Essentially, the findings suggest a significant convergence between teacher and self-reports for depression and anxiety in both boys and girls; however, between the sexes there were nonsignificant
differences. Also, the convergence on depression and anxiety between teacher-parent yielded nonsignificant results; yet, significant results were found between these two raters on aggression. Interestingly, the measures of depression and anxiety between peer- and self-reports corresponded significantly. The overall findings point to the fact that different informant sources have differing patterns of convergence. Therefore, the need exists for further diagnostic criteria and training about these childhood disorders in order to obtain more integrated informant reports.

In a similar study, Crowley, Worchel, and Ash (1992) different types of depression measures and their correlation using items from self-, peer-, and teacher-reported measures. The authors utilized the Children's Depression Inventory (CDI), Peer Nomination Inventory of Depression (PNID), and the Child Behavior Checklist-Teacher Report Form (CBCL-T). The study consisted of 275 school children ranging in age from 10 to 16 years-old. Although a lack of correlation between the informants' responses were found, the authors noted that this may be due to different
questions or content areas being targeted by each of the measures. The authors have suggested that some implications exist regarding the adequate assessment of childhood depression and the need to measure similar content areas when performing assessments.

In their study on the evaluation of subclinical depression in children, Worchel, Hughes, Hall, Stanton, Stanton, and Little (1990) discovered that no particular instrument is a valid indicator of childhood depression. Consequently, it is necessary to use multidimensional assessment tools in order to more accurately assess depression in children. The authors report on their findings using three measurement instruments. The Children’s Depression Inventory (CDI), the Child Behavior Checklist-Teacher Form (CBCL-T), and the Peer Nomination Inventory of Depression (PNID) were administered to a sample of 752 children between the ages of five through nine, and a sample of 142 fifth-graders as a comparison group of peers. These three measurement tools were chosen because they are the most widely used tools to measure depression. Interestingly, this study reported a high correlation
between internalizing and externalizing behaviors among the CBCL-T and the PNID.

Wenz-Gross, Siperstein, Untch, and Widaman (1997) studied stress, social support, and adjustment in 482 sixth-through eighth-grade adolescents and how these factors impact the students in terms of their self-concept, feelings of depression, and academic motivation. The students were administered the School Stress Inventory (Siperstein & Wenz-Gross, 1997) in order to measure particular events and the consequent level of stress associated with such events. In order to assess the students' social support, the adolescents were interviewed using the "My Family and Friends" (Reid, Landesman, Treder, & Jaccard, 1989) format (p.131). Furthermore, to assess adjustment, but particularly school adjustment, the authors used the following four measures: the Self-Perception Profile for Children (Harter, 1985), the Children's Depression Inventory-Short Form (Kovacs, 1992), the School Environment Scale (Elias et al., 1992), and the Liking of School Questionnaire developed by the authors. What is more, the authors break down self-concept into academic self-concept.
and social self-concept. The findings suggest that high academic stress and high peer stress are related to poor academic self-concept and poor social self-concept, respectively. Not surprisingly, peer stress was related to feelings of depression. However, it was also found that emotional family support countered the feelings of depression as a result of peer stress in preadolescents. This suggests the importance of identifying depression in elementary school children in order to provide the child with emotional support through linking measures between the child's teacher and his or her family.

In the study conducted by Turbett and O'Toole (1983), the authors compared the signs and inferred causes of abuse of children which were employed by teachers and compared these results to the authors' previous study comparing variables used by nurses and physicians to detect and report abuse. The authors utilized vignettes which manipulated variables including children's race, socioeconomic status (SES), and level of injury. Two versions of the vignettes were used, altering only the variables being manipulated. The findings point to the fact that teachers, as well as
physicians and nurses recognize and report obvious abuse. However, teachers tended to use behavioral and medical signs to detect child abuse; whereas, physicians and nurses mostly relied on physical signs of abuse. Moreover, of the three groups studied, only physicians’ judgements tended to be more influenced by the parents’ SES and ethnic status. To be sure, the authors report that both teachers and nurses looked at a child’s abusive upbringing and stress as causes of child abuse in contrast to physicians who listed poverty and substance abuse as the primary causes, and stress and mental illness as secondary causes of child abuse. The implications of this study are that teachers, who have daily contact with children, are in a position to note behavioral changes in children, and may have knowledge of children’s family background.

School psychologists’ perceptions and practices, too, have been studied. To illustrate, Clarizio and Payette (1990) conducted a study in which 66 state-certified school psychologists were given a survey to obtain their impressions about childhood depression. Although all respondents affirmed the existence of childhood depression,
the majority (82%) of the respondents stated that it is commonly seen in the children referred to them. However, the study also found a difference between the psychologists' conceptualizations of childhood depression and the opinions found in the literature. Additionally, the study suggests that the use of the available scales by school psychologists is limited. The implications offered by the authors of this study regarding limited usage of scales are, first, limited use are first, that psychology programs need to increase their training in the use of these techniques. Second, a need also exists for psychologists practicing in schools to receive in-service training in order to become familiarized with the available scales. The authors suggest another interesting point and that is for a consultation model to be implemented whereby the teacher performs cognitive-behavioral strategies with the supervision from a psychologist. This is in concurrence with the need to develop collaborative efforts among various professionals.

**Teachers' Behavioral Management Style**

Vitaro, Tremblay, and Gagnon (1995) explored teachers' style of managing behavior problems in the class setting and
compared any changes in teachers' ratings of children's behavioral problems from kindergarten to first grade. This study sampled 1,573 boys and girls rated by their teachers, mothers, and peers on aggressive-hyperactive, anxious-withdrawn, and social skill deficit behaviors. The authors found that teachers with a low autonomy oriented style demonstrated an increase in ratings of children's externalizing behaviors in contrast to teachers with a high autonomy oriented style who did not show an increase in their ratings of externalizing behaviors in children. Additionally, when teachers used more directive behavioral management styles, they tended to rate externalizing behaviors more severely than their high autonomy oriented counterparts. Consequently, the authors suggest that "The fact that teachers' management styles were related to externalizing ratings but not to internalizing or prosocial behaviors may indicate that teachers are mostly concerned with externalizing problems," (p. 896). Again, the implications of these findings suggest that children who internalize behaviors, and most likely depressive symptoms, possibly are not being identified by teachers, and,
inevitably, are not receiving the needed interventions to assist them in dealing with their depression.

Harrington, Bredenkamp, Groothues, Rutter, Fudge, and Pickles (1994) have suggested that a link exists between depression in children and suicidal behaviors during adulthood. This is explained on the basis that depressive disorders are usually recurrent, impair psychosocial functioning, and are clinically difficult to treat. The link between childhood depression and adult suicide often stems from depression in childhood which later becomes major depression in adulthood.

To further illustrate the link between suicide and depression, Woods, Lin, Middleman, Beckford, Chase, and DuRant (1997) studied a sample of 3,054 students ranging in grades from ninth through twelfth. Although the authors attempted to study other risk factors which are associated with suicide, such as involvement in physical fights, drug use, cigarette use, and sexual activity to name just a few, their study also suggested that suicide attempts are associated with depression.

Although a clear link appears to exist between
depression and suicide, the psychological risk factors associated with suicide need to be considered in order to prevent or ameliorate this problem. The authors Silbert and Berry (1991) have done just that in their study on the effects of suicide prevention on adolescent’s levels of stress, anxiety, and hopelessness. The authors studied a sample of 323 students with and without special needs including an experimental and control group of both types of students. The experimental subjects participated in a suicide prevention unit which consisted of two 50-minute sessions within the class setting, a video about the warning signs of suicide and learning to cope with depression, a handbook of information and activities similar to the class lessons, and a pamphlet of assistance resources. Once the suicide prevention unit was finished, the authors provided the students with a test designed to measure students’ knowledge about suicide prevention. The authors found that a significant decrease in the special needs experimental group’s level of stress and hopelessness was achieved by participating in this project. Moreover, the authors suggest that teachers and schoolmates are usually the first
to observe suicidal signs; however, peers are usually the one's turned to for assistance. Nevertheless, schools have the potential for training students to identify and assist others when this need arises. Yet, in order for students to be taught these skills, teachers, first, must be trained to provide such courses. Consequently, the need exists for suicide prevention curriculum within the school setting.

In addition to the potential for suicide, childhood depression may also affect children's academic and emotional well-being. To illustrate, in her study on the influence school has on children's development, Sylva (1994) suggests that schools have an influence on both the social cognitions and feelings of children. A child's cognitions and feelings, therefore, have an equally intense effect in predicting future outcomes as do intelligence or school curriculum. A notable finding is the impact that teachers' social responses have on children's depressive symptoms. For example, Mullins, Chard, Hartman, Bowlby, Rich, and Burke (1995) found that a relationship exists between children's self-reported depressive symptoms and teachers'
negative social responses. As such, with increased knowledge and understanding about childhood depression, teachers may become more sensitive in working with children who demonstrate depressive symptoms. Indeed, through training, teachers may become more sensitive to their interactions with children, particularly depressed children, and may aid in preventing the exacerbation of depressed symptoms in children. Nevertheless, because children spend a large part of their day in school, the need exists for elementary school teachers to possess knowledge and understanding about the manifestations of childhood depression. Therefore, it is imperative that teachers be trained to recognize the symptoms of childhood depression such that depressed children may receive the earliest intervention possible.

Although few, these studies have identified the need for mental health services for depressed children to be provided within the school and in collaboration with the children’s teachers who are in the unique position to detect depression in children, given the appropriate training. By doing so, the earliest form of intervention may be provided
to children, which may then prevent future problems.
CHAPTER THREE: METHOD

Purpose

This study explored whether a relationship exists between elementary school teachers' knowledge and/or understanding of childhood depression and their referral of children for mental health services. Moreover, this study was concerned with finding whether teachers are able to recognize symptoms of depression, both externalized and internalized, regardless of their ability to define such symptoms as pertaining to depression. If teachers do detect symptoms of depression, where do they refer children, if at all, for help in dealing with their depression?

Design

This study was an exploratory study that utilized both quantitative and qualitative questions to obtain the findings. The researchers used the post-positivist paradigm to determine if a relationship exists between elementary school teachers' knowledge of depression in children and their ability to detect and consequently refer children for the appropriate services.
Sample

The sample of 37 teachers were selected from a school district in the Coachella Valley of Southern California. Thirteen schools encompass the school district; of these, six schools were selected for the study because they were representative of all thirteen schools with respect to the demographic composition of students. The demographics include approximations of several ethnic groups and were provided to the researchers by the school district in the form of a 1997-1998 Ethnicity Report. The ethnic breakdown consists of one percent American Indian, one percent Asian, two percent Filipino, 54% Hispanic, seven percent Black, and 35% White.

The participants included two elementary school teachers from each grade, first through fifth, from four elementary schools, and three teachers from each of the aforementioned grades from two of the largest schools of this school district for a total of 70 teachers. Teachers from five of the schools, including the two largest, were randomly selected by one of the researchers by selecting from a list of teachers from each school every second
teacher from each grade until the adequate number of teachers needed was obtained. However, the principal from one of the participating schools chose to personally randomly select the teachers who participated in our study. The implications involved with the limitation in randomization are discussed later. This sample population was selected in order to assess teachers' knowledge about childhood depression since teaching credential requirements had been standardized throughout the state until last year.

Data Collection and Instruments

An informal preliminary study was conducted at an elementary school in Orange County, California. The participants were coworkers of the mother of one of the researchers. The teachers were written a letter informing them of the informal status and voluntary nature of their cooperation as well as the reason for eliciting their assistance. Then, the teachers were given a questionnaire formulated by the researchers. The responses collected from the informal survey were used to develop the instrument used in the formal research study. The final questionnaire was submitted and approved by the researchers' advisor and the
Approval from the school district was obtained first, by contacting the Director of Pupil Personnel and informing him of our study and our interest in conducting our research within his school district. Second, the researchers met with the Director to provide more elaborate information about the study and to show him a copy of the questionnaire. Then, a letter was written and sent along with a final copy of the instrument to the Director for his final approval. Finally, the Director gave his approval and contacted the Principals of each school in order to encourage their cooperation.

A 15-question questionnaire (see Appendix A) designed to measure teachers' knowledge and understanding about childhood depression was administered to each teacher. The questionnaire packet contained a brief description of the nature of the study, a review of confidentiality issues, and an informed consent form. In addition, the respondents were given a debriefing form at the end of the survey providing them with the telephone number of the researchers and their advisor, and were informed that they could receive a copy of
the results of the study at their request. Although no problems were anticipated, the debriefing form was provided in the event that the respondents had any questions, concerns, or problems with the survey.

A researcher visited five of the schools on a weekly basis for approximately three weeks to collect the completed questionnaires. Then, a reminder letter was distributed informing the remaining teachers of the final collection along with a second copy of the questionnaire packet. Since participation was voluntary, the letter included a check-off section at the bottom, such that the teachers who chose not to participate could put a check mark to inform the researchers of their choice not to participate. This was done in order for the researchers to have a better understanding about the reason behind any lack of completed questionnaires. A second researcher visited the school whose principal randomly selected the participants, distributed the questionnaire packet, and a week later collected the completed instruments. By the end of the final collection, the researchers had collected a total of 37 completed questionnaires.
The limitations of the design include differentiated trainings received by the teachers from each school, and possession of differing levels of education, training, and experience within the teaching profession, thereby limiting the generalizability of the results. Nevertheless, since the study will focus on teachers' knowledge about childhood depression based on standard skills, some internal validity may be inferred. Another limitation of this study is the sample population which will be obtained only from one school district in the Coachella Valley of Southern California; consequently, the external validity will be limited.

Procedure

The participants were provided a questionnaire packet, along with instructions to return the questionnaire and informed consent to the school's secretary. The data collection process took approximately four weeks. Once all instruments were collected, they were separated from their packets and were checked for completeness. Then a number was assigned to each questionnaire in order to track the number of completed instruments.
Protection to Human Subjects

Since human subjects were used in the study, a human subjects review was requested as soon as possible. In addition, permission to conduct the survey at the selected schools was requested in advance from each school. This was done first, by contacting the Director of Pupil Personnel by telephone and informing him about the nature of our study and simultaneously requesting permission to conduct our study using the corresponding schools. Secondly, we also submitted a letter of request to the Director in order to request permission in a formal manner.
CHAPTER FOUR: RESULTS

Data Analysis

The study used a survey design consisting of a questionnaire which listed social and emotional choices as well as internalized and externalized behavioral categories from which to select. Additionally, the survey offered several open-ended questions. The demographic variables measured were the teachers' age, gender, level of education, number of years teaching, grade being taught, and number of training sessions attended that dealt with childhood disorders. Additionally, the questionnaire asked teachers to select from a list of behaviors they commonly observe in the classroom and reasons for referring children for help. Teachers were also asked to specify the strategies they would use to refer children for mental health services. The remainder of the questionnaire asked questions which sought to determine teachers' awareness of social or emotional problems and their perception about the onset and prevalence of childhood depression in any given school year. Following is an explanation of the findings.
The demographic characteristics of the sample are shown in Table 1. According to the findings, of the 37 respondents, 26 were female and 11 were male. Teachers’ ages ranged from 26 to 60 years with 27% of the respondents falling between the ages of 26 through 30, 14% of the teachers were between 31 through 35 years, 11% of the participants were between 36-40 years, 19% were between 41 through 45 years, 8% fell between 46 through 50 years, 16% fell between 51 through 55 years, and only 5% were between 56 through 60 years of age. Moreover, the ethnic composition of the respondents consisted of 8% African American, 84% Caucasian, and 8% Hispanic. The percentage of teachers according to grade level being taught entailed 24% in first grade, 16% in second grade, 11% in third grade, 27% in fourth grade, and 22% in fifth grade.

When looking at the level of education (Table 2), the percentage of teachers surveyed fell evenly between those who had attained an undergraduate education (46%) and those with a graduate level of education (46%). The remainder of the participants (8%) did not respond. Lastly,
with respect to the number of years teaching, the participants responded as follows: 38% of the sample had been teaching from zero to four years, 11% had taught from five to nine years, 16% had been teaching from ten to 14 years, 11% had taught for 15 to 19 years, 5% had taught for 20 to 24 years, and 19% had been teaching for 25 years or more.

Although the number of in-service trainings were collapsed into four categories in an attempt to discuss the findings more clearly, listed here will be the original figures in order to provide a more accurate representation of the findings. Indeed, teachers had a list of twelve in-service training categories from which to select (Table 3). The findings show that none of the respondents had received any training in psychopathology, 60% had received in-service training in drug and alcohol dependence, 22% had taken learning psychology, 40% had training on conduct disorders, 54% had received training in child abuse prevention, 27% had HIV training, 35% obtained training in Attention Deficit Hyperactivity Disorder, 49% had taken courses on learning disabilities, 24% had taken abnormal psychology, 49% had
taken developmental psychology, and 62% had a course in child psychology.

The Chi-square was used to determine the significance of the relationship between in-service training and the behaviors that teachers observe in the classroom. The independent variable was in-service training and the dependent variable was observed behaviors. The overall results, however, were not very significant. Only the in-service training category of behavior with the observed internalized behaviors of children proved to be statistically significant with a p-value of .011. This finding was appreciably circumspect, given the small cell count in some of the data. Nevertheless, the findings do indicate a trend and a need for increased research in this area.

Responses between teachers' level of education and each of the 12 in-service training categories are listed in Table 4. The results show that none of the teachers at all levels of education had ever received training in Psychopathology. Additionally, 27% of teachers with Bachelors or Bachelors+ and 32% of teachers with Masters or Masters+ level of
education had received training in drug and alcohol
dependence; 5% of teachers with Bachelors or Bachelors+ and
16% of teachers with Masters or Masters+ level of education
had training in Learning Psychology; 11% of teachers with
Bachelors or Bachelors+ and 27% of teachers with Masters or
Masters+ level of education received training in Conduct
Disorders, and 3% had no response; 27% of the respondents
with Bachelors or Bachelors+ and 22% of respondents with
Masters or Masters+ had taken Child Abuse Prevention
training, and 5% had no response; 11% of the respondents
with Bachelors or Bachelors+ and 16% of respondents with
Masters or Masters+ had taken HIV training; 16% of the
respondents with Bachelors or Bachelors+ and 16% of
respondents with Masters or Masters+ had training in
Attention Deficit Hyperactivity Disorder, and 3% had no
response; 19% of the respondents with Bachelors or
Bachelors+ and 27% of respondents with Masters or Masters+
received training in Learning Disabilities, and 3% had no
response; 11% of the respondents with Bachelors or
Bachelors+ and 14% of respondents with Masters or Masters+
have had a course in Abnormal Psychology; 22% of the
respondents with Bachelors or Bachelors+ and 27% of respondents with Masters or Masters+ have had a course in Developmental Psychology; and, finally, 24% of the respondents with Bachelors or Bachelors+ and 30% of respondents with Masters or Masters+ have had a course in Child Psychology, and 8% had no response.

In order to see if a relationship exists between teachers' level of education and where children are referred for help (Table 5), a crosstabulation of these two variables was conducted. The data demonstrate that 24% of teachers with Bachelors or Bachelors+ and 14% with Masters or Masters+ referred children to the school principal, and 3% had no response; 38% of teachers with Bachelors or Bachelors+ and 32% with Masters or Masters+ referred children to the school psychologist, and 5% had no response; 22% of teachers with Bachelors or Bachelors+ and 19% with Masters or Masters+ referred children to the parent; 16% of teachers with a Bachelors or Bachelors+ and 19% with Masters or Masters+ referred children to the school nurse, and 5% had no response. Interestingly, only 5% of teachers with a Bachelors or Bachelors+ and 8% with Masters or Masters+
referred teachers to the school social worker, and 3% had no response. Also low were the referral rates to community resources with a response rate of 5% at the Bachelors and Bachelors+ and 3% at the Masters and Masters+ educational levels. Lastly, 14% of teachers with a Bachelors or Bachelors+ and 19% with Masters or Masters+ referred children to other resources.

Teachers were asked to list any observations of social or emotional problems. Following are the ten responses provided by the teachers (Table 6). Of the 37 respondents, 3% have observed problems with drug exposure; 22% observed aggressive behaviors; 5% picked up on disruptive behaviors; 24% noticed children who exhibited ADHD/ADD, 24% observed children with low self-esteem; 5% reported observing children who were abused or neglected; 3% noticed emotional disturbance; 3% observed children who had mood swings; 3% reported fearfulness; and 8% had no response.

When asked to list the strategies used to provide help to children, teachers offered the following responses. Of the 37 participants, 68% reported talking to parents as a strategy; 32% mentioned using the Student Study Team;
24% stated utilizing teacher counseling; 11% suggested the strategy of parent and teacher monitoring; 8% reported observing child; 30% remarked talking with the child as a strategy; 5% stated researching school records; 22% suggested they would make a referral; 5% would refer for peer tutoring; 14% would refer for counseling; 11% would praise child's work; 8% reported they would refer to a resource teacher; 5% would engage in group discussion; about 14% would refer to a school psychologist; and 8% had no response.

Finally, teachers were asked to select from a list any behaviors (Table 7) they commonly see in the classroom in order to determine if teachers were able to detect internalized as well as externalized behaviors. Of these behaviors, 38% of teachers reported seeing impulsiveness; 41% noticed poor social skills; 19% witnessed self-criticism; 30% observed isolation; 81% saw children with learning difficulties; 16% reported cursing; 49% mentioned inflicting self-harmful behaviors; 27% stated excessive fear; 100% of the participants reported seeing children eating too much; 5% reported irritability; 16% mentioned
mood swings; 57% stated getting off task; 30% saw developmental delays; 49% commonly witnessed fighting; 24% reported limited social interactions; 49% observed poor concentration; 46% stated low self-esteem; 73% noticed disruptiveness; 38% saw withdrawn; 49% observed poor hygiene; 11% of respondents reported seeing children eating too little; 78% noticed poor attention-span; 30% observed children sleeping in class; and 3% reported "other."
CHAPTER FIVE: DISCUSSION

Discussion

In this study, we attempted to evaluate elementary school teacher's knowledge of childhood depression and their ability to detect and consequently refer depressed children for services. Additionally, we looked at their level of education, the number of years teaching, and the various in-service training they received.

Our overall findings show that although teachers receive a large number of in-service training and continued education in varied topics, some of which are required, very few represented mental health training. This lack of training in mental disorders, particularly depression, can have long term consequences for a child. With this in mind, it is hoped the findings will serve as a catalyst for incorporating more in-service training in the mental health field for elementary school teachers.

The demographics illustrate that the majority of the respondents were Caucasian women, between the ages of 26 through 30, with zero to four years of teaching experience.
In regards to their level of education, the percentages fell evenly between undergraduate and graduate education. These findings may indicate that younger teachers possibly have received better training within their curriculum which assisted them in accurately identifying children with symptoms of depression. Therefore, this study was unable to reject the null hypothesis because no clear relationship was found between the years of experience and teachers' ability to detect depression. Of course, several reasons may account for this. First of all, teachers may have possessed above average skills. Secondly, the majority of the sample consisted of fairly recent graduates who might have received advanced training during the course of their education. Finally, the researchers were directed to schools with principals that were sensitive to the research process as well as to mental health issues, thereby, possibly skewing the results of this study.

Our findings show teachers received numerous in-service training in varied topics. These included drug and alcohol dependence, learning psychology, conduct disorders, child abuse prevention and reporting, HIV training,
attention deficit hyperactivity disorder, learning disabilities, abnormal psychology, developmental psychology, and child psychology. However, out of 37 teachers, no one had completed a psychopathology course or any type of in-service training in this arena. This suggests the need for added training in this area because psychopathology addresses the identification of mental disorders including childhood depression.

The in-service training choices were collapsed into four categories: Social which represented 33% of the responses and included HIV training, drug and alcohol dependence and child abuse prevention and reporting. Learning which represented 31% of the responses and included learning disabilities, learning psychology, and child psychology. Behavioral which represented 18% of the responses included conduct disorders, attention deficit hyperactivity disorder and Depression which represented 17% of the responses and included psychopathology, abnormal psychology, and developmental psychology.

Our findings indicated the in-service categories to which teachers responded most frequently were Social and Learning.
Interestingly, these findings coincide with this particular school district’s yearly goals which are reading, HIV education, and sexual harassment education according to the director of pupil personnel. The depression in-service category which received the lowest response was consistent with Maag and Forness (1991) in that school personnel play an important role in the identification, assessment, and treatment of depression, but have limited training regarding this disorder and the impact it has on children.

The findings of this study showed that teachers responded greater to externalized behaviors as opposed to internalized behaviors. This was compatible with Mash and Barkley (1996) in that depression in children is often overlooked because what catches the attention of adults is usually externalized behavior, thus, leaving the child with internalized symptoms undetected or lacking assessment. Nevertheless, Vitaro, Tremblay, and Gagnon (1995) suggest that teachers’ management styles determine whether they focus more on externalized behaviors as opposed to internalized behaviors.

Surprisingly, the findings demonstrated a significant
relationship between teachers who responded to the behavioral category of in-service training with those who responded to observation of internalized behaviors. This suggests that when teachers received supplementary training, albeit in an area unrelated to depression, they became better equipped at recognizing other behavioral or emotional problems. Additionally, a near significant relationship was found between teachers who responded to the behavioral category of in-service training with those who responded to observation of learning difficulties. Again, these findings confirm what Maag and Forness (1991) and Werthamer-Larsson (1994) have suggested, that teachers with greater training play an important role in detecting children with mental health problems.

Our findings reveal the referral sources most frequently used by teachers were the school psychologist, the school principal, and parents. Although it’s very important for parents to be aware of their child’s problem, if parents lack knowledge about the adequate resources, the child may go without appropriate help. For this reason social workers, who are trained to access a variety of
community services, would be an asset in the school setting. In contrast, the referral sources with the lowest responses were social worker, and community resources. This may be partly due to the lack of social workers on school sites, and the teacher's reliance on the Student Study Team (SST). This team is located on the school site and may include the teacher, principal, counselor, parent, and student. Its function is to determine an action plan to help solve problems.

In general, due to the limitations of the randomization selection process, the limited sample size, and the instrument used, the results may not be generalizable to the widespread population. It should be noted that two things could be done to improve the instrument utilized for this study. First of all, more specific questions could be asked in regards to any signs or symptoms of depression exhibited by children. Secondly, teachers would be asked to specifically identify the resources, both within the school and in the community, which they would utilize in order to help their students with depression. Additional research
should explore how teachers can receive further training regarding mental health issues.

Implications

According to Maag and Forness (1991) school counselors have been considered to be better at detecting depression in children than teachers. However, California presently does not have mandated professional school counseling services in elementary schools and is pursuing a bill called “Comprehensive Professional School Counseling Act” which hopes to provide such services as was noted in the pamphlet of the California Association of Counselor Educators and Supervisors-California School Counselor Association Task Force Update. Although this bill has not been passed, its ideology is promising, for it proposes to offer services to children in need of counseling who otherwise might not receive such services. By doing so, the long term effects of depression such as suicide may be avoided. The social work policy implications of this bill would be for social workers to be included in this bill since they are qualified to provide counseling, but additionally can provide comprehensive services.
Another consideration to having a qualified professional in the school system, would be to have social workers who are trained to identify and treat depression. In addition to their clinical diagnostic skills, social workers are trained to look at the person in environment and to intervene by developing strategies which can assist the client and his or her family. Social workers are also trained to access community resources thereby providing a broad range of services and interventions which best meet the client's needs. Furthermore, through the various roles of a social worker, such as broker, advocate, teacher, counselor, case manager, etc, families can be linked with the appropriate services.

Lastly, practice implications suggest that social workers can serve as a liaison between teachers, students, and parents through participation in the Student Study Team (SST). As a consultant to school personnel, social workers can provide in-service training on a variety of topics to both teachers and the community, particularly on those related to social and emotional problems.
Due to the limited availability of literature regarding detection of childhood depression by teachers, the implications for future research is the need for further study in this subject matter.

Table 1: Demographic Characteristics of the Sample

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Table 2: Level of Experience Factors

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Table 3: Type of Training

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Table 4: In-Service Training for Bachelors and Masters Level Participants

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<td>24 (9)</td>
<td>30 (11)</td>
<td>8 (3)</td>
</tr>
</tbody>
</table>
### Table 5: Referral Sources Used by Bachelors and Masters Level Participants

<table>
<thead>
<tr>
<th>Referral Sources</th>
<th>Bachelors (%)</th>
<th>Bachelors (n)</th>
<th>Masters (%)</th>
<th>Masters (n)</th>
<th>No Response (%)</th>
<th>No Response (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Principal</td>
<td>24</td>
<td>9</td>
<td>14</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Psychologist</td>
<td>38</td>
<td>14</td>
<td>32</td>
<td>12</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Parent</td>
<td>27</td>
<td>8</td>
<td>18</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Nurse</td>
<td>16</td>
<td>6</td>
<td>19</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>School Social Worker</td>
<td>5</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Community Resource</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>5</td>
<td>19</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 6: Observed Emotional or Social Problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>(%)</th>
<th>(n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Exposed</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Aggressive Behavior</td>
<td>22</td>
<td>8</td>
</tr>
<tr>
<td>Disruptive Behavior</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>ADHD/ADA</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>Abused or neglected</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Emotionally Neglected</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Mood Swings</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Fearfulness</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>No Response</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Behavior</td>
<td>(%)</td>
<td>(n)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Impulsiveness</td>
<td>38</td>
<td>14</td>
</tr>
<tr>
<td>Poor Social Skills</td>
<td>41</td>
<td>15</td>
</tr>
<tr>
<td>Self-Criticism</td>
<td>19</td>
<td>7</td>
</tr>
<tr>
<td>Isolation</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>Learning Difficulties</td>
<td>81</td>
<td>30</td>
</tr>
<tr>
<td>Cursing</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Inflicting Self-harm</td>
<td>49</td>
<td>18</td>
</tr>
<tr>
<td>Excessive Fear</td>
<td>27</td>
<td>10</td>
</tr>
<tr>
<td>Eating Too Much</td>
<td>100</td>
<td>37</td>
</tr>
<tr>
<td>Irritability</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Mood Swings</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Getting Off Task</td>
<td>57</td>
<td>21</td>
</tr>
<tr>
<td>Developmental Delays</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>Fighting</td>
<td>49</td>
<td>18</td>
</tr>
<tr>
<td>Limited Social Interactions</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>Poor Concentration</td>
<td>49</td>
<td>18</td>
</tr>
<tr>
<td>Low Self-Esteem</td>
<td>46</td>
<td>17</td>
</tr>
<tr>
<td>Disruptiveness</td>
<td>73</td>
<td>27</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>38</td>
<td>14</td>
</tr>
<tr>
<td>Poor Hygiene</td>
<td>49</td>
<td>18</td>
</tr>
<tr>
<td>Eating Too Little</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Poor Attention Span</td>
<td>78</td>
<td>29</td>
</tr>
<tr>
<td>Sleeping in Class</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
December 8, 1997

Palm Springs Unified School District
333 South Farrell Drive
Palm Springs, CA 92262
(760) 416-8000

Dear Dr. Borba:

We are Master of Social Work students at California State University, San Bernardino, and are conducting a research project. We are active members of this community and are interested in children's issues. Our interest in children's issues grew out of our participation in a play therapy class. Currently, we are both working with children in our internship placements; Riverside County Department of Mental Health and Riverside County Department of Child Protective Services.

We are interested in learning how well teachers recognize symptoms of depression in children as well as their knowledge about the resources and referral process for these children. In order to obtain a random sampling, we are interested in selecting two teachers from each grade level, first through fifth, in each elementary school from the Palm Springs Unified School District for a total of ten teachers from each school.

Our study intends to evaluate teachers' level of experience, number of years teaching, age, gender, the number of training sessions attended related to childhood disorders, and the grade level being taught in order to determine if recognition of depression is present given these variables.

The information gathered may serve as a benefit to teachers and social workers by including the prospect of prevention of future problems of elementary school-age children, opportunities for in-service training of teachers.
regarding symptoms of depression in children, available resources, and the referral process. In addition, it is hoped that the development of a collaborative relationship between teachers and social workers in agencies providing mental health services will be fostered.

Questionnaires will be the instrument used to collect the data. The completed questionnaires will not require the participants to disclose their names in order to ensure anonymity.

A rough draft of the research project is due on December 6, 1997. Shortly thereafter we are required by the Department of Social Work to obtain written confirmation from the Palm Springs Unified School District granting us permission to conduct this research. Therefore, it would be greatly appreciated if we could receive your response notifying us of your decision.

If you have any further questions, please do not hesitate to contact us at:
(760) 776-9192 Mixel Ventura
(760) 327-9736 Emelinda Figueroa

Our research advisor, Professor Lucy Cardona, may also be contacted for further information at: (909) 880-5501

Thanking you in advance for your consideration in this matter,

Mixel Ventura and Emelinda Figueroa
APPENDIX B: INFORMED CONSENT

This study is being conducted by Mixel Ventura and Emelinda Figueroa, second-year Master of Social Work students, under the supervision of Professor Lucy Cardona. This study is designed to determine how well teachers recognize childhood disorders and, consequently, refer children for the necessary services. This study has been approved by the Social Work Department’s Human Subjects Committee of California State University, San Bernardino.

The University requires that you give your consent before participating in a research study. Although your participation is voluntary, your responses would be very helpful and much appreciated. You will receive a questionnaire with some responses to be checked off and/or filled in by you. This study will involve approximately 10 minutes of your time.

Please be assured that any information you provide will be held in strict confidence by the researchers. All data will be reported in group form only. At the study's conclusion, you may receive a report of the results at your
request.

Please understand that your participation in this research is voluntary. You are free to withdraw consent and discontinue participation in the project at any time. If at any time you have questions about your participation or the study, please call Professor Lucy Cardona at (909) 880-5501.

By placing a mark in the space provided below, I acknowledge that I have been informed of, and understand, the nature and purpose of this study. I freely consent to participate. I acknowledge that I am at least 18 years of age.

Give your consent to participate by marking a check or 'X' mark here: __________

Today's date is ________________
April 7, 1998

Dear Teacher,

Several weeks ago you were given a questionnaire to fill out. Your responses are very important to us and will be very helpful to our research project. We realize that you are very busy, but we hope that you might take a few minutes out of your busy day to fill out the questionnaire. We are sending this reminder notice because we need to collect the remaining questionnaires in order to meet our project’s deadline.

Additionally, we have enclosed a second copy of the questionnaire in the event that you may have inadvertently misplaced the original copy. We will return next Friday to collect the remaining questionnaires and would appreciate if you would turn in the completed questionnaire to the secretary.

Because your participation is voluntary, if you choose not to participate, it would be helpful to us if you would please notify us by placing a check mark on the designated line below.

Thanking you in advance for your consideration to this matter.

Sincerely,

Mixel Ventura and Emelinda Figueroa

_____ I choose not to participate
APPENDIX D: DEBRIEFING STATEMENT

The study in which you have participated is designed to determine your knowledge in accurately recognizing psychological and emotional disorders, particularly depression in children and their referral, thereof. The research data will be collected from the responses you have provided in the questionnaire. All data collected will be kept confidential. You may receive the research findings by contacting Professor Lucy Cardona at (909) 880-5501. If personal issues should arise during or after completing the questionnaire, you may contact the Charter Behavioral Health System by calling (760) 321-2000 or the Riverside County Department of Mental Health at (760) 863-8455.
APPENDIX E: QUESTIONNAIRE

1. Male or Female

   46-50  51-55  56-60  61-65

3. Race/Ethnicity: African American  Caucasian  Hispanic  
   Native American  Asian  Other

4. Grade level being taught: 1st  2nd  3rd  4th  5th

5. How many years have you been teaching? 0-4 yrs  5-9 yrs  
   10-14 yrs  15-19 yrs  20-24 yrs  25+

6. Level of education:
   Credentialed  Not Credentialed  
   Bachelors  Bachelors +  Masters  
   Masters +  Doctoral  
   Other general training
   What was your major or area of concentration?

7. Indicate with a check mark the courses or in-service training you have completed:
   Psychopathology  Abnormal psychology  
   Drug and alcohol dependence  developmental psychology  
   Learning psychology  Child psychology  
   Conduct disorders  Other  
   Child abuse prevention/reporting  
   HIV training  
   Attention deficit hyperactivity disorder  
   Learning disabilities

8. Indicate with a check mark the behaviors you commonly see in the classroom which might lead you to refer a child for help?
   Poor attention-span  Disruptiveness  
   Getting off task  Withdrawn  
   Impulsiveness  Poor concentration  
   Poor social skills  Low self-esteem  
   Self-criticism  Fighting  
   Isolation  Limited social interactions
Learning difficulties ____
Cursing ____
Inflicting self-harm ____
Sleeping in class ____
Poor hygiene ____
Excessive fear ____
Eating too little ____

Developmental delays ____
Irritability ____
Mood Swings ____
Eating too much ____
Other: ____________________
_________________________
_________________________

9. Please check where you normally refer children for help:
   School principal ____
   School psychologist ____
   Parent ____
   Other ____________________
   _______________________
   _______________________

   School nurse ____
   School social worker ____
   Community resource ____

10. Check the reasons for which you would refer a child to the school psychologist/counselor:
    Behavior problems ____
    Social skills problems ____
    Self-esteem problems ____
    Isolating behaviors ____
    Mood Swings ____
    Withdrawn ____
    Poor academic achievement ____
    Fighting ____
    Appearance of neglect ____
    Truancy ____
    Learning difficulties ____
    Appearing troubled or sad ____
    Fearful ____
    Irritable ____
    Anger ____
    Hyperactive ____
    Family problems ____
    Inappropriate conduct ____
    Social immaturity ____
    Other ____________________
    _______________________

11. List the reasons for which you would refer a child to the school nurse:
    Cold/flu symptoms ____
    Dental problems ____
    Frequent headaches ____
    Appearance of abuse ____
    Attention problems ____
    Sad ____
    Inability to cope ____
    Self-harmful behaviors ____
    Sleeping in class ____
    Low self-esteem ____
    Appearance of hunger ____
    Lice &/or lice checks ____
    Appearance of neglect ____
    Poor hygiene ____
    Withdrawn ____
    Problems in the home ____
    Truancy ____
    Other ____________________
    _______________________

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12. When you have a child with a social or emotional problem, what strategies do you use before referring the child for mental health services?

13. Can you name any social or emotional problems you have observed in children you have had in your classroom?

14. At what age do you think depression is first exhibited in children?

15. How many depressed children do you see in class in any given school year?
   - 5 or more students per year ______
   - 2 to 5 students per year ______
   - Less than 1 student per year ______
BIBLIOGRAPHY


