THE PREVALENCE AND PROFILE OF BOYS WITH DEPRESSION WHO ATTEND SCHOOLS FOR PUPILS WITH EMOTIONAL AND BEHAVIOURAL DIFFICULTIES

A thesis submitted to the University of Manchester for the degree of Doctor of Educational Psychology in the Faculty of Humanities

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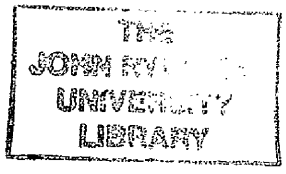

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ABSTRACT

This study aims to explore the prevalence and profile of depression in boys with Emotional and Behavioural Difficulties (EBD). It also aims to examine: (1) the pupils' knowledge of depression and what their views are with regard to the support they are currently receiving from school; (2) issues regarding support currently provided by the EBD schools and outside agencies to pupils who may have depression; (3) Headteachers views about the support they feel they need in order to support their pupils further with particular reference to depression.

Three separate methods were utilised in order to address these aims:

(i) *An Interview-Based Survey:* The Children's Depression Scale (CDS) was administered to each of the 75 participants on an individual basis. The CDS was used to examine the prevalence and profile of depression within the participants.
(ii) *A Structured Interview:* A supplementary questionnaire was administered immediately after the CDS and was used to address the participants' knowledge of depression, their views on support they were currently receiving, and whether or not they wanted to learn more about mental health issues in young people.
(iii) *An Unstructured Interview:* Three Headteachers representing each of the EBD schools were interviewed separately and given the opportunity to address the issues regarding support for their pupils.

According to the present study, depressive symptoms were found in 39 out of 75 pupils who took part (52%). However, on the basis of standardisation data for the Children's Depression Scale, this would not be considered to be a significant deviation from the population as a whole. The profile of depression was characterized predominantly by social problems. Guilt and low levels of self esteem also emerged as significant symptoms within this population.

Responses to the supplementary questionnaire showed that a large percentage of the participants knew the term 'depression' and were able to describe it as an affective disorder. Most of the participants agreed that their school supported their emotional wellbeing but would welcome further information regarding the emotional and mental health of young people.

There was strong agreement between the three Headteachers on issues regarding further training and support from outside agencies. All Headteachers agreed that depression in schoolchildren needs greater attention than it has currently and would welcome any advice and support offered to them and their staff.

The implications of this study highlight issues around training for teachers and school staff in the identification of depression in children so that early intervention can be implemented for those in need. Further resources are required if depression in children is to be identified and alleviated.

DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application of another degree or qualification of this or any other university or other institute of learning.

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This study could not have been conducted without the financial backing of the participating LEA or the co-operation of the Headteachers, staff and pupils of the three EBD schools and also the parents/carers of the 75 pupils involved in the study.

I would also like to thank Shirley and Alice for helping me interview some of the pupils who took part in the study and for sharing the work load.

I would also like to thank Peter Farrell, my supervisor, who has been particularly supportive during the planning and writing of the research, and I am indebted to him for all his help, interest and encouragement throughout my time spent on the Doctorate course.

My sincere thanks and gratitude goes to Anne for her time, patience and word processing skills over the past 4½ years and to Chris Hindley for sharing with me his computer wizardry.

I would also like to extend my sincere thanks to my mother and Lee for all their support and encouragement over the last few years.

This thesis is dedicated to John, my brother.

PREVIOUS ASSIGNMENTS

Three previous assignments were completed as part of the Degree of Doctor of Educational Psychology.

ASSIGNMENT 1: The Impact of Solution Focused Brief Therapy Training (SFBT) on the work of Educational Psychologists (EPs).

This research was concerned with EPs' knowledge of SFBT, their use of it and how effective they perceived it to be. This project was influenced by a two-day in-service training course for EPs working for four separate education authorities.

The study addressed the following questions: (1) Did the EPs use SFBT before and/or after the two-day training course? (2) How did the EPs perceive its efficacy in terms of bringing about a positive change in learning and/or behaviour?

The study utilized a self-completed questionnaire which was completed by 21 EPs following the two-day training course.

The results indicated that the two-day training course had a highly significant effect "eliciting" the EPs' use of SFBT. More EPs used SFBT after the training than had used it previously. No correlation was found to exist between an EP's length of service and episodes of use of SFBT. Similarly, there was no significant difference in EPs' use of SFBT between authorities. However, the study revealed that the training had enhanced EPs' awareness of SFBT's potential advantages and had increased the frequency of its use.

The implications of the study highlighted issues around the possible restrictions of the use of SFBT due to the expectations of EP's role. If EPs are perceived as statutory assessors, it becomes difficult to persuade schools that SFBT is a valid method of supporting a child. EPs need to inform

schools of their wider role and also the wide range of tasks EPs are able to carry out and how they can be best achieved.

ASSIGNMENT 2: The Parent/Child Game: A Single Case Study.

The Parent/Child Game involves training parents how to express warmth and approval to their child when their child's behaviour is appropriate. The parent is taught specific skills which can increase the rate of the parent's child-centred interactions whilst diminishing their child directive style. In addition, parents are taught how to give clear commands followed by Time Out for non-compliance. The aim of this approach is to improve the child's pro-social behaviour and also improve the quality of the parent-chid relationship.

This project considered the efficacy of the Parent/Child Game in:-

1. Improving the child's pro-social behaviour
2. Improving the quality of the Parent/Child relationship
3. The utility of the Parent/Child Game for the Educational Psychology Service (EPS).

For the purpose of this assignment, a single case study (boy aged 4) was selected which focused on the role and relationship between the parent and the child. It allowed a link to be shown between the treatment technique and changes in the target behaviour.

The study indicated that the Parent/Child Game improved the child's pro-social behaviour in the short-term. Long-term follow-up showed that there had been only a marginal improvement in the child's pro-social behaviour and that he was still physically aggressive towards his mother. The study highlighted an improvement in the quality of the parent-child relationship again, in the short-term. The child could be aggressive towards his mother when he did not get his own way.

The Parent/Child Game is a viable option in the work of the EPs but it has implications at a service level and at an individual level. At a service level,

the study highlights issues around training, cost of facilities and equipment, deficits in a schools-only referral system and issues pertaining to a time allocation model for schools. At an individual/personal level, it affords the EP the opportunity for more varied work other than school-based work. It also allows EPs the opportunity to apply psychological theories in their work and it provides the opportunity for EPs to be the key agents of change. For the parent and child, it can have a rapid impact on their relationship. It is activity based which makes it enjoyable for both parties, it can improve the pro-social behaviour of the child and it can have an effect on the parent's well-being. However, the setting is artificial, the parent may not be able to tolerate observation, the parent's intellectual abilities may have an impact on their ability to adopt the techniques and there can be a high attrition rate.

ASSIGNMENT 3: The Prevalence of Depression in Pupils Aged 10-15 in Mainstream Schools in Relation to Mental Health Policies.

This study explored the prevalence of depression in mainstream pupils aged 10-15 years (Year Groups 6-10). It aimed to explore whether or not the incidence of depression was greater in schools where there was no Mental Health Policy.

The study relied upon a self-completion questionnaire, namely The Children's Depression Scale (CDS) by Lang and Tisher (1983). Two hundred pupils took part in the study. They were divided into two groups N=100 per group according to whether or not they attended a school with a Mental Health Policy.

The results indicated that there was greater prevalence of depression amongst girls than boys (compared to a 'hypothetical average child') for each of the academic years studied. Having a policy or not, did not appear to be a significant factor for boys. However, for schools without a policy, the underlying tendency for girls to experience depression (70%) may even be accentuated (to perhaps 80%) by the absence of a Mental Health Policy in year groups 6 and 8.

The implication of this study highlights issues around the presence and implementation of a Mental Health Policy in all schools. It also suggests that careful monitoring or an awareness of children's depression would be a positive contribution on behalf of schools. Options for the dissemination of good practice in schools need to be developed in addition to national training initiatives to raise awareness of mental health issues within school-age children.

CHAPTER 1 INTRODUCTION

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1.1 RATIONALE

(i) Media Headings

'Anxious, depressed, suicidal – and still only a child'
(The Times. August 19, 1997)

'Call for mental-health aid in school'
(TES June 25, 1999 p.12)

'50,000 children taking antidepressants'
(The Guardian. September 20, 2003 p.1)

'Today's youth: anxious, depressed, antisocial'
(The Guardian. September 13, 2004 p.2)

Media headlines such as these, and many others, have drawn to the attention of the public the issues of depression and suicide among children and teenagers. They reflect the growing recognition nationally and internationally that a number of youngsters do indeed suffer from depression and that it can be potentially fatal.

(ii) Depression – The International Picture

In recent years, the immense burden that depression has imposed on individuals, communities and health services the world over has been recognised (Chisholm, D., Sanderson, K., Ayuso-Mateos, J.L. & Saxena, S. 2004). The Global Burden of Disease (GBD) study launched by the World Health Organization (WHO) in the 1990s was intended to provide measures that would relate information regarding disease and injury which included non-fatal health outcomes which in turn would inform global priority-setting for health research and to inform internal health policy and planning (Murray & Lopez 1996). The latest estimate from the GBD 2002 indicate that unipolar depressive disorders account for 4.5% of the Global Disease Burden which equates to 67 million Disability Adjusted Life Years (DALYs) lost in total. One DALY is considered to be one lost year of 'healthy' life and the burden of

disease as a measure of the gap between the current health of a population and an ideal situation were everyone in the population lives into old age in full health (The World Health Report 2004). Mental disorders ranked as high as cardiovascular and respiratory diseases, and these surpassed all cancers combined and HIV infections. Depressive disorders, as a single diagnostic category, were the leading cause of disability outside Africa (Ustun and Kessler 2002).

The WHO global burden of disease research predicted that by the year 2020, depression would be the second leading cause of death and disability across the world (Murray and Lopez 1996), however, this had become the case much sooner as Table 1.2 shows.

Table 1.1 (below) shows the ten leading causes of disease burden amongst men and women aged 15 years and over. Unipolar depressive disorders are the leading cause of burden for females, which reflects the higher prevalence of the disorders in women.

Table 1.1: Leading causes of disease burden (DALYs) for males and females aged 15 years and older worldwide 2002.

Males	% DALYs	Females	% DALYs
1 HIV/AIDS	7.4	***1 Unipolar depressive disorders***	***8.4***
2 Ischaemic heart disease	6.8	2 HIV/AIDS	7.2
3 Cerebrovasular disease	5.0	3 Ischaemic heart disease	5.3
4 Unipolar depressive disorders	***4.8***	4 Cerebrovascular disease	5.2
5 Road traffic injuries	4.3	5 Cataracts	3.1
6 Tuberculosis	4.2	6 Hearing loss, adult onset	2.8
7 Alcohol use disorders	3.4	7 Chronic obstructive pulmonary disease	2.7
8 Violence	3.3	8 Tuberculosis	2.6
9 Chronic obstructive pulmonary disease	3.1	9 Osteoarthritis	2.0

10 Hearing loss, adult onset	2.7	10 Diabetes mellitus	1.9

(The World Health Report 2003 p.14)

Table 1.2 shows that unipolar depressive disorders have become the second most important contributor to the burden of disease amongst adults age 15-59 years.

Table 1.2: Disease Burden – Adults aged 15-59.

Rank	Cause	DALYs (000)
1	HIV/AIDS	68 661
2	***Unipolar depressive disorders***	***57 843***
3	Tuberculosis	28 380
4	Road traffic injuries	27 264
5	Ischaemic heart disease	26 155
6	Alcohol use disorders	19 567
7	Hearing loss, adult onset	19 486
8	Violence	18 962
9	Cerebrovascular disease	18 749
10	Self-inflicted injuries	18 522

(The World Health Report 2003 p.17)

The World Health Report (2003) states that:

> 'More than 150 million people suffer from depression at any point in time; nearly 1 million commit suicide every year; and about 25 million suffer from schizophrenia, 38 million from epilepsy, and more than 90 million from an alcohol or drug use disorder.' (p.19)

The World Health Report (2003) claims that the reason why such a large proportion of individuals do not receive any health care for their condition is partly due to the mental health infrastructure and services in most countries which are grossly insufficient for the large number of people needing support and also because of the prevalent stigma and discrimination towards people with mental health disorders which prevents them from seeking help.

Andrews et al. (2000) calculated that approximately 13% of the burden of depression is currently being averted. They further calculated that only 36% of the burden could be averted using current interventions and knowledge. They conclude that 64% of the burden of major depression cannot be averted. In a later research study, Andrews (2001) stated that in population surveys, one-third of the people who met the criteria for major depression in their lifetimes reported that the first attack occurred before the age of 21. Therefore, the implications are clear. If prevention is to be effective, it must take place in young people.

(iii) Financial cost of conduct disorders

Since this study focuses on depression within the pupils who attend schools for pupils with EBD it is important to consider the cost of educating children in this setting. A study by Scott, Knapp, Henderson, & Maughan (2001) compared the cumulative costs of public services used through to adulthood by individuals with three levels of anti-social behaviour as children. The study involved 142 ten year old children living in an inner London borough. They were divided into three groups: (1) no problems; (2) conduct problems; (3) conduct disorders. The test results showed that by the age of 28, the costs for public services for individuals with conduct disorders were 10 times higher than for those with no problems and 3.5 times higher than those with conduct problems. The mean individual total costs were £70,019 for the conduct disorder group and £24,324 for the conduct problem group, compared with £7,423 for the no problem group. Crime incurred the greatest cost in all three groups followed by extra educational provision, foster and residential care and state benefits. Health costs were smaller. The authors concluded that anti-social behaviour in childhood is a major predictor of how much an individual will cost society.

The Audit Commission (1999) revealed that conduct disorders are the most common reason for referral of children and adolescents to the Mental Health

Services. Conduct disorders are also strongly associated with school exclusions (Rutter, Giller & Hagell 1998).

Taking both depression and conduct disorders into consideration, the financial burden they place on public services are enormous. On a personal level, the costs can also be huge.

(iv) A critical gap in support

A Samaritan spokesperson claimed that they received calls every day from young people regarding the pressure of exams and some of whom have felt depressed and even suicidal (Sunday Express, August 1, 2004. p.41).

The relatively recent development of Child and Adolescent Mental Health Services (CAMHS) are an indication of the necessity to support the growing number of school age children with mental health/emotional difficulties including depression. The Special Educational Needs Code of Practice (2001) states that there should be close links between educationalists and CAMHS since children with special educational needs (SEN) are much more likely to experience mental health problems which include depression than those children without SEN. The Code of Practice states,

> 'Some children and young people identified as having SEN may benefit from referral to CAMHS specialists for the assessment and treatment of mental health problems. CAMHS can also provide advice, support and consultation to family members, carers and workers from health, social care, educational and voluntary agencies.' (p.140)

Indeed, CAMHS offer an invaluable service for children, their families and schools. However, there are many children and teenagers within the Local Education Authority (LEA) already known to CAMHS or who have been referred and are awaiting appointments. Presently, the waiting list is approximately six months (within the LEA used in the study). Children are

prioritised according to the severity of their difficulties so children who are in any imminent danger would be seen very quickly. However, for most, they have to wait. For children with depression, help needs to be afforded much earlier than this. The gap between a referral to CAMHS and an appointment needs to be filled. I feel that Educational Psychologists are in an excellent position to fill this gap in support and offer their services to pupils who are / may be feeling depressed.

(v) My personal interest in childhood depression

My initial interest in the area of childhood depression began during my time employed as a primary school teacher from 1990-1996. During this time, I worked with children from 4 to 11 years of age. Most of the schools in which I worked, were in an urban setting on the outskirts of a city centre. Working closely with these children and their families, I was informed that some of them had witnessed domestic violence or had been victims of physical or emotional abuse. Some children did not live with either of their parents because their parents had drug or alcohol related behavioural problems. I wondered during one maths lesson how relevant it was to teach fractions to a group of Year 6 children knowing that a couple of them lived in appalling conditions in a one-roomed bed-sit, another pupil was in care and quite a number of them had been witness to domestic violence. I wondered whether or not they could be suffering from depression, and whether any depression which they may have been experiencing could be linked to their 'turbulent' home life.

Since becoming an Educational Psychologist (EP) I have worked closely with pupils whose behavioural difficulties have required referral to the Educational Psychology Service by their school. Following lengthy interviews and the filling in of questionnaires, it emerged that some of these pupils were indeed suffering from depression. As a result of this, I decided to further my awareness and understanding of depression in children and adolescents.

There appears to be a paucity of research in the area of depression among non-clinical patients (which will be discussed in more detail in Chapter 2). Research has been conducted in clinical settings with children and adolescents who have been diagnosed as having depression and who also have conduct disorders. Very little published research has been carried out using pupils within mainstream schools. Perhaps childhood aggression and depression which co-exist, may also exist outside clinical settings, and may be prevalent in the mainstream school population. Those pupils who have been excluded from schools due to aggressive or disruptive behaviour, may have been masking a deeper underlying reason for their behaviour, which may have been depression.

In my previous study (2003) it was found that there was a greater prevalence of depression amongst girls than boys particularly throughout Years 6 and 10. This was partially alleviated by attending a school with a mental health policy. The present study attempts to extend the applicability of the 2003 study. It is hoped that the current research will highlight an area of children's mental health, in particular depression. The study will focus on children who have been identified as having behavioural difficulties and who are attending special schools specifically for pupils with Emotional and Behavioural Difficulties (EBD).

Pupils attending EBD schools were specifically targeted for the purpose of this study since research has found a correlation between conduct disorders and depression in clinically referred children (as stated earlier). Could pupils attending EBD schools be depressed?

(vi) Research Questions

This study addresses the following key questions:

1. What is the prevalence of depression in boys aged 8-15 attending schools for pupils with emotional and behavioural difficulties?

2. What is the profile of depression (if any) in these pupils?
3. What is the pupils' knowledge of depression?
4. What are their views on the support they are currently receiving from school?
5. Would the pupils like to learn more regarding mental health issues in young people?
6. How does the support currently provided by outside agencies compare to the support which the Headteachers feel they require in order to be able to support their pupils' emotional needs?

1.2 PURPOSE AND IMPLICATIONS OF THE STUDY

To my knowledge, no previous published research of this nature has been carried out in the participating LEA or any other LEA in the UK. This research does not intend to evaluate the effectiveness of the EBD school provision in managing or changing children's behaviour. Nor is the study designed to prove a cause and effect relationship. It is hoped that the information obtained from the study will inform future assessments and intervention strategies in schools.

If it is found that children are depressed, whether they are aggressive or not, what changes and improvements can be made, and what provision can be made for them? Instead of excluding children from school for being aggressive or anti-social, it may be important to delve deeper and try to find the underlying reason for the aggressive behaviour. If the reason is emotional, it may be possible for the pupil to receive support and it may follow that the aggressive behaviour will decrease or even stop. The pupil would then be able to stay at school and continue their education in the normal fashion. In this way, help is afforded to the child in question, their peers, their family and the schools concerned.

From my visits to schools it has become very apparent over the years which schools are willing to offer pupils with EBD as much support as is needed in order to help the pupil overcome their difficulties. It is also very apparent

which schools are unable to offer such support either due to lack of knowledge and experience on the part of the teachers, or because they are reluctant to tolerate such behaviour in their classrooms. I have witnessed intolerance of disruptive behaviour in some schools I have visited. Despite giving guidance to the staff on how to support the pupils with behavioural difficulties, it has been clear from the outset that the pupil(s) has been referred to the Educational Psychology Service so that the schools can claim to have done 'everything possible' to help the pupil and now they want the child to have a Statement of Special Educational Needs. It is felt by myself and colleagues that expectations of Headteachers, teachers and parents of the EP's assessments often include the acquisition of additional resources in the form of an Education Support Assistant or the removal of the pupil from the school particularly if the child has behavioural difficulties. Since support staff are very few in number within the LEA, the pupil may not receive the amount of support they truly need in order to help them overcome the difficulties which they are experiencing. From my experience as a teacher and an EP, pupils with behavioural difficulties are considered by adults in a different way to pupils who may have emotional difficulties, i.e. those children who cry often or appear withdrawn. Whilst the latter are more likely to receive sympathy and support, children with behavioural difficulties are more likely to have their behaviour targeted and may even be excluded from their school. A recent article in The Daily Telegraph (Friday July 22, 2005, p13) reported that Ofsted had criticised schools for letting down pupils with mental health problems. The article claimed that only a small number of schools were providing adequate support for their pupils' emotional heath and well-being, but Ofsted stressed that all schools should make it a priority.

Information about the prevalence of depression in children and adolescents is essential for planning mental health care and developing strategies for intervention in schools. By registering the incidence or prevalence of depression, unruly or aggressive behaviour could be pre-empted, thereby reducing the number of pupils excluded from schools, which would crucially leave the element of depression masked. Clearly, there needs to be a

change in the way adults think and respond to pupils with behavioural difficulties.

I am hopeful that once LEAs, Headteachers and their staff recognise and accept the link between behavioural difficulties and the underlying reasons for this behaviour, the sooner it will become possible for support to be offered to the child, thereby preventing some exclusions.

Depression in pupils with EBD was specifically chosen as the phenomenon to be investigated in this study, since there is a paucity of published research in this area. In their manual, Lang and Tisher (1983) suggest that further research should be carried out using the Children's Depression Scale (CDS) with other groups of children, such as children with behaviour difficulties. Despite the apparent increase in research during the 1980's and 1990's relating to depression in children and adolescents, I have not been able to find any research which has included this population of schoolchildren. The topic under investigation was driven by a desire to: (1) understand more about the profile of depression in children; (2) explain these findings to other professionals working with children in order to enhance their knowledge and understanding of depression in young people; (3) as a result of the study it is hoped that a positive change in knowledge and support for EBD schools could make a difference to the lives of the pupils and staff within them on the basis of a better understanding of the profile of depression within the EBD population. In turn, this understanding of depression could be disseminated to staff working in mainstream schools.

The outcome of the study could also have implications for the role of EPs with specific regard to future assessments and recommended intervention strategies for schools.

1.3 OUTLINE OF THE STUDY

This thesis will aim to explore the prevalence and profile of boys with depression who attend schools for pupils with emotional and behavioural difficulties.

Following this introduction, the thesis continues with research studies which highlight depression in children and young people. Chapter 3 details various methods used to collect the data and includes a critique of those methods and instruments used. The Methodology chapter is followed by Chapter 4, which includes both the Results and Discussion of the main research questions and those pertaining to the Supplementary Questionnaire. This in turn, is followed by the final chapter, Summary and Conclusions.

CHAPTER 2 REVIEW OF LITERATURE

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2.1 INTRODUCTION

Since the relatively recent increase in research and general interest around childhood depression, numerous definitions have been suggested in order to clarify how a depressed child may feel and how depression manifests itself. This chapter will consider the development of operational definitions of such concepts as Mental Health and Childhood Disorders with particular reference to depression. It will include a list of possible symptoms of depression and its link with other childhood disorders. Thereafter, the main models of depression will be discussed along with relevant empirical studies which pertain to childhood depression. The prevalence of depression and its possible link with suicide will also be considered. Clearly, suicide may be rather easier to define than some of the other concepts under review, but to begin with, mental health and illness will be considered as umbrella terms.

2.2 WHAT IS MENTAL HEALTH OR MENTAL ILLNESS?

The World Health Organisation describe mental illness as psychological symptoms or behaviour which have clinically recognisable patterns, which cause acute or chronic ill health, personal distress or distress to others.

The DfES document Promoting Children's Mental Health Within Early Years and School Settings (2001) states that,

> 'Mental health is about maintaining a good level of personal and social functioning.' (p. iv)
>
> 'For children and young people, this means getting on with others, both peers and adults, participating in educative and other social activities, and having a positive self-esteem.' (p. iv)

Mental health professionals have defined the problems that children can experience as follows:

- emotional disorders, e.g. phobias, anxiety states and depression that may be manifested in physical symptoms;
- conduct disorders, e.g. stealing, defiance, fire-setting, aggression and anti-social behaviour;
- hyperkinetic disorders, e.g. disturbance of activity and attention;
- developmental disorders, e.g. delay in acquiring certain skills such as speech, social ability or bladder control, primarily affecting children with autism and those with pervasive development disorders;
- attachment disorders, e.g. children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major care-givers;
- eating disorders, e.g. pre-school eating problems, anorexia nervosa and bulimia nervosa;
- habit disorders, e.g. tics, sleeping problems, soiling;
- post-traumatic stress syndromes;
- somatic disorders, e.g. chronic fatigue syndrome; and
- psychotic disorders, e.g. schizophrenia, manic depressive disorder, drug-induced psychosis

(p.1-2 DfES Guidance Document (2001) – Promoting Children's Mental Health within Early Years and School Settings)

This Document therefore, has direct relevance to the work of Educational Psychologists in that, at some point in their career, some more often than others, they will be asked by schools for advice relating to behaviours which children are exhibiting and which are causing their teachers considerable concern. The underlying reason for this behaviour could be an emotional disorder such as depression. Depression could also be linked to some of the overt behaviours associated with some of the problems listed above. This will be discussed in more detail later in this chapter.

2.3 MENTAL HEALTH PROBLEMS OR EMOTIONAL AND BEHAVIOURAL DIFFICULTIES?

Medical and mental health professionals tend to use the terms 'mental health problems/difficulties' to describe children and teenagers who display disruptive, hyperactive, withdrawn/isolated or challenging behaviours. A medical practitioner is more likely to define the child as having a 'conduct disorder' whereas within the education system, such children are described as having emotional and behavioural difficulties (EBD). The ICD-10 Classification of Mental and Behavioural Disorders lists Conduct Disorders as one of the behavioural and emotional disorders which has its onset usually occurring in childhood and adolescence. It also lists Mixed Disorders of Conduct and Emotions. The Conduct Disorders and Mixed Disorders of Conduct and Emotions as specified in the ICD-10 are presented in Appendix 1.

The DfES (2001) document states much more simply that the term conduct disorders is used to describe three domains of behaviour which overlap:

1. Defiance - of the will of someone in authority.
2. Aggressiveness
3. Anti-social behaviour – that violates other people's rights, property or person.

Most children will display these behaviours at some time, but when the frequency and severity of the behaviour escalates it can have a detrimental impact on their lives. The main question which should always be asked is 'why is a child displaying such behaviour?' Is the underlying reason physical or emotional? If all behaviour is considered a means of communication, what are anti-social or aggressive children really trying to say?

The Code of Practice (COP) for Special Educational Needs (2001) gives very clear guidance for meeting the needs of children with EBD. This also

includes children with mental health problems. The COP states that evidence of significant emotional or behavioural difficulties are indicated by,

> '... recorded examples of withdrawn or disruptive behaviour; a marked and persistent inability to concentrate; signs that the child experiences considerable frustration or distress in relation to the learning difficulties; difficulties in establishing and maintaining balanced relationships with their fellow pupils or with adults; and any other evidence of a significant delay in the development of life and social skills.' (p.83)

The COP (2001) also states that children and young people who demonstrate features of emotional and behavioural difficulties 'may require help or counselling.' (p.87). By this very statement, the COP is acknowledging that an underlying reason for a child's behaviour difficulties could be emotional, and that the child needs support. This support need not necessarily be provided by health professionals (Greig 2004 a) since for most children with conduct disorders or EBD, their needs can be adequately met within their mainstream school but for others, their needs are such that additional support is needed, usually in the form of specialist EBD provision.

A Statutory Assessment under the Code of Practice for Special Educational Needs would be required in order to determine the level of support the child will require. Educationalists are in a unique position, not only to be able to identify young people experiencing difficulties with their emotional or social development, but also to provide them with support and a stable environment. I am in strong agreement with Cemeron, Gersch, M'Gadzah and Moyse (1995) who argue that Educational Psychologists are one of the few professional groups who are in regular contact with schools and are easily accessible to schools and therefore, are in an excellent position to offer support on a regular basis to school staff who may have children in their care experiencing such difficulties (Greig 2004 b).

As stated earlier, for the purpose of this study, I shall be dealing specifically with depression in young people. The next part of this chapter will consider the ICD-10 and DSM-IV classifications of depression and the symptoms associated with it.

2.4 CLASSIFICATION OF DEPRESSION

During the 1980's major advances in research into childhood and adolescent depressive disorders was noticeable. Whilst reading empirical studies relating to depression in children, it became evident to me that many references cite research conducted during the 1980's and 1990's. Kazdin (1990) says that it is only relatively recently over the last 20 years that childhood depression has been recognised as a clinical disorder. Kazdin (1990) writes that it was during the 1970's and 1980's that children's psychiatric disorders were beginning to be given greater attention. Until that time, orthodox psychoanalytic views proposed that it was after reaching adolescence, with the development of the superego, that depression emerged. Perhaps a major contributing factor to these advances in knowledge relating to depression in young people was the availability of a common approach in adults to diagnose, namely, The Diagnostic and Statistical Manual of Mental Disorders (DSM III) (American Psychiatric Association 1987). So, early classifications on the nature of childhood depression were based on and largely borrowed from adult classifications. Their validity in diagnosing depression in children has been the focus of much research since the beginning of the 1980's.

Everyone feels low, down or glum at some point in their lives, but feeling depressed is a totally different entity. There have been many definitions of depression given over recent years with some discrepancies in agreement, but Professor Oster, a clinical psychologist at the University of Maryland Medical School offers an easily understood definition that sums up every other definition:

> 'Clinical depression refers to a condition marked by changes in one's mood and by associated behaviours that range from a mild degree of sadness to intensely experienced feelings of hopelessness and suicidal thoughts ... a depressive disorder, goes beyond normal mood swings. It encompasses an increase in the intensity and length of the everyday expression of emotions and occurs in combination with other physical and

psychological symptoms.' (Oster and Montgomery 1995 p.43-44)

Anyone who loses a loved one either by death or divorce will grieve, which is quite normal, but it is when the 'normal variability in moods' (Oster and Montgomery 1995 p.44) is exaggerated that a person could be diagnosed as having depression.

Garber and Horowitz (2002) classify depression as a syndrome when it occurs with other symptoms. When this 'syndrome' is characterized by a particular symptom picture with a specifiable course, outcome, treatment response, and aeteological correlates, then, it is considered a distinct nosological disorder. (p.510)

Most classifications defining the syndrome of depression agree that the term is applicable when it is combined with other symptoms. The two most widely used diagnostic tools are The American Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the ICD-10 Classification of Mental and Behavioural Disorders.

Within the DSM-IV, it states that it is fully compatible with the ICD-10. There were many consultations between the developers of the DSM-IV and the ICD-10 which increased the congruence between the two systems.

(i) The ICD-10 Diagnostic Criteria for a Depressive Episode

The ICD-10 classifies depression as a mood (affective) disorder. Depressive episodes are subdivided into Mild depressive episode, (with or without somatic syndrome); Moderate depressive episode, (with or without somatic syndrome); Severe depressive episode (with or without psychotic symptoms).

(a) Mild depressive episode

At least two of the following three symptoms must be present:

(1) depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances, and sustained for at least 2 weeks;
(2) loss of interest or pleasure in activities that are normally pleasurable;
(3) decreased energy or increased fatiguability;

An additional symptom or symptoms from the following list should be present, to give a total of at least *four*:

(1) loss of confidence or self-esteem;
(2) unreasonable feelings of self-reproach or excessive and inappropriate guilt;
(3) recurring thoughts of death or suicide, or any suicidal behaviour;
(4) complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;
(5) change in psychomotor activity, with agitation or retardation (either subjective or objective);
(6) sleep disturbance of any type;
(7) change in appetite (decrease or increase) with corresponding weight change.

(b) Moderate depressive episode

At least two of the three symptoms listed for mild depressive episode and further symptoms from the additional symptoms list should be present to make a total of at least six symptoms.

(c) Severe depressive episode

All three symptoms listed for mild depressive episode should be present and further symptoms from the additional symptoms list should be present to make a total of at least eight symptoms.

(Taken from ICD-10 p.82-84)

Recurrent depressive episodes can also be mild, moderate or severe and can be accompanied by psychotic symptoms. Within the mood disorders, the ICD-10 also lists Manic episodes which includes episodes of hypomania or

mania with or without psychotic symptoms, and Bipolar affective disorder which also includes the same episodes as stated above, with mild, moderate or severe depression.

The ICD-10 also lists depression as a disorder which can occur within other categories of mood (affective) disorders such as Anxiety disorders and Reaction to severe stress, and Adjustment disorders.

(ii) The DSM-IV Diagnostic Criteria for a Depressive Episode

The DSM-IV is used to define depressive disorders for children from pre-school through adolescence regardless of their developmental level.

Within the DSM-IV diagnostic listing, the Mood Disorders are divided into the Depressive Disorders (which is also known as unipolar depression), the Bipolar Disorders, and a further two disorders which are based on aetiology – (i) a Mood Disorder which is due to a General Medical Condition (ii) a Substance-Induced Mood Disorder. More specifically, the Depressive Disorders are classified as:

(i) Major Depressive Disorder
(ii) Dysthymic Disorder
(iii) Depressive Disorder Not Otherwise Specified

Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e. at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression). (p.345)

DSM-IV Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (p.356).

The DSM-IV states that:

> 'The core symptoms of a Major Depressive Episode are the same for children and adolescents, although there are data that suggest that the prominence of characteristic symptoms may change with age.'
> (p.356-345)

Children are much more likely to make somatic complaints, become irritable or become more socially withdrawn, whereas during adolescence and puberty, there is an increased likelihood of psychomotor retardation, hypersomnia, and delusions. In younger children, Major Depressive Episodes occur more frequently in conjunction with other mental disorders such as disruptive behaviour disorders, attention-deficit disorders and anxiety disorder than in isolation. In adolescents, the Major Depressive Episodes are frequently associated with the same disorders as those previously mentioned for children, but there is also an increased association with substance related disorders and eating disorders.

The DSM-IV also lists two long-lasting or chronic disorders namely, Dysthymic and Cyclothymic Disorders. Dysthymic Disorder is characterized by at least 2 years (1 year in children) of depressed mood where the person has more days than not when they are feeling depressed. This is accompanied by additional depressive symptoms which do not meet the criteria for a Major Depressive Episode, i.e. Dysthymia is less severe than unipolar depression but can be more persistent. Other symptoms of dysthymia are poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions and feelings of hopelessness. Cyclothymic Disorder is also characterized by at least 2 years of numerous periods of hypomanic symptoms and numerous periods of depressive symptoms.

The Bipolar I and II disorders are characterized by Major Depressive Episodes in addition to one or more Manic or Mixed Episodes (I) or Hypomanic Episodes (II). Bipolar Disorders are also known as manic depression. At the present time, there are no separate guidelines for the

diagnosis of children with bipolar disorder, and yet, there appear to be some differences in the way bipolar disorder appears in children compared to adults. The Child and Adolescent Bipolar Foundation (CABF) list the symptoms which may appear in children with bipolar disorder:

- an expansive or irritable mood
- depression
- rapidly changing moods lasting a few hours to a few days
- explosive, lengthy, and often destructive rages
- separation anxiety
- defiance of authority
- hyperactivity, agitation, and distractibility
- sleeping little or, alternatively, sleeping too much
- bed wetting and night terrors
- strong and frequent cravings, often for carbohydrates or sweets
- excessive involvement in multiple projects and activities
- impaired judgement, impulsivity, racing thoughts, and pressure to keep talking
- dare-devil behaviours
- inappropriate or precocious sexual behaviour
- delusions and hallucinations
- grandiose belief in own abilities that defy the laws of logic (ability to fly, for example)

  (Manic Depression Foundation 2003 p.2-3)

The ICD-10 and DSM-IV are both standard classifications of depression and have been included in this part of the thesis as they are able to set a framework around what would otherwise be merely a subjective label given to a range of feelings and/or behaviour. Whilst I do not advocate a pure medical model of depression, nevertheless, I consider these classifications to be useful in terms of reference. As educationalists, we spend much of our time with children and having these classifications are useful in that if a child is behaving in such ways, we are able to recognise the possible warning signs

of depression. In our general day-to-day practice as EPs, we do not refer to the DSM-IV or the ICD-10 as they are generally considered to be diagnostic tools and as EPs, we do not **diagnose** depression, as only medically trained professionals are able to give such a diagnosis. Currently within the LEA, any child with significant emotional and behavioural difficulties who cannot be supported by their school, are referred to CAMHS or to the Community Paediatrician. Both services are the responsibility of the Health Authority which I feel reinforces the notion that a child with EBD needs the help and support from a practitioner within the health service, which in turn, reinforces the medical model of emotional and behavioural difficulties. I agree with Greig (2004 a+b) who argues that since most children attend a school, staff could possibly offer a greater level of support given the appropriate training. I am not suggesting that teachers become mental health practitioners, but I agree with Greig (2004a+b) who claims that certainly, if there are some serious concerns regarding a child's mental health such as schizophrenia or paranoia, then children should be referred to CAMHS without question. However, for less serious emotional problems, the education system and educationalists are easily accessible to children and emotional problems need not necessarily be viewed in terms of requiring support from the health services. Instead of referring to the 'mental health' of children, I would argue that we could refer to their 'emotional health'. Again this may help to dissipate the notion that the child needs to be referred to a mental health practitioner and reduce the strength of the medical model and its classifications of depression and instead, strengthen the 'educational' model. I am of the opinion that if mental health problems, depression in particular, were de-stigmatised, the strength of the medical model would also be weakened. Nevertheless, I find classifications such as the DSM-IV and ICD-10 useful tools in order to aid my general understanding of depression in children. This information could also be disseminated to school staff, which in turn, could promote a greater awareness of depression in school-children and hopefully lead to earlier identification and support for those pupils in need. Whilst I am not endorsing a medical model for the identification and support for pupils who may be suffering with depression, nevertheless, I found these standard classifications a useful starting point when initially embarking on this study.

In my general practice as an EP I have provided teachers with the following descriptions of school-specific behaviours (see below) which, they inform me, have been very useful. It is my opinion that these descriptions of children's behaviour seem less 'medical' in nature and more school/classroom-based which teachers naturally find much easier to understand and are therefore, able to relate them to their pupils.

School related behaviours – mood, behaviour or appearance

- Standard of work dropping dramatically
- Becoming subdued or over excited
- Failing to hand in homework
- Refusing school
- Dressing in a different style, looking untidy or obsessively concerned with cleanliness

School related behaviours – general behaviour

- Hyperactive, attention seeking, anxious or restless
- Aggressive, defiant and disruptive of others' work
- Unusually quiet and passive, not in touch with what is going on, withdrawn
- Odd or regressive behaviour
- Appearing tense and unhappy
- Obsessive
- Extremely conscientious, perfectionist

School related behaviours – pattern of work

- Having difficulty settling to work and concentrating in class
- Losing enthusiasm and motivation
- Becoming overly absorbed in study

School related behaviours – pattern of attendance

- Reluctant to leave school or class
- Arriving very late or early
- Missing school or lessons, playing truant

School related behaviours – relationships

- Having difficulty getting on with other children in class; having few or no friends
- Being bullied or bullying others

School related behaviours – younger children

- Extremely clingy or demanding of teacher – frequently breaking down in tears
- Gets into fights with other children – having temper tantrums
- Damaging others' work
- Insisting on initiating sexual play
- Being bossy and over organising others

School related behaviours – older children

- Looking unhappy and solitary, tired and unwell
- Becoming careless or indifferent with work
- Problems with eating
- Drawn into promiscuity, delinquency or misusing drugs or alcohol
- Violent behaviour in playground or class
- Breaking the law outside school
- Self destructive behaviour

2.5 THE SECRET ILLNESS

What are the factors which predispose or inhibit individuals from ultimately receiving mental health support? Kate Hill (1995) gives one explanation and that is that people are afraid to admit that they are depressed because of the stigma attached to mental illness in general, in our society. Hill (1995) reports that,

> 'In 1992 a survey of public attitude towards depression found a prevailing stigma attached to mental health problems/psychiatric disorders, with a presumption of their implying weakness, abnormality and instability.' (p.102)

Furthermore, Hill goes on to write,

> 'Such stigma discourages those who are troubled from seeking help and makes it more likely that mental health problems will be denied, or coped with in defensive ways ... Lessening the stigma associated with depression and other psychological difficulties is important for suicide prevention. As long as mental health problems carry negative connotations, those who need help will be reluctant to admit their difficulties and seek help.' (p. 102)

Is the fact that our society views innermost feelings and attitudes as private, part of the reason why we do not discuss innermost feelings with each other. Suicidal ideation or feelings of utter despair are not discussed openly partly because we feel we do not want others to know how we feel as we may seem socially inadequate or it could be because we view them as totally private. Suicide is still considered to be a social taboo. If this social barrier was broken down, more people, young people as well as adults, suffering from depression could be supported. Until people admit that they are feeling depressed and are in need of support, it is difficult to give them the support they really need.

Shaffer et al. (1988) in their study found that only 30-50% of young people who take their own lives, have consulted mental health care professionals. Another study by Vassilas and Morgan (1993) revealed that young men, who are currently at highest risk of suicide are the least likely to seek help from a doctor or other professional which I find very alarming. In a more recent study by Hirschfeld et al. (1997), it was estimated that 70% to 80% of depressed adolescents never receive treatment. With such a stigma still associated with mental illness, it is not surprising that there is a low rate of utilization among adolescents of the mental health services.

A study was conducted in America by Logan and King (2002) who included 44 adolescents and their parents. It was found that the adolescents whose parents recognised their depression were more likely to access mental health services than those parents who failed to recognise depression in their children. Unfortunately, some parents may not be able to recognise and understand adolescent mood problems. Although this study could be criticized for its relatively small sample size, most of whom were Caucasian and African American, thereby limiting its generalizability. In addition, the authors highlight the limitation of their methods of data collection and agree that by using multiple informants would have increased the reliability and validity of their study. However, one of the major contributions of this study is that it highlights the need for ensuring alternative sources of help, one of them being school. The participants who took part in this study were in a primary care setting, therefore, families who had not used medical services were not included. In this sense, rates of service-use in this sample may be higher in relation to the general population of families with depressed adolescents. These authors are keen to point out that since there are relatively high rates of non-mental health professional service-use among adolescents, it is crucial to offer as many alternative pathways as possible, from problem identification to service-use, so that assistance can be increased to those adolescents most in need of help. Logan and King (2000) state that help needs to be offered closer to home and in schools. This has implications for the role of the EP. Currently, pupils with emotional problems which are causing significant impairment to their work or quality of life are

referred to the CAMHS teams. I would argue that if EPs were called upon by schools earlier than they are at present, perhaps the emotional difficulties experienced by some children could be alleviated sooner.

In 1999, The TES (June 25) published an article headlined *Call for mental-health aid in school.* The article stated that,

> 'A Mental Health Foundation report says that one in five young people is suffering from disorders such as anxiety, depression and psychosis.' (p.12)

Thus, research statistics have indicated for some time that the emotional wellbeing of young people is an important issue which needs to be addressed by professionals working alongside them. I find it surprising that it was only as recently as June 2001 that the DfES published 'Promoting Children's Mental Health Within Early Years and School Settings' and as far as I am aware, this is the first publication of its kind by the DfES which addresses the mental health issues of children. It was written for Local Education Authorities, schools, early years settings and Child and Adolescent Mental Health Services. It was produced in response to a growing recognition of the importance of promoting children's mental health and emotional wellbeing. This Document highlights the growing importance of recognising emotional ill-health in school-children. Again, this has implications for Educational Psychologists, school staff and health professionals. It is crucial that we all work together in order to provide the most beneficial support for children with emotional problems (see also Greig 2004a).

2.6 AETIOLOGIES OF DEPRESSION

(i) Introduction

From the research published in this area, there appears to be no single cause of depression. The reasons could be psychoanalytical, behavioural, cognitive, biological, psychosocial or a combination of all or a few of these. It

would not be possible to provide a comprehensive view of all the aetiological theories within this chapter since they are too numerous. The theories of depression in young people which have most empirical support will be described within this chapter and the relevant research which support those theories will be cited.

(ii) Psychoanalytic Models of Depression

The psychoanalytic theorists (Abraham 1911; Freud 1917; Rado 1928; Klein 1934; Gero 1936) provided the earliest writings on depression (cited by Beck 1967). In this model 'loss' is the key concept.

In many cases, a young person may feel that life is intolerable, things have become too much to bear which leads to feelings of helplessness. Coleman, Lyon and Piper (1995) found that parents and carers of children who have completed suicide said that 'losses' play a crucial part. Losses ranged from the loss of an important person – broken relationships, loss through death of a much loved member of family, suicide of an older sibling, lost contact with father, loss of a cherished ambition or loss of a job. Some suicides had suffered a profound loss of trust coupled with the loss of a sense of themselves due to sexual abuse or neglect within the family.

Specific events, including loss, divorce, bereavement, exposure to suicide alone, or together with other risk factors have been associated with the onset of depression (Brent et al. 1993 a, b; Reinherz et al. 1993; Weller, Weller, Fristad & Bowes 1991).

Derdyn (1983) states that in some cases, children can absorb too much of what a parent is feeling, which in turn, binds the child to that parent in an anxious type of attachment. If the child does not have adequate protection or buffering, their self-esteem can be diminished which can also adversely affect their academic performance.

Cytryn and McKnew (1979) have found that sometimes parents are angry with themselves for a particular reason, but they scapegoat their child by

projecting on to the child the very aspects of themselves that they dislike. These researchers have found that scapegoating is often a cause of depression. It has been found that if a child is separated from his parents, he/she can be left with a feeling of failure or guilt. These authors state that some children turn to drugs and alcohol which can bring temporary relief from their misery, but these can bring further problems into the person's life.

As educationalists, we are not in a position to prevent or solve specific life events, however, if teachers are aware of any problems within a child's homelife, they can then be more aware of any changes in that child's behaviour which may suggest they are depressed.

In an extensive review of literature in this field Oster and Montgomery (1995) say that these psychoanalytic models were not successful in developing specific treatments for the depressed individuals, and so the behaviourist and cognitive models became the most influential approaches to depression. These models will be highlighted next.

(iii) Behavioural Models of Depression

It was during the 1960's and 1970's that behavioural viewpoints on depression became prominent. Environmental influences and contextual factors upon behaviour became the primary focus of attempts to explain depression. The behaviourists argued that depression results from a lack of adequate or sufficient reinforcement. This may be due to loss of one parent through separation/divorce or death; breaking off a relationship with a friend; exclusion from events such as a school team; lack of confidence which limits participation in social events. Since the source of feedback is removed, the opportunities for positive reinforcement diminish and as a result, the feelings of positive regard for oneself would lessen.

> '... behaviours that were being maintained by these rewards become extinguished, and the resulting reduction of behaviours leads to even fewer reinforcement possibilities ..... Depression is the final outcome of this vicious cycle.' (Oster and Caro 1990 p.32).

However, Lewinsohn (1975) went a step further and argued that not everyone who experiences any of the aforementioned points becomes depressed. Lewinsohn claims that individuals are more likely to feel depressed when they are unable to find other ways of receiving personal reinforcement. (cf Seligman 1975 below). So Lewinsohn is suggesting that depression can result when a person is lacking in socially relevant skills that, in turn, obtain rewards. Brady (1984) also suggests that lack of social skills is a key element in depression. Brady claims that it '... leads to interpersonal anxiety, isolation and lowered self-esteem...' (p.34)

If a person is unable to handle the stress they are under, Rehm (1977) states they are more likely to focus on the negative events in their lives. Rehm (1977) claims that these people have inadequate self-regulatory processes for handling stress. These people set themselves targets in life that are unrealistic and unobtainable, and therefore receive little or no positive reinforcement. This situation can lead to 'learned helplessness'.

Seligman (1975) found that,

> '...uncontrollable or unwarranted punishment and failure would lead to deficits in responding, learning, and the expression of emotion.' (p.52)

In other words, non-contiguous, random or unrelated punishment could lead to withdrawal, lack of motivation and disinterest on the part of the child. Adolescents and children may feel that life events are totally beyond their control and that no matter how much effort they put into something, it never turns out right. They can then lose faith in their abilities and lose confidence, which could then result in them behaving in a helpless and dependent way. This has a strong similarity to certain aspects of the cognitive models of depression which will be discussed next.

(iv) Cognitive Models of Depression

During the 1960's and 1970's Beck provided the most thorough explanation of the cognitive view of depression, and later, Garber and Hilsman (1992). Since this date, there has been a large body of literature which relates a person's cognition and depression. A comprehensive review of the literature relating to cognitive models of depression and the evidence to support them would be beyond the scope of this chapter. For reviews see Alloy 1999 and 2001; Abramson et al 1999 and Garber and Horowitz 2002. The cognitive view emphasizes the distortions in the person's thinking which lead to the affective and motivational symptoms that are characteristic of depression. For instance, a person may feel that they are no good, the world is not good and everything is against them, and they can't do anything about it so it will always be that way for them.

Beck (1967) describes a 'primary triad' in depression. The first component of the triad is the way a person constructs experiences in a negative way. They may see their life as full of burdens, obstacles or traumatic situations. The second component is the way they view themselves. They see themselves as inadequate, deficient, unworthy, undesirable and worthless. The third component consists of viewing the future in a negative way. The person feels that the current situation will continue indefinitely. When these components exist within a person's thoughts, Beck states that the person will not be able to think logically, they will over generalize and exaggerate a situation.

Oster and Montgomery (1995) claim that when depressed people experience these cognitive distortions, they

> '(a) may become easily frustrated interpreting small setbacks as monumental; (b) may feel slighted by otherwise harmless statements; and (c) may frequently devalue oneself by never acknowledging strengths and often deflecting compliments. Interpretations of actual events during depressed times are rarely accurate and are consistently negative and self-critical.' (p.53)

Oster and Caro (1990) give some examples of these distortions:

> 'My boyfriend did not call; therefore he does not love me...
> Because one person does not like me, everyone hates me...
> I am to blame for my parents' separation...
> I was lucky to win the match...' (p.36)

Oster and Montgomery (1995) have found that teenagers can develop very pessimistic thought patterns during depression.

> 'They begin to see themselves as inadequate and less able than their peers. Depressed teens no longer perceive themselves as able to cope with even minor problems. They no longer can set obtainable goals. Any demands made on them seem overwhelming. Small obstacles appear insurmountable. They are convinced that there is no end to their problems.' (p.54)

The authors claim that lack of positive self-regard could ensue. In addition, Oster and Montgomery (1995) claim that parental anger, even if it is not directly aimed at the child, can have a detrimental effect on the child's emotional well-being. Children can also feel that that they are to blame for their parents' divorce. During my teaching career I have had to console two young primary school children who had come to school extremely upset after witnessing an argument between their parents who were on the verge of divorce. In both instances, the children told me they felt that it was their fault that their parents were fighting which illustrates the claim made by Oster and Montgomery above.

This pessimistic outlook can lead to feelings of hopelessness and the person can start to feel that no one can help them out of their downward spiral into the depths of despair. This is where the threat of suicide can rise to the surface.

Kazdin, French, Unis, Esveldt-Dawson and Sherick (1983) found that hopelessness is the most important factor associated with both suicidal ideation and suicidal behaviour, not necessarily depression per se. These

negative thoughts can lead to a vicious circle. If someone has such a gloomy outlook on life, this can impair the effort they put into their work and relationships, which can then lead to more failure and negative feedback from teachers and peers, which can lead to withdrawal from others and even less effort is put into their school work, and so on.

Based upon Beck's (1967) theory that depressed people not only have a negative view of themselves, but also of the world and the future, Stark (1990) describes three techniques which have been useful in helping children who are depressed.

> 1. 'What's the evidence?' involves the child working with the therapist (or teacher) to identify or refute automatic thoughts.
> 2. 'Alternative interpretations' involves the child developing alternative constructions for an upsetting event. For instance, a depressed child might feel that someone who had passed them in the corridor without saying "Hello" had done so because they did not like them. The child might be taught that another way of looking at that event was that the other child might have been thinking of something else.
> 3. 'What if' aims to teach the child that an actual outcome of an event may not be as bad as the child predicts.'
> (In Harrington 1993 p.155).

I would argue that these techniques could be adopted by schools. Children could be trained in self-reinforcement (sometimes referred to as 'self-talk' in counselling circles). This would involve them giving themselves rewards for appropriate behaviour which could be something simple like a positive self-statement, to buying a new item of clothing, to going to the cinema. It is important that the teacher also positively reinforces the pupil's good behaviour or work which can boost self-esteem.

Social skills training can improve depressive effect in children. Fine, Forth, Gilbert and Haley (1991) taught social skills to depressed adolescents in a group setting. This included conversational skills, social problem solving and negotiation to resolve social conflict. Each skill and real-life situations were used in role play. The results of these sessions showed a marked improvement in depressed mood. This could be extended to the schools perhaps in drama lessons.

Stark, Reynolds and Kaslow (1987), and Stark (1990), assessed the effectiveness of self-control and behavioural problem-solving approaches in the treatment of 9-12 year olds who were identified as moderately to severely depressed. The self-control therapy focused on self-monitoring, self-evaluation and self-reinforcement. Behavioural problem-solving therapy involved problem-solving skills and self-improvements in pleasant activities. This tended to focus more on social relations. (The children were divided into 2 groups, 5 in each group). It was found that both treatments decreased depressive symptoms in the participants. After 8 weeks, the children were re-assessed and it was found that the gains were still maintained.

Would a school-based programme help to prevent adolescent depression? Shochet et al. (2001) carried out a study to find the efficacy of such a programme in Australia. The study indicated that Year 9 adolescents who took part in the Resourceful Adolescent Program (RAP) (an eleven session school-based resilience building programme as part of the school curriculum) reported significantly lower levels of depressive symptomatology and hopelessness at post-intervention and 10-month follow up, compared with those in the non RAP group. I agree with the authors who argue that it is possible to design and implement classroom-based depression prevention programmes and that the benefits of these programmes can help to overcome low attrition rate, avoidance of stigma, and in the long term, cost the health service less money. However, the programme was led by psychologists and for this reason, the authors claim that a high level of programme integrity was maintained. Each participant within the RAP group whose depression had abated and who had subsequently scored within a

healthy range upon completion of the programme had done so with the benefit of 11 hours of therapist time. Whilst this programme highlights the effectiveness of cognitive therapy in reducing levels of depression, it also highlights the cost in terms of a psychologist's time, which would not be practical in my day-to-day work as an EP with a time allocation which must be strictly adhere to. In terms of sessions, 11 hours would equate to approximately 4 sessions (one session = a morning or an afternoon) and since some of my schools are entitled to 8 sessions in one academic year, this would not leave much time for me to assess other children as is usually the request made by schools.

Cognitive Behaviour Therapy can also be an effective treatment for adolescents and some younger children with depression. Hollon, DeRubeis and Seligman (1992) argue that one of the reasons why CBT may be effective is that it gives the young people the skills they need when encountering stressful life events.

Hains and Ellmann (1994) investigated the effects of stress inoculation training for high school students who were taught three major types of skills: 1) Cognitive-restructuring techniques, evaluating negative interpretations for problems by considering alternatives; 2) Problem-solving skills; generating a variety of solutions, considering consequences and deciding between different options; 3) Relaxation training.

The results suggested that those pupils who were classified as high in emotional arousal compared to those low in emotional arousal, reported a greater reduction in trait anxiety and depressive symptoms from pre to post intervention. However, it can be argued that the reduction or prevention of symptoms should not automatically be interpreted as the prevention of a disorder. CBT may work for some pupils, but not others as a study by Petersen, Leffert, Graham, Alwin and Ding. (1997) suggests. Year 7 pupils were taught cognitive and problem-solving techniques at school. Cognitive techniques included reducing irrational thoughts and increasing positive self affirming thoughts. Problem solving techniques included relaxation training,

identifying goals, brainstorming about solutions, evaluating consequences of decisions, assertiveness and other social skills. Effects on depressive symptoms differed by gender. Girls in the intervention group reported greater reductions in depressive symptoms, but the boys reported higher levels of depressive symptoms than did those in the control group at post-intervention. So, this evidence suggests that the prevention programme was harmful to the boys who participated in it. It is important therefore, to analyse and evaluate very carefully the effects of prevention programmes on young people. Whilst girls may benefit from CBT, boys may not. Different intervention techniques may be needed for boys and girls.

I am aware that some schools I visit offer relaxation training techniques to children especially as a means of controlling anger. However, there are inconsistencies across schools within the LEA in the range of techniques they are able to offer as it is reliant upon staff numbers and knowledge. As far as I am aware, there is no uniform evaluation of such therapeutic techniques across the city at the present time. Since the research by Hains and Ellmann (1994) recognises a difference in the effectiveness of therapeutic techniques between girls and boys, further analysis of techniques being used across the LEA needs to be undertaken. Thereafter, those techniques found to be most useful in reducing levels of depression could be disseminated across the LEA to all schools.

Spence, Sheffield and Donovan (2003) conducted a study which evaluated the effectiveness of the 'Problem Solving for Life Program' as a universal approach to the prevention of adolescent depression. Short-term results indicated that the participants with initially elevated depression scores (high risk) who received the intervention showed a significantly greater decrease in depressive symptoms and an increase in life problem-solving scores from pre to post intervention compared with a high-risk control group. Low-risk participants who received the intervention reported a small but significant decrease in depression scores over the intervention period whereas the low-risk controls reported an increase in depression scores. However, these scores were not maintained at 12-month follow up. In a critique by Andrews,

Szabo and Burns (2002) it is claimed that the difference between the Shochet et al. (2001) study which had a comparatively successful outcome to this study by Spence et al. was that former used psychologists not teachers, small groups not whole classes and it emphasised cognitive therapy as apposed to a problem solving approach.

Depression cannot be prevented according to Gillham, Shatté and Feres (2000), who reviewed literature on cognitive-behavioural and family interventions designed to *prevent* depression. They found that although there was growing evidence to suggest that depressive symptoms could be reduced, the literature was inconclusive as to whether depression could actually be prevented. So if depression cannot be prevented, even if EPs became involved at an earlier stage than they are called upon currently, perhaps it would be more accurate to claim that if support is offered at an earlier stage, then the depressive episode would also end sooner for that child, or at least, not have the opportunity to become more chronic.

CBT techniques may be the most widely used for treating or preventing depression in young people, but they require metacognitive skills which younger children may not be able to access. It may be more effective to teach younger children problem-solving skills. In short, support needs to be tailored to the individual child. Some techniques will prove helpful to some children, but not others.

Another difficulty that I can foresee is with the administration of the cognitive-behavioural techniques. Since there is currently a national shortage of EPs, there may not be enough psychologists to deliver this type of therapeutic intervention. In addition, within my daily practice as an EP, schools are reluctant for me to spend more than one session with any child since our Service operates a time-allocation model which means that each school has a limited number of visits from me. Whilst the LEA remains steeped in the tradition of Statutory Assessments and Statements of Special Educational Needs, most of my work and that of my colleagues will continue to entail cognitive assessments.

(v) Psychosocial Models of Depression

Increased instability and higher demands within families and within society have been proposed as aetiologies explaining increased rates in the prevalence of depression among young people. Sometimes the psychosocial factors in depression are linked to the cognitive factors because not everyone who has to face problematic life experiences becomes depressed. Rather, it may be that some people find life experiences more difficult to cope with than others, based on how they perceive the situation. Psychosocial impairment can affect many different aspects of a child's life such as their relationships with friends, family, other adults, their school-work and leisure activities. Lewinsohn, Rhode, Seeley, Klein and Gotlib (2000) reported that there are many factors associated and correlated with depression: Stressful life events, social support, social interaction, life satisfaction, self-esteem, social skills, coping skills, engagement in pleasant activities and cognitive functioning.

Epidemiological studies have identified a range of important risk factors for depression in children and teenagers. According to the DfES (2001) 'Risk factors are the *probability* of a child developing a mental health problem.' (p.3)

Risk factors have been identified as resulting from problems within the child, within the family and within the community. Risk factors within the child can include academic learning difficulties, a specific developmental delay, behavioural difficulties and low self-esteem. Several studies have found that self-esteem has emerged as a significant symptom within children who are depressed (Bernet, Ingram & Johnson 1993; Rutter 1990; Fleming and Offord 1990; Lewinsohn et al 2000). Studies are not conclusive when considering the causational factor of depression and self-esteem. In summary, some research has suggested that low self-esteem is caused by the depression, whereas other research studies have found that low self-esteem has been apparent within the child prior to the onset of depression.

Risk factors within the family include aspects such as parental conflict, inconsistent or unclear discipline, abuse, parent psychiatric illness or loss/death.

Risk factors within the community include homelessness, discrimination and socio-economic disadvantage. Whilst schools are not in a position to change possible risk factors within the family or community, however, if teachers are aware of them, then they are more alert to any signs that a particular child may be at risk of becoming depressed.

Similarly there are factors within the child, the family and community which serve to promote resilience to adversity. Resilience factors within the child include secure early relationships, higher intelligence, having good problem-solving skills. Resilience factors within the family include aspects such as having at least one good parent-child relationship, affection and consistent discipline. Within the community, resilience factors include good housing, range of sport or leisure facilities and attending schools with a high morale. A more comprehensive list of risk factors and resilience factors can be found in Appendix 2 and 3.

Research studies have reported a relationship between negative life events and depression. Goodyer and Altham (1991 a+b) have found that stressful life events during the last year and loss have been found to be significantly associated with depression or anxiety among children and adolescents. Fleming and Offord (1990) found that psychosocial variables such as family dysfunction, low self-esteem and stressful life events were associated with depressive disorders. Lewinsohn, Roberts et al.(1994) found that chronic daily stress and daily hassles are strongly associated with depressive symptoms among older adolescents.

During teenage years, the young adult faces many changes, physical and emotional. There are increasing demands for academic achievements but with no guarantee of employment at the end. Also, there is pressure on the

teenager to be sociable, outgoing and to have many friends, but if someone is more introvert and has only a few friends they may feel socially inadequate and feelings of loneliness can manifest themselves in the young person. There is pressure on young people to appear as though everything is going well in their life and that they are happy. But if someone does not always feel like that, but perceive everyone else around them as being happy, again this can start to make them feel as though there is something wrong with them. If someone is depressed, it is not the social norm to show or express it in public. This can create enormous confusion in the adolescent and young child.

A study by Sund, Larsson and Wichstrøm (2003) examined the relationships between depressive symptoms among 12-14 year old adolescents in Norway, and the following psychosocial areas: 1) number of stressful events and daily hassles; 2) parental and familial background factors such as death, family structure and number of moves; 3) number of siblings and close friends; 4) ethnic and adoption status; 5) parental socio-economic (SES) and employment status; 6) geographical region (urban-rural differences). The results of the study showed that the correlation between daily hassles and depressive symptoms was higher for girls than boys but depressive symptoms were more strongly correlated with school-related stress among boys than girls. Adolescents who were not living with both natural parents had a higher score on the Mood and Feelings Questionnaire (MFQ). This was also the case for adolescents who had moved more than twice, and those with more than 3 siblings or had fewer than 2 close friends. The study also found that adolescents who were from Third World societies and adopted adolescents, those from lower SES groups, having unemployed parents or living in coastal areas also had higher scores on the MFQ. The results in order of importance were as follows: sum of daily hassles and sum of stressful life events, gender (girls more depressive symptoms), number of friends, ethnicity and mother's employment status. The authors concluded that these psychosocial predictors should be addressed when assessing depressive symptoms in adolescence. The coping strategies used by girls and boys may be different which may account for the higher levels of

depressive symptoms among adolescent girls. In addition, adolescents might be more sensitive to everyday stressful events. A possible limitation of this study could be its restriction to only one geographical region in Norway and to the limited age range of the participants which included 12 to 14 year olds only. The authors claim that although there was a good response rate, those who did not take part in the study may have differed from the rest of the participants in that they may have been experiencing greater emotional or behavioural problems. This study was not able to comment upon the causal inferences regarding the effects of psychosocial factors on depressive symptoms among adolescents due to its cross-sectional design.

In a longitudinal study carried out in Finland (which is still in press) by Haavisto et al. (2004) a 10-year follow-up study of boys examined factors associated with depressive symptoms at the age of 18. The study found that self-reported depressive symptoms at the age of 8 independently predicted an increased number of depressive symptoms 10 years later. Poor adaptive family functioning and in education, having fewer than two close friends, somatic health problems and using illicit drugs were all independently associated with high levels of depressive symptoms at the age of 18. The authors agree that there are possible difficulties with this study which used a rating scale which inevitably includes a cut-off point for clinically relevant levels of depressive symptoms. In addition, it relied heavily upon rating scales which lack the specificity that interviews are able to provide.

Rutter (1990) states that children who are given support in such a way that the likelihood of negative chain reactions arising from the risk are reduced, are much more able to cope with the adversity. In addition, if pupils have the opportunity of achieving success in the things they do, have a good level of self-esteem and self efficacy, have secure and supportive relationships, they are more likely to be resilient to any risk factors.

In a study by Schapman and Inderbitzen-Nolan (2002), 261 participants (13-18 year olds) completed the Religious Behaviour Questionnaire, the

Children's Depression Inventory (CDI) and the Revised Children's Manifest Anxiety Scale. The results showed more frequent religious behaviour and a greater desire to participate in religious activities were associated with lower scores on the CDI. Perhaps the emphasis upon the role of the family unit and shared responsibility for concerns, forgiveness and maintenance of relationships in some persuasions (e.g. the Catholic Church) may account for these findings.

(vi) Genetic and Familial Links

Extensive reviews of the literature on studies of genetic and familial links with depression in young people are provided by Garber and Horowitz, 2002; Merikangas and Avenevoli, 2002; Lewinsohn and Essau, 2002. Studies have clearly indicated the need for a consideration of necessary and sufficient conditions before drawing hard and fast conclusions about factors in depression. A condition, for example, the presence of a dominant gene, may be necessary for depression to develop, but it may not be sufficient by itself to guarantee the manifestation of the disorder. For example, a young person may hold a dominant gene which codes for or predisposes a person for the affect understood by the term depression. However, the environment(s) in which that young person find themselves could be universally positively reinforcing, such as having good friendships, or success at school, etc. In this instance, depression may not have an obvious avenue for expression. In their conclusion on this topic, Garber and Horowitz (2002) cite a study by Plomin (1990) who claims that there is evidence that depression in childhood can be influenced by the environment and their genes. Crucially, Garber and Horowitz (2002) note that family studies confound genetic and shared environmental effects. Evidence from twin studies indicates that genes account for approximately 30 – 50% of the variants in child-reported depression. Furthermore in studies by Eley, Deater-Deckard, Fombonne, Fulker and Plomin (1998) using adoption designs, neither the sibling nor the parent-offspring correlations showed a significant genetic effect but there was evidence of some shared environmental effects.

Similarly Goodman and Gotlib (1999) offer a comprehensive review of the literature of studies of parent-child relationships. Studies claim that environmental factors and genetic factors may be involved in the transmission of depression to children from parents. Therefore, genetic factors alone do not seem to account for depression in children. Furthermore, Hammen (1991) claims that most studies show that depression does indeed run in families, but Essau (2000) claims it is important to note that not all children of depressed parents also have depression.

Goldsmith, Gottesmon and Lemery (1997) and Warner, Mufson and Weissman (1995) report that although a child may have a predisposition or a vulnerability for depression which may be in fact inherited from their parent, it is in fact the environmental risk factors which are necessary for depression to become a disorder in young people (cited in Merikangas and Avenevoli 2002).

So although a specific gene has not yet been found to cause depression, Buka, Monuteaux and Earlsi (2002) claim that research in molecular biology are advancing rapidly and may in the future be able to identify a gene or genes associated with depression. At present, environmental factors within the family appear to give a stronger case than genetics for depression in young people.

Neuman, Geller, Rice and Todd (1997) reported that depressed young people often have depressed parents. In particular, research has found links between maternal depression with affective and/or behavioural problems in their children (Reviews in Gotlib and Hammen 2002). By comparison, paternal depression is less strongly associated with any depression in their children (Foley et al. 2001; Shiner and Marmorstein 1998).

In another study by Beardslee, Versage and Gladstone (1998) it was found that children of depressed parents were approximately three times more likely to experience a depressive episode than children of non-depressed parents. Goodman and Gotlib (1999) argue that maladaptive parenting styles, marital

dysfunction or stress could cause familial depression, and therefore children who are exposed to these conditions may be vulnerable to developing mood disorders. However, there are some reports (cited below) which contradict the conclusions that depressed children rate their family life (including parenting skills) in a negative way (Asarnow, Carlson & Guthrie, 1987; Brewin, Andrews & Furnham, 1996; Hamilton, Asarnow & Tompson, 1999). It is unclear exactly what causes early onset of depression – is it genetic influences or factors within a shared environment where depression is proband?

A recent study in the United States by Reinherz et al. (2003) identified family violence, family composition, internalizing problems during adolescence and low family cohesion to be the most salient factors in predicting major depression during the transition to adulthood (ages 18-26). The participants who had been exposed to family violence by the age of 15 were approximately four times more likely to have major depression in the transition period. Additionally, those with a score of 4 on the family composition index (i.e., older mother, older father, larger family size, and later in birth order) were almost three times as likely to meet the criteria for major depression as were adolescents with a score of 0. Participants who tended to internalize problems were twice as likely to meet the criteria for depression as were participants who did not. Finally, adolescents who felt there was a lack of family cohesion were nearly twice as likely to meet the criteria for depression as those who did not. The authors of this study acknowledge that a limitation of the study relates to the participants who were from Caucasian, working class communities, therefore, the findings may not generalize to other racially and economically diverse populations. However, a particular strength of this study is in its use of repeated administration of standardized instruments from multiple informants over a period of 20 years which the authors claim few studies can match. This study highlights the significance of both biological–genetic and environmental factors in the family domain. These findings support earlier studies which confirm the interaction of familial psycho-pathology within a dysfunctional family environment (Merikangas et al. 1998; Lewinsohn et al. 2000 and Reinherz et al. 2000). This study

illustrates once again the importance of identifying and supporting youngsters who express depressive symptoms. Since family background has such a significant impact on the lives of youngsters, family support also needs to be offered. It is an impossible task to place upon teachers and school staff alone to provide support for children suffering from depression. Parents and siblings also need to know the risk factors associated with depression and also the resilience factors so that these can be utilized or developed in a way that can support the child and thereby alleviate their symptoms. Once again, EPs are in an excellent position to offer this guidance to parents and families of children who may be suffering from depression.

Spence et al. (2002) carried out a longitudinal study involving a large sample of 4,434 families living in Australia. The study examined the degree to which symptoms of anxiety and depression at the age of 14 was associated with earlier childhood experiences of maternal anxiety and depression, poverty, and mother's distress over marital break-up. The results of the study suggested that maternal anxiety and depression, poverty and marital conflict/break-up during a child's early years have a small but significant influence upon the development of adolescent anxiety and depression. The authors go on to add that those risk factors appear to have an additive effect over time, in that repeated exposure to those factors increased the level of risk over and above exposure to only one occasion. They concluded that persistent maternal anxiety and depression place children at an increased risk for future development of anxiety and symptoms of depression. The authors are keen to point out a limitation of their study which relates to the difficulties posed by the relatively weak agreement of reporting anxiety-depressive symptoms between the mothers and their adolescents. They are unable to state with any certainty who gave the more accurate information, mothers or children, since social desirability effects may have influenced the way they rated themselves. The authors openly admit further limitations of the study which concern the use of a questionnaire which included cut-off scores rather than clinical diagnostic interviews, low frequency of data collection with several years passing between assessments and a failure to assess the mental health of the participants' fathers which may have provided crucial

information regarding the predictors of anxiety and depressive symptoms in adolescence.

A study which included an epidemiological sample of twins aged 8 to 17 years investigated the genetic and environmental aetiology of depression. Rice, Harold and Thapar (2002) found significant genetic effects when depressive symptoms were self-rated. For the children aged 8 to 10 years, the shared environmental factors were more important and genetic factors less important. This pattern was reversed for adolescents aged 11 to 17 years. Some, but not all of the shared environmental influences on parent-rated depressive symptoms were accounted for by maternal symptoms of depression and anxiety. There were also differences between the boys and girls for self-rated depressive symptoms. For the boys, genetic factors were of greater importance and common environmental influences of less importance than for girls. Adolescents who scored highly on self-rated depression questionnaires experienced significantly more shared life events and their mothers had significantly higher internalising symptoms than adolescents who scored within the normal range. The authors claim that the results of this study add to the existing evidence that the aetiology of depressive symptoms differ by age. Rice et al. (2002) do not try to account for their findings but reiterate that further work is needed in this area. A possible limitation of this study as indicated by the authors is that all the data was collected by postal questionnaire. A multi-method-approach which also made use of face-to-face interviews could have yielded further information. Also, a proportion of families did not participate in the study, therefore, it was not possible to state with any certainty that non-participation was not random. Rice et al (2002) suggest that future research could focus on the psychosocial risk factors associated with high self-rated depression scores and to examine the effect of recurrence.

In an innovative study by Marmorstein and Iacono (2004) conduct disorder (CD) and major depression (MDD) in adolescents, in relation to parent-child conflict and psychopathology in their parents were examined. The authors claim that this is the first study in which family characteristics have been

associated with both an internalizing disorder – depression, and an externalizing disorder – conduct disorder. As predicted, the study found that adolescents with CD and MDD tended to have mothers with depression. This study also found that there was a strong link between parental antisocial behaviour in particular paternal antisocial behaviour, and antisocial behaviour in their adolescent children.

Neither the study by Marmorstein and Iacono (2004) nor Spence et al. (2002) explain the mechanism of action. Marmorstein and Iacono (2004) make several suggestions as to the possible reasons why adolescent depression would be associated with maternal depression, as opposed to paternal depression. They suggest that mothers generally play a greater role in rearing their children, therefore, any maternal impairment, such as depression, could have a greater impact on their children. The authors also suggest that mothers could become depressed as a result of seeing their children experiencing significant difficulties such as depression or behaviour problems. Another interpretation could be related to mothers modelling anxious or depressed behaviours. Marmorstien and Iacono (2004) note several limitations of their study. Firstly, the participants were primarily Caucasian which may limit the applicability of these findings to other groups. Second, the participants were selected from an epidemiological sample of adolescents, therefore their cases of conduct disorder and/or depression may have been less severe than if these participants had been from clinical settings. Also, the authors state that the participants had histories of these disorders and that they did not necessarily have the disorders at the time of the assessment, nor did they necessarily have the disorders at the same time.

Merikangas and Avenevoli (2002) argue that although these studies provide evidence of familial influence in the aetiology of depression, they do not provide a great deal of information regarding the possible mechanisms through which such factors may operate to produce affective psychopathology in children. Familial aggregation of depression may result

from shared genes, common environmental factors, or a combination of these.

I feel these studies indicate a need for further research which takes into account the complex inter-relationships between family members, their environment and between child and parent psychopathology. They also highlight the importance of support for families experiencing difficulties and that additional support should be offered to children at school. In order for symptoms of depression to be alleviated in children, there needs to be support across both environments, home and school, and EPs are in an excellent position to be able to facilitate this support.

(vii) Neurobiological Links

As educationalists, we are not in a position to offer medication in order to alter any chemical imbalance within children, therefore, whilst acknowledging the importance of the effects of these imbalances, we cannot change this. For this reason, an extensive review of the literature pertaining to the neurobiological links will not be provided.

Garber and Horowitz (2002) provide an excellent review of studies which focus on the neurobiological link to depression in children. They cite studies by Dahl and Ryan (1996); Emslie, Weinberg, Kennard and Kowatch (1994) who focused on the dysregulation in neuroendocrine and neurochemical systems and in disturbances in sleep.

In studies by Zis and Goodwin (1982) and later by Gold, Goodwin and Chrousos (1988) it was found that depressed people have an imbalance of neurotransmitters. These are the natural biochemicals that allow communication within the brain cell. People who suffer from depression-related disorders have been found to have deficits, excesses or imbalances of neurotransmitters. Serotonin is one such neurotransmitter and it has been found that if there is an imbalance of this in the body, it can cause sleep disturbances, irritability and an increase in anxiety. Norepinephrine is

another extensively researched neurotransmitter which regulates alertness and arousal, so if there is an inadequate amount in the brain, it can cause fatigue and a sad mood in the person. Cortisol and acetylcholine are other chemicals in the body which could be out of balance if a person is depressed.

In order to consider the neurochemical factors mediating depression it may be useful to consider the drugs prescribed for treatment of the disorder. Schlaadt & Shannon's review in 1994 noted that although a range of drugs from several drug classes (e.g. the stimulants amphetamine and caffeine, the benzodiazepines Librium and Valium, and barbiturates) were used in treatment, drugs specifically classified as antidepressants were also available.

Two types of antidepressants prevailed in therapy namely monoamine oxidase inhibitors (MAOi) and tricyclics. However both types were associated with significantly adverse side effects such as salivatory problems, perception problems (e.g. visual blurring and drowsiness), skin pock lesions, profuse sweating and increases in body weight being reported. Although not noted for physical or psychological dependence, prolonged use was implicated in kidney and liver dysfunctions. By the end of the century MAOi ceased to be routinely prescribed, although their mode of action in the treatment of depression was nonetheless understood.

Anne & Bill Moir (1998) reviewed studies showing gender differences on several parameters; risk-taking, sensation seeking and impulsive actions. They refer extensively to work by Zuckerman (1994, 1996) on the interplay between MAO and the neurotransmitters dopamine and serotonin. The enzyme MAO is readily detectable in blood samples and is involved in the disposal of serotonin which is thought to play a crucial role between centres responsible for emotion (the primitive limbic structures e.g. amygdala) and the more advanced, developed centres (e.g. frontal lobes) which play a vital executive role. Thus the amygdala's 'flight or fight' preparatory function would be tapered according to the frontal lobes' estimation of risk vis-a-vis wellbeing of offspring, for example. Simultaneously high MAOi levels are

associated with dopamine activation (turnover) which is in turn associated with endogenous opiate (endorphin) release, cocaine-like pleasure rushes and heightened concentration. In terms of a gross, general simplification of the available evidence, low levels of MAO would be indicative of higher impulsivity, risk-taking and less contentment. By contrast, low MAO levels would suggest pleasure and contentment coupled with less need for mood elevation. Interestingly, it has been found that, on the whole, women have higher turnover of serotonin and more receptor sites in the frontal lobe areas for this neurotransmitter than men.

From being the 19th most prescribed drug in the US in 1990, with over 6 million prescriptions, Eli Lilly & Co's Prozac became the most widely prescribed antidepressant. Prozac, in contrast with MAOi, interacts directly and exclusively with serotonin, and further recognises the link between this neurotransmitter and depression. However, the 'wonder drug' is not without its own undesirable side effects, with headaches and insomnia being reported. Alarmingly in the early 1990's it was thought that far from being an antidepressant, Prozac was responsible for suicidal tendencies. Upon investigation by Eli Lilly and The Federal Drug Administration these could be attributed to the clinical profiles clients presented rather than the action of the drug per se (Schlaadt and Shannon 1994).

At the US National Institutes of Health and Washington University School of Medicine Wayne Drevets and colleagues have analysed brain scans and have reported an abnormality in the brains of people with a significant family history of depression. This may indicate a biological basis for depression which in turn has a genetic foundation (Bowley, Drevets, Ongur & Price 2002). The subgenual medial prefrontal cortex, part of the forebrain behind the eyes and between the brain's left and right hemispheres is smaller in the families with incidence of depression overall, than those with the condition absent. This difference in size does not arise from a difference in actual neuron number, but rather from a difference in the amount of glial cells in this region. Glial cells form a support structure for neuronal pathways, providing a super store and may be important in regulating serotonin availability. It

follows that depression may result from a lowering of serotonin turnover in this area of the forebrain.

In February 2003, Myriad Genetics Inc announced that from the Human Genome, it had found a gene likely to be responsible for turning depression 'on or off' as reported by Dr Dean Hamer of the National Cancer Institute on the BBC's Horizon programme (24.02.2005). Known as DEP-I, the gene was found to be crucial in the action of an entirely novel unchartered neurochemical pathway. In contrast to much of the pharmacological data (mentioned above) available up to this time, the gene did not appear to be relevant to the turnover of serotonin, dopamine, noraenaline and acetylcholine. The latest information available on the subject is that Myriad Genetics Inc were screening for depression amongst Mormon families in the Salt Lake City area of Utah. Mormon families were chosen for this purpose since they keep detailed family records and tend to marry other Mormons.

In separate studies by Jenson and Garfinkel (1990) and Ryan et al. (1994), it was found that depressed children hyposecrete growth hormone (GH) (cited by Birmaher et al. 1996). So a dysregulation in the growth hormone system may be a vulnerability marker for depression.

I would also like to include in this category medical problems that can cause the individual considerable concern, and ultimately lead to depression. Oguz, Kurul and Dirik (2002), found that symptoms of anxiety and depression are common among epileptic children, especially during puberty.

In an article by Grey, Whittemore and Tamborlane (2002) the literature was reviewed regarding co-morbid diabetes and depression in children and adolescents. They state that children with diabetes have a 2-fold greater prevalence of depression, and adolescents up to 3-fold greater than youths without diabetes.

In my opinion, the articles by Oguz et al. (2002) and Grey et al. (2002) contain extremely useful information which can be disseminated to schools.

Teachers can be made more aware of the possibility that children with epilepsy or diabetes are at risk of becoming depressed.

2.7 COMORBIDITY: DEPRESSION AND CONDUCT/ AFFECTIVE DISORDERS

Research studies of depression in children have shown that comorbidity appears to be the rule rather than the exception. Angold and Costello (1993) reported that for children and adolescents who were depressed the probability that they would have another disorder increased by at least 20 times. A more recent study by Essau, Conradt and Petermann (2000) found that in 40.1% of the adolescents who had a diagnosis of depression, also had an additional disorder and 17.9% had at least two other disorders.

The following section cites research carried out which report the presence of depression with conduct disorders.

Over thirty years ago, Cytryn and M^{c}Knew (1972) had discussed childhood depression, suggesting that depression in children could be divided into three distinct categories; masked depressive reaction of childhood, acute depressive reaction of childhood and chronic depressive reaction of childhood. The authors recognised that childhood depression was a clinical entity, and that it could take various forms. Furthermore, they cited a case study of a child who had performed delinquent and aggressive behaviour as a defence against unbearable despair and depression, so aggressive and delinquent behaviour can mask the deeper feelings of depression. This study by Cytryn and McKnew (1972) gave the first clinical indication that there was an association between depression and conduct disorders in young people which occurred more frequently than would be expected by chance.

Evidence from a small number of innovative researchers has found that depression has been linked to conduct disorders or aggression within the

clinically referred population. An outline of these studies will now be provided as they link directly to the conditions under investigation within this thesis.

These authors are cited many times within research papers, so they are arguably some of the leading researchers in this field of study. Chiles, Miller and Cox et al. (1980) found that in a study involving 120 delinquent adolescents between the ages of 13 and 15, 23% of them met the criteria for a major affective disorder. Again, this rate is higher than would be expected by chance alone.

Puig-Antich et al. (1978) provide one of the earliest pilot studies which examined the possible link between depression and conduct disorders in 13 pre-pubertal boys. The authors found that all 5 boys over the age of 10 met the criteria for major depression and conduct disorders. They state that the onset of the conduct disorder followed the onset of major depression.

In a later study by Puig-Antich (1982) it was found that there are complex links between depression and conduct disorders in children. It was found that, the onset of major depression was found to precede the onset of conduct disorder in 14 out of the 16 cases (87%). Puig-Antich also found that the conduct disorders included, chronic violation of rules at home and/or school (87%), persistent physical fighting (75%), pathological lying (50%) (other than to avoid punishment), stealing (44%), firesetting (31%), school expulsion (31%) and truancy (31%). Puig-Antich states that although this was a pilot study, these studies are important nonetheless because of poor long-term prognosis of conduct disorders and especially the burden they place upon society.

Marriage, Fine, Moretti and Haley (1986) report that in a study of 60 children and adolescents referred for assessment of depression, 11 cases were found which met diagnostic criteria for both conduct disorder and affective disorder. The study also revealed that when a conduct disorder was present, depressive symptoms were more severe than in cases where dysthymic disorder was present.

The preceding studies by Chiles et al. (1980), Puig-Antich (1982) and Marriage et al. (1986) were conducted in clinical settings with children and adolescents who had been diagnosed as suffering from emotional problems and conduct disorders. Perhaps childhood aggression and depression which co-exist, may exist outside clinical settings, and may be prevalent in the mainstream school population? Indeed, the children who have been excluded from schools for aggressive or anti-social behaviour may be 'masking' a deeper underlying reason for their behaviour, and could that reason be depression?

Carlson and Cantwell carried out some of the earliest recorded research studies relating to depression in children. In a landmark paper, Carlson and Cantwell (1980) found that,

> '... in some children with hyperactivity, aggressive behaviour, and some anti-social behaviour, a depressive disorder co-exists. Insofar as the behaviour disturbance is most outstanding, it may be said to overshadow the depression.' (p.449)

These authors refuted the notion that depression could be 'masked'. They claimed that the symptoms or behaviours exhibited by depressed children and adolescents were also found in children with non-affective disorders. Carlson and Cantwell concluded that if the mask of childhood depression is indeed present, then it is very thin.

In my experience as an Educational Psychologist, there have been very few instances when schools reported they felt a child could be depressed, but many referrals have focused on the child's behaviour difficulties.

Carlson and Cantwell (1980) presented data which indicated that conduct difficulties in primary depression were reported to have commenced after the onset of affective symptoms. So in their study, depression was present before the conduct problems. If the depression had been recognised early, the child may not have developed conduct/behaviour difficulties.

In addition Carlson and Cantwell (op cit.) say,

> 'We also need to know not only what percentage of depressed children are suffering primarily from an affective disorder but also the converse – what percentage of children who deny depression and have other symptoms are actually suffering from a depressive disorder.' (p.445)

In a more recent study by Marmorstein and Iacono (2003) it was found that major depression and conduct disorders co-occur in adolescents at rates higher than would be expected by chance.

However, Kovacs, Paulauskas, Gatsonis and Richards (1988) suggest that conduct problems may develop as a complication of the depression and may persist after the depression remits.

If depression underlies the conduct disorder, and then the depression is treated, it could follow that both disorders could improve. However, in a study by Berney et al. (1991) it was found that children who had both school phobia and depression, the children continued to experience school phobia even after the depression had been treated.

Roza, Hofstra, van der Ende and Verhulst (2003) used a longitudinal study to predict the onset of mood and anxiety disorders in children with emotional and behavioural difficulties in Holland. The results showed that mood disorders were significantly predicted by high scores on the anxious/depressed scale and on the internalizing composite, i.e. withdrawn, somatic complaints, and anxious/ depressed. Anxiety disorders were significantly predicted by the social problems scale and the externalizing composite, i.e. delinquent behaviour and aggressive behaviour. The study found that anxiety disorders predominantly started in childhood and early adolescence, whereas the incidence of mood disorders increased sharply in adolescence and young adulthood. The results found that both boys and girls with problems reflecting inhibited temperament are more vulnerable to depression later in life. A major strength of this study is its long follow-up

period and its large sample size. However, as with most longitudinal studies, the attrition rate could make its generalizability questionable. However, the authors of this study emphasise that which has been stated many times by researchers, that early intervention is crucial in the prevention of behavioural and emotional problems in childhood. They also claim as I have done in my previous research study (2003) that 'for young children with externalizing behaviour, the focus should be not only the disruptive aspects of the psychopathology but also their inner life and emotional needs.' (p.2120)

It could be argued that perhaps depression is simply undetected due to poor assessment procedures so there may not actually be such a thing as 'masked depression' as Carlson and Cantwell (1980) suggest. In turn, this would suggest that it is very important that accurate assessments and measures of childhood depression are developed and widely available to school teachers.

There is evidence in literature cited by the authors of the CDS, Lang and Tisher (1983) that depression is an important component of school refusal (Davidson, 1961; Clyne, 1966; Argras, 1959; Hersov, 1960a + b; Waldfogel, Coolidge & Hahn, 1957). Literature has also made reference to school refusal as an example of a 'depressive equivalent' (Glaser, 1967, Keeler, 1954).

In a long-term follow-up study of child and adolescent depression by Fombonne et al.(2001a), several findings were revealed. The participants who had attended the child psychiatry department at the Maudsley Hospital in South London between 1970 and 1983 were targeted. All the participants met the DSM-IV criteria for major depressive disorder (MDD) with (n= 53) or without (n=96) conduct disorders. They were interviewed 20 years later. Data was collected regarding their history of psychiatric disorders and adult social/ personality functioning. The results showed that the group with comorbid conduct disorders had higher rates of drug misuse and dependence, alcoholism and antisocial personality disorders. The recurrence rates of major depression was 62.6% and of any depressive disorder was

75.2% following an episode of childhood major depression. These figures are higher than those reported in previous studies of adolescent depression. Weissman et al.(1999) reported a rate of 49.3% for MDD recurrence in a longitudinal study of adolescents with depression, Rao et al. (1995) reported a 69% recurrence for MDD; Harrington et al.(1990) reported a 62% for MDD recurrence; 64% MDD recurrence was reported by Garber et al. (1988). All these studies clearly show that there is an elevated risk of adult depression following the onset of depression in adolescence.

Fombonne et al. (2001b) also reported that the comorbid conduct disorder (CD-MDD) group had higher rates of suicidal behaviours, and criminal offences, and exhibited more pervasive social dysfunction than the group with MDD alone. The study also found that adolescent depression is associated with a raised risk of adult suicidality with 44.3% of the participants having attempted suicide once in their lives. In addition, the CD-MDD group reported higher levels of unemployment, lower income, less frequent housing tenure and lower rates of cohabitation compared to the MDD group. The authors state that taking into consideration the large number of negative outcomes, interventions should aim to address not only the depressive symptoms in adolescents, but also comorbid disorders and the broader issues of social functioning. Since adolescents with comorbid disruptive disorders have a heightened risk of suicide, suicide prevention programmes should aim to target this population.

These studies raise some important questions that need to be addressed, such as why is depression so comorbid with other disorders during childhood? Which disorder is present in the child first and does it directly cause the second disorder? These questions raise issues around methods used to assess depression at different age ranges and between girls and boys.

2.8 ONSET, PREVALENCE, FREQUENCY AND SEVERITY OF DEPRESSION

(i) Onset

Until relatively recently, very little research had been carried out which examined depression in very young children. There have been variability in the estimates of age of initial onset of depression, but there was the general notion among clinicians that children under the age of 6 were unable to experience depression because they were considered too immature both emotionally and cognitively to experience depressive effects (Rie 1966). The empirical studies by Puig-Antich et al.(1978), Ryan et al.(1987), Carlson and Cantwell (1980) refuted these notions. Spitz and Wolf (1946) and Spitz (1945), were the first to suggest that very young children could suffer from depression. In later research carried out during the late 1970's and early 1980's, evidence emerged that depression in pre-pubertal children could be identified using the DSM adult criteria for Major Depressive Disorder. Over the last couple of years, Luby et al. (2002 and 2003) have attempted to validate the existence of depression in pre-school children, an age group previously considered to be too young to experience depression. The early manifestations of clinically significant signs and symptoms of depressive disorders were examined. Their work addressed the question of whether or not children's emotions can classify them as 'depressed', since clinicians and researchers are limited by the fact that the current DSM-IV classification does not describe the specific manifestations of affective symptoms for very young children. The children in these two studies were aged between 3 and 5½ years. Luby et al. found that when the DSM-IV was modified (see Appendix 4) in such a way that the 2 week duration criteria were set aside and translations of symptoms to describe age appropriate manifestations were used, then the 'typical' symptoms of MDD in pre-school children could be supported.

However, both the 2002 and 2003 studies by Luby et al. have some limitations. The authors openly admit that their 2002 study could be limited as the structured interview may not have addressed the issue of duration of

symptoms in sufficient detail. So the symptoms may not have been present for over a two week period as they had suggested. Future studies should focus on the duration of the child's depressive symptoms. A limitation of the 2003 study by Luby et al. can be attributed to the fact that it used a population of clinically referred pre-school children. In this respect, these children may not be a representative group of the population at large since so many of these symptoms often go unrecognized in very young children. This study also lacked ethnic diversity which limits it generalizability. However, both studies have highlighted the importance of the identification of depression within pre-school children which then permits the opportunity for early intervention.

There are very few published research studies which have examined the play activities of children and the underlying mechanisms of the development of depression and play. An innovative study by Mol-Lous et al. (2002) investigated the way in which children's play could be considered as an indication of the prevalence of depression within the very young. The study included 90 children aged between 3 and 6 years of age. The children were divided equally into three groups – (i) depressed, (ii) non-depressed clinical and (iii) non-depressed non-clinical children. The depressed and non-depressed clinical children were selected from 20 day care units of clinical institutions for young children with somatic, somatoform, psychiatric and psychosocial problems. The results showed that the depressed children showed significantly less play, in particular less symbolic play than non-depressed children. Instead, they displayed more non-play behaviours such as exploration and undirected behaviours than the non-depressed groups. The depressed group tended to flit from one type of play or non-play to another. The authors claim that their study strongly suggests that the play behaviour of depressed children is typical of depressed children 'and not as descriptive of children with some type of psychopathology.' (p.1035)

The authors also observed that when a negative mood was presented in the play narratives situation, there resulted a decrease in the amount of play in the depressed children. The authors suggest that the regulatory problems

that characterise depressed children have an inhibiting effect on these children's symbolic play.

Mol-Lous et al. (op cit.) acknowledge that observations of play are not enough to be used as a means of a psychiatric diagnosis and that more extensive assessment procedures are necessary. However, for educationalists, such as teachers and EPs, the use of observation of play is a useful tool which can be employed to identify any possible symptoms of depression in very young children.

Whilst there is growing acceptance that depression exists within very young children, however the evidence is still unclear as to whether or not they experience full depressive episodes. Garber and Horowitz (2002) argue that further research examining the prevalence of depression among very young children is needed. They state that further studies should not only assess diagnoses but they should also measure a range of problems that could be age-appropriate manifestation of mood disorder symptoms. Should the research conclude that these symptoms do in fact represent depressive disorders, further research would need to take into consideration the continuity across time.

(ii) Prevalence

Epidemiological studies have highlighted discrepancies in terms of the prevalence of depression in young people. Merikangas and Avenevoli (2002) state that the wide variation in estimates of prevalence of depression across studies which can be attributed to methodological inconsistencies such as the use of different assessment instruments and sampling frames across studies. In population studies of children and adolescents, the prevalence rates of depression in children has ranged from 0.4% and 2.5% and between 0.4% and 8.3% in adolescents (Anderson and M^{c}Gee, 1994; Fleming and Offord, 1990; Kashani et al. 1987; Lewinsohn et al. 1986, 1993, 1994).

Kashani and Carlson (1987) found that the prevalence rates for a major depressive disorder (MDD) in a sample of one thousand pre-school children to be about 1%. In a study involving older children Cohen et al. (1993) reported a prevalence rate of 2% for MDD in children aged 10-13 years. The prevalence rate was reported to be higher in a study by Polaino-Lorente and Domenech (1993) who found a prevalence rate of 6% for MDD and 3% for DD in children aged 8-11. These rates were based on information from clinicians and teacher rating scales and peer nominations. These rates were higher when the diagnoses were based on self-report questionnaires – 1.8% for MDD and 6.4% for DD.

In studies by Fleming and Offord (1990), Angold and Rutter (1992), Kessler et al. (1994) and Lewinsohn, Clarke, Seeley and Rohde (1994) it was found that the rate of major depressive disorder (MDD) in children was not significantly different for boys and girls. However, in adolescents, the female-to-male ratio increases to approximately 2:1 which parallels the ratio reported in adults with MDD. Girls who experience their first episode of depression during adolescence are at greater risk of prolonged periods of depression in future episodes (Kovacs 1997).

Fleming and Offord (1990) found that the prevalence of depression does not reach the same rate as that found in adults until middle adolescence. Thus, the prevalence of depression in young people is not reported consistently in research. But, the important point is, as Goldberg and Huxley (1992) state that mental health problems are in fact quite common and that one in four people will be affected by some form of mental health problem in any one year. Since these problems are most likely to be mild to moderate forms of anxiety and depression, a significant proportion of them will remain undetected. Unfortunately, since so many people do not seek professional advice or support, the depression can become more intense and feelings of hopelessness can also intensify.

A study by Goodyer (1993) examined depression in school-age children and stated that depression occurs more often than schools realise. However, it

can be very difficult for a classroom teacher, without training, to recognise depressive symptoms, especially at the secondary school age, when they may see very little of individual pupils. It may be a little easier for the primary school teacher to recognise changes in behaviour or mood of a pupil who is permanently in their care, but time constraints may make it difficult for the teacher to talk to the pupil for any length of time regarding any problems the child may be experiencing. If there are no obvious changes in behaviour or mood, in other words, if the depression is repressed or masked, it is even more difficult to recognise a child who is suffering, often in silence. Several possible reasons have been suggested for depression not being identified:

- a belief that children do not experience anxiety or depression and a consequent lack of awareness of the symptoms that the child is presenting with;
- symptoms that may alert us to depression can be dismissed as being 'part of adolescence'. Irritability can be mistaken for 'difficult behaviour';
- sometimes professionals judge the child or young person's presentation as understandable under the circumstances, for example, if a child has been bereaved or abused;
- the belief that if the stressful situation is relieved, the problems will subside;
- if the child or young person is displaying somatic problems, the focus may be fully focused on the physical rather than the emotional signs or symptoms; or
- professionals may not be sure of what to do next, and consequently do not ask relevant questions for fear of upsetting the young person. (DfES 2001 p.30).

(iii) Frequency and Severity

Ryan et al. (1987) found that,

> 'For most of the symptoms of depression, frequency and severity were no different between children and adolescents. However, pre-pubertal children showed somewhat greater

> depressive appearance, somatic complaints, psychosomatic agitation, and hallucinations than did adolescents. In contrast, adolescents showed greater anhedonia, helplessness, hypersomnia, weight change, and lethality of suicide attempt.' (p.138)

All the youths in the study met the diagnostic criteria for depression.

Rutter, Tizard and Whitmore (1970) found that the frequency of depression increased threefold from childhood to adolescence. In later studies by Kovacs et al. (1984 a and b) it was reported that the mean length of an acute depressive episode in children aged 8-13 years was approximately 32 weeks. These studies by Rutter et al. and Kovacs et al. highlight the urgency of early intervention for children who may be experiencing symptoms of depression or who have been diagnosed as having depression.

McCauley et al. (1993) found that initial episodes of depression are more severe and longer in duration for girls than for boys. Again, this study highlights the need for early intervention especially so for girls who appear to be a particularly vulnerable group.

Numerous studies (cited below) have found that, major depression for many youths represents a chronic and recurring disorder. (Kovacs et al. 1984 a, b; M^{c}Cauley et al. 1993; M^{c}Gee and Williams, 1988; Rao et al. 1995; Sanford et al. 1995; Strober and Carlson, 1982; Strober et al. 1993; Fleming, Boyle and Offord, 1993; Hammen et al. 1990; Lewinsohn, Clarke et al. 1994; Warner et al. 1992)

Lewinsohn, Clarke, Seeley and Rohde (1994) reported that most young people recover from an episode of depression. In general samples, 50% of adolescents had recovered within 2 months and 75% had recovered within 6 months. However, the risk of recurrence is high; 12% within 1 year and 33% within 4 years. This study highlights the importance of continued support for children particularly if they are known to have had an episode of depression in the past.

In a study by Newman et al.(1996) it was found that participants who had a mood disorder at the age of 21 were significantly more likely to have a history of previous depressive disorders than non-depressive disorders.

More recently, a study by Lewinsohn and Essau (2002) found that depressed adolescents with 'risk factors' have an elevated risk for major depressive disorder during young adulthood. 'Risk factors' in this particular study were identified as a non-intact household, a high level of conflict with parents, stressful life events, family history of psychopathology, negative cognitions, being female, having depression in adolescence.

In a separate study by Fergusson and Woodward (2002) it was also found that young people with depression in adolescence were at significantly increased risk of major depression later in life. Not only that, they were also at an increased risk of anxiety disorders, nicotine dependence, alcohol abuse or dependence, suicide attempt, unemployment, early parenthood and educational under-achievement.

Garber and Horowitz (2002) raise some interesting questions regarding the phenomenology and epidemiology of depression in children and adolescents. With regard to epidemiology, the authors argue that studies need to examine the possible reasons for the increase in depressive disorders from pre to post adolescents. What are the mitigating factors that cause this increase or is it that there are salient factors that protect very young children so the depression does not manifest itself until they reach adolescence? Why does there appear to be a shift in the sex ratio around puberty? With regard to the phenomenology of depression, Garber and Horowitz (2002) raise questions regarding the structure of depression in young children and adolescents and how this differs between the age ranges. Are there significant differences between the age ranges in relation to the depressive symptoms they experience (e.g. fatigue, feelings of guilt, irritability etc) and if so, what accounts for these differences across time?

2.9 DEPRESSION AND THE LINK TO SUICIDE

'Suicide is probably the most frightening thing. If you mention it to someone they don't want to talk about it. They don't want to talk about it because it's too scary' (Coleman, Lyon and Piper 1995 p.7). These words were spoken by a young woman whose boyfriend had made a serious suicide attempt. Suicide is still a taboo subject.

Over the last decade, research statistics have shown that, suicide is one of the leading causes of death among today's adolescents. Barker (1992), a clinical nurse consultant found that '...as many as 6,000 people commit suicide each year as a function of depression ...' (p.27)

The most recent statistics available by The Samaritans (last updated Jan. 2003) have found that there are at least two suicides every day by young people under the age of 25 in the United Kingdom and Republic of Ireland. 80% of suicides are by young men (15-24 years). (p.1 from website).

A number of longitudinal studies have found a strong link between depression in young people and subsequent suicidal behaviour in adulthood (Harrington et al. 1994; Kovacs, Goldston and Gatsonis, 1993; Myers et al. 1991; Rao et al. 1993). Hammen and Rudolf (2003) report that suicidal ideation is common amongst children who are depressed, with a reported rate of over 60%.

It should be pointed out that it does not necessarily mean that someone is contemplating suicide if they are feeling depressed. Additionally, it is important to recognise that suicidal behaviour can occur in young people in the absence of depression. Depression is therefore neither a necessary nor a sufficient factor for suicide. However the possible link cannot be ignored.

An article by the Royal College of Psychiatrists (1993) says research has shown that,

> '4 out of 10 adolescents have felt so miserable that they have cried and have wanted to get away from everyone and everything ... More than 1 in 5 think so little of themselves that life does not seem worth living ... These common feelings can produce a state of depression that may not be obvious to other people ... emotional disorders are often not recognised, even by family and friends.' (p.5)

The DfES publication (2001) states that:

> 'There are a range of psychosocial disorders which tend to rise or peak during the teenage years; suicide and suicidal/self-harming behaviour, depression, eating disorders ... and abuse of alcohol and psycho-active drugs.' (p.20)

The work of Carlson and Cantwell (1982) found that suicidal ideation increases around puberty and correlates with severity of depression. It should be pointed out that their study focused on 102 children who were psychiatrically referred, and they are keen to point out that these children were more disturbed than other children seen in out-patient clinics or private practice.

As an EP, I agree with Kate Hill (1995) who states,

> 'The attitudes of schools to behaviourally difficult pupils are also vital. Disruptive behaviour often masks emotional vulnerability, and the alienation of a child from the educational system may prove costly. Suspensions and exclusions from school are a common experience among youth suicide victims.' (p.106)

A study of Californian teachers by Ross (1987) revealed that,

> 'Teachers are often anxious about their ability to assess the danger posed by a child's professed suicidal feelings and unclear to whom they should report them. Basic training in how to assess the lethality of a child's suicidal intentions, and clarification of their individual responsibility, substantially boosted teachers' confidence in helping suicidal pupils.' (p.103)

This is also true for recognising a depressed pupil and knowing what further action the teacher needs to take. It is vitally important that what the child says is believed and taken seriously by teachers.

Coleman et al. (1995) claim that,

> 'Far too often suicide attempts are dismissed as 'just a cry for help'. For a young person to feel so bad, so hopeless and helpless as to attempt suicide then this is indeed a cry for help. It is a cry which should be listened to, taken very seriously, and responded to with sensitivity.' (p.10)

The authors go on to state that research has shown that,

> '... approximately 10% of those who make a suicide attempt will do so again within the next twelve months. Those who do try again are those who feel that no-one has listened to them after their first attempt.' (p.24)

In a recent study which looked at deliberate self-harm in adolescents, Hawton et al. (2002) found that one of the factors which was present in females who self-harmed was depression. The authors of the study concluded that since deliberate self-harm is common in adolescent females, school based mental health initiatives are needed. They also suggest that pupils who are 'at risk' for self-harm or showing signs of depression should be screened and pupils should be educated on issues regarding mental health.

It can be very difficult to determine whether or not the underlying difficulties experienced by children and young people displaying disruptive behaviour is really due to mental health problems such as depression. However I feel it is crucial that the child's behaviour is assessed carefully so that the underlying cause of this behaviour can be realised and appropriate support can then be offered to them.

2.10 SUMMARY

Numerous studies have now established that depression has been identified in very young children through to adolescence. It can be a chronic and recurring disorder. This chapter has highlighted the most salient factors which have been identified by the research as possible risk factors for depression in children and adolescents. It has been recognised that depression in young people can be multi-factorial and not necessarily caused by any single risk factor. The research reviewed in this thesis provides an overwhelming rationale for efforts into the prevention of depression in young people. The paper by Roberts (1999) which reviews the risk and protective factors in addition to the efficacy research on early interventions to prevent depression in young people concludes that the prevention of depression is an area of great importance to the psychological health of our communities. Early intervention has the potential to reduce the prevalence of depression. Roberts (1999) suggests important areas for further research which include the effective integration of prevention programmes into the school curriculum and determining the essential elements, length and mechanisms of change of effective programmes. In addition, it is important to determine the most appropriate group facilitators whether they are teachers, school nurses, educational psychologists or counsellors.

The research studies cited in this chapter have demonstrated that youngsters 'at risk' can now be more easily identified. I would argue that this is true, only if the adults who know the children have the knowledge and understanding required to recognize the possible signs of depression.

I agree wholeheartedly with Greig (2004b) who argues that since there are so many potential sources of depression, it should not be exclusively claimed as the domain of the health professional. Anyone who works closely with children and adolescents cannot afford to wait for depression to take hold. Steps should be taken to identify young people at risk and schools are in an excellent position to do this. Since children spend so much of their time in schools, school-based intervention programmes which can be integrated

within the school curriculum, currently offer the most cost-effective means of prevention and/or support for children suffering from depression.

This research aims to supplement previous studies as it examines whether or not there is a prevalence of depression in school children, in particular boys aged 8-15, who have a history of emotional and behavioural difficulties. If depression does indeed exist within this population, its profile can also be studied and thereby provide some evidence as to how these pupils can best be supported in order to alleviate their depression. The study also aims to provide information regarding the support (if any) which these pupils feel would benefit them the most and what additional information and/or support headteachers at the EBD schools feel they need in order to support their pupils further. This information could also be disseminated to headteachers of mainstream schools. Since prevention is better than the cure, preventative measures need to be taken in mainstream schools, thereby possibly eliminating a potential crisis situation.

CHAPTER 3 METHODOLOGY

CHAPTER 3 METHODOLOGY

3.1 INTRODUCTION

This chapter sets out to clarify the aims of the research study. It also describes the research sites and the participants. The research tools are described including their limitations. The procedure is clarified and the data analysis is also described. The chapter concludes with the practical limitations of the study.

3.2 AIMS OF THE RESEARCH

This study aims to address the following questions:

1. What is the prevalence of depression in boys aged 8-15 attending schools for pupils with emotional and behavioural difficulties?
2. What is the profile of depression (if any) in these pupils?
3. What are the pupils' knowledge of depression?
4. What are their views on the support they are currently receiving from school?
5. Would the pupils like to learn more regarding mental health issues in young people?
6. How does the support currently provided by outside agencies compare to the support which the Headteachers feel they require in order to support the pupils' emotional needs?

3.3 RESEARCH SITES

Three specialist EBD schools from one LEA were used in this study.
It would be useful at this point to include some information regarding the EBD provision within the participating LEA. Currently, there are three non-residential special schools for boys with EBD. These schools are also classified as 'Centres of Expertise'. They are able to offer part-time and full-

time placements to pupils at Key Stages 2 and 3. For the purpose of this research study, they shall be referred to as School 1, 2 and 3 in order to preserve their anonymity. The number of places available between the schools range from 25 to 50 so there is the possibility of 115 places in total.

There is also one residential school within the LEA which offers provision for boys only. There is a lack of specialist provision for girls with EBD within the LEA, hence all the participants within this study are boys.

The boys are given a place at one of the EBD schools by the LEA when their mainstream schools feel they can no longer support the needs of the boys. In effect, all the boys have been excluded from their mainstream school. Further information regarding provision and support for pupils with EBD within the LEA can be found in the Appendix (see Appendix 5).

3.4 PARTICIPANTS

The study group consisted of 75 boys across three EBD schools within one LEA. The participants were boys from Year Groups 5-9, (aged 8-15).

Only 2 pupils were not given permission by their parents/carers to take part in the study.

As stated earlier, there was the possibility of a total of 115 boys to take part in this study, but there were a number of factors which limited the number who actually took part to 75. Firstly, some of the older pupils in years 10 and11 were attending colleges or were in 'education otherwise' (e.g. receiving home tuition). In addition, I did not feel it was appropriate to include pupils younger than 8 years of age as Lang and Tisher (1983) state that the CDS is most useful as a diagnostic aid for pupils aged 9 and older. If it is used with children under the age of 9 years, then it needs to be explained in more depth to the younger children who may have difficulty understanding some of the items. Also, there were a few boys from each of the three EBD schools who

were regular non-attendees and therefore, were unable to take part in this study. 75 was the greatest number of participants who could, in effect, take part in this study.

It is the case that the entire population of pupils attending the three EBD schools in the LEA are male.

Three Head teachers from the participating schools took part in an unstructured interview.

3.5 RESEARCH PROCEDURE

(i) Outline of Procedure

The table below outlines the stages of the research procedure.

Table 3.1: Outline of Procedure.

1)	Contacted HTs to request their participation in the research study.
2)	Letters requesting permission were sent to parents.
3)	The CDS was carried out in a one-to-one situation either with the Researcher, the assistant EP or with the research student.
4)	Immediately following the completion of the CDS, the participants were then asked to answer questions from the supplementary questionnaire.
5)	An unstructured interview was carried out by myself, with each of the three HTs individually.
6)	HTs were informed of the names of the pupils who obtained a depression score higher than the norm.
7)	General feedback of the results were given to: ➢ The LEA ➢ The Principal EP ➢ The Head teachers from the participating schools ➢ CAMHS ➢ Behaviour support teams

Initial contact was made by telephone to the HTs of the EBD schools in order to obtain permission to use their schools as a base and for their pupils to participate in the study. I found it surprising that the HTs of the three EBD

schools did not need convincing that this study was worthwhile since I had encountered strong opposition to a similar study in the past which involved mainstream school children. Some of the HTs that I contacted in the past were reluctant to participate as they felt the subject matter was too sensitive and that more difficulties could result. Some HTs were quite honest about their feelings and said that the study, and all that it entailed, would greatly inconvenience the staff and children. After the HTs in the current study gave a conditional agreement to participate in the study, meetings were arranged for us to discuss in more detail information regarding the nature of the study. The HTs were given a copy of the CDS for their information, comments, approval, reservations, etc. It was essential to inform them that should any pupils be found to be depressed, that I was not in a position to offer any support to the school or the pupils. Instead, it was suggested to the HTs that they contact their school Educational Psychologist should further support or advice be needed. Following this meeting, all three HTs gave their consent to participate in the study. A formal letter was then sent to the HTs which outlined the nature of the study (see Appendix 6). Parental request forms were then given to the HTs to distribute to all the pupils. The parental request forms gave an outline of what the study entailed and, crucially highlighted the confidential nature of the study. In so doing, it was hoped that more parents felt able to give consent for their child to participate in the study (see Appendix 7).

In order to be able to include as many participants as possible, it was agreed by myself and the HTs of the schools involved that within the letter of consent to parents/carers they would be told that the research would be taking part in their child's school and that permission would be assumed unless the parents objected. Thus the onus was put on the parents to withdraw their child from the research. The main reason for utilising this method of obtaining consent was due to the difficulties relating to letters being given to pupils from school to give to their parents. My experience as a teacher has taught me that letters are not always received by parents for a number of reasons, either by mistake or they are deliberately destroyed or thrown away by the children. If the study had relied upon written consent being given by the parents who

actually received the letters, it was highly probable that very few pupils would have been able to take part. With hindsight, I consider there to be a number of important issues pertaining to the procedure adopted with regard to obtaining consent. Firstly, the parents were not contacted either by myself or the schools to check whether or not they had received the letter of consent, therefore parental consent should not have been assumed in cases where consent forms had not been returned. It is probably true to say that some parents would not have wished for their child to participate in this study. In future studies, an alternative method of obtaining parental consent would have to be considered in order to ensure that consent has indeed been given.

Appointments were arranged for myself, the assistant EP and research student (i.e. the interviewers) to visit the three schools in order to carry out the study. Children whose parents/carers had given consent were chosen by the interviewers from the school register in a random order. Since all the pupils within the appropriate age range were asked to participate in the research, the results could not be confounded in any way by a more selective method of pupil choice. Participants were individually removed from the classroom during normal school hours. A setting was selected to ensure privacy, confidentiality and reduce distractions.

First, the CDS was completed then the supplementary questionnaire. Since this part of the study involved three interviewers it was important that certain elements of the interviews were standardised in order to keep *interviewer effects* to a minimum. So, before the pupils were asked to complete the scales for depression, they were debriefed in the following standardised manner in order to maintain consistency:

1. The interviewer gave their name and told the participants that they worked for the education authority.

2. The participants were assured that they were not in trouble. The participants were also told that this was not a test. It was noticed by the interviewers that many of the participants visibly relaxed at this

point. The participants were informed that all the boys from Year Groups 5-9 would take part and that no individual had been singled out for any particular reason.

3. It was considered ethical for the participants to be informed that they were taking part in a research project prior to its commencement.

4. The participants were informed that they were taking part in research which involved finding out more about:
   a) their feelings
   b) themselves
   c) school
   d) their home-life.

   Although the word **depression** was not mentioned prior to the completion of the CDS, it was hoped that the participants understood that they were taking part in a potentially informative study.

5. By informing the participants that they would not be named in the research, it was hoped that they would feel more inclined to reveal their true feelings and attitudes during the interviews. Gregory (2003) states,

   > 'Confidentiality is the price demanded for the sharing ... for being privy to the innermost thoughts and feelings of the participant in her research.' (p.51)

6. Before the participants were asked to complete the CDS, they were told that their answers would be treated in strict confidence and that no one else other than the interviewers would see their answers. This left scope for professional and ethical considerations in that since I was to be accountable to the HTs, any pupil found to have a depression score higher than 120 would be reported to the HTs so that any necessary support could then be sought.

7. The participants were informed that once the data had been gathered and analysed from all the pupils taking part, all questionnaires would be

destroyed.

8. The participants were asked to answer the statements truthfully and they would not get into trouble for any information they disclosed.

9. The participants were told that they could withdraw from the investigation at any time, in accordance with the Code of Conduct (6.1p.10). It was imperative that the participants gave their consent to take part in this study since it involved an intrusion into their thoughts, feelings and attitudes towards themselves, school and their family life. They were also informed that they were not obliged to answer each question if they found it upsetting.

Gregory (2003) says that,'... consent should always be sought as a tribute to the autonomy of individuals.' He goes on to state,

> '... it should be sought because there are some things (thoughts, feelings, attitudes, etc) that are private to the individuals concerned, and it is only their consent that can justify entering into that domain of essentially private concerns.' (p.41)

It was important to establish a safe, friendly and caring atmosphere in order to make the participants feel less intimidated by the tasks. It was hoped that this would help to maintain their co-operation.

A note was made regarding whether or not the pupils took the task seriously. It was ensured that all pupils were given enough time to complete the CDS and supplementary questionnaire.

(ii) The Interviewers

Since all the participants in the study had emotional and behavioural difficulties, they could be classified as a 'vulnerable group', therefore particular attention needed to be paid as to the suitability of the interviewers. In this research study all three interviewers were qualified school teachers,

two primary and one secondary trained, with considerable years experience between them. I had 5 years experience as a full-time Educational Psychologist, whilst another interviewer had 2 years experience as an Assistant EP. The third interviewer has a Masters Degree in Educational Psychology. All interviewers had previous experience of research which had included children. The interviewers had the professional skills and insight into the sensitivities of the participants in order to keep their distress to a minimum.

One assistant EP and a research student were able to assist me in interviewing some of the pupils for the study. The assistant EP and research student were requested to familiarise themselves with the **ethical principles for conducting research with human participants** as stated in the Code of Conduct, Ethical Principles and Guidelines document (November 2000). They were also given the opportunity to familiarise themselves with the CDS, since neither the assistant EP nor the research student had previously used this depression scale. They were given instructions with regards to the coding system and any changes I had made to the CDS prior to any interviews being carried out.

Since neither myself, nor the Assistant EP were the Educational Psychologist for the schools who took part in the study, there was no previous knowledge of any of the pupils. As the researcher, I was 'blind' to the pupils' prevalence of depression (if any), a priori at any of the schools.

(iii) Scoring System

All pupils were given verbal instructions and information by the interviewers regarding the scoring system for the CDS. Full details of the CDS, its use and its limitations can be found later in this section. Having used the CDS on previous occasions, it was noted that some pupils had experienced difficulties interpreting the scoring system. In order to overcome these difficulties, the interviewer read aloud the first three items from the CDS and helped the pupils consider which response was most appropriate for these items. This

was carried out for several reasons: Firstly to make the pupils feel less isolated and therefore more comfortable since the interviewer was taking a more active participation in the task; secondly, to ensure that the statements had been read correctly and understood which would thereby help to overcome any ambiguities or misinterpretations; thirdly to provide additional support to the participants in order to help them understand the scoring system. Following items 1 to 3, the participants were asked if they would like to continue on their own without any help from the interviewer. Those who felt confident did so but nearly all of the participants preferred the interviewer to read aloud all the items to them.

The three interviewers (all female) were very aware that the participants (who were all male) may appreciate more personal space, so moved as far away as possible from them without seeming too clinical in their approach. For the participants who wanted the support of the interviewer, either with the reading of the statements or scoring (after number 3) the statements were read from a blank CDS which was held by the interviewer. If the participants were uncertain as to the meaning of any of the questions, they were able to ask the interviewer for help.

Following the completion of the CDS, the interviewer read aloud the questions from the supplementary questionnaire. The supplementary questionnaire was designed to obtain more accurate and further information regarding the participants' knowledge of depression. It was also used to find out if the participants were keen to learn more about mental health issues in young people. When all pupils had completed the CDS and the supplementary questionnaire, an unstructured interview was carried out with HTs on an individual basis by myself.

(iv) Ethical Considerations

It was imperative to familiarize myself with the information contained within The Code of Conduct, Ethical Principals and Guidelines (November 2000) which states that no harm should come to the respondents as a result of their

participation in the research. By so doing, it was hoped that I was exercising my duty of care not only to the participants, but also to their parents. This is one of the basic ethical principals of research studies carried out using humans as participants. It was important to create a warm, caring atmosphere where the participants would not feel threatened in any way. As mentioned earlier, the participants were informed that they could withdraw from the interview at any time should they feel distressed in any way. Some of the statements contained within the CDS, for example, number 10 'Sometimes I wish I was dead' or number 35 'Often I hate myself', it was felt that the participants could become upset by some of them. In this instance, if it was apparent that the participant had become upset then the interview would be abandoned rather than risk causing any more distress to them.

Prior to the commencement of the formal part of the interview, the participants were informed that if they felt upset during the interview, they could leave the room. A total of 2 participants made a decision to abandon the interview during the course of the research study. They made it quite clear to the interviewer that they did not want to participate any longer in the study nor did they wish to be contacted again at a later date, therefore there was no follow-up of these students. Since the information received from these two pupils was incomplete, it was not possible to obtain a total depression score nor was it possible to obtain their knowledge and understanding of depression, therefore, it was not included in the data analysis. The termination of the study by these two pupils raises further important issues particularly in relation to support which they should have been given upon leaving the interview room. As far as I am aware, these two boys returned to their respective classrooms, unaccompanied (both pupils were interviewed by one of the research assistants, not myself). With hindsight, this scenario should have been given considerable consideration and discussed by the three interviewers prior to any interviews taking place. As part of their preparation, the three interviewers should have agreed on a plan of action if any of the pupils had found the interview distressing in any way. It should have been agreed that all pupils would be accompanied back to their classrooms and had any of them become upset during the interview, their

teachers should have been informed so that support could be offered by members of staff who knew the boys well rather than by the researcher. In future studies involving school children, support should be available for any pupil who becomes distressed during the course of an interview. In addition, it is crucial to ensure that any researcher working with pupils with social, emotional and behavioural difficulties and who could be described as 'vulnerable', are fully aware of the possible distress that could be caused especially when the topic under investigation could be described as particularly sensitive in nature. It was assumed that since the three interviewers were experienced school teachers, and in the past had taught pupils with emotional and behavioural difficulties, that they would be particularly sensitive towards the pupils during the interviews and to any distress which the boys may have be feeling. However, in future studies involving pupils experiencing emotional and behavioural difficulties to the extent that they are no longer able to attend mainstream schools, and especially when they are required to respond to questions relating to their innermost feelings and emotions, then it is crucial that the researchers have the opportunity to discuss such issues and remind themselves of how vulnerable these pupils are. The preceding points highlight some of the limitations of the study since some crucial issues were not discussed by the interviewers prior to meeting any of the pupils.

Research using human participants can result in a moral dilemma in that if the researcher is given information which could impede the possible safety of others or to the participants themselves, then, 'The principal of confidentiality in specified circumstances can be outweighed by more compelling moral considerations' (Gregory 2003 p.54). With respect to this, the moral obligation to inform the HTs of any of their pupils who obtained a score on the CDS which was higher than 120 was deemed to outweigh the principal of confidentiality in this research study and I felt it was another way in which to exercise my duty of care to their parents. Since depression can potentially be life threatening, it was not considered ethical to maintain complete confidentiality. It was suggested to the HTs if they became overly concerned regarding any of their pupils who had obtained high depression scores on the

CDS i.e. scores above 120, that they seek further advice from their school EP. I informed the three HTs that a score of 120 or above did not necessarily mean that a child was depressed and that for the purpose of this research, the cut-off point was used solely as a guideline and not as a form of diagnosis. It was important that any pupil with a relatively high score was brought to their attention so that, in turn, teachers could closely monitor the pupil's behaviour. Support could then be provided to those pupils who appeared to be in need.

I discussed the nature of the research with EPs assigned to the three EBD schools prior to its commencement for a number of reasons: Firstly, in order to ensure that no similar work was already being carried out in the schools; secondly, to determine the possible attitudes of the HTs to research of this kind being undertaken in their schools and whether or not they would be amenable to the suggestion; thirdly, in order to be courteous to the EPs themselves since I would be visiting their schools and working alongside pupils whom they already know; finally, so that they would be aware that the school may refer to them some of the pupils who obtained a score higher than 120.

Several months after the research was conducted, I contacted the three HTs in order to find out what action, if any, had been taken by them in relation to the participants who had obtained a depression score above 120. Two of the HTs informed me that they had decided to monitor closely a couple of the pupils since their behaviour was causing the staff considerable concern. Another HT informed me that one of their pupils had become increasingly more aggressive towards other pupils and the staff, but they had not requested support from their EP as they felt that the behaviour could be contained by their own staff and they had enlisted the support of the key worker.

3.6 RESEARCH DESIGN

This study has a hybrid design, i.e. it uses an approach which brings together in one study, characteristics which are typical of different traditions of doing research. It is concerned with one group of individuals and particular aspects of its lifestyle using a combination of fixed and flexible strategies (Robson 2004 p.90). Essentially, the underlying paradigm to the methodology would be described as pragmatic. The pragmatic approach utilises whatever philosophical or methodological approach that works best for a particular research problem. This leads to a mixed-method study where both qualitative and quantitative approaches are adopted. These approaches will be discussed in more detail in section 3.9.

This study incorporates features of a 'fixed design' as it is concerned with group properties rather than what individuals have done. One advantage of a fixed design is that it is able to identify patterns which can be linked to social structures or to group or organisational features. Fixed designs also tend to use the concept of variables which can vary and therefore, can be measured and compared. In this study, the variables SE, GL etc can be measured; the measurements vary and they can be compared to one another.

A fixed design is theory-driven, so with respect to this study, the theory would be that there would be a prevalence of depression within this population and perhaps it would be greater than the prevalence of depression found within the general population. By implementing a fixed design, the study is engaged in a confirmatory task.

A 'flexible design' is sometimes referred to as a qualitative design. They can incorporate quantitative methods of data collection as is the case in this study.

This study could be described as a piece of Action Research i.e. there is an intention to initiate change. The intention is to improve the knowledge and understanding of depression within the EBD school population and also to extend that knowledge to adults working alongside pupils within mainstream schools. There is also the intention that any support which the HTs feel they require in supporting their pupils further will be forthcoming from the LEA. There may also need to be a change in the practice of EPs or the situation in which the practice takes place.

3.7 METHODS OF DATA COLLECTION

The research study utilised three types of interviews as a method of data collection. In accordance with a hybrid design mentioned earlier, three techniques were used:

1. Interview-based survey.
2. Structured interview.
3. Unstructured interview.

3.8 RATIONALE AND LIMITATIONS OF THE INTERVIEW METHODS OF DATA COLLECTION

(i) Interview-based Survey

The Children's Depression Scale (CDS) (see Appendix 8a and b) was originally intended to be used as a self-completion questionnaire. However, for the purpose of this research study, the participants were given a choice as to whether or not they preferred the interviewer to read the statements from the CDS aloud to them. Since most of the participants did indeed prefer this method, it changed from a self-completion questionnaire to an interview-based survey. An advantage of this method was that the sincerity and honesty of the pupils could be checked. In addition, it made it possible to ascertain whether or not exaggeration could have occurred, i.e. '...inventory

responses are especially susceptible to distorting tendencies on the part of the patient' (Beck 1967 p.176-177). An advantage of the face-to-face interview as used in this research study (as opposed to the self-completed questionnaire), was that the interviewers could control the question-order. The interviewer could also clarify any questions which the participant may have.

Another reason for using the interview technique as opposed to a self-report questionnaire, was in order to keep missing data to a minimum. Having used the CDS in its intended form as a self-report questionnaire method in the past, and received incomplete records, it was felt that the presence of the interviewer would help to focus the participants on the task in hand so statements would not accidentally be left out. The completed CDS was checked to ensure there were no gaps in responses, especially if the participant chose to complete the scale by himself.

This study has some potentially crucial elements of missing data which includes those pupils who regularly do not attend school. In the Lang & Tisher (1983) study, their first use of the CDS included a group of pupils who were described as 'a group of relatively severe cases of school refusal' (p.18 Manual). These school-refusers were independently assessed by clinicians who knew the children well. Ratings were made along a seven point continuum of 'happy or unhappy' which corresponds to the 'affective response'. Over 87% of the children were rated as 'unhappy'. It was therefore assumed that this group of school-refusing children were depressed. Perhaps then, the pupils in the present study who did not attend school regularly could also have a depression score higher than the norm as in the study cited above. Crucial data could be missing from this study since these pupils were not available to take part. In this sense, it could be said that there could be some 'correlated biases' (Oppenheim 2003 p.280).

Is *response set* a possible outcome of experimenter expectancy? (Robson 2004 p.112). Due to the sensitive nature of the statements contained within the CDS it was hoped that *response set* could be avoided by ensuring that

the participants' responses would remain confidential: For example, Question 33 'Sometimes I feel that life is not worth living' and Question 36 'I have many friends' may have had more truthful responses if the participants had been alone when completing the CDS rather than in the company of the interviewer and thereby avoiding a *response set*. It was hoped that by not making any comments to any of the responses made by the participants, that they would feel confident enough to respond truthfully, thereby eliminating a potential threat to the validity of the research.

(ii) Structured Interview

The supplementary questionnaire was designed by myself (see Appendix 9). Changes had been made to some of the questions contained within the original supplementary questionnaire which I had used previously in a pilot study. It was hoped that any ambiguous questions had been eliminated thereby giving a more accurate account of the participants' perceptions, knowledge and understanding of depression and mental health issues in young people. The intent of the supplementary questionnaire was to provide useful information as to whether or not the participants felt their emotional needs were being met in school and what other support they felt would benefit them (if any).

The questions from the supplementary questionnaire were read aloud and recorded by hand on the form by the interviewers for the following reasons:

1. To ensure that each question had been read correctly and to save any embarrassment to the pupils with reading or spelling difficulties.
2. To save time.
3. Some of the phrases or words could be changed to ensure the young participants had fully understood their meaning; for example, Question 6 'Do you feel this school supports your emotional wellbeing?' was changed to 'Do you feel this school helps you with your emotions and feelings?'

The supplementary questionnaire included closed and open questions. Open questions were used in order to give the participants freedom to answer as broadly or as succinctly as they wished. These questions allowed the participants to use their own ideas and language. This type of questioning allowed for more in-depth answers and it gave the interviewer the opportunity to clear up any misunderstandings. It was also used to test the limits of the participant's knowledge. However, one of the disadvantages of using open-ended questions was that the responses needed to be coded for analysis which was time consuming.

In relation to the closed questions, the respondents were offered a choice of alternative replies namely, Yes, No and Don't Know. Some of the closed questions were attitudinal as well as factual. Question 6 'Do you feel this school supports your emotional wellbeing?' is an example of an attitudinal question. Question 1 'Have you heard of the medical condition – DEPRESSION?' is an example of a factual question.

The responses were recorded on the sheet itself by the interviewers. Miles and Huberman (1994) provide a useful tactic which can be used to generate meaning from the information given by the participants:

1. Note patterns, themes and trends within their answers.
2. Clustering – group responses which have similar patterns or characteristics.
3. Counting frequency of responses.
4. Making contrasts and comparisons which establish similarities and differences between the sets of data. This tactic was used for the purpose of this research.

The coding frame was derived from the sample of responses obtained during the interview. Individual responses were classified into smaller groups which included responses which were similar in content without hopefully, losing vital information (see Appendix 10 for example of coding frame for Question 2).

Some positive responses to Question 6 'Do you think this school supports your emotional wellbeing?' from the supplementary questionnaire could have occurred due to interviewer effects. The participants may have answered 'Yes' to this question of they perceived it to be the answer expected by the interviewer. A more useful method of obtaining this information would have been to ask the participants to rate the amount of quality of support they had received on a scale from 1 to 10 (1 being no support to 10 being very good support).

The one-to-one method of interviewing has advantages over group testing as shown below:

Table 3.2: Advantages of 1-1 Administration against Group Administration.

1-1 Administration	Group Administration
Allows participants to ask for clarification of a statement in CDS.	Many participants can take part– time saving.
Tester can see non-verbal cues from participants e.g. emotional reaction to items and thereby gain more accurate information about the participant.	Anonymity may produce more honest responses particularly from adolescents who want to present themselves to others in a socially desirable way. A 1-1 situation may prevent this.
All questions can be read to the participant if they have reading difficulties.	
Tester can ensure all statements are responded to.	
Tester can ensure that scoring system has been understood.	
Provides the participant with the opportunity to discuss feelings openly with the tester.	
Participants have the opportunity to comment, provide feedback on any of the items.	

The table clearly shows that individual testing has a wide range of benefits in comparison to group testing. Although this study had all the advantages of one-to-one testing, it took approximately 30-40 minutes for each pupil to complete the CDS which highlights one of the disadvantages of 1-1 administration.

(iii) Unstructured Interview

All three HTs were interviewed on separate occasions by myself. Each interview lasted approximately 1 hour. Since I considered this research to be an example of Action Research, which implies that something will happen at the end of it as a direct result of the findings, it was hoped that by interviewing the HTs, that the LEA would provide the support the schools felt was required, rather than the support which the LEA considered to be needed.

Oppenheim (2003) refers to this type of interview as *exploratory or depth* interviews. The purpose of the depth interview was to collect *ideas* rather than *data*. Oppenheim states that this free-style type of interview would consist mostly of a continuous monologue by the participant on the topic of the research with a few acknowledgements by the researcher. I felt that by using an unstructured interview technique with the HTs that this would be the easiest way to find out their honest opinions with regard to the support they were currently receiving by outside agencies, support they were currently able to offer their pupils and further support they felt was required.

There was a deliberate intent on my part not to link questions relating to the CDS and to possible levels of depression, to this part of the study. It was assumed that the HTs would already consider the possibility that some of their pupils would be depressed therefore, it was not considered necessary to explore this aspect with them. This could be considered a methodological weakness of the study since the HTs' knowledge of the prevalence of depression within the pupils could have confirmed the prevalence of

depression within certain children. In this way, the study would not have relied solely upon the participants' own responses to the statements on the CDS. However, this raises issues around the ability of HTs and class teachers to identify behaviours which are indicative of childhood emotional difficulties, such as depression.

In future studies, if it is found that teachers and parents are accurately able to identify behaviour indicative of depression within children, it would permit the use of triangulation (Denzin 1988 p.174 in Robson 2004) as a method of data collection. However, it can be argued that until parents and teachers are able to recognize the symptoms of depression within children, and that the children are also able to recognize it within themselves, triangulation may not add to the validity of research in this area. Bloor (1997) argues that obtaining information from three sources can possibly lead to differences of opinion, therefore the discrepancies between the informants' data could actually increase difficulties with a study's validation. Since I had a clearly defined purpose when interviewing the HTs, I felt that the flexibility which the unstructured interview permitted would provide the most useful method of gathering information, since it would not introduce any confounding experimenter expectation effects (hopefully). In addition, it would allow flexibility in achieving a complete picture of attitudes of the HTs without being seemingly intrusive. I wanted the HTs to feel able to criticise the Educational Psychology Service if they so wished and during the interview. I stressed to all three HTs that they should feel free to state how the felt with regard to the support they were currently receiving not only from the Educational Psychology Service but from other outside agencies without the fear of any reprisals. In order to maintain professionalism, I requested that no individual Educational Psychologist be named by the HT should any criticism be forthcoming.

As a method of data collection, unstructured interviews can possibly lead to a lack of direction especially if a participant feels they have a lot to say about a particular issue. A weakness of this method can result in the participant straying too far from an agenda or lingering too long a time on any particular

issue. I was very conscious of this during the interviews with the HTs but it was important to give them sufficient time to expand their thoughts and feelings regarding issues relating to support within their schools.

Since there were no fixed questions to be asked, the HTs were encouraged to discuss certain issues around the quality and quantity of support they were currently receiving from outside agencies and how this differed from that which they would like or felt they needed to receive. It also included information regarding the type of support the staff were able to provide to the boys in their schools. I took detailed notes during the interviews. By interviewing the HTs personally, rather than by a postal questionnaire, the problem of *response rates* was overcome. In addition, information given by the HTs was not restricted to any set questions. Since I visited the schools regularly during the testing period, it did not add to travel costs nor did it require paper, envelopes or stamps. Also, call-backs were not required. However, unstructured interviews were costly in terms of my time as the information needed to be coded in some way especially as a comparison of the respondents' information was made.

To a large extent, it can be argued that these methodological weaknesses reflect the time limitations of the study. The data collection had to be administered in term time and arranged around pupil examinations. Nevertheless, despite these weaknesses, the study provides some insights into the prevalence and profile of depression within the population of boys attending schools for pupils with EBD.

3.9 DATA ANALYSIS

(i) Data from the CDS

The research provided data in both qualitative and quantitative form derived from the CDS, the supplementary questionnaire and the Headteacher interviews. As stated earlier, the research design utilised both fixed and flexible designs. In general, confirmatory data analysis is used when fixed or quantitative designs have been used and exploratory data analysis is used when the design is more flexible or qualitative in style. Since the intention of the study was to examine the prevalence of depression, a confirmatory analysis was the most appropriate method to use. In contrast, the supplementary questionnaire and interviews with the HTs offered a more exploratory type of data analysis.

In the case of the CDS, a quantitative data analysis was used in order to identify the number of pupils suffering from depression. The participants' responses were categorised in terms of affective response, social problems, self-esteem, preoccupation with own sickness and death, guilt and pleasure and enjoyment. An overall level of depression, (D) from the CDS was compiled for each of the participants. For this purpose, the scoring method advocated by and explained by Lang and Tisher (Manual p.14) was employed. The manual provides a table showing a range of total depression scores for a 'normal population', which served as a Control Group. Lang and Tisher's control group consisted of 37 pupils (22 boys and 15 girls) who were regular school attenders and who had not missed more than ten days during the year. All the children were aged between 9 and 16 years (mean age 13 years 1 month).

Children with scores above 120 could be considered to be depressed or at least have some symptoms of depression. Children with scores up to and including 120 are not considered to be depressed. Once the total D score had been obtained, it was possible to examine how many of the participants

had obtained a score above the cut-off point of 120 which would indicate a prevalence of depression.

A Chi-square test was used to identify any difference in levels of depression across the three schools between two age ranges 8-11 and 12-15. The calculations can be found in Appendix 13.

In order to examine the profile of depression, the study utilised a 'within subject analysis' across levels of depression. A multiple regression analysis indicated, "... the proportion of variants in the criterion variable which is accounted for ... by our set of predictor variables. Furthermore, R square (R^2) is the square of the measure of correlation ... a measure of how good a prediction of the criterion variable we can make by knowing the predictor variables" (Brace, Kemp & Snelgar 2002 p.209).

By the use of a Multiple Regression Analysis as outlined, it was hoped that the relative contributions of the Predictor Variables to depression would be revealed. As noted by Brace, Kemp & Snelgar (2002):

> "In ANOVA we are trying to determine how much of a variance is accounted for by our manipulation of the independent variables ... in Multiple Regression we do not directly manipulate the IVs but instead just measure the naturally occurring levels of the variables and see if this helps us predict the score on the dependent variable (or criterion variable)." (p.207)

(ii) Data from the Supplementary Questionnaire

Data from the Supplementary Questionnaire was processed by myself. It provided both quantitative and qualitative data. As stated earlier, a coding frame was devised which enabled the responses (raw data) to be categorised into smaller groups which were similar in content. This information was presented graphically using histograms in order to show any similarities or differences between the two groups in their responses.

(iii) Data from Interviews with Headteachers

The unstructured interviews with the HTs provide a qualitative aspect to the study.

During the interviews I recorded very detailed handwritten notes of the information provided by the HTs and these were later coded and categorised in a way very similar to responses made to the Supplementary Questionnaire. The responses were coded into common themes which became very apparent upon completion of all three interviews. The common themes which emerged could be categorized as follows:

1) Support which they were currently being able to provide for their pupils;

2) Support which the school was currently receiving from outside agencies;

3) Support which they felt their school needed in order to provide more effective support to their pupils and staff;

4) Training issues.

3.10 DESCRIPTION OF THE CHILDREN'S DEPRESSION SCALE

A note by the authors of the CDS, Lang and Tisher, states that the use of the CDS should be encouraged as a clinical instrument, but they warn against it as a sole diagnostic tool, and rather it should be used as a **diagnostic aid**. For the purpose of this study, the CDS was used as a screening instrument to examine the prevalence and profile of depression within the EBD school population. It was not used to diagnose depression in the participants. However, as a precaution, the HTs were informed of any participant who obtained a total depression score above 120 (Lang and Tisher's prescribed cut-off point).

The CDS is a 66-item self-report questionnaire that measures the severity of depression. It includes 48 depression items; for example, "Often I feel miserable / weepy / unhappy" and "I feel that life is miserable for me", and also 18 positive items; for example, "I feel proud of most of the things I do" and "In our family we all have lots of fun together". These suggestions are written on target cards and the child is required to place each one in turn into one of five labelled boxes – "Very Wrong", "Wrong", with "Don't Know/Not Sure" as the midpoint, and "Right", "Very Right". Unfortunately, the official boxes and target cards were no longer available for use, so the participants gave their response to each item on the record sheet by writing the numbers 1-5 as appropriate. Not having the boxes was not detrimental to the procedure. In fact, since there were three interviewers there were times when interviews were carried out simultaneously in order to save time. It would not have been possible for all three interviewers to use the boxes at the same time.

The CDS contains statements which could be seen as negative or positive in affect for a child. Thus, the CDS requires a child to categorise or put a value judgement on each of 66 feelings, affects or emotions regarding events, behaviour or other people.

Scoring is in the direction of positive symptomatology on one of eight defined subscales, of which five (e.g. "self-esteem", "affect", "preoccupation with own sickness", "guilt" and "social problems") make up the total depression score. A total pleasure scale is included. Also, there is a miscellaneous depression sub-scale which includes 9 depressive items that do not relate to the other sub-scales nor theoretically to each other. There are a further 10 positive items which are scored as miscellaneous pleasure sub-scale which do not theoretically belong to a sub-scale.

There is also a CDS adult/parent version (administered in the same way as above) for which items have been rephrased in the third person singular.

The 66 items are grouped into sub-scales with approximately the same number of items in each sub-scale.

Affective Response (AR): refers to the feeling, state, and mood of the respondent. Items are:

7 Often school makes me miserable.

10 Sometimes I wish I was dead.

27 I feel like crying often when I am at school.

32 Often I feel miserable/weepy/unhappy.

33 Sometimes I feel that life is not worth living.

45 When I am away from home I feel very unhappy.

51 Sometimes I don't know why I feel like crying.

54 I feel that life is miserable for me.

Social Problems (SP): refers to the difficulties in social interaction, isolation, and loneliness of the child. Items are:

16 Often I feel nobody cares for me.

18 Often I feel lonely.

20 Often I can't show anybody how unhappy I feel inside.

28 When I am at school I often feel lonely and lost.

40 Most of the time I feel nobody understands me.

49 Nobody knows how unhappy I really am inside.

56 Often I feel I am no use to anyone.

64 When I am away from home I feel empty inside.

Self-Esteem (SE): refers to the child's attitudes, concepts, and feelings in relation to his/her own worth and value. Items are:

9 Often I feel I'm not worth much.

19 Often I am annoyed with myself.

25 I hate the way I look or the way I act.

35 Often I hate myself.

38 Often I feel ashamed of myself.

52 Sometimes I wonder whether I may be a very bad person inside.

53 When I fail at school, I feel that I am nobody.

58 Most of the time I feel I am not as good as I wish to be.

Preoccupation with own sickness and death (SD): refers to the child's dreams and fantasies in relation to his/her sickness and death. Items are:

12 Often I wake up during the night.

13 I feel more tired than most children I know.

14 Most of the time I am not interested in doing anything.

26 Often I don't feel like waking up in the morning.

30 Often I feel dead inside.

48 I feel tired most of the time when I am at school.

60 I often imagine myself hurt or killed.

Guilt (GL): refers to the child's self blame. Items are:

21 Often I feel as if I'm letting my mother/father down.

23 Sometimes I believe that my mother/father do or say things which make me feel as if I've done something terrible to them.

37 Sometimes I am afraid that I do things which might harm or upset my mother/father.

39 Often I feel I deserve to be punished.

46 I sometimes feel upset because I don't love my mother/father as much as I should.

47 I feel that people love me even though I don't deserve it.

55 Sometimes I believe that I do things which could make my mother/father ill.

61 I sometimes feel upset because I can't give my mother/father the attention and love that they need.

Pleasure and Enjoyment (PE): refers to the presence of fun, enjoyment, happiness in the child's life, or to his/her capacity to experience these things. Items are:

1 I enjoy myself most of the time.

2 I'm always looking forward to the next day.

8 I'm always keen to do lots of things when I am at school.
22 I get fun out of the things I do.
24 Often I enjoy myself at school.
41 I'm a very happy person.
65 I feel I'm a beaut person.
66 I'm successful in most of the things I try.

The items in each of these sub-scales are mutually exclusive (i.e. each item belongs to only one sub-scale). There are nine depressive items which do not cluster together and which do not belong to any of the sub-scales. These are scored as 'Miscellaneous D items'. Similarly there are 10 positive items which do not belong to a sub-scale; these are scored as 'Miscellaneous P items'.

Miscellaneous D (MD) items are:

3 I feel that there is a lot of suffering in life.
4 When somebody gets angry with me I get very upset.
6 When I feel very angry I usually end up crying.
42 Often my schoolwork makes me miserable.
43 Often I am upset about my mother's health.
50 Sometimes in my dreams I am hurt or killed.
59 Often I'm very upset because I don't get the opportunity to do things I want to do.
62 Often I feel I'm not getting anywhere.
63 Sometimes I feel there are two persons inside me pulling me in different directions.

Miscellaneous P (MP) items are:

5 I feel proud of most of the things I do.
11 Most of the time my mother/father make me feel the things I do are pretty good.
15 In our family we all have lots of fun together.

17 When somebody gets angry with me I get angry in return.
29 I feel my mother/father are very proud of me.
31 It is all right to feel angry.
34 I sleep like a log and never wake up during the night.
36 I have many friends.
44 I spend my time doing many interesting things with my father.
57 Many people care about me a lot.

> In investigating a particular child's depression, it is important to look at his scores on the sub-scales as well as his total scores. Different children manifest their depression in different ways; these sub-scales allow several aspects of childhood depression to be considered separately.
> (p.5-7 Lang and Tisher 1983 CDS Manual).

3.11 RATIONALE AND CRITIQUE OF THE CDS

The CDS was chosen as the instrument for measuring the prevalence and profile of depression for this study for practical, logistical, financial feasibility and empirical reasons.

(i) Practical, logistical and financial feasibility

The Educational Psychology Service did not have a specific depression scale which was widely used and the Service was not in a position to buy any new materials especially as the research was about to commence at the end of the financial year (March 2004). A decision had to be made urgently as to which depression scale was going to be used, therefore one of the practical reasons for using the CDS as a tool for measuring depression was that it was easily accessible from a children's hospital. Permission was given by the clinicians at the hospital for it to be used in this study since it would not be used during the duration of the testing period (March-July 2004). There was no charge either to myself or to the Educational Psychology Service for

borrowing the test battery. The manual was also available for loan at no cost, nor was there a time limit placed upon the loan.

It is worth noting at this point that there was an absence of any depression rating scales/checklists available for use within the EPS. The Birleson Depression Scales (see Appendix 11) and Yesavage Depression Scales (see Appendix 12) were used exclusively by myself and were given to me by EPs in other authorities. It could be that the culture within the EPS is such that they perceive depression as a health issue and not something which EPs would necessarily assess. Following the outcome of this study, this ethos may change.

Working as a fulltime Educational Psychologist meant that time was a huge limiting factor during this research study. The EPS for whom I work operate a time allocation model. Unfortunately no time was allocated to me to carry out this research therefore, time officially allocated to administrative work was instead devoted to visiting the schools, administering the CDS and interviewing the HTs. Fortunately, I had the support of the assistant EP and research student. Theoretically, it would have taken 19 sessions to complete the interviews with the children (1 session = a morning or afternoon). It was possible to interview 4 pupils per session on average. However, in reality, more researcher time was taken than this and particularly when some pupils were not available on the days arranged to visit schools and subsequent visits had to be made.

Although there were some reservations about contacting the HTs since I was not known to them previously, fortunately all three HTs were willing participants and were enthusiastic about the nature of the study. They were more than happy to give me the time and space within their schools to carry out the study. The HTs appreciated the significance and importance of the possibility of the existence of depression within their pupils. The HTs welcomed the study as it is not the norm for EPs to assess for depression unless children are clearly showing signs of it. The HTs reported that they were keen to learn of the results of the study so that they could then provide

any necessary support to the pupils who were found to be depressed or who were showing symptoms of depression. This illustrates the difference in ethos between the way in which the HTs of EBD schools regard the emotional well-being of their pupils and HTs of mainstream schools. My previous assignment involved the exploration of the prevalence of depression in mainstream schoolchildren. The HTs I had previously approached to request their participation in the study said that they did not want to take part especially since it involved a potentially sensitive subject.

(ii) Empirical reasons

One of the main reasons for choosing to use the CDS for this research study was because it was the first test of childhood depression which had not been derived from any test for adults (cf Kovacs and Beck 1977). Lang and Tisher (1983) state that the items on the CDS were phrased in such a way that the depressed child would be able to recognize the feelings or attitudes described by the item if, indeed, this was part of his or her experience.

The CDS is a self-rating scale which measures the respondent's own perceptions of their feelings and there seems to be a growing acceptance that a youngsters' view of their own behaviour is a valid way of obtaining information. In the past, parental reports have been relied upon for the diagnosis of depression in children but it is now accepted that children can provide valuable information about their own feelings. The scale items were developed using the information already obtained regarding the 'depressed' young people in the Lang and Tisher study. The subscales are extremely useful in that they can be used to determine the child's relative areas of strengths and weaknesses which could then point the way forward for support in areas in which the child is experiencing difficulties. In the Kovacs (1980-1981) study of rating scales as a tool to assess depression in school age children it concludes that they 'provide a common medium of communication for workers in the field' (p.313). Kovacs (op cit) emphasises

that the CDS should be used as a severity measure of depression and not as a diagnostic tool.

(iii) Reliability, Stability and Validity

The authors of the CDS claim that the scale has reliability and validity. According to Lang and Tisher, the internal consistency and stability of the CDS was assessed by the Cronbach Alpha (Cronbach 1949). The level of Alpha was found to be high (0.96) which suggests that the CDS has a good level of internal consistency (Cronbach 1949, cited in Lang and Tisher Manual p.19).

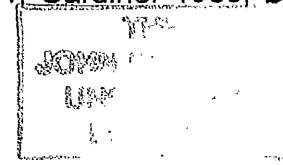
Lang and Tisher also state that the CDS has internal consistency in that each item makes a statistically significant contribution to the total score. Lang and Tisher claim that the CDS is able to discriminate between three groups of children: (i) children known to be depressed; (ii) a clinical group where there is an expectation of some depression; (iii) a normal group (Table 7 in Manual p.24). The CDS is able to discriminate between clinic and non-clinic youngsters with a positive 'diagnosis' of depression. They claim that this would appear to be 'a clear statement of support for the construct validity of the CDS.' (p.24)

Diagnostic systems such as the DSM-IV or the ICD-10 are essentially criterion-referenced tests which state that a specific number of signs or behaviours need to be present before a diagnosis of a particular condition can be given. So children who meet the criteria would be given a diagnosis and the offer of support and those who do not meet the defined criteria, are not given the diagnosis or any treatment. This could also hold true for youngsters who have been assessed for depression using the CDS. The CDS has a clearly defined cut-off point of 120 which is the cut-off point for 'the norm' i.e. scores above 120 are considered to be indicative of a prevalence of depression. So, for pupils in this study who obtained a total depression score up to and including 120, they would not be described as being depressed. However, those pupils who obtained a score of 121 or

above would be described as being depressed, despite there only being a difference in their respective scores of one. Had these pupils obtained these scores within the context of a clinical setting, then those pupils who had obtained a depression score of 120, 119 or 118 may have been in need of support but would not have received any as their scores did not meet the criteria for depression. I would argue that the distance between 120 and 121 is not significant in terms of support the participants need. I would suggest that a definitive cut-off point where scores above 120 indicate a prevalence of depression and scores below do not, are not particularly useful to educationalists as a way of developing a profile of a child's strengths and difficulties and inform future planning. I feel that caution should be exercised when considering the reliability of rating scales as diagnostic tools and in the interpretation of their clinical meaning.

Kovacs (1980-1981) provides a short critique of the CDS and argues that the 'decile' scores were derived from a relatively small sample of school-age children, therefore the generalizability of the CDS is questionable. Just because a child scores higher than 'the norm', this does not automatically warrant the label of 'depression'. The score of 120 may have been calculated to be the median of all the scores obtained in the Lang and Tisher (1983) study, however if their sample size was arguably small (Kovacs op cit), then using a larger population may provide a different median and therefore a higher or lower cut-off point. For the purpose of the current study, I had not intended to use the CDS as a diagnostic tool, but rather as a screening instrument for depression. No diagnosis was given to any of the pupils who obtained a score above the cut-off point prescribed by Lang and Tisher. The cut-off point of 120 was used as a guide only for the purpose of this study.

In so far as the current study uses the CDS which is a widely accepted measurement of depression, the internal validity of the study was not compromised. The CDS was one of the self-report measures within the Marriage et al. (1986) study cited in Chapter 2 of this research study. In their manual, Lang and Tisher (1983) cite other studies which have been carried out using the CDS (Tonkin and Hudson 1981; Gardiner 1980; Bath 1982) in



countries such as Australia, Japan, Spain and Holland. The CDS is therefore, a well-established benchmark for analysing depression in children.

The CDS has a total of 66 items, 18 of which are 'positive' (e.g. 'I enjoy myself most of the time'). The positive items are intermingled with the 48 depressive items for two reasons. Firstly, to reduce the likelihood of response set occurring and secondly, to test for 'inability to experience pleasure' as a component of depression. In addition to the above reasons, they were also intended to keep the child interested by varying the nature of the statements.

One of the reasons for its length was due to an attempt to allow for as many features of childhood depression to be covered. However, a disadvantage of its length, is that it can take a Year 6 pupil up to 40 minutes to complete, which is much longer than, for example, the Yesavage Depression Scale or Birleson depression Scales which, by comparison, would only take up to approximately 15 minutes to complete (see Appendices 11 and 12 for Yesavage and Birleson Depression Scales). For this reason, I have not used the CDS by Lang and Tisher in my day-to-day work as an EP, but have tended to use the Yesavage or Birleson Scales. However, these two scales do not include such as a useful profile of childhood depression as the Lang and Tisher CDS. Since the CDS does not solely provide a total depression score, but gives 5 subscales and a miscellaneous depression scale, a profile of children's depression can also be derived from it, which provides more useful information than a total depression score alone. Since the pattern of an individual's scores can be obtained, it becomes possible to determine the aspect of their lives which is causing them the greatest problems. When the pattern of results is examined more closely, the child may achieve a relatively normal score on self esteem but have a low score for social problems. In planning future therapy with the child, their relative high self esteem could be important. The therapist could then concentrate on helping the participants improve the social aspects of their life.

Lang and Tisher claim that the CDS can be used to determine the nature and extent of childhood depression both in clinical settings and in the general community. Therefore, this depression scale could also be used to assess levels of depression within the mainstream school population. By using such a tool whilst a pupil still attends their mainstream school could lead to an early identification of depression which could then afford early intervention and support for that pupil, which in turn, could prevent a more chronic illness developing.

There is an updated version of the record form presently available so that the Adult Form can be completed by the parents at the same time the child completes their part. The CDS Adult Form is now called Parents Questionnaire. The main reason for this change was due to the expense of producing sets of boxes, which meant since only one set of boxes was supplied with each kit, only one person in the family could do the CDS at any one time.

The CDS – Parents Questionnaire was not used for this study primarily due to time limitations, but also to ensure confidentiality and anonymity of the young people who took part in it. In future studies, using other informants such as teachers or parents could provide more comprehensive information than relying solely upon one respondent's information. Follow-up studies could possibly include a teacher rating scale of children's depression which could then be compared to the children's rating scales. For the purpose of this study I decided not to utilise a teacher's rating scale partly due to time constraints but also because I was not interested in the teacher's views at this time. As previously mentioned earlier in Chapter 3 Section 3.8(iii), until teachers and/or parents are accurately able to identify behaviour indicative of depression within children, then obtaining information from different sources can possibly lead to differences of opinion, which in turn, can lead to discrepancies between the informants' data. Since there is a lack of consensus at present among teachers as to what constitutes depression, there would undoubtedly be differing opinions on the matter. The behaviours that one person may consider to be indicative of depression would probably

be different to another. Observer error could be high if teachers' responses were taken into consideration. Although this additional information could have added another dimension to the study, it is my opinion that without a general consensus of opinion, all that would have been obtained would be an 'impression' of what constitutes depression in a child. In short, I did not feel that the teachers would be able to offer any information that would add to the validity of the study. At this particular point in time (without a general consensus of opinion) I considered the study would have a greater degree of validity by obtaining information directly from the children themselves as they know how they feel, even if they are unable to articulate their feelings precisely. Had parents been involved, further information regarding family problems (if any) could have been obtained which may have proved useful. It is important not to over emphasise agreements between parents and child responses as empirical evidence suggests that the agreement is generally low (Barrett et al., 1991; Walker, Moreau and Weissman, 1990). The evidence suggests that children tend to give a more accurate account of how they feel (internalizing symptoms) whereas parents appear to be more aware of overt behaviour difficulties.

Another reason for choosing to use the CDS was that it was intended for use with children aged 9-16 years predominantly the age group used in this research study. It could also be used with younger children or for children with reading difficulties as the interviewer could read the statements to them as was the case in this study. The CDS was intended for use on a one-to-one basis, the interviewer and the respondent, so that non-verbal cues could be observed and so that the child could feel comfortable with the interviewer which may encourage him/her to share their feelings more fully. However, the authors state that 'Group testing may also be undertaken for research purposes' (Manual p.10).

(iv) 'Don't Know/Not Sure' Response

One criticism I have of the CDS is that it has a Don't Know/Not Sure (3) response which may be overused and therefore not yield useful information.

If a respondent uses 3 frequently, this can give a high score but in fact, does not in itself convey any useful information. It has been argued that some respondents give a 'Don't Know/Not Sure' response in order to avoid thinking about the question or to avoid committing themselves (Oppenheim 2003 p.129). It is crucial that a questionnaire does not always force a response when a 'don't know' response is appropriate. However, it was noted by the interviewer when a participant frequently used the 'don't know' response.

(v) Likert Scales

A difficulty with the total subscale score is that the same score could be achieved by giving different responses to statements within the subscale, so it was more useful to examine individual responses. A pattern of responses may have given more information than the total score for any subscale. The Likert-type scale was useful in that it was possible to compare the participants' responses across similar questions as a means of testing their reliability. It also gave more precise information regarding the degree of agreement or disagreement of each response. Consistency of responses could be checked across similar questions for example, Number 10 and 33.

(vi) Changes to the Scoring System and Wording of the CDS

Since I have used both the CDS and supplementary questionnaire on previous occasions, it allowed any ambiguous statements or questions to be revised prior to any interviews taking place for the purpose of the current study. The following changes were made to the CDS:

Although the scoring key was written at the top of the record sheet the interviewer wrote additional information to aid the participant's understanding:

- Very Wrong was given an alternative of Always Wrong.
- Wrong was given an alternative of Mostly Wrong.
- Right was given an alternative of Mostly Right.
- Very Right was given the alternative of Always Right.

Some of the statements within the CDS were worded in such a way that some of the participants had experienced difficulty responding to them in the

past, especially the statements which appeared to contain a double negative. It was hoped that the additional or alternative scoring key would help to eliminate any such difficulties.

For Number 3 'I feel that there is a lot of suffering in life', the phrase 'suffering in life' was clarified as meaning suffering for that participant, not suffering in general. In other words this statement was made specific to the participant and was not supposed to be generalised to other people. Before the participants reached Number 11 'Most of the time my mother/father make me feel the things I do are pretty good' they were asked who looked after them and the statement was changed to include only the person who looked after them. If any of the participants were in care, the words mother and father were crossed out and the name of the person who took care of that participant was inserted.

Number 65 'I feel I'm a beaut person' – a slight modification was made to the original version of the scale due to the unsuitability of this item which had been written using an Australian slang word. The word 'beaut' was replaced by 'great' which would be more widely used in the region in which the participants lived, so that they could understand the statement more easily.

3.12 SUMMARY

Seventy five boys aged 8-15 attending schools for pupils with EBD participated in this research study. Firstly, each pupil completed the CDS. A total depression score (D) was compiled for each participant to determine a prevalence of depression in this population. This was obtained using the scores from the CDS. Two Multiple Regression Analyses were conducted upon the data in order to establish the profile of depression. Secondly, all participants were required to respond orally to questions from the supplementary questionnaire, which were also presented verbally by the interviewer. The aim of the supplementary questionnaire was to obtain further information regarding the knowledge and perceptions of depression in

young people. It also provided information regarding the adequacy of support the participants felt they were being given by their school. Finally, it established whether or not the participants wanted to learn more about issues relating to mental health of young people. Thereafter, issues regarding mental health could be tailored to the children's specific needs. The CDS and supplementary questionnaire provided both qualitative and quantitative data.

Thirdly, three HTs were asked to provide additional information regarding issues relating to support their school was currently being able to provide to the pupils and how this compared to the resources and support they felt they needed in order to cater for the emotional needs of their pupils.

CHAPTER 4 RESULTS AND DISCUSSION

PART A – The CDS

PART B – The Supplementary Questionnaire

PART C – Interviews with Headteachers

CHAPTER 4 RESULTS AND DISCUSSION

4.1 INTRODUCTION

This chapter of the thesis has been divided into three sections. Part A includes the results and discussion pertaining to the CDS and the main research questions namely, "What is the prevalence of depression in boys aged 8-15 attending schools for pupils with EBD?" and "What is the profile of depression?" Part B provides the results and discussion relating to the Supplementary Questionnaire. Part C will include a summary and discussion of the informal interviews conducted with the three HTs of the schools which took part in this study. The main research questions have been reiterated for the convenience of the reader. The process by which the data was collated and analysed has also been described.

Included in this chapter is a section which highlights the implications of the research on the role of the Educational Psychologist.

This chapter concludes with suggestions for future research within the field of childhood depression.

Seventy-five boys participated in this research study. All the boys attended schools for pupils with Emotional and Behavioural Difficulties. Three EBD schools from one LEA participated in this study. The total number of participants who participated from each school was as follows:

School 1: 18 School 2: 27 School 3: 30

PART A – THE CDS

4.2 RESULTS FOR RESEARCH QUESTION 1: WHAT IS THE PREVALENCE OF DEPRESSION IN BOYS AGED 8-15 ATTENDING SCHOOLS FOR PUPILS WITH EBD?

In order to answer this question fully, two analyses were conducted:

(1) To determine the number of participants who obtained a total depression score (D) above 120 (the cut-off point) which may indicate a prevalence of depression;

(2) To determine any difference in D scores between the two age ranges, 8 – 11 and 12 – 15 across the three EBD schools.

(1) Number of participants who obtained a total depression score (D) above 120.

In order to obtain the results for research question 1, the participants were required to record their response to each statement on the CDS. All 66 items were scored as follows:

Table 4.1: Scoring Key.

Response Type	Score Items
Very Wrong	1
Wrong	2
Don't Know/Not Sure	3
Right	4
Very Right	5

The participants recorded their response on the CDS questionnaire by entering a score in the empty box along the appropriate sub-scale for all 66 items. When all items had been scored, a total score for each sub-scale was obtained by adding together the raw scores in the column. A total depression score (D) was then obtained by summing scores on all five depression sub-scales plus the scores for the Miscellaneous D items (MD). Table 4.2 illustrates this information.

Table 4.2: Total depression score (D) for all participants at each of the 3 EBD schools.

SCHOOL 1	
Pupil	**D**
1	140
2	122
3	140
4	178
5	175
6	222
7	137
8	157
9	164
10	132
11	202
12	109
13	116
14	76
15	104
16	100
17	116
18	72

SCHOOL 2	
Pupil	**D**
19	108
20	102
21	78
22	85
23	115
24	76
25	116
26	83
27	75
28	96
29	112
30	119
31	134
32	151
33	141
34	125
35	191
36	115
37	123
38	185
39	141
40	145
41	187
42	124
43	110
44	184
45	76

SCHOOL 3	
Pupil	**D**
46	171
47	155
48	191
49	159
50	124
51	159
52	131
53	177
54	128
55	139
56	178
57	129
58	195
59	146
60	108
61	118
62	77
63	86
64	80
65	67
66	91
67	97
68	71
69	72
70	88
71	104
72	162
73	96
74	95
75	163

Once the total score for each sub-scale had been obtained and recorded, it was then possible to examine how many of the participants had obtained a score of above 120. Lang and Tisher (1983) claim that scores up to and including 120 are considered to be within the normal range and scores above 120 would indicate a prevalence of depression. As mentioned earlier in section 3.11(iii) the score of 120 was not used as a definitive measure of the prevalence of depression, instead it was used as a convenient guide for the purpose of this study.

The data obtained from the present study were compared and contrasted with those provided by Lang & Tisher (1983). In their presentation of the CDS (Second Research Edition) the researchers provided data from a Control Group of children aged 9-16 years (see table 4.3). Since Lang and Tisher (1983) specifically refer to a control group in their study, I felt it would be useful to compare the total depression scores of the participants in this study to those of Lang and Tisher's control group.

Table 4.3 below has been taken from Lang & Tisher's Manual (1983) and has been brought forward to this point for the convenience of the reader. Within this table, the cut-off point of 120 has been highlighted.

Table 4.3: Decile Scores of Lang and Tisher's Control Group (*N* = 37).

Deciles	A.R.	S.P.	S.E	S/D	GL	Total D Depression Score	PE	P Scale
10	29.0	31.0	37.0	27.0	38.0	197.0	10.5	30.0
9	26.5	27.0	28.5	22.5	30.0	166.0	11.5	33.5
8	24.0	24.0	27.0	21.0	26.0	147.0	12.5	36.5
7	20.0	22.5	25.5	18.5	24.5	131.5	15.0	39.0
6	18.0	18.5	24.5	17.5	22.5	127.0	16.0	42.0
5	17.0	16.0	23.0	16.0	20.0	**120.0**	16.5	43.0
4	16.0	13.5	21.0	14.0	19.0	111.0	18.0	47.0
3	14.0	11.5	18.5	12.5	17.0	98.5	20.5	50.0
2	12.0	10.0	12.0	11.0	12.0	75.0	22.0	51.0
1	9.0	10.0	10.0	10.5	11.0	68.0	28.0	63.0

The table below provides the data pertaining to the current study. It provides information regarding the number of boys from each school who obtained a total depression (D) score above the cut-off point of 120.

Table 4.4: Percentage of boys with total depression (D) scores above 120.

School	No of Pupils with D Above the 120 cut-off point	%
1	11 (out of 18)	61%
2	12 (out of 27)	44%
3	16 (out of 30)	53%
	Total	52%

The total number of participants with scores above the cut-off point of 120 is 39 (52%). The results indicate that with regard to prevalence of depression 52% of the participants obtained a score higher than the cut-off point of 120 referred to above.

Discussion

Given that 50% of the scores would naturally fall above and below the average for the population as a whole, the observation that 52% of the participants in the current study obtained a score above the expected average score of 120 is not in itself a significant deviation from the population as a whole. In this regard, it was deemed that no statistical analysis would be useful, since, there was only a 2% difference in the prevalence of depression between Lang and Tisher's (1983) Control Group and the EBD population in the current study.

Crucially, since previous studies by Cytryn and McKnew (1972), Puig-Antich et al. (1978), Carlson and Cantwell (1980), Chiles et al. (1980), Marriage et al. (1986), Kovacs et al. (1988), Fombonne et al. (2001) and Roza et al. (2003) have found a comorbidity for depression and behavioural difficulties, one could reasonably expect a replication of these findings. Thus, the absence of any significant comorbidity in the present study may indicate that there are other mechanisms at play which I had not initially considered. Had this study a hypothesis, it would be predicted that there would indeed be a prevalence of depression within this population, in addition, the prevalence would be greater than would be expected to be found within the general population. However, this was not the case. One possible explanation for this outcome could be that EBD schools in the North West of England adequately fulfil their role in supporting the emotional needs of their pupils and reduce the prevalence of depression within their pupils. If this is true, then there is a strong case for not reducing the number of places available within the EBD provision. It would be useful for future studies to examine in

more depth the support that EBD schools offer their pupils and if this has a direct impact on levels of depression. It could be the case that pupils attending EBD schools have greater therapeutic intervention and/or emotional support than pupils attending mainstream schools. Future studies could examine children with emotional and behavioural difficulties attending mainstream schools and assess their level of depression (if any), its profile and the level of support offered to those pupils. If there is no change in behaviour and the pupil is excluded, they could be re-assessed to find out whether or not there has been a reduction in the level of depression following the transition to the EBD school. Until this data is available, i.e. the 'before' and 'after' data, it is difficult to say with any certainty that EBD schools play a significant part in reducing the prevalence of depression within its pupils.

As stated in the methodology chapter, this study utilises a fixed design which is theory-driven. In relation to this study, the theory is that there would be a prevalence of depression within this population and that it would be higher than expected for the general population. Since this was not the case, it could reasonably be argued that there is a general weakness in my research procedure in so much as a fixed design should be piloted. Although I had carried out research using the CDS for a previous assignment, it had been piloted using a mainstream population. It could be argued therefore, that I was on the wrong lines conceptually with regards to my understanding of this particular phenomenon i.e. levels of depression within the EBD population. Whilst it is not possible at this stage to revise my understanding of the phenomenon under investigation, however, it provides an important breakthrough suggesting a basis for further research.

An alternative explanation for these findings is that the CDS is not a good instrument for measuring depression. Lang and Tisher (1983) claim that the CDS has a high level of internal consistency (r=.96) but Kovacs (1980-81) argues that this is difficult to evaluate since it was derived from combining the child and adult forms. However, Lang and Tisher (1983) claim that there were strong correlations with high scorers on the CDS and children rated as 'unhappy' by clinicians who had worked closely with them for some time.

Again, this is criticised by Kovacs (1980-81) who argues that caution should be exercised before rating a child who has been described as 'unhappy' as depressed. In addition, Kovacs (op cit) argues that the decile scores used by Lang and Tisher were derived from a small sample which makes their generalizability and recommended use questionable. Kovacs (op cit) argues that more work is needed in order to establish the validity of the subscales, the internal consistency of the child and adult versions, separately, and the correlation of the CDS with independent diagnosis. In future studies I would endeavour to persuade some of the participants to complete a second questionnaire, such as the Children's Depression Inventory developed by Kovacs, which is a modification of the Beck Depression Inventory for adults. If there is a high level of consistency between the two rating scales, the results could be deemed to be valid. Since only one depression inventory was used in this study, the validity of the results is questionable.

If I was to repeat this study, a control group could be utilised which includes pupils from mainstream schools instead of relying solely upon Lang and Tisher's (1983) control group. Children in mainstream schools could be matched according to their sex, age and ethnic origin to the pupils attending the EBD schools. Depression scores could then be compared across the two groups.

(2) An examination of differences in D scores between the two age ranges: 8-11 and 12-15 across the three EBD schools.

A further analysis was made in order to ascertain whether or not there was a significant difference in the incidence of depression between the two age ranges, 8-11 and 12-15 across the three schools. The results are shown in table 4.5 below:

Table 4.5: Incidence of pupils presenting D scores above the cut-off point of 120 across each of the age ranges for the three EBD schools.

Age Range	School		
	1	2	3
8-11	7	4	5
12-15	4	8	11

An application of a chi-square test (test of independence) to each of the individual cells in the contingency table revealed no significant differences in incidence of depression between the two age ranges or across the three schools (see Appendix 13). At none of the schools, for any of the age ranges, could D scores be said to be significantly different ($p<.05$ level) to that which could be expected by chance alone. Appendix 19 provides an explanation for the use of a chi-square test.

At face value, the results above would again indicate or tend to suggest, that the prevalence of depression within the EBD population is brought to a level which could be expected in the student population as a whole.

A discussion of these results will now follow and will include issues concerning the validity of this research. In addition, more general issues such as administration difficulties encountered during the research and the applicability of the findings to mainstream schools will also be discussed.

Discussion

(i) Generalizability (External Validity)

A methodological limitation of this study relates to its limited cohort. The population used in this research study were boys attending schools for pupils with EBD, therefore the generalizability of the results is questionable. Since the majority of exclusions for aggressive behaviour in the LEA participating in this study involved boys, it would always be the case that this study would include more boys than girls. Even if girls attended the EBD schools they

would be fewer in number than boys. This could be classed as a limitation of the study since no girls were able to participate, therefore a prevalence of depression in girls with EBD cannot be confirmed. It could be assumed that depression does exist, since in my previous study (2003) a greater prevalence of depression was found to exist amongst girls in mainstream schools than boys for each of the academic years studied – Year Group 6 to 10.

In further studies, a comparison of the profiles of depression for boys and girls could yield useful information. Since the participants in this research study cannot be classified as representative of all school children (all boys with significant emotional and behavioural problems) can the findings be generalized to the mainstream population? Perhaps pupils displaying EBD within mainstream schools could also be suffering from depression. Although this study does not examine whether or not depression is a precursor to behavioural difficulties, it could be that the general findings of this research, i.e. that depression does indeed exist in some boys attending EBD schools, then it could be argued that pupils within mainstream schools who display similar behaviour problems could also have symptoms of depression. It is also important to consider the possibility that other pupils, who may appear withdrawn, and not necessarily displaying any behaviours considered problematic by the staff, could also have symptoms of depression. This could possibly be more so for girls who do not tend to display as much defiant or aggressive behaviour as boys, i.e. externalizing behaviours.

It may be the case that there is a clear difference between the manifestation and expression of depression between girls and boys. Girls' depression may be internalized and covert whereas boys' may be overt and externalized. It follows then, that EBD schools will serve an almost exclusively male population, since the behaviours displayed by boys will be of a 'type' most frequently depicted as problematic for schools and society.

The participants' ethnic origin was not specifically noted, however, a general estimation can be made that the majority of them were from a White British

origin. The lack of ethnic diversity in the study sample is an additional limitation in relation to the generalizability of the findings. Future studies that investigate the profile of depression should include details regarding the ethnic origin of the participants as there may be correlations between certain ethnic groups and depression. Future studies may wish to focus on a more ethnically diverse population.

In children, the range of depressive symptoms may include a reluctance to attend school to the point of refusing to attend. Numerous children were regularly unavailable to participate in the study as they rarely attended school therefore valuable data may be lost as these pupils may have been suffering from depression. It is disappointing that perhaps the pupils with the greatest hypothesised risk of depression and for whom the strongest effects on the criterion variable are likely to be shown, were those who were not available for the study due to frequent absenteeism.

(ii) The Specificity of Depression: Consideration of consistency and stability of findings

The nature of the statements on the CDS request the participants to consider how they are feeling presently so if a child was feeling more depressed three months previously, the CDS does not take this into consideration. The depression level for the participant was representative of how they felt at the time the research was undertaken. Their case notes were not examined and therefore it was not known whether or not the participants had a history of depression. If a particular child was feeling unhappy on the day they took part in the research study, their results could indicate a more depressed person than they are in general. This could have resulted in a 'transference effect' which may have temporarily affected the score. Some participants may have felt happy about being out of the classroom for a short time and could have indicated they were not feeling particularly depressed at the time the research was carried out. The results therefore would show them as not being depressed (i.e. total D score less than 120).

This raises a few issues which are worth considering, such as:

- Were the participants depressed before they were transferred to the EBD school?
- Is their current depression score higher now than it would have been when they were attending their mainstream school?
- Were the ND group depressed before going to the EBD school but more contented now? If so, what has changed? Perhaps the ND group were not depressed prior to testing, but they may be more content generally. Has there ever been depression in the ND group in the past?

It would be useful to find out the age of the participants in group D at the onset of depression in order to examine any possible 'risk factors' which could account for their high depression score.

Some pupils may have indicated on the depression scale that they were not depressed because it is not considered 'normal' within our society to be depressed. Society can strongly influence how we show ourselves to others. In particular boys are not encouraged to talk about their feelings or emotions, therefore, experimenter expectation or more specifically a *response set* could have affected some of the responses to the statements on the CDS.

What about children who deny depression but complain of other symptoms, e.g. somatic complaints (especially headaches, stomach aches, etc)? Somatization is a known manifestation of depression in older children and adults especially for those who live in cultures where it is not generally considered acceptable to express their feelings of depression (Katon, Kleinman and Rosen 1982). The children who do not express depression directly could be classed as having masked depression. The CDS is a useful tool as it includes a preoccupation with sickness sub-scale, which may reveal more accurately how a child is feeling.

Unfortunately, the CDS does not include any family history of psychiatric illness nor does it focus on any major upheavals in the family background such as deaths, divorce or abuse. Such issues are extremely important and as mentioned in Chapter 2 are "high risk" factors. So whilst the CDS gives an overall depression score and some independent sub-scale scores, it is unable to give information regarding the actual source of the depression itself. This is where further individual interviews with pupils could be extremely useful in providing more specific information regarding the source or reasons for their depression.

The CDS does not include information on how long a child has been depressed and therefore it is not possible to state that the severity of depression can be correlated to the length of its persistence for any of the participants. Further studies using other methods of assessment for depression would be useful in order to determine the effects (if any) of the severity of depression and its persistence.

(iii) Administration Difficulties

One of the disadvantages of the CDS is the length of time it takes to read each individual statement to a pupil with reading difficulties. As previously stated, each statement on the CDS was read to most of the participants by the interviewers in order to overcome any ambiguities and in order to support those children who may have reading difficulties within the groups. This process took approximately 45 minutes. Using shorter depression scales could have overcome difficulties of this nature but they may not give such specific information as the CDS and consequently they may not provide such detailed information about the child's emotions.

A number of participants made comments regarding the similarity of some of the statements. It was noted by the interviewers that two boys became annoyed as they felt some questions were exactly the same as others; for example, number 10 and number 33 also number 50 and number 60. It was felt that honesty was the best policy at this point. It was put to the

participants that although the statements appeared to ask the same question, they were in fact worded slightly differently. It was also explained to them **why** some questions were similar. In other words, to ensure they were answering truthfully and consistently. When using this tool in the future, it would be good practice to inform the participants of the similarity of some of the statements but that they are included intentionally in order to ensure the participants are answering consistently but are not intended to "trick" the participant.

(iv) Practical Issues for Schools: Consideration of applicability of these findings

One HT from one of the participating schools expressed their concern that if there was a prevalence of depression in schools, the teachers may be asked to become skilled mental health practitioners, in addition to all the other duties that a teacher is currently required to undertake. This particular HT stated that it would be "just another thing they have to do!" Schools without a Mental Health Policy may be required to devise one in the future but I feel that EPs could play a crucial role in supporting schools either directly by providing useful information which could be contained within the Mental Health Policies or indirectly by providing in-service training to teachers regarding depression and mental health issues of young people. Even though a school may have a Mental Health Policy it does not automatically mean that it is delivered appropriately or even if it is, it may not necessarily be effective or have a useful impact on the children's lives. Does a Mental Health Policy have any bearing on the children's emotional/mental health? Has it been implemented effectively? Do teachers need more training in the effective delivery of a Mental Health Policy within their curriculum areas? How long have the schools had a policy in place? The above questions are extremely important and these questions would need to be explored thoroughly in order to find out whether or not the existence of a Mental Health Policy had a significant effect upon the level of depression in school children. Further studies of this kind would need to consider these issues very carefully.

Additionally, should pupils displaying EBD within their mainstream schools be screened for the prevalence of depression? If depression was identified, support could be given to the child and their aggressive or disruptive behaviour may reduce or even stop. This may prevent the pupil from being excluded from their mainstream school.

4.3 RESULTS FOR RESEARCH QUESTION 2: WHAT IS THE PROFILE OF DEPRESSION?

In order to examine the profile of depression within the participants, The Statistical Package for the Social Sciences (SPSS) was used to analyse the data, specifically SPSS 11.5 for Windows 2000. Each participant's total scores for all sub-scales were entered into the computer package (see Appendix 14 for raw data). Following this, two Multiple Regression Analyses were conducted upon the data. In addition, responses relating specifically to the home and school settings were analysed.

Brace et al. (2000 p.208) state that a Multiple Regression Analysis requires a large number of observations. The number of participants must exceed the number of predictor variables by five times. This research study included a maximum of eight predictor variables and seventy-five participants, which qualifies for the use of this statistical analysis.

A multiple regression analysis enabled an examination of the relative importance of, or contributions of each constituent to best predict the profile of the criterion variable – D. In order to do this, the regression coefficients have been converted in order to allow for the different scales on which they have been measured. When this is done, they are referred to as BETA WEIGHTS (Robson 1996 p.347).The beta value is a measure of how strongly each predictor variable influences the criterion variable. The higher the beta value, the greater the impact of the predictor variable on the criterion variable (Brace et al. 2000 p.208).

R-squared is the Multiple Coefficient of Determination. This is a "measure of the proportion of the variance in the dependent variable which is explained by the independent variables in the equation, e.g. if R^2 is 0.52, the proportion of the variance explained is 52 per cent.

There are different ways that the relative contributions of each predictor variable can be assessed. The Stepwise Regression Analysis is the most sophisticated of the statistical methods. The Stepwise Regression Analysis "starts with the simplest possible model and then step-by-step examines the implications of adding further independent variables to the equation" (Robson 1996 p.349).

(1) Multiple Regression Analyses

(i) Stepwise 1

For the first Multiple Regression Analysis performed on the data, only the six Depression subscales were considered, i.e. Social Problems (SP), Self Esteem (SE), Guilt (GL), Preoccupation with own sickness and death (SD), Affective Response (AR) and Miscellaneous Depression (MD) items. These were used as predictor variables. These subscales were measured against the total Depression score (D) which served as the criterion variable. Whilst it is recognized that D is a measure of the sum of its constituent parts (i.e. predictor variables), it will therefore be expected that the best predictor of the criterion will be a combination of all its constituents. (Refer to Appendix 15 for computer analysis).

The Multiple Regression Analysis yielded the predictors of total D scores in order of importance. This information is provided in Table 4.6 below.

Table 4.6: The profile of depression in boys attending schools for pupils with EBD.

Criterion variable	=	D Depressed
Predictor variables	=	SP Social Problems
		GL Guilt
		SE Self Esteem
		AR Affective Response
		SD Preoccupation with own sickness and death
		MD Miscellaneous depression

The ANOVA results table in Appendix 15 confirms that F values were significant for all models $p<0.01$.

Discussion

When Depression items (i.e. AR, SP, SE, SD, GL and MD) are considered in models of regression analyses, the outcomes suggest that the profile of depression in school children in EBD schools is characterised predominantly by social problems.

It follows that pupils attending schools designed to cater for their emotional and behavioural requirements will do so because of the social problems which they experience and present.

Guilt is also predominantly evident. Guilt emerged as a highly significant factor in the profile of depression within this population. This finding conflicts with those of Garber and Flynn (2001) who claim that the concept of guilt may not be as applicable to depression in children as in adults due to their level of cognitive development. It may be the case that a child has to reach a certain level of cognitive or physiological maturation before they are capable of experiencing feelings of guilt. Clearly the participants in this study were mature enough to feel guilt. Symptoms relating to guilt may be higher in girls since Roberts, Lewinsohn and Seeley (1995) reported that depressed girls

experience feelings of worthlessness/guilt 82.5% compared to depressed boys 67.5%. So, if girls had been included in this study, Guilt may have overtaken Social Problems as the most significant factor in the profile of depression.

Self-esteem also emerged as a significant symptom. These findings support those of Bernet, Ingram and Johnson (1993), Rutter (1990), Fleming and Offord (1990) and Lewinsohn et al. (2000) who have also found that low self-esteem is an important and significant symptom in depression. This has implications within the classroom since the teacher is in a powerful position to enhance the self-esteem of their pupils. A small amount of praise of a child's work or behaviour can have a positive effect in raising that child's self esteem. Similarly, it is true to say that unkind comments, or if their efforts have gone unrewarded, a child's self-esteem could be lowered by a teacher. It is quite likely that if a child is given extra attention but in the right way, in other words, positively, this can help to raise their self-esteem and also make them feel more positive towards the teacher. This could also have a 'knock-on' effect in that if the child is given positive feedback on their work, their self-esteem is raised a little, they may begin to believe that they really **can** do good work and that they are not failures, and perhaps, their work may indeed improve. Changing a child's belief system about themselves may take some time, but it is certainly worth persevering with. Providing differentiated work so that pupils can access the NC at their level of ability can also help reduce an individual's anxiety and maintain a good level of self-esteem.

Whether low self-esteem is causal or consequential in depression is not important in itself, but recognising it in a person is very important, and then helping to raise their feelings of worth is crucial.

It can be seen that the profile of depression observed, will depend on the number of predictor variables that are considered worthwhile examining depending on the amount of variance in the data to be analysed. So, the profile of depression could be different, if other predictor variables had been

included. In order to examine this point further, a second Multiple Regression Analysis was conducted which included all eight sub-scales.

(ii) Stepwise 2

It was felt that a more appropriate quantitative measure could perhaps be represented by a product which took into account Depression scores minus Pleasure scores which could then be referred to as Discontentment (C).

In this instance, all sub-scales were considered including the Pleasure and Enjoyment and Miscellaneous Pleasure sub-scales. These were used as predictor variables and were measured against the discontentment score (C) which served as the criterion variable.

The Multiple Regression Analysis, as shown in Appendix 16, yielded the predictors of discontentment scores (C) in the following order of importance. This information is provided in Table 4.7 below.

Table 4.7: The profile of discontentment in boys attending schools for pupils with EBD.

Criterion variable	=	C	(discontentment = D-P)
Predictor variables	=	SP	Social Problems
		SE	Self Esteem
		PE	Pleasure and Enjoyment
		GL	Guilt
		SD	Preoccupation with own sickness and death
		MD	Miscellaneous depression items
		MP	Miscellaneous pleasure items
		AR	Affective Response

Tables 4.6 and 4.7 illustrate clearly the differences in order of importance of the predictor variables as they measure against the two criterion variables – D and C.

Tables 4.6 and 4.7 show that when pleasure items (PE and MP) are considered in models of regression analysis, significant changes occur in the profile of the criterion variables (D to C). However, the contribution of SP remains the same. The changes that occur are as follows:

1. The contribution of Guilt (GL) is markedly reduced and is overtaken by Self Esteem (SE);
2. Pleasure and Enjoyment (PE) overtakes Guilt (GL) as a predictor;
3. The effect of Affective Response (AR) is diminished.

Although Lang and Tisher (1983) primarily utilized the MP and PE sub-scales in order to balance for internal consistency and validity, nevertheless, they provide a most convenient insight into the actual/ overall level of depression. Is a child depressed about all aspects of their life, or are there particular elements which provide pleasure? A more accurate and efficacious quantitative indicator of the overall profile of depression, may involve consideration of the pleasure sub-scales in addition to the depression sub-scales.

(2) Responses relating specifically to home and school settings

In order to cast light upon the aetiology of any depression observed in the pupils who took part in the present study, a factor analysis was conducted from subsets of questions in the CDS. Specifically, particular questions (see Table 4.8) addressed depression relating to depression 'at home', whilst others addressed depression associated with the school setting.

Two groups of pupils were identified by their score on the CDS depressed ('D'n = 36), and non-depressed ('ND'n = 39), respectively. These two groups

were compared and contrasted with respect to their scores on questions relating to home-based and school-based issues, in turn.

In order to conduct these analyses one subject from the ND group (n = 36) was paired at random with one subject from the D group (n = 36/39): thus three subjects were disregarded from the D group (chosen randomly) in order to provide 36 pairs of subjects – one experimental (D) and one control (ND).

If a consistent trend indicated differences between D and ND subjects at home or in school, then it would be possible to draw conclusions on the aetiology of the basis of that depression. The experimental questions to be tested were specifically: Is the depression recorded chiefly/entirely apparent at (1) home, (2) school, (3) both environments? If depression was derived from the home alone, it would be expected that a significant difference would exist between the D and ND groups on home-based answers alone. Likewise a difference between the groups on school-based answers would indicate a depression specific to the school environment. Differences on both indicators would suggest a non-specific or general level of overall depression.

The relevant questions and their respective answers were reassessed/ coded so that consistency and internal validity (direction of strength of response) could be maximized, as follows:

(1) negative home response	= 2
(2) neutral home response	= 1
(3) positive home response	= 0
(4) negative school response	= 2
(5) neutral school response	= 1
(6) positive school response	= 0

(See Appendix 17 for Coding Frame for Responses to Statements relating to Home and School Settings).

Thus Likert Scales (Phillips 1976 p206/7) were utilized to measure pupils' responses to the specific questions. The 'yes/not sure/ no' dichotomous range of possible responses was covered to ensure Measurement Validity (Phillips 1976 p137).

Thirteen items on the CDS related to the home and eight items to school, respectively.

Table 4.8: CDS Items Relating to Home and School Life.

Item No:	*Relating to Home Life*
11	Most of the time my mother/father make me feel the things I do are pretty good.
15	In our family we all have lots of fun together.
21	Often I feel as if I'm letting my mother/father down.
23	Sometimes I believe that my mother/father do or say things which make me feel as if I've done something terrible to them.
29	I feel my mother/father are very proud of me.
37	Sometimes I am afraid that I do things which might harm or upset my mother/father.
43	Often I am upset about my mother's health.
44	I spend my time doing many interesting things with my father.
45	When I am away from home I feel very unhappy.
46	I sometimes feel upset because I don't love my mother/father as much as I should.
55	Sometimes I believe that I do things which could make my mother/father ill.
61	I sometimes feel upset because I can't give my mother/father the attention and love that they need.
64	When I am away from home I feel empty inside.

Item No	*Relating to School Life*
7	Often school makes me miserable.
8	I'm always keen to do lots of things when I am at school.
24	Often I enjoy myself at school.
27	I feel crying often when I am at school.
28	When I am at school I often feel lonely and lost.
42	Often my schoolwork makes me miserable.
48	I feel tired most of the time when I am at school.
53	When I fail at school, I feel that I am nobody.

Item numbers 45 and 64 were excluded from this particular analysis for the following reason. Even if a child does not feel empty or unhappy away from home, it does not necessarily mean that they are glad to be away from home or indeed, that they are unhappy at home. Therefore, although these items relate to home life, it was felt that responses to them would not be useful in answering this particular research question.

For each pupil in either D or ND groups (n=36 per group) a maximum score of 22 was available (11 items given a score of 2) for items relating to any home-based depression and the minimum would be 0. Similarly each pupil could score a maximum of 16 and a minimum of 0 for 8 school items.

If pupils in the D group scored consistently higher on school-based items than their paired control ND pupils then it would be indicative of school-based depression. Similarly, consistently higher scores for home-based items would suggest depression at home. Sign tests (Robson 1994 p37-39) were used to analyse the participants' scores.

For home-based questions, 33/36 pupils in the D group scored higher than their ND control counterpart. A significant difference $p<0.05$ could therefore be said to exist between the two groups in relation to home-based items.

For school-based questions, 31/36 pupils in the D group scored higher than their ND control. Again, a significant ($p<0.05$) difference existed between the two groups.

Discussion

In relation to the participants' responses to items relating specifically to home and school settings, the D group scored consistently higher on both sets of items compared to the ND group. Taken together, these findings clearly indicate that any depression which is observed in EBD schoolchildren is not restricted to school or home environments. The general state of depression may transfer across both environments.

Finding out the source of the problem is crucial if the symptoms of depression are to be alleviated. Since the D group scored consistently higher on both sets of items, the underlying reason for their depression is more difficult to ascertain. A pupil may be feeling depressed for a number of reasons, and school work could be one of these reasons. If a pupil has learning difficulties the EP could then assess the pupil, and suggest useful tuition approaches. I feel it is important for EPs to continue their assessments of children's learning abilities and difficulties as they can highlight areas for which the child needs support.

One of the 'within child' risk factors according to the DfES Code of Practice document (2001) is a Specific Learning Difficulty. During interviews with two of the Headteachers who took part in this study, I was informed that some of their pupils had a Specific Learning Difficulty (of a dyslexic nature) even though they did not have general learning difficulties as specified in the criteria for entry into the EBD schools. Could it be perhaps that their Specific Learning Difficulties contributed to the behaviour difficulties of these pupils?

It could have been possible that the pupils had been underachieving because their behaviour had become a barrier to their learning. For some children at least, if assessments had been carried out at a younger age whilst they were attending their mainstream schools, perhaps their difficulties could have been realised earlier and support put in place before emotional problems arose which then became a behaviour problem which the school found more difficult to deal with. The participants' attainments in reading and spelling were not analysed for the purpose of this research wholly due to time constraints. In order to obtain this information, further assessments would have been required. It would not have been feasible to carry out these assessments on the same day as the CDS and supplementary questionnaire as it was clearly evident from some of the participants that they had already concentrated for as long as they could completing the other questionnaires. I do not feel they would have willingly co-operated with further assessments even at a later date. Again this would not have been possible on the part of the researchers due to time limitations. Further studies could include an examination of a possible correlation between depression and level of attainments in reading and spelling within school children. This information could prove to be extremely useful should a correlation be found to exist. In short, there could be several underlying reasons for why a child is feeling depressed. By enlisting the support of an EP, further investigations could be carried out and therapeutic interventions provided to support the pupil, the school and their parents. Once again this study has highlighted the importance of the role of an EP.

4.4 SUMMARY

In summary, when considering the prevalence of depression, the data analyses indicate that 52% of the participants obtained a total depression (D) score above 120 which would not be considered to be a significant deviation from the population as a whole. However, it does provide evidence for the prevalence of depression in boys with EBD which cannot be ignored. There was less depression prevalent amongst the EBD participants than in Lang and Tisher's (1983) Experimental Group, but there was no difference

between the prevalence of depression within the EBD schoolchildren and the children within Lang and Tisher's Control Group (The Control Group being considered to be a 'normal population').

Similarly, there was no significant difference in incidence of depression between the two age ranges: 8 – 11, 12 – 15, or across the three EBD schools.

When considering the profile of depression, if only the six depression sub-scales are taken into consideration, the predictors of depression were as follows in order of importance: Social Problems, Guilt, Self Esteem, Affective Response, Preoccupation with Own Sickness and Death, Miscellaneous Depression Items. However, when Pleasure and Enjoyment variables were considered, there was a change in the order of predictor variables as follows: Social Problems, Self Esteem, Pleasure and Enjoyment, Guilt, Preoccupation with Own Sickness and Death, Miscellaneous Depression Items, Miscellaneous Pleasure Items and Affective Response. So, Social Problems remained the most important characteristic within the profile of depression within children in EBD schools.

When considering responses to home or school-based items, the D group scored higher than their ND control counterpart on both.

PART B –SUPPLEMENTARY QUESTIONNAIRE

4.5 INTRODUCTION

This section of the research aims to give an account of the participants' perceptions and knowledge of depression. It also provides information as to whether or not the participants felt their emotional needs were being met in school and what other information they considered to be of benefit to them.

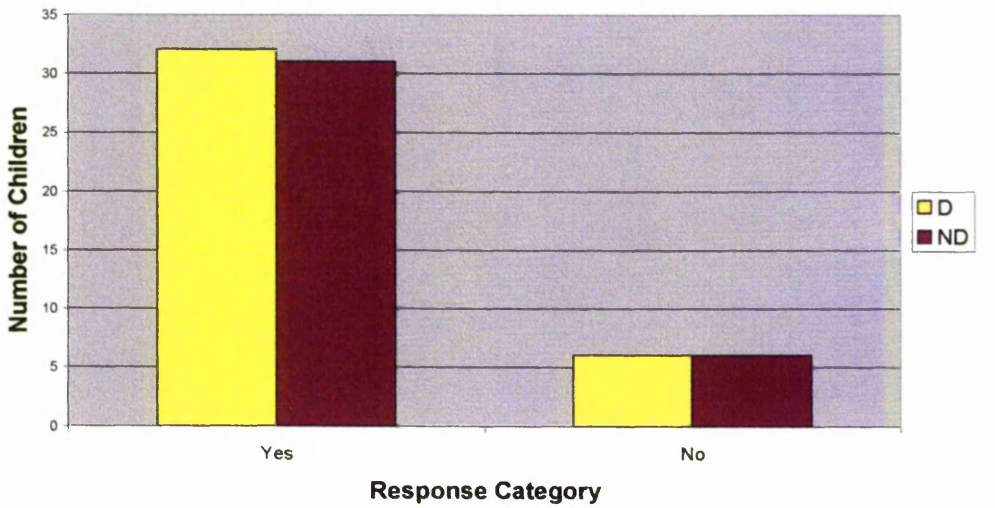
(i) Format of Section

Each question from the supplementary questionnaire has been reiterated (for the readers' convenience) followed by a histogram which is intended to illustrate the nature and number of responses given to each question by the participants. The histogram illustrates the raw scores obtained for each question (see Appendix 18 for raw data). The participants were grouped according to their scores on the CDS. Therefore any participant who achieved a total depression score above 120 (120 being the cut-off point) was allocated to the 'Depressed' (D) group. Any participant who obtained a total depression score up to and below 120 on the CDS was allocated to the 'Non-Depressed' (ND) group. It is important to reiterate that these classifications were used merely as a convenient way to distinguish between the two groups and that the group (D) were not given any diagnosis of depression. Since the responses from the two groups did not appear to be widely different, it was deemed that no statistical analysis to compare any differences between the groups would be useful. A discussion of each question follows the histograms.

4.6 QUESTION 1: HAVE YOU HEARD OF THE MEDICAL CONDITION – DEPRESSION?

Yes ☐ No ☐ *(If No, go to number 4)*

FIGURE 4.1 : Histogram Showing Responses to Question 1.

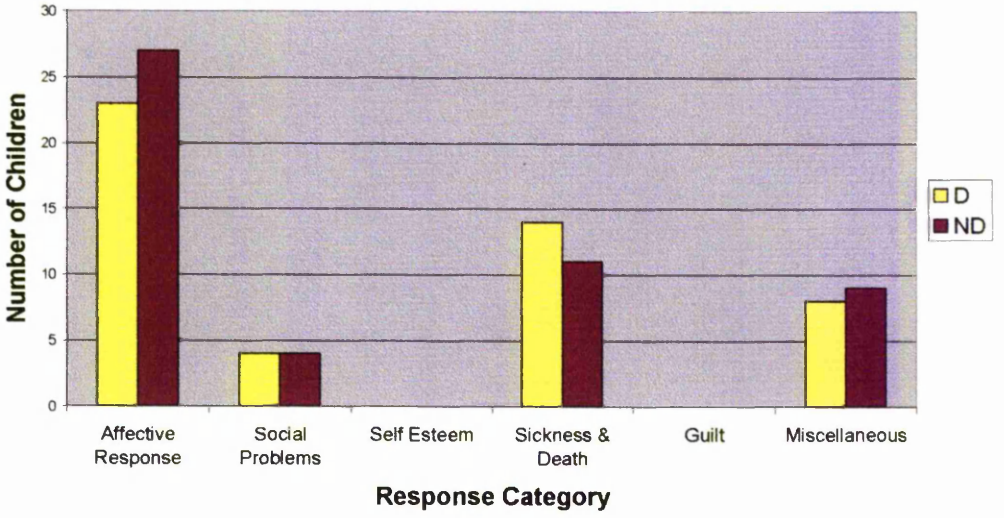


All participants were required to answer this question. 84% of the participants reported that they had heard of depression or had heard someone say that they felt depressed. Following on from the participants' response to this question, further questioning with reference to the source of their knowledge could have yielded useful information with regard to where or how youngsters are currently able to access information about depression; for example, within lessons at school, from a magazine, television programme, family member, friend, or had the pupil ever been diagnosed with depression and thereby learned about depression from first-hand experience. It was a conscious decision on my part not to ask the participants directly if they had ever been diagnosed with, or thought that perhaps they might have suffered from depression, as I felt they could regard this question as being too intrusive and consequently, may not have responded truthfully, due to the stigma associated with mental illness. However, from the responses to question 2, it

would appear that regardless of the source of the participants' knowledge on depression, it is, on the whole, accurate. This is discussed in more detail below.

4.7 QUESTION 2: TELL ME WHAT YOU THINK DEPRESSION IS – TELL ME WHAT YOU KNOW ABOUT IT.

FIGURE 4.2 : Histogram Showing Responses to Question 2.



Not all the participants were requested to answer this question. If they did not know what depression was (Q1) they would not be able to answer this question. Similarly some participants gave more than one answer to this question.

The derivation of the origins of these categories will now be explained in more detail.

The participants' responses to this question were grouped in accordance with the classification of the sub-scales used in the CDS. A total of 100 responses were given to this question.

Affective Response (AR) - *refers to the feeling state and mood.*
50% of the total responses given to this question were related to the feelings or mood of the person.

The most frequent response given by the participants was that a person who was depressed would feel 'unhappy'. This response accounted for 27 out of a total of 50 responses. The next most frequently given response was 'angry' (8) followed by 'stressed' (7). Other responses included 'cry a lot' (3), 'worried' (1), 'scared' (1), 'fed up' (1), 'feel like killing themselves' (1) and 'stressed' (1).

Social Problems (SP) - *refers to the difficulties in social interaction, isolation and loneliness.*
8% of the responses given by the participants to this question referred to social problems.

'Feeling lonely' was the most frequent response made. 5 out of the total of 8 responses made reference to feelings of isolation or loneliness. Other comments included that a depressed person would have 'no-one to talk to' (1), 'feel left-out' (1), 'can't express their feelings' (1).

Self-Esteem (SE) - *refers to attitudes, concepts and feelings in relation to the worth and value of the self.*
Interestingly, none of the participants gave any responses relating to self-esteem as being a possible measure of depression. Perhaps a reason for this is due to the language children understand and use to interpret feelings. It could be that children do not tend to use words or phrases such as 'feeling worthless' to describe how they are feeling or perhaps, they do not have the language skills or vocabulary to be able to express how they are feeling. So, although some of the participants may have felt like this they may not be able

to articulate it in this way. This highlights the importance of teaching children the language associated with emotional health.

Sickness and/or Death (SD) - *refers to responses which refer to illness or death.*

25% of the responses given by the participants to Question 2 included items which related to sickness or death. A total of 16 participants stated that they thought a depressed person would feel 'tired a lot' or 'want to sleep a lot'. 4 of the participants said that someone who was depressed would not be interested in doing anything. The participants expressed this as 'can't be bothered'.

3 of the participants said that a depressed person would feel 'ill' or 'sick'. 1 participant said that a depressed person would 'feel like dying' and another participant said a depressed person would have high blood pressure.

Guilt (GL) - *refers to self blame*

None of the participants gave any responses to this question which related to feelings of guilt as part of depression.

Although none of the participants made reference to aspects of guilt as a possible characteristic of depression, however, scores on the CDS indicated that Guilt was the second highest predictor of depression after Social Problems. It seems that guilt does not feature predominantly in children's views as being problematic. The interpretation of this could be that they do not *perceive* feelings of guilt to be part of the profile of depression. So although Guilt is a big predictor of the total depression score (D), this may only become apparent during the process of a questionnaire or survey. It may not impact on a child's day-to-day behaviour per se.

Miscellaneous (MD) - *miscellaneous items include responses which do not fit into any of the aforementioned categories*

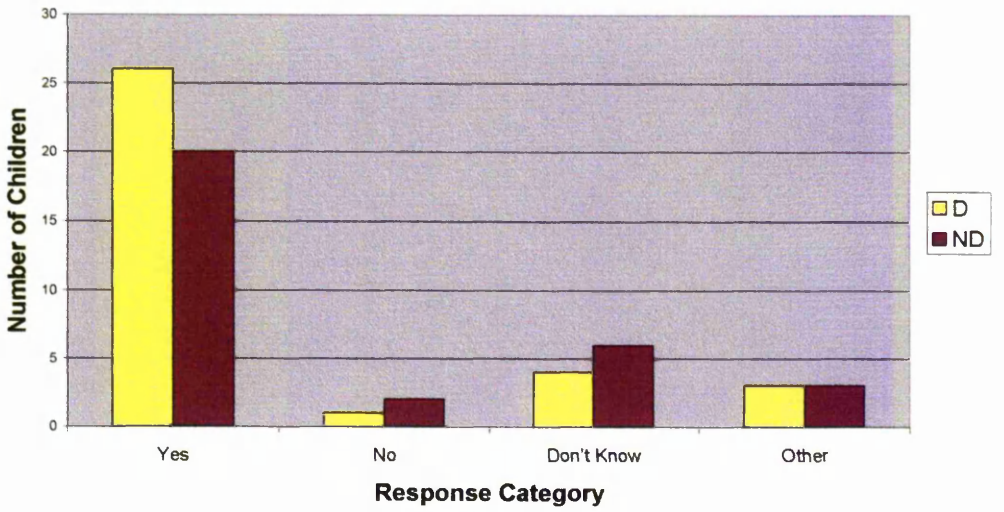
17% of the responses given to Question 2 could not be considered part of any of the previous categories.

5 out of the 17 responses made reference to a depressed person 'not being able to enjoy themselves'. 2 out of the 17 responses made suggested that a depressed person 'works too hard'. The following responses were made once only 'need counselling', 'want to change the past', 'feel the world is against you', 'can't cope', 'not good', 'have a nervous breakdown', 'when you harass your mother', 'need tablets to stop them harming themselves', 'feel bored', 'don't know'.

4.8 QUESTION 3: DO YOU THINK CHILDREN AND TEENAGERS SUFFER FROM DEPRESSION?

Yes ☐ No ☐ Don't Know ☐

FIGURE 4.3 : Histogram Showing Responses to Question 3.



As for Question 2, not all participants were required to answer this question. If they were not able to answer positively to Question1, i.e. they did not know what depression was, then they would not be able to answer this question accurately.

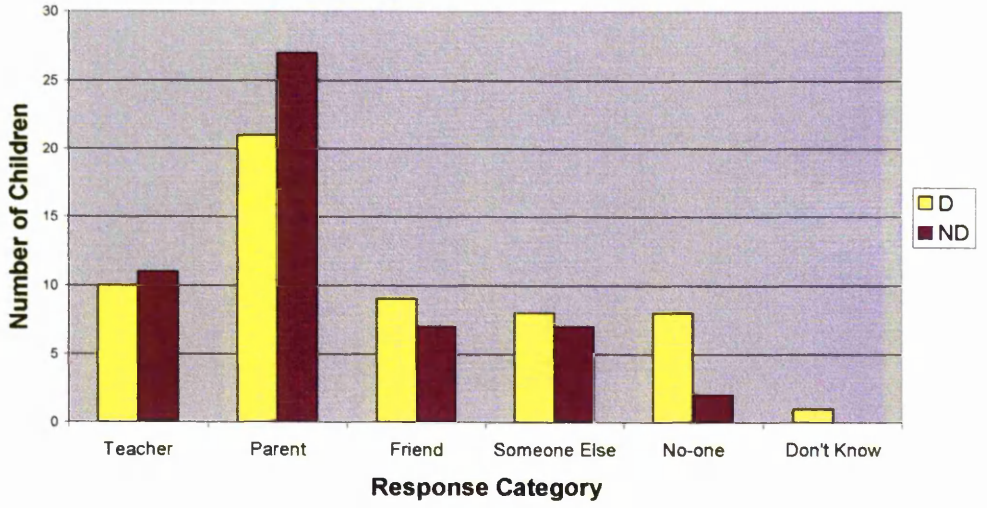
From the total number of participants who felt they were able to answer this question, 71% of them said that they thought children and teenagers suffer from depression. Only 5% felt that young people could not get depressed.

15% said that they 'did not know' whether or not young people could get depressed. However, 8% of the participants who answered this question said that they thought teenagers could get depressed, but not children. One pupil said that he preferred not to give an answer to this question so it was difficult to ascertain his knowledge regarding this question. This response had not been included in the supplementary questionnaire. However, a noteworthy point was that some of the participants felt that depression was something which children do not suffer from and that it is teenagers and adults who suffer from it. I feel the way they chose to answer this question indicated that they had thought carefully about the answer.

4.9 QUESTION 4: IF YOU HAVE ANY WORRIES, WHO DO YOU TALK TO?

Teacher	☐	Parent	☐	No-one	☐
Friend	☐	Someone Else	☐	Don't Know	☐

FIGURE 4.4 : Histogram Showing Responses to Question 4.



All participants were requested to answer this question. Some participants gave more than one answer to this question .The most frequently given response was 'parent' which received 59% of the total responses given by the participants to this question. 'Teacher' had 26% of the responses, followed by 20% for 'friend' and 19% for 'someone else'. When the participants were asked to clarify this, most of them said that they would discuss any worries they had with a grandparent. Other responses tended to relate to family members such as siblings or aunt/uncle.

Only 10 out of the 81 responses given (12%) by the participants indicated that they would not talk to anyone regarding any worries that they might have?

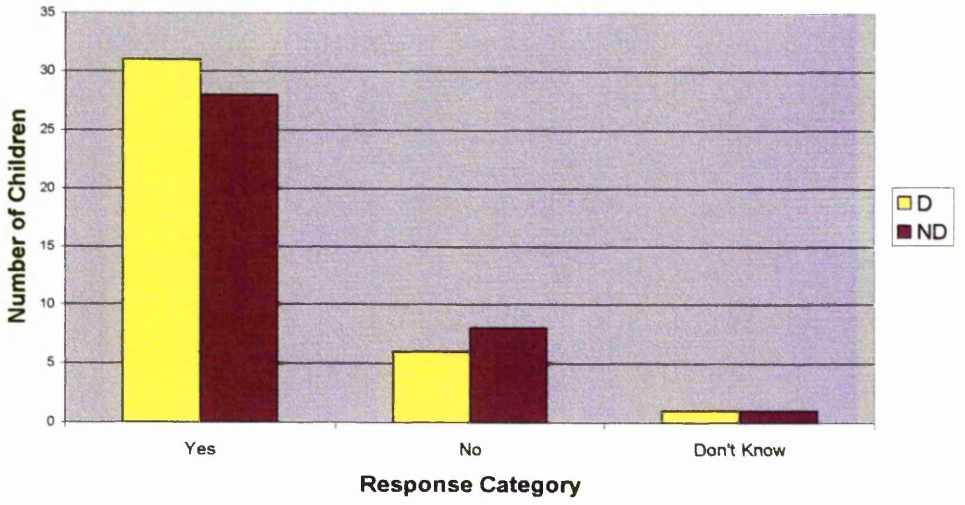
The responses to this question illustrate that children and teenagers value their teachers and feel they can discuss any concerns that they have with them. Would this percentage increase if there was a built-in structure to the school day which allowed pupils to talk to a teacher about any emotional problems they may have?

I feel it is important to create a listening and caring ethos in schools, where children feel safe, not only in a physical sense, but also emotionally. There should be opportunities for children to talk privately to someone about their feelings, and they should be given a lot of reassurance that they were right to confide in someone. This has certainly been supported by the responses the pupils in the current study gave to this question.

4.10 QUESTION 5: DO YOU THINK THERE SHOULD BE AN ADULT IN SCHOOL THAT YOU CAN TALK TO IF YOU HAVE ANY PROBLEMS OR WORRIES?

Yes ☐ No ☐ Don't Know ☐

FIGURE 4.5 : Histogram Showing Responses to Question 5.



All participants were required to respond to this question. 79% of the participants (59 out of 75) responded 'yes' to this question, 18% said 'no' and 3% said that they 'did not know'.

The results clearly show that the participants feel that having someone to talk to at school, with regard to any problems or worries that they have, is important. The participants were not required to consider the elements of this question as two separate issues. It was hoped that the boys would automatically consider both worries and problems that they had when responding to this question. Since all the questions in the supplementary questionnaire were read to all participants, any misunderstandings could be clarified by the interviewer if necessary. Certainly during the interviews which

were conducted by myself, this question did not appear to confuse any of the participants and no clarification was requested.

In the absence of a counsellor at school, the pupils are limited to their teachers and support staff if they wish to discuss any worries that they have. With reference to Question 4, it can be seen that 20% of the participants reported that they would discuss problems with a teacher and for Question 5, 79% of the participants said they thought there should be an adult at school with whom they could discuss any problems. This percentage figure may have been higher if there was a trained counsellor or therapist on site full-time. The participants were not asked to comment specifically regarding whether or not they felt they would benefit from having a counsellor at school with whom they could discuss any worries or problems, for the simple reason, they may not be aware of the work carried out by a counsellor and may not know if this service would be of any benefit to them. Currently, the three EBD schools are required to share one member of staff trained in therapeutic interventions which means that some of the boys would not have had the opportunity to access this support due to the therapist's time constraints. Had all the participants been given the opportunity to receive some therapeutic intervention from the trained counsellor, they would have been able to make an informed judgment regarding the usefulness of a trained counsellor at school. Since it would be an impossible task for the therapist to work alongside all the pupils within the EBD schools, this could account for the responses given to Question 4. In future studies useful information may be obtained by asking participants if they have received any counselling (or therapy) at school and then ask them to comment upon its usefulness/effectiveness.

The Special Educational Needs Code of Practice (2001) states that pupils should have the opportunity to discuss any issues including any health related problems with 'a relevant health professional, educational psychologist, education welfare officer, counsellor or other professional' (p.89). Since most adolescents with depression do not receive treatment, either because they are not referred to the mental health services, or do not

refer themselves, I strongly agree with Keller et al. (1991) who argue that a school counselling service could provide an initial source of support for pupils. Adults who are able to use counselling skills, and build trust in pupils can be of huge benefit to individual pupils and the whole school. EPs are able offer a form of listening service but this is costly when schools could offer this service. However, the role of EPs appears to be changing or has already changed in some authorities in that EPs have become more involved with group work, supporting groups of children with EBD (e.g. BEST offers support of this kind). Perhaps there is a need for EPs to offer a counselling service for pupils, but this would entail further training for qualified EPs and a change in EPs professional training course.

School counselling emerged as a result of the recommendations of the National Association for Mental Health at a conference held in 1963. Milner (1980), states that one way in which schools can promote their caring ethos is to provide a counselling service. By doing so, the schools can also promote the personal development and well-being of their pupils. In this sense, schools would be providing a preventive mental health service.

One of the issues raised during the interviews with the HTs was the support the children were currently receiving within their schools. It has been recognised by the HTs that, at the very least, young people should have access to informal counselling during periods of difficulty. (Issues relating to support are discussed in more detail in Part C of this Chapter). However, I do not know of any full-time school counsellors working in schools within the LEA which took part in this study. Although every school is allocated a nurse, during an interview with one nurse at a school, it became apparent that nurses have taken on the role of counsellors, despite not being trained counsellors.

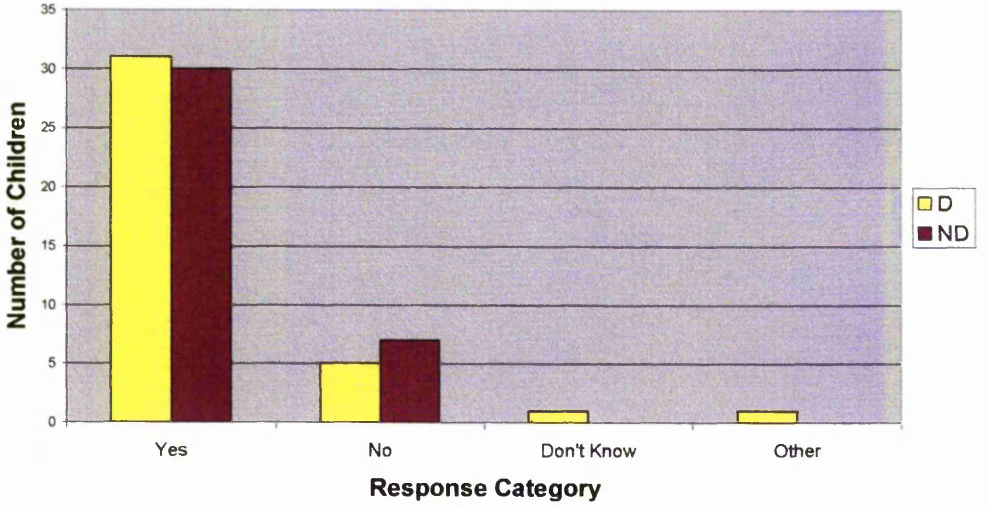
The responses given to Question 5 has highlighted the need, as felt by the participants, for an adult to be present at school with whom they can discuss any worries or problems that they may have. In general, the information I am given by teachers during my visits to schools in my capacity as an EP, is that

they do not feel confident enough to offer any form of therapeutic intervention as they have not received any formal training in such techniques. Consequently, many pupils may never receive the support that they feel they would like to have. Even if pupils do not request this support for themselves within the course of their schooling, nevertheless, it is clear from their responses to this question that they should, at the very least, have this opportunity available to them.

4.11 QUESTION 6: DO YOU FEEL THIS SCHOOL SUPPORTS YOUR EMOTIONAL WELL BEING?

Yes ☐ No ☐ Don't Know ☐

FIGURE 4.6 : Histogram Showing Responses to Question 6.



An overwhelming majority of 81% of the participants (61 out of 75) reported that in their opinion, the school which they attended supported their emotional wellbeing. Since most of the pupils feel supported, then this could account for the prevalence of depression within this population of EBD children being the same as would be expected within the normal population. Only 16% said that they did not feel their emotional needs were being met by the school. Only one participant responded by saying he 'did not know' and one participant said that he did not wish to answer the question and when questioned, would

not give his reasons why. The pupils who responded 'no' to this question were then asked how the school could help them more. All the participants claimed that the teachers should listen more.

The 1989 Children Act embodied the principle of listening to children. This did not apply solely to Law Courts, but to all professional agencies who work with children.

It is considered good practice to ask pupils their views on how they feel their needs could be met (Code of Practice 2001 DfES p.92).

Charlton (1996) gives several reasons for listening to children, as listed below:

- to find out more about them in order to understand them better and provide help for them;
- in order to allow them to discuss any concerns or fears and hopefully resolve them;
- in order to diagnose;
- in order to help remove any learning difficulties;
- in order to involve children in school affairs.

> 'By listening to their views we extend our knowledge of *their* perceptions of those experiences. If we listen carefully we may learn more about our own successes and failures; and we should be prepared to consider changes in our provisions and practices in the light of such comment.' (p.50)

It was with these reasons in mind that Questions 5, 6, 7 and 8 were asked within the supplementary questionnaire.

For 26% of the participants in this study, their teacher was someone with whom they felt they could discuss their concerns, worries or fears. This percentage is encouraging especially since children spend so much time at school. The EBD schools participating in this research study have a very caring ethos and since the pupil number in each class is relatively small compared to a mainstream school, the teachers are in a position where they

are able to give their time to listen to their pupils. This is probably completely different in a busy mainstream school. Even if the teachers did have spare time to listen to pupils experiencing any emotional difficulties, there may be some reluctance on the part of the teachers as they may feel they are unqualified to deal with such matters.

Charlton (1996) argues that teachers do not have to be qualified counsellors in order to help their pupils. He claims that teachers can adapt skills which fit well with Carl Rogers' (1951) Client-Centered Therapy which essentially is very much a 'listening' style therapy. Charlton (op cit) states that talking itself can be therapeutic to pupils especially if they have a sympathetic ear. It could be possible for teachers to adopt Rogers' non-directive style of counselling whilst maintaining a detachment from the intricacies of the pupil's problems.

Charlton (1996) reviews the work carried out in schools which illustrate the benefits of active listening. He states that,

> 'Children stand to derive much from being listened to: their academic success can be improved, their personal problems can be reduced, their self-esteem and motivation can be enhanced. Schools benefit too.' (p.62)

Charlton concludes,

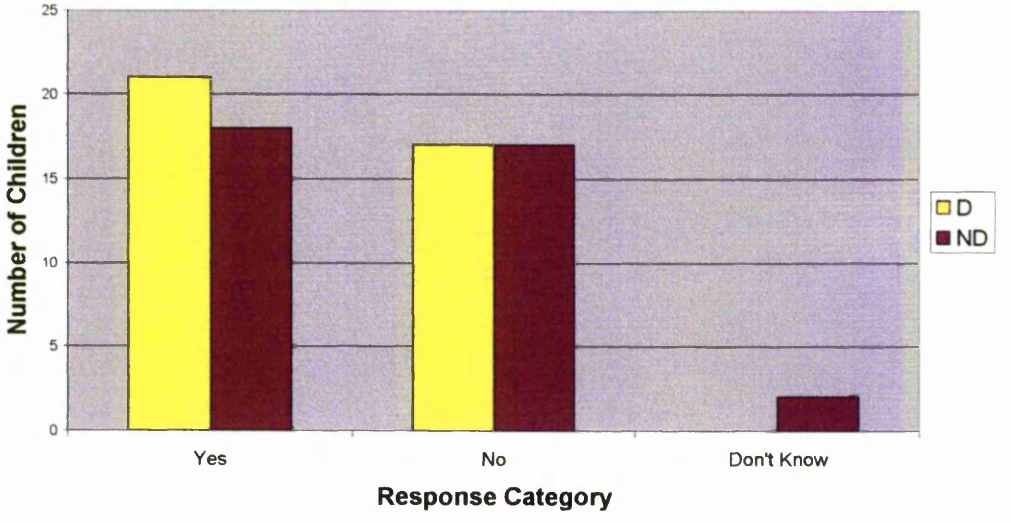
> 'A reluctance to heed children in these ways is irresponsible and is neglectful of what is one of their basic rights.' (p.63)

Attitudes of the staff are crucial and opportunities have to be available for the pupils to discuss their problems. The skills of listening need practice and this could be part of school INSET training days. There also needs to be the time built into the school day for pupils to talk to staff. There needs to be careful planning of staff roles and responsibilities if this is to be successful.

4.12 QUESTION 7: WOULD YOU LIKE TO FIND OUT MORE ABOUT THE EMOTIONAL HEALTH OF YOUNG PEOPLE?

Yes ☐ No ☐ Don't Know ☐

FIGURE 4.7 : Histogram Showing Responses to Question 7.



52% of the participants responded 'yes' to Question 7, 45% responded 'no' and 3% responded with 'don't know'.

Once again most of the participants said they felt it would be useful to learn more about the mental and emotional health of young people. Perhaps this result is not surprising since all the participants who took part in the study have or have had emotional problems. It could be that this cohort of pupils has a greater knowledge and understanding of their emotions and those of other young people, as a result of their own experiences. These pupils may feel that by enhancing their knowledge and understanding of their emotions and feelings, that they would have greater control over them and in a sense, be able to help themselves more instead of relying on others for support especially if support is not always readily available. I would argue that raising awareness of depression and also suicide should extend to the pupils, as suicide prevention work in schools involves them as well as the staff. In the USA suicide prevention programmes in schools has become increasingly common. Ross (1987) reports that the general aim of the school programmes was to raise awareness and also to try to encourage pupils to

seek help if they felt they needed it. With increased information regarding depression and suicide warning signs, including treatment available, it was hoped that the students would recognise the warning signs in themselves or their friends. However, this has its critics who say that it is important not to glamorize suicide, or to give someone the idea in the first place. Indeed, Shaffer, (1993) in one assessment study found that,

> '... adolescents did not seek help for emotional problems following a school programme, but a small proportion did move towards the view that suicide was a reasonable solution to problems.' (p. 104)

Therefore, to encourage school children to share their problems with others, there has to be a delicate balance between de-stigmatising mental illness, depression and suicidal feelings, but at the same time, maintaining the suppression of suicide ideation. Perhaps a more general health education would be easier to implement, or one which teachers would feel more at ease with. Once again, EPs could play a role in helping schools develop a mental health policy. Almost twenty years ago Gillet (1987) suggested that schools could enable their pupils to gain a further understanding of stress and depression by offering a more general health education. If pupils could not understand why they were feeling so low, sometimes every day, it could lead to fear and frustration. It was not until fourteen years later that the DfES (2001) made a statement in their guidelines which informed schools that they could play a vital role in recognising and treating pupils with some mental health problems.

Ross (1987) suggested that,

> 'Basic skills for emotional survival might be promoted in schools – strengthening the children's ability to cope constructively with disappointment, failure and rejection, as well as to court success and popularity.' (p.105)

Diekstra and Hawton (1987) argued that if children and adolescents were taught problem-solving skills, they were then in a better position to evaluate

the problems they were facing, and perhaps, be able to find their own solutions to their problems.

I am aware of numerous EPs from several different LEAs including the Authority for whom I work, who are currently involved in evaluating and promoting Emotional Literacy (Goleman, 1995) in schools. As part of the Primary National Strategy, one of my colleagues is involved in promoting the SEAL initiative (Social and Emotional Aspects of Learning – a whole curriculum approach). The theory behind the SEAL development is that students who are angry, anxious or depressed are not able to learn.

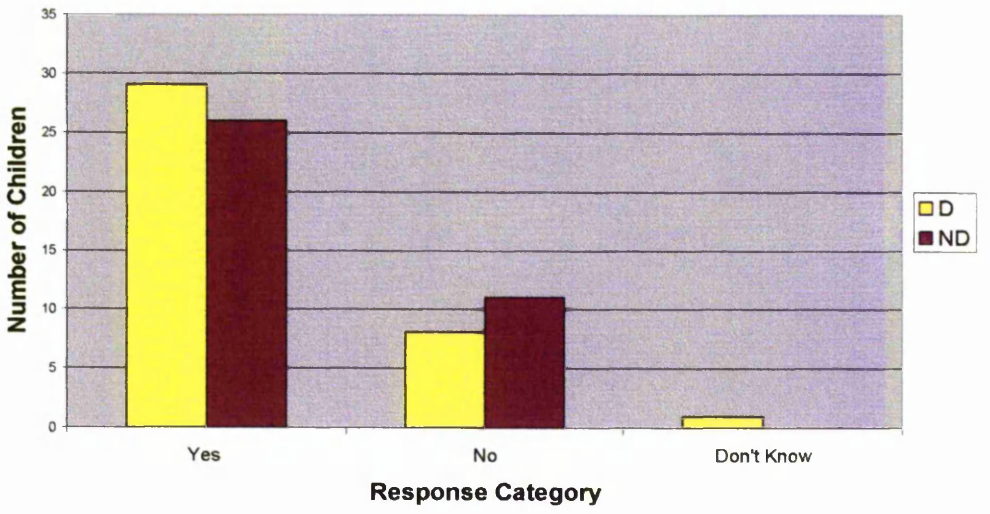
Children and adolescents may be helped if they are able to recognise different emotions in themselves and others. Some schools within my Authority have started to include these elements into their curriculum through activities such as Circle Time in order to develop the pupils' deeper understanding of emotions. The frequency with which they take place vary between schools but it is encouraging that some schools have recognised the need to promote this aspect of their pupils' development and have started to use the SEAL materials in their lessons.

Developing the emotional literacy curriculum could help to promote children's knowledge and understanding of their emotions. EPs could help schools develop programmes for children with emotional and/or behavioural needs. Once again, there are training implications for staff which EPs can provide.

4.13 QUESTION 8: DO YOU THINK IT WOULD BE USEFUL TO HAVE BROCHURES OR POSTERS WITH INFORMATION IN THEM (INCLUDING A HELPLINE) ABOUT THE EMOTIONAL HEALTH OF YOUNG PEOPLE?

Yes ☐ No ☐ Don't Know ☐

FIGURE 4.8 : Histogram Showing Responses to Question 8.



73% of the participants (55 out of 75) said they felt it would be useful to have such information in and around their school in the form of brochures or posters. They felt that a helpline would be very useful for the boys (if not necessarily for themselves) should they need to contact someone for advice or help outside school hours. 25% of the participants (19 out of 75) said they did not feel brochures or posters would be useful. Some of the participants said that the brochures or posters would be ripped up or simply thrown away by the other pupils. One participant responded 'don't know' to this question.

EPs could have a role to play in this instance as they could provide schools with leaflets and adverts which would provide pupils and staff with a greater knowledge and understanding of depression. Some leaflets provide emergency telephone numbers of organisations that offer help, e.g. The Samaritans and Childline. EPs could suggest relevant books for the school library that could provide more useful information and help to pupils and staff.

Although leaflets and adverts alone cannot save lives, yet greater public awareness of depression could well avert some tragedies. Where depression and suicidal feelings and behaviour are poorly understood many crises escalate unchecked as vital danger signals are missed (Hill 1995).

A point worth noting is that none of the participants offered to give additional information about themselves during the supplementary questionnaire. More in-depth interviews with the participants could have highlighted useful personal information and/or reflections upon their own depression (if any existed or had in the past). Whilst this information could have proved useful, not only to add depth to the results and discussion of this research, but also to enhance our understanding and knowledge of depression in young people, however, there may have been reluctance on the part of the children to divulge more personal information than they had already given through their responses to the statements on the CDS. Nevertheless, this could be considered to be a methodological weakness of this study, therefore, future studies could include a more in depth interview with each (or a smaller number) of participants which could yield information relating to the onset and duration of their depression. In addition, information pertaining to the factors within the school environment which help alleviate their symptoms and similarly, the factors the children feel prolong these feelings, could be obtained. The children may be able to inform further studies of what they regard to be mitigating circumstances which could possibly have led to their depression.

It is possible that the responses given to the supplementary questionnaire could have been contaminated. By this, I mean that some of the participants could have been tired or bored by the questioning at this point since they had already had to concentrate for approximately ½ - ¾ of an hour responding to the statements on the CDS. It is possible that some of the participants could have given a shorter response than they could actually give in order to bring the interview to a close. However, had the supplementary questionnaire been presented first, before the CDS, this would have given the participants a greater awareness of the subject under investigation, which in turn, could

have skewed the results. Trying to control for this confounding issue is extremely difficult if it is at all possible. Altering or randomising the order of presentation of the parts of this study would certainly lead to a response set and possibly conform to experimenter expectation, thereby once again, giving false results.

4.14 SUMMARY

In essence, responses relating to the supplementary questionnaire indicate that there was no significant difference between the two groups, D and ND, in terms of their participants' response to each question. The data can be judged as showing a high level of agreement between the two groups (although different in their positions on the CDS depression scale). Most of the participants had heard of the medical condition 'depression' and were able to describe it in terms of an affective response. 71% of the participants said they were aware that children and teenagers can suffer from depression.

If the children had any worries they said that they would prefer to discuss them with their parent(s) or with a teacher. It appears that the pupils would readily embrace the idea of a mentor or counsellor at school. Overall, 81% of the participants felt they were adequately supported (emotionally) by their school but would like to find out more information regarding the emotional well-being of young people.

PART C – INTERVIEWS WITH HEADTEACHERS

As stated within the Ethical Considerations subsection of Chapter 3 the HTs were informed of the pupils who obtained a depression score above that which would be considered to be 'the norm' within the general population of children.

Their reaction was one of surprise, not with regard to the fact that some children had obtained such a high score on the depression scale, rather, they were surprised at the **number** of pupils who had obtained such a score. All

HTs had expected some of their pupils to achieve a significantly high score of depression, but much fewer in number than the study found. Once the HTs had been given this information, they were keen to discuss issues relating to support for their pupils. Unfortunately, giving the HTs knowledge of the number of pupils with a high depression score prior to the interviews could have led to *experimenter effects* since they were then aware of how many of their pupils had obtained a relatively high depression score, It could be argued that their comments during the interviews were strongly influenced by this information and inevitable that they felt they needed more support for their pupils and their staff. However, it could also be argued that the HTs would have made these claims regardless of this information in the hope that more support would be forthcoming. I did not feel it was ethical to withhold the names of the pupils with a high depression score until the interviews with the HTs had been completed, since the interviews with the pupils took place over a period of approximately four months. Some of the pupils who had been interviewed in the first stages of the study did indeed obtain high depression scores and I felt it was necessary to inform the HTs immediately of these pupils so that they could be provided with the necessary support. Withholding these names for the benefit of overcoming experimenter effects in my opinion was not considered to be ethical.

Through the process of an unstructured interview, the HTs were given the opportunity to freely discuss issues regarding:

1. Support which they were currently being able to provide for their pupils.
2. Support which the school was currently receiving from outside agencies.
3. Support which they felt their school needed in order to provide more effective support for their pupils and staff.
4. Training issues.

The three HTs were interviewed individually by the researcher. Each interview lasted for approximately half an hour.

4.15 SUPPORT CURRENTLY AVAILABLE TO PUPILS ATTENDING EBD SCHOOLS

(i) Internal Support

All three HTs reported that they have specialist support in their schools but there is a discrepancy in the amount and frequency this support can be accessed. In order to obtain further information regarding support available to the schools, I was able to have a brief discussion with the key worker. I was informed that the key worker had been working for the LEA for approximately 2½ years. The key worker has a certificate in counselling, a post graduate diploma working with children and young people and a diploma in hypnotherapy. The key worker informed me that teachers can refer pupils to her but the children can also refer themselves. The level and quantity of support which she gives is dependent upon their level of need. The key worker works extremely closely with the CAMHS Team and if for any reason there is a breakdown in the work carried out by a member of the CAMHS Team, the key worker would continue with the work at school.

When the key worker initially began her work at the three schools, all the boys were given the opportunity to work with her once a week in a 6 week cycle. Some of the boys with more significant difficulties were given more sessions. Currently the key worker works with the pupils with long term needs so not every boy works with her.

The key worker works very closely with parents and she told me that without parental or carer support, her work would not be as effective.

The key worker is able to provide social skills training, anger management techniques, emotional therapy which includes raising self-esteem. She is also able to provide group family work which includes aspects such as play therapy and positive parenting skills training. Boys can attend her sessions on an individual basis or in a group.

Two sessions are available to boys per week if they have very significant difficulties and if necessary, every day. The key worker is also able to provide training to teachers and she also works in the home. Currently, her time is divided between the three EBD schools: 80% at one of the schools and 20% is divided between the other two schools.

(ii) Support from Outside Agencies

All three HTs reported that they have access to outside professional agencies. The agencies which are used most regularly are the Educational Psychology Service, Social Services, Education Welfare Officers, CAMHS, Youth Opportunity Teams and the Police. However, all HTs reported a difficulty accessing some of these agencies quickly in a crisis situation. One HT in particular reported that some of the Educational Psychology reports had been rather vague with their recommendations and the school was not able to provide any further support for the child as it had not been given advice which they felt would have been most useful. The same HT also commented that feedback from mental health practitioners and the CAMHS Team is very limited due to confidentiality issues. Again, this does not give the HT or class teachers any indication of how to help the child in the best way.

(iii) Further Support Required

Although the three HTs were interviewed individually and on separate occasions, all agreed on the following issues. Firstly, all three HTs stated that they wanted more time from the Educational Psychology Service. One HT in particular felt that the quality of the EPs reports needed to be improved especially with regard to their recommendations which school could use in order to help their children experiencing emotional difficulties. The HTs from two of the schools stated that they would appreciate a greater awareness of what the EPS can offer so that they could utilise the Service in a more effective way and not merely for a cognitive assessment. The HT from one of the schools mentioned that they would appreciate more time spent by Educational Psychologists observing the pupils within the classroom. It was

felt by this HT that some Educational Psychologists had been out of the teaching profession too long and had forgotten what it must be like for teachers with children in their care with significant emotional and behavioural difficulties on a daily basis. All The HTs commented to the effect that they would appreciate more information from EPs with regards to daily classroom management and strategies which could prevent, or at the very least, reduce unruly or aggressive behaviour during lesson times.

All HTs reported that they do not receive any support from the BEST Teams and that they would greatly appreciate any support which they could provide.

All HTs stated that they wanted additional support from a full-time or at the very least a 0.5, outreach worker with qualifications in counselling or psychotherapy. This of course would require further funding for the therapist.

All three HTs agreed that they wanted easier access to or a 'fast-track' method of accessing the CAMHS Teams or clinical psychologists. They also wanted easier access to the ADHD and ASD Clinics which the LEA provides. With specific reference to the ADHD Clinic, one HT stated that within his school there are a number of children who had been diagnosed with having ADHD. According to the LEA's criteria for entry into the EBD special school provision, these pupils should not have been attending this school. This HT felt that these particular children had been wrongly placed within this EBD school. Had the pupils been diagnosed with ADHD earlier, i.e. prior to being excluded from their mainstream school, then they may have been given their medication earlier and their behaviour difficulties could have been resolved without them being excluded from their school.

(iv) Training Issues

All three HTs claimed that they felt that their staff would benefit from further training especially in how to recognise depression in young people and how

to support them within the school environment. One of the HTs stated quite clearly and quite forcefully that 'Teachers are not counsellors' and went on to say that although some teachers may feel that counselling skills would be useful, they certainly would not have time within the school day to use these counselling skills fully. However, further training would help teachers to recognise the signs and symptoms of depression and low self-esteem, etc. One HT mentioned that they would appreciate training in the area of family support so that they can provide further support for the families of the children in their care.

4.16 SUMMARY

In short, the schools' responses to the emotional needs of pupils are inevitably affected by resources, staff workload and the level of liaison the school has with other professional and voluntary groups. All three HTs within this study agreed on certain issues such as: Further training, greater input and advice from the EPS and CAMHS Teams. There also needs to be more work with parents and families both within and outside the home environment. There needs to be a multi-agency approach to helping schools and children with EBD and with that there should be a greater empathy for each profession and what they can offer to the schools. This has implications for the role of the Educational Psychologist and these implications will be highlighted below.

4.17 IMPLICATIONS OF THE RESEARCH ON THE ROLE OF THE EDUCATIONAL PSYCHOLOGIST (EP)

Although the level of depression which was found to be prevalent within the participants who took part in this study was not significantly greater than that which would be expected within the general population of school children, nevertheless, the fact remains that there was prevalence and this cannot be completely ignored. Indeed, some of the participants obtained a very high

depression score on the CDS and it was essential to inform their HT of this so that support could be provided to them. Since this study and previous research has found that children can suffer from depression, how can EPs help to support these children? This section will consider the role of the EP in relation to the support (direct and indirect) they can provide to pupils who may be suffering from depression.

Both The Mental Health Foundation (1999) and The Code of Practice (2001) have highlighted the important role that psychological services can have in supporting pupils with emotional difficulties. The Code of Practice (2001) states that the Educational Psychologist can be a very important resource for the school in that the psychologist's knowledge of the school and its context is key (p.136) and I strongly agree with the Code of Practice on this matter. Since depression is regarded as a mental health issue, children with such problems are most likely to be referred to the CAMHS Teams. However, it is not part of their training for mental health practitioners or clinical psychologists to have experience of the education system and therefore they are not in such a strong position as EPs to offer advice and support to school staff. EPs are qualified teachers and therefore understand and appreciate the demands placed upon school teachers every day. EPs can appreciate the support which can be realistically offered to the pupils who may be depressed.

Studies cited within Chapter 2 of this thesis have highlighted the benefits of prevention and the early identification of depression in school children. This in turn has implications for the role of the EP. It also has training implications for EPs and could possibly facilitate the development of a specialist in this area of children's special educational needs. This has been highlighted over recent months as I have been asked to give two seminars on the subject of depression in school children; one to a group of Learning Mentors and another to a group of Special Educational Needs Co-ordinators. It appears that depression in children is becoming an increasing concern for schools and staff have requested information regarding the identification pupils who

may be depressed and also what support they can realistically offer those pupils. These issues were also raised during the interviews with the HTs who took part in this study.

In my capacity as an EP, I have been informed by teachers and HTs that mental health practitioners do not tend to work within the school environment, rather the child and family are given appointments in clinics. HTs and SENCOs have explained to me on several occasions that they have not received any feedback from CAMHS Teams in the form of information as to how school staff can help the child further at school, very often because the parents have requested that the information remains confidential. I want to state quite strongly that I am not making a personal criticism as I would not wish to criticise my colleagues in the CAMHS Teams as I know they provide a great deal of support for children and families and some schools have received feedback from them. The point I am trying to stress is that there is an obvious gap in teachers' perceptions, knowledge and understanding of children's depression and the clear message I am receiving is that they want to close this gap. Since every school in the Authority for whom I work have an allocated EP who visits on a regular basis, we are in an excellent position to bridge this gap in teachers' knowledge of depression in school children.

EPs can provide both direct and indirect support to schools and children in the following ways. Initially, EPs can provide support not only to the three EBD schools who took part in this study, but also to all schools, so that preventative measures can be put in place, such as raising awareness of the existence of depression in young people. Raising awareness of depression could prevent some tragedies. If danger signals are spotted, some crises could be checked in time.

Getting evidence about depression is very difficult, and at present, it is up to individual teachers to decide what signs or behaviours constitute depression. However, one teacher may have a different opinion to another. This is where a whole school policy could help in defining a consistent approach to

depression, and EPs could have a significant input into this policy. Once a teacher suspects that a child may be depressed, then they could be referred to an EP, or better still, to a mentor or counsellor (if based at the school) initially, and then referred to an EP for further advice or intervention if necessary. EPs could provide training days to staff to help them recognise emotional problems and depression in pupils. This in turn, could build their confidence in knowing how to deal with a pupil who has confided that they are depressed and may even be feeling suicidal.

In addition to working alongside teachers, EPs can indirectly help a depressed pupil by helping and offering advice to the parents involved. Evidence from previous research has shown that children can become depressed as a result of problems at home (Fleming and Offord, 1990; Sund et al., 2003; Neuman et al., 1997; Goodman and Gotlib, 1999; Asarnow, Carlson & Guthrie, 1987 ;). In addition to the evidence found in previous research, the current study revealed that participants who obtained a depression score above 120 were in general as unhappy at home as they were in school. There was no significant difference between their scores relating to their home life and their school life so their scores were not specific to one environment alone. Reassuring parents that their child will be cared for and helped as much as possible in school can help to alleviate some of the concerns that parents may have. During my day-to-day practice as an EP, I have found that teachers and parents both appreciate the close liaison between all parties so that they can be kept up-to-date with the development of the child. This liaison can also provide the opportunity for the EP to educate parents about the possible detrimental effects that extreme family discord can have on young people. Working with families of depressed children could help parents understand the nature of depression in their child. They could be taught to identify 'risk factors' and then be alert to early symptoms of depression in their child and then be taught how to respond to this and provide support. The DfES publication (2001) advocates close liaison with parents of pupils with EBD. Recommendations are listed which include home visits, parent 'drop-ins', parenting classes which help develop parents' skills in engaging with their children (p.15). This issue was also raised by the

HTs who took part in this study who also suggested that there should be greater liaison between parents and schools which they feel could be of enormous benefit to the pupils. Unfortunately, I was informed by the HTs that not all parents are supportive and do not attend meetings when invited.

It is important that parents are aware of the support that is being offered by the education system and that offered by other services, where to go and who to ask for support. It is also important that stigma is removed from children with EBD or mental health problems, so that parents do not feel any shame and consequently are happier to seek advice and support. Of course, it is crucial that parents are able to recognise that their child is experiencing difficulties outside of the norm. By working alongside parents it is hoped that EPs can promote the mental health of school children experiencing such difficulties.

The results to the second research question regarding the profile of depression highlighted social problems, guilt and self-esteem as the three most important variables. EPs can provide direct support to children in a one-to-one or group (if agreed by all pupils) situation by utilising behavioural and cognitive based therapies since interventions which have utilised social skills training and inter-personal psychotherapy as highlighted in Chapter 2 of this thesis have been found to be very effective in helping pupils with (and without) depression (Fine et al., 1991; Stark, Reynolds & Kaslow, 1987; Stark, 1990; Shochet et al., 2001; Hains and Ellmann, 1994; Spence et al., 2003). But can such programmes be feasible and effective in the hectic 'real-world' of school life? With careful planning and co-ordination, I would argue that these could be implemented into the educational system, and do not necessarily need to be carried out in a 1-1 situation by the EP and the pupil, but could just as easily be carried out by a trained member of staff. Again, EPs can suggest schools carry out these strategies and can provide some training to staff on how to implement these techniques on a daily basis within their lessons. With training, I would argue that it would be feasible for teachers to provide lessons which include self-evaluation training which is the process of comparing a child's performance with their own internal standard.

It has been found that negative self-evaluation is a common symptom of depression in children (Kendell, Stark and Adam, 1990,). For instance, if a child sets excessively high, unattainable standards in their work, and are unable to reach them, depression can result. So perhaps the teacher can set more realistic goals for that pupil and by doing so, train the pupil to change how they evaluate themselves and change their own expectations of themselves. These studies have important implications for schools. If this kind of problem-solving therapy can be incorporated into the National Curriculum, perhaps in PSHE lessons, surely, it can only serve to help all the children, not solely the children who are depressed.

Although this study did not include pupils approaching school-leaving age, nevertheless, it is important not to forget these pupils since statistics show that young men in their early twenties constitute the greatest number of suicides in Britain at the present time. One approach using questionnaires has been used in American schools by pupils aged between 14 and 18. The questionnaire included items about depression, suicidal feelings, previous attempts, alcohol and drug use as well as other more general health questions. The pupils were willing to answer the questions and if any pupil was found to be vulnerable or showing signs of depression, they were then offered the opportunity to talk to a counsellor (Shaffer 1993 cited by Hill p.106). This approach is extremely useful as it can identify the pupils who were not previously regarded as being depressed or having any serious emotional problems by schools. In fact, The Samaritans have confirmed that, adults often are not aware of suicide attempts made by some children. EPs could work with individuals or groups of pupils approaching school-leaving age focusing on any worries which they may have about the future.

EPs have the knowledge and expertise to offer a wide range of support to schools, pupils and their families. However, the number of children needing support may be too great for an individual EP to manage effectively. This has further implications for the role of the EP. Perhaps multi-agency work is the key to providing the necessary support to the staff, families and children with emotional difficulties (as the HTs who took part in this study suggested). The

EP Service could help to provide multi-agency support by joining CAMHS teams and school nurses. Within my practice as an EP, multi-agency working has proved quite difficult to manage since the EPS for whom I work is constrained by a time-allocation model and as a result, it is not always possible to attend assessments and/or meetings with other professionals. However, since the three HTs remarked that that multi-agency working would be of great benefit to them, the wider elements of working together would need to be carefully considered such as time allocation, supervision and management so that this can become an integral part of the work of an EP. Multi-agency work would involve compromises by all those involved. It would require an understanding of the ways each professional works. However, it is my opinion that the gains of working in this way far outweigh the difficulties initially encountered when developing this way of working. It must be regarded in a more positive light than the current way of working which at times, I feel is quite isolated. I would argue that joined-up working with other services could provide a more efficient and effective response to schools who have children in their care with EBD.

In the DfES document (2001) Educational Psychologists are listed under 'Specialist Mental Health Professionals' alongside Clinical Psychologists, Psychiatrists and Community Psychiatric Nurses. Educational Psychologists would work within the parameters of Tier Two, whilst Tiers Three and Four provide a more specialist service for the more severe, complex and persistent disorders.

With reference to the role of the EP, I feel that EPs need to promote the work which they are qualified to undertake. SENCOs with whom I have discussed such issues and the HTs who took part in this study have told me that they are unaware of the range of work EPs are qualified to do. If schools were made aware of the wider range of work EPs are qualified to undertake, in relation to the emotional well-being of schoolchildren, then they may not feel it necessary to refer the pupils to the CAMHS teams so readily without first consulting with the EPS.

4.18 LIMITATIONS OF THE RESEARCH AND FUTURE DIRECTIONS

Some of the methodological limitations of the study have already been discussed in detail within previous chapters. The Methodology chapter includes a detailed critique of the methods of data collection and also a critique of the use of the CDS. Chapter 4 provides a discussion regarding the limitations of the study's reliability, generalizability and applicability of the results. Therefore, this section will not include a critique of the points made previously. Instead, a more general critique will be provided regarding the limitations of the study and how future studies could possibly overcome some of these limitations.

In order to determine whether the conduct disorders are sequel to or precursors of the depression, longitudinal studies may be useful. Could depression be a precipitating or mitigating factor for aggressive behaviour? Evaluating children and adolescents before depressive symptoms increase may help professionals to pinpoint more accurately the important factors precipitating the initial depressive episode. Further studies could consider this possibility which is beyond the scope of the present study, although relevant nonetheless.

This study has demonstrated that HTs and their staff want more information regarding depression in school-age pupils. Speaking on behalf of their staff, the HTs informed me (during the interviews) that they are aware of a lack of knowledge among teachers relating to depression in school children. Even when some teachers are able to recognise some of the symptoms of depression, the general consensus of opinion is that they do not feel that they have the knowledge and skills to respond. It may be useful to find out how many HTs are aware of the DfES document 'Promoting Children's Mental Health' (2001) and how many of them have actually read it. It would be useful also to find out how many schools have a whole school approach to

promoting children's mental health and how many schools are trying to implement the interventions outlined in the DfES document. Information regarding the effectiveness of these interventions in terms of any reduction in the number of children with emotional and behavioural difficulties would also be useful.

In future studies, useful information could be obtained from screening mainstream pupils including girls for a prevalence and profile of depression and these scores could be examined and compared to pupils attending EBD schools. However, Roberts (1999) claims that screening children for depression has its limitations since there is the potential that some children will be labelled in the eyes of their peers which some children would find embarrassing. Unless it is handled in a very sensitive way, there is the risk of causing distress to the children and their families.

Since adolescence is a time where there is a significant increase in symptoms of depression, this would seem a particularly informative time to study risk factors and the development of depression. This study needs to be expanded further to confirm the existence of this 'target' group and perhaps to clarify other associated behaviours. It would be of great interest to me to receive information regarding any similar studies undertaken nationally so that the universality of the results found in this study and their application to schooling methods could be examined further (i.e. examine its external validity further). Due to time constraints, only pupils within one LEA could realistically be screened, but future studies could include pupils attending schools within other LEAs. A national picture of depression in school children could prove extremely informative which in turn, could provide crucial information to professionals working alongside youngsters as to how they can be supported further.

Perhaps another useful study could include a longitudinal design which examines depression scores for pupils who are attending their mainstream school but who are experiencing emotional and behavioural difficulties. If the pupil(s) are consequently excluded, their levels of depression (if any) could

be re-tested once they have been placed in an EBD school to see whether or not there is a change in the severity or profile of their depression scores. If a difference exists, what has contributed to the difference? Was depression affected by educational or non-educational influences? If the levels of depression fall after transferring to the EBD school, has there been a change in the nature and severity of the behaviour problems? Has attending the EBD school and all that it entails, e.g. smaller class size, high teacher-pupil ratio, differentiated work, additional counselling-type support, made a significant difference? In this case EBD provision could claim to be the appropriate place for that pupil. If the child is still depressed, and the behaviour continues, is a specialist EBD school the best provision for that pupil? Similarly, what if the pupil was not depressed before being excluded but has depression after transferring to the EBD school? This would raise some important issues regarding the efficacy of EBD provision. Ideally, should these pupils be found to be experiencing depression prior to exclusion, one would hope that the mainstream school would provide the necessary help and support for the pupil so that the severity of the behaviour does not escalate to a degree where the HTs and staff of the school feel that they can no longer support the pupil.

Other longitudinal studies could examine any differences in the prevalence and profile of depression in pupils on their return to mainstream schools from an EBD school.

4.19 SUMMARY

Taking into consideration all of the above, it can be argued that this study relates directly to the work of EPs. EPs can have a direct and indirect impact on supporting pupils with depression. It is hoped that the results of this research study will inform the LEA, EPs and other professionals working closely with children with depression or EBD. From this, it is hoped that it will

have a direct bearing on the lives of these children, their parents and their schools.

Whilst it is recognised that for a small minority of pupils, e.g. pupils presenting extreme aggression or presenting overtly sexualised behaviour, mainstream school is not an appropriate setting. However, it should be recognised that the majority of pupils with EBD could maintain a mainstream placement in the long term, if given appropriate levels of support. In order for the present rate of permanent exclusion to be reduced, mainstream schools will need extensive guidance on behaviour management and on the pedagogy of inclusion.

EPs can be involved in giving guidance and training to schools with regard to the management and support of pupils with EBD but in order to do this, there needs to be a shift in emphasis from statutory work to offering schools advice on interventions, therapeutic work with children and their families, in addition to schools (Greig 2004b). It suggests that, at the very least, careful monitoring or an awareness of children's depression would be a positive contribution on behalf of schools.

CHAPTER 5 SUMMARY AND CONCLUSIONS

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This study was an attempt to examine the prevalence and profile of depression within boys attending schools for pupils with Emotional and Behavioural Difficulties. The study revealed that depressive symptoms were prevalent in 39 out of the 75 pupils who took part (52%). At first glance, this percentage would appear alarming; statistically however, this number would not be greater than would be expected in the general population. It suggests that perhaps, EBD schools cater for the emotional needs of their pupils and actually prevent some of them from becoming depressed. Alternatively, it could be that the CDS is not an accurate measure of depression, but is a measure of a construct other than depression.

The study revealed that the profile of depression in school children attending EBD schools is characterised predominantly by social problems. Low levels of self esteem also emerged as a significant symptom within this population.

The study highlighted a strong similarity between the two groups (D, ND) with specific reference to their knowledge and understanding of depression. It also demonstrated a strong similarity in the way the participants felt their respective schools had supported them and what further support they felt would be beneficial.

The study also highlighted a strong agreement between the three HTs on certain issues such as further training and more support from outside agencies. All HTs agreed that depression in school children needs a greater profile than it has currently and would welcome any advice and support offered to them and their staff.

This study has highlighted a number of important issues which need to be addressed not only by the EBD schools who took part in this research, but I would go so far as to say that if the prevalence of depression in school children is to be reduced, then it needs to be given more attention not only in

schools but in society at large. A change needs to take place on several levels: Nationally (at a government level), locally (at an LEA level) and at the School level. It could be argued that a change has already taken place at a national level with the publication of the DfES (2001) document 'Promoting Children's Mental Health' and more recently the Guardian newspaper (14.9.04) reported that Louis Appleby, the government's mental health tsar, had stated that the budget for children's mental health would increase by £300 million over the next few years. The article reported that the government had accepted the recent research which showed that adolescent mental health had deteriorated.

At a local government level, the LEA for whom I work has identified the Mental Health of pupils as one of its priorities within its Common Assessment Framework. In response, the EPS has highlighted the emotional wellbeing of children as a priority with the Children's Services for us to develop our capacity to respond to school's request for advice upon such matters.

At a school level, HTs who took part in this study have acknowledged there is a need to provide more emotional support for their pupils, but they feel they need greater knowledge of depression in children and skills in order to offer the support the children need, or that which would be considered adequate. I strongly feel that the ethos and cultures of the EBD schools involved in this research study is such that they are willing to accept that their pupils need more emotional support and I feel they are prepared to make the necessary changes in order to implement this support. However, the overriding concern of the HTs is related to the funding which would be a necessary prerequisite to change. The HTs feel unable to fund the personnel which would be necessary in order to provide the support their pupils and staff need. The HTs are aware that their staff may need additional training but they are prepared to undertake this training. Perhaps further negotiations need to take place between the HTs of the EBD schools and the LEA with particular regard to funding and/or resources.

Initially, school staff need to be made more aware of the possibility of the existence of depression among its pupils. The HTs who took part in this study were not surprised that some of their pupils had obtained a high depression score. It could be argued that due to the severity of difficulties their pupils experience, these HTs are possibly more aware of the fact that childhood depression exists in comparison to their mainstream colleagues.

Recognising when a pupil is suffering from depression can be very difficult, but schools can play a vital part in ensuring that mental health problems are quickly recognised and responded to. Teachers are in an excellent position to help pupils with emotional problems since children spend a lot of their time at school but of course, the quality and quantity of support is determined by the level of knowledge and resources available, staff workload and also the level of liaison it has with other professionals and voluntary groups. Teachers also need information regarding significant events in the pupil's life so that these pupils can be targeted early to reduce the risk of depression occurring. Having the opportunity to liaise with parents/carers on such matters can be crucial in order to pre-empt any change in a child's behaviour. This issue was raised by all three HTs during their interviews. Options for the dissemination of good practice in schools also need to be developed in addition to national training initiatives to raise awareness of mental health issues within schools.

All three HTs reported that training teachers and staff in their schools could promote better identification of symptoms of depression in youngsters. Therefore, it is important that teachers and others responsible for looking after children increase their awareness and understanding of mental health problems in young people. This has already started to take place within the LEA for whom I work as I have been able to give in-service training to a number of Secondary and Primary SENCOs and Learning Mentors. The focus of these training sessions was to develop their knowledge and understanding of depression in young people and particularly their knowledge regarding the possible warning signs of depression. Whilst the classification of childhood depression of the ICD-10 and DSM-IV are theoretically useful, I

would argue that they are not terribly useful to teachers. With this in mind, I provided some information for the staff which highlights school related behaviours which may be indicative of depression (see Chapter 2).

73% of the participants in this study felt that they would find it useful to have posters or brochures around school containing information regarding the emotional well-being of young people. With respect to this, schools could help advertise services available to youngsters. *Young Minds Magazine* (October 1996) states that a range of services are needed which young people can access easily ranging from telephone crises lines, information drop-in centres, counselling in schools as well as specialist mental health services. Information regarding other services could be promoted in schools either directly in lessons or in the form of posters or leaflets which could be placed on notice boards around the school.

Over half of the participants in this study said that they would like to find out more about the emotional well-being of young people so, perhaps, young people should be introduced to a range of issues that affect their emotional health. They should be able to have the opportunities to explore their feelings which are **associated with** emotional well-being and the factors which **contribute to** their emotional well-being. Again this could be effectively carried out during lessons. It is important for young people to explore the issues around emotional ill health and the distress it can have on their daily lives. HTs and classteachers need to be convinced that giving the children opportunities to discuss issues would benefit all in the long-term. If pupils are not keen to discuss issues with an adult then there should be alternative methods of support available to these pupils. It is hoped that by helping teachers or the pupils themselves identify signs or symptoms of depression, that the individuals would seek help before they reached the point where they needed support from a GP or mental health practitioner.

The HTs who were interviewed in this study agree that prevention rather than the cure is far more effective. However, as one HT said, 'Teachers are not counsellors' and even if teachers had counselling skills, they do not have the

time to offer this support to pupils within the school day. But, since depression is prevalent among school children, should there be professional counsellors employed in schools to help these pupils? The British Association of Counselling (BAC) says that there should be some access to counselling within the school environment (cited in Mabey and Sorensen 1995). However, the number of counsellors employed in schools is very few in Britain today, so for many pupils, this potentially life-saving resource is not available. There are learning mentors, but they have not necessarily been trained to work with pupils suffering from depression. As the current study has shown, 79% of the pupils who took part in it reported that having someone to talk to at school with regard to any worries that they might have is very important.

At the initial stages of change, teachers may be more concerned about how the change will affect them personally, in terms of their work within the classroom and any additional duties they may be expected to undertake. This concern may overshadow the potential benefits of the change. Within this research study, one teacher expressed their concern that if the study found a significant number of children were depressed, would the teachers be expected to become mental health practitioners? If change requires knowledge and skills which are beyond that which already exists, there may be reluctance on the part of the teachers to implement the change. I agree with Fullan (op cit) who claims that change needs to be conceived of in a 'multidimensional way'; changes in the goals of schools, skills of teachers, the philosophy or belief that children and teenagers do get depressed. If these changes take place, then there is the chance that a change in practice will also take place.

I am optimistic that a change in practice will indeed take place. Once parents, teachers and other adults who work closely with children increase their knowledge and understanding of the prevalence of depression in children and adolescents, then the planning of mental health care and strategies for intervention in schools can be developed.

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APPENDICES

Appendix 1

ICD-10 Classification of Conduct Disorders and Mixed Disorders of Conduct and Emotions

F91	Conduct Disorders
F91.0	Conduct disorder confined to the family context
F91.1	Unsocialized conduct disorder
F91.2	Socialized conduct disorder
F91.3	Oppositional defiant disorder
F91.8	Other conduct disorders
F91.9	Conduct disorder, unspecified
F92	**Mixed disorders of conduct and emotions**
F92.0	Depressive conduct disorder
F92.8	Other mixed disorders of conduct and emotions
F92.9	Mixed disorder of conduct and emotions, unspecified

The ICD-10 gives the diagnostic criteria for conduct disorder as follows:

"G1. There is a repetitive and persistent pattern of behaviour, in which either the basic rights of others or major age- appropriate societal norms or rules are violated, lasting at least 6 months, during which some of the following symptoms are present..." (p.157)

The ICD-10 then lists the behaviours which fulfil the criteria for conduct disorder:

The individual:

(1) has unusually frequent or severe temper tantrums for his or her developmental level;

(2) often argues with adults;

(3) often actively refuses adults' requests or defies rules;

(4) often, apparently deliberately, does things that annoy other people;

(5) often blames others for his or her own mistakes or misbehaviour;

(6) is often "touchy" or easily annoyed by others;

(7) is often angry or resentful;

(8) is often spiteful or vindictive;

(9) often lies or breaks promises to obtain goods or favours or to avoid obligations;

(10) frequently initiates physical fights (this does not include fights with siblings);

(11) has used a weapon that can cause serious physical harm to others (e.g. bat, brick, broken bottle, knife, gun);

(12) often stays out after dark despite parental prohibition (beginning before 13 years of age);

(13) exhibits physical cruelty to other people (e.g. ties up, cuts, or burns a victim);

(14) exhibits physical cruelty to animals;

(15) deliberately destroys the property of others (other than by fire- setting);

(16) deliberately sets fires with a risk or intention of causing serious damage;

(17) steal objects of non-trivial value without confronting the victim, either within the home or outside (e.g. shoplifting, burglary, forgery);

(18) is frequently truant from school, beginning before 13 years of age;

(19) has run away from parental or parental surrogate home at least twice or has run away once for more than a single night (this does not include leaving to avoid physical or sexual abuse)

(20) commits a crime involving confrontation with the victim (including purse-snatching, extortion, mugging);

(21) forces another person into sexual activity;

(22) frequently bullies others (e.g. deliberate infliction of pain or hurt, including persistent intimidation, tormenting, or molestation);

(23) breaks into someone else's house, building or car.
(ICD-10 p.158-159)

The ICD-10 states that the symptoms in 11, 13, 15, 16, 20, 21 and 23 need only have occurred once for the criterion to be fulfilled.

The classification recommends that the age of onset of the behaviours should be specified and recommends that if at least one of the conduct problems starts before the age of 10 years that this is classed as '*childhood onset type*' and should the conduct problems begin after 10 years, this should be classed as '*adolescent onset type*'.

A prognosis, is determined by the *severity* of the symptoms which is indexed by the *number of symptoms* a person is displaying. The ICD-10 distinguishes between *socialized* and *unsocialized* disorders which is determined by whether or not the person has been able to form meaningful peer relationships. It also provides a category for disorders which are confined to the family alone.

The ICD-10 recommends that the cases should also be described in terms of their scores on three dimensions of disturbance, namely: (i) hyperactivity (2) emotional disturbance (3) severity of conduct disorder which is in turn subdivided into mild, moderate and severe.

(i) The conduct disorder is classified as *mild* if only a few of the conduct problems are in excess of those required to make the diagnosis, and when the conduct problems cause only minor harm to others.
(ii) The conduct disorder is described as *moderate* when the number of conduct problems and the effects on others are intermediate between *mild* and *severe*.
(iii) The conduct disorder is classified as *severe* where there are many conduct problems present or the conduct problems cause considerable harm to others, e.g. severe physical injury, vandalism or theft.
(ICD-10 p.159-160)

F91.0 Conduct disorder confined to the family context

A. The general criteria for conduct disorder (F91) must be met.

B. Three or more of the symptoms listed for F91 criterion G1 must be present, with at least three from items (9)-(23)

C. At least one of the symptoms from items (9)-(23) must have been present for at least 6 months

D. Conduct disturbance must be limited to the family context.

F91.1 Unsocialized conduct disorder

A. The general criteria for conduct disorder (F91) must be met.

B. Three or more of the symptoms listed for F91 criterion G1 must be present, with at least three from items (9)-(23).

C. At least one of the symptoms from items (9)-(23) must have been present for at least 6 months.

D. There must be definitely poor relationships with the individual's peer group, as shown by isolation, rejection, or unpopularity, and by a lack of lasting close reciprocal friendships.

F91.0 Conduct disorder confined to the family context

A. The general criteria for conduct disorder (F91) must be met.

B. Three or more of the symptoms listed for F91 criterion G1 must be present, with at least three from items (9)-(23)

C. At least one of the symptoms from items (9)-

(23) must have been present for at least 6 months

D. Conduct disturbance must be limited to the family context.

F91.1 Unsocialized conduct disorder

A. The general criteria for conduct disorder (F91) must be met.

B. Three or more of the symptoms listed for F91 criterion G1 must be present, with at least three from items (9)-(23).

C. At least one of the symptoms from items (9)-(23) must have been present for at least 6 months.

D. There must be definitely poor relationships with the individual's peer group, as shown by isolation, rejection, or unpopularity, and by a lack of lasting close reciprocal friendships.

F91.2 Socialized conduct disorder

A. The general criteria for conduct disorder F91 must be met.

B. Three or more of the symptoms listed for F91 criterion G1 must be present, with at least three from items (9)-(23).

C. At least one of the symptoms from items (9)-(23) must have been present for at least 6 months.

D. Conduct disturbance must include settings outside the home of family context.

E. Peer relationships are within normal limits.

F91.3 Oppositional defiant disorder

A. The general criteria for conduct disorder (F91) must be met.

B. Four or more of the symptoms listed for F91 criterion G1 must be present, but with no more than two symptoms from items (9)-(23).

C. The symptoms in criterion B must be maladaptive and inconsistent with the developmental level.

D. At least four of the symptoms must have been present for at least 6 months.

F91.8 Other conduct disorders

F91.9 Conduct disorder, unspecified

This residual category is not recommended and should be used only for disorders that meet the general criteria for F91 but that have not been specified as to subtype or that do not fulfil the criteria for any of the specified subtypes.

F92 MIXED DISORDERS OF CONDUCT AND EMOTIONS

F92.0 Depressive conduct disorder

A. The general criteria for conduct disorders (F91.-) must be met.

B. Criteria for one of the mood (affective) disorders (F30-39 must be met.

F92.8 Other mixed disorders of conduct and emotions

A. The general criteria for conduct disorders (F91.-) must be met.

B. Criteria for one of the neurotic, stress-related, and somatoform disorders (F40-48) or childhood emotional disorders (F93.-) must be met.

F92.9 Mixed disorder of conduct and emotions, unspecified.

(ICD-10 p.160-161)

Appendix 2

Risk Factors in the Child:

- Specific learning difficulties
- Communication difficulties
- Specific developmental delay
- Genetic influence
- Difficult temperament
- Physical illness especially if chronic and/or neurological
- Academic failure
- Low self-esteem

Risk Factors in the Family:

- Overt parental conflict
- Family breakdown
- Inconsistent or unclear discipline
- Hostile or rejecting relationships
- Failure to adapt to a child's changing needs
- Physical, sexual or emotional abuse
- Parental psychiatric illness
- Parental criminality, alcoholism or personality disorder
- Death and loss – including loss of friendship

Risk Factors in the Community:

- Socio-economic disadvantage
- Homelessness
- Disaster
- Discrimination
- Other significant life events

Appendix 3

Resilience Factors in the Child:

- Secure early relationships
- Being female
- Higher intelligence
- Easy temperament when an infant
- Positive attitude, problem-solving approach
- Good communication skills
- Planner, belief in control
- Humour
- Religious faith
- Capacity to reflect

Resilience Factors in the Family:

- At least one good parent-child relationship
- Affection
- Clear, firm and consistent discipline
- Support for education
- Supportive long-term relationship/absence of severe discord

Resilience Factors in the Community:

- Wider supportive network
- Good housing
- High standard of living
- High morale school with positive policies for behaviour, attitudes and anti-bullying
- Schools with strong academic and non-academic opportunities
- Range of positive sport/leisure activities

Appendix 4

Diagnostic Criteria for Preschool Major Depressive Disorder

A. Five (or more) of the following symptoms have been present *but not necessarily persistently* over a 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure *in activities or play. If both (1) and (2) are present a total of only four symptoms are needed.*

1. Depressed mood *for a portion of the day for several days, as observed (or reported) in behaviour. Note: may be irritable mood*
2. Markedly diminished interest or pleasure in all, or almost all, activities *or play for a portion of the day for several days (as indicated by either subjective account or observations made by others).*
3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) *that may be evident in play themes.*
8. Diminished ability to think or concentrate, or indecisiveness, *for several days* (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or a suicide attempt or a specific plan for committing suicide. *Suicidal or self-destructive themes are persistently evident in play only.*

Note: Modification from standard DSM-IV criteria are shown in italics

(Luby et al. 2002 p.931)

Appendix 5

LEA PROVISION FOR PUPILS WITH EBD

It would be useful at this point to include information regarding the provision provided for pupils with emotional and behavioural difficulties within the LEA taking part in this research.

Within the LEA support is provided for pupils who experience social and/or emotional and/or behavioural difficulties. The population includes pupils who:

1. Are at risk of exclusion or who have been excluded from mainstream school.
2. Have problems of a psychological or psychiatric nature.
3. Are school phobic.
4. Are particularly vulnerable emotionally.
5. Have Attention Deficit Hyperactivity Disorder.

The criteria for entry into the EBD schools stipulate that the pupils should be of average general ability or above and that they should not have general learning difficulties. It has been recognised by the LEA that in recent years, there has been a lack of continuum of provision for pupils with EBD across the age range and between mainstream and special school provision. There has been an acknowledgement that lack of early intervention has resulted in a significant increase in difficulties experienced by pupils with EBD transferring from Year 6 to Year 7. Until recent changes were made in LEA policy, there had been an increase in the number of pupils who were excluded from their mainstream schools due to the change in the nature of provision. Without support at Key Stage 3, there was an increased risk of that placement breaking down and reintegration was no longer an option. Pupils were then offered a place in a special EBD school. Additionally, lack of early intervention had been blamed for the growing number of pupils who had been excluded from their mainstream schools. Schools had informally admitted to me in the past to excluding pupils at the ages of 14 and 15 as a strategy to obtain access to resources in the special school EBD sector. As a

result, older pupils have taken the places at the special schools with very little prospect of successful reintegration into their mainstream schools. In response to this problem, in January 2001, the LEA proposed a restructure of the EBD provision which stands as the current structure.

Day EBD Schools

Currently within the LEA there are three non-residential special schools for boys with EBD. These schools are also classified as 'Centres of Expertise'. They are able to offer part-time and full-time placements to pupils at Key Stages 2 and 3. For the purpose of this research study they shall be referred to as School 1, 2 and 3 in order to preserve their identities. The number of places available differs between the schools but the total number of places available between the three schools is 115.

There is one residential school (Key Stages 3 and 4) within the LEA which offers provision for boys only. It offers 45 residential placements.

There is a lack of specialist provision for girls with EBD within the LEA. For girls at Year 9-11 a resource within a girls' high school offers fifteen places. The curriculum they follow includes work on self esteem and life skills. They have access to counselling, therapy and careers advice. There are links with other agencies. There is no specialist provision for girls at Key Stage 1 and 2.

These 3 specialist schools also offer Outreach Support in mainstream schools.

Outline of Outreach Support

Over the last couple of years, the LEA has set up Outreach Support Services. These teams were established as part of the LEA Special Educational Needs (SEN) Strategy. Team members are based in the EBD schools. Team members are able to offer support to children in mainstream schools, carers, educational psychologists, education welfare officers, health professionals and social services. Their main aims are to:

- Develop early intervention plans that enable pupils to remain in mainstream school.
- Help develop strategies for a positive whole-school approach to pupils' special learning and behaviour needs.
- Plan, develop and deliver training activities to school staff.
- Maintain knowledge of current ideas and practice in supporting learning needs and behaviour management.
- Disseminate information, resources and knowledge to schools and the wider education community.
- Develop and maintain a system to plan, monitor and evaluate the progress of identified pupils.
- Access and provide therapeutic intervention for children who need more intensive support.
- Work with children, on a one-to-one basis on specific aspects of their learning and/or behaviour in a secure, supported environment.
- Help develop IEPs, IBPs, home/school contacts and support plans for the individual pupils.

(Taken from LEA Special Schools Behaviour and Learning Support Outreach Support Services document March 2003).

The team offers support which includes training for all staff including ESAs and lunchtime supervisors. They are also able to train teaching staff techniques in Behaviour Management. They are able to offer support with writing and implementing Individual Education Plans and Individual Behaviour Plans. They can offer advice on differentiation of the curriculum for pupils with learning difficulties and EBD.

The team can withdraw individuals or groups of pupils for specific work, e.g. social skills training, anger management, self awareness, self esteem raising, relationship work, counselling, bullying work, organisational skills, gender or race issues. Work with individuals is based on 2 x ½ hour sessions per week, usually for six months with a 12 week review to adjust the programme if necessary. In order to receive Outreach Support, schools must apply to the LEA for it. Schools are required to give detailed information regarding the nature of the difficulties experienced by the pupil. The Educational Psychology Service must have been involved with the pupil prior to the referral being made. The LEA Panel will then decide whether or not the pupil needs Outreach Support and inform the school of their decision. If the school is granted Outreach Support, a teacher from the team will contact school to make arrangements within two weeks of the Panel's decision. The pupil does not need a Statement of Special Educational Needs to access this support.

Pupil Referral Units (PRUs)

These units are designed to cater for pupils who are presenting as disaffected and disruptive within their mainstream school but for whom long term specialist EBD provision is thought to be inappropriate.

PRUs usually run a 6 week cycle within each half term. Any days either side of this 6 weeks will be spent either in the feeder schools interviewing the parents/carers and pupils for the next cycle or interviewing parents/carers and pupils who are on the exclusion register for the next cycle. Throughout the 6 week period the PRU staff liaise with the schools who have received pupils from the centre to facilitate support for those pupils within the mainstream school.

Referrals to PRU's

Pupils referred to PRU's:

- If they are persistently disruptive.
- If they frequently exhibit aggressive, abusive or violent behaviour.
- Pupils who exhibit a combination of chronic disaffection traits, such as very poor attendance, under achievement, poor work rate, poor attitude to school, etc., who are failing educationally.
- Pupils who have been accepted on roll to a mainstream school after a permanent exclusion.

PRU Programme

The main aim of PRU's is to improve children's behaviour through the use of positive behaviour management.

Whilst at the PRU the pupils are disapplied from the National Curriculum in order to facilitate programmes designed to:

i. Raise their self esteem and confidence.
ii. Identify and assess problems.
iii. Increase on-task time.
iv. Improve organisational skills.
v. Improve listening skills.
vi. Improve concentration.
vii. Improve their perceptions of school and engender a sense of hope for the future.
viii. Improve ability to respond to the norms and rules of school life.

PRU Programme Strategies

To achieve these aims PRU's use a skills based curriculum which affirm and concentrate on the positive aspects of the child as well as the positive aspects of education. Pupils are taught as a class with differentiated work where applicable.

Subjects taught: English, Maths, Science, ICT, PE, PSHE, Art, RE.

In general, the curriculum is used as a tool to teach good behaviour. The aim is to enable pupils to practice different disciplines and learn to behave in ways which will be expected of them when they return to their mainstream school.

Specific management strategies are built into the timetable. Approximately 3 sessions per week focus on anger management, self-awareness, problem solving, bullying, relationship work, social skills, training, etc.

There is also one session of counselling per week available for each pupil.

Class Structure

Approximately five classes of 5-6 pupils – primary model is adopted initially with the possibility of leading to a specialism in some areas of the curriculum according to staff expertise.

Staffing (This may vary between the PRU's)

Unit Leader
5 Class Teachers
5 ESA's
1-2 Counsellors
2 Outreach Workers

Admission

(i) Pupils attend on a 6 week basis.
Pupils from named feeder schools who are at School Action Plus or above of the Code of Practice are eligible to attend. 3 classes each half term therefore a total of 90 pupils could attend per academic year.

(ii) Pupils from the exclusion register.
For these pupils there are 2 classes each half term therefore 60 pupils per academic year could attend but flexibility is inbuilt into the programme where agreed by all agencies.

Behaviour and Education Support Team (BEST)

In 2003 this multi-agency team was set up to support a number of comprehensive schools and their primary feeder schools (total = 31).

The purpose of the BEST Team is to promote positive behaviour for all children and to prevent the escalation of emotional and behavioural problems in children at risk, through the provision of multi-agency support in schools and individual families.

BEST Schools

Each school has Lead Behaviour Professional (LBPL) to act as key worker in school and to liaise with BEST Team.

Each school has a key worker from the BEST team to liaise with school.

Referral Pathway

1. LBP from school and BEST key worker consult.
2. Referral form completed by school.
3. BEST initial assessment.
4. BEST Team discuss and allocate.
5. Intervention/action plan.
6. Support for school/family/child.
7. Review.

Criteria for Referral

1. Child would benefit from multi-agency approach. Case is not just classroom behaviour, but behaviour in a number of settings.
2. School have exhausted all normal interventions, i.e. run down IBP with little effect.
3. Quick response is needed because of major escalation in behaviour or change of family circumstances.

Cost

The LEA strategy for SEN states that,

"... children should be educated in the most inclusive environment that is compatible with meeting their special and general educational needs ... and can be adequately and effectively funded by the LEA within reasonable constraints." (LEA document Provision for Pupils with Social, Emotional and Behavioural Difficulties (SEBD) Jan. 2001 p.6)

However, it currently costs the LEA approximately £11,000-£11,500 per year to educate a pupil at an EBD school. By comparison, a pupil attending a mainstream secondary school costs approximately £4,000 per year.

Over the last 5 years, there has been growing concern over the number of pupils funded by the LEA attending placements 'Out of City' in residential special schools. Despite this number being relatively small, it has resulted in a large percentage of the LEA budget being spent in this area. As a result, less money has been available to fund alternative solutions.

EBD Statistics

At present, the total number of pupils who have been identified within the LEA as having EBD as their **primary need** and who have a Statement of Special Educational Needs is 236. Of this total, 109 pupils attend day schools for pupils with EBD. This number does not include pupils with Attention Deficit Hyperactivity Disorder (ADHD) with Statements. The total number of pupils with ADHD as their **primary need** is identified as 11 within the LEA. However, whilst conducting this research study it came to my attention that there were pupils within the EBD provision who had been diagnosed as having ADHD for which they were receiving medication. Pupils with ADHD can display very similar behaviour characteristics to pupils with behaviour difficulties. Since most children with ADHD are being educated with and without support within their mainstream school, could the same support be given to pupils who do not have ADHD but have behaviour problems? It

appears to me that children with ADHD get some degree of sympathy from their teachers, but a child with no such diagnosis does not. From informal discussions with classteachers, I have learned that some of them are much more reluctant to have a pupil in their class with behaviour difficulties than with ADHD. This could account for why a larger number of pupils with ADHD are educated in mainstream schools whilst a relatively large number of pupils with EBD are excluded from mainstream schools.

The number of pupils identified as having an Autistic Spectrum Disorder (with a Statement) is 184. Other pupils have been given Statements for physical difficulties, sensory impairments or learning difficulties as their **primary need**. It can be claimed however, that although their **primary need** is not emotional and behavioural, it may be that these pupils do indeed have emotional and behavioural difficulties.

Appendix 6

OUTLINE OF STUDY

The study will be concerned with the prevalence and severity of depression within pupils who have a Statement for Special Educational Needs for emotional and behavioural difficulties. All pupils attend a specialist school.

All the pupils attending the EBD schools will be asked to take part in the study.

Each pupil will be asked to complete a questionnaire and this will be followed by a semi-structured interview. This will be on a one-to-one basis with myself or an assistant EP. This procedure should take no longer than 45 minutes. (Older pupils will take less time). A setting will be required to ensure privacy, confidentiality and keep distractions to a minimum.

No child or school will be named in the study.

Ethical Issues

Should a pupil be found to be severely depressed, their Headteacher will be informed.

Feedback

All results will be formally reported to the Headteacher of the schools involved in the research. The general findings will be reported to the LEA, Principal EP and BEST Manager.

Ann Grifftiths
Educational Psychologist

Appendix 7

Our Ref:

Dear Parent/s

I am writing to ask you if you will give permission for your son to take part in a study of school children which is being carried out by the School of Education at the University of Manchester. Alongside my research for the university, I am an Educational Psychologist working for an Education Authority.

The research is concerned with the development of children's relationships with each other and responsible adults around them. If you agree for your son to take part, he will be asked to complete a questionnaire.

The results will be ***completely confidential***. No name or identity will be revealed, nor will the schools taking part in the study be named.

I would greatly appreciate your co-operation in this study. It is hoped that as many parents as possible will volunteer their children's participation as it will benefit schools by clarifying appropriate behaviour management processes.

IF YOU DO NOT WISH FOR YOUR CHILD TO TAKE PART IN THE STUDY PLEASE COMPLETE AND SIGN THE FORM BELOW.

Yours faithfully

Ann Griffiths
Educational Psychologist

.....

Reply Slip

I do not give permission for my child ....., Form .....
to take part in the research study.

Signed ..... Parent/Guardian **Date** .....

Appendix 8a

Official CDS Record Form Revised Edition (1983)

CDS

DATE OF TESTING ...../...../....

THE REVISED
CHILDRENS DEPRESSION SCALE
RECORD FORM: CHILD and PARENTS

	Examiners Rating (Optional)	DECILE SCORES Child	Mother	Father	Others	RAW SCORES Child	Mother	Father	Others	
AFFECTIVE RESPONSE										AR
SOCIAL PROBLEMS										SP
SELF ESTEEM										SE
PREOCCUPATION WITH SICKNESS										SD
GUILT										GL
MISCELLANEOUS *D* ITEMS										MD
TOTAL *D* SCORE										
PLEASURE AND ENJOYMENT										PE
MISCELLANEOUS *P* ITEMS										MP
TOTAL *P* SCORE										

CHILD: Name ..... BOY/GIRL

School .....

Year .....

Address .....

.....

DATE OF BIRTH

...../...../19.....Postcode .....

Childrens Decile Scores

Deciles	A.R.	S.P.	S.E.	S/D	GL	Total D Depression score	PE	P scale
10	29.0	31.0	37.0	27.0	38.0	197.0	10.5	30.0
9	26.5	27.0	28.5	22.5	30.0	166.0	11.5	33.5
8	24.0	24.0	27.0	21.0	26.0	147.0	12.5	36.5
7	20.0	22.5	25.5	18.5	24.5	131.5	15.0	39.0
6	18.0	18.5	24.5	17.5	22.5	127.0	16.0	42.0
5	17.0	16.0	23.0	16.0	20.0	120.0	16.5	43.0
4	16.0	13.5	21.0	14.0	19.0	111.0	18.0	47.0
3	14.0	11.5	18.5	12.5	17.0	98.5	20.5	50.0
2	12.0	10.0	12.0	11.0	12.0	75.0	22.0	51.0
1	9.0	10.0	10.0	10.5	11.0	68.0	28.0	63.0

MOTHER: Name .....

Occupation .....

Age: ..... Living with child: Yes/No.

FATHER: Name .....

Occupation .....

Age: ..... Living with child: Yes/No.

Parents Decile Scores

Deciles	A.R.	S.P.	S.E.	S/D	GL	Total P Depression Score	PE	P scale
10	35.0	27.5	27.0	20.0	27.5	152.5	12.0	32.5
9	21.7	20.5	22.5	18.0	21.2	125.0	13.5	34.7
8	17.5	19.0	19.5	15.5	19.5	113.0	14.7	36.0
7	16.2	18.0	18.0	15.0	18.0	110.5	15.5	37.5
6	15.5	16.5	17.5	14.0	17.5	104.0	15.5	39.0
5	14.5	15.5	16.5	13.5	16.5	99.0	16.0	40.5
4	14.0	15.0	16.0	13.0	15.5	94.7	16.5	41.5
3	13.2	13.5	14.7	12.5	15.0	93.8	17.0	43.5
2	12.7	12.5	14.0	11.5	14.5	89.2	17.5	45.7
1	10.7	12.0	13.7	10.7	13.5	81.7	19.5	47.0

OTHER PERSONS LIVING WITH CHILD:

Siblings: Name Sex Age

1 .....

2 .....

3 .....

4 .....

Others .....

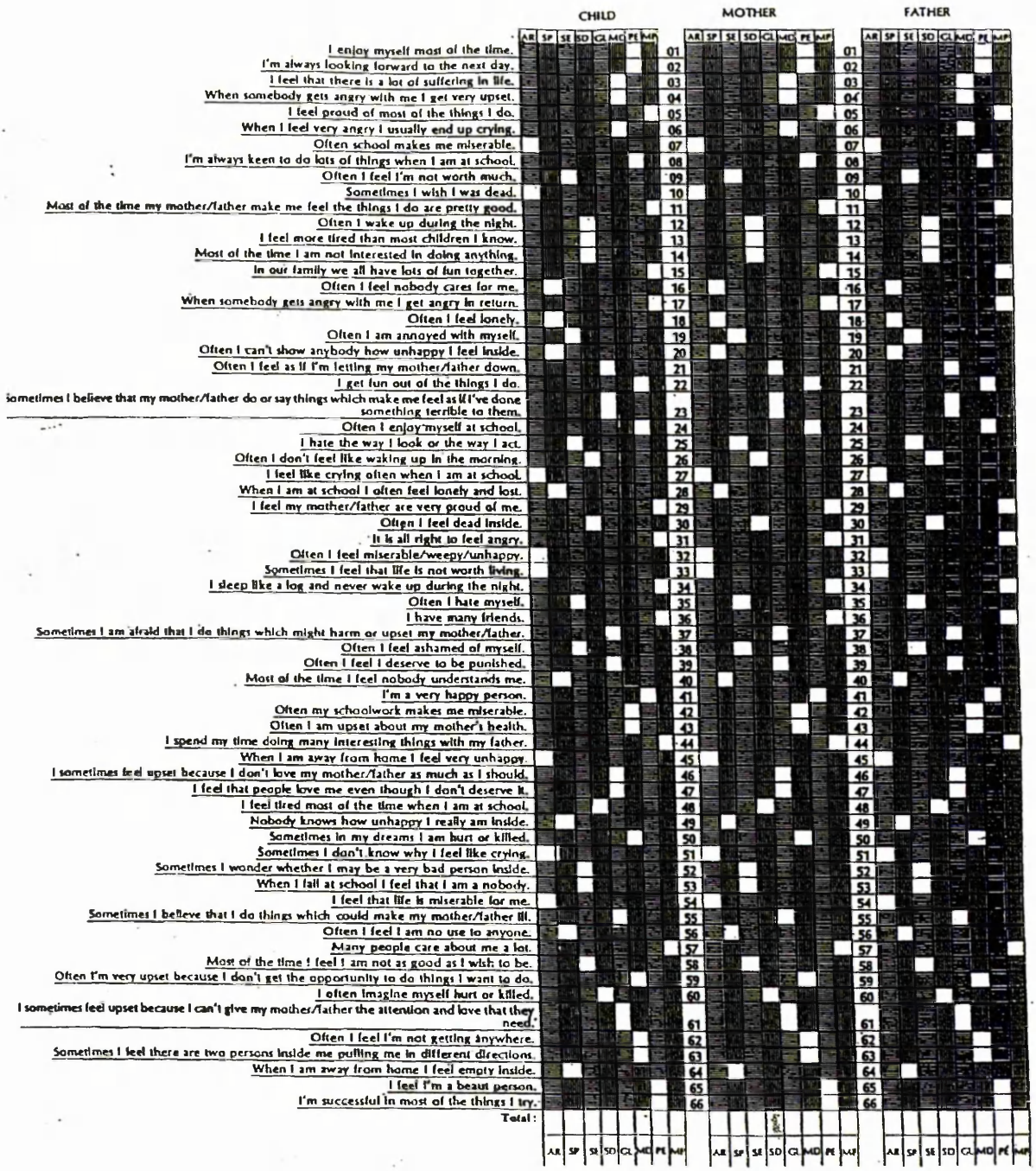
Language/s spoken at home:

Reasons for referral:

Referred by:

Tester's name:

Scoring Key: Very wrong 1; Wrong 2; Don't know/Not sure 3; Right 4; Very right 5.



NOTES

GENERAL OBSERVATIONS AND IMPRESSIONS

(Sad-happy; withdrawn-communicative; shy-outgoing; hostile-friendly. General comment re quality of rapport between respondent and examiner)

BEHAVIOUR/ATTITUDE DURING TESTING

(Level of involvement of respondent in task; any emotional reaction to items. Note whether child appears to comprehend items)

CHILD'S COMMENTS ABOUT TEST

(During test or after completion. Suggest that examiner asks respondent after completion how he/she felt about it)

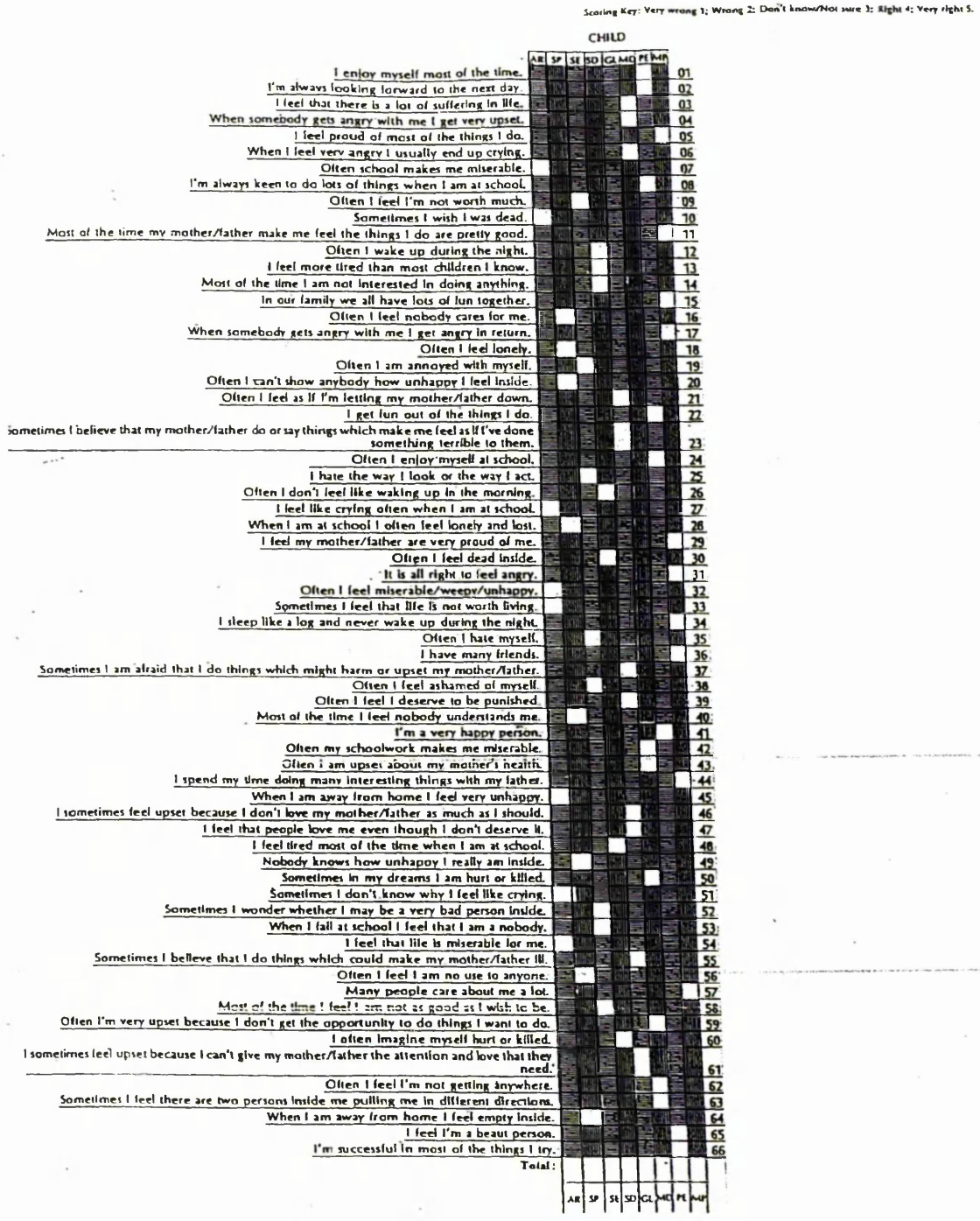
OTHER COMMENTS

The Australian Council for Education Research Limited
Radford House, Frederick Street Hawthorn Victoria 3122

ISBN 0 85563 346 8 (Record Form)
ISBN 0 85563 344 1 (Complete Set)

Appendix 8b

Section of CDS used for this study



Appendix 9 - Supplementary Questionnaire

1. **Have you heard of the medical condition – DEPRESSION?**

   Yes ☐ No ☐ *(If no, go to number 4)*

2. **Tell me what you think depression is – tell me what you know about it.**

3. **Do you think children and teenagers suffer from depression?**

   Yes ☐ No ☐ Don't Know ☐

4. **If you have any worries, who do you talk to?**

   TEACHER ☐ PARENT ☐ NO-ONE ☐

   FRIEND ☐ SOMEONE ELSE ☐ DON'T KNOW ☐

5. **Do you think there should be an adult in school that you can talk to if you have any problems or worries?**

   Yes ☐ No ☐ Don't Know ☐

6. **Do you feel this school supports your emotional wellbeing?**

   Yes ☐ No ☐ Don't Know ☐

7. **Would you like to find out more about the emotional health of young people?**

   Yes ☐ No ☐ Don't Know ☐

8. **Do you think it would be useful to have brochures or posters with information in them (including a Helpline) about the emotional health of young people?**

   Yes ☐ No ☐ Don't Know ☐

9. **Is there anything you would like to say or ask me about what you have done today?**

Appendix 10

Example of coding frame from responses to the supplementary questionnaire

Question 2: Tell me what you think depression is – tell me what you know about it

Total Responses Given			
	School 1, 2 & 3		
'D'	Total	'ND'	Total
Affective Response			
Scared = 1	1	Cry a lot = 111	3
Worried = 1	1	Worried = 1	1
Stressed = ~~1111~~	5	Stressed = 11	2
Unhappy = ~~1111 1111~~ 11	12	Unhappy = ~~1111 1111 1111~~	15
Angry = ~~111~~	3	Angry = ~~1111~~	5
Feel like killing themselves = 1	1	Fed up = 1	1
	23		**27**
Social Problems			
Lonely = 2	2	Lonely = 111	3
No-one to talk to = 1	1	Feel left out = 1	1
Can't express feelings = 1	1		
	4		**4**
Self-Esteem			
	0		**0**
Answers relating to sickness and death			
High blood pressure = 1	1		
Feeling Tired = ~~1111~~ 111	8	Feeling Tired = ~~1111~~111	8
Feeling sick/ill = 111	3	Feel like dying = 1	1
Can't be bothered = 11	2	Can't be bothered = 11	2
	14		**11**
Guilt			
	0		**0**
Miscellaneous depression items			
Have a nervous breakdown = 1	1	Need counselling = 1	1
Can't enjoy themselves = 111	3	Feel world's against you = 1	1
Bored = 1	1	Want to change the past = 1	1
Can't cope = 1	1	Can't enjoy themselves = 111	3
Need tablets to stop harming themselves = 1	1	Work too hard = 11	2
Not good = 1	1	When you harass your Mum = 1	1
	8		**9**

Appendix 11 - Birleson Depression Scale

Questionnaire

		Most	Sometimes	Never
1.	I look forward to things as much as I used to	.....	....	.....
2.	I sleep very well	.....	.....	.....
3.	I feel like crying	.....	.....	.....
4.	I like to go out and play	.....	.....	.....
5.	I feel like running away	.....	.....	.....
6.	I get tummy aches	.....	.....	.....
7.	I have lots of energy	.....	.....	.....
8.	I enjoy my food	.....	.....	.....
9.	I can stick up for myself	.....	.....	.....
10.	I think life isn't worth living	.....	.....	.....
11.	I am good at things I do	.....	.....	.....
12.	I enjoy the things I do as much as I use to	.....	.....	.....
13.	I like talking with my family	.....	.....	.....
14.	I have horrible dreams	.....	.....	.....
15.	I feel very lonely	.....	.....	.....
16.	I am easily cheered up	.....	.....	.....
17.	I feel so sad I can hardly stand it	.....	.....	.....
18.	I feel very bored	.....	.....	.....

Instructions. Please answer as honestly as you can. The statements refer to *how you have felt over the past week.* There are no right answers, it is important for you to say how you have felt. Thank you.

(Score 0, 1, 2)
Use - children 7 – 13
Score 13+ indicates depression

Score Positive (0, 1, 2) Items 1, 2, 4, 7, 8, 9, 11, 12, 13, 16
Score Negative (2, 1, 0) Items 3, 5, 6, 10, 14, 15, 17, 18
BW/a4/birleson

Appendix 12

The Yesavage Depression Scale	Check		Score for Each Answer	
Choose the best answer for how you felt this past week	**Yes**	**No**	**Yes**	**No**
1. Are you basically satisfied with your life?	☐	☐	0	1
2. Have you dropped many of your activities and interests?	☐	☐	1	0
3. Do you often feel that your life is empty?	☐	☐	1	0
4. Do you often get bored?	☐	☐	1	0
5. Are you hopeful about the future?	☐	☐	0	1
6. Are you bothered by thoughts you cannot get out of your head?	☐	☐	1	0
7. Are you in good spirits most of the time?	☐	☐	0	1
8. Are you afraid that something bad will happen to you?	☐	☐	1	0
9. Do you feel happy most of the time?	☐	☐	0	1
10. Do you often feel helpless?	☐	☐	1	0
11. Do you often get restless and fidgety?	☐	☐	1	0
12. Do you prefer to stay at home, rather than going out and doing new things?	☐	☐	1	0
13. Do you frequently worry about the future?	☐	☐	1	0
14. Do you feel you have more problems with memory than most?	☐	☐	1	0
15. Do you think it's wonderful to be alive now?	☐	☐	0	1
16. Do you often feel downhearted and blue?	☐	☐	1	0
17. Do you feel pretty worthless the way you are now?	☐	☐	1	0
18. Do you worry a lot about the past?	☐	☐	1	0
19. Do you find life very exciting?	☐	☐	0	1
20. Is it hard for you to get started?	☐	☐	1	0
21. Do you feel full of energy?	☐	☐	0	1
22. Do you feel that your situation is hopeless?	☐	☐	1	0
23. Do you think that most people are better off than you are?	☐	☐	1	0
24. Do you frequently get upset over things?	☐	☐	1	0
25. Do you frequently feel like crying?	☐	☐	1	0
26. Do you have trouble concentrating?	☐	☐	1	0
27. Do you enjoy getting up in the morning?	☐	☐	0	1
28. Do you prefer to avoid social gatherings?	☐	☐	1	0
29. Is it easy for you to make decisions?	☐	☐	0	1
30. Is your mind as clear as it used to be?	☐	☐	0	1
	Total Score ≥15 indicates depression			

Appendix 13

Chi-square test calculations on D Scores above 120 across each of the age ranges for the three EBD schools.

Age Range	School			
	1	2	3	Total
8- 11	7	4	5	16
12-15	4	8	11	23
Total	11	12	16	39

Expected $\frac{16 \times 11}{39}$ $\frac{16 \times 12}{39}$ $\frac{16 \times 16}{39}$

$\frac{23 \times 11}{39}$ $\frac{23 \times 12}{39}$ $\frac{23 \times 16}{39}$

Expected Scores (e)

Age Range	School		
	1	2	3
8- 11	4.51	4.92	6.56
12-15	6.48	7.07	9.43

o-e	$\frac{(o-e)^2}{e}$
7 – 4.51	1.37
4 – 4.92	.17
5 – 6.56	.37
4 – 6.48	.95
8 – 7.07	.12
11 – 9.43	.26
	$\sum = 3.21$

df = (r-1) (c-1) = 1 x 2 = 2

p>.2

Appendix 14

SPSS RAW DATA

	pupil	ar	sp	se	sd	gl	md	pe	mp	d	p
1	1	21	22	21	24	26	25	30	39	140	69
2	2	14	16	20	17	22	33	39	42	122	81
3	3	22	24	20	20	27	27	30	39	140	60
4	4	24	30	36	19	30	39	19	27	178	46
5	5	26	29	32	28	29	31	29	40	175	69
6	6	37	35	40	34	36	40	30	43	222	73
7	7	18	14	15	20	35	35	32	49	137	81
8	8	25	21	32	22	27	30	31	43	157	74
9	9	22	23	28	27	32	32	32	43	164	75
10	10	16	20	26	23	18	29	31	32	132	63
11	11	33	34	30	30	35	40	31	43	202	74
12	12	15	19	17	12	19	27	30	39	109	69
13	13	13	13	21	18	24	27	37	40	116	77
14	14	8	8	9	8	20	23	38	48	76	86
15	15	18	12	16	13	19	26	30	40	104	70
16	16	13	14	20	12	19	22	34	44	100	78
17	17	17	19	12	20	22	26	26	38	116	64
18	18	8	10	9	18	14	13	37	33	72	70
19	19	19	12	24	11	17	25	33	45	108	78
20	20	14	14	17	13	21	23	35	36	102	71
21	21	8	14	9	22	14	11	37	37	78	74
22	22	12	12	13	11	19	18	30	38	85	68
23	23	18	15	19	24	17	22	20	36	115	56
24	24	10	9	14	10	18	15	34	44	76	78
25	25	14	25	24	16	12	25	30	21	116	51

	C
1	71
2	41
3	80
4	132
5	106
6	149
7	56
8	83
9	89
10	69
11	128
12	40
13	39
14	-10
15	34
16	22
17	52
18	2
19	30
20	31
21	4
22	17
23	59
24	-2
25	65

	pupil	ar	sp	se	sd	gl	md	pe	mp	d	p
26	26	12	15	16	10	12	18	40	44	83	84
27	27	16	9	10	14	13	13	37	50	75	87
28	28	20	16	8	15	20	17	32	45	96	77
29	29	20	20	16	20	16	20	26	30	112	56
30	30	18	24	16	15	18	28	30	45	119	75
31	31	16	18	21	26	27	26	33	38	134	71
32	32	23	23	19	30	30	26	35	41	151	76
33	33	22	25	23	28	17	26	32	39	141	71
34	34	17	24	21	23	16	24	36	41	125	77
35	35	25	29	36	31	32	38	29	42	191	71
36	36	15	18	18	18	22	24	32	37	115	69
37	37	21	17	16	23	20	26	31	40	123	71
38	38	22	34	33	33	29	34	16	24	185	40
39	39	28	25	15	16	28	29	32	37	141	69
40	40	19	22	27	23	20	34	31	34	145	65
41	41	25	30	33	27	38	34	30	42	187	72
42	42	19	19	17	24	22	23	32	34	124	66
43	43	16	18	16	16	22	22	32	36	110	68
44	44	34	29	32	27	28	34	27	31	184	58
45	45	14	11	10	13	13	15	39	44	76	83
46	46	28	26	24	22	39	32	35	40	171	75
47	47	19	28	24	27	18	39	38	43	155	81
48	48	27	31	33	30	34	36	34	39	191	73
49	49	23	16	30	27	34	29	36	42	159	78
50	50	17	20	19	26	20	22	20	26	124	46

	C
26	-1
27	-12
28	19
29	56
30	44
31	63
32	75
33	70
34	48
35	120
36	46
37	52
38	145
39	72
40	80
41	115
42	58
43	42
44	126
45	-7
46	96
47	74
48	118
49	81
50	78

	pupil	ar	sp	se	sd	gl	md	pe	mp	d	p
51	51	23	23	28	22	29	34	31	34	159	65
52	52	20	15	19	25	23	29	22	40	131	62
53	53	20	37	31	31	23	35	28	23	177	51
54	54	14	22	24	25	23	20	30	34	128	64
55	55	24	23	16	23	20	33	15	41	139	56
56	56	26	35	27	24	26	42	29	34	178	63
57	57	20	21	14	26	22	26	34	40	129	74
58	58	29	34	31	31	32	38	24	42	195	66
59	59	28	17	20	30	28	23	18	38	146	56
60	60	18	12	15	19	20	24	29	38	108	67
61	61	18	20	19	11	27	23	34	48	118	82
62	62	11	9	10	11	12	24	40	45	77	85
63	63	21	12	10	14	8	21	34	44	86	78
64	64	12	12	8	11	13	24	37	43	80	80
65	65	12	7	11	7	14	16	36	42	67	78
66	66	10	16	10	13	21	21	40	44	91	84
67	67	12	14	16	22	11	22	40	46	97	86
68	68	9	12	8	12	16	14	33	35	71	68
69	69	11	10	10	15	10	16	29	39	72	68
70	70	12	20	12	15	13	16	32	39	88	71
71	71	17	17	15	16	18	21	31	35	104	66
72	72	29	22	25	24	29	33	24	34	162	58
73	73	9	11	19	13	18	26	32	45	96	77
74	74	11	12	23	7	19	23	36	41	95	77
75	75	27	28	22	26	24	36	32	33	163	65

	C
51	94
52	69
53	126
54	64
55	83
56	115
57	55
58	129
59	90
60	41
61	36
62	-8
63	8
64	0
65	-11
66	7
67	11
68	3
69	4
70	17
71	38
72	104
73	19
74	18
75	98

Appendix 15

Multiple Regression Analysis – Stepwise 1

Variables Entered/Removed(a)

Model	Variables Entered	Variables Removed	Method
1	SP	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
2	GL	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
3	SE	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
4	AR	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
5	SD	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
6	MD	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).

a Dependent Variable: D

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.899(a)	.809	.806	16.737	.809	308.443	1	73	.000
2	.964(b)	.930	.928	10.228	.121	123.456	1	72	.000
3	.980(c)	.961	.959	7.704	.031	55.928	1	71	.000
4	.990(d)	.980	.979	5.501	.020	69.258	1	70	.000
5	.995(e)	.990	.990	3.884	.010	71.409	1	69	.000
6	1.000(f)	1.000	1.000	.253	.010	16238.692	1	68	.000

a Predictors: (Constant), SP

b Predictors: (Constant), SP, GL

c Predictors: (Constant), SP, GL, SE

d Predictors: (Constant), SP, GL, SE, AR

e Predictors: (Constant), SP, GL, SE, AR, SD

f Predictors: (Constant), SP, GL, SE, AR, SD, MD

ANOVA[g]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	86401.135	1	86401.135	308.443	.000[a]
	Residual	20448.785	73	280.120		
	Total	106849.9	74			
2	Regression	99317.217	2	49658.608	474.653	.000[b]
	Residual	7532.703	72	104.621		
	Total	106849.9	74			
3	Regression	102636.3	3	34212.108	576.481	.000[c]
	Residual	4213.596	71	59.346		
	Total	106849.9	74			
4	Regression	104731.9	4	26182.973	865.336	.000[d]
	Residual	2118.030	70	30.258		
	Total	106849.9	74			
5	Regression	105809.1	5	21161.815	1402.868	.000[e]
	Residual	1040.843	69	15.085		
	Total	106849.9	74			
6	Regression	106845.6	6	17807.597	278988.4	.000[f]
	Residual	4.340	68	.064		
	Total	106849.9	74			

a. Predictors: (Constant), SP

b. Predictors: (Constant), SP, GL

c. Predictors: (Constant), SP, GL, SE

d. Predictors: (Constant), SP, GL, SE, AR

e. Predictors: (Constant), SP, GL, SE, AR, SD

f. Predictors: (Constant), SP, GL, SE, AR, SD, MD

g. Dependent Variable: D

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	37.665	5.435		6.930	.000
	SP	4.546	.259	.899	17.563	.000
2	(Constant)	13.627	3.964		3.438	.001
	SP	3.119	.204	.617	15.314	.000
	GL	2.352	.212	.448	11.111	.000
3	(Constant)	13.813	2.986		4.627	.000
	SP	2.232	.194	.442	11.512	.000
	GL	1.778	.177	.338	10.046	.000
	SE	1.496	.200	.313	7.478	.000
4	(Constant)	10.966	2.159		5.079	.000
	SP	1.659	.155	.328	10.722	.000
	GL	1.270	.140	.242	9.048	.000
	SE	1.426	.143	.298	9.962	.000
	AR	1.429	.172	.246	8.322	.000
5	(Constant)	7.756	1.571		4.937	.000
	SP	1.314	.117	.260	11.266	.000
	GL	1.197	.099	.228	12.034	.000
	SE	1.326	.102	.277	13.028	.000
	AR	1.201	.124	.207	9.666	.000
	SD	.888	.105	.164	8.450	.000
6	(Constant)	.146	.118		1.234	.221
	SP	.989	.008	.196	123.575	.000
	GL	1.006	.007	.192	151.519	.000
	SE	1.007	.007	.211	142.429	.000
	AR	1.002	.008	.172	121.704	.000
	SD	1.007	.007	.185	145.931	.000
	MD	.985	.008	.191	127.431	.000

a. Dependent Variable: D

Excluded Variables[f]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics
						Tolerance
1	AR	.461[a]	8.078	.000	.690	.429
	SE	.495[a]	8.503	.000	.708	.391
	SD	.361[a]	5.505	.000	.544	.434
	GL	.448[a]	11.111	.000	.795	.603
	MD	.475[a]	7.898	.000	.681	.394
2	AR	.263[b]	5.783	.000	.566	.325
	SE	.313[b]	7.478	.000	.664	.317
	SD	.236[b]	5.754	.000	.564	.402
	MD	.285[b]	6.360	.000	.602	.316
3	AR	.246[c]	8.322	.000	.705	.324
	SD	.204[c]	7.097	.000	.647	.396
	MD	.200[c]	5.271	.000	.533	.279
4	SD	.164[d]	8.450	.000	.713	.377
	MD	.161[d]	6.178	.000	.597	.271
5	MD	.191[e]	127.431	.000	.998	.266

a. Predictors in the Model: (Constant), SP

b. Predictors in the Model: (Constant), SP, GL

c. Predictors in the Model: (Constant), SP, GL, SE

d. Predictors in the Model: (Constant), SP, GL, SE, AR

e. Predictors in the Model: (Constant), SP, GL, SE, AR, SD

f. Dependent Variable: D

Appendix 16

Multiple Regression Analysis – Stepwise 2

Variables Entered/Removed [a]

Model	Variables Entered	Variables Removed	Method
1	SP	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
2	SE	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
3	PE	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
4	GL	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
5	SD	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
6	MD	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
7	MP	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).
8	AR	.	Stepwise (Criteria: Probability-of-F-to-enter <= .050, Probability-of-F-to-remove >= .100).

a. Dependent Variable: C

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.905(a)	.819	.816	18.421	.819	329.454	1	73	.000
2	.946(b)	.894	.891	14.153	.076	51.675	1	72	.000
3	.970(c)	.942	.939	10.604	.047	57.262	1	71	.000
4	.985(d)	.970	.968	7.657	.028	66.178	1	70	.000
5	.991(e)	.982	.980	6.049	.012	43.131	1	69	.000
6	.994(f)	.988	.986	5.008	.006	32.698	1	68	.000
7	.997(g)	.993	.993	3.666	.006	59.869	1	67	.000
8	1.000(h)	.999	.999	1.116	.006	656.951	1	66	.000

a Predictors: (Constant), SP

b Predictors: (Constant), SP, SE

c Predictors: (Constant), SP, SE, PE

d Predictors: (Constant), SP, SE, PE, GL

e Predictors: (Constant), SP, SE, PE, GL, SD

f Predictors: (Constant), SP, SE, PE, GL, SD, MD

g Predictors: (Constant), SP, SE, PE, GL, SD, MD, MP

h Predictors: (Constant), SP, SE, PE, GL, SD, MD, MP, AR

ANOVA[i]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	111798.5	1	111798.514	329.454	.000[a]
	Residual	24772.153	73	339.345		
	Total	136570.7	74			
2	Regression	122149.0	2	61074.523	304.915	.000[b]
	Residual	14421.621	72	200.300		
	Total	136570.7	74			
3	Regression	128587.5	3	42862.500	381.207	.000[c]
	Residual	7983.166	71	112.439		
	Total	136570.7	74			
4	Regression	132467.1	4	33116.766	564.912	.000[d]
	Residual	4103.601	70	58.623		
	Total	136570.7	74			
5	Regression	134045.5	5	26809.104	732.562	.000[e]
	Residual	2525.148	69	36.596		
	Total	136570.7	74			
6	Regression	134865.5	6	22477.578	896.363	.000[f]
	Residual	1705.198	68	25.076		
	Total	136570.7	74			
7	Regression	135670.1	7	19381.449	1442.003	.000[g]
	Residual	900.523	67	13.441		
	Total	136570.7	74			
8	Regression	136488.5	8	17061.057	13696.828	.000[h]
	Residual	82.211	66	1.246		
	Total	136570.7	74			

a. Predictors: (Constant), SP

b. Predictors: (Constant), SP, SE

c. Predictors: (Constant), SP, SE, PE

d. Predictors: (Constant), SP, SE, PE, GL

e. Predictors: (Constant), SP, SE, PE, GL, SD

f. Predictors: (Constant), SP, SE, PE, GL, SD, MD

g. Predictors: (Constant), SP, SE, PE, GL, SD, MD, MP

h. Predictors: (Constant), SP, SE, PE, GL, SD, MD, MP, AR

i. Dependent Variable: C

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-44.750	5.982		-7.481	.000
	SP	5.171	.285	.905	18.151	.000
2	(Constant)	-53.791	4.765		-11.289	.000
	SP	3.205	.350	.561	9.153	.000
	SE	2.381	.331	.441	7.189	.000
3	(Constant)	15.817	9.867		1.603	.113
	SP	2.750	.269	.481	10.216	.000
	SE	2.251	.249	.417	9.051	.000
	PE	-1.854	.245	-.239	-7.567	.000
4	(Constant)	2.888	7.300		.396	.694
	SP	2.468	.197	.432	12.503	.000
	SE	1.551	.199	.287	7.788	.000
	PE	-1.828	.177	-.235	-10.332	.000
	GL	1.431	.176	.241	8.135	.000
5	(Constant)	-9.428	6.065		-1.555	.125
	SP	1.990	.172	.348	11.558	.000
	SE	1.429	.158	.264	9.017	.000
	PE	-1.619	.143	-.209	-11.294	.000
	GL	1.248	.142	.210	8.805	.000
	SD	1.076	.164	.175	6.567	.000
6	(Constant)	-16.424	5.167		-3.178	.002
	SP	1.653	.154	.289	10.714	.000
	SE	1.146	.140	.212	8.181	.000
	PE	-1.616	.119	-.208	-13.614	.000
	GL	1.025	.124	.173	8.291	.000
	SD	1.149	.136	.187	8.432	.000
	MD	.860	.150	.147	5.718	.000
7	(Constant)	.883	4.395		.201	.841
	SP	1.349	.120	.236	11.285	.000
	SE	1.001	.104	.185	9.593	.000
	PE	-1.282	.097	-.165	-13.215	.000
	GL	1.243	.095	.209	13.114	.000
	SD	1.144	.100	.186	11.463	.000
	MD	1.073	.113	.184	9.452	.000
	MP	-.750	.097	-.102	-7.737	.000
8	(Constant)	.245	1.338		.183	.855
	SP	1.028	.038	.180	26.696	.000
	SE	.990	.032	.183	31.182	.000
	PE	-1.008	.031	-.130	-32.107	.000
	GL	1.031	.030	.174	34.314	.000
	SD	.984	.031	.160	31.745	.000
	MD	.963	.035	.165	27.679	.000
	MP	-.993	.031	-.136	-32.033	.000
	AR	1.005	.039	.153	25.631	.000

a. Dependent Variable: C

Excluded Variables[h]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics Tolerance
1	AR	.399[a]	6.580	.000	.613	.429
	SE	.441[a]	7.189	.000	.646	.391
	SD	.366[a]	5.817	.000	.565	.434
	GL	.354[a]	7.166	.000	.645	.603
	MD	.365[a]	5.419	.000	.538	.394
	PE	-.258[a]	-5.633	.000	-.553	.830
	MP	-.079[a]	-1.469	.146	-.171	.839
2	AR	.310[b]	6.384	.000	.604	.400
	SD	.285[b]	5.747	.000	.563	.411
	GL	.246[b]	5.274	.000	.531	.489
	MD	.204[b]	3.125	.003	.348	.307
	PE	-.239[b]	-7.567	.000	-.668	.827
	MP	-.090[b]	-2.222	.029	-.255	.838
3	AR	.241[c]	6.473	.000	.612	.376
	SD	.221[c]	5.850	.000	.573	.391
	GL	.241[c]	8.135	.000	.697	.489
	MD	.208[c]	4.531	.000	.476	.307
	MP	.010[c]	.280	.781	.033	.694
4	AR	.148[d]	4.432	.000	.471	.302
	SD	.175[d]	6.567	.000	.620	.376
	MD	.127[d]	3.489	.001	.387	.279
	MP	-.076[d]	-2.998	.004	-.339	.598
5	AR	.119[e]	4.426	.000	.473	.293
	MD	.147[e]	5.718	.000	.570	.276
	MP	-.072[e]	-3.703	.000	-.410	.597
6	AR	.095[f]	4.121	.000	.450	.282
	MP	-.102[f]	-7.737	.000	-.687	.562
7	AR	.153[g]	25.631	.000	.953	.256

a. Predictors in the Model: (Constant), SP

b. Predictors in the Model: (Constant), SP, SE

c. Predictors in the Model: (Constant), SP, SE, PE

d. Predictors in the Model: (Constant), SP, SE, PE, GL

e. Predictors in the Model: (Constant), SP, SE, PE, GL, SD

f. Predictors in the Model: (Constant), SP, SE, PE, GL, SD, MD

g. Predictors in the Model: (Constant), SP, SE, PE, GL, SD, MD, MP

h. Dependent Variable: C

Appendix 17

Coding Frame for Responses to Statements Relating to Home and School Settings

HOME ITEMS

Participants D		*Item No*											*TOTAL*
		11	**15**	**21**	**23**	**29**	**37**	**43**	**44**	**46**	**55**	**61**	
SCHOOL 1	**1.**	0	2	2	2	2	2	2	2	0	0	2	16
	2.	0	1	2	2	0	2	2	0	0	2	1	12
	3.	0	0	2	0	0	2	2	0	2	2	2	12
	4.	0	0	1	0	0	0	0	0	2	2	0	6
	5.	0	0	2	1	0	2	2	0	1	2	0	10
	6.	0	0	2	1	0	2	2	1	0	2	2	12
	7.	0	0	2	1	0	2	2	0	2	2	2	13
	8.	0	0	0	0	0	0	2	0	1	0	1	4
	9.	0	1	2	2	0	2	2	2	2	2	2	17
	10.	0	0	1	1	0	1	2	0	0	0	2	7
SCHOOL 2	**11.**	0	1	2	0	0	2	2	0	0	2	2	11
	12.	0	0	2	0	0	2	2	0	0	0	2	8
	13.	0	0	2	2	0	2	2	0	2	2	2	14
	14.	0	0	2	1	0	2	2	0	0	0	0	7
	15.	1	0	2	2	1	0	2	0	2	2	0	12
	16.	0	0	0	0	0	2	2	0	0	0	0	4
	17.	0	0	2	0	0	2	2	0	0	2	2	10
	18.	0	0	2	0	0	0	0	0	0	0	0	2
	19.	0	2	0	2	0	1	2	0	0	0	0	7
	20.	0	0	2	2	0	0	0	0	2	2	2	10
	21.	0	0	1	2	0	2	2	0	0	0	2	9
SCHOOL 3	**22.**	0	2	2	2	2	0	0	2	0	0	2	1 2
	23.	0	0	2	2	0	2	2	0	2	2	2	14
	24.	0	0	2	0	0	2	2	0	0	0	2	8
	25.	0	0	2	2	0	2	0	0	2	2	2	12
	26.	0	0	2	2	0	2	1	0	2	0	2	10
	27.	0	0	2	2	2	2	2	2	0	0	2	14
	28.	2	2	1	2	1	0	2	2	1	1	0	14
	29.	1	0	2	1	0	1	2	0	0	2	0	9
	30.	0	0	2	2	2	2	2	2	0	0	0	12
	31.	0	0	2	2	0	2	0	0	0	0	0	6
	32.	0	2	2	0	0	2	2	0	0	0	2	10
	33.	0	0	2	2	0	2	2	0	2	0	0	10
	34.	0	0	2	2	0	2	2	2	2	0	1	13
	35.	0	2	2	2	0	2	2	0	2	1	2	15
	36.	0	2	2	2	0	2	0	1	2	2	0	13

HOME ITEMS

Participants ND		Item No											TOTAL
		11	15	21	23	29	37	43	44	46	55	61	
SCHOOL 1	1.	0	0	2	1	1	0	0	2	0	0	0	6
	2.	0	1	1	0	0	1	1	1	1	0	2	8
	3.	0	0	0	2	0	2	2	0	0	0	0	6
	4.	0	1	2	1	0	1	2	0	0	0	0	7
	5.	0	1	2	2	0	2	2	0	0	0	0	9
	6.	0	0	2	0	0	1	0	2	1	0	2	8
	7.	0	0	2	0	0	2	2	0	0	0	0	6
	8.	0	0	2	0	0	0	0	0	0	0	1	3
	9.	0	0	0	0	0	0	0	0	0	0	0	0
	10.	0	0	0	0	0	2	0	0	0	0	0	2
	11.	0	0	2	0	0	2	1	0	0	0	2	7
	12.	0	0	2	1	0	2	0	0	0	0	0	5
	13.	0	0	2	0	2	0	0	0	0	0	0	4
SCHOOL 2	14.	0	0	2	0	0	2	2	0	0	2	0	8
	15.	0	0	2	0	0	1	2	0	0	2	0	5
	16.	2	1	0	0	0	0	0	0	0	0	0	3
	17.	0	0	0	0	0	0	0	2	0	0	0	2
	18.	0	0	1	0	0	1	2	0	0	0	0	4
	19.	0	0	2	0	1	2	0	0	0	0	0	5
	20.	0	0	2	0	2	2	0	1	0	0	0	7
	21.	0	0	1	0	0	0	0	2	0	1	0	4
	22.	0	0	0	0	0	0	1	0	1	2	1	5
	23.	0	2	0	0	0	0	0	2	0	2	0	6
	24.	0	0	2	2	0	2	2	0	0	2	0	10
	25.	0	0	0	0	0	0	2	0	0	0	0	2
	26.	0	0	0	0	0	0	2	2	0	0	0	4
SCHOOL 3	27.	0	0	0	0	0	2	2	0	0	0	0	4
	28.	0	0	0	0	0	0	2	0	2	0	2	6
	29.	0	0	2	0	0	0	2	0	0	0	0	4
	30.	0	0	0	0	0	2	0	0	0	0	0	2
	31.	0	0	0	0	0	1	0	0	2	0	0	3
	32.	0	0	0	0	0	0	0	2	0	0	0	2
	33.	1	0	0	0	2	2	0	2	0	0	0	7
	34.	0	2	0	0	0	2	2	0	0	0	0	6
	35.	0	0	2	0	0	2	2	0	0	0	2	8
	36.	0	0	2	0	0	2	0	0	0	0	0	4

SCHOOL ITEMS

Participants D		Item No								TOTAL
		7	8	24	27	28	42	48	53	
SCHOOL 1	1.	2	0	2	0	2	2	2	2	12
	2.	1	0	0	1	2	1	1	1	7
	3.	2	0	2	0	0	2	2	0	8
	4.	0	0	0	0	0	2	0	0	2
	5.	0	0	0	1	0	0	0	1	2
	6.	1	1	0	2	1	1	2	0	8
	7.	2	0	2	2	2	2	2	2	14
	8.	0	0	0	0	0	0	2	2	4
	9.	2	2	0	2	0	2	2	2	12
	10.	2	0	0	0	0	1	1	0	4
SCHOOL 2	11.	2	1	0	2	0	1	2	2	10
	12.	2	0	0	0	0	0	2	0	4
	13.	0	0	0	1	2	0	2	2	7
	14.	0	1	0	0	0	2	2	2	7
	15.	2	0	0	2	1	2	0	0	7
	16.	2	0	0	0	0	2	2	0	6
	17.	2	0	2	0	0	2	2	2	10
	18.	0	0	0	0	2	1	2	0	5
	19.	1	0	0	0	0	0	2	2	5
	20.	0	0	0	0	2	0	2	0	4
	21.	0	0	0	0	0	1	2	0	3
SCHOOL 3	22.	0	0	0	0	0	2	2	0	4
	23.	0	0	0	2	0	2	2	0	6
	24.	2	0	0	0	0	2	2	2	8
	25.	2	0	0	0	2	2	2	2	10
	26.	2	0	0	0	0	2	2	2	8
	27.	2	0	0	0	0	2	2	2	8
	28.	1	2	2	0	0	0	2	0	7
	29.	2	2	2	0	0	2	2	0	10
	30.	2	0	0	0	2	2	2	2	10
	31.	1	1	0	0	2	1	2	0	7
	32.	2	2	2	0	0	2	0	0	8
	33.	2	2	0	2	2	2	2	2	14
	34.	0	1	0	0	0	0	1	0	2
	35.	2	0	2	0	2	2	2	0	10
	36.	2	0	2	0	0	0	2	2	8

SCHOOL ITEMS

Participants ND		Item No								TOTAL
		7	8	24	27	28	42	48	53	
SCHOOL 1	1.	0	0	0	0	0	0	1	0	1
	2.	1	0	1	0	0	1	1	0	4
	3.	0	0	0	0	0	0	0	0	0
	4.	0	1	0	2	0	0	0	0	3
	5.	0	0	0	0	0	0	0	0	0
	6.	0	0	0	0	0	2	0	1	3
	7.	0	0	0	0	2	0	0	0	2
	8.	2	2	0	0	0	2	0	0	6
	9.	0	0	0	0	0	2	0	0	2
	10.	0	0	0	0	0	0	0	0	0
	11.	0	0	0	0	0	2	2	0	4
	12.	2	0	0	0	0	2	2	0	6
	13.	2	0	0	0	0	2	2	0	6
SCHOOL 2	14.	2	2	2	0	0	2	0	0	8
	15.	2	0	0	0	0	0	0	0	2
	16.	0	0	0	0	0	0	0	2	2
	17.	0	0	0	0	0	0	2	0	2
	18.	0	0	0	0	0	0	0	0	0
	19.	2	2	1	0	0	0	2	0	7
	20.	2	2	0	0	0	0	0	0	4
	21.	0	0	0	0	0	0	2	0	2
	22.	1	0	0	0	0	1	0	0	2
	23.	0	0	0	0	0	0	0	0	0
	24.	0	0	0	0	0	2	0	0	2
	25.	2	0	0	0	0	0	0	0	2
	26.	2	0	1	0	0	0	0	0	3
SCHOOL 3	27.	0	0	0	0	0	0	0	0	0
	28.	0	0	0	0	0	0	2	0	2
	29.	0	0	0	0	0	0	0	0	0
	30.	0	0	0	0	2	0	2	0	4
	31.	0	0	1	0	0	2	2	0	5
	32.	0	2	0	0	0	2	0	0	4
	33.	2	2	0	0	0	2	2	0	8
	34.	2	0	0	0	0	0	0	0	2
	35.	0	0	2	0	0	2	2	0	6
	36.	2	0	0	0	0	2	0	2	6

Appendix 18

RAW DATA FOR SUPPLEMENTARY QUESTIONNAIRE

4.1

	D	ND
Y	32	31
N	6	6

4.2

	D	ND
AR	23	27
SP	4	4
SE	0	0
SD	14	11
G	0	0
MD	8	9

4.3

	D	ND
Y	26	20
N	1	2
DK	4	6
Other	3	3

4.4

	D	ND
T	10	11
P	21	27
F	9	7
SE	8	7
N	8	2
DK	1	0

4.5

	D	ND
Y	31	28
N	6	8
DK	1	1

4.6

	D	ND
Y	31	30
N	5	7
DK	1	0
Other	1	0

4.7

	D	ND
Y	21	18
N	17	17
DK	0	2

4.8

	D	ND
Y	29	16
N	8	11
DK	1	0

Appendix 19

Explanation for use of Chi-square analysis

1. The Chi-square analysis is a measure of the total spread of ACTUAL SCORES from best ESTIMATE VALUES.

2. The best ESTIMATE VALUES which can be used are those which utilise values which have already been found in real life (in the research study).

3. For this purpose the ESTIMATE VALUE is the combined score of all participants/groups (irrespective of the classification of those participants/groups e.g. Depressed, Non-Depressed on a particular question under investigation (e.g. Yes, No, Don't Know).

4. It follows that Chi-square is a measure of (a) The TENDENCY of the ACTUAL SCORES to fall on one side of the expected ESTIMATE VALUE and also (b) The magnitude of that TENDENCY.

5. Used as a TEST OF INDEPENDENCE (of groups) Chi-Square can be seen to be a measure of DIFFERENCE between groups. The greater the Chi-Square value for any set of degrees of freedom (items under investigation – 1), the greater the possibility that the spread of ACTUAL SCORES from best ESTIMATE VALUES derives from a genuine TENDENCY for the ACTUAL SCORES' sources to score differently and consistently.

6. As more items are considered (PREDICTOR VARIABLES in Multiple Regression terms), the degrees of freedom increase and a greater value for Chi-square is required before it is appropriate to conclude that the groups truly do differ from one another for a particular level of probability.