

Childhood Depression: Recognition of Behavioural Symptoms
and Management Guidelines for Primary Schools

Umzwangedwa nokukhwantabala ebantwaneni: Izinkomba ekuziphatheni
nezinsizangqangi ezikoleni ezisemazingeni aphansi

By

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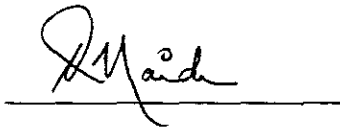
2008

DECLARATION

I, Rekha Naidu, Student number 206001002, hereby declare that the thesis entitled:

“Childhood Depression: Recognition of Behavioural Symptoms and Management
Guidelines for Primary Schools”

is the result of my own investigation and research and that it has not been submitted in
part or in full for any other degree or to any other university.

A handwritten signature in cursive script, appearing to read 'R Naidu', is written above a horizontal line.

Signature

2008-08-05

Date

DEDICATION

I would like to dedicate this thesis to my late parents, Mr and Mrs V.M Waghmarae, and to Bhagwan Shree Sathya Sai Baba, whose divine love gave me strength, guidance and wisdom to persevere and complete this thesis.

Om Sai Ram

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ABSTRACT

Research indicates that the prevalence of childhood depression is increasing, the onset of depression is occurring earlier in life, and that depression coexists with other mental health problems such as anxiety and disruptive behaviour disorders. Teachers are more responsive to behavioural manifestations such as hyperactivity, disruptive behaviour and aggression. They are less responsive to interpersonal difficulties and less disruptive behaviours such as withdrawal and social isolation. While they can correctly recognize that internalizing symptoms such as withdrawal and sadness are indicators of depression, they are unable to correctly recognize that externalizing behaviours such as disruptiveness and aggression can also be indicators of depression. Since many of these symptoms of depression manifest in the school, it is imperative that teachers are able to correctly identify the symptoms of depression. The correct management of the child prevents the depression from worsening and leading to disastrous consequences.

The purpose of this study was to establish whether teachers were fully knowledgeable about the behavioural symptoms of depression. A further purpose was to determine the management strategies used at school, and to develop a guideline document for teachers. Survey methodology and interview techniques were used to collect data for the study. These methods provided quantitative and qualitative data. The participants comprised 56 primary school teachers from three randomly selected schools. Two questionnaires were specially designed to gather data for the study.

The results of the study revealed that teachers were not fully knowledgeable about the behavioural symptoms of depression and that they lacked the depth of knowledge required to recognize the significance of the diagnostic criteria of depression which manifest as behavioural symptoms in school. The results showed that more than 57 % of participants felt that parents and home factors were responsible for depression. Results also indicated that the majority of participants were not able to recognize the multiplicity of factors that could cause and result in depression. In the perceived absence of psychological support from the Department of Education, participants indicated a need for guidelines for identification and management of symptoms of depression. There was overwhelming support for the implementation of a self-esteem programme at schools. At the conclusion of the study, a document which outlined recognition and management of the behavioural symptoms of depression, was developed by the researcher.

As a result of the findings of the study, recommendations were made to teachers, the schools' management team, as well as to the Department of Education.

Recommendations made to teachers included training the child in social skills and cognitive strategies, and maintaining contact with parents. One important recommendation to the schools' management was the timely referral of depressed children to mental health professionals. Recommendations made to the Department of Education included the facilitation of the formation of multidisciplinary teams which would comprise teachers, management staff, parents and school psychologists. These multidisciplinary teams would manage the successful implementation of programmes that will foster healthy social and emotional development of all children.

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CHAPTER ONE

INTRODUCTION

This chapter outlines the context, rationale, purpose, research questions, and research methodology of the study. It describes the structure of the study and places the various chapters in context.

1. Context of the study

The Global Context

Depression in children has long been an overlooked health problem. While it is fairly well known that clinical depression affects 10 % – 15 % of the adult population, it is not commonly known that depression is a major health problem for children and adolescents (Goldman, 2000, p.1). Depression in children can, if left untreated, affect school performance and learning, social interactions and the development of normal peer relationships, self esteem, and parent child relationships. It can lead to substance abuse, disruptive behaviours, violence and aggression, and even suicide (Goldman, 2000, p.1).

Major depression was the fourth most important determinant of the burden of human disease in 1990 and is expected to rank second in the world by 2020. It is the principal cause of disability in developed countries (Andrews, 2001). The central question asked by researchers is why the burden of depression is not receding at the same rate as the burdens of infectious and perinatal disorders, which in 1990 were diseases of greater burden (Andrews, 2001).

The past 5 years have seen increased recognition that depression is a recurring condition that might best be managed as a chronic disease. In population surveys, one-third of people who have met criteria for major depression in their lifetime report that the first episode occurred before the age of 21. Identification and management of symptoms and prevention, if they are to be effective, must therefore take place in young people (Andrews, 2001).

Mental health problems not only have significant implications for school communities but also for society in general. Most mental health disorders, such as anxiety and depression, substance abuse and psychosis have their peak period of onset during adolescence (Davis, Martin, Kosky, & O'Hanlon, 2000). Research has shown that young people experiencing anxiety disorders have lower academic achievement (Ialongo, Edelsohn, Werthamer-Larsson, Crockett, & Kellam, 1995), peer relationship problems and impairments in general social competence (Messer & Beidel, 1994).

Excessive school absenteeism and impaired peer relationships associated with anxiety lead to poor vocational adjustments (Stoep, Weiss, Kuo, Cheney, & Cohen, 2003) and self-concept problems Strauss (1984 cited in Shafii & Shafii (Eds), 1992, p. 52) as well as psychiatric disorders later in life Kovacs and Devlin (1998 cited in Offord, Kraemer, & Kazdin, 1998, p. 687). Children with depression exhibit impaired interpersonal relationships and academic problems (Birmaher, Ryan, Douglas, Williamson, Brent & Kaufman, 1996 , Part 1).

An initial episode of depression in childhood is often a forerunner to future depressive episodes (Rao, Ryan, Birmaher, Dahl, Williamson, Kaufman, Rao, & Nelson, 1995) and impairment in adult life (Reinherz, Paradis, Giaconia, Stashwick, & Fitzmaurice, 2003); it is also the single most prominent risk factor for adolescent suicide (Brent , Perper, & Goldstein, 1988; Kutcher & Marton,1991). Adolescents with emotional and behavioural problems have reported substantially more suicidal ideation and behaviour as well as smoking and drug and alcohol abuse (Sawyer, Arney, Baghurst, Clark, Graetz, & Kosky, 2001). Thus adolescent mental health has been highlighted as a major social issue in the last decade (Patton, Coffey, Posterino, Carlin, & Wolfe, 2000).

The rate of adolescent suicide is increasing at an alarming rate (Fritz, 1995). Yet depression and other affective disorders continue to be an area primarily ignored by the public schools (Lamarine, 1995). One of the factors that make depression so difficult to diagnose in children and adolescents is that the common behaviour changes normally associated with the hormonal changes of this period are similar to the behavioural symptoms of depression. It has only been in recent years that the medical community has acknowledged childhood depression and viewed it as a condition that requires intervention (Lamarine, 1995).

Although controlled studies are still lacking, it has been postulated that, if not treated early enough, childhood depression can lead to serious consequences, perhaps the most damaging being interference with normal psychosocial development, the impact of which can have lifelong consequences (Lamarine, 1995). Behaviours relating to conduct

disorder displayed by depressed children have been known to serve as a smoke screen distracting parents and school personnel from a correct determination of the causes of underlying dysfunction. Another concern is that parent and teacher ratings and student self-ratings often are incongruent, leading to the assumption that childhood and adolescent depression are significantly underestimated (Lamarine, 1995).

Views on child and adolescent depression have changed significantly since the 1970's where childhood depression was thought to be masked by other conditions. The debate continues, even today, as to whether other childhood and adolescent behaviours are simply 'masks' for childhood depression (Kahn, 1995 cited in Nunley, 2006, p.2).

Fritz(1995 cited in Nunley, 2006: p.2) states that depression may often be seen in physical ailments such as digestive problems, sleep disorders or persistent boredom. Lamarine (1995) considers that in children, depression may often be mistaken for other conditions such as Attention Deficit Disorder (ADD), aggressiveness, physical illness, sleep and eating disorders and hyperactivity.

There are barriers to learning that need to be addressed whether a child 'acts out' (demonstrates bad behaviour openly) or 'acts in' (is withdrawn). Children 'acting out' may be aggressive, threatening, disruptive and demanding of attention - they can also prevent other children learning (Marmorstein & Iacono, 2001). Children 'acting in' may have emotional difficulties which can result in unresponsiveness or even self-damaging behaviour. They can appear to be depressed, withdrawn, passive or unmotivated and their apparent irrational refusal to respond and co-operate may cause frustration for teachers and other children (Alatorre Alva & de Los Reyes, 1999).

One of the reasons that depression in children is both under diagnosed and misdiagnosed is that it is not recognized for what it really is (Goldman, 2000). Often children's behavioural problems are only brought to professional attention when they become obvious: causing classroom disruption, expulsion from school, substance abuse, suicidal thoughts and attempts, school failure or causing harm to themselves or others (Goldman, 2000). These behaviours may be identified as Attention Deficit Hyperactive Disorder (ADHD), delinquency, truancy, conduct disorder or other vague problems that are sometimes not recognized to be manifestations of an underlying depressive disorder (Goldman, 2000). As a result of these diagnoses, the management of the abovementioned behaviours becomes questionable.

1.2 The South African Context

An investigation by the Sunday Tribune (2007) found that certain suburbs in Durban, South Africa are hotspots for the seedy world of prostitution, drug and alcohol abuse, violence, pimps, rape and HIV and Aids (Premdev, 2007). This investigation which described the behaviours of children highlighted the following pertinent issues which needed urgent attention: risky sexual behaviour, children engaging in sexual acts from an early age, rape, substance abuse, illegal visits to nightclubs, staying away from school, and disinterest in school matters. The report on the investigation should lead the reader to ask: What is causing the youth of today to go astray?

Teachers in schools say this sort of behaviour starts from the home (less or no supervision of children because of working hours of parents, poor parenting skills, single parent families, and poor role modelling by parents) (Figure 4.4). The parents say that teachers are not doing their job properly (teachers being too friendly with children, poor role modelling, not teaching) (Anecdotal evidence). From the preceding comments it is evident that both parents and teachers are unaware that many of the abovementioned behaviours could be acting out behaviours of depressed children (researcher's observations). Although external factors (environmental) are very often blamed for these behaviours, consideration must also be given to the fact that while the child is influenced by environmental inputs, the environment is influenced by and responds to the characteristics of the child (Cicchetti, Rogosch, & Toth, 1994).

South African schools and teachers have to contend with difficult, aggressive, disruptive children who test patience, ignore the boundaries and challenge the rules (researcher's observations). Many of these children may well be acting out their depressive symptoms. Teachers are not equipped to identify the symptoms of depression and recognize the link between the presenting symptoms and the behavioral symptoms of depression (researcher's assumption). Very often the management strategies used by parents and teachers (punishment, suspension, and expulsion) serves to exacerbate the very behaviour that they are trying to eliminate (researcher's observations). Therefore it is hypothesized that equipping school personnel with guidelines in identifying symptoms of depression as well as management guidelines for those who fit the diagnostic criteria of depression will contribute significantly in ameliorating the deleterious effects of depression.

There have been a number of studies in other countries which investigated the ability of teachers to correctly identify the behavioural symptoms of depression. The number of South African studies however, to the best of the researcher's knowledge, has not kept up the momentum with studies in other countries like the United States, Britain and Australia. It is hoped therefore that this study will fill in the gap on the paucity of research studies in South Africa on teachers' ability to correctly recognize the behavioural symptoms of childhood depression.

1.3 Rationale for the study

The results of an earlier study by the researcher on the prevalence of childhood depression and the factors contributing to the depression, indicated that 10.3 % of the participants were depressed (Naidu, 2003). These findings were similar to the findings of other studies on prevalence of depression. For example Hammen and Rudolph (1996 cited in Gilbert, 1997, p. 223), found overall rates for Major Depressive Disorder to be between 6 % and 9 %.

Naidu (2003) concluded that factors from home, school and the individual contributed to depressive symptoms. One of the factors highlighted from the school factors was a flawed pupil-teacher relationship as perceived by the children. One important recommendation of the study was the provision of mental health promotion and prevention programmes which would generally help the broad school population and specifically those children at risk for developing a depressive disorder.

These findings were further augmented by a formal and informal working relationship of the researcher with teachers and children from many different schools. Many children reported that teachers did not understand them, punished them unfairly or did not care about their feelings. The teachers conveyed to the researcher informal narratives of many mental health problems present in their classrooms (including anxiety, learning disorders and depression) which often first present as disruptive behaviour.

The teachers reported declining discipline, unmotivated children, low staff morale, work pressure, and changing curricula to substantiate their reports. Many teachers gave the impression that they did not possess the necessary skills to effectively deal with behaviour problems in the classroom. Many felt overwhelmed by the situation. Roeser and Midgely, (1977 cited in Roeser and Eccles, 2000, p. 136), found that approximately two-thirds of a sample of elementary school teachers reported feeling overwhelmed by the kinds of emotional and behavioural difficulties some of their students presented in class. Conoley and Conoley (1991) felt that providing insights and support to teachers may ultimately ease the burdens felt by many teachers.

It was the researcher's assumption that while certain children who presented with depression displayed disruptive behaviours as a way of coping with their unhappiness, others became withdrawn and uncommunicative. It was clear however, that both disruptive behaviours (acting out – externalizing) and withdrawn behaviours (acting in – internalizing) were being noticed by their teachers.

Since depressive symptoms like increased agitation or irritability, unexplainable decline in school performance, withdrawal from peers, disruptive behaviour, and physical complaints are more likely to be noticed in the classroom, it might be reasonable to assume that school teachers would be a more reliable source of information than parents (Peterson, Wonderlich, Reaven & Mullins, 1987). If appropriate action is not taken early, the child's inability to socialize normally may lead to a relentless state of diminishing psychological well-being continually reinforced by negative feedback from peers, family, and significant others (Peterson et al., 1987).

The rationale of this research study was therefore to facilitate teachers' efforts in correctly identifying the symptoms of depression, thereby ensuring that depressed children were appropriately managed at school.

1.4 Purpose of Study

School personnel (especially teachers) are instrumental in reporting the first signs of depression (Adelman & Taylor, 1998). Teachers often notice a gradual decline in attentiveness, quality of school work and general social interaction of a student (Adelman & Taylor, 1998). Observation, recognition of risk signs, and timely referral are the most important steps for a teacher to take when a child is suspected to be depressed. Untreated academic and socio-emotional problems undermine not only pupils' learning but also teachers' capacity to teach (Adelman & Taylor, 1998).

Given the increasing numbers of children experiencing behavioural problems at school (researcher's observations at schools), it is not surprising that teachers frequently identify a need for intervention. In moving towards that need, according to Adelman and Taylor (1998), teachers need to:

1. Be aware of some of the factors which may cause children to become depressed
2. Understand and identify the behavioural symptoms of depression
3. Engage in 'active listening' and 'conversational techniques'
4. Provide appropriate support within the school setting and
5. Know when and where to refer for more specialist help.

The purpose of the study was therefore to:

1. Establish if teachers were fully knowledgeable in identifying the behavioural symptoms of childhood depression.
2. Determine the management strategies used by teachers to manage children who exhibit the behavioural symptoms of depression.
3. Develop a guideline document for school personnel that would assist them in correctly identifying the symptoms and managing children with depression.

1.5 Research Questions

The research questions which framed the study are:

1. Are teachers fully knowledgeable in recognizing the behavioural symptoms of depression in children?
2. How are children with depressive symptoms managed at school?
3. Do schools need a guideline document to help identify and manage the behavioural symptoms of depression?

1.6 Assumptions made by the researcher are:

1. Teachers are not fully knowledgeable about childhood depression.
2. Children with depressive symptoms are not appropriately managed at school.
3. Schools do not have / were not given guidelines for identification and management of depressed children at school.

1.7 Value of the study

Information gathered from this study will form the basis for the guidelines for school personnel. These guidelines will greatly assist the teachers in correctly identifying and managing the behavioural manifestations of depression in children. The findings of this study will assist teachers to be cognizant of the symptoms of depression. This will empower them in the management of the more difficult behaviours and give them a greater sense of control in the classroom.

The recommendations made to the schools' management team will ensure that children with depressive symptoms will receive appropriate care and referral if necessary.

The findings from the study will add to the existing literature nationally and internationally on the subject of teachers' ability to correctly recognize the behavioural symptoms of childhood depression.

1.8 Research Methodology

Both qualitative and quantitative methodology was used to gather data for the research.

Three primary schools in the Reservoir Hills and Westville suburbs of Ethekwini (Durban) in KwaZulu Natal were randomly selected.

Two questionnaires were especially developed for the purposes of this study. The purpose of the first questionnaire was to establish the depth of knowledge that school personnel were equipped with. The second questionnaire was designed to elicit more in depth information about management at school of children with depressive symptoms. Its purpose was also to ascertain if schools had a guideline document that assisted school personnel in identifying and managing the behavioural symptoms of depression.

The two questionnaires were administered to school personnel in each of the three schools in the following manner: The researcher, after prior consultation with the principal of the school, met with the staff and formally administered the first questionnaire to all members of staff. After completion of the first questionnaire, five

members of staff from each school were randomly selected to participate in answering the second questionnaire. At the appointed date and time decided on by each participant, the researcher proceeded to administer the second questionnaire.

1.9 Structure of the Research Study

Chapter one serves as an introduction to the study. It outlines the context within which the study was developed. The rationale, purpose, research questions, and research methodology of the study are revealed. The value of the study, which is the need for teachers to recognize symptoms of depression, is highlighted. This chapter describes the structure of the entire study and places the various chapters in context.

In chapter two the relevant literature pertaining to the research questions is examined. Research studies on the etiology, behavioural symptoms of depression, the diagnostic criteria, the co morbidities of depression, home and school risk factors and the effectiveness of teachers' efforts in identifying symptoms of depression as exhibited by children at school will be presented.

Chapter three presents all the various theories that were and are still employed to explain the etiology of depression in children. The theoretical framework that framed this research is elaborated on. A detailed research methodology plan together with descriptions of the two questionnaires used is outlined.

Analyses of the data gathered are reported on and the discussion of the results forms the basis of chapter four.

Chapter five discusses limitations and strengths of the study. Conclusions are drawn and recommendations are made.

In chapter six a document outlining the diagnostic criteria, the behavioural manifestations of depression and the management of behavioural symptoms of depression at school is presented.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

For much of the 20th century, some mental health professionals believed that children were incapable of experiencing depression (Lamarine, 1995). Other mental health professionals believed that children could be depressed, but would most likely express their symptoms indirectly through behaviour problems, thereby ‘ masking ’ their depression (Hammen & Compas, 1994). According to Fleming and Offord (1990), children experience and manifest depression in ways similar to adults, albeit with some symptoms unique to their developmental age.

In general, depression affects a person’s physical, cognitive, emotional and motivational well being. While the prevalence rates show that a significant number of children experience depressive symptoms, it is often not noticed by those around them (like teachers and parents) (Garber, 2000). This is because these behavioural symptoms of depression can be less obvious than other more disruptive behaviour disorders. Left untreated, depression can have a significant negative impact on personal, academic, and social development. Untreated depression has been cited as the major cause of suicide (Garber, 2000).

Internalizing and externalizing behavioural symptoms of depression manifest in school (Ines & Sacco, 1992). Children spend at least a third of their day at school where they are constantly being observed and evaluated. They come into contact with well educated,

observant and skilled teachers. Therefore before intervention programmes are implemented, it is important to ascertain that teachers are able to identify the internalizing and externalizing behavioural symptoms of depression (Ines & Sacco, 1992).

In this chapter some of the relevant studies on childhood depression that framed this research are examined. The discussion of the research studies establishes certain trends and links in relation to the research questions posed in chapter one. The following aspects will be discussed:

- The etiology of depression
- Comorbidities (the extent to which symptoms or symptom clusters co-occur)
- Behavioural symptoms of depression
- Diagnostic criteria for assessment of depression
- Recognition and assessment of depression

2.2 The etiology of depression

Depression is experienced by a significant proportion of children and adolescents (Markham, 2005). Since a depressive disorder can produce long-lasting detrimental effects on a child's life, the question of etiology is predictably raised. Three etiological factors in identifying specific determinants of depression will be discussed: biological (including studies on inherited characteristics), psychological (focusing on cognitive and affective activity), and environmental (such as stressful life events).

2.2.1 Biological Factors

Research indicates that depression has been found to run in families (Rice, Harold, & Thapar, 2002). By studying twins, researchers have found evidence of a strong genetic influence in depression. Studies have found that children are vulnerable to depression even when raised by adoptive parents (Rice et al., 2002). Additionally, children of parents with depression are at increased risk for a number of negative outcomes, ranging from severe mental illness to poor behavioural and social functioning (Rice et al., 2002).

While some of these negative outcomes result from genetic influences, others develop from, or are heightened by, environmental risk factors (Goodman & Gotlib, 1999). According to Goodman and Gotlib (1999), the risk for an affective disorder (e.g., depression, anxiety, or bipolar disorder) in the adult first-degree relatives of a person with depression is 20–25%, compared with a general population risk of 7%. These findings suggest that the vulnerability to depression can be inherited (Rice et al., 2002).

Family studies of early onset depressive disorder evaluated the inheritability of the disorder. One study found the prevalence of major depressive disorder in first degree relatives to be two-fold in comparison to non-affective psychiatric controls (Cicchetti & Toth, 1998). Another biological factor implicated in the determination of the etiology of major depressive disorder is the abnormal functioning of the prefrontal cortex of the brain (Markham, 2005).

The prefrontal cortex plays a critical role in the regulation of mood. Some abnormalities in the prefrontal cortex have been identified and implicated in the pathogenesis of major depressive disorder (Nolan , Moore, Madden, Farchione, Bartoi, & Lorch, 2002). Certain brain chemicals, called neurotransmitters, play an important role in regulating moods and emotions, providing further evidence of the biological etiology of depression (Markham, 2005). Evidence supporting this theory was found in research on the effects of antidepressant medication, which work by increasing the effectiveness of neurotransmitters (Nolan et al., 2002).

Depression has been linked to various other medical and biological conditions such as dietary deficiencies, degenerative neurological disorders, strokes in the frontal lobe of the brain, certain viral infections such as hepatitis, and medications such as steroids (Nolan et al., 2002).

2.2.2 Psychological Factors

Psychological factors of depression focus on the way children think and behave. Sigmund Freud believed that a person's unconscious anger over loss weakens the ego, resulting in self-hate and ultimately resulting in melancholy (Freud, 1959 cited in Markham, 2005, p.5).

Cognitive factors of depression emphasize the role of irrational and illogical thought processes. Beck (1979 cited in Kazdin, 1990, p. 141) proposed that early in their life children learn self-defeating ways of looking at the world. These irrational and illogical

thought patterns exacerbate negative situations, which then increase the risk of depression, particularly in highly stressful situations.

American psychologist, Martin Seligman (1975 cited in Kazdin, 1990, p. 141) explained that depression in children stems from what he terms 'learned helplessness', an acquired belief that one cannot control the outcome of events. An adaptation of this theory is the hopelessness theory of depression. This theory attributes depression to a pattern of negative thinking in which children blame themselves for negative life events, and view the causes of those events as permanent (Seligman, 1975 cited in Kazdin, 1990, p. 141).

2.2.3 Environmental Factors

Researchers agree that stressful experiences can trigger depression in children, especially those predisposed to the disorder (Silberg, Pickles, Rutter, Hewitt, Simonoff, & Maes, 1999). For example, the death of a loved one may trigger depression. Other stressful experiences or negative life events may include divorce of parents, moving to a new school, addition of a sibling, and hormonal changes during puberty (Silberg et al., 1999).

Children who experienced physical or sexual abuse tend to be quite vulnerable to experiencing depression (Silberg et al., 1999).

Evidence from several studies has shown that children and adolescents can develop major depressive disorder from experiences associated with academic underachievement and poor psychosocial functioning (Eley, 1997). Their diminished self concept and perceived

inefficiency, when they compare themselves to their peers, can directly impact on their mood and emotions (Eley, 1997).

Parents diagnosed with depression and their children are likely to experience higher rates of stress than non-depressed families (Fendrich, Warner, & Weissman, 1990). Children in these families are exposed not only to their parents' depression but also to a variety of stressors associated with the illness: more job stress, higher marital conflict, financial stress, conflict in parent-child relationship, (Fendrich et al., 1990). In addition, researchers have discovered that children of parents with depression are at increased risk for alcohol dependence and are more likely to report suicidal thoughts or behaviours (Klimes-Dougan & Bolger, 1998; Weissman, Warner, & Wickramaratne, 1997).

The results of a study by Messer and Gross (1995) that examined the relationship among family environmental factors and childhood depression from a social-interaction perspective, revealed that both children and parents in families with a depressed child perceived their lives to be more stressful than did controls. Similarly, other researchers have reported that parental major depression is associated with higher rates of phobias, panic disorder, disruptive behaviour disorders, poorer social functioning, and worse academic performance in their children (Anderson & Hammen, 1993; Beiderman, Faraone, & Hirshfeld-Becker, 2001; Weissman et al., 1997).

The children of parents with early-onset depression (before the age of 19) were found to have even more withdrawn, anxious, and depressed feelings and have worse social functioning (Petersen, Alpert, Papakostas, Bernstein, Freed, Smith, & Fava, 2003). These

children also exhibited higher rates of social problems, thought problems, attention problems, delinquent behaviour, and aggressive behaviour (Petersen et al., 2003).

Research with children of depressed parents at risk for depressive disorders suggests that depressed mothers' childrearing interactions are less stimulating, less affectionate, and more hostile than controls (Hammen, 1991). Further, early-onset depression in mothers is associated with a 14-fold increase in the risk of onset of major depression before age 13 in their children (Weissman, Gammon, John, Merikangas, Warner, Prusoff, & Sholomskas, 1987).

The stressful context on children's lives can be another source for the development of psychopathology. Fendrich, Warner, and Weissman (1990) have found that the presence of environmental risk factors such as parents' marital discord, parent-child discord, low family cohesion, affectionless control, and parental divorce is associated with higher rates of major depression, conduct disorder, and any psychiatric diagnosis in children.

Children's success in their educational endeavours and their general socio-emotional adjustment are influenced by a variety of personal characteristics and environmental experiences (Rudolph, Hammen, Burge, Lindberg, Herzberg & Daley, 2000). One of the most powerful determinants of children's developmental course is the social context in which they live (Rudolph et al., 2000). In particular, experiencing a stable and supportive environment during childhood is likely to foster healthy cognitive, social and emotional development, whereas experiencing a disruptive or stressful environment has been linked to a wide range of adverse mental health outcomes, including depression (Rudolph, et al., 2000). Stress and the accompanying emotional distress may then interfere with some of

the major tasks of childhood, such as academic achievement and fulfillment of educational goals (Rudolph et al., 2000).

The etiology of depression can therefore be a result of the combination of the interaction between a child's biological and psychological vulnerabilities and a stressful environment. It would be unscientific to place emphasis on one factor, as research shows that in all probability depression results from a combination of factors (Fendrich et al., 1990; Rudolph et al., 2000).

2.3 Comorbidities

The term comorbidity most commonly refers to the presence of any additional disorder in a patient with a particular disorder. In some cases, however, researchers have used the term to refer to the extent to which symptoms or symptom clusters co-occur (Kazdin, 1990). This approach is useful because the presence of sub-clinical disorders or symptom clusters not meeting an additional diagnosis can also have etiological and predictive value (Gilbert, 1997).

Although it is debatable whether other mental disorders precede, co-exist with, or follow childhood depression, their co-occurrence is not (Gilbert, 1997). A review of six epidemiological studies indicated that the existence of childhood depression increases the likelihood of other disorders 20-fold (Angold & Costello, 1993).

Depression is not an easy diagnosis to make. Many other psychiatric disorders and other medical symptoms can present with similar signs and symptoms (Kazdin, 1990). Depression can also co-exist with other problems including anxiety disorders, conduct disorders, attention deficit hyperactivity disorder, learning disorders or substance abuse (Kazdin, 1990).

According to a review of the literature, (Birmaher, Ryan, Douglas, Williamson, Brent, & Kaufman, 1996) found that 40% to 70% of depressed children and adolescents develop an additional or comorbid disorder, with 20% to 50% estimated to have two or more comorbid diagnoses. The most frequent comorbid diagnoses include anxiety disorder, disruptive disorder, and substance abuse (Harrington, Rutter, & Fombonne, 1996).

2.3.1 Anxiety and Depression

Depression and anxiety are often related. Diagnostic studies of clinical samples have shown that children with one of these disorders often meet the criteria for the other as well (Kazdin, 1990). Anxiety disorders are the most prevalent comorbid conditions with childhood depression (Ollendick & Yule, 1990).

A number of investigators have begun to examine the association between anxiety and depression in children and adolescents (Manassas & Bradley, 1994). The results of a study by Berney, Bhate, Kolvin, Famuyiwa, Barrett, Fundudis, and Tyrer (1991), found that anxious children with comorbid depression may be particularly vulnerable to social and academic impairment. Strauss, Last, Hersen, and Kazdin (1988) examined the

overlap of anxiety and depressive disorders in 106 children referred for evaluation to an outpatient child and adolescent anxiety disorders clinic. Strauss et al., (1988), found that 30 of the children with an anxiety disorder also met criteria for a depressive disorder.

The abovementioned studies provide some support to the assertion of the comorbidity of anxiety and depression in children and adolescents.

2.3.2 Alcohol, Substance Abuse and Depression

Major depression typically precedes the onset of alcohol or substance abuse by approximately four and a half years, thereby providing an important window period for the prevention of substance abuse in depressed adolescents (Birmaher, Ryan, Douglas, Williamson, Brent, Kaufman, & Dahl, 1996).

Comorbidity of alcohol or substance abuse has been documented in two studies, one by Deykin, Levy, & Wells, 1987 cited in Speier, Sherak, Hirsch, and Cantwell, 1995, p. 472), and the other by Kashani, Carlson, Beck, Hoepfer, Corcoran, McAllister, Fallahi, Rosenberg, & Reid, 1987). Both studies demonstrated that up to 25% of those subjects meeting criteria for depression also met criteria for substance abuse.

In the long-term, continued alcohol misuse is likely to affect social functioning, including school performance (Kashani et al., 1987). Alcohol misuse while young is associated with heavy drinking in later life, and there is an association between alcohol and the use of illegal drugs (Angold & Costello, 1993). There is evidence that it is associated with

poor nutrition, and that alcohol can disrupt some of the biological mechanisms involved in physical growth during puberty. Moreover, it may also impair psychological and emotional development (Angold & Costello, 1993).

2.3.3 Conduct Disorder and Depression

Conduct disorder and related problems, including aggressive behaviour, are associated with deficits in social functioning. For example, aggressive children are typically rejected by peers and have poor social problem-solving skills (Dodge, Pettit, McClaskey, & Brown, 1986).

Marmorstein and Iacono (2001) conducted a study with twin adolescent girls with major depressive disorder and or conduct disorder. The results of the study suggest that both depression and conduct disorder are related to significant academic difficulties. Previous research indicates that depression and disruptive behaviour together are related to more school problems than disruptive behaviour alone (Lewinsohn, Rohde, & Seeley, 1995).

In clinical samples, from 36 % to 80 % of depressed juveniles meet criteria for conduct disorder (Ferro, Carlson, Grayson, & Klein, 1994; Kovacs, Paulauskas, Gatsonis, & Richards, 1988). As Angold and Costello (1993) have shown, such high rates of comorbidity for depression with anxiety, and depression with conduct disorder, could not occur by chance alone. What this strong association between these disorders means, however, is unclear. They question whether these so called internalizing disorders (depression, anxiety, etc.) are pathogenetically related, representing different etiologies

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and outcomes from patients with externalizing (e.g., conduct) disorders (Angold & Costello, 1993).

2.3.4 Impaired Social Functioning and Depression

There is considerable evidence that depression in childhood is associated with impaired social functioning (Kennedy, Spence, & Hensley, 1989). Children with depressive symptoms or depressed affect usually are less socially skilled or accepted than non-depressed peers (Kennedy et al., 1989) and typically have low self-esteem (Renouf & Harter, 1990).

The goal of a study by Renouf, Kovacs, and Mukerji (1997), was to examine the relationship of depressive, conduct, and comorbid disorders and two domains of social functioning, namely, social competence and self-esteem. The researchers hypothesized that children with comorbid depressive and conduct disorders have worse social functioning than those with either disorder or some other disorder. The results showed partial support for the hypothesis. The findings also suggest that social impairment associated with comorbid depression and conduct disorder is mostly due to conduct disorder (Renouf et al., 1997).

The findings of a study reported on by Bandura, Pastorelli, Barbaranelli and Caprara (1999), demonstrated that low perceived social and academic self efficacy contributed to

depression both directly and through their effects on academic achievement, prosocial behaviour and problem behaviour.

The hypothesis that depressed children would be less socially skillful was partially supported by a study by Sacco and Graves (1984). The results of the study suggest that children who report depressive symptoms show evidence of deficits in academic and interpersonal functioning. A critical question of the study, having both theoretical and practical significance, is what causal sequence results in the variety of problems found associated with childhood depression (Sacco & Graves, 1984). For example, does poor academic performance lead to a lowering of self esteem, followed by depression with social skill deficits as a secondary symptom of depression? Sacco and Graves(1984) also question whether depression, due to factors external to the school environment (e.g., parental divorce) results in deficits in both academic and interpersonal areas (Sacco & Graves, 1984).

2.3.5 Self Esteem and Depression

Researchers have found that there is a strong correlation between self esteem and depression (Davila, Hammen, Burge, Paley, & Daley, 1995). The correlation may be viewed as a vicious cycle. The inability to relate positively in social situations may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate with others which then adds to the feelings of low self-esteem (Davila, et al., 1995).

According to Rao, (1994) behaviours in social situations are not the result of low self-esteem, but rather the result of social rejection which leads to low self-esteem. In other words, self-esteem does not cause a person to behave in a certain way, it is rather the result of poor social relationships.

2.3.6 Suicide and Depression

Research into the relationship of suicide and depression shows that there is a clear association between suicide and depression (Kaplan, 1994 cited in Gilbert, 1997, p. 223). Suicide attempts are not only diagnostic criteria and outcomes of depressive disorders but also risk factors for future episodes of depression. Overall prevalence rates for suicide increase with age (Kaplan, 1994 cited in Gilbert, 1997, p. 223).

According to Ameen, (2005) and the South African Depression and Anxiety Group, (2000), the similarities between warning signs of suicide and the warning signs of depression are:

- Presence of a mood disorder (depression or bipolar illness, a conduct disorder
- Psychosocial conditions - parental loss, family disturbance, history of suicide in a family member, friend, or classmate
- Extreme changes in behaviour
- A previous suicide attempt
- Suicidal threats or statements
- Physical complaints such as frequent headaches and/or stomach aches

Research has shown that teenage suicides in South Africa have increased considerably in recent years (Govender, 2008 cited in Premdev, 2008 , p. 4). According to the provincial minister of education in KwaZulu- Natal, Ina Cronje, the incidence of suicide is prevalent in children as young as 10 years old. She mentioned that according to the results of the first South African National Youth Risk Behaviour Survey conducted in 2002, 24.6% of pupils indicated that they felt sad or had such hopeless feelings that they wanted to die (Cronje, 2008 cited in Premdev, 2008, p. 4).

In an attempt to explain these figures, Cronje (2008 cited in Premdev, 2008, p. 4) listed causes such as lack of access to basic services, poverty, socio-emotional dysfunction, physical, emotional and sexual abuse, political, domestic and community violence, crime, the impact of HIV and Aids, substance abuse, disabilities, and genetically predisposed depression. Lourens Schlebusch (2008 cited in Premdev, 2008, p. 4), a South African and international expert on suicidal behaviour, reports that suicidal behaviour must be addressed at an early age. He emphasizes that studies have demonstrated that schools and parents are obvious targets for identifying and preventing suicidal behaviour.

Suicide has been shown to have links with early indications of emotional disturbance, especially the internalising disorders such as depression (Gardiner, 1999). Primary school teachers' ability to identify and then react appropriately to indications of such disturbance was the purpose of a study where teachers were surveyed with regard to their responses to descriptions of children with behavioural disturbances (Gardiner, 1999). A comparison between their responses to externalising behaviours (e.g., conduct disorder),

and internalising disorders (e.g., depression) suggests that teachers respond less to internalising disorders. Of concern was the finding that a student had to demonstrate a very severe disturbance in order to have a good chance of being referred for professional help. These findings have serious implications for the early identification of at-risk students (Gardiner, 1999).

The link between depression and suicide has been clearly demonstrated in adolescents over a number of research studies (Baechler, 1979). A study of adolescent psychiatric in-patients (Pfeffer, Newcorn, Kaplan, Mizruchi, & Plutchik, 1989) found significant relationships between internalising syndrome symptoms (e.g., major depressive disorders, chronic depressive symptoms, peer relationship problems) and suicidal adolescents. In contrast, violent or assaultive adolescents were more related to externalising disorder symptoms, and less related to depressive symptoms (Pfeffer et al., 1989).

The South African Depression and Anxiety Group (Sadag) has designed a suicide prevention programme targeted at young people during the ages when they are described as most vulnerable, yet difficult to reach. The programme aims to empower teachers, students and parents to become more alert to the signs and symptoms of depression and suicide (Sadag, 2007) .

If current trends continue, statistics show that more than 5 000 South Africans, many of them as young as 10, will kill themselves before the end of 2007 (Sadag, 2007). In addition, 9% of all teenage deaths in the country are suicides (Sadag, 2007). Alarmingly, one in every twelve adolescents has attempted suicide at least once (Sadag, 2007). These

facts and figures serve as warning bells that our children's lives are in crisis. According to Sadag (2007), children commit suicide for a variety of reasons including extreme poverty, dysfunctional families as a result of abuse and divorce, peer pressure, failure to achieve at school or even serious illness and depression (Sadag, 2007).

2.3.7 Masked Depression

During the 1960s the predominant view in the psychoanalytic literature was that depressive conditions resembling adult depression could not occur in children because the personality structure of the child was too immature (Rie, 1966 cited in Harrington, 1993, p. 12). Rochlin (1959 cited in Harrington, 1993, p. 12), for example, considered that depression was impossible in middle childhood because the child does not have a sufficiently formulated superego to direct aggression against his own ego.

Glaser (1967 cited in Harrington, 1993, p. 13), postulates that middle childhood has also been seen as a time when depression does occur, but in a "masked" form. Children between the ages of six and ten years of age are in a transition period and are able to experience adult-like depressive conditions but they express these feelings in a different way. Glaser (1967 cited in Harrington, 1993, p. 13).

Studies have indicated that depression in children does not necessarily mirror the classic symptoms of depression in adults (Hammen & Compas, 1994). While depressed children may demonstrate such features as mood disturbance, lack of energy and sleep disturbance

that are generally linked to depression, they may also evidence masked depression (Hammen & Compas, 1994). They may show anxiety-tension, learning problems, psychosomatic illnesses and perfectionism. This suggests that unless the observer is aware of the ways that depression is manifested in children it may go unrecognised. Teachers are not commonly exposed to training in child psychopathology and at best could be expected to recognise only those symptoms associated with depression in adults (Hammen & Compas, 1994).

Cytryn and McKnew (1972) proposed that the most common type of depression in childhood was masked depression, which could be diagnosed on the basis of features such as facial expression, and fantasy content. However, these authors also described a "typical" depressive syndrome occurring in children. This consisted of symptoms such as hopelessness, psychomotor retardation, sleep problems, appetite disturbance, social withdrawal and other symptoms seen in adult depressive disorders (Cytryn, & McKnew, 1972).

Assessment of depression can be problematic because it does not always display itself in a recognisable form (Lewinsohn, Hyman, Roberts, Seeley, & Andrews, 1993). They found that at least 43% of children diagnosed with depression have at least one other behavioural problem that is not a symptom of depression. Behaviours such as aggression, hypochondrias, enuresis, psychosomatic illness, somatic complaints, delinquency and even attention deficit hyperactivity disorder have been thought to mask depression (Cantwell (1983 cited in Cantwell & Carlson, 1983: p. 201); Cytryn, 2002). If the child

fulfils the criteria for a depressive disorder then other diagnostic features are stated as ancillary. It is thought that they are unable to tolerate the prolonged feelings of sadness and so move their attention onto other behaviours (Hammen & Compas, 1994).

Kovacs and Beck (1977 cited in Carlson & Cantwell, 1980, p. 445), noted that there are two basic viewpoints on the manifestation of childhood depression. One view holds that except for some development - specific modifications, childhood depression resembles adult depression. The alternative view essentially states that most children do not express depression directly and that it must be inferred from behaviours and symptoms "masking" the underlying depressive feelings (Kovacs & Beck, 1977 cited in Carlson & Cantwell, 1980, p. 445).

2.3.8 Conclusion

One of the recurring findings in childhood and adolescent psychopathology in general is the high rate of co-occurrence of disorders (Kazdin, 1990). With respect to depressive disorders, comorbidity is the rule rather than the exception (Birmaher, Ryan, Douglas, Williamson, Brent, & Kaufman, 1996). Comorbid diagnoses appear to influence the risk for recurrent depression, duration of the depressive episode, suicide attempts or behaviours, functional outcome, and response to treatment (Brent, Perper, & Goldstein, 1988).

According to Klerman, (1990, cited in Kendall & Brady 1995, cited in Craig & Dobson (eds), 1995, p. 5), discussions and studies of comorbidity must consider the question:

Which is the primary diagnosis? In some cases, the distinction between primary and secondary diagnoses is made on the basis of which disorder appeared first. In other cases, clinical severity is the distinguishing factor. And still in other cases, the causal relationship between two disorders is examined, and the primary disorder is held to be the one that causes the other disorder (Klerman, 1990, cited in Kendall & Brady 1995, cited in Craig & Dobson (eds) 1995, p. 5).

2.4 The Behavioural Symptoms of Depression at School

2.4.1 Internalizing Symptoms

Children who report frequent feelings of internalized distress show diminished academic functioning in terms of quantitative achievement-related behaviours (Roeser & Eccles, 2000). Symptoms of depression are associated with lower teacher-rated grades and standardized test scores, and a lack of classroom participation among children and adolescents (Blechman, McEnroe, Carella & Audette, 1986; Kellam, Rebok, Mayer, Ialongo & Kalodner, 1994). Although discrepancies exist in the literature (Parker & Asher, 1987), there is some indication that children who manifest high levels of internalized distress and concomitant poor peer relations during primary school years also show academic difficulties and a greater likelihood of dropping out during high school (Olendick, Greene, Weist & Oswald, 1990).

One pattern of co-occurring academic and emotional problems that can arise in educational settings involve children who show academic difficulty joined with

internalized symptoms of emotional distress (Roeser & Eccles, 2000). Studies have shown that academic difficulty can cause subsequent internalized distress (Weiner, 1986) and internalized distress can cause subsequent academic difficulties (Nolen-Hoeksema, Girgus & Seligman 1986). Achievement-related behavioural characteristics of such children include avoidance of academic challenges, failure to persist on difficult tasks, withdrawal classroom activities and poor achievement (Roeser & Eccles, 2000).

2.4.2 Externalizing Symptoms

A second pattern of academic and emotional problems that is seen among some children in educational settings involves achievement difficulties that co-occur with externalized forms of distress such as disruptive behaviour and aggression (Hinshaw, 1992). Such children do poorly in school, show academic skill deficits and spend a great deal of time off-task in learning settings, have poor peer relations, and are disruptive in the classroom (Dishion, French, & Patterson, 1995; Hinshaw, 1992).

Children with externalized distress in the form of conduct problems, attention problems, or both, also show poorer behavioural functioning at school (Hinshaw, 1992). Externalizing difficulties in children are associated with poorer teacher-rated grades and standardized test scores, more time off-task in the classroom, and more behavioural problems within and outside the classroom (Astor, 1998; Hinshaw, 1992; Dishion, French, & Patterson, 1995; Roeser, Eccles, & Stroebel, 1998).

There have also been cognitive factors identified in children with behavioural problems, particularly for those children who act out with aggression (Parker & Asher, 1987). They show impaired social problem-solving ability, with selective attention to hostile cues and a hostile attributional bias (Parker & Asher, 1987).

Children with depression often have altered behaviour that distracts them from their school work (Durlak, 1995). Some are sad and tearful whilst others may act out their frustration with aggressive behavior, similar to that seen in attention deficit disorder. Lowered self-esteem may make students hesitant to become involved in group activities (Durlak, 1995). Children with chemical imbalance as the primary cause of their depression may exhibit decreased motor function that makes them clumsy and uncoordinated (Durlak, 1995).

Children who express their depression by acting out in destructive behaviour lose valuable class time when removed for disciplinary reasons (Goldstein, Paul, & Sanfilippo-Cohen 1985). Depression is sometimes secondary to learning disabilities and these concurrent problems will need to be addressed in order to treat the depression (Goldstein et al., 1985).

Research has shown that for some children academic difficulty can cause subsequent feelings of frustration, inferiority, anger and aggression that can result in behaviour problems in and out of school (Hinshaw, 1992). There is also indication that symptoms of externalized distress such as anger and aggression can also cause subsequent academic problems (Roeser & Eccles, 2000).

Angry children often show heightened fears, concerns, provocation and control by others (Roeser & Eccles, 2000). These heightened sensitivities distract such children from focusing on academic work. If such sensitivities are accompanied by aggression towards others, such children can create conditions in which peers and teachers are less willing to offer assistance (Roeser & Eccles, 2000). Inattention and lack of support due to the child's misconduct can in turn precipitate subsequent academic problems (Dishion et al., 1995).

2.4.3 Academic Difficulties

As models of affective disorders have been applied to younger populations, deficits in cognitive and academic domains have received the most attention (Brumback, Jackoway, & Weinberg, 1980). An association between depressive disorder in young people and impaired academic performance has been documented in several studies. Puig-Antich, Lukens, Davies, Goetz, Brennan-Quattrock, and Todak (1985) found that depressed children were more impaired than normal controls for the items measuring school behaviour and school achievement. Berney, Bhate, Kolvin, Famuyiwa, Barrett, Fundudis, and Tyrer (1991), reported that children with depressive disorder were much more likely to absent themselves from school than non-depressed controls.

Research findings suggest that children with depression report low self-esteem, make negative self-statements and experience hopelessness and helplessness (Allen & Tamowski, 1989), resulting in poor academic performance by taking less

responsibility for academic outcomes (Kendall, Stark, & Adam, 1990). Implicitly, a relationship between children's affective and academic functioning is suggested. Perhaps, affective disorders impact academic performance indirectly by affecting students' motivation and concentration which in turn result in poor academic performance (Kendall et al., 1990). Stressful life circumstances may influence school adjustment in many ways (Berney et al., 1991). For example, dealing with stress in other areas of their lives may interfere directly with children's performance at school by depleting the amount of time, energy, and focused attention available for academic tasks and school involvement, such as completing homework or engaging in after-school activities (Berney et al., 1991).

Fosterling and Binser (2002), investigated the link between depression and school performance. The research findings confirmed that high depression scores were associated with low overall grades, and demonstrated the vicious cycle that exists between depression and low grades.

In a research study conducted by Chen, Rubin, and Li (1995), a sample of primary school children in Shanghai, People's Republic of China, participated in a 2-year longitudinal project on depression. The mean depression scores of Chinese children were found to be similar to those found for children in the West. Depression was positively associated with aggressive-disruptive behaviour and negatively associated with social competence. School, social and academic difficulties were concurrently and positively correlated with depression. Finally, decline in social and academic performance was related to depressed affect. Given the social conditions in Chinese schools, it seems reasonable to predict that

social and academic difficulties, including peer rejection, low social status, and poor academic performance, would be associated with child depression (Cole, 1991).

Evidence to support the association between perceived competence and depression was found in a study by Chan (1996). The findings of the study reflected that those students who perceived themselves to be academically and socially competent were less likely to be depressed. Those who perceived themselves to be either academically or socially incompetent were more likely to be depressed, but those who perceived themselves to be incompetent in both areas were most likely to be depressed. Thus it should be recognized that perceived incompetence may lead to depression and depression may lead to perceived incompetence and a third unknown factor may cause both (Chan, 1996).

From the research reviewed in this section there is not only a clear link between mental illness and academic achievement, but between mental illness and every aspect of healthy functioning in children and adolescents.

2.5 Recognition, Identification and Assessment Issues

2.5.1 Introduction

Identification and recognition of depression are the first steps in helping a child or young person get the help they need. Teachers and other professionals in school have an important role to play in prevention, early identification and in supporting children and young people with depression (Moor, Maguire, McQueen, Wells, Elton, Wrate, & Blair,

2006). There are a number of ways that schools can use to actively promote the emotional health and well-being of all children.

Because children's difficulties are likely to surface within the complex social and achievement milieu of the school, school personnel are in a position to spot indicative symptoms before, or even more reliably than parents (Peterson, Wonderlich, Reaven, & Mullins, 1987). This is especially true when the parents' contribution to familial distress causes them to deny the existence of their child's depressive behaviours (Peterson et al., 1987).

2.5.2 Teacher Identification and assessment of depression and other school related problems

A study by Ines and Sacco (1992) found moderate correspondence for teacher ratings and student self-ratings of depression. Instruction (to teachers about depression) improved knowledge, but not correspondence. School related behaviours yielded the highest correspondence. This study examined several factors influencing the correspondence between teacher and student ratings of depression. First, the teacher rating scales may have ineffectively assessed their true awareness of depression in their students. In earlier studies, teachers made global judgements of overall depression level and the results reflected moderate to low correspondence between teacher ratings and levels of depression (Jacobsen, Lakey, & Strauss, 1983).

According to a national survey of school psychologists (Harris, Gray, Rees-McGee, Carrol, & Zaremba, 1987 cited in Shah & Morgan, 1996, p. 337), classroom teachers were the first to report a potential problem in 54 % of the cases referred to school psychologists. A substantial portion of these children were referred for problematic social behaviours or deficits in social competence. With further evaluation, some of these children may show psychological disorders that would warrant some type of intervention by school psychologists or other practitioners (Harris et al., 1987 cited in Shah & Morgan, 1996, p. 337).

The objective of a study by Shah and Morgan(1996), was to determine if teachers could discern differences in situational social competence in children who, independent of their teachers' knowledge, had reported either high or low levels of depressive symptoms. The results of the study suggested that children who reported high levels of depressive symptoms were identified by teachers to show problematic behaviour in social situations (Shah & Morgan, 1996).

The study by Shah and Morgan (1996) elicited complex and challenging questions of "cause and effect" that is, are children depressed because they lack social competence, or is the social incompetence the result of their being depressed, or is there an interactive or synergistic effect between these two factors (Shah & Morgan,1996)? These questions might be addressed by longitudinal studies that examine whether children with social incompetence show a greater tendency to later develop depressive symptoms, or,

conversely, whether children show a significant decrease in social competence with the onset of depression (Kennedy, Spence, & Hensley, 1989).

A recent study by Moor, Maguire, McQueen, Wells, Elton, Wrate, and Blair (2006), evaluated the effectiveness of a schools' based psycho-educational intervention designed to help teachers recognize the symptoms of depression in children. The ability of the experimental group (who received training) and the control group (who did not receive training), did not improve after instruction in the recognition of symptoms of depression.

A comparative study of teachers from Norway and Estonia (Kikas, 2004) had two aims. Firstly it sought to establish through comparison which group of teachers was more knowledgeable in 3 different areas of childhood psychopathology, one of which was childhood depression. It was found that both groups of teachers had good overall knowledge about childhood depression. However, both groups of teachers underestimated the seriousness of depression.

Secondly the study evaluated how the two different groups helped children with depression. The results reflected that teachers found disruptive and aggressive behaviour to be more of a serious nature than withdrawn behaviour. It is assumed that this is the reason that children with emotional internalizing disorders (such as depression) are often ignored by teachers (Cooper & Bilon, 2002). The results indicated that both groups of teachers were able to list important ways to help children with depression (Kikas, 2004).

Teachers play a major role in the identification and assessment of children's academic and behavioural problems, and make primary decisions on how to help them (Cooper & Bilon, 2002). Snider, Busch, and Arrowood (2003) report that teachers are involved in making the initial referral for academic and behaviour assessment 40 % to 60 % of the time. It is therefore of critical importance that teachers are knowledgeable and objective if they are to play a role in the identification of children's psychological problems and subsequent referral to mental health professionals. Since teachers are often faced with the consequences of depressive symptoms in the classroom a good knowledge of the causes of those symptoms is important (Cooper & Bilon, 2002).

Despite arguments to increase attention to extra-familial sources useful in gathering information on children's behavioural and emotional functioning, teacher ratings continue to be underused sources of information in the assessment of childhood pathology (Epkins,1993). Teachers have been used in the assessment of externalizing disorders (Pelham, Gnagy, Greenslade, & Milich,1992). This is likely because the behaviours assessed are objective and lend themselves well to being observed and judged reliably by others. In contrast, internalizing symptoms such as anxiety and depression are more difficult for others (like teachers) to observe because of the subjective nature of the symptoms (Achenbach, McConaughy, & Howell,1987).

Teachers can accurately identify students at risk for future school failure (Shinn, Tindall, & Spira, 1987;) based on academic, behavioural and emotional need (Abidin & Robinson, 2002). However, it has been reported that they often do not refer these students

for assistance (Shinn et al.,1987). Internalising problems of anxiety and depression, however, are both under-identified and under-referred by teachers (Abidin & Robinson, 2002; Pearcy, Clopton, & Pope, 1993).

Researchers have compared teachers' ratings of depression to children's self-report on the Children's Depression Inventory (CDI) (Kovacs, 1983), and found inconsistent findings when teachers' global ratings were used, ranging from low and non-significant correspondence (Sacco & Graves, 1985) to moderate but significant agreement (Ines & Sacco, 1992). One study has compared teacher reports for children in community and clinical samples. Using comparable measures, Sawyer, Baghurst, and Mathias (1992) found 10-to-16-year-olds self reported significantly more externalizing behaviours than their teachers, while clinic-referred children reported significantly less externalizing behaviours and reliably more internalizing behaviours than their teachers reported.

In a report on investigating the links between mental health and behaviour in schools by the Scottish Executive (2002), the following significant details about teachers' ability to recognize externalizing and internalizing symptoms are reported : although it is argued that teachers are more sensitized to the link between behavioural problems and emotional disorders (Connor, 2003), a degree of consensus was evident that those children who were disruptive were most likely to be identified and conversely, that those whose behaviour was withdrawn or passive would be more likely to be overlooked since they posed no immediate threat to classroom order (Frey & George-Nichols, 2003).

The report highlighted the fact that teachers were sensitive to the link between emotional disorders (depression) and externalizing symptoms, but that they (teachers) lacked the capacity to identify what underpinned this link (Head, Kane, & Cogan, 2003). Some teachers in the interviews indicated that withdrawn children were more difficult to identify in class. Their response that boys typically 'act out' and girls typically 'act in' is well documented in studies (Kyriakou, 2001). Consequently, if schools have greater difficulty identifying the needs of very quiet children, this may operate to the disadvantage of girls experiencing emotional problems in their lives (Head et al., 2003).

A study by Campbell (2004), reported on the process utilized by two Australian high schools that trialled an identification process for at-risk students for anxiety/depression using indicated prevention programmes. The study reported on the benefits of using teachers, support staff and student self-identification in the process outlined. Students are identified in multiple settings (such as home, classroom and playground) by multiple informants (such as parents, teachers, peers and self-report) using a variety of methods (such as teacher nomination, rating scales, observation, self-reports. Teacher nominations are often the starting point for referral of students in school (Gresham, MacMillan, & Bocian, 1997).

The results of the study by Campbell (2004) supported the effectiveness of the process that used both teacher referrals and student self-report to identify students who were "at-risk" or showed mild symptoms of anxiety and depression. Classroom teachers identified

37% of all the identified students in the urban school with 48% in the rural school (Campbell, 2004).

Although it has been suggested that school staff are poor at identifying students with internalizing problems (Abidin & Robinson, 2002; Conoley & Conoley, 1991), the staff at the two schools in this study seemed to be quite aware that these problems existed and were somewhat accurate in identifying individual students with early signs of an internalizing disorder. The results supported the effectiveness of the process that used both teacher referral and student self-report to identify students who were “at-risk” or showed mild symptoms of anxiety and depression (Campbell, 2004). A similar process of teacher and support staff identification of at-risk students has been shown to be successful in the primary school (Campbell, 2003).

Emotional difficulties, and especially depressive symptomatology, constitute a serious and relatively frequent childhood problem which is often overlooked (Kleftaras & Didaskalou, 2004). Teachers' responses to pupils' depression seem to be related to their understanding concerning the causes of this problem (Kleftaras & Didaskalou, 2004).

The aims of the study by Kleftaras and Didaskalou (2004), was to examine teachers' readiness and ability to identify those pupils who manifested signs of depression. The study also sought to ascertain teachers' perceptions concerning the causation of pupils' behavioural-emotional problems including depression. The results indicated that while approximately 30 percent of the students manifested a high level of depressive symptoms, their teachers seemed to lack readiness and skills in identifying their

symptoms. The teachers reported more externalizing behaviour problems and tended to attribute students' difficulties to factors lying outside the school context. These results have implications in terms of programmes for greater support for pupils experiencing depressive symptoms (Kleftaras & Didaskalou, 2004).

An interesting finding by Percy, Clopton, and Pope (1993) was that teacher referral increased as the severity of the student's externalising problems increased but decreased as the internalizing problems of the students became more severe. The results indicated that teachers had more experience with referring students with externalising behaviours than those with internalising behaviours. They considered that "internalising problems such as anxiety and depression may go unnoticed more often than the disruptive externalising problems of hyperactivity and aggression", due to the greater classroom disturbance of externalising behaviours (Percy, Clopton, & Pope, 1993, p. 166).

Even though teachers are not very accurate in identifying specific mental health concerns, they are none the less, crucial to the success of interventions in schools (Percy et al., 1993). Therefore, their involvement in the identification process is one way to ensure support and cooperation in intervention programmes in schools. These programmes need to be time efficient because of teachers' work intensification (Patton, Glover, Bond, Butler, Godfrey, & DiPietro, 2000).

2.5.3 Conclusion

If teachers are employed for the assessment of externalizing behaviours, and no efforts are implemented to assess internalizing symptoms, treatment efforts may be compromised if an undetected internalizing disorder is present (Verhulst & van der Ende, 1991). It is unfortunate that few studies have addressed teachers' ratings of internalizing symptoms in school children. It is important to determine teachers' effectiveness at identifying the presence and severity of internalizing symptoms not only to simply validate other measures, but also to determine if teachers can be helpful as monitors of treatment effects (Verhulst & van der Ende, 1991).

2.6 Management Strategies - Intervention Programmes

A primary rationale for prevention of mental health disorders is that the current mental health system is not reaching most children and adolescents who need help (Martin & Cohen, 2000). Large scale prevention programmes could at least double the number of children who receive attention for mental health disorders (Martin & Cohen, 2000). Up to 30 % of children display some form of depressive disorder during their school career resulting in behavioural and or social adjustment. Their difficulties may affect their academic and social development (Martin & Cohen, 2000).

In addition to the abovementioned areas of concern, the current behaviour profile of children and adolescents is disturbing: risky sexual acts, poor academic achievement and drug abuse (Durlak, 1995). Some researchers contend that the current mental health system is so strained that it does not make sense to expend part of the critical resources

on prevention, particularly primary prevention that involves currently normal children (Durlak, 1995). From a public health perspective, some simple arithmetic suggests that there is a greater need for primary prevention than for treatment of diagnosed mental health disorders (Durlak, 1995).

Although the above comments were made for the American population, the researcher believes that the comments bear a striking similarity to the situation in South Africa. Although research statistics are not quoted here, anecdotal evidence together with the researcher's experience in the field of education and psychology, suggests that the comments in the American literature about the mental health system, the delinquent acts of the children of today and the decline in academic performance is similar to the South African situation (Researcher's opinion).

Prevention and early intervention initiatives can be classified as universal, selective and indicated programmes (Munoz, Mrazek, & Haggerty, 1996). Universal programmes are offered to all students, while selective programmes work with students considered at risk of developing a disorder. Indicated programmes target students who have mild symptoms of a disorder. Universal programmes, by including all students, avoid the need for any identification of participants. They have the potential to be embedded in the regular curriculum and avoid any stigma attached to the selection of students (Munoz et al., 1996).

Shochet, Dadds and Holland (2001) reported on a study that implemented a depression prevention programme within the school curriculum. Children in the programme received a 11-session, small group programme, largely modelled on cognitive therapy approaches. The results of the study illustrated a significant reduction in depressive symptoms that continued unabated at the 10-month follow-up. The 11 hours of therapist time per successful participant seemed more efficient than clinical treatment. As a result of the findings of this study, the researchers argued for the wider implementation of universal prevention programmes of depression (Shochet et al., 2001).

Clarke, Hornbrook and Lynch (2001) achieved a similar result in 150 adolescents with symptoms of depression. Using the same cognitive therapy programme as Shochet et al., (2001), they found that after 12 months, the incidence of major depression in the intervention group was about half of that in the control group (14.5% v. 25.7%). Using the same calculations as Shochet et al., (2001), Clarke et al., (2001), presumed that prevention was cheaper than waiting for these adolescents to develop into cases and then treating them.

Health promotion interventions assume that enhanced functioning resulting from skills acquisition will ultimately be preventative for any number of reasons; for example, individuals will be better able to deal with stress, will be more adept in social situations, have greater self-confidence, or be interpersonally more flexible and adaptable (Martin & Cohen, 2000). In contrast secondary prevention is prompt intervention with individuals displaying sub-clinical problems. It involves some systematic screening or evaluation

process to identify those in a population displaying early signs of dysfunction (Martin & Cohen, 2000).

MindMatters (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000) is a mental health promotion programme aimed at promoting the mental health and wellbeing of all young people in school. However, this programme also recognises the need for specific, targeted interventions to address the needs of students who require additional support for mental health problems (Wyn et al., 2000).

Recent epidemiological studies in Australia have found that adolescent mental health issues are an important public health problem (Sawyer, Arney, Baghurst, Clark, Graetz, & Kosky, 2001). These problems are often manifested in the classroom. As many as one in five Australian children aged from 4 to 17 have significant mental health concerns (Zubrick, Silburn, Burton, & Blair, 2000). However, only one in four of these young people receive professional help (Sawyer et al., 2001).

To assist in preventing mental health problems, schools in Australia have been trialling innovative strategies in mental health promotion, prevention and intervention such as the Gatehouse Project (Patton, Bond, Butler, & Glover, 2003) and MindMatters (Wyn et al., 2000). When selected or indicated prevention strategies are employed there is a need for identification of those students either at-risk or who have mild symptoms of a disorder. This process needs to be efficient and effective, using multiple informants and multi-methods (Zubrick et al., 2000).

Prevention and early intervention of mental health disorders during the critical adolescent period has been called the “window of opportunity” (Martin & Cohen, 2000, p. 1549).

The ability of adolescents to reflect on their inner distress and the emergence of efficacious early interventions makes the early identification of young people crucial (Reinherz, Paradis, Giaconia, Stashwick, & Fitzmaurice, 2003). Schools, where adolescents spend half their waking hours, is often the place chosen for mental health promotion, prevention and early intervention efforts because of the ease of access to the adolescents (McBride, Midford, & James, 1995).

Schools are potentially able to offer prevention and intervention measures that address mental health problems from a developmental and ecological perspective, thus enabling the promotion of wellbeing for the majority while preventing escalation of difficulties for those students already experiencing problems (Barnes, 1998). Two examples of successful mental health promotion, prevention and early intervention programmes in Australian secondary schools are the Gatehouse Project (Patton et al., 2003) and MindMatters (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000). The Gatehouse Project (Patton et al., 2003) addresses the social context of high schools in order to change students’ sense of school connectedness and therefore promoting the social and emotional development of young people. The strategies used are multi-level including curriculum-based materials for all (i.e. a universal approach) (Patton et al., 2003).

“Child-friendly schools” are a World Health Organization (WHO) mental health initiative to promote a sound psychosocial environment in the school to complement the life skills

curriculum (World Health Organization, 2004). A child-friendly school encourages tolerance and equality between boys and girls and different ethnic, religious and social groups. It promotes active involvement and cooperation, avoids the use of physical punishment, and does not tolerate bullying (World Health Organization, 2004). The school should be developed as a supportive and nurturing environment, providing education which responds to the reality of the children's lives. Finally, it helps to establish connections between school and family life, encourages creativity as well as academic abilities, and promotes the self-esteem and self-confidence of children (World Health Organization, 2004).

Children with mental health problems do not get enough help in schools, according to a report on a study published in Britain (Ross, 2006). The study came amid concern over rising numbers of children with a range of mental health issues. The study, conducted by researchers in London, indicated that teachers were concerned about the impact arising from the inadequate support of pupils with mental health needs (Ross, 2006). It was reported that the government has suggested that schools could play a key role in providing mental health services (Ross, 2006). The report highlighted the fact that teachers often struggled to identify pupils with mental health problems such as anxiety, depression and social withdrawal. The report recommended more training for teachers in managing pupils with mental health problems. The researchers reported that the government should develop more support for schools to help them identify and tackle behavioural problems due to mental health, including referral for more specialist help (Ross, 2006).

Children's experiences in school have the capacity to promote developmental competencies associated with learning and achievement motivation, emotional functional and social relationships (Roeser & Eccles, 2000). Schools remain a crucial social institution for the education of children in preparation for life. They also need to be more involved in a broader educational role fostering healthy social and emotional development of all pupils (Zubrick et al., 2000).

2.7 Diagnostic Criteria

2.7.1 Introduction

Although the assessment of depression starts with using diagnostic criteria, such as those proffered in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV: American Psychiatric Association (APA), (1994) or in the International Classification of Diseases (ICD –10 cited in Harrington, 1993, p. 8), a comprehensive assessment must use complementary types of evaluative methods.

According to the reports by the National Institute of Mental Health (NIMH), the prevalence rates of depression in children and adolescents are increasing (Lewinsohn, Hyman, Roberts, Seeley, & Andrews, 1993; National Institute of Mental Health, 2000). It is unlikely that the genetic make up of the population changed substantially to account for the increase in depression in younger people. However, it is more probable that the increase in prevalence rates resulted from environmental factors or the interaction of environmental and genetic factors (Gershon, Hamovit, & Nurnberger, 1987). Cultural

trends such as greater social mobility and the breakdown of the family might create more stress and reduce available resources for coping, thereby resulting in more depression (Gershon et al.,1987).

2.7.2 Prevalence of depression in children

Collapsing data from eight epidemiological surveys of children that were completed between 1987 and 1993, Hammen and Rudolph (1996 cited in Gilbert, 1997, p. 223), found overall rates for major depressive disorder to be between six percent and eight percent. Between two percent and three percent of 6-to 11 year old youths are reported to have a depressive disorder, and between five percent and eight percent of adolescents are reported to have depressive symptoms. Birth – cohort studies provide some evidence that prevalence rates of depression are increasing (Hammen and Rudolph, 1996 cited in Gilbert, 1997, p. 223).

Several reports suggest that the prevalence rates of depression in Western cultures may be increasing (e.g., Lewinsohn, Hyman, Roberts, Seeley, & Andrews,1993). In addition, these reports suggest that average age of onset may be decreasing (National Institute of Mental Health, 2000). Recently researchers have reported that by 14 years of age, as many as 9% of children have experienced at least one episode of severe depression (National Institute of Mental Health, 2000).

A number of epidemiological studies have reported that up to 2.5 percent of children and 8.3 percent of adolescents in the United States suffer from depression (Shaffer, Fisher, &

Dulkan, 1996). An NIMH-sponsored study of 9 – 17 year olds estimates that the prevalence of depression is more than 6 percent in a 6 month period. In addition, research indicates that depression onset is occurring earlier in life today than in the past decades (Shaffer et al., 1996).

The National Institute of Mental Health (NIMH) in the USA estimates that up to 11 % of young children and adolescents suffer from depression, with 50 % of those having another psychiatric disorder (NIMH, 2000). Of children treated for major depression, 66 % to 70 % will experience a relapse (NIMH, 2000). In spite of its high incidence, depression remains one of the more difficult disorders for parents, teachers, and health care providers to identify (NIMH, 2000).

A survey published in the UK in 2000 showed that 10 per cent of children aged 5 to 15 years had a mental health problem According to The Stationery Office, (2000), the three most common groups of childhood mental health problems are:

- emotional disorders (such as depression and anxiety)
- hyperactivity (involving inattention and over-activity)
- conduct disorders (involving awkward, troublesome, and aggressive behaviour).

Several recent surveys of Australian youth have found that a significant proportion of school age students have mental health problems (Sawyer, Arney, Baghurst, Clark, Graetz, & Kosky, 2001; Zubrick, Silburn, Burton, & Blair, 2000). The prevalence rate of depression in children and adolescents in Australia, aged from 4 to 17-years-olds, distributed in gender groups, has been estimated to be 14% (Sawyer et al., 2001).

However, these figures have been estimated to be as high as 20% - 25% for adolescents from 12 to 17 year old (Zubrick et al., 2000).

An Australian study using self-report of depressive symptoms with students in Melbourne, Australia (Patton, Coffey, Posterino, Carlin, & Wolfe, 2000), found that 30% of students fulfilled criteria for a depressive episode, plus one in five who did not meet the criteria and still reported depressed mood. The prevalence of 28% and 46% of students with anxious/depressed symptoms seems comparable to other studies (Patton et al., 2000). Roberts, Andrews, Lewinsohn, and Hops (1990) in their study found up to 50% of adolescents reported high levels of depressive symptomatology.

A South African study found that 10, 3% of children aged 11 – 14 years were found to have displayed depressive symptoms (Naidu, 2003). According to the South African Depression and Anxiety Group, a study of 9 to 17 year olds reported that more than 6% were depressed (Sadag, 2007).

In South Africa cultural and sub-cultural influences on prevalence rates have yet to be resolved. There is some evidence that culture can modify the expression of depression symptomatology in some groups, resulting in under diagnosis of the condition. The reasons why depression is less frequently diagnosed in certain non-westernized ethnic groups in Southern Africa are complex (Schlebusch, 1992).

In some of the African languages, for example, the word depression does not even occur, although there are alternate words which express related distress (Ben-Tovim, 1987).

Likewise, a lack of the concepts of chance in the world-view of some traditional African

people lead to them blaming external forces, such as the supernatural, ancestors, or humans employing the supernatural means to bring about misfortune or disease (Schlebusch 1992). This confuses the diagnosis of depression and could contribute to it being overlooked as a disorder requiring treatment (Ben-Tovim, 1987; Schlebusch, 1992).

Research has found a correlation between depression in adolescence and depression in young adulthood (Rao, 1994). The significance of these research findings is that if depressive symptoms are not resolved in adolescence, the chances are that depression may resurface in young adulthood. An equally alarming finding is that this prevalence rate is increasing (Zubrick, Silburn, Vimpami, & Williams, 1999). Furthermore, it appears that mental health problems and disorders appear to be affecting people at younger ages than previously. These problems significantly affect young people's quality of life and are often manifested in schools (Zubrick et al., 1999).

2.7.3 Diagnostic criteria of the National Institute for Mental Health

The National Institute of Mental Health (NIMH) suggests that if one or more of these warning signs of depression persist for one month or more, the child should be referred to a mental health professional (NIMH, 2000):

- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomach aches or tiredness
- Frequent absences from school or poor performance in school
- Talk of, or efforts to run away from home

- Outbursts of shouting, complaining, unexplained irritability, or crying
- Being bored
- Lack of interest in playing with friends
- Alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Reckless behavior
- Difficulty with relationships

The following are specific examples of behaviours that a child with depression might exhibit (The Depressed Child, 1992):

- A child who used to play often with friends may now spend most of the time alone and without interests.
- Things that were once fun now bring little joy to the depressed child.
- Children and adolescents who are depressed may say they want to be dead or may talk about suicide.
- Depressed adolescents may abuse alcohol or other drugs as a way to feel better.
- Children and adolescents who cause trouble at home or at school may actually be depressed but not know it. Because the youngster may not

always seem sad, parents and teachers may not realize that troublesome behaviour is a sign of depression.

2.7.4 The Diagnostic criteria of DSM IV and ICD-10 Criteria

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994) provides a list of symptoms to assist with the diagnosis of major depression. A minimum number of symptoms must be present, for a minimum time period, for a diagnosis of major depression.

The current formal diagnostic systems are the 10th revision of the International Classification of Diseases (ICD-10), World Health Organization, 1992 cited in Harrington, 1993, p. 6), and the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994). The DSM IV uses clinical criteria (i.e. symptoms and behavioural signs) to classify subtypes of depressive experience and functional impairment (Hammen & Rudolph, 1996 cited in Gilbert, 1997, p. 223).

The specific diagnostic criteria of the DSM-IV for depression are:

- Persistent sad or irritable mood
- Diminished interest or pleasure in activities once enjoyed
- Significant changes in body weight or appetite
- Difficulty in sleeping or oversleeping
- Psychomotor agitation or retardation

- Unexplained loss of energy or fatigue
- Feelings of worthlessness or inappropriate guilt
- Diminished ability to think, concentrate or remember
- Recurrent thoughts of death or suicide

Symptoms must coexist for two weeks and produce significant functional changes and represent a change from previous functioning (APA, 1994; Kaplan 1994 cited in Gilbert, 1997, p.222; National Institute of Mental Health, 2000). Pre-pubertal children often exhibit sad affect, exaggerated somatic complaints, psychomotor agitation, separation anxiety, fears, hallucinations, irritability, uncooperativeness, and disinterest (Kashani, Holcomb, & Orvaschel, 1986 cited in Gilbert, 1997, p. 222; Ryan, Puig-Antich, Ambrosini, Rabinovich, Robinson, Nelson, Iyengar, & Twomey, 1987). Adolescents experience a loss of interest in activities, feelings of hopelessness, hypersomnia, weight changes, use and abuse of illicit substances, and suicidal ideation and attempts (Ryan et al., 1987).

Depressive symptoms in children can be subtle and varied depending on the severity of the disorder (Lamarine, 1995). Listlessness, diminished ability to concentrate, and eating and sleeping disorders all have been associated with childhood depression. Anhedonia, the inability to experience pleasure, is characteristic of many depressed persons as are feelings of anger, boredom, and apathy. Differentiation between normal and pathological status is usually related to the persistence of symptoms and to their level of interference with normal functioning (Lamarine, 1995).

2.8 Conclusion

The use of the diagnostic criteria of the DSM IV, the ICD, and the NIMH criteria probably excludes some cases of childhood depression by failing to incorporate the age-related influences of cognitive, emotional, behavioural, and social development on symptom expression (Cicchetti and Schneider-Rosen, 1986; Hammen & Rudolph, 1996 cited in Gilbert, 1997, p. 221).

This chapter has examined the current thinking and research on the causes, manifestations and diagnosis of childhood depression. Chapter three critically examines models and theories that have been postulated to clarify the etiological factors of depression and relates them to the theoretical framework for this study.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.1 Introduction

Chapter three presents an overview of the various theories that attempt to clarify the etiology of childhood depression. Classical theories of psychoanalytic, cognitive, behavioural and biological theories will be discussed in an attempt to elucidate the etiology of depression. The discussion will conclude with a comprehensive synopsis of the developmental psychopathology theory that framed this research study.

Stated simply the determination of the etiology of a complex concept such as depression is a difficult and complicated process involving numerous hypotheses. This process is characterized by inconsistencies and confusions. Current accepted theories are modified and expanded on. There is always a search for the answers to the questions of what causes mental disorders such as depression and how they can be prevented. It must be noted that in terms of research on the etiology of childhood depression, the progress is in its early stages (Messer & Gross, 1995). Although it is tempting to identify a single causative agent of childhood depression, it is becoming increasingly clear that multi-factorial analyses must be utilized to carefully assess the biological, psychological, and

socio-cultural factors that may contribute to this disorder (Cicchetti & Toth, 1998; Hammen, Burge, Daley, Davila, Paley, & Rudolph, 1995).

The study of depression in children and adolescents has gone through a series of contradictory formulations as theorists have attempted to understand this complex form of disorder in children and adolescents (Cicchetti, Rogosch, & Toth, 1994). Historically, little empirical work was done in the area of childhood depression because of the controversy that surrounded the very existence and nature of childhood depression (Kaslow, Brown, & Mee, 1994). From the 1980's, a consensus position has emerged in which depression in childhood is considered to be similar to depression in adults. The emergence of this consensus view has enabled research in the field to burgeon (Kaslow et al., 1994).

Conceptualizations have ranged from Freud's explanation that people with depression respond to psychological loss by turning their anger inward (Freud, 1917 cited in Gilbert, 1997, p. 221), to the belief that depression in children was impossible due to the immaturity of ego development prior to adolescence and the concomitant inability to experience guilt (Rie, 1966, cited in Cicchetti, Rogosch, & Toth, 1994, p. 123), to the belief that depression in children is prevalent (Cytryn & McKnew, 1972), to the assertion that symptoms indicating depression are the same across the age span from childhood to adulthood (Puig-Antich, 1980, cited in Cicchetti, Rogosch, & Toth, 1994, p. 123). Such divergence in thinking indicates that the topic of depression in children and adolescence is an area of active and significant theoretical and empirical inquiry

(Cicchetti et al., 1994).

Several theories have been proposed, looking at psychodynamic, cognitive-behavioural, family/ genetic, social, biological and developmental psychopathological models as the basis for depression. A number of biochemical agents, called neurotransmitters, have been identified that may underlie depression (Conner, 2001). Bio-psychosocial models of depression suggest that a number of factors like genetic vulnerability, developmental events, physiological stressors and personality traits, may interact or operate singularly as a cause of depression (Conner, 2001). Psychosocial models of depression suggest that depression is a result of interaction with the environment. Social models of depression suggest that certain events in the person's life can precipitate the fall into depression (Conner 2001).

While it is at present generally accepted that children do experience depressive symptoms, there are many disparate views about the theories of the etiology of depression (Cicchetti, Rogosch, & Toth, 1994; Rutter, Izard, & Read, 1986). Many of the explanations of causes of childhood depression represent downward extensions of theory and empirical findings from the study of depression in adulthood (Rutter et al., 1986).

These explanations may view depression as:

- A response to stress or negative life events
- A consequence of distortions in cognitions or attributional style
- A result of learned helplessness arising from perceived loss of control over events
- The result of interpersonal skill deficits or lack of social support
- An outgrowth of early unresolved loss or separation experiences and

- A genetically inherited disorder resulting in neurophysiological anomalies (Rutter, Izard, & Read, 1986 cited in Cicchetti, Rogosch, & Toth, 1994, p. 124).

3.2 Psychoanalytic Theories of Depression

Many theories of the etiology of depression have arisen from the psychoanalytic perspective. Only two of importance will be included in this discussion.

3.2.1 Reaction to loss - Sigmund Freud

In the first model, that of Freud (1917 cited in Speier, Sherak, Hirsch, & Cantwell, 1995, p. 468), depression is seen as anger turned inward. Freud compared depression with grief, but emphasized the importance of loss of self-esteem in depression. He theorized that the anger and disappointment that had previously been directed toward a lost object are internalized, leading to a loss of self-esteem and a tendency to engage in self-criticism. Freud believed that the predisposition to this reaction to loss has its origins in a particular early childhood experience in which the young child experienced a loss of the mother, or of the mother's love. In order to lessen the impact of this loss, the child learns to internalize a representation of the lost object. The anger directed at the lost object, however, is now directed at a part of the child's own ego, thereby predisposing to future depressive episodes following significant losses (Freud, 1917, cited in Speier, Sherak, Hirsch, & Cantwell, 1995, p. 468).

Studies of boys and girls using self-report measures find that children with high scores of depressive symptoms can outscore their peers in measures of outward - directed hostility (Akiskal & McKinney, 1975 cited in Speier, Sherak, Hirsch, & Cantwell, 1995, p. 468).

In other words, they express their anger outwardly rather than inwardly (Puig-Antich, Lukens, Davies, Goetz, Brennan-Quattrock, & Todak, 1985).

3.2.2 Object loss - Bowlby

The second psychoanalytic theory proposed in the etiology of depression is that of object loss, or separation (Bowlby, 1960 cited in Gilbert, 1997, p. 221). Psychoanalytic conceptualizations of depression regard as central to this disorder the imagined or real loss of a valued or loved " object " through death, separation, rejection, or symbolically, through the loss of some ideal concept. Object loss is theorized to be the "final stress" that precipitates a vulnerable individual into depression (Beardslee, Schultz, & Selman, 1987 cited in Speier, Sherak, Hirsch, & Cantwell, 1995, p. 468).

Furthermore, psychoanalytic theorists also emphasize the importance of loss in early childhood and the quality of the mother-child relationship in the first year of life, as vulnerability factors for subsequent depression. Bowlby (1960, cited in Gotlib & Hammen, 1992, p. 48), in particular, believed that adult depression is related to the failure in early childhood to form a stable and secure attachment with the parents, or to the experience of actual loss of a love object. The key role of attachment and the pathological effects of separation in infancy and childhood were elaborated on by Bowlby (Bowlby, 1980 cited in Gilbert, 1997, p. 221).

information processing, and negative self-schemas. The cognitive triad refers to a depressotypic pattern of thinking in which depressed persons exhibit a negative view of themselves, their current situation, and the future (Beck, 1976 cited in Kazdin, 1990, p. 141). According to Beck (1974), the existence of the cognitive triad is apparent through the misperceptions and misinterpretations by depressed persons of their environment. Beck (1974) contends that the cognitive triad is responsible for many of the typical depressive symptom patterns, including deficits in affective, motivational, behavioural, and physiological functioning.

Beck also suggests that depressed persons are characterized by a number of common systematic errors in thinking, including arbitrary inference, selective abstraction, overgeneralization, magnification and minimization, personalization and all-or-none thinking. Beck formulated the term "negative self-schema" to explain why depressed persons persist in self-defeating attitudes in the face of contradictory evidence. According to Beck's theory, in a formulation suggestive of those offered by psychoanalytic theorists, schemas develop from early negative experiences in childhood (Beck, 1987 cited in Kazdin, 1990, p. 191).

Partial support for Beck's theory was found in a study by Sacco and Graves (1984). The results of the study found that depressed children attributed positive events to external causes and negative events to internal causes more than non-depressed children, reflecting a negative style posited by cognitive theories of depression (Sacco & Graves,

1984). These results are consistent with those reported by Leon, Kendall, and Garber (1980).

3.3.2 Martin Seligman - Theory of Learned Helplessness

The reformulation cognitive theory that has received the most empirical and theoretical attention is that outlined by Abramson, Seligman, and Teasdale (1978). These theorists proposed that the individual's attributional style, or way of explaining things, is important. For example, if an individual experiences a negative outcome and then attributes that negative outcome to internal, stable and global causes, then that person is at risk for depression. A person exposed to uncontrollable stimuli exhibits deficits in response to initiation and learning. When human beings experience events over which they have no control, they perceive that they will have no control over future events, resulting in motivational and cognitive deficits and emotional helplessness (Seligman, Peterson, Kaslow, Tanenbaum, Alloy, & Abramson, 1984).

Seligman et al., (1984) found that a community sample of children with depressive symptoms more frequently endorsed internal, stable, and global explanations for negative outcomes compared with children without depressive symptoms. They also found that the mother's attributional style correlated with the child's, lending support to the belief that this may be a learned process wherein the mother and child reinforce each others' attributional style and symptoms (Seligman et al., 1984).

Studies examining the relations among cognitions, stress and depression in children have found some developmental changes from middle childhood through early adolescence (Nolen-Hoeksema, Girgus, & Seligman, 1992). These researchers found that in 8-year-old children, negative life events, but not attributional style, significantly predicted depressive symptoms, whereas in 11- to 12-year-old children, a pessimistic explanatory style both alone and in conjunction with negative events significantly predicted depressive symptoms (Nolen-Hoeksema et al., 1992).

3.4 Behavioural Theories of Depression

Behavioural theories of depression are concerned primarily with the analysis of overt behaviour. Rather than postulating underlying mental causes for behaviour, these theories focus on understanding behaviour in terms of environmental events that either precede or follow the behaviour. The most influential behavioural theories are the social - skills and activity-level perspective of Lewinsohn (1974 cited in Kaslow, Brown, & Mee, 1994, p. 98) and the self-control model of Rehm (1977).

3.4.1 Lewinsohn- The Social-skill and Activity- Level Theory

The social-skills and activity-level theory of Lewinsohn (1974 cited in Kaslow, Brown, & Mee, 1994, p. 98) has its origins in operant psychology. According to this perspective, depressed persons receive insufficient positive reinforcement from significant others due to the depressives' inadequate social skills for eliciting positive interpersonal responses. These social-skill deficits are viewed as causative in eliciting a depressogenic pattern of reinforcement. Depressed individuals are often less adept at reinforcing others, further

diminishing the rate of reciprocal social reinforcement (Lewinsohn, 1974 cited in Kaslow, Brown, & Mee, 1994, p. 98).

In Lewinsohn's (1974, cited in Speier, Sherak, Hirsch, & Cantwell, 1995, p. 468) behavioural theory of depression, a vicious cycle occurs when the child has a "loss of reinforcement" and thus fails to use his/ her adaptive resources adaptively. This results in maintenance of the depressed state, because the child fails to elicit more positive feedback from others. This is also consistent with the idea of reduced social competence (Lewinsohn, 1974 cited in Speier, Sherak, Hirsch, & Cantwell, 1995, p. 468).

Children learn about themselves and their world from direct feedback from important people in their lives, including teachers (Dweck & Licht, 1980), peers (Hirsch, Engel-Levy, DuBois, & Hardesty, 1990), and parents (Goodman, Adamson, Riniti, & Cole, 1994). When the communications are persistently negative, children assimilate this information into a depressive cognitive schema about themselves and the world (Hirsch et al., 1990).

3.4.2 The Self-Control Theory of Rehm

The self-control theory of depression of Rehm (1977) is derived from the more general self-control theory of Kanfer (1970 cited in Rehm, 1977, p. 789). The theory described the adaptive processes of self-monitoring, self-evaluation, and self-reinforcement. Depressed individuals are believed to have deficits in one or more specific self-control behaviours (Rehm, 1977). In terms of self-monitoring, depressives selectively attend to

negative events to the exclusion of positive events, and they frequently monitor immediate as opposed to delayed consequences of behaviour. They emphasize the setting of unrealistic goals, distorted perceptions of personal success and failure, and a decreased amount of positive self-feedback, and excessive self-abasement. Rehm's self-control model attempts to integrate behavioural and cognitive aspects of the disorder (Rehm, 1977).

It has become apparent that the behavioural theories of depression have evolved from relatively simple and constricted stimulus-response formulations to more complex conceptualizations placing greater emphasis on the individual's characteristics and his/her interactions with the environment (Gotlib & Hammen, 1992). There is a greater awareness that depressed individuals often function in demanding and stressful environments. Moreover, some investigators contend that depressed persons themselves may be instrumental in engendering much of this stress (Gotlib & Hammen, 1992).

Given this changing perspective, it is clear that behavioural researchers and clinicians must examine depressed individuals in the context of their environment (Lewinsohn & Gotlib, 1995 cited in Beckham & Leber, 1995, p. 357)

3.5 Biological Theories of Depression

Biological theories of depression attribute the symptoms and affect of depression to chemical or molecular physical irregularities (Hart, 1991). The nature of the particular irregularities postulated to be responsible for depression varies with different biological

theories. One of the influences on the development of a mood disorder, as well as the age of its onset, is timed biological events that create challenges and provide new opportunities in every developmental phase (Hart, 1991).

Psychopathology in a family can significantly contribute to depression. Family, twin and adoption studies have shown that genes contribute to the risk for depression (Kendler, 1995). Parental depression, especially maternal depression, appears to be a nonspecific risk factor in the development of psychopathology in children (Hammen, Burge, Burney, & Adrian, 1990). Children of depressed parents have been found to be about three times more likely to have depressive episodes themselves, compared to children whose parents have not had depression (Hammen et al., 1990).

A number of investigations have shown that there is a greater prevalence of mood disorders in the relatives of depressed persons than in the general population (Weissman, Warner, & Wickramaratne, 1997) and a higher probability of disorder among relatives who are more closely related (McGuffin & Katz, 1989). Moreover, twin studies reveal greater concordance of depressive disorder in monozygotic rather than dizygotic twins (McGuffin & Katz, 1989). Adoption studies also have been used to disaggregate shared genetic and environmental influences (McGuffin, Katz, Watkins, & Rutherford, 1996). These studies have shown increased rates of depression in biological relatives as compared to adopted children (Cadoret, 1978; McGuffin et al., 1996).

3.5.1 Diathesis – Stress Theory

The broad question that leads to the diathesis-stress theory is whether a family's social or environmental interactions cause depression in children, or whether genetic inheritance of depression causes environmental and social problems (Hilsman & Garber, 1995). The diathesis - stress model posits that although the origins of depression may be attributable to genetics, the course of the disorder is affected by the interplay among biological and environmental factors such as stress and social support (Hammen, Burge, Daley, Davila, Paley, & Rudolph, 1995; Hilsman & Garber, 1995). A major gap in the understanding of genetic modes of transmission lies in the paucity of research in children and adolescents (Speier, Sherak, Hirsch, & Cantwell, 1995).

3.5.2 Developmental geneticists

Developmental geneticists maintain that genetic contributions to psychopathological disorders must be conceptualized within a dynamic framework that considers the operation of genetic factors in concert with environmental factors across the life span (Goldsmith, Gottesman, & Lemery, 1997; Rutter, 1991).

3.6 Developmental Psychopathology Theory of Depression

Developmental psychopathology, a diagnostic mode of analysis that first gained acceptance during the 1970's, represents a complex attempt to coordinate a variety of disciplines- including general developmental psychology, genetics, clinical psychiatry, behavioural psychology, and the medical model - under one rubric (Cicchetti, 1993). Commentaries on developmental psychopathology have referred to the approach as a

synthesis or a mosaic embracing the vast amount of data generated during the past few decades (Cicchetti, 1993).

3.6.1 Characteristics of the Developmental Psychopathology Theory

The first notable feature of the developmental framework is that it is receptive to research gathered from a broad spectrum of diverse sources (Harrington, Rutter, & Fombonne, 1996). In a word, the developmental model permits eclectic analysis: phenomena derived from one particular discipline may be effectively integrated into the developmental model along with data extrapolated from an ostensibly unrelated discipline (Harrington et al., 1996).

The developmental approach embodies this flexibility as a research tool primarily because it posits that fruitful psychiatric analysis can be achieved only when individual capacities and experiences are conceived of as occurring along a chronological continuum, a temporal axis, which spans birth through adulthood (Sroufe & Rutter, 1984). This is not to suggest that behaviours will be continuous, undeviating, or stable over time. Rather the totality of genetic factors with which the child is endowed, as well as the myriad of environmental factors that sculpt experience, need to be viewed as elements contributing to the composite portrait of individual personality (Sroufe & Rutter, 1984).

Secondly, the developmental perspective permits us to analyse how various genetic factors intertwine with environmental factors at any given point in development,

motivating the individual to devise effective coping strategies or in contrast, creating frustrating "snags" in development that may provoke subsequent psychopathology (Harrington et al, 1996).

A developmental psychopathology conceptualization of the depressive disorders of childhood and adolescence espouses the viewpoint that to comprehend human development, it is essential to understand the integration of developmental processes at multiple levels of biological, psychological, and social complexity within individuals over the lifespan (Cicchetti & Toth, 1998). Thus, multidisciplinary efforts to unify and integrate the advances that have taken place in the fields of developmental psychology, clinical psychology, psychiatry, epidemiology, sociology, neurobiology, genetics, and the neurosciences within the developmental psychopathology perspective are essential to address the critical issues involved in the development of depressive disorders (Cicchetti & Toth, 1998).

The developmental model is deemed useful in conceptualizing the interaction between the depressed youth and the environment and the individual competencies and environmental resources associated with resiliency in overcoming depression (Cicchetti & Toth, 1992). It is recognized that cognitive and behavioural processes associated with depression are embedded in the broader framework of developmental psychopathology (Cicchetti & Toth, 1992).

The researcher concurs with developmental psychopathologists who assert that children from diverse familial and cultural environments with varying biological endowments manifest depressive symptoms in age-appropriate ways (Cicchetti & Schneider-Rosen, 1986). This approach highlights the interplay among advances and lags in cognitive, social, emotional, and neurobiological systems for the developing child (Cicchetti & Schneider-Rosen, 1986). The developmental psychopathology model describes the link among attachments with caretakers (parents, teachers), negative cognitive schemata, difficulties with the modulation of negative affect, and the development of depressive symptoms (Kaslow, Celano, & McCarthy, 1994, cited in Kaslow, Brown, & Mee, 1994, p. 98).

Developmental psychopathology draws attention to both the similarities and the differences among normal and psychopathological conditions (Cicchetti, Rogosch, & Toth, 1994). As a result we are able to distinguish the specific pathways leading to various psychopathologies (e.g., depression) as well as to understand the commonalities underlying both normal and psychopathological functioning. Through this integrated developmental approach, informed direction is given to efforts to prevent depressive disorders as well as to the provision of intervention for those who are already experiencing depression (Cicchetti et al., 1994).

Depressive disorders occur at any point in the lifespan. The belief in continuity of depression across the lifespan is reflected in the DSM - IV through the directive to apply a single set of criteria to children, adolescents, and adults (Speier, Sherak, Hirsch, &

Cantwell, 1995). Developmental concerns are acknowledged, in that diagnosticians are permitted to make certain substitutions when establishing a diagnosis of depression. For example, in children, irritable mood is weighted as equivalent to an adult's depressed mood. Similarly, the failure of a child to attain an expected weight gain is considered equivalent to the adult symptom of weight loss (Speier, Sherak, Hirsch, & Cantwell, 1995).

3.6.2 Principles of Equifinality - Multifinality

The principles of equifinality and multifinality derived from general systems theory are relevant in developmental theories (von Bertalanffy, 1968 cited in Cicchetti, Rogosch, & Toth, 1994, p. 126). Equifinality refers to the observation that a diversity of paths may lead to the same outcome. As such, a variety of developmental progressions may eventuate in depression, rather than positing a singular primary pathway to disorder (Cicchetti & Rogosch, 1996). In contrast, multifinality suggests that any one component may function differently depending on the organization of the system in which it operates. Thus, for example, loss of a major attachment figure in childhood will result in numerous outcomes for children depending on the context of their environment and their individual competencies and coping capacities (Cicchetti & Rogosch, 1996).

Given the diversity in process and outcome apparent in development, it should not be surprising that a developmental psychopathology approach to depression does not have a simple, unitary etiological explanation (Cicchetti, Rogosch, & Toth, 1994). The occurrence of depression during the life course most likely results from a multiplicity of

pathways in different individuals (Cicchetti et al., 1994). Although commonalities in pathways in different clusters of depressed children may be delineated, it is also possible that depression is not the only outcome associated with each pathway (Cicchetti et al., 1994). Thus the study of depression needs to be part of a larger body of inquiry into the developmental patterns that promote adjustment difficulties and psychopathology (Cicchetti et al., 1994).

3.6.3 Nature versus Nurture variables within the Developmental Model

Among the risk factors the developmental model dwells on most extensively for diagnosing depression are those arising from child environmental transactions (Kendler, 1995). The developmental model suggests that risk factors that shape these transactions may be characterized as either “genetic” or “environmental” and that these two categories of factors may interact in potentially subtle ways (Kendler, 1995).

As Kendler (1995) argues, discerning the etiology of psychiatric disorders necessitates an understanding of pertinent genetic risk factors, pertinent environmental risk factors, and the mechanism of interaction between these two sets of variables. He has further divided the domain of the environment into two states, the “protective environment” and the “predisposing environment” (Kendler, 1995, p. 896). Contact with the protective environment (e.g., maternal nurturance) reduces the likelihood of psychiatric disturbance. Conversely, contact with the predisposing environment (e.g., maternal abuse) enhances the probability of illness (Kendler, 1995).

3.6.4 Interpersonal life-stress model of depression

Stress and coping models of developmental psychopathology have begun to assume a central position in the child depression literature (Goodyer & Altham, 1991). Initial life-stress conceptualizations implicated exposure to stressful events as a risk factor for the emergence, perpetuation, and recurrence of depressive disorders (Goodyer & Altham, 1991). In support of this view, a growing body of empirical research has revealed consistent, albeit fairly modest associations between the experience of stressful life events and depression in children (Goodyer & Altham, 1991).

However, existing life-stress models often are characterized by an adevelopmental perspective that does not account for the dynamic interface between stress and psychopathology over time (Rudolph, Hammen, Burge, Lindberg, Herzberg, & Daley, 2000).

In a study entitled: "Toward an interpersonal life-stress model of depression: the developmental context of stress generation", Rudolph et al., 2000, investigated the validity of a developmentally based life-stress model of depression. Three major questions were addressed: (a) can a stress –generation model of depression be applied to children? (b) does interpersonal stress play a salient role in child and adolescent depression? (c) what is the role of chronic stress in child psychopathology? The results were consistent with the proposed stress-generation model wherein depressed children precipitated stressful events and circumstances in their lives (Rudolph et al., 2000: p. 220).

Stressful life experiences as well as acute and chronic periods of depression may interrupt the normative progression of developmental milestones (Roeser & Eccles, 2000).

Given the prominent role that schools play in children's lives, the school setting represents a salient context for development and mental health (Roeser & Eccles, 2000).

Stressful experiences and emotional difficulties are therefore likely to undermine a variety of school-related competencies, including academic motivation and school engagement, goal orientation, scholastic performance, and school conduct (Roeser & Eccles, 2000).

A critical tenet of the developmental psychopathology paradigm is its emphasis on a transactional approach to development (Cicchetti, Rogosch, & Toth, 1994). A transactional perspective challenges traditional notions of children as passive recipients of experiences and emphasizes the reciprocal influences between children and their environments (Rudolph et al., 2000). For example, in a recent conceptualization of the role of social context in the development of psychopathology, Rudolph et al., (2000, p. 216) emphasized the need to identify 'modalities of influence' or the processes by which children and their environments exert transactional effects.

The present study adopts a transactional, developmental perspective that considers the mechanisms through which children contribute to their environments. A stress-generation model suggests that depressive symptoms and associated impairment actually may cause individuals to precipitate stress, which in turn may trigger future depression (Rudolph & Hammen, 1999).

Understanding the association between individuals' contributions to the stressful circumstances in which they live and their experience of psychopathology is particularly important in children, given that early life experiences set the stage for future adaptive or maladaptive functioning (Harrington, Rutter, & Fombonne, 1996).

3.7 Future research and conclusion

Future research will benefit from increased attention to the interface between the psychological and biological domains (Cicchetti, Rogosch, & Toth, 1994). How, for example, might insecure internal representational models affect neuro-physiological functioning, and how might genetic heritage alter tendencies for certain forms of representational processes to occur (Cicchetti et al., 1994)? Future research also should provide more detail regarding the differential strength of various risk and protective factors in development and how these vary during different developmental periods (Cicchetti et al., 1994).

Diversity in process and outcome are the hallmarks of the developmental perspective. It is expected that there are multiple contributors to depressive outcomes in any individual, that the contributors vary between individuals, that there is heterogeneity among depressed children in the features of their depressive disturbance, and that there are numerous pathways to any depressive outcome (Cicchetti & Toth, 1998).

The etiology of depression is most likely multi-factorial, with some subsets of depression weighted toward a psychodynamic – cognitive – environmental etiology and others based more on genetic – biological factors (Speier, Sherak, Hirsch, & Cantwell, 1995). This is strongly suggested by the different “paths” seen clinically in depressive symptomatology to depression as a diagnosable condition (Cicchetti, 1993). Some children, under environmental stress move slowly from dysthymia (neurotic depression) to a full blown depressive disorder. Other children without noticeable stressors, rapidly move from a well functioning state into an acute depressive episode (Speier et al., 1995).

SECTION B

3.8 METHODOLOGY

This section of the chapter will outline the research method employed in this study and describe the location of the study, the participants, the measuring instruments, and the procedure of the study.

3.8.1 Introduction

Research is a disciplined attempt to address questions, solve problems, and test hypotheses through careful collection and analysis of data for the express purpose of description, explanation, generalization and prediction (Babbie, 1977).

However, the researcher must not lose sight of the aims and objectives of the research. This means that in the final analysis the research must be able to make valuable and positive inputs into existing knowledge around the topic. This could be achieved via the clarification of those aspects that lead to confusion, debates and even misunderstandings prior to the research being undertaken (Anderson, 1990).

It will be recalled that the purpose of the study was to:

1. Establish if teachers were knowledgeable in identifying the behavioural symptoms of childhood depression.
2. Determine the management strategies used by teachers to manage children who exhibit the behavioural symptoms of depression.
3. Develop a guideline document for school personnel that would assist them in correctly identifying the symptoms and managing children with depression.

3.8.2 Research Questions

The research questions that framed the study therefore are:

1. Are teachers knowledgeable in recognizing the behavioural symptoms of depression in children?
2. How are children with depressive symptoms being managed at school?
3. Do schools need a guideline document to help identify the behavioural symptoms of depression and manage those children displaying depressive symptoms?

3.8.3 Research Methodology

A number of research method options are available to the social researcher. In studying social phenomena qualitative methods of data collection yield a rich variety of insight and information (Bless & Achola, 1988). A direct way of obtaining information is the interview. This process involves direct, personal contact with the participant when answering questions (Bless & Achola, 1988).

The study followed a quantitative and qualitative approach. The two methods used in this study were the survey and interview methods.

3.8.4 Ethical Considerations

Ethical consideration was crucial in this study as sensitive information was shared by the participants. Fully informed consent was obtained from the Department of Education of KwaZulu Natal (Appendix 1&6), the principals of the three schools (Appendix 2), and the participating staff members from each school (Appendix 3).

3.8.5 Selection of topic

During formal and informal visits to the schools by the researcher in a professional capacity, staff would discuss their difficulties with regard to the misbehaviour of the children in their care. Informal sessions with the children revealed that the source of some children's unhappiness stemmed from the flawed relationships with teachers, parents and peers. While some children acted out their unhappiness (difficult and unruly), others became withdrawn and unresponsive.

When the researcher enquired about the management of these difficult behaviours, teachers gave the impression that they were powerless to help these children. Their responses led the researcher to assume that some teachers believed that strong disciplinary action would remedy the situation. Other teachers felt that parenting styles were faulty and some parents were poor role models to their children.

Many of the children who were formally and informally assessed by the researcher, showed classic symptoms of externalizing and internalizing behavioural symptoms of depression. The conceptualization of this study was the result of the interaction between the schools and the researcher. The topic of the study therefore emerged out of a perceived dilemma (researcher's) in the 'misdiagnosing' and the subsequent mismanagement thereof of children's behaviour problems at school.

3.8.6 The location of the study

To the best of the researcher's knowledge, research on teachers' knowledge and management of behavioural symptoms of childhood depression has not been undertaken in the suburbs of Reservoir Hills or Westville in the province of KwaZulu-Natal.

Since the researcher worked on a daily basis in these two suburbs while formally and informally supporting most of the schools in the area, for psychological services, it was a natural course of action for three schools from these two suburbs to be randomly chosen. The researcher envisaged that the results and recommendations from the study would then cascade down to the other schools in these two suburbs and eventually to the schools in the province. It is hoped that this envision is effected by the Department of Education on receipt of a copy of the thesis.

The following three schools were then randomly selected for the reasons stated above: Durwest Primary (School 1), Pitlochry Senior Primary (School 2), and Resmount Primary (School 3). The first and third schools are in the Reservoir Hills suburb and the second school is in the Westville suburb.

3.8.7 Participants

In the three randomly selected schools, all members of staff were expected to complete the first questionnaire. At this administration, 5 members of staff from each school were randomly selected to participate in the semi structured questionnaire, which is questionnaire 2. The gender composition of the sample for both questionnaires matched

/reflected an informal observation by the researcher of the demographics of the teaching staff in primary schools of the two suburbs that the researcher had work experience in. This will be revealed when the profile of the participants is discussed in Chapter 4.

The total number of participants for questionnaire 1 was 56, distributed as follows: Durwest – 19; Pitlochry – 16; Resmount – 21. 12,5% of these were male and 87,5 % were female.

The total number of participants for questionnaire 2 was 15, that is 5 from each of the three schools. The gender composition was: 13,3 % male and 86,7 % female.

3.8.8 Measuring Instruments – The Questionnaires

Two questionnaires were especially designed for this study. Therefore there are no available norms or other statistical data. Although there are descriptive statistics in both questionnaires, much of the analysis was qualitative in nature.

Questionnaire 1 (Appendix 4)

The purpose of this questionnaire was designed to answer the first research question of the study: Are teachers knowledgeable in recognizing the behavioural symptoms of depression?

Questions 1 – 5 at the beginning of the questionnaire contained questions that would provide biographical data, which was used for quantitative and statistical purposes.

Section A – Participants had to state their opinion on the existence and symptoms of childhood depression

Section B – Participants had to agree or disagree with statements about internalizing and externalizing behavioural symptoms of depression

Section C – A table with 10 symptoms of depression was presented. Participants had to rate each symptom as being most important or least important in terms of diagnosing depression

Section D – Participants could comment on a statement about the increasing rate of depression in children. This section was included to ascertain their opinions about the status of childhood depression.

Section E – Participants had to decide on whether a factor caused or resulted in depression. There were 20 factors, all representing the various theories about the etiology of depression. This table was included to answer the first research question. Also an assumption made by the researcher in chapter one was that teachers were not fully knowledgeable about the factors contributing to depression, the behavioural manifestations as well as management of children with depressive symptoms.

Questionnaire 2 (Appendix 5)

The second questionnaire was a semi-structured document with 9 sections. These interviews were conducted on a one-to-one basis. The questions were read to the participants, and they answered while the researcher recorded their responses on an individual form. This questionnaire was designed to answer questions 2 and three of the research questions

Section A – Biographical data

Section B – definition of a term – participants were asked to define “masked depression”

Section C –Participants were expected to discuss their management strategy with a child with internalizing depressive symptoms

Section D -Participants were expected to discuss their management strategy in terms of discussion with parents

Section E -Participants were expected to discuss their views on the contributory factors to depression

Section F - Participants were expected to answer about the support from the department of education in respect of children with depression

Section G –Participants answered whether they were aware of a document from the department of education in respect of children with depression

Section H-Participants were asked if they would support a programme at school that improved the self-esteem of children

Section I –Participants were asked their opinion of the ideal management strategy at school of children with depression

3.8.9 Procedure of study

A pilot study was conducted to validate the questionnaires by identifying and assessing possible problems that could commonly appear during a study. The pilot was an attempt to clear up confusion and misunderstandings that were directly related to the questionnaire, for example:

- time management and length of questionnaire
- ambiguities and confusion of instructional language
- grammatical errors
- repetition of questions

A pilot study was conducted at Rippon Primary school with 5 teachers. After questionnaire 1 was read out, the participants completed it in 20 minutes. There were no queries. This could be interpreted as the questionnaire being free of any errors. However, after completion of the questionnaire, the teachers concerned expressed the urgency with which they needed assistance with difficult children in their classrooms. They said that they now understood that professional help was needed, since whatever they were doing was not bringing the desired results. Questionnaire 2 was piloted on one teacher from the 5 that completed the first questionnaire.

On the conclusion of the pilot study the following facts were arrived at:

Time management and length of questionnaires were satisfactory in terms of allocated time. All items were pertinent to the study and covered all aspects of the research questions. There were no ambiguities or grammatical errors in both the questionnaires. The two questionnaires were found to be suitable for the purposes of the study.

3.8.10 Preliminary Visits

The researcher visited each principal and outlined the nature of the study and administrations of questionnaires (the topic was not mentioned). Each principal verbally

agreed on condition that the study and the use of staff and school time was authorized by the Department of Education. A letter requesting permission to conduct research at the three schools was sent to the Department of Education (Appendix 1)

On receipt of the letter of permission from the Department (Appendix 6), the researcher visited the principals, to set the date for the administration of the first questionnaire. Each principal informed the researcher that they would inform all teachers of the date set for the administration of the questionnaire.

3.8.11 General Observations during the administration of the Questionnaires

In school 3, one person queried if whether it would be ethical for her to complete the questionnaire. It turned out that she was a parent who was helping out at the school for that week. She was duly given permission to leave as the questionnaire was for teachers.

In school 3 one teacher declined participation in completion of the first questionnaire, as she felt that it was time consuming. Furthermore, she said she was currently involved in a six month research programme. After a short discussion as to the nature and duration of the present study, she readily agreed to continue with the proceedings.

3.8.12 Administration of Questionnaire 1

After a short introduction, the participants were informed that although departmental permission as well as principals' permission had been granted, they still could decline to participate. All teachers present were willing to assist with the research programme.

The principal was first asked to sign a consent form to validate their verbal permission (Appendix 2). It must be noted that this would be the first time the principal would know what the topic was, as during the first meeting as well as the permission letter from the department, the topic was not revealed.

Consent letters were distributed to the teachers and collected as they were signed. The principal also received a consent letter. The participants were assured of the anonymity of their responses in the questionnaire. They were informed that they need not write their names or any other identifying information on the questionnaires. They were further reassured that their responses would be kept confidential and used for research purposes only.

The questionnaires were handed out and the instructions for answering each question were read to the participants. One participant in school 1 wanted to know in which box she should tick her age category as she had just turned 30. A minor limitation of this questionnaire was that the age categories were 20 – 30; 30-40 etc. they should have been 20 – 30; 31 – 40 etc. which would have eliminated the confusion.

The questionnaires were completed in 25 minutes. After each participant had finished, they handed the completed questionnaires to the researcher. When all were collected, the researcher proceeded to randomly select 5 members to participate in the second

questionnaire. Those selected were informed that the researcher would return to set dates to suit each individual for the administration of the second questionnaire.

3.8.13 Administration of the second questionnaire

At the outset, each participant was asked if they preferred writing their responses or responding verbally while the researcher recorded their responses. All participants chose the latter option. The researcher assumed that they chose this option as it allowed them to be more expressive as it relieved them of dual tasks of thinking and writing simultaneously.

The first part of chapter three outlined the theories relevant to the etiology of depression. The discussion concluded with the theory that framed this research study. The second part of the chapter described the methodology used in gathering the data that will be analysed and discussed in Chapter four.

CHAPTER FOUR

ANALYSIS OF DATA AND DISCUSSION OF RESULTS

In this chapter the data obtained from the two questionnaires is presented. Discussion of the findings from the analysis of data follows the presentation of data.

4.1 Objectives of the Research Study

The broad purpose of this study was to establish whether teachers were fully knowledgeable in identifying the behavioural symptoms of childhood depression. A related purpose was to determine the management strategies used by teachers to manage children who exhibit the behavioural symptoms of depression. A further purpose was to develop a guideline document for school personnel that would assist in correctly identifying and managing the symptoms of depression in children.

The research questions that framed this research study are:

1. Are teachers knowledgeable in recognizing the behavioural symptoms of depression in children?
2. How are children with depressive symptoms managed at school?
3. Do schools need a guideline document to help identify and manage those children displaying depressive symptoms?

The first questionnaire was designed to provide data to answer the first research question.

The second questionnaire was designed to provide data to answer the second and third research questions. However, data from both questionnaires was used to answer all three research questions.

Assumptions made by the researcher:

1. Teachers are not fully knowledgeable about childhood depression.
2. The management strategies with children with depression are not appropriate.
3. Schools do not have or were not given guidelines for identification and management of depressed children at school.

4.2 General Observations of Participants and Administration of Questionnaires

The participants were the teaching staff members of three randomly selected schools in the Reservoir Hills and Westville suburbs of KwaZulu Natal, South Africa. For questionnaire 1, there were 56 participants made up as follows:

School 1 – Durwest – 19 participants

School 2 – Pitlochry – 16 participants

School 3 – Resmount – 21 participants

For questionnaire 2, there were 15 participants – 5 randomly selected from each school. For the administration of both questionnaires it was observed that the participants were very professional in their interaction with the researcher. They were eager to get started and co operated with the researcher in all respects.

4.3 Statistical Analysis

The *Statistical Package for Social Sciences Programme* was used to analyse the data generated from questionnaire 1 and questionnaire 2.

4.4 Analysis and Discussion of results from Questionnaire 1

4.4.1 Profile of Participants

Figure 4.1 (a) Gender Distribution of Participants

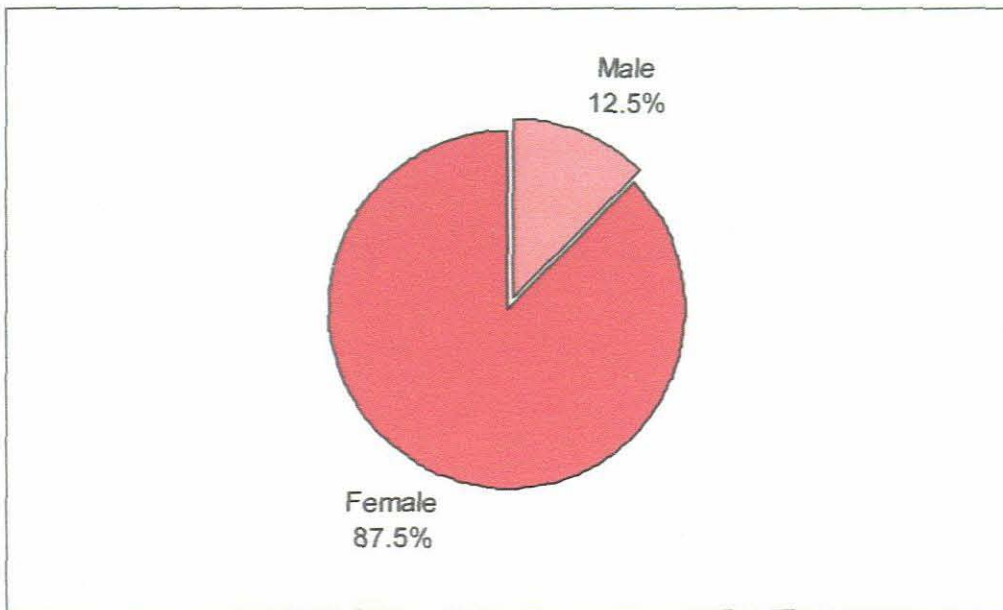


Figure 4.1 (b) Age of Participants

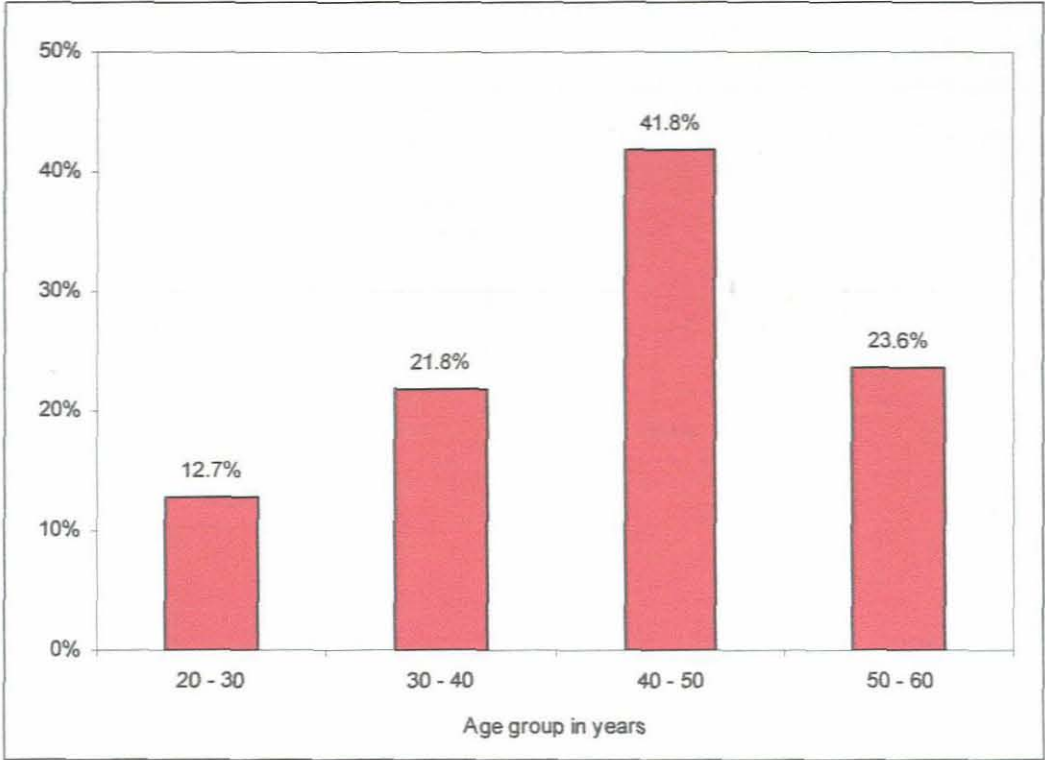


Figure 4.1 (c) Qualifications of Participants

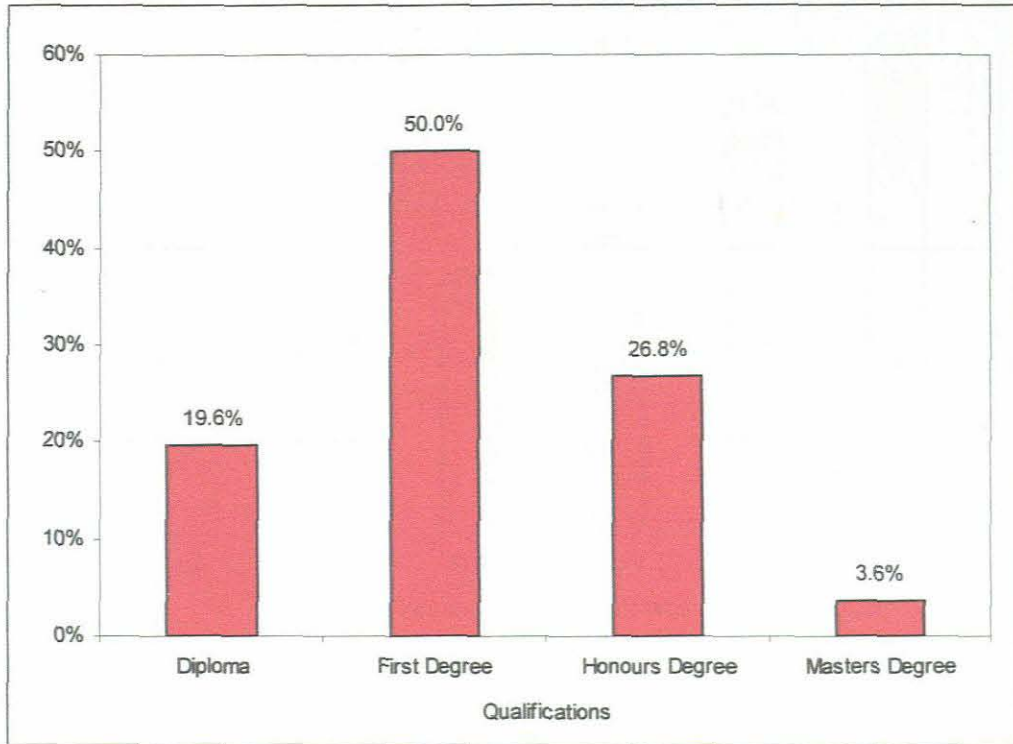
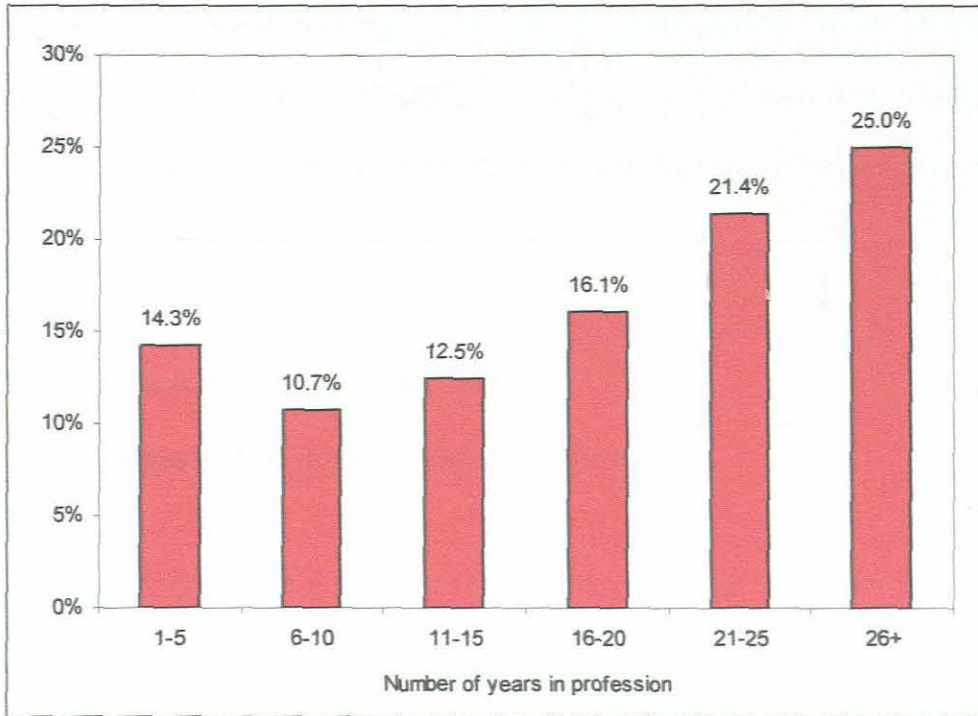


Figure 4.1 (d) Teaching Experience of Participants



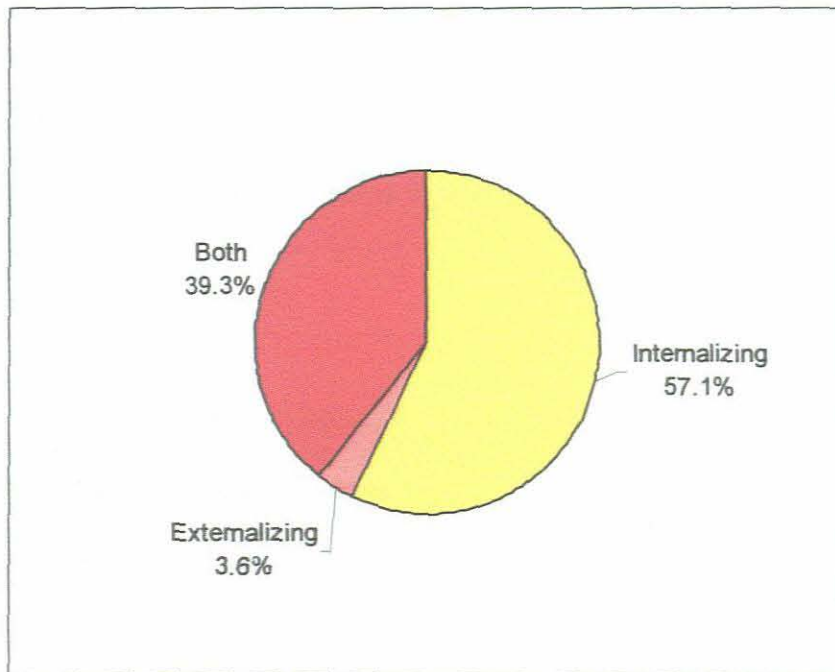
Figures 4.1 (a) to 4.1 (d), provides the profile of the participants that completed the first questionnaire. 87.5% of the participants were female whilst 12, 5% were male; the age range was between 20 to 60 years; 19, 6 % only had a teaching diploma, while 50 % studied for their first degree, 26,8 % had their second degree, and 3,6 % had a third degree; and 62,5 % of the sample had been teaching for more than 16 years.

An observation made was that there were significantly more female participants than males (Figure 4.1 a) and this is in keeping with the realistic gender profile of educators in primary schools of the researcher’s experience. Only a small percentage of participants

did not study for a degree Figure 4.1 (c), and a small percentage were relatively inexperienced as teachers (Figure 4.1 (d). It is significant that over 60% of participants had over 16 years of experience (Figure 4.1d) and thus their responses would be drawn over a fairly long period of both observation and interaction. (The significance of these statistics will be highlighted when experience in recognizing behavioural symptoms of depression is discussed).

4.4.2 Recognition of Symptoms of Depression

Figure 4.2 Recognition of Symptoms of Depression



The results revealed that more than 57% of participants described internalizing symptoms as signs that a child is depressed, whilst less than 4% cited externalizing symptoms. Of the participants almost 40% mentioned both internalizing and

externalizing symptoms. These results are similar to those found by Hinshaw (1992). An important finding by Percy, Clopton and Pope (1993) was that teacher referral increased as the severity of the student's externalizing problems increased but decreased as the severity of the internalizing problems of the student became more severe.

In keeping with research findings (Percy et al., 1993) the researcher expected only internalizing symptoms to be recognized. Contrary to current thinking on the abilities of teachers to recognize externalizing symptoms of depression, the results indicated that a percentage of teachers were able to see that some externalizing behaviours could be indicators of depression. These results will find further support in Figure 4.3.

4.4.3 Rating of the Symptoms of Depression

The following table of symptoms (Figure 4.3) was drawn up using information from the following two sources:

(A) The 5 Criteria for diagnosis of depression according to the DSM – IV (1994):

- Persistent sadness and hopelessness
- Increased irritability and agitation;
- Lack of Concentration;
- Frequent Physical complaints
- Thoughts of death and suicide

(B) The 5 behavioural symptoms of depression as outlined by the NIMH (2000):

- Drug and Alcohol abuse
- Withdrawal from friends
- Poor school performance
- Poor self Esteem
- Changes in sleeping and eating habits

These symptoms were placed randomly into the table.

The ratings were grouped in the following manner:

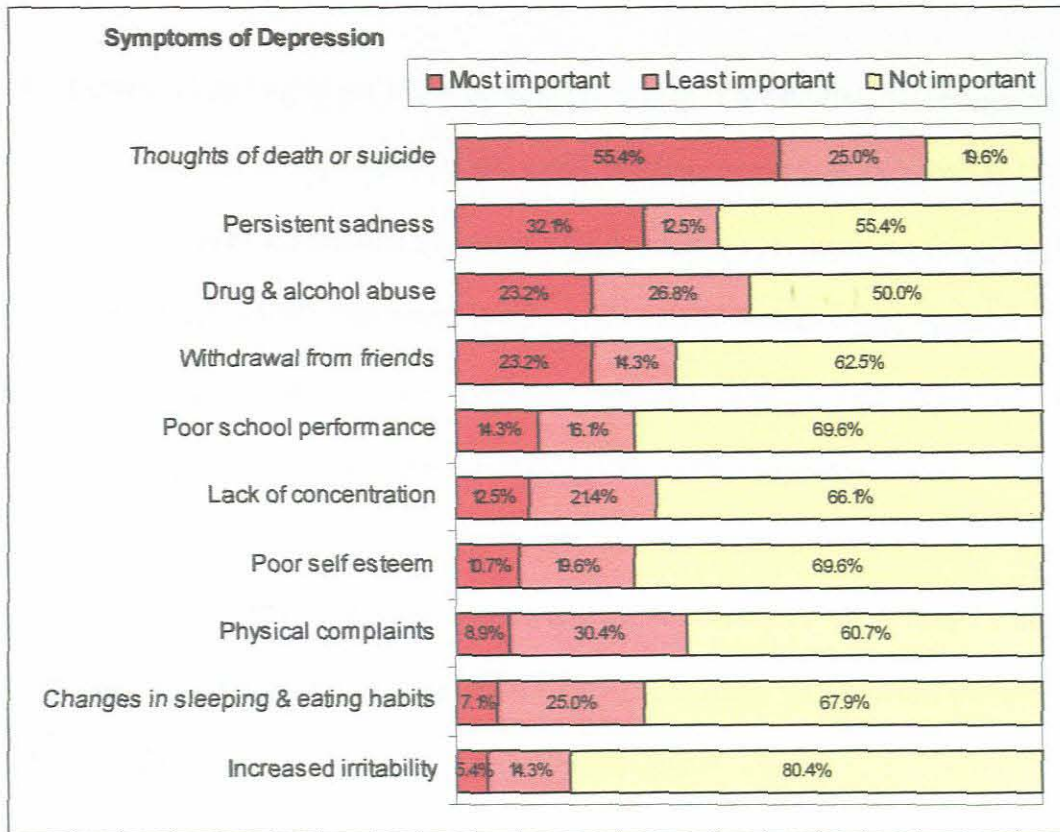
If a symptom was rated:

1, 2 or 3, it was classified as most important

If it was rated 4, 5, or 6, it was classified least important.

If it was rated 7, 8, 9, 10, it was classified as not important.

Figure 4.3 Rating of the Symptoms of Depression



From the statistics it is clear that teachers' ability to recognize the diagnostic features of depression is deficient as 4 of the 5 DSM IV criteria for diagnosis of depression were rated by the majority of participants as not important. The four criteria under discussion were rated as follows:

Increased irritability -80.4% not important

Lack of concentration – 66.1% not important

Frequent physical complaints – 60.7% not important

Persistent sadness – 55.4% not important

These percentages are actually higher if the percentage for those who considered these characteristics 'least important' are also added.

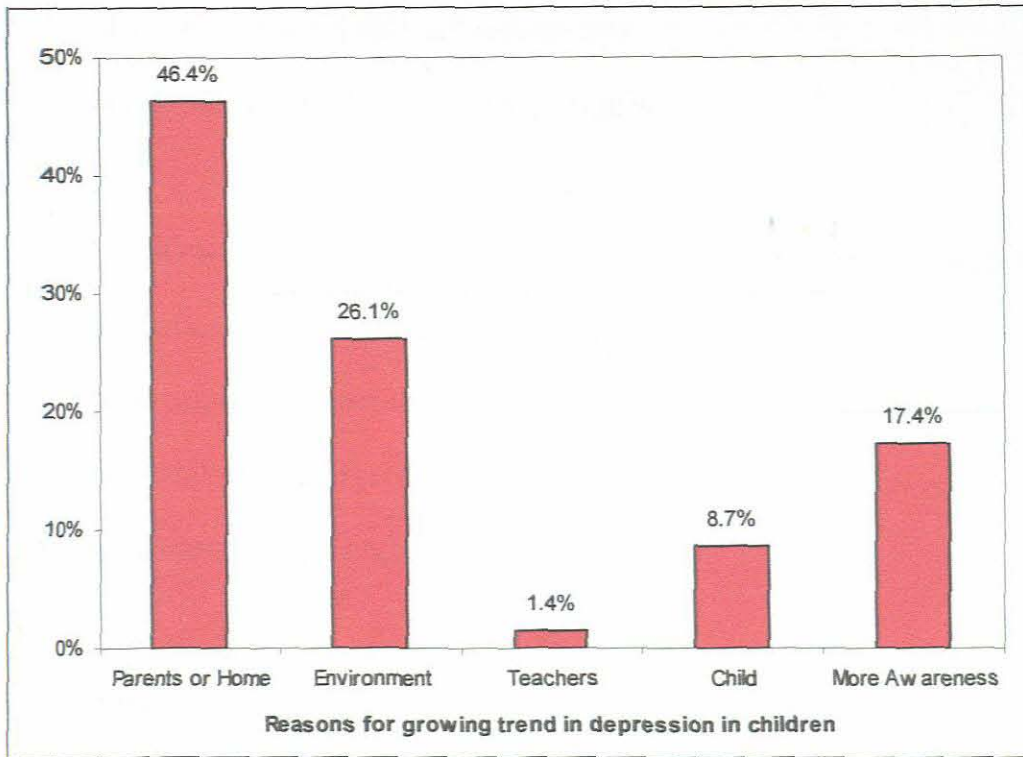
Increased irritation and agitation is a critical factor which is most often not recognized by teachers as a symptom of depression. Since many teachers mentioned in informal discussions about large classes and increased workload, it is not surprising therefore, that 80 % rated this factor as not important. In effect this means therefore that teachers' knowledge which guides them in their ability to recognize symptoms of depression as described by diagnostic criteria of the DSM IV (1994) is incomplete.

The results showed an apparent contradiction in teachers perceived knowledge of the symptoms of childhood depression and their actual knowledge. They lacked a certain depth that would enable them to correctly rate the diagnostic criteria of depression. This information provides justification for the development of a document that would guide teachers in *correctly recognizing and managing the symptoms of depression* (Assumption 3 of the researcher).

4.4 4 Reasons for Increased Incidence of Depression in Children

This was an open ended question which invited the participants to comment on the *growing incidence of depression in children. Comments were summarized into five main themes* (figure 4.4) It must be noted that participants cited more than one reason in their responses. Each of these five themes is elaborated on further.

Figure 4.4 Reasons for increased incidence of depression in children



The five themes are:

(a) Parents / Home factors

It was interesting that almost 47% of participants considered that parent and home factors were a major cause of depression. Some of the statements made by the participants to justify their responses are:

- Parents expect more responsibility from their children
- The divorce rate is high; families are dysfunctional
- There is less family time and no quality interaction

- Parents need to spend more time at home with their children
- Families live life at a hectic pace
- Insensitive / abusive parents
- In a divorce the child is torn between parents
- Parents do not support or listen to their children

The results of a study by Messer and Gross (1995) corroborated this theme. Messer and Gross (1995) found that parent pathology and family dysfunction were critical factors in the development and maintenance of depression in children. Another study by Petersen, Alpert, Papakostas, Bernstein, Freed, Smith and Fava, (2003), reported that negative family factors are predictive of child psychopathology.

(b) Environment

The world we live in is becoming increasingly degenerative in nature. Rising inflation and prices, unemployment, increase in violent crime and a decrease in moral values is descriptive of the society we live in. An increase in teenage pregnancies, drug and alcohol addictions, and sexual crimes, are some of the characteristics of the youth of today (anecdotal evidence). Children are bombarded with unsavoury information from their peers and the media (anecdotal evidence). The responses of more than 26% of participants supported the above anecdotal comments by citing:

- Poor housing / poverty
- Children are exposed to more negative influences
- Society is becoming more competitive

- Increasing pace of technology/ myriad gadgets available - distracting
- Peer pressure and media influence
- Children exposed to stressful situations
- Children not equipped to deal with social ills
- Decline in morals and values
- High crime – insecurity- adds stress – results in depression
- Impact of HIV and AIDS
- Lifestyle, values and morals of today children – fast paced - stressful

(c)Teachers

It is significant to note that only one participant cited teachers as being contributory factors to the increase in the incidence of childhood depression. Teachers need to be more aware that since children spend a significant portion of their day at school, the interaction between teachers and children might not always be positive and heartwarming.

Some teachers' views on depression and its manifestation could be influenced by:

- The personality of teacher
- World view of the teacher
- The personal experience or family experience of depression
- Belief systems
- Ignorance of the multiplicity of the etiology of depression.

Since only less than 2% mentioned that teachers' attitudes and interaction with children could contribute to depressive symptoms in children at school, it must be concluded that teachers' knowledge of the causes of childhood depression is incomplete.

(d) Inability of Child to Cope

A small percentage of participants (8.7%) stated that the inability of the child to cope with the pressures of home and school contributed to an increase in childhood depression.

With HIV and AIDS so rampant in the communities, it is not uncommon to find parents infected with the illness and unable to care for their children (anecdotal evidence).

Children have to take care of their siblings and themselves. As a result many children are psychologically ill equipped to deal with taking on the adult role expected of them (anecdotal evidence). Some of the statements from participants that validate these observations are:

- Parents ill with HIV and AIDS– child has to take care of himself/herself
- Child feels the need to live up to the expectations of peers and parents
- Children display helplessness – withdrawal or very disruptive behaviour
- Children do not have coping skills to deal with 'stuff' thrown at them
- Child feels can not cope with pressures from family and peers
- No emotional support from parents

(e) More Awareness of the Concept of Depression

Information on depression in children is regularly being published in the media. Although these articles are thoroughly researched and well written, the researcher is of the opinion that they do not provide the clear guidelines and other information required to allow parents and teachers to recognize critical diagnostic criteria. However participants are of the opinion that the incidence is increasing for the following reasons:

- Children expressing problems through suicide – therefore more awareness in factors that may cause depression
- People are more aware of the signs nowadays
- Teachers and parents better equipped to detect problems.

4.4.5 Causes and Results of Depression

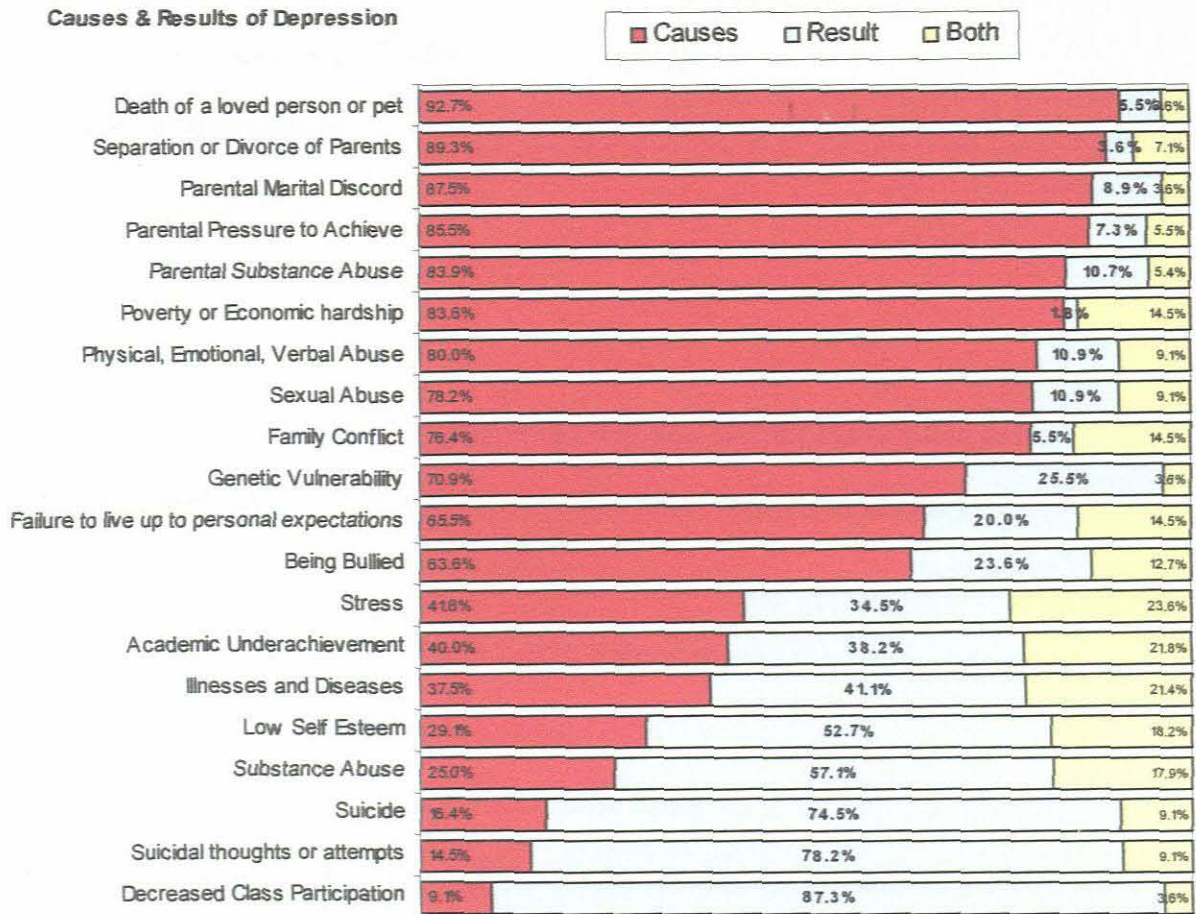
The causes and result factors were collated from the following sources:

- Miller, J. The childhood depression sourcebook (1999)
- The National Institute Of Mental Health (NIMH - 2000)
- Shafii and Shafii. Clinical Guide to Depression in Children and adolescents (1992)
- Stark, K.D. Childhood depression: School based interventions (1990)

This table was included to test the researcher's assumption that teachers were not fully knowledgeable about childhood depression. It also served to answer the first research question, namely: Are teachers knowledgeable about childhood depression?

In this section participants were expected to rate whether certain factors could cause depression, were a result of depression, or both a cause and a result of depression.

Figure 4.5 Causes and Results of Depression



While three factors can be only a cause of depression (death of a loved one; poverty ; genetic vulnerability), one factor can be only a result of depression (suicide), while the other factors can be both causes and results of depression (Miller, 1999; Shafii & Shafii, 1992; Stark, 1990).

The results show that the majority of teachers could correctly recognize the following factors as being:

Only a cause of depression.

Death of a loved person (92, 7 %)

Poverty / economic hardship (83, 6 %).

Only a result of depression:

suicidal thoughts or attempts 78,2 % and

decreased classroom participation (87,3 %) .

It was expected that 100% of participants would correctly rate suicide as being only a result of depression. However 16, 4 % thought suicide could cause depression.

The results show that some of the teachers were unfamiliar with the causes of depression.

An example to illustrate this point is:

The factor genetic vulnerability can only be a cause of depression. Although 70.9 % rated it as a cause of depression, 25.5 % thought it was a result of depression and 3.6 % thought it was both a cause and a result of depression.

During the administration of this questionnaire, the researcher offered to clarify any issues regarding any ambiguities or confusions that the participants might encounter. In all three administrations of this questionnaire, the researcher was not asked any questions. The response that depression can cause genetic vulnerability, may have been for one of

the following reasons: participants could have been embarrassed to be the only one asking or there was genuine unawareness on the causes of depression.

The assumption that teachers are not fully knowledgeable in childhood depression found much support in this section. As predicted the majority of participants (87,3%) did not recognize that school factors constituted a significant factor in the etiology and consequences of depression.

Conclusion of results from Questionnaire 1

Research question 1 was: Are teachers knowledgeable in recognizing the behavioural symptoms of depression?

Questionnaire 1 was designed to elicit data to answer the question. Results of the different sections of the questionnaire found that teachers' knowledge about the behavioural symptoms of depression was deficient because they lacked the depth of knowledge required to identify the critical factors which are used to diagnose depression. These factors represent behaviours that manifest in the classroom. As a result of the lack of depth of knowledge, support was found for the provision of a document to assist teachers recognize the behavioural symptoms and diagnostic criteria of childhood depression.

The results from questionnaire 1 are similar to a study by Head, Kane and Cogan in 2003. The results found that while teachers were sensitive to the link between depression and externalizing symptoms, they lacked the capacity to identify what underpinned this link (Head et al., 2000).

4.5 Analysis and Discussion of results from Questionnaire 2

Figure 4.6 (a) Gender Distribution

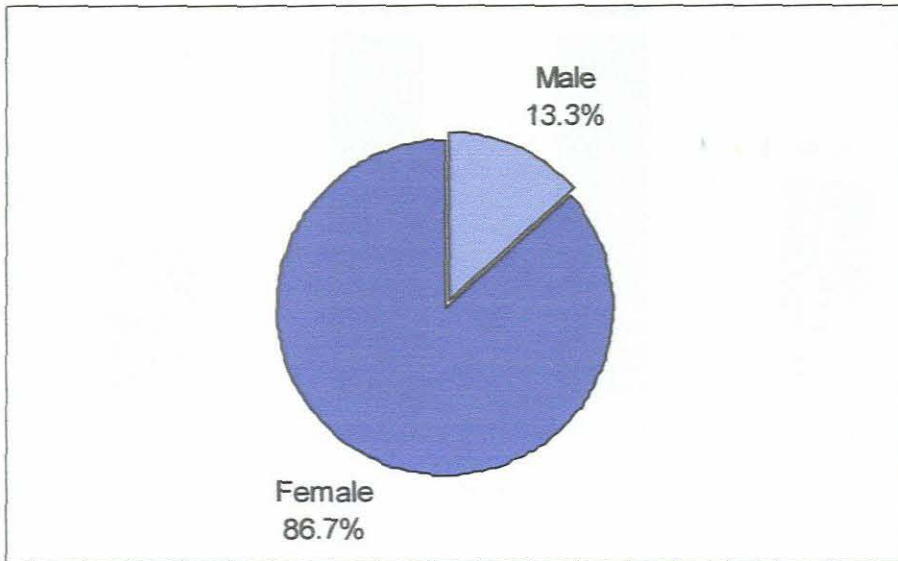


Figure 4.6 (b) Age of Participants

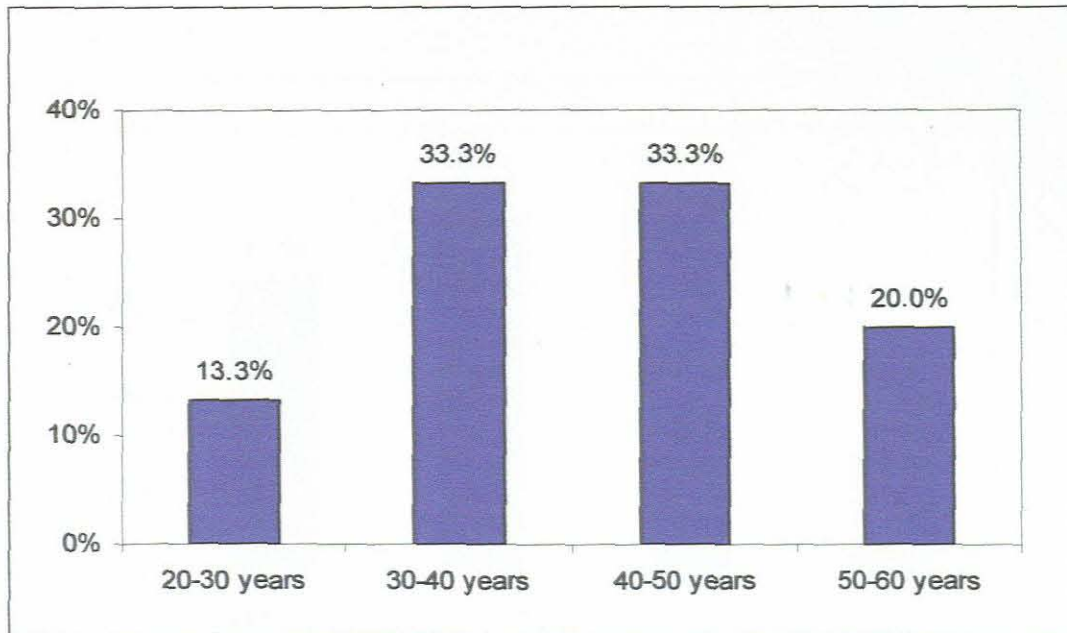


Figure 4.6 (c) Qualifications of Participants

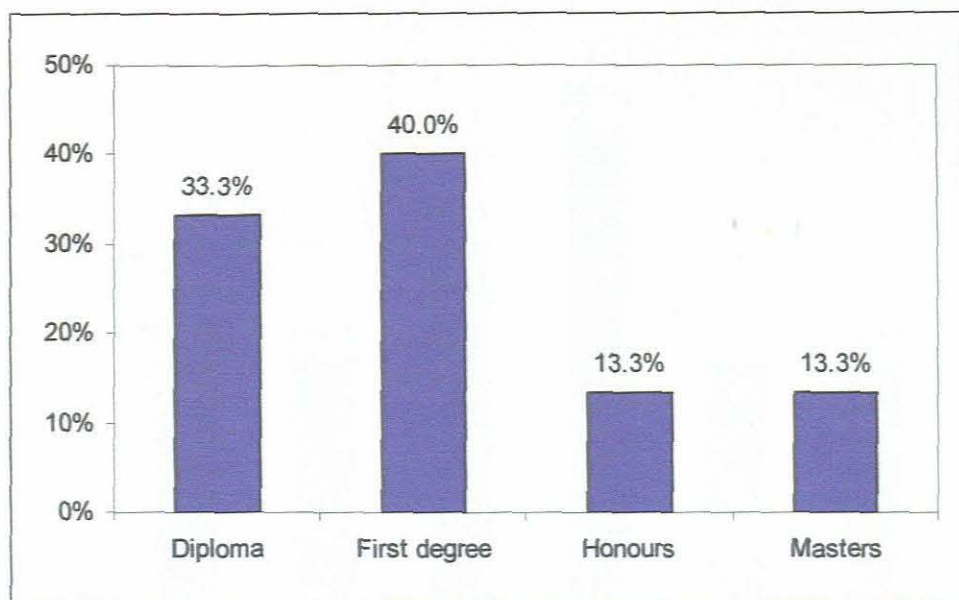
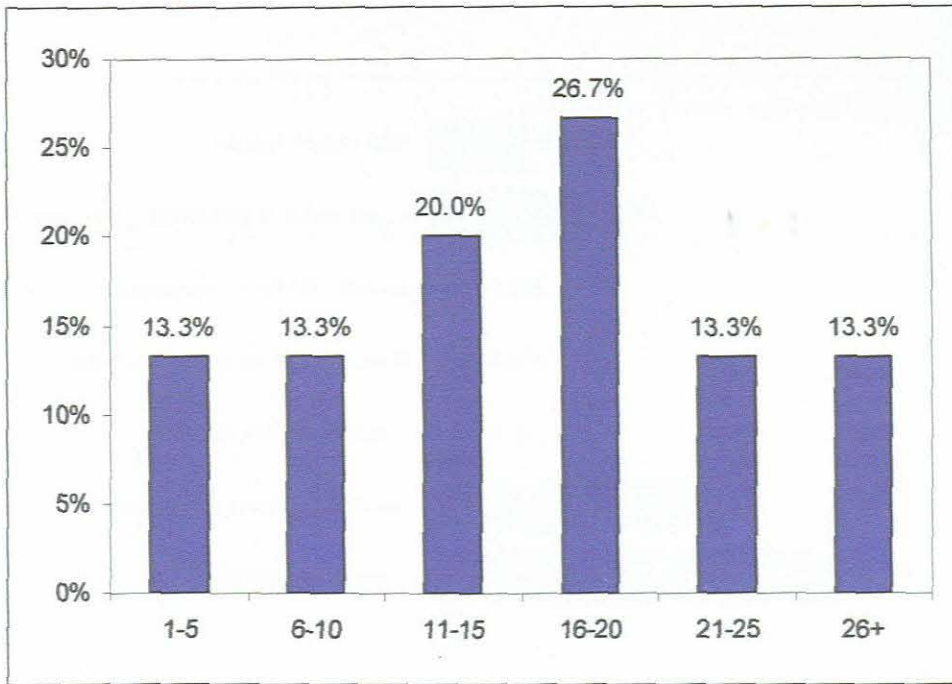


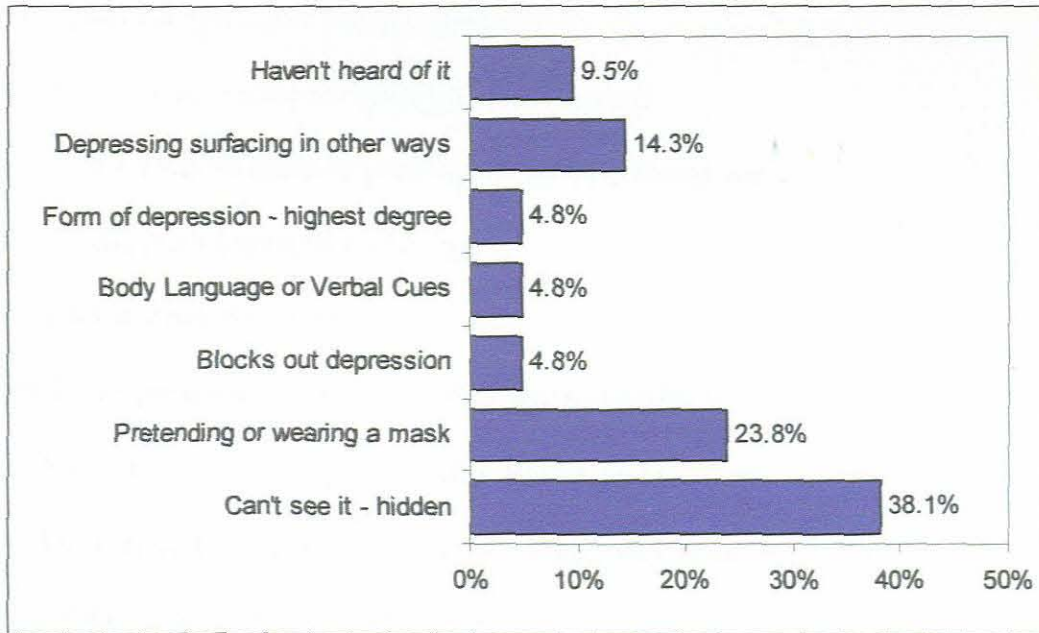
Figure 4.6 (d) Teaching Experience of Participants



The profile of the participants of questionnaire 2 was similar to the profile of participants in questionnaire 1. The sample can be described as 13.3 % male and 86.7 % female; the majority of participants were between 30 and 60 years old; the majority had at least one degree, and the majority was teaching for more than 16 years. The participants of this questionnaire can therefore be described as relatively experienced as teachers. This profile helps support the fact that the sample is more knowledgeable about children's behavioural and academic problems which manifest at school.

4.5.2 Definition of Masked Depression

Figure 4.7 Definition of Masked Depression



The responses from this question serve to provide data for the first research question: Are teachers knowledgeable in recognizing the behavioural symptoms of depression? Data from the answers will add to the evidence gathered in questionnaire 1. The assumption that teachers were not fully knowledgeable will be further supported in this question.

Generally, participants thought of the term as a mask and a significant percentage of participants (38, 1 %) referred to depression as being hidden. Participants who thought that it was a severe level of depression numbered 4,8%; while another 4,8 % of participants believed that body language reveals that the depression was being hidden; and 9,5 % of participants admitted that they had not heard the term before. All these

responses contributed to support the hypothesis that teachers were not fully knowledgeable about childhood depression. However, it was significant to note that 14,3% of participants were able to describe the term correctly.

Seven themes emerged from the question;

What does the term 'masked depression' mean to you?

Some actual responses made by participants for each theme are:

Theme 1 – Haven't heard of it (9,5 %)

- I haven't heard of it before.

Theme 2 – Depression surfacing in other ways (14,3 %)

- Moodiness, cries easily, irritable, seeks attention
- Depression surfacing in various ways which cannot be recognized e.g. rebelliousness, withdrawn behaviour
- Not easily recognizable- exhibited in extroverted ways.

Theme 3 – Highest Form of Depression (4,8%)

- It is depression in the highest degree.

Theme 4 – Body language or verbal cues (4,8%)

- Body language and verbal cues tell you something is wrong.

Theme 5 – Blocks out depression (4,8%)

- The child blocks out depression and doesn't show it.

Theme 6 – Pretending or wearing a Mask (23,8%)

- It's a camouflage kind of thing –you have to be perceptive
- It's like someone wearing a mask – putting on a show – everything is ok
- Child is pretending that all is well at home
- The person is faking, giving a false impression.

Theme 7 – Can't see the Depression -it's hidden (38,1%)

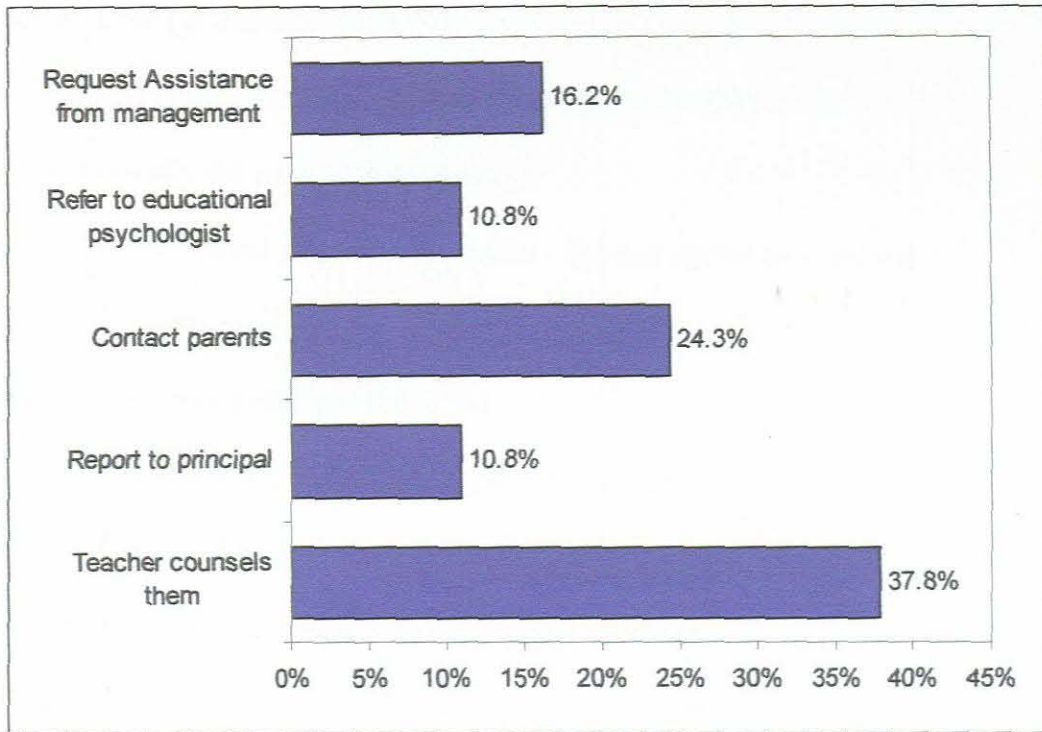
- The child tries to conceal the depression – it's difficult to detect
- I think the depression is hiding.

Six of the seven themes support the assumption that teachers' knowledge about depression is incomplete. Of significance is the fact that 85, 7 % of the participants incorrectly defined the term. Only 14, 3% of participants correctly defined the term as depression surfacing in other ways.

4.5.3 Management of Symptoms of Depression

Participants were asked to comment on a case where an academically average pupil becomes withdrawn and refuses to co operate with teachers. The use of the word 'becomes' represents a change from a former state of functioning, which is one of the distinguishing features of the DSM IV criteria for symptoms of depression.

Figure 4.8 Management of Symptoms of Depression



It must be noted here that participants answered more than one management strategy.

It is evident from the data that 37.8 % felt confident in their ability to counsel those with depression. The responses in this section can be classed into 5 themes and actual statements include:

Theme 1 – Request Assistance from Management (16,2 %)

- Seek assistance from management
- Be caring, be patient, talk to him, send him to school support team.

Theme 2 -Refer to Educational Psychologist (10, 8 %)

- It's important to refer to a psychologist.

Theme 3 - Contact Parents (24, 3 %)

- Contact the parents if the child does not respond to the teacher
- It's actually the parents' responsibility
- I'm not trained to diagnose depression – parents should be involved
- If the problem is ongoing – contact the parents.

Theme 4 - Report to Principal (10, 8 %)

- First try to solve it on my own – then refer to office.

Theme 5 - Teacher Counsels Child (37, 8 %).

- I'm a class based teacher – so I'll counsel the child
- I'll talk to child and win his confidence so I can help him
- I would want to reach out to the child and talk to him
- I'll ask him what's wrong and help him to put it right
- Teachers must talk to their children and guide them.

In terms of the management strategies at school, the results show that the 37,8% of participants' responses reveal unawareness of the manifestation and correct management of behavioural symptoms. Their comments on counselling the child reveals their belief that the management of depressive symptoms involves simply talking to and counselling the child. In the researcher's opinion these are comments made by caring and concerned teachers who are however, misguided by their lack of depth of knowledge about the management of childhood depression.

An interesting observation here is that 24,3 % stated that parents should be involved in the management of a depressed child. This can be interpreted in two ways: In figure 4.4 , 46,4 % of participants felt that parents and home factors were responsible for the increase in depression in children. It could be assumed that the 24, 3 % of participants from questionnaire 2 were part of this percentage. As a result they concluded that parents should be responsible for the management and treatment of their child. The second interpretation is that these participants (24,3%) correctly recognized the need for a multidisciplinary team including parents for the effective management of behavioural symptoms of depression.

Two groups of participants found that referring to agencies within the school provided adequate management of depressive symptoms. Of the participants 16,2% stated that they would refer the child to the support team at school, while 10,8 % felt that referring to the principal would be the solution to the problem. This may be interpreted as these participants having great confidence in the abilities of these two agencies at school. It is possible that this is what happens in most schools. When a child is referred to one or both of these agencies, and when there is a slight change in behaviour and attitude it is interpreted as the intervention being successful (researcher's assumption).

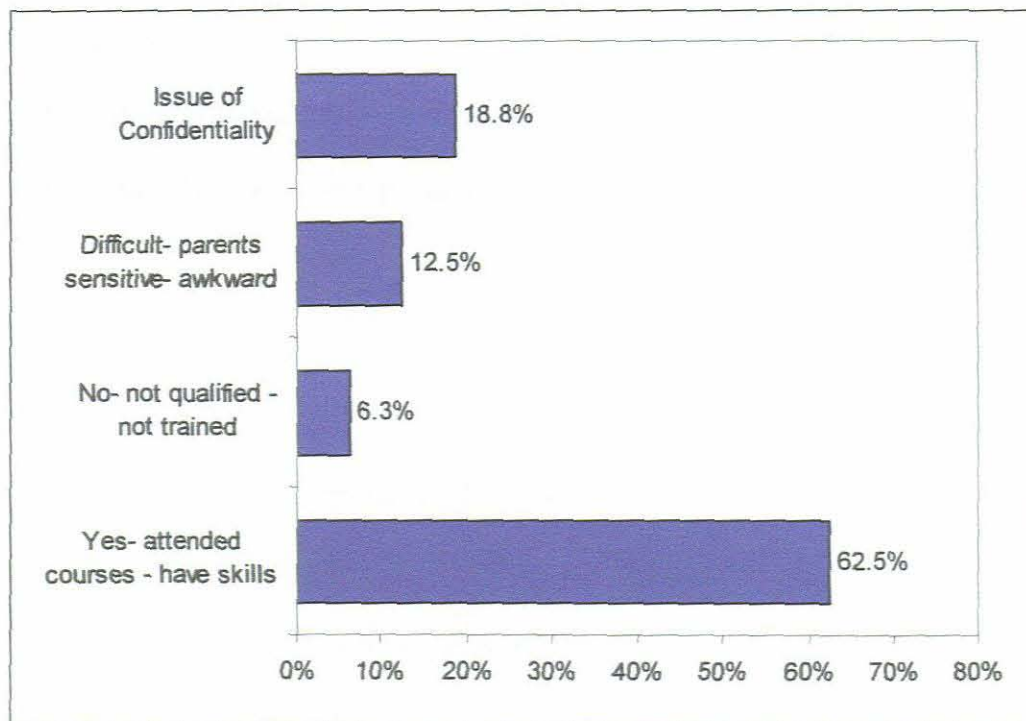
It was significant to note that less than 11% of participants realized the importance of correctly referring the child to a psychologist for a more comprehensive assessment and management of the child's difficulties. The responses in this section provide ample

justification for the drawing up of the guidelines for recognition and management of behavioural symptoms of depression at school.

4.5.4 Discussing Mental Health with Parents

Participants were asked if they felt comfortable discussing mental health issues with parents.

Figure 4.9 Discussing Mental Health with Parents



The responses of the participants centred around four themes:

Theme 1 - Issue of Confidentiality (18,8%)

Of the participants 18, 8 % were perceptive enough to know that confidentiality plays an important role when discussing issues with parents. This was highlighted by the following responses:

- If the child insists don't tell my mother – you should respect their wishes
- If the child has confided in me I would not feel comfortable to discuss with parents
- Teachers should keep it secret – unless the problem is severe
- If the child says don't speak to anyone then I would not be comfortable.

Theme 2 - Difficult – Awkward-Parents Sensitive (12,5%)

Some participants indicated that they might find themselves in an awkward situation because they could not pre-empt the responses of parents. Some comments were :

- It's a sensitive issue – children can have resentment towards teachers
- If the issue is deep-seated – it would be awkward – I would not know how to handle it – How will the child handle it? How will the parents react?

Theme 3 - Not Qualified (6,3%)

Some of the participants felt they would be out of their depth in this situation:

- I would not- not qualified in field
- No, you need a trained professional
- After discussing with the child – call in a professional to place it in context.

Theme 4 - Yes – have Attended Courses – have Skills (62,5%)

The majority of participants showed that they had confidence in their ability to discuss emotional health especially depression with parents. Their comments reflect this confidence:

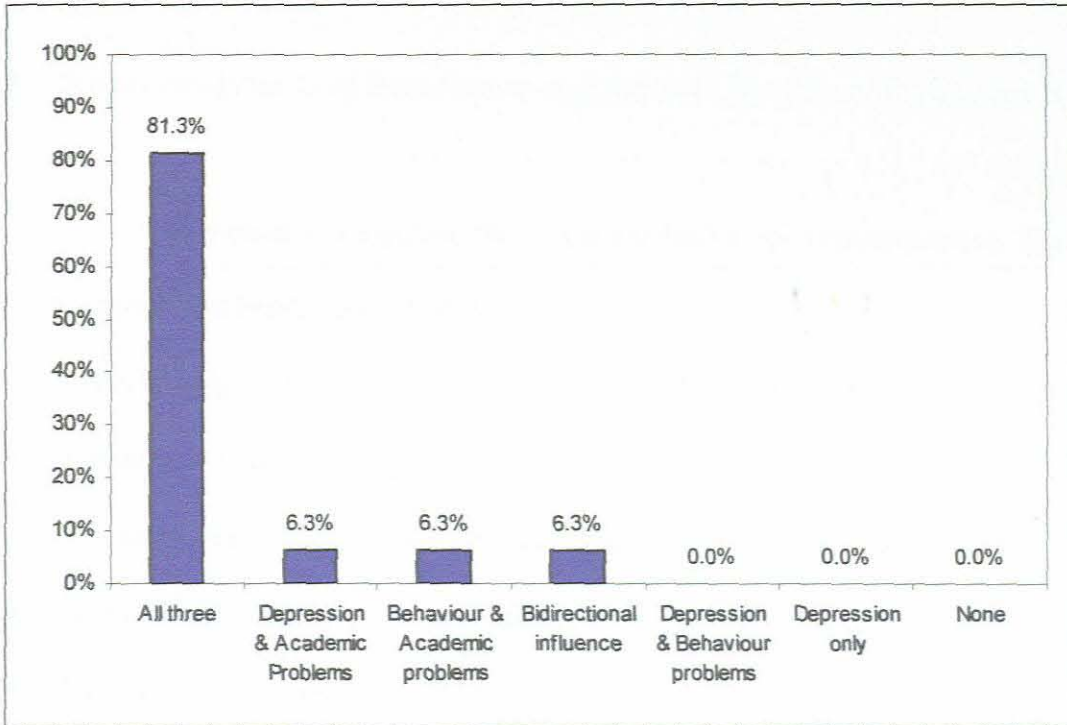
- I have average knowledge about emotional health
- I have attended courses and workshops
- Yes being a teacher – you have to do this
- Yes we work in JP (Junior Primary Grade 1 to grade 3) – children trust you-
- You should tell parents
- I would be comfortable because I have in depth knowledge
- Being a teacher – you'll be concerned about the emotional health of the child
- I will not diagnose but I have to be frank & honest with parents
- Yes I would – I have the necessary skills
- Yes – if it is affecting their schoolwork.

Responses from this question highlight the fact that while some teachers feel confident to address emotional issues with parents, there were others who felt that it was the responsibility of a trained professional. Emotional health is linked to a range of other factors, and experience is necessary to discuss the wide spectrum of causes and results of poor mental health. The results of this question reveal that 62, 5 % believe that they have this necessary depth of knowledge.

4.5.5 The Effects of Stress on children

Participants were asked to comment on whether stress leads to depression, academic problems or behaviour problems in children. It was expected that participants would recognize that while stress could lead to all three consequences, each consequence could in turn lead to stress.

Figure 4.10 The Effects of Stress on children



None of the participants felt that stress would lead only to depression. The results reveal that 6,3% of participants answered that stress leads only to behavioural problems and academic problems but not to depression:

- Will lead to behavioural problems, lead to academic underperformance but not to depression.

The results also revealed that 6,3% of participants stated that stress leads only to depression and academic problems (not to behaviour problems).

- Hinders his learning – blockage in mind then leads to depression

Only one participant answered that stress shares a bi-directional relationship with the consequences listed:

- Stress contributes to all three factors – but the three factors contribute to stress as well.

The majority of participants recognized that stress can lead to all 3 consequences. The following statements verify this position:

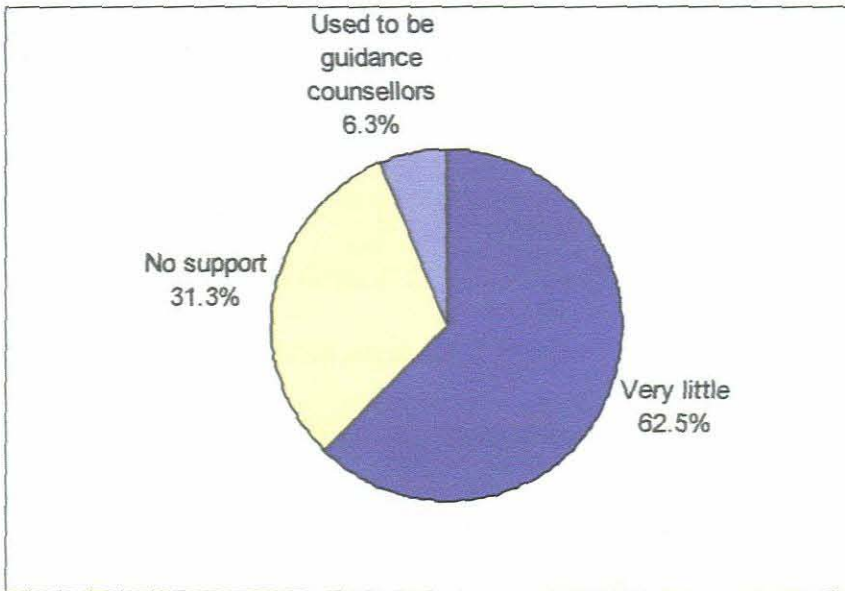
- Stress leads to distrust, lying , drinking, unacceptable behaviour
- It leads to attention seeking behaviours
- Too much stress- memory affected and thought processes blurred
- When a child is stressed – he hits others, takes it out on others
- With stress a child can become demotivated
- If we are stressed, it affects all aspects of your functioning
- Stress contributes to a feeling of hopelessness- so all three will be affected

The results from this section add to the evidence that teachers are not fully knowledgeable about childhood depression. This is further validation for the development of a document assisting teachers to correctly identify and manage the behavioural symptoms of depression.

4.5.6 Support from Department of Education

The participants were asked to comment on the type of support available from the Department of Education with regards to children with emotional problems like depression.

Figure 4. 11 Support from Department of Education



The participants' responses could be divided into two clear themes:

No support (31, 3 %)

- I haven't seen heard or experienced any support from department
- Children must be referred to a psychologist as there is no support from the department
- None whatsoever – we have to wait for months
- Nil – we have lots of discipline problems but the department has not responded
- Some schools have to have their own psychologist, since the department has none
- No support – Department has psychologists- we have not seen them

Very little support (62, 5 %)

- I don't know if they would respond to a referral now
- I have referred – absolutely no response at all yet
- Department does not have enough psychologists - *minimal support*
- Minimal help from department. In our school we have a psychologist
- Department has a team called the PGSES – but there is no follow up
- Psychological services very slow to respond
- Department has only two psychologists- it could take years
- problems can get worse

One participant reminisced about the time years ago when schools had counsellors:

- “I remember when schools had guidance counsellors—they were of tremendous help in these situations.”

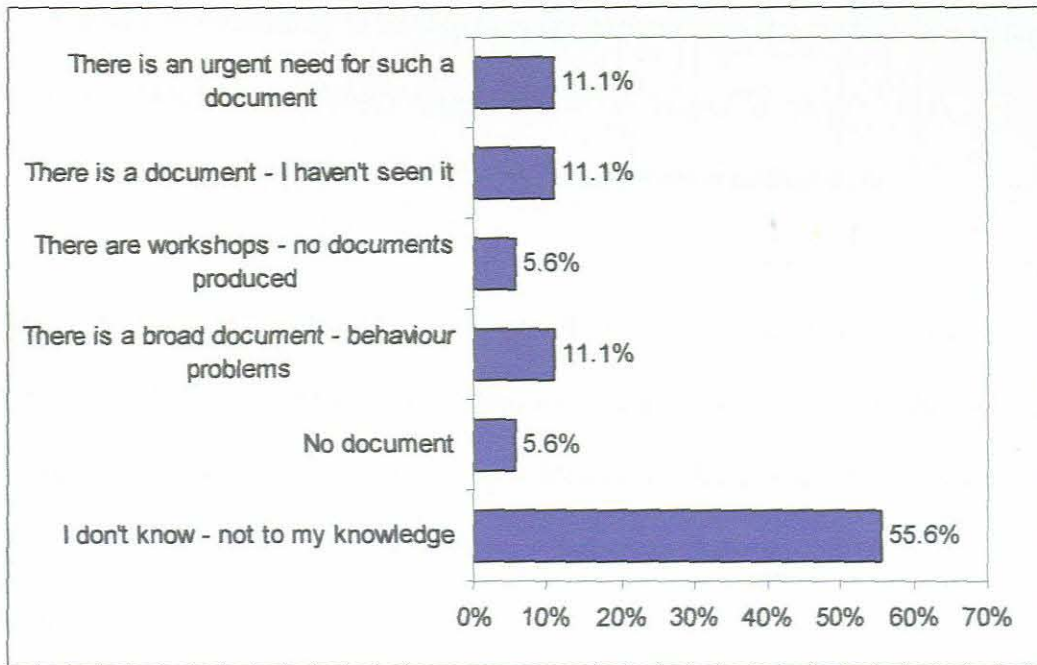
Govender, (2008 cited in Premdev, 2008: p. 4), reported that school guidance counsellors played an important role in pupils’ lives. When the role of the school guidance counsellors fell away, there was a noticeable decline in pupils’ behaviour and their attitudes to studies and life.

The responses from this question provide justification for the development of a guideline document to assist teachers in the recognition and management of the behavioural symptoms of depression. The statements also reveal the frustration experienced by teachers at the absence of the supportive role previously provided by the Department of Education.

4.5.7 Existence of a guideline document

The participants were asked if they were aware of a document guiding teachers in the recognition and management of behavioural symptoms of depression.

Figure 4.12 Existence of a guideline document



The responses could be grouped into six themes. Those of significance are:

Unaware of a Document (55,5%)

- If there is – we have not been made aware of it
- There might be – I don't know about it
- I don't know
- I don't know if there is a document at our school
- Not that I know of

Urgent Need for Such a Document (11,1 %)

- There is an urgent need for a document guiding teachers
- There is a need for such a document to be circularized to all teachers
- It would be interesting to be able to judge depression – it would be nice to have a guideline to help us identify symptoms
- I don't know – there should be one as the situation is critical now

The implication here is that teachers are aware of the dire need for such a document, since in their opinion the Department of Education has not produced one. This provides further support for the development of such a document which would provide correct diagnostic criteria, risk factors, checklists and management guidelines for school personnel.

4.5.8 Support for a programme on self-esteem

The participants were asked if they would support a programme in schools that targets the improvement of self esteem of young children. There was a 100% positive response to the question. Some of the comments offered to justify this emphatic response are listed:

- Children need to be uplifted – more positive attitude to work
- It will improve learners performance- they will more confident
- In schools today many children suffer from low self-esteem
- It would impact positively on behaviour problems

- When children are confident they achieve so much more – need to know they are unique
- The programme will help them to accept themselves and there won't be behaviour problems
- In order to empower children you must boost their self-esteem
- It will make them confident so they will behave
- Good self esteem will improve performance in the classroom and sports field
- It's a winner- children need good self-esteem
- Absolutely – work will improve, behaviour will too
- If the self-esteem is healthy the children will produce good results.

These responses show that teachers are aware of the link between poor self esteem and depression which manifests as academic underperformance and behaviour problems.

Theme 1 - Teacher Counselling (24, 1%)

- When teacher is counselling – child gets individual attention
- Teacher should isolate him from his class- spend an hour a day talking to him

Theme 2 - Refer to Psychologist (27, 6 %)

- Refer to psychologist – teachers don't have in depth knowledge of depression
- Need a psychologist to help correctly diagnose
- Someone professional handles the child's problems

Theme 3 -Develop a Support Team at School (17, 2 %)

- Develop a support team – include a psychologist
- Refer to the school management who should develop a support team

Theme 4 - Get Parents involved (13, 8 %)

- Contact the parents
- Parents are an important part of helping the child
- The problem is at home- so involve the parents

Miscellaneous responses

- More workshops to help teachers identify symptoms
- Teachers must know signs and symptoms
- Have a self-esteem course for teachers first

The findings from Questionnaire 2 reveal that a significant percentage of teachers feel confident of their ability in the management of children with depression. However data from other questions reveal that their knowledge does not meet the necessary depth required to correctly identify and manage children with depression.

Findings from Questionnaire 1 and Questionnaire 2

The purpose of this study was to establish if teachers were knowledgeable in identifying the behavioural symptoms of depression. A second purpose was to determine the management strategies used by teachers to manage children who exhibit the behavioural symptoms of depression. A third purpose was to develop a guideline document for teachers that would assist them in correctly identifying and managing the behavioural symptoms of depression in children.

The research questions that framed this research study are:

1. Are teachers knowledgeable in recognizing the behavioural symptoms of depression in children?
2. How are children with depressive symptoms managed at schools?
3. Do schools need a guideline document to help identify and manage children with depressive symptoms?

The findings of the study reflect that teachers are not fully knowledgeable about the behavioural symptoms of depression. They also lack the depth of knowledge necessary to correctly identify the diagnostic criteria of depression. The management strategies used at

school may seem adequate but require professional input into developing appropriate methods. In the perceived absence of a guideline document from the Department of Education, there was adequate support throughout both questionnaires for the need to develop a guideline document to assist teachers to correctly identify and manage the symptoms of depression at school.

The findings of the questionnaires were reported on in this chapter. These findings will be further reinforced in Chapter five. Chapter five will report on the significant findings, strengths, limitations, recommendations and conclusions of the study.

CHAPTER FIVE
FINDINGS, STRENGTHS AND LIMITATIONS,
RECOMMENDATIONS, CONCLUSIONS

The broad purpose of this study was to establish whether teachers were fully knowledgeable about childhood depression. A related purpose was to determine the strategies that were used in the management of children with depressive symptoms. A further purpose was to develop a document to guide school personnel in identifying and managing the symptoms of depression.

5.1 Findings of Study

The purposes of this study were addressed and fully realized. The level of teachers' knowledge was established, management strategies in use at schools were ascertained, and it was documented that teachers were either unaware or schools did not possess a document guiding them in the identification and management of depressive symptoms in children.

It was found that teachers were not fully knowledgeable about childhood depression. Their perceived knowledge lacked the level of confidence necessary to recognize the behavioural symptoms of depression as diagnostic criteria. Teachers were using some inappropriate management strategies to assist children with depressive symptoms. In fact many felt that just talking to children was sufficient to eliminate the symptoms. Some teachers expressed very little confidence in their ability to see the links between externalizing and internalizing symptoms and depression.

With respect to the existence of a guideline document, a significant percentage of teachers were unaware of a document, and a small percentage indicated that there was a possibility of a document, but they had not seen it.

5.2 Strengths and Limitations of the study

Despite the rescheduling of the administration of the first questionnaire as a result of the teachers' strike in June 2007, the teachers in all three schools were still enthusiastic about assisting the researcher. It must be noted that although each school had scheduled a further meeting after the departure of the researcher, teachers were co operative and were in a positive frame of mind. The researcher counts as a strength of the study the co-operation of the Department of Education, the principals of all three schools, and all the teachers who participated in the study.

On a more academic note one of the strengths of this study is that the findings and recommendations will add to the research studies on the topic both nationally and internationally. Much new information was extracted from the questionnaires and these have special significance for the South African research community.

A limitation of the study was the fact that the researcher should have included more open ended questions in questionnaire 1. In this way teachers would have the opportunity to be more expressive in their individualized responses concerning the causes and results of depression.

5.3 Recommendations

5.3.1 Teachers

Teachers are in an advantageous position to observe children in many different situations. Children spend more time in school than in most other structured settings outside the home and their most extensive contact is with teachers. It is critical therefore that teachers are able to identify depressive symptoms and be supportive of those children with depression.

The following three tips for teachers come directly from a child who suffered depression: (Alexandra Madison, 2008).

1. Don't ignore depressed students. It shows you don't care and invites the student to give up, guaranteeing their failure. Draw them out in class discussion and do whatever it takes to stimulate their minds, so that they don't, in turn, learn to ignore you.
2. Let them know that you care, but without getting too personal. Help them to update any missing assignments, or set up extra study time – whether they accept your efforts or not at all depends on the severity of the depression. The fact that you've proven you care can make all the difference in the world.
3. Never give up on the student- regardless of how long they did not put an effort in your class. Students can tell when a teacher no longer believes in them and expects them to fail, and it only ends up making the situation worse.

5.3.2 Schools' management team

The implementation of prevention and early intervention strategies to prevent or minimize the occurrence of mental health problems can be addressed by:

- Working with parents and educators to create positive school environments
- Increased awareness of mental health stressors and strategies
- Teaching parents and educators skills to address behaviour problems
- Screening for mental health and learning problems
- Developing suicide awareness and prevention programmes
- Developing school programmes to prevent bullying and aggression
- Fostering tolerance and understanding of diversity
- Helping students develop skills to solve conflicts and problems independently
- Teaching students social skills, self-management, and coping strategies
- Consulting with teachers on classroom interventions

5.3.3 Department of Education

It is imperative that the Department of Education move towards prevention and early intervention of children at risk of depression. The psychological services wing of the Department of Education must endeavour to facilitate teamwork and coordination of services. Effective school mental health services are implemented by a team of professionals including departmental psychologists, teachers, management staff, parents, school psychologists, social workers, and counsellors.

This team of professionals must develop programmes that improve academic and social outcomes for children and youth by:

- Developing and maintaining collaborative relationships with community mental health services

- Developing coordinated school/community crisis response

- Consulting with policymakers on and advocating for mental health and education legislation

- Seeking funding for integrated school/community services

- Providing in-service training for parents, educators, and community members

- Advocating for the needs of individual students both within and outside of the school

setting

- Helping teachers and parents understand and effectively address a child's problem

- Helping families gain access to community resources

- Facilitating co-ordination between parents, schools, and community services

- Establishing and reviewing outcomes of interventions

- Helping families and schools deal with crisis and loss

- Working directly with children and families to address barriers to academic and social

success

The recommendations to schools' management and the department of education are adapted from: Depression in Children: A Guide for school based staff. www.nice.org.uk

5.4 Conclusion

The world presently is characterized by the breakdown of the nuclear family, increasing divorce rates, unusually high rates of child abuse, and increasing pressure for younger children to attain adult sexual sophistication. With this status quo, there is reason to believe that the impact on children's academic, personal and social development will be negative. It would be reasonable to assume that this would result in the increase in prevalence rates of childhood depression.

Until the 1980's, some mental health professionals believed that children were incapable of experiencing depression. Other mental health professionals believed that children could be depressed, but would most likely express their symptoms indirectly through behaviour problems, thereby 'masking' their depression. Today we know that children experience and manifest depression in ways similar to adults, with some symptoms unique to their developmental age.

Schools are a natural environment for prevention programmes because most children attend school, and through them an infrastructure exists for reaching large numbers of children during their formative years. Teachers can make a substantial contribution to the correct identification and management of behavioural symptoms of childhood depression. Schools offer an appropriate and ideal setting for attention to childhood depression, not only because schools play such an important part in children's lives, but also because school represents a performance, personal, cognitive and peer social milieu (Hart , 1991).

The World Health Organization (WHO) has developed a 'life skills' educational curriculum, which teaches a wide range of skills to school age children to improve their psychosocial competency. The skills include problem-solving, critical thinking, communication, interpersonal skills, empathy and methods to cope with emotions. These skills enable children and adolescents to develop sound and positive mental health. This programme is an example that schools could use and adapt to suit their individual needs (WHO, 2004).

Fortunately, childhood depression is now a recognized problem and research is deepening our understanding and broadening the treatment options available. The triad of psychotherapy, psychopharmacology, and support systems from parents and teachers, ensure a brighter future for children with depression. Awareness, education and implementation of health promotion programmes for all children will go a long way in ameliorating the deleterious effects of depression.

CHAPTER SIX

GUIDELINES FOR TEACHERS AND SCHOOL MANAGEMENT STAFF

RECOGNITION AND MANAGEMENT OF SYMPTOMS OF DEPRESSION

Foreword

This document is primarily aimed at school teachers and management staff.

However other school staff such as school counsellors, school doctors, school nurses and social workers will also find the information useful. This document briefly describes the concept of childhood depression, presents the risk factors and diagnostic criteria and indicates how to identify and manage the behavioural manifestations of childhood depressive symptoms within the school.

Recommendations are made to the management team at schools.

Although depression was usually considered an adult problem, a number of research studies have reported that increasing numbers of children and adolescents suffer from depression and that the age of onset is decreasing. Depression is a disturbance in mood, thought and body characterized by sadness, loneliness, hopelessness and self-doubt.

Depression in children can, if left untreated, affect school performance and learning, social interactions, life skill acquisition and relationships with parents, teachers and peers. Untreated depression can lead to disruptive behaviours, violence and aggression, anti – social behaviours, substance abuse, suicidal threats and suicide.

Depression is believed to result from a biochemical imbalance in the brain that affects how children think, how their bodies function and how they behave. Some researchers believe that this imbalance together with psychosocial and environmental stressors interact to cause depressive symptoms. That means that sometimes behaviour problems are not just attitude problems — they are surface signs of a deeper cause. Identifying and understanding the causes of depression is necessary to lessen the negative consequences and manage the symptoms appropriately.

It is critical therefore that teachers and parents know how to identify symptoms, how to manage the behavioural manifestations of depressive symptoms and when to seek medical or professional advice.

Some of the risk factors implicated in the development of childhood depression are:

- Being bullied
- Death of a parent, relative or someone close
- Family conflict or break-up
- Moving to a different area / school
- Other members of the family being depressed
- Having other illnesses
- Physical, sexual or emotional abuse
- Stress of school work
- Living in institutional settings
- Being homeless

- Being treated differently because of race
- Attention deficit disorder
- Conduct disorder
- Learning disorders
- Trauma (accident, natural disasters, crime, rape)
- Chronic illness such as diabetes or cancer

Diagnostic Criteria (DSM IV, 1994)

Five or more symptoms to be present during the same 2 week period.

These symptoms must signify a change from previous functioning:

- Persistent sad or irritable mood
- Marked diminished interest in all or most activities
- Significant weight loss or weight gain
- Observable psychomotor agitation or retardation nearly every day
- Insomnia or hypersomnia nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness
- Diminished ability to think or concentrate
- Recurrent thoughts about death

Symptoms of Depression

Physical Symptoms

Physical symptoms of depression in children can include:

- Significant change in body weight
- Frequent vague complaints of physical illnesses, such as headaches and stomachaches
- Unexplained low energy levels
- Fatigue

Mental Symptoms

Mental symptoms can include:

- Difficulty in concentration
- Thoughts or expressions of death, suicide, or self-destructive behaviour
- Difficulty making decisions.

Emotional Symptoms

Emotional symptoms of depression in children can include:

- Frequent sadness, tearfulness, or crying
- Empty or hopeless feelings
- Feelings of inadequacy, unworthiness, and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Clinging to a parent or worrying that the parent may die.

Behavioural Symptoms

Behavioral symptoms can include:

- A decreased interest in activities or an inability to enjoy former favorite activities
- Persistent boredom
- Withdrawal from other children and adults
- *Isolation and poor communication with others*
- Difficulty with relationships
- Pretending to be sick or refusing to go to school
- Poor performance in school
- Talk of, or efforts to run away from home
- Alcohol or substance abuse
- Frequent absences from school
- Emotional outbursts
- Unexplained irritability
- Crying for no obvious reason
- Increased anger or hostility
- Reckless behaviour

A CHECKLIST OF DEPRESSIVE SIGNS

If, after observing the aforementioned symptoms and diagnostic criteria, a teacher suspects that a child may be depressed, the following checklist should be used to verify and specify their suspicions to a psychologist or psychiatrist. Each sign could be rated on a scale of 0 – 5 to provide information on the intensity of the symptoms.

Academic Signs

- Unexplained decline in performance of school work
- Loss of interest in school subjects
- Gives up easily when attempting schoolwork
- Low motivation and effort

Cognitive signs

- Difficulty in concentration
- Forgetfulness
- Indecisiveness
- Diminished ability to think and analyze
- Lack of confidence in one's ability
- Lack of energy, feelings of fatigue

Social / Behavioural Signs

- Disruptive behaviour
- Restlessness
- ADHD like behaviours: impulsivity, inattention, hyperactivity
- Reckless behaviours
- Anti-social behaviours (lying, stealing)
- Withdrawing from social contact
- Does not want to participate in activities that are fun for others
- Alienating themselves from peers
- Loss of appetite
- Unreasonable fears
- Looking tired or falling asleep

Emotional signs

- Poor self image / concept
- Expresses feelings of sadness
- Expresses excessive guilt or remorse over his/her actions
- Expresses feelings of helplessness
- Expresses feelings of worthlessness
- Talks / draws / writes about suicide and or death
- Irritable and cranky
- Excessive complaining
- Does not display pleasure / happiness when other children are

Management Guidelines for the child displaying symptoms of depression

For the teacher

If after talking to a supportive adult, the teacher is certain that the depressive symptoms have receded, no further intervention or referral would be necessary. If however, the symptoms persist and intensify, the teacher should engage in careful observation and:

- Try to understand the reasons for any deterioration in behaviour
- Promote a healthy lifestyle, e.g. regular exercise, a balanced diet
- Offer non-directive support including active listening
- Encourage children to talk to their parents and friends if they can, or to talk to a teacher or other adult they can trust
- Offer activities that raise self-esteem and help them to express their feelings
- Teach self-reward and self-praise
- Promote activities which help develop supportive friendships

Team efforts between the teacher, school counsellor, and parents are often necessary to provide the consistent support system needed to aid a depressed child. The following list describes some intervention strategies that could be used by teachers to assist a child who is depressed:

- Initiating and maintaining communication with the child's parents
- Training the child in social skills
- Providing opportunities for safe social interaction with peers
- Limiting attention to depressive episodes
- Eliminating misdirected sympathy, assurance and support
- Reinforcing positive behaviours

- Training the child in cognitive strategies to extinguish negative thinking
- Ensuring daily successful experiences
- Teaching the child to use positive affirmations
- Teaching behaviour changing skills when depressive symptoms appear

For the school

The management team of the school should consider making a referral to, or asking for advice from an educational psychologist when one or more of the following apply:

- Continued presence of at least two of the identified symptoms of depression
- History of depression in other family members which, along with other symptoms, may place the child at greater risk for depression
- No improvement in symptoms as a result of support offered in school after two months
- Relapse after an initial period of improvement
- Unexplained self-neglect of at least 1 month's duration (e.g. sudden lack of interest in personal hygiene)
- Suicidal ideas or plans
- Child or parent requests referral
- A referral from a teacher after completing the checklist

The child should be assured at all times about the confidentiality of information. Staff should respond sensitively to a child missing schoolwork because of absence and assist in updating their work.

It is important to recognize and correctly manage the symptoms of depression, before the effects of depression interferes with the child's interpersonal, academic and psychosocial development.

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APPENDIX 1: Letter to Department of Education requesting permission

Mr S R Alwar
Dept of Research, Strategy,
Policy development & ECMIS
Private Bag X 9137
Pietermaritzburg
3200

RE: PERMISSION TO CONDUCT RESEARCH

I, Rekha Naidu, hereby seek permission to conduct research at Pitlochry Senior Primary School, Durwest Primary School and Resmount Primary School.

I am a PhD student at the University of Zululand. My dissertation is entitled: "Childhood Depression : Recognition of Behavioural Symptoms and Management Guidelines for Primary Schools." The dissertation will be promoted by Professor H S B Ngcobo of the University of Zululand.

The purpose of the study is to:

- Conduct an audit of the present levels of knowledge amongst educators in respect of childhood depression
- Raise the awareness of educators about childhood depression and its manifestations in the school environment
- Formulate a pragmatic guidelines document that will assist educators to work with those children who exhibit those behaviours in school

Interviews will be conducted and questionnaires will be administered after teaching hours at the selected schools. Strict confidentiality will be maintained throughout the research process. Principals' and teachers' permission has been sought and granted.

I look forward to your assistance.

Yours sincerely

Rekha Naidu

Contact Details:

Telephone Numbers : 031 – 2625277 (Home)

031 – 2629330 (office)

APPENDIX 2 Letter to principals requesting permission

The Principal
Primary School

Dear

RE: PERMISSION TO CONDUCT RESEARCH

I, Rekha Naidu, hereby seek permission to conduct research at Pitlochry Senior Primary School.

I am a PhD student at the University of Zululand. My dissertation is entitled: "Childhood Depression: Recognition of Behavioural Symptoms and Management Guidelines for Primary Schools." The dissertation will be promoted by Professor H S B Ngcobo of the University of Zululand.

At the first level I will administer questionnaires to the whole staff including management staff. This will be in a group situation. It is estimated that filling in the questionnaire will take approximately 20 minutes. At the second level I will randomly select 5 staff members with whom I will conduct semi-structured interviews. This will be on a one to one basis and is estimated to last 30 minutes. These interviews will take place on different days decided on by the staff member concerned.

On both levels of research : it will not be necessary to write names or any identifying information ; strict confidentiality will be maintained; teaching time will not be used. All arrangements will be made with the management staff at the school.

I look forward to your assistance.

Rekha Naidu

Date

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I, \_\_\_\_\_, principal of Pitlochry Primary School hereby grant permission to Rekha Naidu to conduct research at the abovementioned school.

**APPENDIX 3:Letter to teachers requesting assistance**

Dear Educator / Teacher

I, Rekha Naidu, am a PhD student at the University of Zululand.

My dissertation is entitled :

“ Childhood Depression : Recognition of Behavioural Symptoms and Management Guidelines for Primary Schools.” The dissertation will be promoted by Professor H S B Ngcobo of the University of Zululand.

I request your assistance to compile my research data.

At the first level I will administer questionnaires to the whole staff including management staff. This will be in a group situation. It is estimated that filling in the questionnaire will take approximately 20 minutes. At the second level I will randomly select 5 staff members with whom I will conduct semi-structured interviews. This will be on a one to one basis and is estimated to last 30 minutes. These interviews will take place on different days decided on by the staff member concerned.

On both levels of research : it will not be necessary to write names or any identifying information ; strict confidentiality will be maintained; teaching time will not be used. All arrangements will be made with the management staff at the school.

Please do not hesitate to ask me any questions before you sign this consent letter. I look forward to your support with my research.

\_\_\_\_\_  
Rekha Naidu

\_\_\_\_\_  
Dr S Ngcobo

\_\_\_\_\_  
Date

.....

I, \_\_\_\_\_, a teacher at Resmount Primary school hereby consent to assisting Rekha Naidu as outlined above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**APPENDIX 4 : Questionnaire 1**

**Please complete the following details.**

1. Gender  M  F

2. Age Group  20 - 30  30 - 40  40 - 50  50 - 60

3. Qualifications:  

|              |         |         |           |
|--------------|---------|---------|-----------|
|              |         |         |           |
| First degree | Honours | Masters | Doctorate |

4. Number of years in profession:

5. Grades that you are teaching this year:

**A. Answer the following questions.**

1. Do children in primary school suffer from depression?  
\_\_\_\_\_

2. If yes, name at least three signs that would alert you to this fact.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Do you agree or disagree with the following statements?**

- 1. Teachers are the first to spot the symptoms of depression in children. \_\_\_\_\_
- 2. When a child is misbehaving, it has nothing to do with depression. \_\_\_\_\_
- 3. Disruptive children need a teacher's attention more than a withdrawn child. \_\_\_\_\_

**C. Rate the following statements with a number to indicate their importance in terms of diagnosing childhood depression .**

1 = most important

10 = least important

| Statement                                                | Rating |
|----------------------------------------------------------|--------|
| Persistent sadness and hopelessness                      |        |
| Withdrawal from friends                                  |        |
| Increased irritability and / agitation                   |        |
| Poor school performance                                  |        |
| Changes in sleeping and eating habits                    |        |
| Drug and alcohol abuse                                   |        |
| Frequent physical complaints eg. Stomachaches, headaches |        |
| Lack of concentration                                    |        |
| Poor self esteem                                         |        |
| Thoughts of death / suicide                              |        |

**D. Depression in children was unheard of in the past, but today it seems to be a growing trend. Please comment on this statement.**

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**E. Would you say that the following factors cause depression or are a result of depression in children. Place a tick in the appropriate column / s.**

| <b>FACTOR</b>                                   | <b>Causes depression</b> | <b>Result of Depression</b> |
|-------------------------------------------------|--------------------------|-----------------------------|
| 1. Genetic vulnerability                        |                          |                             |
| 2. Illnesses and diseases                       |                          |                             |
| 3. Parental marital discord                     |                          |                             |
| 4. Parental substance abuse                     |                          |                             |
| 5. Separation or divorce of parents             |                          |                             |
| 6. Family conflict                              |                          |                             |
| 7. Parental pressure to achieve                 |                          |                             |
| 8. Academic underachievement                    |                          |                             |
| 9. Stress                                       |                          |                             |
| 10. Substance abuse                             |                          |                             |
| 11. Low self esteem                             |                          |                             |
| 12. Decreased classroom participation           |                          |                             |
| 13. Being bullied                               |                          |                             |
| 14. Sexual abuse                                |                          |                             |
| 15. Physical, emotional, verbal abuse           |                          |                             |
| 16. Failure to live up to personal expectations |                          |                             |
| 17. Poverty / economic hardship                 |                          |                             |
| 18. Death of a loved person / pet               |                          |                             |
| 19. suicide                                     |                          |                             |
| 20. suicidal thoughts / attempts                |                          |                             |

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Your assistance in answering this questionnaire is greatly appreciated.

Thank you.

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Rekha Naidu

**APPENDIX 5 - Questionnaire 2**

**A. Complete the following details**

1. Gender

|   |   |
|---|---|
| M | F |
|---|---|

2. Age Group

 20 - 30 30 - 40 40 - 50 50 - 60

3. Qualifications

|                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| First degree             | Honours                  | Masters                  | Doctorate                |

4. Number of years in profession :

5. Grades that you are teaching this year :

6. General Interests

7. Interests in Education

**B. What does the term 'masked depression' mean to you ?**

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**C. What action would you take in a case where an academically average student becomes withdrawn, and refuses to co operate with teachers.**

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**D. Would you be comfortable discussing the emotional health of a student with his or her parents? Explain your answer.**

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**E. Does stress in children contribute to depression, lead to behavioural problems or contribute to academic underperformance?**

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**F. What kind of support is given by the Department of Education to assist children with emotional problems like depression?**

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**G. Is there a document which guides the school's management in terms of procedure and management of depressed children?**

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**H. Would you support a programme in schools that targets the improvement of self esteem of young children? Give reasons for your answer.**

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**I. What would be the ideal management strategy at school of a child with depression?**



# APPENDIX 6

PROVINCE OF KWAZULU-NATAL  
ISIFUNDAZWE SAKWAZULU-NATALI  
PROVINSIE KWAZULU-NATAL

DEPARTMENT OF EDUCATION  
UMNYANGO WEMFUNDO  
DEPARTEMENT VAN ONDERWYS

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Pietermaritzburg, 3201



**INHLOKOHHOVISI**

**PIETERMARITZBURG**

**HEAD OFFICE**

Inquiries:  
Imibuzo: M Francis  
Izavrae:

Reference:  
Inkomba: 0026/07  
Verwysing:

Date:  
Usuku:  
Datum: 23/07/2007

To: Rekha Naidu

RE: APPROVAL TO CONDUCT RESEARCH

Please be informed that your application to conduct research has been approved with the following terms and conditions:

That as a researcher, you must present a copy of the written permission from the Department to the Head of the Institution concerned before any research may be undertaken at an educational institution bearing in mind that the institution **is not obliged to participate** if the research project.

Research should not be conducted during official contact time, as **education programmes should not be interrupted**, except in exceptional cases with special approval of the KZN Department Of Education.

The research is not to be conducted **during the fourth school term**, except in cases where the KZNDoE deem it necessary to undertake research at schools during that period.

Should you wish to extend the period of research after approval has been granted, an application for extension must be directed to the KZN Department Of Education, Superintendent General.

**The research will be limited to the schools or education institutions for which approval has been granted.**

A copy of the completed report, dissertation or thesis must be provided to the KZN Department Of Education, Head of Department. For attention: Mrs PT Nkosi, Research Subdirector.

**Lastly, you are required to sign the attached declaration that, you are aware of the procedures and will abide by the same.**

for **SUPERINTENDENT GENERAL**  
KwaZulu Natal Department of Education