

Depression in School-Aged Children: Implications for School Counselors

by

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A dissertation submitted to the Graduate Faculty
of Auburn University
in partial fulfillment of the
requirements for the Degree of
Doctor of Philosophy

Auburn, Alabama
August 3, 2013

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Abstract

Depression is a serious, debilitating and often overlooked illness among children and adolescents (Carr, 2008; Herman et al., 2009; Stark, 1990; Zalaquett & Sanders, 2010). Despite the overarching negative consequences associated with an early diagnosis of depression and the increased implementation of school based mental health services, it is questionable whether school counselors are prepared to adequately identify depression in children and adolescents (Abrams & Karen, 2005; Carr, 2008; Cash, 2003; Lewinsohn & Clarke, 1999; Zalaquett & Sanders, 2010). This study seeks to examine school counselors' ability to identify both external and internal characteristics of depression, as well as examine school counselors' beliefs related to training and preparation received from their counselor education programs of study in this same area. A third purpose of this study is to examine school counselors' perceived competency as it relates to assessing, identifying, and intervening with students who are possibly experiencing depressive symptoms. Finally, this study will seek to understand the relationship between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children.

Acknowledgments

I want to begin by acknowledging my Lord and Savior, Jesus Christ. Through Him, all things are possible. He blessed me with a mother who exudes strength, determination and a strong work ethic; I am thankful that she instilled all of these qualities in me. Thank you to my partner in life and love for your support and patience, as well as for taking over all the countless nights of homework and preparing dinner for Caleb when I was too tired. Thank you to my extended family for the encouragement and for taking care of the men in my life while I pushed towards the finish line. I am surrounded by greatness and beyond blessed to have such an amazing family. I cannot begin to express the gratitude that I feel for your loving support and encouragement; without it this academic milestone would not have been possible. For those of you, who I did not mention by name, please know that your support and encouragement has not gone unnoticed.

It is also important that I take the time to acknowledge those who were pivotal in the completion of my doctoral program. I want to begin by expressing gratitude to my major professor and committee chair, Dr. Chippewa Thomas for her guidance and encouragement throughout my dissertation process. Thank you for seeing the light at the end of the tunnel before I did. I would also like to express my sincerest gratitude to my committee members, all of which brought their own special expertise to the process: Dr. Jamie Carney for your unwavering assistance and support throughout my studies; Dr. David Shannon who has gone above and beyond, providing invaluable guidance and support during the data analysis process; and Dr.

Suhyun Suh for your feedback during this process. Next, I would like to express my appreciation to Dr. Thomas Smith, who was the outside reader for my research study. I am thankful for your suggestions, which strengthened and provided depth to my research. I am also thankful for your confidence in my abilities as a clinician, as well as a future educator; without your constant encouragement, this journey would not have begun.

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CHAPTER I. INTRODUCTION

School counselors are fundamental to the educational system in that they facilitate maximum opportunities to learn. The American School Counselor Association National Model (ASCA, 2005) specifically states that school counselors are to make an effort to “help students focus on academic, personal/social and career development so they achieve success in school and are prepared to lead fulfilling lives as responsible members of society.” This expectation of school counselors is important, as they are often the first to respond to problematic behaviors via referrals from other school faculty and administrators, as well as students (Abrams & Karen, 2005). As such, they are responsible for the emotional, social and academic development of all students (ASCA, 2004). This responsibility often places them in a pivotal position where having the ability to recognize and assist in resolving issues are paramount.

In an effort to meet the social and emotional needs of each student, a large percentage of these services are provided via school-based mental health (SBMH) services (Committee on School Health, 2004). Rones and Hoagwood (2000) defined SBMH services as any program or intervention delivered within the school setting with a purpose of influencing students’ emotional, behavioral or social functioning. SBMH services have become increasingly important as events involving incidents in the education setting are broadcast. Schools are continuing to reach out to community mental health centers for assistance in managing disruptive behaviors, residual effects of behaviors, and to assist in the prevention of such behavior. This trend of disruptive behaviors and media broadcast has been evolving over the past 30 years,

leading to an increase in emotional and social difficulties for children and adolescents. In fact, 5–8% of children and adolescents report experiencing depressive symptoms (Zalaquett & Sanders, 2010). Of critical concern is the increase in suicide and attempted suicide among children and adolescents ages 10–19. According to National Alliance on Mental Illness (NAMI), over 2 million adolescents attempt suicide every year. This fact makes the task of identifying precursors as well as providing adequate SBMH services, such as depression prevention and intervention, vital.

The responsibility of accurately identifying childhood depression can be a daunting task for school counselors. Accurate identification of depression requires sufficient knowledge of the Diagnostic and Statistical Manual, 4th Ed., Text Revision (DSM IV-TR, 2000) criteria for depression. A key factor in inadequate identification and diagnosing of depression in children and adolescents by school counselors may be deficiencies in training related to the DSM IV-TR. Additionally, the current standards for the Council for Accreditation of Counseling and Related Educational Programs (CACREP) do not require school counselors to have direct training in or intimate knowledge of the various mental disorders (<http://www.cacrep.org>). Another significant factor is the variance of depressive symptoms across age groups and developmental stages in children and adolescents (Tisher, 2007). Professional School Counselors must be knowledgeable of the social and emotional development of students at varying ages and its role in the presentation of behaviors.

Statement of the Problem

The school environment is designed to cater to learning and academic growth; however, in order for all children to receive the maximum opportunities to learn, the school must first take responsibility of addressing issues that may hinder the emotional development of students. One

clinical issue that is very serious and often overlooked is depression (Carr, 2008; Herman, Reinke, Parkin, Traylor, & Agarwal, 2009; Stark, 1990; Zalaquett & Sanders, 2010). Depression is a psychological disorder that has a great effect on the emotional development of children (Carr, 2008; Fergusson & Woodard, 2002; Herman et al., 2009; Lebrun, 2007; Zalaquett & Sanders, 2010). As such, it imposes a threat to the social, emotional and academic success of the student (Herman et al., 2009; Reynolds, 1990). ASCA (2012) states in the school counselor competencies that professional school counselors should be able to articulate and demonstrate an understanding of the following: the continuum of mental health services, including prevention and intervention strategies to enhance student success (I-A-9) and an ability to provide counseling for students during times of transition, separation, heightened stress and critical change (III-B-3e).

One would argue the necessity of having knowledge of precursors and symptoms of social, emotional or behavior disorders before being able to provide appropriate and adequate prevention or intervention strategies. However, the 2009 CACREP Standards do not currently require school counselors to have direct training in or intimate knowledge of the various mental disorders (<http://www.cacrep.org>). Surprisingly, this has occurred while the typical school environment has changed vastly, causing the school counselor to shift roles and accept more responsibility for the health and well-being of students (Committee on School Health, 2004; Paisley & Borders, 1995). Therefore, there is actually a greater need for school counselors to be able to identify depression and precursory behaviors to depression, among students.

Nevertheless, there are indications that school counselors may be inadequately prepared to meet this challenge and children may not be receiving the appropriate services needed to foster a

healthy and positive growth development (Abrams & Karen, 2005; Carr, 2008; Cash, 2003; Lewinsohn & Clarke, 1999; Zalaquett & Sanders, 2010).

Significance of the Study

This research is significant for a variety of reasons. Depression has been linked to suicidal behavior in children and adolescents (Bossarte & Swahn, 2011; Carr, 2008; Greening, et al., 2008; Lin, et al., 2008; McCarthy, Downes & Sherman, 2008). NAMI (2009) reports that the increase in childhood suicide due to depression is fast becoming the leading cause of death among children ages 10–19. Over 2 million adolescents attempt suicide every year (NAMI, 2009). Secondly, it's even more disconcerting to know that school officials have a history of inaccurately viewing the symptoms of depression as defiance, and associating the symptoms with a behavior disorder (Cash, 2003; Lewinsohn & Clarke, 1999). Finally, research shows that depression can cause a wide variety of psychological and physical symptoms (Chrisman, Egger, Compton, Curry & Goldston, 2006; Lebrun, 2007; Reynolds, 1990).

It is imperative that school counselors receive the necessary training to be able to accurately evaluate the behavior of children and determine if the child is actually experiencing symptoms of depression, rather than behavioral issues. It is also vital for school counselors and teachers to be able to recognize internalizing behaviors such as social withdrawal, and academic withdrawal, as well as externalizing behaviors such as defiance, truancy, delinquency, disruptive behaviors, and lack of motivation as potential symptoms of depression (Evans, Veslor & Schumacher, 2002; Lin et al., 2008). Additional training related to recognizing internalized, as well as externalized behaviors as potential signs of depression could prevent students who are experiencing depressive symptoms being referred to the counselor's office to receive help managing anger or following the rules. While the research indicates that students are mostly

receiving services for externalized behaviors, counselors should also consider the possibility of internalized disorders when evaluating externalized behaviors. This practice would increase the potential for children to receive the appropriate services, as well as improve academic performance and overall quality of life.

Purpose of the Study

In the past, school counselors have been responsible for vocation and educational decision making; more recently the focus has changed to include personal growth and developmental programs (Dahir, 2004; Paisley & Borders, 1995). This transformation supports the fact that school counselors are now being held more accountable for the well-being of all students; this change in focus is partly due to the changing climate and challenges of the school environment (Committee on School Health, 2004). In the Professional Practice Standards related to school counselors, Section C.1.(Knowledge) of the CACREP Standards states that school counselors should know the theories and processes of effective counseling and wellness programs for individual students and groups of students; Section D. 2. (Skills and Practice) states that school counselors will provide individual and group counseling and classroom guidance to promote the academic, career, and personal/social development of students; and Section D. 4. states that school counselors will demonstrate the ability to use procedures for assessing and managing suicide risk (CACREP, 2009). These standards indicate that school counselors who graduated from a CACREP-accredited program are adequately prepared to promote the academic, career, and personal/social development of all K–12 students (CACREP, 2009). The purpose(s) of this study was to examine school counselors' ability to identify both external and internal characteristics of depression, as well as school counselors' beliefs related to training and preparation received from their counselor education programs of study in this same area. A third

purpose of this study was to examine school counselors' perceived competency related to assessing, identifying, intervening and referring students who are possibly experiencing depressive symptoms. Finally, this study sought to understand the relationship between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children.

Research Questions:

1. What is the knowledge level of school counselors as it relates to the assessment, identification and intervention of depression among school-aged children?
2. What are school counselors' perceptions of training related to the assessment, identification and intervention for depression among school-aged children?
3. Do school counselors who graduated from a CACREP Accredited Program have more knowledge related to the assessment, identification and intervention of childhood depression than school counselors who did not graduate from a CACREP Accredited Program?
4. What are school counselors' perceptions of their knowledge related to assessing, identifying, and intervening with students who are possibly experiencing depression?
5. Are there differences between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children?

Definition of Terms

Adolescent: for the purposes of this study, adolescents refer to anyone in the age range of 12–17 years of age.

American Psychiatric Society (APA): National professional organization for psychiatrists or persons in the process of becoming psychiatrists. APA publishes the DSM.

American School Counselor Association (ASCA): National professional organization for school counselors.

Children: for the purposes of this study, the term ‘children’ refers to anyone in the age range of 6–12 years of age.

Council for Accreditation of Counseling and Related Educational Programs (CACREP): an independent agency recognized by the Council for Higher Education Accreditation to accredit graduate-level counseling programs offered by institutions throughout the United States and some international programs.

Depression: a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for 2 weeks or longer (DSM IV, TR).

Diagnostic and Statistical Manual, 4th edition, Text Revision (DSM IV-TR): The DSM codifies psychiatric conditions and is used worldwide as a key guide for diagnosing disorders.

Externalizing Behaviors: a broad class of problematic behaviors that are directed to persons and/or things (disruptive or acting out behaviors such as physical and verbal aggression, defiance, etc.)

Internalizing Behaviors: a broad class of behaviors in which children direct feelings and emotions inward (cutting, negative eating habits, substance abuse, etc.).

National Alliance on Mental Illness (NAMI): NAMI is the nation’s largest grassroots mental health organization, advocating for access to services, treatment, supports and research for people affected by mental illness.

Perceived Competency of School Counselors: School counselors' perception of their ability to correctly identify and provide services for students who may be experiencing depressive symptoms.

School Based Mental Health Services (SBMH): services provided within the school setting that are designed to prevent, and treat and intervene with students who are having social, emotional and developmental issues that affects academic performance, as well as overall quality of life.

School Counselor: A professional with a master's degree in school counseling and the required state issued certificate or license.

CHAPTER II. REVIEW OF LITERATURE

Introduction

Prior to 1970, clinicians questioned whether children were capable of experiencing depression (Tisher, 2007). It was thought that children lacked the mature cognitive structure needed to experience depression (Malhotra & Das, 2007; Son & Kirchner, 2000). In 1970, the Fourth Congress of the Union of Pedito-psychiatrists brought attention to the potential for children to experience symptoms of depression that were comparable to the standard criteria of DSM at the time (Son & Kirchner, 2000). This recognition caused researchers to further explore this phenomenon, and as a result the body of evidence confirming that children could experience depression began to grow. In 1980, the American Psychiatric Association (APA) began to acknowledge childhood depression as a disorder; and included it for the first time in the DSM III (Evans et al., 2002; Tisher, 2007). Even with recognition by the APA, child and adolescent depression continues to be “a silent crisis in our schools and communities” (Lebrun, 2007). This crisis is reflected in the increase of suicide attempts and completions for children and adolescents (The American Academy of Pediatrics, 2008), as well as the influx of children and adolescents being prescribed anti-depressants (Dopheide, 2006).

Relevance

Depression in children and adolescents is a serious and debilitating issue that is often overlooked (Carr, 2008; Herman et al., 2009; Stark, 1990; Zalaquett & Sanders, 2010). It has the potential to cause problems with social, emotional and behavioral functioning (Carr, 2008;

Fergusson & Woodard, 2002; Herman et al., 2009; Lebrun, 2007; Zalaquett & Sanders, 2010). The aforementioned problems can lead to a host of difficulties for the youth, such as poor school performance, substance abuse and dependence, other mental health problems, prevention of the development of normal peer relationships, as well as places the youth at risk for engaging in suicidal behaviors (Auger, 2005; Carr, 2008; Ferguson & Woodard, 2002; Herman et al., 2009; Lebrun, 2007; Stark, 1990; Vail, 2005). The American Academy of Pediatrics (2008) reported that suicide is the 3rd leading cause of death among children and adolescents, just behind accidents and violence. Despite these facts, depression in children and adolescents continues to be under-researched (Auger, 2000; Lebrun, 2007; Stark, 1990), untreated and unrecognized (Lebrun, 2007; Stark, 1990; Zalaquett & Sanders, 2010). As if to echo this observation, Pfeiffer and Reddy (1998) reported that only 3% of students in need of mental health treatment actually received the services needed. This is distressing since more recent data indicates that depression in school-aged children is increasing. For example, in 2009 the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that over 2 million adolescents were diagnosed with depression the previous year.

When depression in children and adolescents is left untreated, there are long-term negative consequences that may continue to persist into adulthood (Allen-Meares, Colarossi, Oyserman & DeRoos, 2003; Auger, 2005; Fergusson & Woodard, 2002; Herman et al., 2007). These consequences have the potential to be far reaching, affecting both social and academic aspects of the child's environment, as well as their ability to form strong bonds (Vail, 2005). Difficulties with untreated depression may also contribute to issues such as unemployment and early parenthood (Stark, 1990). Additionally, untreated depression is also associated with additional psychiatric disorders and has also been linked to an increased risk of attempted and

completed suicide (Fergusson & Woodward, 2002). The data related to suicide rates for adolescents is also troubling; it is reported that just over 2 million adolescents attempt suicide every year (NAMI, 2009). In order for these children to become productive, contributing members of society, it is imperative that mental health professionals (school, community and private) enhance their ability to identify and treat child and adolescent depression.

Prevalence

Although literature indicates that the number of children and adolescents being diagnosed with depression is steadily increasing, it is difficult to ascertain an unwavering amount of occurrences in this age group (Lebrun, 2007). Accurate identification of depression amongst this age group affects the number of occurrences that are reported (Lebrun, 2007; Zalaquett & Sanders, 2010). Factors such as socio-economic background, race, education, gender and population must also be considered when looking at the rate of depression in children and adolescents (Allen-Meares et al., 2003; Lebrun, 2007). Zalaquett and Sanders (2010) reports that prevalence in depressive symptomology increases with age and tends to increase even more around puberty. In 2009, the data from the National Survey on Drug Use and Health (NSDUH) indicates that females (11.9%) tend to be diagnosed with depression more frequently than males (4.6%). There also appears to be a link between depression and other mental disorders. About 40-70% of children and adolescents diagnosed with depression also suffer from other diagnosable mental illnesses (Birmaher, Williamson, Brent, & Kaufman, 1996; Costello, Egger & Angold, 2005). Twenty percent of these children and adolescents have two or more diagnosable mental illnesses (Birmaher et al., 1996; Costello et al., 2005).

The aforementioned research provides a rationale for the wide variance in prevalence rates for child and adolescent depression. Research data indicates that the prevalence of

depression in children ranges from 1-5%, while prevalence in adolescents ranges from 5-8%. According to Vail (2005) and Dubuque (1998) one out of thirty-three children and one out of eight adolescents suffer from depression. Geroski, Rodgers, and Breen (1997) report that depression affects 8% of the adolescent population and 2% of the younger population; Zalaquett and Sanders (2010) report similar findings of 5–8% rate of depressive symptoms experienced by adolescents, while Costello et al. (2005) report depressive symptoms at a rate of 1–8% among adolescents ages 12–17.

Identifying the Symptoms of Depression

Depressive symptomology amongst children, adolescents and adults is exhibited differently in all three populations (Dubuque, 1998). The DSM IV, TR provides a diagnostic criterion that is typical for adults. Surprisingly, it does not make much allowance for differentiating between descriptors of depression within these populations (Allen-Meares, 1987; Carr, 2008; McCann, Lubman & Clark, 2012). In fact, there are only two annotations within the diagnostic criteria that specifically references children and adolescents. More specifically, the annotations reference an irritable mood and failure to make expected weight gains in children and adolescents (DSM IV, TR). Clinicians who utilize the DSM III manual as the only resource for identifying childhood or adolescent depression could potentially have difficulty adequately identifying depressive symptoms in these populations, causing a variance in prevalence rates of depression for children and adolescents (Allen-Meares, 1987).

Depressive Symptoms in Adults

Depression in childhood or adolescence has been linked to a diagnosis of depression in adults (Harrington, et al., 1994). As with children and adolescents, depression in adults can be debilitating and cause a wide variety of psychological and physical problems (Brent & Birmaher,

2002; McCarthy et al., 2008). Individuals experiencing depressive symptoms may experience both internal or and external symptoms. External symptoms are considered observable behaviors or signs, while internal symptoms or signs are not as easily observed. According to the National Institute of Mental Health (NIMH, 2012), the most common symptom in adults is persistent sadness. Other symptoms may be described as diminished interest or pleasure in almost all activities, a significant disturbance in weight (weight gain or weight loss), insomnia or hypersomnia, psychomotor agitation, loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to concentrate and/or recurrent thoughts of death (DSM, IV TR; Luby, et al., 2009; NIMH, 2012).

Depressive Symptoms in Children

Obtaining a clear diagnosis of childhood depression can be a complex task, as typical behaviors may change or vary from one childhood developmental stage to the next (Birmaher et al., 1996a; Zalaquett & Sanders, 2012). Factors such as developmental stages may cause difficulty determining if the presenting behaviors are a result of developmental milestones (Tisher, 2007), or if the child warrants a diagnosis of depression. For example, prior to puberty children may demonstrate more somatic complaints and psychomotor agitation, as well as separation anxiety and phobias, as opposed to defiance or delinquency (McCarthy et al., 2008). The child's current developmental stage may also determine how depressive symptoms are exhibited. For example, research indicates that adolescents who are experiencing depressive symptoms may display aggression or suffer from eating disorders (Geroski et al., 1997); while pre-school children become socially withdrawn or throw temper tantrums (Luby, et al., 2002)

Early warning signs of depression in pre-school-age children may include externalized behaviors such as temper tantrums and excessive crying, physical complaints or loss of interest in

activities (Allen-Meares, 1987; Luby et al., 2002; Ramsey, 1994). Examples of internalized behaviors in pre-school children are brief periods of sadness, social withdrawal or guilt (Gartstein & Bateman, 2008; Luby et al., 2002; Vail, 2005). Parents or caregivers may also notice externalized behaviors such as lethargy, eating problems, or constant displays of anger (Gartstein & Bateman, 2008; Luby et al., 2002; Vail, 2005). Adding to the layers of ambiguity, it should be noted that pre-school-age children are in the process of developing a stable concept of self (Smith & Handler, 2007). Therefore additional internalized symptoms in this age group may also manifest as shame or embarrassment (Luby et al., 2009). It is imperative that the appropriate services are rendered, or the child is put at risk for experiencing internalizing problems later in life (Gartstein & Bateman, 2008).

Early warning signs in school-age children are quite different from pre-school-age children. Early warning symptoms may include refusal to attend school, lack of interpersonal relationships, poor self-efficacy, etc. (Herman et al., 2009). The typical somatic symptoms may include morbid thoughts, listlessness, sadness, fatigue, irritability, difficulty concentrating, frequent headaches or stomach aches (Brent & Birmaher, 2002; DSM IV-TR, 2000; Vail, 2005). Furthermore, symptoms of depression in school-aged children may be masked by externalized behavioral issues such as conduct disorders, hyperactivity, and school refusal (Allen-Meares, 1987; Chrisman et al., 2006; Fuller, 1992; Lin et al., 2008). Additional internalized symptoms may present as emotional problems, consistent periods of sadness, separation anxiety, and suicidal ideations (Allen-Meares, 1987; Chrisman et al., 2006; Fuller, 1992; Lin et al., 2008). As mentioned earlier, it is not uncommon for children who suffer from depression to receive complaints about their behavior. Behavior complaints may include unexplained anger or behaviors that are linked to Attention Deficit Hyperactivity Disorder (ADHD) (Brent &

Birmaher, 2002; McCann et al., 2012). Untreated symptoms of depression in school-aged children have the potential to be quite substantial, affecting both social and academic aspects of the child's environment, as well as their ability to form strong bonds (Vail, 2005).

Depressive Symptoms in Adolescents

According to Allen-Meares (1987), adolescents may exhibit depressive symptoms similar to the symptoms of adults, as well as, symptoms that are unique to pre-school and school-aged children. More often than not, there are a diverse set of behaviors or early warning symptoms in adolescents who are suffering from depression; these behaviors become quite noticeable when the child enters middle school (Harvard Mental Health Letter, 2002). As adolescents progress towards teenage years, symptoms of depression, if left untreated, may continue to evolve into other maladaptive behaviors, as well as manifest during adult years (Carr, 2008; Ferguson & Woodard, 2002). Geroski et al. (1997) described manifestations of depression in adolescents as externalized behaviors such as aggression, sexual promiscuity, defiance, delinquency and substance abuse, as well as, physical ailments such as anorexia or other psychosomatic illnesses. Adolescents may also exhibit internalized behaviors such as indecisiveness, low self-esteem, pessimism, irritability, anhedonia, hopelessness, helplessness, hypersomnia and suicidal ideations (Carr, 2008; Chrisman et al., 2006; Farmer, 2003; Ramsey, 1994; Seagull & Weinshank, 1984). In addition, it should be known that these children are also hypersensitive to criticism and are usually uncommunicative (HMHL, 2002). It is critical that school counselors realize that these symptoms are not just "childhood growing pains" or developmental milestones, but that these behaviors may indicate a serious clinical issue. It is essential to remember that while depression in adults is frequently easy to diagnose, variance in developmental stages of children and adolescents causes it to be more difficult to diagnose depression in these age groups. These

differences are critical when attempting to identify symptoms of depression in children and adolescents.

Outcomes Associated with Significant Levels of Depression

While there has been abundance of research focused on outcomes of children of depressed mothers, research outcomes for children who are depressed is still developing. Similar to adults, there is evidence that childhood and adolescent depression has the ability to affect all facets of life (Fergusson & Woodard, 2002). The outcomes associated with childhood and adolescent depression can vary, dependent upon factors such as treatment, age of on-set, socio-economic background, gender, etc. (Lebrun, 2007; Ferguson & Woodard, 2002). While all these factors influence outcomes, the most researched areas of outcomes are associated with school performance. Depression in children and adolescents has consistently been linked to negative school-related outcomes such as academic, social and behavioral difficulties (Allen-Meares, 1987; Carr, 2008; Ferguson & Woodard, 2002; Herman et al., 2009). There is also research indicating that childhood and adolescent depression is associated with negative outcomes outside of the school environment and these outcomes have a tendency to persist into adulthood (Fergusson & Woodard, 2002; Herman et al., 2009).

It is vital to remember that although children and adolescents are challenged with similar functional impairments, adolescents experience these impairments slightly different than children (Allen-Meares, 1987; Dopheide, 2006; Stark, 1990). These variations are due to a difference in social and emotional development stages for each group (Fergusson & Woodard, 2002). Given the high frequency of the diagnosis of depression amongst children and adolescents, as well as other mental disorders that are associated with this diagnosis, it is important to understand the

impact that such problems can have on overall functioning (Ferguson & Woodard, 2002; Lebrun, 2007).

Academic Concerns

Research indicates that emotional and behavioral problems in youth are linked to a lack of academic success (Herman et al., 2009; Lebrun, 2007; Merrell, 2008; Nelson, Benner, Lane & Smith, 2004). More specifically, depression in children is associated with low academic achievement, lack of persistence in the face of academic challenges, decreased classroom participation, and truancy (Ferguson & Woodard, 2002; Herman et al., 2009; Lebrun, 2007; Merrell, 2008; Nelson et al., 2004). In a study completed by Seagull and Weinshank (1984), childhood depression was found to be associated with low academic achievement in a group of seventh-graders. Additionally, the lack of energy and motivation, as well as difficulty concentrating that is associated with severe depression may discourage youth from attending school or completing assignments (Allen-Meares, 1987; Herman et al., 2009; Lin et al., 2008). As such, when students are not participating in class or remains absent from instruction, they miss valuable opportunities to learn the academic material, leading to poor grades and decreased self-esteem (Lin et al., 2008; Seagull & Weinshank, 1984). Poor grades and decreased self-esteem has the potential to be instrumental in continuing the cycle of depression, resulting in school refusal and eventually dropout (Lee & Miltenberger, 1996; Van Ameringen et al., 2003). It is important to note that symptoms and/or outcomes of depression are not only associated with current academic difficulties, but negative outcomes also persist during postsecondary education (Ferguson & Woodard, 2002). Youth who experienced an early onset of depression are likely to experience academic difficulties when enrolled in post high school education (Fergusson & Woodward, 2002; McCarthy et al., 2008).

Social

Children and adolescents who experience an early on-set of depression typically have diminished self-concept and self-esteem, as well as and poor social competence (Fergusson & Woodard, 2002; Lin et al., 2008; Merrell, 2008). Lack of social competence and social withdrawal causes difficulty with peer relationships (Fergusson & Woodard, 2002; Lin et al., 2008; Zalaquett & Sanders, 2010). As such, Vail (2005) observed that adolescents who are depressed tend to have difficulty forming strong bonds with peers and participating in social situations. Social withdrawal may also lead to the loss of friendships or the inability to form positive peer relationships, while placing the youth at a risk of getting involved in deviant or abusive future relationships (Fergusson & Woodard, 2002).

Behavioral

There are several studies that suggest that an early on-set of depression in children and adolescents is associated with risk taking or dangerous behaviors. These behaviors may include reckless driving, vandalism, breaking the rules at school, sexual promiscuity (Kosunen, Kaltiala-Heino, Rimpela & Laippala, 2003; Wilson, Asbridge, Kisley & Langille, 2010) or otherwise getting in trouble with the law (Pesa, Cowdery, Westerfield & Wang, 1997). There is also research to support an increase in substance abuse among these populations. Research suggests that self-medicating through substance abuse may begin as early as 13 years of age (Bossarte & Swahn, 2011; Centers for Disease Control and Prevention [CDC], 2009; Pesa et al., 1997). In fact, a study completed by Bossarte and Swahn (2011) focused on the relationship between the use of alcohol and suicide attempts among adolescents. The study found significant correlations between age of first use of alcohol and suicide attempts in adolescents who have a history of

major depression. Further, Ferguson and Woodard (2002) noted that when childhood depression continues into adolescence, there is a higher incidence of suicidal behavior and early parenthood.

More recent studies have begun to link relational aggression and depressive symptoms such as low self-esteem and loneliness. For example, Fite, Stoppelbein, Grenning and Preddy (2011) conducted a study to examine the association between relational aggression, depression and suicidal ideation in a child clinical population. The results of the study indicated that there was a strong correlation between relational aggression, depression and suicidal ideations. The National Institute of Mental Health (NIMH, 2007) reports that suicide is the 3rd leading cause of death in children and adolescents; this indicates that suicide due to depression is fast becoming the leading cause of death in children ages 10 to 19. Since over 2 million adolescents attempt suicide every year (NAMI, 2009); it would be beneficial to gain a better understanding of these three variables (relational aggression, depression and suicide).

Comorbidity

There is an increased potential for youth who experienced an early onset of depression or a depressive episode to be plagued with recurrent depressive episodes or co-occurring mental illnesses (Compas, Conner-Smoth & Jaser, 2004; Copeland, Shanahan, Costello, & Angold, 2009; Fergusson & Woodard, 2002; Zalaquett & Sanders, 2010). For example, research has linked conduct disorder (CD) and ADHD with an early onset of depression in children and adolescents (Bittner, et al., 2007; Copeland et al., 2009; Reynolds, 1990). Anxiety and substance abuse disorders have also been associated with depression (Bittner et al., 2007; Copeland et al., 2009; Fergusson & Woodard, 2002), as well as attempting or completing suicide later in life (Fergusson & Woodard, 2002; Merrell, 2008).

Role of the Schools

School represents a developmental milestone for children (Herman et al., 2009). In fact, school entry may be the first time a child experiences significant failure when compared to peers, potentially leading to a decrease in social and academic competence (Jimerson, Pletcher & Graydon, 2006). Additionally, children spend more than half of their waking hours in school (Auger, 2005; Evans, et al., 2002). Developmental changes, transitioning into the school environment and the pressures of academic and behavioral success permits schools to play a very strategic role in the academic, social and emotional development of children (Herman et al., 2009; Aviles, Anderson & Davila, 2006). More specifically, schools are in the position to promote or hinder academic, social and emotional development of children (Herman, et al., 2009; Grzywacz & Fugua, 2000). Positive academic and social school environments have a part in contributing to healthy emotional development of students (Cicchetti & Toth, 1998; Herman et al., 2009). Case in point, students who have positive academic and social experiences within the school environment usually have healthy relationships with peers and demonstrate traits such as positive self-esteem and positive coping skills (Herman et al., 2009; Roeser, Eccles, & Sameroof, 2000). Similarly, when problems arise in the school environment such as negative school climate, bullying, academic or social difficulties, there is also the potential for emotional difficulties (Herman et al., 2009; Roeser et al., 2000). These students may exhibit behavioral issues, social withdrawal or poor peer relationships (Aviles et al., 2006; Herman et al., 2009).

Traditionally, the primary role of schools and educators are to contribute to the academic achievement and success of students. However, schools are now challenged with addressing non-academic barriers to learning such as behavioral or emotional disorders (Herman et al., 2009; Koller & Bertel, 2006; Zalaquett & Sanders, 2012). This added responsibility of meeting

the social and emotional needs of all children, while simultaneously closing the education achievement gap (samhsa.gov, Committee on School Health, 2004; Hoagwood & Erwin, 1997) can be a very complex task with no easy solutions.

Nonetheless, schools play a significant role in the mental health well-being of students (Ringelisen, Henderson & Hoagwood, 2003); as well as addressing non-academic barriers to learning. Many school districts are confronting non-academic barriers by implementing school-based mental health services (SBMH). This refocus or addition to school priorities has led to the schools being recognized as the primary provider of mental health services for children and adolescents (Hoagwood & Erwin, 1997; Rones & Hoagwood, 2000; Committee on School Health, 2004). In fact, schools are now providing approximately 75% to 80% of psychosocial or mental health services to youth in need (Committee on School Health, 2004; Burns et al., 1995; Hoagwood & Erwin, 1997; Magg, J. & Katsiyannis, 2011; Lyon, Charlesworth-Attie, Stoep, & MacCauley, 2011). According to the results from the 2009 National Survey on Drug Use and Health (NSDUH), approximately 12% of youth surveyed reported receiving specialty mental health services (Substance Abuse and Mental Health Services Administration, 2009). All of the youth surveyed reported receiving specialty mental health services within the school setting via school support staff such as school counselors, school psychologists or school social workers (SAMHSA, 2009). This number is encouraging since Pfeiffer and Reddy (1998) reported that only 3% of students in need of specialty mental health services actually received those services.

Role of School Counselors

The American School Counselor Association (ASCA) (2009) defines the role of a school counselor as, “to help all students in the areas of academic achievement, personal/social development and career development, ensuring today's students become the productive, well-

adjusted adults of tomorrow” (<http://www.schoolcounselor.org>). The ethical standards for school counselors further states in Section A.5 further states the following:

Professional School Counselors make referrals when necessary or appropriate to outside resources for student and/or family support. Appropriate referrals may necessitate informing both parents/guardians and students of applicable resources and making proper plans for transitions with minimal interruption of services. Students retain the right to discontinue the counseling relationship at any time.

The definition and ethical standards highlight the critical role of professional school counselors in helping students resolve problems that affect academic success or cope with issues of developmental concerns. Often times, developmental concerns become behavioral difficulties or classroom disruptions (Benshoft & Poidevant, 1994). Problematic behavior within the classroom has the potential to significantly impact the academic achievement for the disruptive student, as well as the other students in the classroom. Given the potential impact on academic performance school counselors are often pressured with addressing the problematic behaviors (Adams, Benshoft & Harrington, 2007). Adding to the pressure to address problematic behaviors is the drastic increase in school violence involving children and adolescents, as well as ethical implications requiring school counselors to identify, respond to and work with students who could possibly be a danger to others (Hermann & Finn, 2002). As a result, there has been a significant focus on the role of school counselors and their ability to address or provide prevention services aimed at school violence (Bernes & Bardick, 2007).

School counselors are often the first mental health professional to work with students who are experiencing academic, social, emotional or behavioral difficulties (Abrams & Karan, 2005; Dubuque, 1998; Froeschle & Meyers, 2004; Paisley & McMahon, 2001). These student

difficulties typically consist of a wide range of social, emotional and behavioral issues (Levitt, Saka, Romanelli, & Hoagwood, 2007; SAMHSA, 2009), and are managed via SBMH services. While ASCA (2007) recognizes the expertise of school counselors in the area of discipline, as well as their role it relates to encouraging appropriate school behavior, it clarifies that the school counselor should play a collaborative, neutral role regarding conflict and discipline. A study completed by Friedrich and Suldo (2010) found that when students receive services for social, emotional and behavioral issues, a disproportionately larger number of these children are identified for behavioral issues that are related to externalized disorders. In fact, 70% of the students received services for ADHD, 42% for anger and aggression and 46% for general externalizing concerns. Externalized behaviors are described by Allen-Meares (1987) as refusing to complete assignments, continued problems with peer interactions, skipping school, withdrawal, or hyperactivity. Friedrich and Suldo (2010) further reported that only a small percentage of children are receiving services for internalized disorders such as anxiety (17%) and depression (16%). Internalized behaviors are described as withdrawal, repression, low self-esteem, and guilt (Lebrun, 2007). This data is troubling since Foster, Rollefson, Doksum, Noonan, Robinson and Teich (2005) report that approximately 10% of children and adolescents are diagnosed with a disruptive behavior disorder (e.g., ADHD, ODD, CD), while Huberty (2008) estimates that approximately 15-20% of children and adolescents have depressive or anxiety problems that require intervention.

There could be several reasons for the discrepancy in services provided for externalized and internalized disorders. The most plausible rationale is that school administrators are often pressed to address these externalizing behaviors in an effort to ensure the academic success of the student, as well as his/her peers (Vail, 2005). A second explanation is that researchers have

observed that externalized behaviors correlate with DSM IV-TR criteria for diagnoses such as ADHD, Oppositional Defiant Disorder, or Conduct Disorder (DSM-IV-TR, 2000). It is important to note that there has also been research indicating that a display of these external behaviors could also be attributed to internalized disorders such as depression (Lebrun, 2007; Vail, 2005). According to Cash (2003), school administrators and counselors erroneously identify externalizing symptoms as defiance, or a lack of motivation and respect for school or as behavior disorders (i.e. ADHD, CD, Behavior Disorder, etc.). Consequently, students who are experiencing symptoms as a result of an internalized disorder such as such as anxiety or depression often receive inappropriate treatment or are simply overlooked. Since literature indicates that the symptoms for depression can sometimes be convoluted, appearing similar to the symptoms of behavior disorders, it is questionable whether children are receiving appropriate treatment (Carr, 2008; Cash, 2003; Zalaquett & Sanders, 2010). Further, dependent upon the level of development, child and adolescent depression can vary in intensity, duration, and severity (Carr, 2008; Fergusson & Woodard, 2002; Vail, 2005).

There are several reasons for schools, school counselors in particular, to be aware and responsive to potential variations in child or adolescent depression. Students who are experiencing depressive symptoms do not normally self-refer (Evans et al., 2002) and depressive symptoms have the potential to negatively affect academic performance (Carr, 2008; Herman et al., 2009; Zalaquett & Sanders, 2010). The most recent trend in education is accountability and the push for higher academic performance (Barna & Brott, 2011). The 2001 No Child Left Behind Act (NCLB; U.S. Department of Education, 2001) holds all educators, including school counselors, accountable for the academic performance and healthy development of students. This movement towards accountability has increased the importance of school counselors' articulation

of their role and worth as a school counselor (Dahir, 2000; Gysbers, 2001). In its vision statement, ASCA (2012) also underscores the responsibility of school counselors to promote academic achievement through the use of data. In theory, school counselors are held accountable for contributing to students' academic achievement by means of promoting the personal and social development of students (DiPerna & Elliot, 2002). An additional reason for school counselors to be aware of potential variations of behaviors in children who are depressed is the research findings indicating a higher incidence of co- morbidity amongst students who have an early on-set of depression (Allen-Meares et al., 2003; Fergusson & Woodard, 2002). For example, child and adolescent depression has been linked to emotional and behavioral problems (e.g., anxiety, conduct disorder, eating disorders, substance abuse), as well as a higher incidence of suicide (Fergusson & Woodard, 2002; Herman et al., 2009; Reynolds, 1990). The identification and treatment of depression are dependent upon the counselor's ability to recognize both typical and atypical depressive symptoms in students. Unfortunately, there is a paucity of research examining school counselors' knowledge about depression. Likewise, there is a paucity of research exploring the competency of school counselors as it relates to identifying, assessing or treating child and adolescent depression.

Professional Standards

Professional standards dictate professional practices of counseling professionals. There are a variety of expectations for school counselors in respect to professional standards. ACA, CACREP and ASCA will be discussed. While all of the counseling organizations to be discussed promote the professional competence and enhancement of the counseling profession, the role of each organization is different. This section will review the focus of each organization

with respect to school counselors' preparation and training related to the identification and treatment of child and adolescent depression.

American Counseling Association (ACA)

While ACA promotes the growth and enhancement of the counseling profession, this organization was also instrumental in identifying ethical standards for the counseling profession. The ethical standards provide a foundation for acceptable and ethical practices for all professionals within the counseling profession. The standards described in the ACA Code of Ethics are more global; therefore, one might say that ACA acts as the governing council to all counseling professionals. As reflected on its website, ACA's stated goal is to promote public confidence and trust in the counseling profession so that professionals can further assist their clients and students in dealing with the challenges life presents. The following sections of the ACA Code of Ethics address counseling practice:

- Section C discusses professional responsibility and practicing within boundaries of one's professional competence;
- Section E identifies the ethical guidelines for evaluation, assessment and interpretation of assessment instruments; and
- Section E2 addresses the competence to use and interpret said instruments.

American School Counselor Association (ASCA)

ASCA, the guiding body for school counselors helps to facilitate school counselors' decision-making, as well as helps to standardize professional practice within the school counseling practice (Retrieved from <http://www.schoolcounselor.org/content.asp?contentid=240>). The focus of ASCA centers on student outcomes, student success and accountability or adherence to a standardized counseling model. ASCA states in the School Counselor

Competencies (2012) that professional school counselors should be able to articulate and understand and demonstrate the following via responsive services such as individual or group counseling, consultation with parents, teachers or other educators, psycho-education and through the use of referrals:

- the continuum of mental health services, including prevention and intervention strategies to enhance student success (I-A-9);
- provides responsive services ((III-B-3);
- complies resources to utilize with students, staff and families to effectively address issues through responsive services (III-B-3c);
- understands appropriate individual and small-group counseling theories such as rational emotive behavior therapy, cognitive behavior therapy, Adlerian, solution-focused brief counseling, person centered counseling and family systems (III-B-3d); and
- the ability to provide counseling for students during times of transition, separation, heightened stress and critical change (III-B-3e).

Council for Accreditation of Counseling & Related Educational Programs (CACREP)

CACREP is recognized by ACA as the accrediting agency for counseling education programs (Retrieved from <http://www.counseling.org/students/graduateprograms/TP/home/CT2.aspx>). The primary focus of CACREP is the promotion of professional competence via the curriculum and standards that drive counselor education programs. In pursuit of professional competence, CACREP provides a corresponding set of standards for each counseling related field. The 2009 CACREP Standards for School Counseling state that school counselor preparation and training requires school counselors to:

- Understand the potential impact of crises, emergencies and disasters on students, educators and schools, and know the skills needed for crisis intervention (Section C6);
- Provide individual and group counseling to promote the academic, career and personal/social development of students (Section D2);
- Demonstrate the ability to use procedures for assessing and managing suicide risk (Section D4);
- Understand the influence of multiple factors (e.g. abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression) that may affect the personal, social and academic functioning of students; and
- Select appropriate assessment strategies that can be used to evaluate a student's academic, career and personal/social development (Section H2).

The professional standards of ACA, ASCA and CACREP all share and support similar visions for the counseling profession. While CACREP supports the vision(s) of ACA and ASCA, there also appears to be a discrepancy between the CACREP standards and the identified curriculum in the area of school counseling. More specifically, the sections that address the school counselors' ability to engage students and promote personal/social development are not seamlessly streamlined. For example, all three organizations indicate that school counselors should possess the ability to use theory, understand the continuum of mental health services, provide responsive services of personal/social development, understand the influence of factors such as eating disorders or childhood depression and select appropriate assessments. In respects to identifying childhood depression or other psychopathology, the standards and the identified curriculum become quite convoluted. Although CACREP requires that school counselors have

some understanding of the influence of multiple factors (e.g. abuse, violence, eating disorders, attention deficit hyperactivity disorder, childhood depression) that may affect the personal, social and academic functioning of students, the 2009 CACREP standards do not currently require school counselors to have direct training in or intimate knowledge of the various mental disorders (<http://www.cacrep.org>). Not requiring school counselors to have thorough knowledge of various mental disorders potentially hinders the counselors' ability to provide adequate services. One would argue the necessity of having knowledge of precursors and symptoms of social, emotional or behavior disorders before being able to provide appropriate and adequate prevention or intervention strategies.

Summary and Conclusions

Depression in adolescents and children is a serious and often overlooked medical condition (Carr, 2008; Herman et al., 2009; Stark, 1990; Tisher, 2007; Zalaquett & Sanders, 2010). Twenty percent of children and adolescents experienced depressive symptoms in 2008, and that percentage is continuing to increase (Huberty, 2008; Lebrun, 2007). Difficulties experienced through childhood and adolescent depression leads to problems with emotional well-being (Carr, 2008; Fergusson & Woodard, 2002; Herman et al., 2009; Lebrun, 2007; Zalaquett & Sanders, 2010); and although it is now included in the DSM, there continues to be challenges related to identifying this disorder in children.

As mentioned previously, the 2009 CACREP standards do not require school counselors to have thorough knowledge of the DSM. Nor do school counselors gain benefit of a clinical environment, since traditional school counselor students complete their practicum and internship requirements within a regular school setting. Although the 2009 CACREP Standards requires coursework that addresses counseling, prevention and intervention services, it only requires that

school counselor have knowledge of the influences of external factors that have the potential to affect personal, social, and academic functions of the student (<http://www.cacrep.org>). These external factors are defined as abuse, violence, eating disorders, attention deficit hyperactivity disorder, and childhood depression (<http://www.cacrep.org>). While the current standards require knowledge of these factors, it does not provide provisions or suggestions for relevant coursework that will increase school counselors' ability to identify these factors from a clinical perspective.

Other than current school counselor training, the identification of depression in students can be problematic in other substantial ways. The symptoms of depression in children and adolescents vary across developmental stages (Birmaher et al., 1998; Tisher, 2007; Zalaquett & Sanders, 2012). Therefore, depending upon the developmental stage of the child, symptoms of depression can mimic the symptoms of behavior disorders such as ADHD or oppositional Defiant Disorder (Lebrun, 2007; Tisher, 2007; Vail, 2005). Another significant obstacle is that the DSMV- TR does not differentiate between depressive symptoms in adults and depressive symptoms in children (Carr, 2008; DSM IV-TR, 2000; Tisher, 2007), making the identification of depression in children and adolescents a complex task. For that reason, even for the experienced clinician, the ambiguity related to the DSM IV-TR criteria of childhood and adolescent depression makes diagnosing difficult. This ambiguity may impose an even bigger challenge for school counselors. It is reasonable to believe that the aforementioned increase of children and adolescents battling depression, as well as its far reaching consequences will require school counselors' training and preparation programs to reexamine the way in which current school counseling competencies are addressed. Perhaps requiring school counselors to be more clinically knowledgeable about depression will be examined more carefully. Likewise,

it will be of interest to see how childhood and adolescent depression is listed in the upcoming revision of the DSM.

CHAPTER III. METHODOLOGY

This chapter includes a description of the research design and methodology being used to examine school counselor's ability to identify both external and internal characteristics of depression, as well as examine school counselors' beliefs related to training and preparation received from their counselor education programs of study in this same area. A third purpose of this study was to examine school counselors' perceived competency as it relates to assessing, identifying, and intervening with students who are possibly experiencing depressive symptoms. Finally, this study sought to understand the relationship between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children. This chapter includes the research questions addressed, a description of the participants, the instrument used, data collection procedures and the method for data analysis.

Research Questions

A cross sectional survey design was utilized to answer the following research questions:

1. What is the knowledge level of school counselors as it relates to the assessment, identification and intervention of depression among school-aged children?
2. What are school counselors' perceptions of training related to the assessment, identification and intervention for depression among school-aged children?

3. Do school counselors who graduated from a CACREP-accredited program have more knowledge related to the assessment, identification and intervention of childhood depression than school counselors who did not graduate from a CACREP-accredited program?

4. What are school counselors' perceptions of their knowledge related to assessing, identifying, and intervening with students who are possibly experiencing depression?

5. Are there differences between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children?

According to Robson (2002) and Creswell (2009), the most common method to examine the relationship between variables is to employ a cross-sectional study. Therefore, the researcher has ascertained that the cross-sectional survey design will be most appropriate to examine the relationship between school counselor training and their ability to assess, identify, intervene with students who are experiencing symptoms of depression, as well as gauge school counselors' perceived competency in this same area.

Participants

The prospective participants were school counselors, recruited from the 2011–2012 membership list of the Alabama Counseling Association (N = 750), which is approximately 40% of all the school counselors in Alabama (N = 1856). An e-mail was sent to the members (via the listserv) requesting their participation in this study. Participants responded to the Depression Knowledge Inventory (DKI), which was designed by the researcher to gather information related to school counselors' identification and assessment of children ages 5–19 who exhibit depressive symptoms, examine school counselors' beliefs related to training and preparation received from their counselor education programs of study in this same area, as

well as examine school counselors' perceived competency as it relates to assessing, identifying, and intervening with students who are possibly experiencing depressive symptoms. The DKI is located in Qualtrics and a link to the survey was provided in the information letter. Based on the numbers of variables in the study it is estimated that a minimum of 105 participants was required to obtain an effect size of .80 with coefficient alpha of .05 (Cohen, 1988).

Instrumentation

Demographic Questionnaire

The demographic questionnaire was developed by the researcher to collect descriptive information about the participants. Descriptive data included ethnicity, gender, degree level, accreditation status of program of study, grade levels serviced, years of experience and type(s) of clinical experience. The descriptive data collected was utilized to describe the basic features of the data, as well as examine the variables across years of experience, type of program accreditation and population in which services are provided.

Depression Knowledge Inventory

During the literature review, there was no existing instrument found to measure school counselor's knowledge or perceptions of competency as it relates to identifying child and adolescent depression. Therefore, the researcher developed an instrument to examine the training, knowledge and perceived competency of school counselors, as it relates to the assessment, identification, intervention and referral of children and adolescents who experience depressive symptoms. The resulting instrument, the Depression Knowledge Inventory (DKI) was designed to answer the research questions proposed for this study. The DKI consists of forty-eight questions with items focused on knowledge, training and perceived competency, as it

relates to assessing, identifying, intervening and referring children and adolescents who exhibit depressive symptoms.

Section A (Knowledge of Depression) corresponds with research question number 1 and was developed utilizing literature identifying internal and external characteristics of depression (Allen-Meares, 1987; Allen-Meares, et al., 2003; Beck et al., 1996; Carr, 2008; Chrisman et al., 2006; Dopheide, 2006; Evans et al., 2002; Fergusson & Woodard, 2002; Fite et al., 2011; Gartstein & Bateman, 2008; Herman et al., 2009; Kovacs, 1992; Lebrun, 2007; Lin et al., 2008; Luby et al., 2009; McCann et al., 2012; McCarthy et al., 2008; Reynolds, 1990; Rice & Leffert, 1997; Seagull & Weinshank, 1984; Stark, 1990; Tisher, 2007; Vail, 2005; Zalaquett & Sanders, 2010). In addition, criterion for childhood depression identified in the DSM IV-TR, a review of commonly used depression scales for children and adolescents such as the Beck Depression Inventory II (BDI II; Beck, Steer & Brown, 1996) and the Children's Depression Inventory (CDI; Kovacs, 1992) was instrumental in constructing the survey. Section B (Training) of the DKI was developed by the researcher in efforts to gain a better understanding of graduate school training related to the research topic; this section corresponds to research question number 2. Section C (Competence) of the DKI was developed utilizing the School Counselor Self-Estimate Inventory (COSE; Larson, et al., 1992); this section corresponds to research question number 4.

The DKI was constructed in three sections. The sections sought data connected to training, perceived competency and knowledge related to assessment, and identification and intervention with school-aged children who are depressed. Data from Section A of the survey will allow participants to identify actual characteristics of child and adolescent depression, as well as respond to open ended questions related to professional development training and concerns related to identifying, intervening and referring children and adolescents who exhibit

depressive symptoms. Data from Sections B and C of the survey will be examined utilizing a combination of multiple choice questions, a Likert scale and open ended questions. For the Likert scale, the participants choose between the following potential responses: 1 = Strongly Disagree, 2 = Disagree, 3 = Undecided, 4 = Agree and 5 = Strongly Agree. Data from Section A of the survey allowed participants to identify actual characteristics of child and adolescent depression, as well as respond to open ended questions related to professional development training and concerns related to identifying, intervening and referring children and adolescents who exhibit depressive symptoms.

Section A: Knowledge related to identifying, assessing and treating depression in school-aged children. This section sought to examine the participants' ability to identify characteristics of depression in children and adolescents, identify the DSM-IV, TR criteria for childhood depression and types of professional development training related to the identification, assessment and treatment of child and adolescent depression. Additional items in this section are framed as open-ended questions, with the purpose of seeking to gain a better understanding of participants' protocol for referring students who exhibit depressive symptoms, as well as participants' concerns related to the identification, assessment and treatment of these students.

Section B: Training related to identifying, assessing and treating depression in school- aged children. Items in this section are focused on the types of training received during the graduate program related to the identification, assessment and treatment of children exhibiting depressive symptoms, as well as any professional development sought after graduation.

Section C: Perceptions of competency related to identifying, assessing and treating depression in school-aged children. This section sought to examine the participants' perceived

competency related to assessment, identification and intervention with school-aged children who are depressed. The items focused on the participants' perceived competency related to the identification of various categories of depression, and the use of the DSM-IV-TR, as well as instruments used to assess depression in children and adolescents. There were also items that examined the participants' perceived competency related to sufficient experience, training, and application of previously acquired knowledge related to the identification, assessment and treatment of children and adolescents who exhibit symptoms of depression.

The DKI was evaluated during the course of two pilot studies. The pilot studies consisted of four participants who were practicing school counselors. Of the four participants, three were graduates of a CACREP Accredited Program. The pilot study participants were providing services to various age groups. The pilot studies served several purposes: (1) to determine the readability and fluency of the survey questions, as well as the time commitment to completing the survey; (2) to determine the appropriateness of the survey design and determine the accuracy of the survey items as it relates to characteristics of child and adolescent depression; and (3) examine the face validity of the instrument. Due to their participation in the pilot study, they were excluded from the researcher's final study. During the pilot studies, the participants were instructed to take the survey and answer the following questions:

1. Were the instructions easily understood?
2. Were the survey questions easily understood?
3. Do any of the questions need further clarification?
4. Did the questionnaire appear to measure school counselors' training, knowledge and self-efficacy beliefs related to the assessment, identification and treatment of child and adolescent depression?

5. How long did the questionnaire take to complete?

All participants of the pilot studies agreed that the instrument was found to contain items that measures school counselors' knowledge about the identification of childhood depression, confidence in degree program, as well as perceptions of competency. Although the measure appeared to contain face validity, there was feedback that resulted in revisions. In the initial pilot, there was feedback that suggested the modification and separation of survey items (i.e. Please rate your level of knowledge in reference to the assessment and identification of depression among children and adolescents). There was also feedback recommending the addition of more items to capture more data related to the study. All four participants reported that the questionnaire took approximately 20 minutes to complete. The aforementioned feedback from the participants was used to modify the instrument. The modifications included additional questions, separation of variables into individual questions and the inclusion of open ended questions.

After making the recommended changes to the measure, it was presented to the researcher's dissertation committee for review. During the review, there were several additional recommendations. The recommended revisions are listed below:

1. The concept of self-efficacy was replaced by perceived competency
2. Depressive symptoms for pre-school children was added
3. Additional open ended questions related to training were added
4. Several questions were rearranged

Following the revisions requested by the researcher's dissertation committee, the survey was re-piloted. During the re-pilot, participants reported that the survey took between 15–25 minutes to complete. The responses from participants indicated some variance in school counselors'

knowledge of depression in school-aged children, response protocol, and the use of assessments, as well as their perceived competency in their ability to assess, identify and intervene with school-aged children who may be depressed.

Procedures

After receipt of approval from the Auburn University Institutional Review Board (see Appendix A), participants received an email recruitment letter (see Appendix B) requesting their participation in the research study. Respondents were provided with a link at the bottom of the recruitment letter that granted them access to the information letter (see Appendix C) that is stamped with IRB approval. Once accessing the information letter, participants were given the opportunity to agree to participate in the study by selecting ‘yes’ or ‘no’ at the end of the information letter. Participant who selected ‘no’ were immediately transported to the end of the survey, which contained a letter thanking them for considering participation in the study. Participant who selected ‘yes’ were instructed to select the next button. After selecting ‘next’, the participant was transported to the online survey (see Appendix F) in Qualtrics.

The email was sent to approximately 750 school counselors via the 2011–2012 membership list of the Alabama Counseling Association. Two weeks after the initial e-mail, a second e-mail was sent out on the ALCA listserv, and a final email was sent out five weeks after the initial email, in an effort to solicit maximum participation in this study (see Appendix D). No incentives or motivators were offered to participate in the research study.

Data Analysis

Qualtrics’ web-based survey software which allows for the development of surveys and collection of data was used to collect quantitative data. The participants’ e-mail addresses were not captured; therefore participants’ data will remain anonymous. The Statistical Package for the

Social Sciences (SPSS) was utilized to analyze the collected quantitative data. Quantitative data was collected from the Demographic Questionnaire, as well as the DKI and analyzed using descriptive statistics. Descriptive statistics enable researchers to organize, summarize and describe observations (Creswell, 2009). In addition to summarizing the sample's demographic characteristics, descriptive statistics (e.g. means, standard deviations, ranges), inferential statistics (multiple regression) was used to examine the relationship between program types, years of experience, knowledge base of childhood depression and perceived competence of certified school counselors.

Summary

This study was accomplished by obtaining information from practicing, professional school counselors in the state of Alabama. The participants provided anonymous data regarding: training, (2) perceived competency and (3) knowledge related to the assessment, identification and intervention of children and adolescents who exhibit symptoms of depression; as well as basic demographic information. The data was descriptive in nature and collected via the Demographic Questionnaire and the Depression Knowledge Inventory (DKI). The purpose of utilizing descriptive data is to organize, summarize and describe observations (Creswell, 2009), as well as examine the relationship between the variables identified within the survey. Qualtrics was used to collect the data; the data was then organized by questions and imported into a spreadsheet for data analysis by SPSS. Results from the study are addressed in Chapter 4.

CHAPTER IV. RESULTS

The purpose of this study was to examine school counselors' ability to identify both external and internal characteristics of depression, as well as school counselors' beliefs related to training and preparation received from their counselor education programs of study in this same area. Another purpose of this study was to examine school counselors' perceived competency related to assessing, identifying, intervening and referring students who are possibly experiencing depressive symptoms. Finally, the study sought to understand the relationship between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children.

Research Questions

This chapter will provide the results of data analyses utilized to address the five research questions:

1. What is the knowledge level of school counselors as it relates to the assessment, identification and intervention of depression among school-aged children?
2. What are school counselors' perceptions of training related to the assessment, identification and intervention for depression among school-aged children?
3. Do school counselors who graduated from a CACREP-accredited program have more knowledge related to the assessment, identification and intervention of childhood depression than school counselors who did not graduate from a CACREP-accredited program?

4. What are school counselors' perceptions of their knowledge related to assessing, identifying, and intervening with students who are possibly experiencing depression?

5. Are there differences between school counselors' program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children?

Participants

The participants in this study were practicing elementary, middle, junior high and high school counselors in the state of Alabama. The participants were identified via the 2012-2013 ALCA listserv. At the time of the study there was a total of 750 Professional School Counselors registered on the ALCA listserv. According to the Alabama State Department of Education's website, there are approximately 1,856 school counselors in Alabama. Professional School Counselors on the ALCA listserv represent approximately 40% all counselors in Alabama. Out of the 750 registered Professional School Counselors, 101 (13.47 %) visited the site (<https://auburn.qualtrics.com/ControlPanel/?T=3sXhWP>) and selected "Yes" at the end of the electronic disclosure statement (see Appendix A). After agreeing to the disclosure statement, approximately 33 participants did not complete the survey for a variety of reasons. Many participants who selected option 2 on survey question number 3 (I am a school counselor, but I am not working in a school setting) did not completed the survey. By selecting this option, the participant was automatically transferred to the end of the survey. Additionally, the primary investigator received several emails from potential participants explaining that although they received a degree in school counseling, they were no longer working in school counseling positions or had assumed administrative roles within the profession. Consequently, these 33 participants were not included in the data analysis. Sixty-nine (69) participants provided usable

data, resulting in a response rate of 9.1 percent. According to Nulty (2008), electronic surveys typically receive lower response rates than mailed surveys. Therefore, although this response rate appears rather low, this is a typical response rate for the school counseling population.

Response rates for counselors are typically 10–20 percent. For example, Bruce and Bridgeland (2012) reported a response rate of only 4.09 percent in the 2012 National Survey of School Counselors completed for the College Board Advocacy and Policy Center. Another national survey of school counselors (Larrier, et al., 2012) — School Counselor’s Perspectives of the Barriers and Facilitators Associated with their Involvement of Childhood Obesity Epidemic— reports a response rate of 8 percent. An additional study completed by Moyer, Sullivan Growcock (2012) researching perceptions of school counselors as it relates to ethical decision making when reporting risk taking behaviors reported a response rate of 14.3 percent.

The initial portion of the instrument was comprised of a demographic questionnaire, which was developed by the primary investigator. The demographic questionnaire collected information regarding ethnicity, gender, highest degree level, population grade level, and years of experience. Of the total respondents, 57 (82.6%) were female and 8 (11.59%) were male; there were 4 (5.79%) respondents that did not identify a gender. Ethnic origin was also reported. The results were: African American, 21.73% (n = 15), Caucasian, 71.01% (n = 49), Asian, 1.44% (n = 1), Hispanic, 1.44% (n = 1), and other, 1.44% (n = 1). Among the participants, the degree levels were represented: Master’s in school counseling, 69.56% (n = 48), Master’s in another field, 8.69% (n = 6), Ed. S. in school counseling, 8.69% (n = 6), and Education Administration, 1.44% (n = 1). There were a total of 8 (11.59%) who did not identify an education level. Further, the sample revealed that the average years of experience were 8.9 years and a total of

seventeen (25.4%) respondents have worked in a clinical setting. Descriptive statistics for the participants are summarized in Table 1.

Table 1

Demographic Characteristics (N = 69)

Demographic	n	%
Gender		
Male	8	11.59
Female	57	82.6
Missing Data	4	5.79
Ethnicity		
Caucasian	49	71.01
African American	15	21.73
Asian	1	1.44
Hispanic	1	1.44
Other	1	1.44
Missing Data	2	2.89
Total Years of Experience		
1–5	19	27.53
6–11	23	33.33
12–16	13	18.84
>16	14	20.28

(table continues)

Table 1 (continued)

Demographic	n	%
Highest Degree Earned		
Master's in Counseling	48	69.56
Master's in another field	6	8.69
Ed.S. in School Counseling	6	8.69
Education Administration	1	2.44
Missing Data	8	11.59
Grade Levels		
K-2	6	8.69
K-5	12	17.39
K-8	3	4.34
K-12	1	1.44
3-5	7	10.14
3-8	2	2.89
6-8	8	13.04
6-12	7	10.15
9-12	18	26.08

Reliabilities

For this study, Cronbach's alpha (α) was used to examine internal consistency and reliability for the items on the Depression Knowledge Inventory (DKI). The test revealed an overall reliability of .862, indicating a relatively high internal consistency among the items in the

instrument. Examining the individual subscales for the DKI yield coefficient alphas ranging from .774 to .951. The Knowledge subscale consisted of 16 items ($\alpha = .956$), the Training subscale consisted of 6 items ($\alpha = .774$), and the Competency subscale consisted of 17 items ($\alpha = .951$). Item total statistics are displayed in Table 2.

Table 2

Subscale Reliabilities

Scale	Mean (SD)	Number of Items	Cronbach's Alpha
Knowledge	9.125 (7.88)	16	.956
Training	2.2 (2.01)	6	.774
Competency	53.55 (12.84)	17	.951

Results

Research Question 1

Research question 1 was, “What is the knowledge level of school counselors as it relates to the assessment, identification and intervention of depression among school-aged children?” Section A of the DKI was utilized to assess the participant’s knowledge of internal and external symptoms of depression in school-aged children. Section A of the DKI also collected qualitative data related to the participant’s concerns about the assessment, identification and intervention of depression in school-aged children. Descriptive statistics were used to analyze the participant’s level of knowledge regarding the assessment, identification and intervention of depression amongst school-aged children. Each survey item was analyzed with respect to frequency and percentage of responses on each survey item, the mean and standard deviation was also calculated. This determined how often participants were able to correctly identify symptoms of

childhood depression, as well as determine basic knowledge related to assessment and intervention of depressive symptoms in school-aged children. The Knowledge Subscale consisted 17 items that examined the participants' knowledge of internal and external symptoms of depression in various child developmental ages, DSM IV-TR criteria for depression in children and basic knowledge about the rate of occurrence in these age groups. The overall mean knowledge score for the sample ($n = 68$) was 15.64 ($SD = 3.67$). This outcome indicates that the participants are generally knowledgeable concerning the symptoms of depression in school-aged children, as each participant, on average, got 15.64 of the 17 items for this subscale correct. While the results indicate that participants have sufficient knowledge of symptoms of depression in school-aged children, examination of individual items indicate difficulty differentiating between internal and external symptoms. More specifically, the average percent correct for items exclusively referencing internal or external symptoms was approximately 52.8%, with a range of 24-75%. Additionally, only 25% of participants are knowledgeable concerning instruments used to measure depression in school-aged children. Table 3 provides a list of each item within the knowledge scale, as well as the percentage of participants who answered the item correctly.

Table 3

Descriptive Statistics for Knowledge Subscale

Item	Percentage Correct
Please select the DSM IV, TR criteria for Attention Deficit Hyperactivity Disorder (ADHD)	94%
Which risk factor(s) are precursors to depression in school-aged children?	93%
Please select the DSM IV, TR criteria for an episode of depression.	93%
Which of the following statements about school-aged children is TRUE ?	92%
Which of the following statements about depression in school-aged children is TRUE ?	88%
Please select the symptoms or behaviors that are consistent with Childhood Depression AND ADHD or other behavior disorders.	85%
Which of the following statements about depression in school-aged children is FALSE ?	81%
Which of the following is NOT a common symptom of depression in preschool children?	77%
Please select the symptoms or behaviors that are considered internalized behavior in preschool children who are depressed.	75%
What are the prevalence rates for depression in school-aged children?	65%
Please select the symptoms or behaviors that are considered externalized behavior in preschool children who are depressed.	64%

(table continues)

Table 3 (continued)

Item	Percentage Correct
Please select the symptoms or behaviors that are considered internalized behavior in preschool children who are depressed.	60%
Please select the symptoms or behaviors that are considered externalized behavior in preschool children who are depressed.	51%
Which of the following statements about depression in school-aged children is TRUE ?	43%
Please select instruments/assessments that are widely used to evaluate depressive symptoms in children.	25%
Which of the following statements about symptoms of depression in preschool-aged children is FALSE ?	24%

Research Question 2

Research question 2 asked, “What are school counselors’ perceptions of training related to the assessment, identification and intervention for depression among school-aged children?” Section B of the DKI was utilized to assess participants’ perceptions of training received during their degree program related to the identification, assessment and intervention of depression in school-aged children. Descriptive statistics were used to analyze participants’ percept of training received during their graduate school program in regards to the assessment, identification and intervention for depression amongst school-aged children. Each survey item was analyzed with respect to frequency and percentage of responses on each survey item, the mean and standard deviation was also calculated. This assessed whether participants felt their degree program

provided sufficient training related to the assessment, identification and intervention of depression in school-aged children. The overall mean for the Training Subscale for the sample (n=68) was 2.62 (SD = 1.52). This outcome reveals that participants either disagreed, or were not sure if their graduate program provided training related to the assessment, identification and intervention of depression in school-aged children. Table 4 summarizes participants' perception of their graduate program training as it relates to these areas.

Table 4

Descriptive Statistics for Training Subscale

Item	n	Mean	(SD)
During graduate school, I received training focused on the identification of DSM IV, TR criteria for mental disorders.	66	3.2769	(1.46317)
During graduate school, I received training focused on the correct use and identification of DSM-IV, TR.	66	3.2424	(1.42570)
My graduate program included training focused on the use of evidenced based research findings for treating depression in school-aged children	66	3.0455	(1.38599)
After graduate school training, I sought further knowledge related to DSM-IV, TR categories of childhood depression.	66	2.6970	(1.55879)
During graduate school, I was provided with examples of rating scales/instruments commonly used to assess childhood depression.	65	2.5385	(1.42606)
My graduate school program included training focused on the use of rating scales/instruments to assess depression in school-aged children.	65	2.5232	(1.34754)
My graduate program included training focused on identifying characteristics of depression in school- aged children.	67	2.4925	(1.48092)

Research Question 3

Research question 3 asked “Do school counselors who graduated from a CACREP-accredited program have more knowledge related to the assessment, identification and intervention of childhood depression than school counselors who did not graduate from a CACREP-accredited program? Data for this particular research question was gathered from the following item on the instrument: “*Is your past or current school counseling degree program accredited by a recognized accrediting board?*” If the respondent replied with yes, they were given an opportunity to enter the name of the accrediting board. Of the total respondents, only 35 (50.72%) actually provided a response. Examples of responses included the names of educational institutions (i.e. Auburn University, Jacksonville State University, and UAB) and accrediting bodies related to education institutions (i.e. SACS and Alabama State Department of Education). Fourteen (40%) of the responses specifically identified CACREP as the accrediting board for their school counseling program. The wording of the survey item was potentially confusing; causing it to be difficult to discern whether the respondent actually graduated from a CACREP accredited school counseling program. As indicated in the research question, the primary investigator was specifically interested in the relationship between CACREP accredited programs and school counselors knowledge of identification, assessment and intervention of childhood depression. Therefore, due to the wording of the survey item, as well as the responses received, this research question was removed from the study.

Research Question 4

Research question 4 was “What are school counselors’ perceptions of their knowledge related to assessing, identifying, and intervening with students who are possibly experiencing depression?” Section C of the DKI was utilized to assess participants’ perceptions of

competence in knowledge related to the identification, assessment and intervention of depression in school-aged children. Descriptive statistics were used to analyze participants' percept of skills in regards to these same constructs. Each survey item was analyzed with respect to frequency and percentage of responses on each survey item, the mean and standard deviation was also calculated. This assessed whether participants have confidence in the assessment, identification and intervention of depression in school-aged children. The average level of confidence indicated by the respondents was 2.17 (SD = 1.78), signifying that participants did not feel competent in their abilities identify, assess, or intervene with school-aged children who are depressed. Table 5 summarizes the participants' perception of their ability to provide services to school-aged children who are depressed.

Table 5

Descriptive Statistics for Competency Subscale

Item	N	Mean	Std. Deviation
I am confident in my ability to use current evidenced based research findings to intervene effectively with school-aged children who exhibit symptoms of depression.	66	2.6061	1.70861
I am confident that I can apply previously obtained knowledge to assess for depression in school-aged children.	64	2.5313	1.73634
I am confident in my knowledge level regarding identification of Major Depression Disorder in school-aged children.	66	2.4091	1.50872
I have sufficient experience in the identification of depression in school-aged children.	65	2.3692	1.38710
I am confident that I can apply previously obtained knowledge to identify depression in school-aged children.	66	2.3030	1.82268

(table continues)

Table 5 (continued)

Item	N	Mean	Std. Deviation
I have sufficient training regarding intervention with school-aged children who are depressed.	64	2.2813	1.38551
I am confident in my ability to choose depression assessment instruments that are appropriate for the student's gender.	65	2.2769	1.78104
I am confident in my knowledge level regarding the identification of various categories of depression in school- aged children.	66	2.2424	1.61779
I have sufficient training in the identification of depression in school-aged children.	65	2.1538	1.40569
I have sufficient training in the use of assessment instruments utilized to identify school-aged children who may be depressed.	65	2.0769	1.18990
I am confident in my ability to choose depression assessment instruments that are appropriate for the student's educational level.	64	2.0625	1.54175
I am confident in my knowledge level regarding identification of Dysthymic Disorder in school-aged children.	66	2.0000	1.37001
I am confident in my ability to choose depression assessment instruments that are appropriate for the student's cultural background.	66	1.9848	1.52409
I am confident in my ability to choose depression assessment instruments that are appropriate for the student's age.	63	1.9365	1.51203
I have sufficient experience in the assessment of depression in school-aged children.	65	1.9231	1.25384
I am confident in my knowledge level regarding identification of Depression Disorder, NOS in school-aged children.	65	1.9077	1.41115
I am confident in my knowledge level regarding the use of assessment instruments for school-aged children who may be depressed.	66	1.8485	1.41685

Research Question 5

Research question was, “Are there differences between school counselors’ program type, years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression among school-aged children?” The fifth research question was designed to examine the relationship between knowledge of childhood depression, years of experience and graduate school training. Of the total respondents, the average years of experience were 8.9 years. As mentioned previously, the training subscale yielded an overall mean of 2.62 (SD= 1.52), indicating that on average respondents reported that their graduate school program did not provided training on the identification, assessment and intervention of depression in school-aged children.

A multiple regression analysis was conducted to test if years of experience and graduate school training predicted participants’ knowledge level related to the assessment, identification and intervention of depression in school-aged children. Table 6 summarizes the results of the analysis. As depicted in Table 6, there is a very weak positive relationship between knowledge level and years of experience ($r = .161$), as well as a weak positive relationship between knowledge level and graduate school training ($r = .063$). The results of the regression indicate that the two predictor variables (training and experience) did not significantly predict the dependent variable (knowledge level). Actually, only 4.4% of the variance ($R = .209, R^2 = .044$) is explained by the predictor variables. Ultimately, the overall multiple correlation $F(2, 63) = 1.473, p > .05$ indicates that years of experience and graduate school training are not significantly related to school counselor’s knowledge level pertaining to the assessment, identification and intervention of depression in school-aged children.

Table 6

Multiple Regression Analysis for Knowledge, Years of Experience and Training

Variable	R	Beta	Sig.
Total Training	.063	.143	.284
Total Experience	.161	.215	.111

$R^2 = .044$ ($F_{2,63} = 1.473$, $p > .05$)

Qualitative Analysis

Qualitative data was gathered with the purpose of gaining a better understanding of participants’ knowledge of depression. This data was analyzed by reviewing all participants’ responses to identify themes and patterns related to areas such as concerns regarding the identification, assessment and intervention with students who exhibit symptoms of depression, internship experience, established protocol for referring students who are depressed and professional development training. The analysis revealed several key findings for Professional School Counselors.

Question number thirty requested information regarding participants’ established protocol for referring students who exhibit depressive symptoms. Of the total respondents, only 39.13% responded to this item. Thirteen respondents reference preliminary evaluation of the student, followed by a referral to an outside agency such as a community mental health. For example several respondents wrote, “*Contact the parents and refer the child for services at a mental health facility*”, “*Individual counseling session followed by referral to an outside agency*”, “*Contact administrator, parents and local mental health center.*” Although the responses were

limited, school counselors' who provided a response to the question appear to have an established protocol to address student depression.

Questions thirty-one through thirty-three were related to participants concerns regarding identification, assessment and intervention with children and adolescents who exhibit symptoms of depression. Of the total participants, there was a response rate of 65.2%. Several participants wrote similar statements: *"inadequate training to assess", "I haven't been trained to diagnose", the variations at which counselors would assess the depressed state", "misdiagnosis" and "I don't feel that we are trained as school counselors to assess and intervene to the extent necessary"* to describe their concerns related to identification, assessment and intervention with children and adolescents who are depressed. The common themes surrounding these particular questions suggest that school counselors do not feel as though their training has prepared them to provide services to students who are depressed.

Questions forty-five through forty-six address school counselors' concerns related to internship experiences. Of the total participants, there was a response rate of 66.6%. Although several respondents indicated that their internship experience was not sufficient, the majority of them reported an adequate internship experience. The majority of participants wrote statements such as *"It was a positive experience", "I learned a great deal from hands on situations", "the part spent with a good counselor was very useful", and "I was able to learn a lot from my supporting counselor."* The common themes surrounding concerns related to internship suggest that internships are adequate, as well as a valuable learning experience.

Summary of Findings

The current study resulted in several interesting findings. There was an expectation for graduate school training and years of experience to have significantly affected school counselor's knowledge level pertaining to the assessment, identification and intervention of depression in school-aged children. However, the results indicated that there was not a significant relationship between the independent variable (knowledge level of school counselors) and the predictor variables (years of experience and graduate school training). The implications of the study are discussed in the next chapter.

CHAPTER V. DISCUSSION

School counselors are fundamental to the educational system in that they facilitate maximum opportunities to learn. Experiencing depressive symptoms and not receiving appropriate treatment could potentially hinder the student's learning process. Consequently, according to recent literature, childhood depression is not always reported and children do not always receive the appropriate treatment (Carr, 2008; Herman, Reinke, Parkin, Traylor, & Agarwal, 2009, 2010; Miller, DuPaul, & Lutz, 2002; Stark, 1990; Zalaquett & Sanders, 2010). The ability for school counselors to assess, identify and intervene when students are experiencing symptoms of depression is central to the academic success and overall wellbeing of the student.

However, there is a paucity of research about depression with younger age groups. This includes limited research that provides information on the ability of school counselors to identify and treat depression in school-aged children. In response to the absence of research in this area, this study explored how practicing Professional School Counselors view depression in various age groups. This included their ability to identify both external and internal characteristics of depression, as well as their beliefs related to training and preparation received from their counselor education programs as it relates to childhood depression. Further, this study examined Professional School Counselors' perceived competency related to assessing, identifying, intervening and referring students who are possibly experiencing depressive symptoms. Finally, this study examined the relationship between school counselors' years of experience, training and their knowledge level pertaining to the assessment, identification and intervention of depression

among school-aged children. This was completed by examining quantitative as well as qualitative data from an electronic survey. This chapter provides a discussion of these findings, limitations of the study, potential implications and future recommendations for research.

Discussion of Findings

The first research question examined the knowledge level of school counselors as it relates to the assessment, identification and intervention of depression among school-aged children. The results indicated that Professional School Counselors have strong knowledge related to these factors. A number of possibilities exist for this finding. The average years of experience was found to be around 9 years and approximately 25.4% of the total participants reported previous clinical experience. Participants also indicated that they sought professional development activities related to childhood depression and other child disorders. The aforementioned factors are plausible explanations for the reported knowledge score of 15.64 (SD= 3.67). The results are encouraging since recent literature questions school counselors' abilities to identify depression in students (Abrams & Karen, 2005; Carr, 2008; Cash, 2003; Lewinsohn & Clarke, 1999; Zalaquett & Sanders, 2010).

The second research question examined school counselors' perceptions of training related to the assessment, identification and intervention of depression in school-aged children. The overall findings of the study indicated that Professional School Counselors did not feel their program of study provided sufficient training related to these factors. Several participants provided statements similar to the following: *"I don't feel that we are trained as school counselors to assess and intervene to the extent necessary."* Therefore, while participants have knowledge of depression in school-aged children, they do not believe they are prepared to identify, assess and intervene with students who are depressed.

The third research question intended to examine the difference in knowledge of depression for school counselors who graduated from a CACREP Accredited Program and school counselors who did not graduate from a CACREP Accredited Program. Of the total respondents, only 35 (50.72%) actually provided a response. Of the thirty-five respondents, fourteen (40%) of the responses specifically identified CACREP as the accrediting board for their school counseling program. As indicated in the research question, the primary investigator was specifically interested in the relationship between CACREP accredited programs and school counselors' knowledge of depression in school-aged children. The wording of the survey item was potentially confusing. Although this particular research question had the potential to provide preliminary insight related to coursework in school counseling programs, the lack of sufficient data needed to address this question necessitated that the research question be removed from the study.

The fourth research question examined school counselors' perceptions of their knowledge related to depression in school-aged children. Participants' perception of knowledge was consistent with their perceptions of training received during their program of study. Again, this phenomenon is consistent with the literature that suggests that school counselors are ill equipped to identify depression in school-aged children (Carr, 2008; Cash, 2003; Zalaquett & Sanders, 2010). As a matter of fact, an article discussing depression in teens suggested that school administrators and counselors erroneously identify externalizing symptoms as defiance, or a lack of motivation and respect for school or as behavior disorders (i.e. ADHD, CD, Behavior Disorder, etc.) (Cash, 2003).

The fifth research question was designed to examine the relationship between knowledge of childhood depression, years of experience and graduate school training. Results did not

support a relationship between knowledge and the predictor variables (years of experience and graduate school training).

Since there was no indication in previous literature detailing the abilities of professional school counselors as it relates to providing services to younger students who are depressed, these findings are encouraging. While these findings are encouraging, there was an unexpected discrepancy related to school counselors' knowledge of depression, graduate school training and competency as it relates to the assessment, identification and intervention of depression in school-aged children. As mentioned previously, the survey results indicated that school counselors have a strong knowledge of symptoms of depression in school-aged children. However, a large percentage of the school counselors completing the survey did not agree that their graduate school program provided sufficient training in this area, nor did they have confidence in their abilities to provide services to students experiencing depression. Many counselor expressed concern about correct identification, lack of assessments and lack of system or parental support. Furthermore, the very small correlation between knowledge, years of experience and training during degree program did not explain why school counselors do not feel confident in their abilities to provide services to these students.

Limitations

There were several limitations to this study. More specifically, there were two limitations that impact the generalizability of the study: sample size and response rate. The study was primary in that the survey was only made available to Professional School Counselors in the state of Alabama. Further, a condition of receiving the electronic survey was active enrollment on the ALCA listserv. Utilizing only Alabama Professional School Counselors in the study was advantageous in that the participants were easily accessed via the electronic survey and the

sampling procedure required little effort and time, however the utilizing the convenience sampling procedure was problematic in that it potentially introduced sample error and sample bias. Every school counselor in Alabama may not be a member of ALCA, or all ALCA members may not be active on the listserv. Additionally, the Professional School Counselors in Alabama do not necessarily represent an accurate cross-section of the school counseling population. This limitation is problematic in that it potentially skews the results of the study, causing the study to be difficult to replicate (Dillman, 2000). This inability to replicate the study also affects the ability to generalize the study results to the remaining school counseling population (Dillman, 2000).

Another significant limitation was the response rate. Although, 102 counselors accessed the survey, only 69 respondents provided usable data. Consequently, the 33 incomplete surveys were only missing responses from the knowledge scale. Although the low response rate provided indispensable insight into school counselors' knowledge level as it relates to depression in school-aged children, the lack of response rate in general, as well as the lack of response to the Knowledge Scale portion was problematic. It was problematic in the sense that school counselors' knowledge level related to the identification, assessment and intervention of depression in school-aged children was central to the study. Nevertheless, the researcher was only able to make assumptions about the lack of response to the Knowledge Subscale, as there was no data to tangible reasons for the lack of response. The lack of response rate also introduced sample error (Nulty, 2008); potentially resulting in data that is misrepresentative and misinformative of summative judgments regarding the knowledge level of school counselors as it relates to identify depression in school-aged children. Similar to the limitations with sample size, the ability to generalize or replicate the study is affected by low response rates (Dillman, 2000).

Additionally, the wording of the survey item that corresponded to Research Question number 3 presented a problem. The survey item is worded as follows: *“Is your past or current school counseling degree program accredited by a recognized accrediting board?”* The wording of the corresponding survey item was potentially confusing; leading participants to provide a variety of responses that were not related to their graduate program being accredited by CACREP. The variety of responses caused it to be difficult to discern whether the respondent actually graduated from a CACREP accredited school counseling program. Perhaps, the item should have allowed the respondent to select “CACREP”, “APA” or “Neither.” As a result, the data gathered was not sufficient enough to provide an answer to this research question. Perhaps, the item should have allowed the respondent to select “CACREP”, “APA” or “Neither.”

In addition to the previous limitations, the fact that this study was completed just prior to the publication of an updated version of the DSM is also a limitation, as it is not fully known how this will affect the diagnosis of depression in children. The American Psychiatric Association has a link that provides preliminary information on proposed updates, and the most recent update on proposed revisions indicates that there will be a category called Disruptive Mood Dysregulation Disorder (www.dsm5.org). Supposedly, this new category will assist in differentiation from Oppositional Defiant Disorder. Additionally, there is discussion of utilizing a dimensional rating that notes severity of symptoms (Patterson, 2011). This change will undoubtedly initiate questions related to how this change will either cause over-diagnosis of depression in children, or more importantly under-diagnosing in this age group.

Implications

While it is encouraging to know that school counselors within this sample were able to successfully identify the symptoms of depression in school-aged children, a closer look at the

actual response data continues to present questions related to their ability to be effective with students who are experiencing depression. Both quantitative and qualitative data indicated that school counselors feel as though their program of study did not provide the training needed to identify, assesses or intervene with students who are depressed. If school counselors are not confident in their abilities to be effective with a student, there is the potential for them to provide inappropriate interventions or no interventions at all.

Perhaps there is a need to review required coursework, as well as internship experiences for school counselors graduating from a CACREP Accredited Institution. The changes suggested are more coursework related to the identification of common childhood disorders, as well as more coursework on the use of the DSM. Additionally, the quantitative data responses indicate that participants did not always benefit from their internship experiences. Perhaps, there is a need for school counselors to be exposed to clinical experiences such as the type of experiences received by clinical mental health students.

As mentioned at the beginning of this study, school counselors are the first line of defense as it relates to providing the academic, social and emotional support for students. As such, they are the most vital practitioners in the “chain of structure” to help address emotional difficulties. The identification of these emotional difficulties, as well as appropriate intervention and referral is instrumental to student short term and long term success. It would be beneficial for the counseling profession to determine ways in which to continue to facilitate professional growth, as it relates to childhood disorders

Recommendations for Future Research

To address the initial limitations of this study, it would be advantageous to expand the population sample to counselors outside of the state of Alabama. Other ways that may increase

the response rate is to send the instrument via traditional mail, as well as electronically or utilize focus groups to gain more contextual data. Literature states several ways to increase response rates in electronic surveys: repeat reminder emails to non-respondents, ensure potential respondents that the data will be used, keep the survey brief and provide incentives in the form of prizes for respondents awarded through a lottery (Dillman, 2000; Quinn, 2002). An additional way to increase response rate would be to present preliminary data at a conference and then collect additional data during a session at the same conference. The benefits of expanding the population sample include the possible increase of sample size and response rate, which would provide the ability to generalize the study to the target population, as well as allow the study to be replicated. The ability to replicate studies is important to counseling research, as it establishes a framework from which to begin creating additional evidenced-based treatments (Sexton, 1999), as well as provides a spring board for sound program evaluation. The use of evidenced-based practices increases the effectiveness of services provided to clients (Sexton, 1999), as well as creditability with managed care companies.

Another possible path for future research is to investigate specifically the contributing factors that affect counselors' self-efficacy as it relates to identifying, assessing and intervening with students who may exhibit depressive symptoms. Furthermore, as mentioned in the previous chapter, there was an indication that although participants have sufficient knowledge of symptoms of depression in school-aged children, there was some difficulty differentiating between internal and external symptoms, as well as a lack knowledgeable about widely used depression instruments for school-aged children and knowledgeable of symptoms related to depression in pre-school children. Finally, future studies may focus on the following: differences of the manifestation of depression in pre-school children versus older children, how the changes

within the impending DSM V impact the rate of diagnosis of depression in this age group, as well as the counselors' ability to identify the new criteria for depression.

Summary

This research study was designed to explore professional school counselors' ability to identify, assess and intervene with school-aged children who are depressed. A secondary interest of this study was the relationship among knowledge levels, years of experience and graduate school training. Depression in this age group is a very important issue, particularly since literature indicates that it is overlooked (Carr, 2008; Herman, Reinke, Parkin, Traylor, & Agarwal, 2009; Stark, 1990; Zalaquett & Sanders, 2010). According to recent literature, 5-8 % of children and adolescents report experiencing depressive symptoms (Zalaquett & Sanders, 2010). Of even more concern in school-aged children is the link between suicide and a diagnosis of depression (Bossarte & Swahn, 2011; Carr, 2008; Greening et al., 2008; Harwitz & Ravizza, 2000; Vahia, Sonavane, Gandhi & Vahia, 2000).

Overall, counselors were able to identify depression in the targeted age group and they felt as though their graduate schools provided appropriate training in providing services for students who are depressed. The research findings indicated an exceedingly weak correlation among these variables, explaining only 4.4 % variance in the knowledge level of counselors who responded to the survey. Of major concern in this particular study are the results indicating that school counselors who responded to the survey are not confident in their skills to provide services to students who are depressed. Since school counselors are usually the initial contact that students will have with a mental health provider, it is paramount that counselors are confident in their abilities to provide services to students who may be depressed. Equally

important, will be the support of school systems, community agencies and medical insurance providers when providing services to these students.

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APPENDIX A

AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) PROTOCOL LETTER

**AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD for RESEARCH INVOLVING HUMAN SUBJECTS
RESEARCH PROTOCOL REVIEW FORM**

For Information or help contact THE OFFICE OF RESEARCH COMPLIANCE, 115 Ramsay Hall, Auburn University
Phone: 334-844-5966 e-mail: hsubjec@auburn.edu Web Address: <http://www.auburn.edu/research/vpr/ohs/>

Revised 03.26.11 - DO NOT STAPLE, CLIP TOGETHER ONLY.

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1. PROPOSED START DATE of STUDY: October 1, 2012

PROPOSED REVIEW CATEGORY (Check one): FULL BOARD EXPEDITED EXEMPT

2. PROJECT TITLE: Depression in School Age Children: Implications for School Counselors

3. Sherrionda Heard SERC 334-559-6632 smh0024@tigermail.auburn.edu
PRINCIPAL INVESTIGATOR TITLE DEPT PHONE AU E-MAIL
 4077 Mara Vista Drive Auburn, AL 36832 tasha.heard@opelikaschools.org
 MAILING ADDRESS FAX ALTERNATE E-MAIL

4. SOURCE OF FUNDING SUPPORT: Not Applicable Internal External Agency: _____ Pending Received

5. LIST ANY CONTRACTORS, SUB-CONTRACTORS, OTHER ENTITIES OR IRBs ASSOCIATED WITH THIS PROJECT:

N/A

6. GENERAL RESEARCH PROJECT CHARACTERISTICS

6A. Mandatory CITI Training	6B. Research Methodology								
<p>Names of key personnel who have completed CITI: Sherrionda Heard / _____ _____ _____</p> <p>CITI group completed for this study: <input checked="" type="checkbox"/> Social/Behavioral <input type="checkbox"/> Biomedical</p> <p align="center">PLEASE ATTACH TO HARD COPY ALL CITI CERTIFICATES FOR EACH KEY PERSONNEL</p>	<p>Please check all descriptors that best apply to the research methodology.</p> <p>Data Source(s): <input checked="" type="checkbox"/> New Data <input type="checkbox"/> Existing Data</p> <p>Will recorded data directly or indirectly identify participants? Yes <input checked="" type="checkbox"/> No</p> <p>Data collection will involve the use of:</p> <p>_____ Educational Tests (cognitive diagnostic, aptitude, etc.) _____ Interview / Observation _____ Physical / Physiological Measures or Specimens (see Section 6E.) <input checked="" type="checkbox"/> Surveys / Questionnaires <input checked="" type="checkbox"/> Internet / Electronic _____ Audio / Video / Photos _____ Private records or files</p>								
6C. Participant Information	6D. Risks to Participants								
<p>Please check all descriptors that apply to the participant population.</p> <p><input checked="" type="checkbox"/> Males <input checked="" type="checkbox"/> Females <input type="checkbox"/> AU students</p> <p>Vulnerable Populations</p> <p><input type="checkbox"/> Pregnant Women/Fetuses <input type="checkbox"/> Prisoners</p> <p><input type="checkbox"/> Children and/or Adolescents (under age 19 in AL)</p> <p>Persons with:</p> <p><input type="checkbox"/> Economic Disadvantages <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Educational Disadvantages <input type="checkbox"/> Intellectual Disabilities</p> <p>Do you plan to compensate your participants? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Please identify all risks that participants might encounter in this research.</p> <table border="0"> <tr> <td><input type="checkbox"/> Breach of Confidentiality*</td> <td><input type="checkbox"/> Coercion</td> </tr> <tr> <td><input type="checkbox"/> Deception</td> <td><input type="checkbox"/> Physical</td> </tr> <tr> <td><input type="checkbox"/> Psychological</td> <td><input type="checkbox"/> Social</td> </tr> <tr> <td><input checked="" type="checkbox"/> None</td> <td><input type="checkbox"/> Other:</td> </tr> </table> <p>_____</p> <p>_____</p> <p>_____</p> <p>*Note that if the investigator is using or accessing confidential or identifiable data, breach of confidentiality is always a risk.</p>	<input type="checkbox"/> Breach of Confidentiality*	<input type="checkbox"/> Coercion	<input type="checkbox"/> Deception	<input type="checkbox"/> Physical	<input type="checkbox"/> Psychological	<input type="checkbox"/> Social	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Other:
<input type="checkbox"/> Breach of Confidentiality*	<input type="checkbox"/> Coercion								
<input type="checkbox"/> Deception	<input type="checkbox"/> Physical								
<input type="checkbox"/> Psychological	<input type="checkbox"/> Social								
<input checked="" type="checkbox"/> None	<input type="checkbox"/> Other:								
<p>Do you need IBC Approval for this study? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - BUA # _____ Expiration date _____</p>									

The Auburn University Institutional Review Board has approved this document for use from 11/15/12 to 11/14/15
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DATE OF IRB REVIEW: 11/15/12 by CC	APPROVAL CATEGORY: 45CFR 46.101(b)(2)
DATE OF IRB APPROVAL: _____ by _____	INTERVAL FOR CONTINUING REVIEW: 3 years
COMMENTS: no revisions	

7. PROJECT ASSURANCES

PROJECT TITLE: Depression in School Age Children: Implications for School Counselors

A. PRINCIPAL INVESTIGATOR'S ASSURANCES

1. I certify that all information provided in this application is complete and correct.
2. I understand that, as Principal Investigator, I have ultimate responsibility for the conduct of this study, the ethical performance this project, the protection of the rights and welfare of human subjects, and strict adherence to any stipulations imposed by the Auburn University IRB.
3. I certify that all individuals involved with the conduct of this project are qualified to carry out their specified roles and responsibilities and are in compliance with Auburn University policies regarding the collection and analysis of the research data.
4. I agree to comply with all Auburn policies and procedures, as well as with all applicable federal, state, and local laws regarding the protection of human subjects, including, but not limited to the following:
 - a. Conducting the project by qualified personnel according to the approved protocol
 - b. Implementing no changes in the approved protocol or consent form without prior approval from the Office of Human Subjects Research
 - c. Obtaining the legally effective informed consent from each participant or their legally responsible representative prior to their participation in this project using only the currently approved, stamped consent form
 - d. Promptly reporting significant adverse events and/or effects to the Office of Human Subjects Research in writing within 5 working days of the occurrence.
5. If I will be unavailable to direct this research personally, I will arrange for a co-investigator to assume direct responsibility in my absence. This person has been named as co-investigator in this application, or I will advise OHSR, by letter, in advance of such arrangements.
6. I agree to conduct this study only during the period approved by the Auburn University IRB.
7. I will prepare and submit a renewal request and supply all supporting documents to the Office of Human Subjects Research before the approval period has expired if it is necessary to continue the research project beyond the time period approved by the Auburn University IRB.
8. I will prepare and submit a final report upon completion of this research project.

My signature indicates that I have read, understand and agree to conduct this research project in accordance with the assurances listed above.

Sherrionda Heard, M.Ed.

Printed name of Principal Investigator


Principal Investigator's Signature
(SIGN IN BLUE INK ONLY)

10/25/12
Date

B. FACULTY ADVISOR/SPONSOR'S ASSURANCES

1. By my signature as faculty advisor/sponsor on this research application, I certify that the student or guest investigator is knowledgeable about the regulations and policies governing research with human subjects and has sufficient training and experience to conduct this particular study in accord with the approved protocol.
2. I certify that the project will be performed by qualified personnel according to the approved protocol using conventional or experimental methodology.
3. I agree to meet with the investigator on a regular basis to monitor study progress.
4. Should problems arise during the course of the study, I agree to be available, personally, to supervise the investigator in solving them.
5. I assure that the investigator will promptly report significant adverse events and/or effects to the OHSR in writing within 5 working days of the occurrence.
6. If I will be unavailable, I will arrange for an alternate faculty sponsor to assume responsibility during my absence, and I will advise the OHSR by letter of such arrangements. If the investigator is unable to fulfill requirements for submission of renewals, modifications or the final report, I will assume that responsibility.
7. I have read the protocol submitted for this project for content, clarity, and methodology

Chippewa Thomas, Ph.D.

Printed name of Faculty Advisor / Sponsor


Signature (SIGN IN BLUE INK ONLY)

10/29/12
Date

C. DEPARTMENT HEAD'S ASSURANCE

By my signature as department head, I certify that I will cooperate with the administration in the application and enforcement of all Auburn University policies and procedures, as well as all applicable federal, state, and local laws regarding the protection and ethical treatment of human participants by researchers in my department.

Dr. Everett D. Martin, Ph.D.

Printed name of Department Head


Signature (SIGN IN BLUE INK ONLY)

11/01/12
Date

Signature Authority for Dr. E. Davis Martin, Jr.

Please select or type in the response that best describes you. Please give only one response per item.

NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT. INFORMATION LETTER for a Research Study entitled Depression in school aged children: Implications for school counselors

You are invited to participate in a research study to examine school counselors' knowledge and understanding of the characteristics of child and adolescent depression, as well as share your perceptions of training provided in your degree program. The study is being conducted by Sherrlonda Heard, a graduate student in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you are a certified school counselor in the state of Alabama and also provide services to the target population (grades K-12).

Your participation in this study is totally voluntary. If you choose to participate in this research study, you will be asked to complete an online survey that will consist of a demographic measure and one structured questionnaire. Your total time commitment will be approximately 20 minutes. There are no risks associated with participation in this study.

If you choose not to participate, simply do not respond to the email request. Once survey packets have been submitted you will be unable to withdraw from the study because survey results are not individually identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, and the Department of Special Education, Rehabilitation, and Counseling.

If you have questions about this study you may contact me at smh0024@tigermail.auburn.edu (334-559-6632), or my advisor, Dr. Chippewa Thomas at thoma07@auburn.edu.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

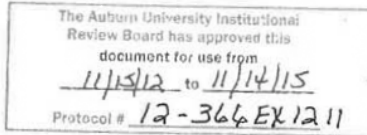
HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE SELECT "YES" BELOW. YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

Sherrlonda M. Heard M.Ed
Investigator's Signature

10/25/2012
Date

Consent: Yes indicates your willingness to voluntarily participate, and that you are of legal age in the state of Alabama.

- Yes
- No



Please add this information in sentence form.
Send us link to this document

Please select or type in the response that best describes you. Please give only one response per item.

Race/Ethnicity:

- Black/African American
- Hispanic/Latino
- Caucasian
- Asian
- Caucasian
- Other (please specify)

APPENDIX B
RECRUITMENT LETTER



DEPARTMENT OF SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

November 26, 2012

Dear Professional School Counselors:

I am a *graduate student* in the Department of Special Education, Rehabilitation, and Counseling at Auburn University, as well as a practicing school counselor. I would like to invite you to participate in my research study to examine school counselors' knowledge and understanding of the characteristics of childhood depression, as well as share your perceptions of training provided in your degree program. You were chosen as a potential participant because you are registered as a certified school counselor in the state of Alabama, and provide services to students who are in grades K-12.

If you decide to participate in the research study, you will be asked to complete an online survey. The estimated time to complete the survey is approximately 20 minutes. There are no anticipated risks associated with this study. The data will be both anonymous and confidential. However, if you become uncomfortable answering questions, you can exit your browser and discontinue participation. There will be no direct benefit or compensation for completing the survey. However, your response will be instrumental in helping to identify potential concerns for training and preparation within school counseling programs, as well give a better indication of school counselors' needs as it relates to addressing childhood depression. There is also the potential to indirectly improve the academic achievement and the overall quality of life for students and their families.

If you would like more information about this study, an information letter can be obtained by clicking on the link below. If you decide to participate after reading the information letter, you can access the survey from the letter by selecting "yes" at the bottom of the information letter to proceed.

If you have any questions, please contact me at smh0024@tigermail.auburn.edu or my advisor, Dr. Chippewa Thomas at (334) 844-2895 (thoma07@auburn.edu). Thank you in advance for your consideration,

Sherrionda Heard, M. Ed.
Doctoral Candidate–Auburn University

[PLEASE OPEN HERE TO READ INFORMATION LETTER AND ACCESS THE SURVEY](#)

APPENDIX C

EMAIL INVITATION FOR ONLINE SURVEY



DEPARTMENT OF SPECIAL EDUCATION,
REHABILITATION AND COUNSELING

NOTE: DO NOT AGREE TO PARTICIPATE UNLESS AN IRB APPROVAL STAMP WITH CURRENT DATES HAS BEEN APPLIED TO THIS DOCUMENT. INFORMATION LETTER for a Research Study entitled:

Depression in School-Aged Children: Implications for School Counselors

You are invited to participate in a research study to examine school counselors' knowledge and understanding of the characteristics of child and adolescent depression, as well as share your perceptions of training provided in your degree program. The study is being conducted by Sherrionda Heard, a graduate student in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you are a certified school counselor in the state of Alabama and also provide services to the target population (grades K-12).

Your participation in this study is totally voluntary. If you choose to participate in this research study, you will be asked to complete an online survey that will consist of a demographic measure and one structured questionnaire. Your total time commitment will be approximately 20 minutes. There are no risks associated with participation in this study.

If you choose not to participate, simply do not respond to the email request. Once survey packets have been submitted you will be unable to withdraw from the study because survey results are not individually identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, and the Department of Special Education, Rehabilitation, and Counseling.

If you have questions about this study you may contact me at smh0024@tigermail.auburn.edu (334-559-6632), or my advisor, Dr. Chippewa Thomas at thoma07@auburn.edu.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

"The Auburn University Institutional Review Board has approved this document for use from November 15, 2012 to November 14, 2015. Protocol #12-366 EX 1211."

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE SELECT "YES" BELOW. YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

Sherrionda M. Heard M.Ed.

10/25/2012

Investigator's Signature

Date

Consent: Yes indicates your willingness to voluntarily participate, and that you are of legal age in the state of Alabama.

- Yes
- No

[PLEASE OPEN HERE TO READ INFORMATION LETTER AND ACCESS THE SURVEY](#)

APPENDIX D

INITIAL REMINDER EMAIL AND THANK YOU LETTER



DEPARTMENT OF SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

December 10, 2012

Dear Professional School Counselors:

Two weeks ago, an email was sent to you asking you to visit a website and complete a questionnaire examining school counselors' knowledge and understanding of the characteristics of childhood depression, as well as share your perceptions of training provided in your degree program. You were selected to participate because you are a certified school counselor in the state of Alabama, providing services to students in grades K-12.

Your response will be instrumental in helping to identify potential concerns for training and preparation within school counseling programs. Your response will also give a better indication of school counselors' needs as it relates to addressing childhood depression. This could potentially improve academic achievement and the overall quality of life for students and their families. If you have already completed the questionnaire, please accept my thanks. If not, hopefully your schedule will allow you to do so today.

If you have any questions, please contact me at smh0024@tigermail.auburn.edu or my advisor, Dr. Chippewa Thomas at (334) 844-2895 (thoma07@auburn.edu).

Thank you in advance for your consideration,

Sherrionda Heard, M. Ed.
Doctoral Candidate–Auburn University

[PLEASE OPEN HERE TO READ INFORMATION LETTER AND ACCESS THE SURVEY](#)

APPENDIX E

SECOND REMINDER EMAIL AND THANK YOU LETTER



DEPARTMENT OF SPECIAL EDUCATION,
REHABILITATION, AND COUNSELING

December 17, 2012

Dear Professional School Counselors:

Three weeks ago, an email was sent to you asking you to visit a website and complete a questionnaire examining school counselors' ability to adequately identify the characteristics of depressive symptoms and their confidence in the training received from their counselor education programs of study. The study also aimed to examine school counselors' self-efficacy beliefs in assessing, identifying, intervening and referring students who are potentially experiencing depressive symptoms. You were selected to participate because you are a certified school counselor in the state of Alabama, providing services to students in grades K-12.

Your response will be instrumental in helping to identify potential concerns for training and preparation within school counseling programs. Your response will also give a better indication of school counselors' needs as it relates to addressing childhood depression. This could potentially improve academic achievement and the overall quality of life for students and their families. If you have already completed the questionnaire, please accept my thanks. If not, hopefully your schedule will allow you to do so today.

If you have any questions, please contact me at smh0024@tigermail.auburn.edu or my advisor, Dr. Chippewa Thomas at (334) 844-2895 (thoma07@auburn.edu).

Thank you in advance for your consideration,

Sherrionda Heard, M. Ed.
Doctoral Candidate–Auburn University

[PLEASE OPEN HERE TO READ INFORMATION LETTER AND ACCESS THE SURVEY](#)

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE AND DEPRESSION KNOWLEDGE INVENTORY

DEMOGRAPHIC QUESTIONNAIRE

Please select or type in the response that best describes you. Please give only one response per item.

1. Race/Ethnicity:

- Black/African American
- Hispanic/Latino
- Asian
- Caucasian
- Native American
- Other, Please specify _____

2. Gender:

- Female
- Male

3. My highest education level (related to school counseling) is:

- Master's degree in school counseling
- Master's degree in another field
- Doctoral degree (please specify): _____
- Other (please specify): _____

4. Is your past or current school counseling degree program accredited by a recognized accrediting board?

- Yes, Please specify _____
- No

5. Please select the grade level(s) that best describes your student population (select all that apply).
- Grades K–2
 - Grades 3–5
 - Grades 6–8
 - Grades 9–12
6. How many years have you worked as a school counselor? _____
7. How many years have you been a school counselor in the State of Alabama? _____
8. When did you complete your training as a school counselor? _____(year)
9. Have you provided clinical services in a setting other than school counseling?
- Yes, Please specify _____
 - No

DEPRESSION KNOWLEDGE INVENTORY

SECTION A — DEPRESSION KNOWLEDGE

Please select the best answer for each statement.

1. Please select the symptoms or behaviors that are considered internalized behavior in school-aged children who are depressed.
 - Feelings of sadness or guilt
 - Poor self-esteem
 - Anxiety
 - Irritable mood
 - All of the above

2. Which of the following statements about school-aged children is **TRUE**?
 - Children who are depressed only experience internalized symptoms.
 - Children with externalizing problems are referred to the school counselor more often than children with internalizing problems.
 - Only children who experience external difficulties are at high risk for school failure.
 - Children lack the mature cognitive structure needed to experience depression.

3. Please select the DSM IV, TR criteria for an episode of depression.
 - Depressed mood (feeling sad or empty)
 - Depressed mood (feeling irritable)
 - Diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
 - Diminished ability to think or concentrate, or indecisiveness, nearly every day
 - All of the above

4. Which of the following statements about depression in school-aged children is **TRUE**?
 - Childhood on-set of depression naturally diminishes over time.
 - Children with depression often exhibit co-morbid disorders.
 - Cognitive behavioral therapy is not effective with depressive symptoms.
 - Depressive symptoms in children are not likely to be recurrent.

5. Which risk factor(s) are precursors to depression in school-aged children?
- A family history of depression
 - Uncertainty regarding sexual orientation
 - Negative school experience
 - Abuse or neglect
 - All of the above
6. Which of the following is **NOT** a common symptom of depression in pre-school children?
- Sleeping/eating problems
 - Suicidal ideations
 - Inattention
 - Socially withdrawn
7. Please select the symptoms or behaviors that are considered internalized behavior in pre-school children who are depressed. (please select all that apply)
- Feelings of shame or guilt
 - Temper tantrums or anger
 - Decreased curiosity
 - Irritable mood
 - Sad facial expressions
8. Please select the DSM IV, TR criteria for Attention Deficit Hyperactivity Disorder (ADHD).
- Often has difficulty organizing tasks and activities
 - Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
 - Often does not follow through on instructions and fails to finish schoolwork, chores or duties
 - Is often forgetful in daily activities
 - All of the above
9. Please select instruments/assessments that are widely used to evaluate depressive symptoms in children. (select all that apply)
- Weinberg Depression Scale for Children and Adolescents (WDSCA)
 - Child Depression Inventory (CDI)
 - Adjustment Scales for Children and Adolescents (ASCA)
 - Beck Depression Inventory for Youth (BDI-Y)
 - Mood Disorder Questionnaire (MDQ)

10. Please select the symptoms or behaviors that are consistent with Childhood Depression **AND** ADHD or other behavior disorders.

- Lack of motivation to complete tasks
- Poor academic performance
- Easily annoyed
- Diminished cognitive abilities
- All of the above

11. Please select the symptoms or behaviors that are considered externalized behavior in school-aged children who are depressed. (please select all that apply)

- Physical illness (headaches, stomach aches, etc.)
- Social withdrawal
- Poor academic performance
- School refusal
- Impaired concentration

12. Which of the following statements about depression in school-aged children is **FALSE**?

- Depression in school-aged children is often overlooked.
- Depression does not significantly impact the student's academic capabilities.
- Children who are depressed may experience difficulties in peer relationships.
- Children who are depressed may appear irritable.

13. Please select the symptoms or behaviors that are considered externalized behavior in pre- school children who are depressed. (please select all that apply)

- Frequent crying
- Somatic complaints
- Separation Anxiety
- Lethargy

14. Which of the following statements about symptoms of depression in pre-school-aged children is **FALSE**?

- Pre-school children who are depressed often experience separation anxiety.
- Anger is a common expression of pre-school-aged depression.
- There is no empirical evidence indicating that toddlers experience depressive symptoms.
- Guilt is a common symptom of pre-school depression.

15. Which of the following statements about depression in school-aged children is **TRUE**?

- Boys are diagnosed with depression more often than girls.
- Exposure of an adolescent to a peer suicide increases the risk of being diagnosed with depression.
- 1% of school-aged children are diagnosed with depression.
- Suicide is not a risk factor for school-aged children who are depressed.

16. What are the prevalence rates for depression in school-aged children?

- Between 15% and 30%
- Less than 1%
- More than 25%
- Between 1% and 8%

17. Do you have an established protocol for referring students who exhibit symptoms of depression?

- Yes
- No
- I don't know

If yes, please describe

18. What are your concerns related to the assessment of depression among school-aged children?

19. What are your concerns related to the identification of depression among school-aged children?

20. What are your concerns related to the intervention of depression among school-aged children?

SECTION B — TRAINING DURING DEGREE PROGRAM

Please rate the following statements on a scale of 1–5.

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Undecided
- 4 = Agree
- 5 = Strongly Agree

21. My graduate program included training focused on identifying characteristics of depression in school-aged children. 1 2 3 4 5
22. My graduate program included training focused on the use of rating scales/instruments to assess depression in school-aged children. 1 2 3 4 5
23. During graduate school, I was provided with examples of rating scales/instruments commonly used to assess childhood depression. 1 2 3 4 5
24. My graduate program included training focused on the use of evidenced based research findings for treating depression in school-aged children. 1 2 3 4 5
25. During graduate school, I received training focused on the correct use and identification of DSM-IV, TR. 1 2 3 4 5
26. During graduate school, I received training focused on the identification of DSM IV, TR criteria for mental disorders. 1 2 3 4 5
27. After graduate school training, I sought further knowledge related to DSM-IV, TR categories of childhood depression. 1 2 3 4 5

Please answer the questions below.

28. What type(s) of professional development or training specifically related to identification of childhood depression or other mental health issues have you participated? (please select all that apply)
- Workshops/Conferences/Webinars
 - Graduate level courses
 - Research activities
 - Other, please specify _____

29. What type(s) of professional development or training related specifically to interventions with children who are depressed have you participated?

- Workshops/Conference/Webinars
- Graduate level courses
- Research activities
- Other, please specify _____

30. Internship is an essential component of clinical training; please describe your internship experience.

31. What experiences during your graduate school training was instrumental in your preparation as a school counselor?

SECTION C — PERCEPTIONS OF COMPETENCE

Please rate the following statements on a scale of 1-5.

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Undecided
- 4 = Agree
- 5 = Strongly Agree

32. I am confident in my knowledge level regarding the identification of various categories of depression in school-aged children. 1 2 3 4 5

33. I am confident in my knowledge level regarding identification of Major Depression Disorder in school-aged children. 1 2 3 4 5

34. I am confident in my knowledge level regarding identification of Dysthymic Disorder in school-aged children. 1 2 3 4 5

35. I am confident in my knowledge level regarding identification of Depression Disorder, NOS in school-aged children. 1 2 3 4 5
36. I am confident in my knowledge level regarding the use of assessment instruments for school-aged children who may be depressed. 1 2 3 4 5
37. I have sufficient training in the use of assessment instruments utilized to identify school-aged children who may be depressed. 1 2 3 4 5
38. I have sufficient training in the identification of depression in school-aged children. 1 2 3 4 5
39. I have sufficient training regarding intervention with school-aged children who are depressed. 1 2 3 4 5
40. I have sufficient experience in the assessment of depression in school-aged children. 1 2 3 4 5
41. I have sufficient experience in the identification of depression in school-aged children. 1 2 3 4 5
42. I am confident that I can apply previously obtained knowledge to identify depression in school-aged children. 1 2 3 4 5
43. I am confident that I can apply previously obtained knowledge to assess for depression in school-aged children. 1 2 3 4 5
44. I am confident in my ability to choose depression assessment instruments that are appropriate for the student's gender. 1 2 3 4 5
45. I am confident in my ability to choose depression assessment instruments that are appropriate for the student's age. 1 2 3 4 5
46. I am confident in my ability to choose depression assessment instruments that are appropriate for the student's educational level. 1 2 3 4 5
47. I am confident in my ability to choose depression assessment instruments that are appropriate for the student's cultural background. 1 2 3 4 5
48. I am confident in my ability to use current evidenced based research findings to intervene effectively with school-aged children who exhibit symptoms of depression. 1 2 3 4 5