TEACHER REFERRAL OF CHILDREN WITH
INTERNALIZING PROBLEMS

by

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ABSTRACT

Teacher Referral of Children with Internalizing Problems

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A survey addressing teacher referral of children with internalizing symptoms was developed and distributed to 883 first- through sixth-grade teachers in the state of Utah. The survey presented vignettes of children exhibiting symptoms of internalizing disorders. Respondents were asked if they would refer the child described in each vignette. The survey also asked respondents for information regarding the number of years they had been teaching, training they had received regarding children’s mental health, the types of mental health services available within their schools, and their beliefs regarding types of services schools should provide. Four ANOVAs were calculated in analyzing the potential factors influencing teachers’ decisions to refer the children in the vignettes. Further, descriptive data were used in illustrating additional information provided by the survey regarding the referral of children with internalizing disorders. Among the factors considered, teacher training was found to be statistically significant.
Number of years of experience, teacher beliefs, and number of services available did not reach statistical significance. The majority of teachers supported a variety of school-based mental health services.
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CHAPTER I

INTRODUCTION

Background

The child exhibiting symptoms of an externalizing disorder such as oppositional defiant disorder, who acts out in school, is generally easily recognized by teachers as one who may be in need of services. However, a child who has an internalizing disorder, such as depression or anxiety, is not as easily identified as one who needs services. Teachers often are unaware of the symptoms of internalizing disorders in children (Reynolds, 1990). Until the 1980s, internalizing disorders did not receive much attention in research literature (Reynolds, 1990). However, interest in childhood depression and anxiety has recently proliferated. Internalizing disorders in children are now gaining even more attention, particularly in light of the fact that many of the recent acts of school violence have been committed by adolescents who were not described as disruptive students, but were more apt to be suffering from internalizing problems (Skiba, 1999). However, there is still much left to be learned about childhood depression and anxiety, particularly in terms of initial identification of children suffering from these internalizing symptoms. Practical methods for identifying children with such internalizing symptoms remain unclear.

Developing effective ways of identifying children with internalizing symptomatology is critical in the pursuit of early intervention. A majority of depressed adults report that their first depressive episode occurred during adolescence (Burke,
Burke, Regier, & Rae, 1990); earlier ages of onset have also been reported (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994) states that more than half of individuals seeking treatment for generalized anxiety disorder report onset in childhood or adolescence (APA, 1994). Early detection is critical in preventing these problems from increasing in severity and becoming a life-long problem (Cicchetti & Toth, 1998; Forness, Kavale, MacMillan, Asarnow, & Duncan, 1996; Stark et al., 1997).

Teachers play an important role in the early identification of mental health problems a child may be experiencing (Wu et al., 1999), and can help facilitate mental health services by referring children to appropriate school-based mental health professionals.

Symptoms of internalizing disorders in children tend to be covert and inner-directed (Reynolds, 1990). The fact that many of the symptoms of such disorders are difficult to observe may contribute to the problem of underidentifying children who are in need of services (Reynolds, 1990). In fact, children’s self-reports often show higher rates of internalizing problems than do the reports of parents and teachers (Kolko & Kazdin, 1993). However, behaviors associated with internalizing disorders, such as deficits in social functioning (Bell-Dolan, Reaven, & Peterson, 1993; Huberty, 1997; Shah & Morgan, 1996) and a drop in academic performance (Huberty, 1997; Stark, 1990), are observable by others. If early intervention is the goal, recognizing such symptoms before they reach diagnostic levels is essential.

The negative impacts associated with depressive disorders include reduced competence in functioning of the child (Kovacs et al., 1984), and increased likelihood of
depressive episodes in adolescence and adulthood (Cole, Peeke, Martin, Truglio, & Seroczynski, 1998; Stark et al., 1997). Anxiety can lead to learning problems, decline in school performance, and social problems (Huberty, 1997). Additionally, internalizing disorders tend to be persistent; more than half of adults suffering from either anxiety or depression had their first onset of symptoms in childhood (Kovacs & Devlin, 1998). Unfortunately, children with internalizing problems generally go unnoticed in the classroom. However, training of teachers, regarding the symptoms of internalizing disorders such as depression, can help in identifying children with such problems (Stark 1990; Stark et al., 1997).

Although research has recently increased in the area of childhood depression, it has predominantly focused on epidemiology, etiology, course, outcome, and treatment response (Cicchetti & Toth, 1998). Anxiety disorders in children were also researched extensively in the 1980s (Reynolds, 1990). To date, however, very little research has focused on initial identification of children exhibiting internalizing symptoms, particularly within the school environment. Very few research studies exist with regard to teacher referral of children with internalizing problems.

The review of the literature begins with a brief description of internalizing disorders in children, including both anxiety and unipolar depression. Current knowledge regarding children’s manifestation of symptoms of each of the disorders is discussed briefly. Estimates of the prevalence rates for anxiety and depression, and the comorbidity of the disorders in children are also addressed. The importance of early identification and
Intervention for each of these persistent disorders is emphasized throughout the discussion.

Since internalizing disorders began receiving the attention of researchers only a little over two decades ago, research regarding internalizing disorders in educational settings specifically is predictably sparse. However, the few research studies that have given attention to this issue are described in the literature review. The current literature regarding teacher referral practices will be reviewed including those factors believed to impact teacher referral decisions. Studies involving issues of teacher referral of children with internalizing symptoms, teacher perception of school-based services, and teacher training in the area of children’s mental health will be briefly described and summarized.

Problem Statement

Internalizing disorders such as depression have prevalence rates of at least 2.5% in school-age children. Anxiety disorders are present in approximately 13% of children and adolescents. However, it is difficult to observe children’s behaviors that are indicative of internalizing disorders. For example, children’s self-reports often show higher rates of depression than do the reports of parents and teachers. Children may be better reporters of some of the symptoms of depression due to the nature of the symptoms, such as feelings of worthlessness or guilt, that are difficult for others to observe. Thus it is likely that the prevalence rate of depression is underreported. The fact that symptoms of such disorders are difficult to observe contributes to the problem of underidentifying children who are in need of services. Educating teachers regarding observable behaviors that are symptoms of
disorders such as depression and anxiety may help identify children who are in need of assessment and treatment. For example, an increase in withdrawal from peers may indicate problems with depression. A child who is visibly distressed by less than perfect scores on assignments may be experiencing problems with anxiety. A teacher who is educated regarding observable symptoms of anxiety and depression may be more likely to refer children with such problems. The purpose of this study was to assess possible factors associated with elementary school teachers’ willingness to refer children who are described as exhibiting symptoms associated with internalizing disorders.
CHAPTER II
REVIEW OF THE LITERATURE

Internalizing Disorders

In this chapter, a brief overview of childhood anxiety and depression is offered. Comorbidity and referral issues related to the two disorders are discussed. Following a description of each of the disorders, a review of relevant research in the area of teacher referral of children with internalizing disorders is presented. The review includes studies that address referral of children with internalizing disorders, teacher perception of school-based services, and teacher training in children's mental health.

Anxiety and depression are described as internalizing disorders, a domain that involves disturbance of mood or emotion (Kovacs & Devlin, 1998). Syndromes within the internalizing domain are typically described as overcontrolled and involve withdrawal, fearfulness, inhibition, or anxiety (Kovacs & Devlin). The more prevalent anxiety disorders in youth include separation anxiety disorder, generalized anxiety disorder, and specific phobia (APA, 1994; Kovacs & Devlin). The most prevalent depressive disorder in youth is major depression (Kovacs & Devlin).

Although depression and anxiety are distinct disorders and occur independently of each other (Ollendick & King, 1994), there are overlapping attributes between the two disorders. Anxiety and depression frequently co-occur (APA, 1994) and this high rate of comorbidity has led some researchers to believe that there are underlying variables involved in the development of both disorders. This line of thinking is supported by the
high correlation between negative affectivity and each of these disorders (Clark, Watson, & Mineka, 1994; Kovacs & Devlin, 1998). For instance, in a review of the literature regarding the association between temperament, personality, and the mood and anxiety disorders, Clark and her colleagues (1994) addressed the possibility that a negative attributional style, where an individual’s tendency to attribute negative life events to internal, global, and stable variables, may be associated with both anxiety and depression.

Anxiety and depression often first occur during childhood, share similar underlying variables (i.e., negative affectivity), and are frequently missed by school personnel with regard to identification and intervention. Both anxiety and depression are of particular interest in developing methods of early identification because both disorders tend to be persistent (Kovacs, 1996). The following sections provide a brief description of each of these disorders.

Anxiety Disorders

There are 12 separate disorders listed under the anxiety disorders section of the DSM-IV (APA, 1994) in addition to separation anxiety disorder, which is listed in the section for disorders first diagnosed in infancy, childhood, or adolescence. Anxiety disorders occur relatively frequently in childhood, affecting approximately 13% of children and adolescents (Shaffer et al., 1996). Kovacs and Devlin (1998) suggested that early childhood is a high-risk period for the onset of anxiety disorders. While a child exhibiting a single symptom of an anxiety disorder may not necessarily be cause for concern, a syndrome (or cluster of symptoms) may be an indication that intervention is necessary
even if the criteria for a disorder, as described in the DSM-IV, is not met. It is certainly preferable to intervene with a child before symptoms reach diagnostic levels, especially considering the persistence of anxiety disorders. As noted previously, the most commonly occurring anxiety disorders in children are separation anxiety disorder, generalized anxiety disorder, and specific phobia (Kovacs & Devlin, 1998). In the next section, each of these disorders is briefly described.

**Separation anxiety.** According to the DSM-IV, the central characteristic of separation anxiety disorder is “excessive anxiety concerning separation from the home or from those to whom the person is attached” (APA, 1994, p. 110). In order for a diagnosis to be made, the disturbance must be present for a period of at least 4 weeks and begin before the age of 18. This disturbance must also cause significant impairment in social, academic, occupational, or other important areas of functioning in order for a diagnosis to be made. School refusal can be a result of this disorder (APA).

The prevalence rate of separation anxiety disorder is estimated at about 4% (APA, 1994). Early onset of this disorder is specified if it is present in a child younger than 6 years of age. Younger children typically will not verbally express specific fears. As children develop, they may express their anxiety more in terms of specific fears of dangers such as kidnapping. During middle childhood, children may manifest symptoms by becoming anxious specifically in anticipation of separation (APA).

**Generalized anxiety disorder.** The essential feature of generalized anxiety disorder is excessive anxiety occurring more days than not for a period of at least 6 months (APA, 1994). In children, one of the following additional symptoms must also be present for a
diagnosis: (a) restlessness or feeling keyed up or on edge, (b) being easily fatigued, (c) difficulty concentrating or mind going blank, (d) irritability, (e) muscle tension, and (f) sleep disturbance (APA). Also required for a diagnosis is the child’s inability to control the anxiety, the anxiety is not confined to worries involved with other disorders (such as social phobia), and it causes significant impairment in the child’s social, academic, or other important areas of functioning (APA).

In an epidemiological study where data were collected longitudinally for 1,037 children at ages 11, 13, 15, 18, and 21, generalized anxiety disorder was diagnosed in 1.9% (n = 18) of the participants (Newman et al., 1996). Over half of individuals seeking treatment for generalized anxiety disorder report onset in childhood or adolescence and state that they have felt anxious and nervous all their lives (APA, 1994).

Specific phobia. The essential feature of specific phobia is a persistent fear of distinct, circumscribed objects or situations (APA, 1994). Exposure to the object or situation almost invariably causes symptoms of anxiety in the individual. Children may not recognize that their fears are excessive or irrational. Generally, children with this disorder avoid feared objects or situations. If this significantly impacts functioning, a diagnosis of specific phobia can be made if symptoms have been present for at least 6 months (APA).

During childhood, a peak prevalence rate occurs for specific phobia. The epidemiological study conducted by Newman et al. (1996) found a 1-year prevalence rate of 8.4% (n = 80) for simple phobia (now termed specific phobia by the DSM-IV, APA, 1994).
Childhood Depression

Despite the relatively recent interest in the area of childhood depression, much knowledge regarding the taxonomy, prevalence, and environmental factors involved in the disorder has been gained (for a comprehensive review see Cicchetti & Toth, 1998). Current knowledge about unipolar depression in children, including major depressive episode (MDE), major depressive disorder (MDD), and dysthymic disorder (DD), is briefly described in this section. Although diagnostic criteria are specifically addressed, it should be noted that symptoms of depression do not need to reach a diagnostic classification in order to warrant intervention. Once clinically referred children and adolescents have experienced a MDE, the likelihood of another episode is discouragingly high (70%; Kovacs, 1996), underscoring the need for early identification and intervention.

Point prevalence rates of depression in children ages 6 through 12 have ranged from 0.4% - 2.5% (Lewinsohn, Duncan, Stanton, & Hautzinger, 1986). The point prevalence rate of dysthymia in children has ranged from 0.6% - 1.7% (Lewinsohn et al.). However, when both DD and MDD are accounted for, the point prevalence rate is between 5% - 7% for children in Grades 4 - 7 (Stark, 1990; Stark et al., 1997). This is a striking statistic considering that “the vast majority of depressed children are never identified” (Stark, 1990, p. 76). Also, these are point prevalence rates for a diagnosis for disorder; percentages of children suffering from symptoms of depressive disorders that do not necessarily meet diagnostic criteria would presumably be even higher. Early intervention with such a persistent disorder is essential; thus, it would be best to identify children in need of services before their symptoms reach diagnostic levels.
The prevalence rate of depressive disorders for males and females is relatively equal for elementary school-aged children; this rate becomes less balanced as children reach puberty. In adolescence, females begin to experience depression more frequently than males at an approximate ratio of 2:1 (Stark et al., 1997), which is similar to the ratio of MDD reported in adults (Lewinsohn, Clarke, Seeley, & Rhode, 1994).

Major depressive episode. According to the DSM-IV (APA, 1994), a MDE is characterized by dysphoric mood or loss of pleasure in activities previously found enjoyable. Four of the following seven symptoms must also be present: (a) change in appetite or weight, (b) change in sleep patterns, (c) change in psychomotor activity, (d) decreased energy, (e) feelings of worthlessness or guilt, (f) difficulty thinking or concentrating, or indecisiveness, and (g) recurrent thoughts of death or suicidal ideation. These symptoms must be present most of the day and nearly every day for two consecutive weeks for a diagnosis of MDE. In addition, these symptoms must either cause impairment in social or academic arenas, or take a great deal more energy to function in these areas than it did prior to the episode. It should be noted that in children, irritable mood may take the place of dysphoric mood (APA), which is frequently the case. Stark (1990), in a study including 11 children with major depression in Grades 4 - 7, found that 5 children reported irritable mood. It should also be noted that the symptom of “change in appetite or weight” could be considered in children as “failure to make expected weight gains” (APA, p. 327). Many depressive symptoms impact a child’s functioning in school. For example, an inability to concentrate could potentially cause a significant drop in grades (APA). This is of particular concern when the average length of
a depressive episode in children is 7 - 9 months (Birmaher et al., 1996), perhaps a significant proportion of a child’s school year.

**Major depressive disorder.** According to the DSM-IV (APA, 1994) diagnostic classification system, MDD is characterized by one or more major depressive episodes. Also reported in the DSM-IV (APA) is that as many as 15% of individuals with MDD commit suicide. Although MDD is not as common in children as it is in adults (DSM-IV, APA, 1994), this statistic illustrates the need for early intervention when symptoms of depression are present in children. In fact, Kovacs (1996) reported that population studies have shown that up to 40% of adults with MDD had their first onset of the disorder in childhood.

**Dysthymic disorder.** The cardinal symptom of dysthymia in children is a chronically depressed mood for most of the day, for the majority of days, over a period of 1 year (DSM-IV, APA, 1994). Again, irritable mood may be the symptom exhibited by children rather than depressed mood. In addition to dysphoric or irritable mood, a child must present with two of the following six symptoms for a diagnosis of dysthymia: (a) poor appetite or overeating, (b) insomnia or hypersomnia, (c) low energy or fatigue, (d) low self-esteem, (e) poor concentration or indecisiveness, and (f) feelings of hopelessness. During the 1-year period, intervals where the child is not experiencing symptoms must be less than 2 months (DSM-IV, APA). The DSM-IV states that children with DD may experience “impaired school performance and social interaction” (p. 347). Kovacs and colleagues (1984), in a longitudinal study of children with depressive disorders, found that
of 27 subjects with dysthymia, 50% went on to experience a MDE within 3 years and 4 months (Kovacs et al., 1984).

Comorbidity of Internalizing Disorders

Comorbid disorders are common in children with depression. According to Cicchetti and Toth (1998), 40% - 70% of children and adolescents with depressive disorders develop another disorder. Dysthymia and anxiety disorders are the most frequently co-occurring diagnoses with MDD. For each disorder, researchers have found comorbidity rates ranging from 30% - 80% (Birmaher et al., 1996). Disruptive behavior disorders are also common comorbid diagnoses (10% - 80%). Depressed individuals who have a comorbid disruptive behavior disorder have fewer recurrences of depression than those with a depressive disorder alone, as well as fewer melancholic symptoms. Those who have major depression comorbid with either dysthymia or an anxiety disorder tend to have more severe and longer episodes, increased suicidality, and more psychosocial problems (Birmaher et al.). Due to differences in symptoms, course, and outcome between groups of children with depression alone, or with depression comorbid with another internalizing disorder, and children with comorbid depressive and disruptive disorders, it is possible that the depressed children with comorbid disruptive disorder diagnosis are an etiologically distinct group (Birmaher et al.).

Referral of Children with Internalizing Disorders

Because children generally do not refer themselves for mental health services,
identification of children in need of services is a critical issue requiring attention. Teachers and parents are essential when it comes to identification and referral for children who require mental health services (Wu et al., 1999). Referral of a child generally requires the recognition of a problem by an adult, so it is more likely that a child with a disruptive behavior disorder will gain the attention of school personnel and be referred for services whereas a child with depression, or depression comorbid with another internalizing disorder such as an anxiety disorder, will be less likely to be referred for services (Stark, 1990).

Although research has increased in the area of childhood depression and anxiety, very little research exists that address teacher referral rates of children with internalizing disorders. One study was located that addressed internalizing disorders with respect to teacher referral rates. Lloyd and colleagues analyzed the special education referral records for children in kindergarten through middle-school and found that depression was “rarely included” as a referral reason (Lloyd, Kauffman, Landrum, & Roe, 1991). Of 382 referral forms that were reviewed, 1% included depression as a possible area of concern. This is an extremely low percentage when considering that this is 1% of those referred for special education and not of those in the general population, and in light of Stark’s estimate of a 5% - 7% point prevalence rate of depressive disorders in children in Grades 4 - 7 (Stark, 1990; Stark et al., 1997). The second of two categories specific to internalizing symptoms was “anxious, fearful, and withdrawn” (Lloyd et al., p. 119) and was listed as a reason for referral on 2% of the forms; again, much lower than the prevalence rate of anxiety disorders in children. It is important to note, however, that it is unclear from the data
reported in this article whether internalizing symptoms were listed as the sole reason for referral, or they were listed in conjunction with other problems. Thus, even in these cases, the internalizing problem may not have been the major impetus for the referral.

Teachers’ Perceptions of School-Based Services

Even if a child receives a clinical diagnosis of either a depressive disorder or an anxiety disorder, he or she may not qualify for special education classification under the Individuals with Disabilities Education Act (IDEA; Pub. L. No. 94-142) unless it is demonstrated that the disorder is adversely affecting academic performance. However, even if a child qualifies for such services, special education placement may not be the best decision for the child. Stark (1990) cautioned that special education placement may not be the best decision for the depressed child, given that many special education programs use a “pull-out” system where the child goes to a resource room for services. This action could inhibit social connections with classmates, which is of particular concern for children with depressive symptoms. In addition, this could reinforce children’s negative thoughts about their abilities by making them feel as though they are not as intelligent as their classmates and must receive special services as a result (Stark). There are alternatives to pull-out programs, however. Adaptation of curriculum (e.g., extended time or shortened assignments), and an individually designed educational plan are features of special education that can potentially benefit a child suffering from symptoms of either depression or anxiety.

It is possible that teachers who are in school systems with traditional pull-out
special education programs will be less likely to refer a child with depressive or anxious symptomatology to school professionals with knowledge of mental health issues (i.e., school psychologists). For example, if teachers are under the impression that referring a child for evaluation is purely for special education qualification purposes, the teacher may be hesitant to make such a referral. In this case, it is the school resources available that may be affecting referral and intervention for children with internalizing symptoms.

Although research regarding variables that affect teacher referral of children with internalizing disorders remains sparse to nonexistent, some researchers have shown that teachers' perceptions, attitudes, and beliefs affect the decision to refer a child.

Pugach (1985), in a survey of 39 elementary and junior high school teachers, reported that over half (54%) of the teachers initiated a referral in hopes of obtaining auxiliary services rather than having a change in placement as the primary goal of referral. Many of the teachers indicated that special education was not necessarily an appropriate intervention, but felt that it was the only option available (specific data in support of this statement were not reported). Nineteen percent of the respondents used referral for special education solely as a method of gaining additional information about their student and not as a means for a change in placement. Although these teachers referred children, it remains unclear whether a lack of options for school-based mental health services influences a teacher's decision to refer. Perhaps teachers would refer more children if more services were available. Or, perhaps teachers would be less likely to refer children for special education evaluation, and more likely to refer children for school-based, mental health services if such services were available to children who might benefit from such
services, but not necessarily from special education. How these issues affect referral decisions with respect to children with internalizing problems is an area sorely in need of further investigation.

Mamlin and Harris (1998) conducted a qualitative study with three teachers at an elementary school that had implemented inclusion in striving toward the goal of integrating regular and special education. Through interviews, observations, and inspection of student file data, the authors concluded that the number and variety of resources available, as well as teachers' belief systems about inclusion were influential factors in the teachers' decisions to refer. Interestingly, the three teachers who were included in this study had referred children in the preceding year primarily for social-behavioral problems and academic problems were seen as secondary.

In a study addressing special education referrals, Waldron and colleagues, following a semistructured interview format, interviewed 24 elementary school teachers who were nominated by their principals as either low-referring (n = 12; less than one referral in the last 2 years) or high-referring (n = 12; approximately five referrals in the last 2 years; Waldron, McLeskey, Skiba, Jancaus, & Schulmeyer, 1998). The researchers then categorized the teachers' responses into broad categories including: (a) interventions initiated prior to referral, (subcategories of pre-referral interventions that are potentially relevant to children with internalizing symptoms included affective interventions and information about the students' home situations), (b) resources used to make the referral decision, (c) factors teachers considered when deciding whether to refer, and (d) general referral practices. Regarding pre-referral interventions, low-referring teachers were more
likely to use grouping, adapted curriculum materials, affective interventions, and classroom management. High-referring teachers were more likely to use one-on-one interventions and peer assistance. High- and low-referring teachers were approximately equally likely to try contacting parents and use school programs. Regarding affective interventions, teachers reported attempting to increase students' self-concepts and levels of motivation. It is interesting to note that none of the high-referring teachers attempted such interventions but that four (33%) of the low-referring teachers reported using such interventions. Resources that teachers used when referring children included a review of previous information, consultants, parent requests for referral, and information about the student's home. High-referring teachers were more likely to review previous information, contact consultants, act on a parent request for a referral, and find out more information about the student's home. Factors that teachers considered when deciding whether to refer children included the student's academic performance, the student's behavioral performance, whether the teacher had "exhausted all options," whether the teacher suspected a disability, the student's family characteristics, and the student's ability. High-referring teachers were more likely to consider academic performance, the student's family characteristics, and they were more likely to suspect a disability. Low-referring teachers were more likely to exhaust their options before making a referral. High- and low-referring teachers equally considered the student's behavioral performance, and the student's ability. The authors concluded that attitudes, beliefs, and values affected the referral practices of the teachers participating in the study. In addition, the authors mentioned that low-referring teachers tended to be more willing to adapt instruction
before making a referral. Although this is certainly not viewed as problematic, in the case of internalizing disorders, it is unlikely that instructional adaptations in isolation will adequately address the problem. This study demonstrates that some of the teachers involved in this investigation took an interest in playing an active role in helping children with emotional problems. Perhaps teachers with increased knowledge about symptoms of internalizing disorders in children can help not only by modifying instruction in the classroom for children who may be suffering from anxiety or depression, but also by taking action by referring children who may need additional support from mental health professionals.

These studies provide preliminary evidence that a relationship exists between teacher characteristics, such as willingness to use prereferral adaptations, flexibility in the use of school resources, beliefs about inclusion, and teachers' likelihood of referring children for special education. What these studies do not address is the likelihood of a teacher to refer a child with an internalizing disorder such as depression or anxiety in light of the teacher's beliefs about services provided by the school. Whether or not teachers believe schools should be involved at all in the assessment and treatment of children with emotional problems and how this belief might impact referral decisions is another area that needs to be addressed. Such research is needed to explore the relationship between teacher beliefs regarding whether school-based mental health services should be provided, and a teacher's willingness to refer children with internalizing symptoms. The relationship between teacher perception of the services currently available in schools and the likelihood of teacher referral is also in need of further exploration. Both these relationships need to
be investigated in order to provide critical information regarding early identification of children with internalizing symptoms. Implementation of an early identification and intervention program specifically for children with internalizing disorders will not be successful unless a deeper understanding of teachers’ perceptions of school-based mental health services for such disorders exists.

Teacher Training in Children’s Mental Health

Teachers’ perception of the services available to children is just one factor related to the identification of children with internalizing symptoms. Teachers’ knowledge of the symptoms associated with internalizing problems is another factor that warrants consideration. Educating teachers regarding observable behaviors that are symptoms of internalizing disorders may help identify children who are in need of assessment and treatment. In a review of the literature in the area of teacher knowledge of children’s emotional disorders, three studies were identified that addressed this issue (i.e., Cheney & Barringer, 1995; Green, Clopton, & Pope, 1996; Ines & Sacco, 1992). The focus of most of these studies was solely on depression, while anxiety was not considered.

Ines and Sacco (1992) specifically addressed the issue of the effectiveness of teacher training in the area of childhood depression by measuring the change in correspondence between teacher and child reports of depressive symptoms after an inservice training on depression was provided to teachers. In this investigation, 418 students and their 31 teachers completed the Children’s Depression Inventory (CDI; Kovacs, 1992). Items for the teacher version were completed “in a way that best
described that child over the previous 2 weeks." Of the 418 students who completed the first CDI, 181 were then randomly selected by the investigators as "target" students who scored low (CDI = 0-5; n = 61), middle (CDI = 6 - 11; n = 60), and in the upper third (CDI = 12 - 40; n = 60). Two target students (1 male and 1 female) from each scoring category were selected from each classroom, yielding a total of 6 children per classroom.

Sixteen teachers were then randomly selected to participate in a training session that consisted of a 25-minute video addressing the symptoms of depression according to DSM-III (APA, 1980) criteria. These teachers were asked to observe the target children in their classrooms for the next 3 days, after which they were again asked to complete a teacher-CDI. Teachers who received the training did not improve their teacher-CDI correspondence rates with their students' CDI self-reports (all ps > .10 between pre- and posttest; correspondence rates with r = .44, p < .001 for both groups at pretest).

However, it was found that teachers who reported higher levels of familiarity with target students had significantly higher correlations (r = .49; p < .01 for both groups at pretest) than with target students with whom they were not as familiar (r = .01) at the pretest. In addition, pretest results showed that CDI items addressing school-related behaviors, such as "I have to push myself all the time to do my schoolwork," "I do very badly in subjects I used to be good in," and "I never do what I am told," had moderate correlations between teacher and student reports ranging from .31 to .33. Another teacher-CDI item addressing self-evaluation, "I can never be as good as other kids," was moderately correlated with the corresponding student item (.31). Not surprisingly, items that addressed problems that would be difficult for teachers to observe such as sleep habits (r = .05) and appetite (r =
.00) were not significant. This illustrates the fact that teachers can identify certain symptoms of depression better than others and that perhaps a training program should emphasize symptoms that are more easily recognizable in the school setting. The fact that one study investigating the effectiveness of teacher training in the area of childhood depression did not show promising results (e.g., an increase in correspondence between teacher and student CDI reports) should not discourage further research in this area. Educating teachers about behaviors associated with internalizing problems that they are likely to see in the school setting, in conjunction with education regarding appropriate referral practices, may show more promising results, such as an increase in referral of children with internalizing problems for mental health services.

Ines and Sacco (1992) also assessed teacher knowledge regarding symptoms of depression. Knowledge of symptoms increased after a training session. Teachers listing an average of 2.86 symptoms at a pretest administered before the training session listed an average of 6.71 symptoms at posttest, whereas teachers who did not receive the training showed no improvement (pretest $M = 2.64$; posttest $M = 2.27$). The major limitation identified by the authors of the study was that the 25-minute videotape might not have been sufficient regarding content and length, and student-teacher correspondence may have increased at posttest if the training had been more in-depth. However, as noted earlier, teachers may not be aware of symptoms that are not exhibited at school (e.g., a child’s sleep patterns). Thus, student-teacher correspondence rates will certainly never reach a perfect correlation. However, teachers can observe symptoms that are present in schools and training should focus on such aspects of childhood depression (and anxiety).
In addition, this study did not address the issue of whether or not teachers would refer target students for evaluation. It is possible that referrals would increase as a result of the training session. Stark (1990) reported in his book, *Childhood Depression: School-Based Intervention*, that after completing an inservice on childhood depression, he usually sees an increase in the label of depression for referred students. Nonetheless, it is possible that in some schools where mental health services are not emphasized, teachers would not be as likely to refer children with depressive symptoms as a result of an inservice. Even if teachers are aware of the symptoms of depression, if they feel the services available are inadequate, they may be less likely to refer their students. Future research in this area needs to address this possibility.

In a study conducted by Green et al. (1996), the investigators addressed the referrability of children exhibiting symptoms of internalizing versus externalizing disorders. The authors analyzed survey data from 135 first-, second-, and third-grade regular education teachers. Surveys included a demographic questionnaire, four vignettes describing children with either externalizing or internalizing problems, and questions about referral issues for the children described in the vignettes. The vignettes were modeled after symptoms listed on the Child Behavior Checklist Teacher Report Form (CBCL-TRF; Achenbach & Edelbrock, 1986). One vignette was of a boy with an externalizing disorder; another was of a girl with an externalizing disorder. Symptoms of internalizing disorders were described for both a boy and a girl in the remaining two vignettes. According to the teachers’ responses to the referral questions about the vignettes, children with externalizing disorders were more likely to be referred than children with internalizing
disorders (86% and 55%, respectively). It is interesting to note that the girl with internalizing problems (65%) was more likely to be referred than the boy with internalizing problems (38%). The authors concluded that gender and problem-type (i.e., internalizing vs. externalizing) were significant in a teacher’s decision to refer a child. Not only are children with internalizing problems less likely to be referred than their externalizing counterparts, but boys with internalizing problems may be less likely than internalizing girls to be referred, leaving internalizing boys sorely underserved. The majority of teachers (79%) responded that they had encountered a male student similar to the one described in the internalizing disorder vignette. Sixty-nine percent of the teachers reported encountering a girl similar to the one depicted in the internalizing disorder vignette. In a question regarding whether or not teachers thought that the students’ problems would dissipate with maturation, 61% of teachers thought the students with internalizing problems would improve whereas 41% of teachers thought that students with externalizing problems would improve. These results indicate that teachers believe externalizing disorders are “more chronic and severe than internalizing ones” (Green et al., 1996, p. 188), despite clear empirical research documenting that depression is a chronic problem (e.g., Kovacs et al., 1984). It is of particular interest that many teachers commented on a feedback sheet that they “felt insecure about referring children to mental health services because they had not received training in the area of children’s mental health” (p. 189), although specific data on this issue were not reported. It is not clear from the quoted comments whether or not the teachers wanted to have an active role in the referral of children to mental health services.
Green et al. (1996) reported that their findings are limited in generalizability because all teachers were from the same geographic region (southwest Texas) and they recommend replicating the study with other groups of elementary school teachers. They also mention the limitation of the vignettes with respect to the fact that the descriptions of the boy and the girl experiencing the same type of problem (i.e., internalizing vs. externalizing) were not identical. However, the authors stated that “care was taken to keep the overall severity of the problems comparable for the four vignettes” (p. 189). The fact that the vignettes were developed based on a commonly used behavior checklist (Child Behavior Checklist [CBCL]; Achenbach & Edelbrock, 1986), and they were validated by school professionals and child psychologists lends credibility to their survey. One drawback to their study is that they did not systematically assess teacher training as a factor in referral. The information regarding training was only made available through informal feedback from the respondents.

Cheney and Barringer (1995), as part of a pilot phase of an investigation regarding the knowledge and skills that teachers need in order to educate students with emotional and behavioral disorders (EBD), found that teachers’ perceptions of their own competence in this area was low. The self-report instrument, Emotional and Behavioral Disorders Teacher Competency Survey (Braaten, 1993), was administered to 26 teachers who were teaching fifth, sixth, and seventh grades. Using a 5-point scale ranging from 1 (little or no competence) to 5 (mastery), teachers were asked to respond to items indicating their level of competence in a variety of areas such as knowledge of characteristics of students with EBD. Overall, teachers participating in the investigation
reported that they had only little to moderate competence regarding knowledge or skills in
five domains: (a) characteristics of learners, (b) managing the learning environment, (c)
communication and collaboration, (d) managing children with EBD, and (e) monitoring
individual students with EBD. Specifically regarding characteristics of children with EBD,
the mean score was 1.93 (SD = .88). Concerning referral processes to appropriate
professionals in state or local agencies, the mean score was 1.66 (SD = .14). One of the
limitations of this study mentioned by the authors includes the fact that support from
professional specialists within the schools was not considered systematically, an issue
requiring further investigation. Another limitation recognized by the authors is that the
sample size was relatively small. In addition, the researchers focused mainly on
externalizing disorders and once again, internalizing disorders were given very little
acknowledgment, even though students with anxiety and depression can be considered
emotionally and behaviorally disordered.

In summary, these studies reveal several items of interest. One study looked
directly at teacher training regarding emotional and behavioral disorders and found that
the majority of teachers felt unprepared to deal with such problems. Another study found
anecdotal evidence that teachers felt they did not have enough training in mental health
issues to make adequate referrals. Finally, one study found that teacher training has an
effect on teacher knowledge regarding symptoms of depression, but that it does not affect
correspondence between teacher-student reports of depression (yet perfect student-
teacher correspondence is not necessary in identifying children with internalizing
symptoms). All three studies demonstrate a need for training. No studies addressed the
possible impact on the number of years of teaching experience on teacher referral rates, another factor worthy of exploration.

According to teachers' self-reports in the previously mentioned studies, there is a serious need for training teachers in the area of children's mental health. Although it should not be expected that teachers accurately classify children's emotional and behavioral problems, it is essential for teachers to be able to identify children who are in need of further assessment and possible mental health services for early detection of internalizing symptoms. Further research needs to be conducted involving a teacher needs assessment regarding training in children's mental health. Although teachers have reported that their competence and training in the area of emotional and behavioral disorders are low to nonexistent, this does not necessarily imply that teachers want to have this training. This issue needs to be explored in order to determine the possible effectiveness of teacher training regarding symptoms of internalizing disorders in children.

Together, the research reviewed shows that students with internalizing disorders are not as likely to be referred for services as their externalizing counterparts; internalizing problems are rarely listed as a reason for referral. Also, teacher beliefs, attitudes, and values may be influential in teachers' decisions to refer children with internalizing problems. In addition, the number and variety of resources available in a school may influence a teacher's decision to refer. Last, the research shows that teachers lack training in dealing with children who have emotional and behavioral disorders, but that training indeed increases teacher knowledge about the symptoms of an internalizing disorder. Teachers play a critical role in the identification and referral of children who need mental
health services. It is important to understand more fully the potential impact that various factors have on teachers’ decisions to refer children exhibiting symptoms of anxiety and depression. These factors include teacher characteristics (such as years of teaching experience), teacher beliefs about school-based services, teacher perceptions of the services available in their school systems, and finally, teacher training. A preliminary survey of teachers addressing these factors will provide critical information in the area of teacher referral of children with internalizing problems.
CHAPTER III
PURPOSE AND OBJECTIVES

The present research study investigated relationships between teachers' perceptions of mental health services in schools, and their likelihood of referring children with internalizing symptoms. Possible factors influencing a teacher's decision to refer a child with an internalizing disorder were explored, including teachers' beliefs about whether or not schools should provide mental health services, teachers' perceptions of existing mental health services within their schools, teachers' exposure to information about childhood depression and anxiety, and number of years of teaching experience. These factors and their relationships with a teacher's decision to refer a child exhibiting symptoms of an internalizing disorder were investigated. Specifically, the present research study addresses the following research questions:

1. What factors impact a teacher's recommendation to refer a child with internalizing symptoms? Specifically, what is the relationship between teachers' referral decisions and the following teacher variables: training about childhood anxiety and depression, years of experience, available mental health services for children, and beliefs about school provision of mental health services.

2. What types of school-based mental health services do teachers think should be available to children with internalizing disorders?

Answers to these research questions provide needed information in designing and implementing programs for training teachers in the area of childhood depression and
anxiety. Regarding the first research question, it was hypothesized that teachers who reported having received a greater amount of training regarding anxiety and depression would be more likely to refer children with internalizing symptoms. In contrast, it was hypothesized that teachers with more years of experience would be less likely to refer children like the ones described in the internalizing vignettes. It was also hypothesized that teachers who reported a lack of availability of school-based mental health services for children with symptoms of anxiety or depression would be less likely to refer children with such problems. Finally, it was predicted that teachers who reported believing schools should not provide school-based mental health services would not be as likely to refer children with internalizing problems. In addressing the second research question, it was predicted that teacher consultation, parent education, group counseling, and individual counseling would be endorsed by the majority of respondents as being appropriate services for children within the schools.
CHAPTER IV

METHOD

Participants

Participants were 282 regular education, first- through sixth-grade teachers in the state of Utah. Two-hundred-fifty-five were female (90.4%), and 27 were male (9.6%). Two-hundred-seventy-five were White (97.5%), three were Hispanic/Latino (1.1%), and three were Asian/Pacific Islander (1.1%). Only one respondent elected not to respond to the ethnicity question in the demographics section.

Approximately half of the respondents (51%) taught early elementary grades (first through third grades), and slightly less than half of respondents (43%) taught upper elementary grades (fourth through sixth grade). The remaining respondents (6%) reported teaching a combination class with more than one grade. With regard to education level, the majority of teachers reported holding a bachelor’s degree. A fairly even distribution is present in the sample with regard to teachers’ reports of the number of years of experience they had in teaching. The mean number of years of experience was 13.92 years. The reader is referred to Table I for a full breakdown of the demographic information.

Measure

The instrument for the present study was a survey divided into three sections. Part I was the vignette section, Part II was the training and services section, and Part III was the demographic section. Each section included questions regarding both internalizing and
Table 1

Demographic Breakdown of Survey Respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Grouping</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Female</td>
<td>255</td>
<td>90.4</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>27</td>
<td>9.6</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White</td>
<td>275</td>
<td>97.5</td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latino</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>Asian/Pacific Islander</td>
<td>3</td>
<td>1.1</td>
</tr>
<tr>
<td></td>
<td>Other/No response</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Grade level taught</td>
<td>First</td>
<td>53</td>
<td>18.8</td>
</tr>
<tr>
<td></td>
<td>Second</td>
<td>52</td>
<td>18.4</td>
</tr>
<tr>
<td></td>
<td>Third</td>
<td>38</td>
<td>13.5</td>
</tr>
<tr>
<td></td>
<td>Fourth</td>
<td>45</td>
<td>16.0</td>
</tr>
<tr>
<td></td>
<td>Fifth</td>
<td>38</td>
<td>13.5</td>
</tr>
<tr>
<td></td>
<td>Sixth</td>
<td>37</td>
<td>12.8</td>
</tr>
<tr>
<td></td>
<td>Combination (early elementary)</td>
<td>7</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Combination (upper elementary)</td>
<td>6</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td>Combination (k-6; 1-8)</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>Highest degree</td>
<td>Bachelor’s</td>
<td>197</td>
<td>70.0</td>
</tr>
<tr>
<td></td>
<td>Master’s</td>
<td>83</td>
<td>29.4</td>
</tr>
<tr>
<td></td>
<td>Doctorate</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Years of experience</td>
<td>0-5</td>
<td>65</td>
<td>23.0</td>
</tr>
<tr>
<td></td>
<td>6-10</td>
<td>48</td>
<td>17.0</td>
</tr>
<tr>
<td></td>
<td>11-15</td>
<td>51</td>
<td>18.1</td>
</tr>
<tr>
<td></td>
<td>16-20</td>
<td>50</td>
<td>17.7</td>
</tr>
<tr>
<td></td>
<td>21 plus</td>
<td>68</td>
<td>24.1</td>
</tr>
</tbody>
</table>

The vignette section was comprised of the four vignettes developed by Green et al. (1996). The vignettes were created based on the CBCL-TRF (Achenbach & Edelbrock, 1986). Green et al. designed each of the vignettes so that the children being described would be placed at approximately the 85th percentile on the CBCL-TRF. One vignette
described an internalizing boy; another described an internalizing girl. There were also two externalizing vignettes, one describing a girl and the other a boy. To increase face validity of the vignettes, Green et al. requested that special services staff provide feedback for preliminary versions of the vignettes. The investigators then presented finalized versions to child clinical psychologists who verified that the vignettes depicted children exhibiting symptoms at approximately the 85th percentile on the CBCL-TRF. These vignettes were then used in the survey conducted by Green et al. (1996) in their investigation of gender differences in referral of children for mental health services.

In the present study, the externalizing vignettes were used in addition to the internalizing vignettes in order to help disguise the purpose of the survey. Although data from the externalizing vignettes were not the main focus this study, a precautionary modification was made—the wording was altered slightly for the externalizing boy vignette. The original vignette stated that some of the boy’s classmates had reported that he had “threatened them.” When the current survey was piloted with 32 students majoring in education at Utah State University, nearly every respondent stated they would “definitely refer” the externalizing boy. Given recently well-publicized acts of school violence, it was determined that the wording in the externalizing vignette was too strong. Therefore, the wording was changed to say that some of the boy’s classmates had reported that he was “mean to them.” For a review of each of the vignettes, the reader is referred to the survey in Appendix A.

Three questions followed each of the four vignettes. The first question regarded whether or not teachers would refer the children described in the vignette. Respondents
were asked to circle one of four Likert-scale responses: 1 = definitely not refer, 2 = probably not refer, 3 = probably refer, and 4 = definitely refer. The second question asked respondents to report how many students similar to the one in the vignette they had referred within the last year. The last question asked respondents to rank order the individuals with whom they would consult when seeking assistance with such a child (e.g., school counselor, colleague, school psychologist, principal).

The training and services section of the survey included nine items addressing teacher training in the area of children’s mental health, types of mental health services their schools provide for students, if the respondent thinks schools should provide mental health services in schools, and if they desire future training in the area of children’s mental health. For two items in this section, teachers were asked to place a check mark next to any of four areas in which they had received preservice or inservice training, including attention-deficit/hyperactivity disorder (ADHD), behavioral interventions, depression, anxiety, and disruptive behavior. For both items, they were also given the opportunity to list any other areas concerning children’s mental health in which they received training. A third item addressed mental health services currently available within the teachers’ schools. Respondents were asked to state whether or not services were available to students who had ADHD or disruptive behavior problems but who did not qualify for special education services or Section 504 plans. The next question asked respondents to identify methods of service delivery available to children with ADHD or disruptive behavior disorders, including teacher consultation, group counseling, individual counseling, and parent education. Teachers were asked to place a check mark next to each applicable service.
The next two items followed the same format, asking the same questions with regard to children with depression and/or anxiety. Again, for both items, teachers were given the opportunity to list any other services that were available. The seventh item in the training and services section asked teachers to select, from a list, methods of service delivery they felt their schools *should* provide. The list included the services mentioned in the previous items. Item eight asked teachers to state whether they wished to receive training in the area of children's mental health by checking "yes" or "no." Finally, the last question in the second part of the survey asked teachers to rank order the children's mental health areas in which they would like to receive training. These areas included ADHD, disruptive behavior, anxiety, and depression. Again, a space was provided for them to list any other areas in which they wished to receive training.

The third and last part of the survey included six demographic questions addressing gender, ethnicity, education level, specialization, grade level taught, and number of years of experience. A section at the end of the survey was reserved for comments so that teachers could include additional information they felt needed to be considered. A cover letter accompanied the survey that introduced the principal investigator and the reason for the research study regarding students with emotional and behavioral problems, and is included in Appendix B.

**Procedures**

Surveys were sent to approximately 10% of the teachers in the state of Utah. In the 1997-1998 school year, approximately 8,830 first- through sixth-grade teachers were
employed by school districts in the state of Utah (Utah State Office of Education, 1998); thus, 883 names were requested from the Utah State Office of Education. Names were randomly selected to prevent any bias and provide a good representation of school districts with varying means of providing mental health services to children. The Teacher Certification Department of the USOE was unable to randomly select the names; therefore, a full database with teachers’ names and addresses was made available to the investigators. Using Microsoft Excel, 883 teachers who taught first through sixth grades were randomly selected to participate in the survey.

Once the random sample of participants was selected, 883 surveys with accompanying cover letters were mailed. The cover letter requested that the surveys be returned within one month. As an incentive for returning surveys within this time period, participant numbers were entered in a drawing for a $75.00 reward. Two-hundred-fifty-seven surveys were returned before the deadline. After one month, follow-up postcards reminding teachers to respond to the survey were sent to those who had not yet responded. An additional 50 surveys were returned, resulting in a 34.8% response rate.

Although the database of teacher names provided by the Utah State Office of Education identified those who taught special education, and those teachers were removed from the sample from which the random selection took place, two returned surveys were from teachers who taught in self-contained classrooms. Because the survey was intended for regular education teachers, those two surveys were dropped from the sample. Thirteen surveys were excluded due to incomplete data. Eight surveys were excluded because respondents had not answered critical items in the survey regarding services they
believed should be available, future training they desired, and demographic information.

Some respondents did not indicate their likelihood of referral on at least one of the vignettes in the vignette section of the survey. Those who did not respond to any of the four vignettes were dropped from the analysis (n = 4). In all, 25 surveys were dropped from the obtained sample, resulting in a sample size of 282 teachers (32% of the surveys that were sent).
CHAPTER V

RESULTS

Results for each of the research questions will be presented in this section, as well as a description of supplementary survey data. The first research question asked if specific variables were related to a teacher’s decision to refer a child in a vignette who is described as exhibiting symptoms of an internalizing disorder. The variables of interest were training about childhood anxiety and depression, years of teaching experience, available mental health services for children, and beliefs about school provision of mental health services. The second research question asked what types of mental health services teachers believe schools should provide. Descriptive data are used in reporting results regarding which types of services (i.e., teacher consultation, individual therapy, group counseling, and parent education) were endorsed. Following a description of the results of the research questions, descriptive data are presented on the outcome of additional items of interest that emerged from the survey data. Items of interest include overall referral rates of the children in each of the four vignettes, consultation resources, school-based services teachers reported as being available to children with anxiety and depression, training teachers received in children’s mental health, and future training desired. Finally, teacher comments are summarized.

Initial Data Analyses

Data were first coded numerically so that ANOVAs could be calculated. Because
students in schools are either referred or not referred, and probable referrals do not allow
a child access to services, the referral categories from the Likert-scale responses were
collapsed from four groups into two groups. For each of the internalizing vignette
questions in the survey, a response was considered a referral if the teacher marked that
he/she would either “probably refer” or “definitely refer” a child like the one in the
vignette. A response was considered a nonreferral if the teacher marked that he/she would
either “probably not refer” or “definitely not refer” the child. Teacher referral decisions
were then divided among three categories: “refer neither,” “mixed,” and “refer both.”
Those in the “refer neither” category were those who chose not to refer either of the
children in the internalizing vignettes. Those in the “mixed” category were those who
referred one of the children exhibiting internalizing symptoms, but not the other. Those in
the “refer both” category were those who referred both of the children described as
experiencing internalizing problems. Thus, teacher referral was coded using an ordinal
scale where “neither” = 0 (where 0 of the 2 children were referred; n = 64), “mixed” = 1,
(where 1 of the 2 children were referred; n = 88) and “both” = 2 (where 2 of the 2 children
were referred; n = 130). Single-factor ANOVAs were then calculated in analyzing each
of the potential factors of interest involved in teachers’ decisions to refer the children in
the internalizing vignettes. Alpha was set at .05 in determining statistical significance for
each factor. In all, four ANOVAs were calculated, one for training, one for years of
experience in teaching, one for number of services available in schools, and another for
number of services teachers feel should be available in schools. Following each ANOVA,
effect sizes were calculated using eta squared for each factor. Effect sizes of .10 to .24 are
considered small; .25 to .39 are considered medium, and .40 and above are considered large (Cohen, 1969, as cited in Spatz, 1997). Descriptive data were used in analyzing the remainder of the data and are reported using frequencies and percentages.

Possible Variables Influencing Referral Decisions

This section presents the results of the ANOVAs that were calculated in answering the first research question: What factors influence a teacher’s decision to refer the children in the internalizing vignettes? Table 2 provides the reader with a summary of the results for each factor.

Training

To evaluate the relationship between teacher referral and training, both preservice and inservice training were collapsed together and counted as having received training (either preservice or inservice) in anxiety or depression, both anxiety and depression, or neither anxiety nor depression. The following categories were used: Group 1 = “Anxiety or Depression,” reflecting training in either anxiety or depression ($n = 31$); Group 2 =

Table 2

Potential Factors in Teachers’ Referral Decisions

<table>
<thead>
<tr>
<th></th>
<th>F</th>
<th>p</th>
<th>ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>3.7</td>
<td>.03</td>
<td>.03</td>
</tr>
<tr>
<td>Experience</td>
<td>.86</td>
<td>.49</td>
<td>.01</td>
</tr>
<tr>
<td>Services</td>
<td>.67</td>
<td>.61</td>
<td>.01</td>
</tr>
<tr>
<td>Beliefs</td>
<td>.30</td>
<td>.88</td>
<td>.00</td>
</tr>
</tbody>
</table>

Note. For each factor, $n = 282$, with the exception of Services, where $n = 244$. 
“Both,” reflecting training in both anxiety and depression (n = 51); and Group 3 = “Neither,” denoting those who reported no training in either anxiety or depression (n = 200).

A statistically significant relationship was found to exist between teacher training and teachers’ decisions to refer the children in the internalizing vignettes (F = 3.7; p < .03). Effect size was calculated by using eta squared (η²). The resulting effect size was 03, which is considered small. Table 3 presents the training ANOVA.

Although this method of analysis does not provide information regarding the direction of the relationship between the two variables, examination of the raw data shows those who received training in both anxiety and depression are more evenly distributed than the remaining two referral categories (see Table 4). For those who received training in just one of the disorders, and for those who received no training, the number of nonreferrals for both internalizing children is substantially larger than the number of referrals. Thirty-five percent of teachers who received training in both anxiety and depression referred both children (n = 51), and 16% of teacher who received training in

Table 3

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>4.65</td>
<td>2</td>
<td>2.32</td>
<td>3.73</td>
<td>0.0252</td>
</tr>
<tr>
<td>Within groups</td>
<td>173.90</td>
<td>279</td>
<td>0.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>178.55</td>
<td>281</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4

Referral of Children in Internalizing Vignettes, Broken Down by Teacher Training in Anxiety and Depression

<table>
<thead>
<tr>
<th>Area of training</th>
<th>Referral group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Both</td>
</tr>
<tr>
<td>Anxiety or depression</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>5.0</td>
</tr>
<tr>
<td>Total percentage</td>
<td>1.8</td>
</tr>
<tr>
<td>Group percentage</td>
<td>16.1</td>
</tr>
<tr>
<td>Anxiety and depression</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>18.0</td>
</tr>
<tr>
<td>Total percentage</td>
<td>6.4</td>
</tr>
<tr>
<td>Group percentage</td>
<td>35.3</td>
</tr>
<tr>
<td>Neither anxiety, nor depression</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>41.0</td>
</tr>
<tr>
<td>Total percentage</td>
<td>14.5</td>
</tr>
<tr>
<td>Group percentage</td>
<td>21.0</td>
</tr>
</tbody>
</table>

Note. N denotes the number of teachers in the sample who responded according to the categories in the table. Total percentage is the percentage of teachers in the entire sample, and Group percentage is the percentage of teachers within each training category.

either anxiety or depression referred both children (n = 31). Twenty-one percent of teachers who received no training in either anxiety or depression referred both children (n = 200).

Years of Teaching Experience

Teachers’ reports of the number of years they had been teaching were sorted by using the following categories: 0-5 years, 6-10 years, 11-20 years, and 21 plus years. A single-factor ANOVA revealed that the relationship between the number of years of experience and a teacher’s decision to refer the children in the internalizing vignettes was not statistically significant (F = .86; p < .49, see Table 5). The effect size calculated using
Table 5

Results of Single-Factor ANOVA for Years of Teaching Experience and Referral of Children in Internalizing Vignettes

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>2.18</td>
<td>4</td>
<td>0.55</td>
<td>0.86</td>
<td>0.4907</td>
</tr>
<tr>
<td>Within groups</td>
<td>176.37</td>
<td>277</td>
<td>0.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>178.55</td>
<td>281</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[ \eta^2 \] is .01 and is considered small. In fact, as Table 6 illustrates, referral was fairly evenly distributed across experience categories, with the exception of the number of non-referrals for both children in the internalizing vignettes for those who had 21 plus years of experience.

Services Available

Reports of the services available for children with anxiety and/or depression but who did not qualify for special education or Section 504 services were categorized numerically for the ANOVA and were counted as 0, 1, 2, 3, or 4 or more services. Thirty-eight teachers selected “don’t know” as a response to this question and were subsequently excluded from this analysis, reducing the sample to 244. No statistically significant results emerged \((F = .67; p < .61)\). Using eta squared \((\eta^2)\) the effect size that resulted was .01, which is considered small. Table 7 presents the services ANOVA. Just over 7% \((n = 20)\) of teachers referred both children in the internalizing vignettes, yet stated that no services were available for children with anxiety and/or depression and who did not qualify for special education or Section 504 services. However, as depicted in
Table 6

Referral of Children in Internalizing Vignettes and Number of Years of Teaching Experience

<table>
<thead>
<tr>
<th>Years of experience</th>
<th>Referral group</th>
<th>Both</th>
<th>Mixed</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0-5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>18.0</td>
<td>19.0</td>
<td>28.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>6.4</td>
<td>6.7</td>
<td>9.9</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>27.7</td>
<td>29.2</td>
<td>43.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6-10 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>7.0</td>
<td>15.0</td>
<td>26.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>2.5</td>
<td>5.3</td>
<td>9.2</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>14.6</td>
<td>31.3</td>
<td>54.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11-15 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>9.0</td>
<td>21.0</td>
<td>21.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>3.2</td>
<td>7.4</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>17.6</td>
<td>41.2</td>
<td>41.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>16-20 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>14.0</td>
<td>15.0</td>
<td>21.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>5.0</td>
<td>5.3</td>
<td>7.4</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>28.0</td>
<td>30.0</td>
<td>42.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>21 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>16.0</td>
<td>18.0</td>
<td>34.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>5.7</td>
<td>6.4</td>
<td>12.1</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>23.5</td>
<td>26.5</td>
<td>50.0</td>
<td></td>
</tr>
</tbody>
</table>

Note. N denotes the number of teachers in the sample who responded according to the categories in the table. Total percentage is the percentage of teachers in the entire sample, and Group percentage is the percentage of teachers within each category.

Table 7

Results of Single-Factor ANOVA for Number of Services Available and Referral of Children in Internalizing Vignettes

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between groups</td>
<td>1.70</td>
<td>4</td>
<td>0.42</td>
<td>0.67</td>
<td>0.6124</td>
</tr>
<tr>
<td>Within groups</td>
<td>151.04</td>
<td>239</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>152.73</td>
<td>243</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8, the raw data show the number of nonreferrals of both internalizing children is largest in the zero-services category.

Teacher Beliefs

Less than 1% (n = 2) of respondents did not mark any of the possible services, indicating that they believed schools should not provide any of the services listed in the survey (i.e., teacher consultation, individual therapy, group counseling, and parent education). Due to this low number, those who believed that 0 services and 1 service should be provided by schools were collapsed into one category ("0 to 1 Services"). Those who were counted in the "5 Services" category marked each of the four services listed in addition to "other" and specified the additional service they felt should be provided. No statistically significant relationship surfaced between the number of mental health services teachers believed should be offered by schools, and teachers' decisions to refer the children in the internalizing vignettes (F = .30; p < .87, see Table 9). The effect size is .00. Table 10 presents teachers' referral decisions broken down by the number of mental health services they believed should be offered by schools.

Types of Services Teachers Believe Schools Should Provide

Descriptive statistics were used in addressing the second research question regarding the types of school-based mental health services teachers think should be provided for children with anxiety and depression. The majority of respondents reported that schools should provide each of the services listed in the survey. Seventy-nine percent
Table 8

Referral of Children in Internalizing Vignettes and Number of Services Available

<table>
<thead>
<tr>
<th>Number of services</th>
<th>Referral group</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Both</td>
<td>Mixed</td>
<td>Neither</td>
<td></td>
</tr>
<tr>
<td>Zero</td>
<td>20.0</td>
<td>25.0</td>
<td>52.0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>7.1</td>
<td>8.9</td>
<td>18.4</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>20.6</td>
<td>25.8</td>
<td>53.6</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>11.0</td>
<td>13.0</td>
<td>18.0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>3.9</td>
<td>4.6</td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>26.2</td>
<td>30.9</td>
<td>42.9</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>8.0</td>
<td>17.0</td>
<td>19.0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>2.8</td>
<td>6.0</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>18.2</td>
<td>13.6</td>
<td>43.1</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td>8.0</td>
<td>12.0</td>
<td>11.0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>2.8</td>
<td>4.3</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>25.8</td>
<td>38.7</td>
<td>35.5</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four or more</td>
<td>7.0</td>
<td>10.0</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>2.5</td>
<td>3.5</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>23.3</td>
<td>33.3</td>
<td>43.3</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. The total sample = 244. N denotes the number of teachers in the sample who responded according to the categories in the table. Total percentage is the percentage of teachers in the entire sample, and Group percentage is the percentage of teachers within each category.

Table 9

Results of Single-Factor ANOVA for Teacher Beliefs about Services

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>0.78</td>
<td>4</td>
<td>0.19</td>
<td>0.30</td>
<td>0.8764</td>
</tr>
<tr>
<td>Within Groups</td>
<td>177.78</td>
<td>277</td>
<td>0.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>178.55</td>
<td>281</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 10

Referral of Children in Internalizing Vignettes and Teacher Beliefs about Services

<table>
<thead>
<tr>
<th>Number of services</th>
<th>Referral group</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Both</td>
<td>Mixed</td>
<td>Neither</td>
<td></td>
</tr>
<tr>
<td>Zero – one</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>3.0</td>
<td>6.0</td>
<td>9.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>1.1</td>
<td>2.1</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>16.7</td>
<td>37.5</td>
<td>56.3</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>9.0</td>
<td>13.0</td>
<td>22.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>3.2</td>
<td>4.6</td>
<td>7.8</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>20.5</td>
<td>29.5</td>
<td>50.0</td>
<td></td>
</tr>
<tr>
<td>Three</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>14.0</td>
<td>20.0</td>
<td>25.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>5.0</td>
<td>7.1</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>23.7</td>
<td>33.9</td>
<td>42.4</td>
<td></td>
</tr>
<tr>
<td>Four</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>31.0</td>
<td>46.0</td>
<td>67.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>11.0</td>
<td>16.3</td>
<td>23.8</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>21.5</td>
<td>31.9</td>
<td>46.5</td>
<td></td>
</tr>
<tr>
<td>Five</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>5.0</td>
<td>2.0</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td>Total percentage</td>
<td>1.8</td>
<td>.71</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>Group percentage</td>
<td>35.7</td>
<td>14.3</td>
<td>50.0</td>
<td></td>
</tr>
</tbody>
</table>

Note: N denotes the number of teachers in the sample who responded according to the categories in the table. Total percentage is the percentage of teachers in the entire sample, and Group percentage is the percentage of teachers within each category.

of respondents reported that teacher consultation should be made available. Group counseling was supported by 82% of respondents, individual counseling was endorsed by 75%, and 88% felt that parent education should be provided by schools. Services listed in the “Other” category included teacher training, social skills training, and lower class sizes.

Table 11 presents the frequencies and percentages of responses.
Table 11

Mental Health Services Respondents Feel Should be Provided by

Schools

<table>
<thead>
<tr>
<th>Services</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher consultation</td>
<td>223</td>
<td>79.1</td>
</tr>
<tr>
<td>Individual therapy</td>
<td>214</td>
<td>75.9</td>
</tr>
<tr>
<td>Group counseling</td>
<td>232</td>
<td>82.3</td>
</tr>
<tr>
<td>Parent education</td>
<td>248</td>
<td>87.9</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Description of Survey Results

This section addresses results that were obtained from the survey that were not directly related to the research questions but nevertheless provide information regarding referral of children with internalizing problems and the possible services available to them. Results are reported using descriptive statistics for the following: Referral rates of the children in the internalizing vignettes versus the externalizing vignettes; the professionals who respondents reported would be most helpful to them when seeking assistance with children like the ones described in the internalizing vignettes; supplemental information regarding services available to children with anxiety and/or depression; additional results regarding the training that teachers reported they received both before and during their teaching careers; and teachers' desire for future training. Finally, a summary of the comments that teachers submitted with their surveys is presented.

Referral Rates

The internalizing children in the vignettes were less likely to be referred than were
their externalizing counterparts. Ninety percent of respondents stated that they would either “probably refer” or “definitely refer” the boy in the externalizing vignette. The externalizing girl was referred by 72% of the respondents. Less than a third (30%) of respondents stated that they would refer the internalizing boy, and 47% responded that they would refer the internalizing girl.

The data gathered regarding teachers’ self-reports of their actual referrals of children similar to the ones in the vignettes varied widely, with some stating they referred no one, and others reporting that they referred 10 such students within the last year. The mean for actual referrals for the externalizing boy was 1.4 (SD = 1.7), .51 (SD = .9) for the externalizing girl, .32 (SD = .9) for the internalizing boy, and .43 (SD = .8) for the internalizing girl.

Consultation Resources

Several respondents placed check marks near the consultation resources, rather than rank ordering them. If more than one check mark was present, the data were considered unusable for this analysis. If just one check mark was present near a consultation resource, then it was counted as a “1.” For example, if someone placed a check mark by “colleague” but left the remaining spaces blank, it was assumed that the respondent thought that a colleague would be the most helpful consultation resource.

Given these parameters, the sample size for the internalizing girl vignette was reduced to 269 and to 268 for the internalizing boy vignette. Overall, the professional that teachers felt would be most helpful to them when seeking assistance with children like the
ones described in the internalizing vignettes was a colleague (42.9% - boy; 33.5% - girl), followed by a school counselor (16% - boy; 26.4% - girl). School psychologists were ranked third most helpful overall (11.9% - boy; 20.1% - girl). Principals were reported as being the least helpful (5.2% - boy; 6.7% - girl). Several respondents marked “other” as the most helpful individual with whom they would consult (23.9% - boy; 14.1% - girl). The most commonly cited individual in the “other” category was a parent. Other commonly cited individuals were special education teachers and a team of school professionals. Table 12 provides a summary of the findings.

Services Available

For students with anxiety and/or depression but who do not qualify for special education or Section 504, 43.6% of teachers reported that individual counseling was available, followed by group counseling (39%), teacher consultation (18.8%), and parent education (19.1%). Just over 2% of teachers reported services in addition to those listed in the survey and included a school nurse, and additional services provided by a school

Table 12

Consultation Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Internalizing girl (n = 269)</th>
<th>Internalizing boy (n = 268)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Colleague</td>
<td>90</td>
<td>33.5</td>
</tr>
<tr>
<td>School counselor</td>
<td>71</td>
<td>26.4</td>
</tr>
<tr>
<td>School psychologist</td>
<td>54</td>
<td>20.1</td>
</tr>
<tr>
<td>Other</td>
<td>38</td>
<td>14.1</td>
</tr>
<tr>
<td>School principal</td>
<td>16</td>
<td>6.7</td>
</tr>
</tbody>
</table>
psychologist and/or school counselor. Over 13% of teachers reported being unaware of services that might be available in their schools. Table 13 presents a summary of the services teachers reported as being available in their schools.

**Training Received**

Table 14 presents a breakdown of teachers' reports of the children’s mental health training they received both before and during their careers as teachers. In both preservice and inservice training, teachers reported having received the most training in behavioral interventions and in disruptive behavior. Areas where teachers were least likely to receive training were anxiety and depression. In each area, reports of inservice training were greater than reports of preservice training.

**Training Desired**

Ninety percent of respondents stated they would be interested in receiving additional training in the area of children’s mental health. Of those, depression was the area that received the most interest (83.3%), followed by anxiety (75.9%). ADHD and

Table 13

**Teacher Reports of Services Available to Children with Anxiety and Depression**

<table>
<thead>
<tr>
<th>Service</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling</td>
<td>123</td>
<td>43.6</td>
</tr>
<tr>
<td>Group counseling</td>
<td>110</td>
<td>39.0</td>
</tr>
<tr>
<td>Teacher consultation</td>
<td>53</td>
<td>18.8</td>
</tr>
<tr>
<td>Parent education</td>
<td>54</td>
<td>19.1</td>
</tr>
<tr>
<td>Unknown</td>
<td>38</td>
<td>13.5</td>
</tr>
</tbody>
</table>
Table 14

Teacher Reports of Preservice and Inservice Training in the Area of Children’s Mental Health

<table>
<thead>
<tr>
<th>Area of training</th>
<th>Preservice</th>
<th></th>
<th></th>
<th>Inservice</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>ADHD</td>
<td>134</td>
<td>47.5</td>
<td></td>
<td>154</td>
<td>54.6</td>
</tr>
<tr>
<td>Anxiety</td>
<td>26</td>
<td>9.2</td>
<td></td>
<td>51</td>
<td>18.1</td>
</tr>
<tr>
<td>Behavioral interventions</td>
<td>180</td>
<td>63.8</td>
<td></td>
<td>198</td>
<td>70.2</td>
</tr>
<tr>
<td>Depression</td>
<td>30</td>
<td>10.6</td>
<td></td>
<td>49</td>
<td>17.4</td>
</tr>
<tr>
<td>Disruptive behavior</td>
<td>185</td>
<td>65.6</td>
<td></td>
<td>193</td>
<td>68.4</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>4.6</td>
<td></td>
<td>30</td>
<td>10.6</td>
</tr>
</tbody>
</table>

disruptive behavior were also areas of interest (70.2% and 69.5%, respectively). Just over 10% of teachers stated they would like to receive training in other areas involving children’s mental health such as grief and loss, and child abuse and neglect.

Teacher Comments

Many teachers took the time to complete the optional comments section on the survey. Thirty-two respondents re-emphasized the need for more training in the area of children’s mental health in their comments. Fifty-five teachers reported that they needed more support for mental health issues; many indicating that their schools did not have adequate staffing for providing services for children in need of help. Two individuals stated that they would “refer more” but that the services in their schools were too limited. One of those respondents stated that she would like to refer more children like the ones in the internalizing vignettes, but because services are limited, she is unable to do so. Five individuals reported that early intervention in mental health issues is important. Thirteen
teachers reported that they have seen an increase in mental health problems in their classrooms. Another 13 respondents indicated that they feel they are overworked or that they feel too much is expected of them. Finally, six teachers cited problems in the referral system that have become prohibitive in referring children for services.
CHAPTER VI
DISCUSSION

In this chapter, results are discussed and then summarized in light of the research presented in the literature review. Limitations of the current study in addition to suggestions for future research are also addressed. To review, this study investigated possible factors involved in a teacher’s decision to refer a child portrayed in a vignette as having internalizing problems. Factors that were addressed included: teacher training in children’s mental health, number of years of teaching experience, services currently available in schools, and services that teachers believe should be provided by schools. This study also looked at the specific types of school-based mental health services teachers believe should be available to children in elementary schools. The services that were specified in the survey were teacher consultation, individual therapy, group counseling, and parent education. In addition to the findings directly related to the research questions posed by this study, examination of the comments made by teachers provided valuable qualitative information regarding teachers’ experiences with school-based mental health services.

Teacher Training

Results of this study suggest a statistically significant relationship between teacher training and the decision to refer a child in the internalizing vignette. However, the effect size of .03 indicates that the magnitude of the relationship is small. Some of the
respondents marked that they had received training in these areas but that it was “very little,” or that the training was superficial and merely provided them with information regarding what the disorders were.

Few teachers received training in anxiety and depression alone \((n = 15; n = 16, \text{ respectively})\). Fifty-one teachers reported having received training in both anxiety and depression. Given these relatively low numbers, it is possible that teachers reporting similar training either attended the same universities or worked in the same districts, and thus received the exact same training. Therefore, the possible difference could be the method of training or the effectiveness of the trainer, rather than the topic of the training. No firm conclusions should be drawn from these preliminary results. As mentioned in the review of the literature, research in the area of teacher training in anxiety and depression and its impact on referral decisions is virtually nonexistent. Stark (1990) provided anecdotal evidence that his training sessions on depression have led to increases in teachers listing depression as a possible problem on their referral forms, but no research investigations have been conducted to confirm these observations. Likewise, no research has been conducted studying training in anxiety and its impact on teacher referral decisions. Clearly, research needs to continue in this area in order to gain a deeper understanding of the potential that teacher training has on the referral of children with internalizing problems. Training is, as this study has shown, a significant factor.

It is noteworthy that 17.4% and 18.1% of teachers reported that they had received training in depression and anxiety, respectively, through inservice, which is nearly twice the number of those who reported they had received training in depression and anxiety.
prior to beginning their teaching careers (10.6% and 9.2%, respectively). Some teachers reported in their comments that they felt unprepared for dealing with mental health problems in their classrooms and wished they had received such training during their college education. Many teachers commented that they wished to receive more training in children’s mental health so that they can help their students more effectively. The fact that 83% of teachers reported a desire for training in depression, and 76% reported wanting training in anxiety is encouraging. These findings are similar to those of Green et al. (1996), who reported anecdotally that many of their survey respondents expressed on a feedback sheet that they felt insecure about referring children for mental health services because of their lack of training in the area. These problems could be reduced if more children’s mental health training was included in teachers’ preservice education, as well as in continued inservice training.

Number of Years of Teaching Experience

No significant relationships emerged from the data with regard to years of experience and referral of the children in the internalizing vignettes. The rates of referral for each of the internalizing children remained fairly constant, regardless of the number of years of experience. Unfortunately, the data suggest that children with internalizing problems may not be well recognized by teachers regardless of the number of years of teaching experience. In essence, teachers are not being trained in this area any more than they were 20 years ago. Although much more knowledge about childhood anxiety and depression exists today than it did 20 years ago, this knowledge is not being passed on to
teachers who need training in order to correctly identify and refer children experiencing symptoms of anxiety or depression.

On the other hand, these data are encouraging when considering that years of experience is not necessarily something that one can manipulate when trying to make a change in the referral process in a school system. Although referral rates for each of the internalizing children in the vignettes were low, it is possible that teacher training for teachers with varying levels of experience can make an impact. Even teachers with 20 plus years of experience expressed desire for additional training in children’s mental health, suggesting an opportunity for educating teachers of all experience levels about their roles in the need for calling more attention to children who may need additional support.

Services Available

No significant relationship emerged between the number of services teachers reported as being available for children with anxiety and depression and their decisions to refer the children in the internalizing vignettes. As mentioned in the Results section earlier, a surprising outcome surfaced regarding referral and the report of zero services being available. In fact, 40% of teachers reported that no services were available. Twenty teachers who referred both of the internalizing children had reported that no services were available to students with anxiety and/or depression who did not qualify for either special education or Section 504 services. It was hypothesized that referrals for the children in the internalizing vignettes would decrease as the number of mental health services for
children with anxiety and/or depression decreased. This hypothesis was not supported. One possible explanation for this outcome is that teachers will, in fact, refer students with internalizing problems for special education or Section 504 evaluation. However, as stated in the Review of the Literature, it may not be beneficial to qualify a child with anxiety and/or depression for special education or Section 504 because of the social stigma attached to the classification. In addition, early intervention with children who exhibit internalizing symptoms may not always require academic accommodations (which special education and Section 504 imply), but may provide children and their families with necessary, school-based mental health services. Pugach’s (1985) finding that 19% of teachers referred students for special education services simply to gain more information about their students provides another possible explanation. It is possible that teachers in the current study would have referred the internalizing children in order to receive additional information, rather than as a means to a change in placement (e.g., special education classification). Another explanation for this outcome is that teachers will refer children, hoping that parents will become more involved and seek outside services.

One discouraging result from this survey is the finding that 13.5% of teachers reported being unaware if services were available for children with anxiety and depression who did not qualify for special education or Section 504. It is certainly disappointing that numerous teachers are unaware of the services that might be available to their students. It is conceivable that teachers’ lack of awareness of services could affect the availability of services for children. This is particularly discouraging when teachers reported in their comments that they needed additional support in the children’s mental health arena.
Perhaps in some cases, more mental health services are available in schools (or school districts) than teachers realize. If more teachers received training in children's mental health and were informed of the availability of services, more children would receive the early intervention that is so critical.

Teacher Beliefs

No significant relationship emerged between teacher beliefs of the number of services that should be provided by schools and teachers' decisions to refer the children in the internalizing vignettes. Notably, there was little variability among teachers' endorsements of the services they felt schools should provide. Very few teachers ($n = 2$) believed that schools should not provide any mental health services. Individual counseling received the fewest endorsements by teachers, yet 76% of teachers felt it should be provided. Overall, teachers overwhelmingly supported the provision of school-based mental health services. The service that was endorsed the most was parent education.

Many teachers included in their comments that they felt parents should become more involved and may also need extra support in helping their children at home.

Consultation Resources

It is possible that many respondents misunderstood the intent of the consultation resources question in the survey. The intent of the question was to address the issue of professional consultation resources teachers would access when seeking assistance with children similar to the ones described in the vignettes. However, because many teachers
marked "other" and cited "parent" as another individual with whom they would consult, it is possible that their definition of consultation was different from the investigator's intent. Many respondents may have felt that consultation meant a gathering of information, as opposed to a consultation provided by a professional. However, it is certainly encouraging that many teachers expressed the desire for involving parents when they are concerned about their students.

Summary of Findings

Few studies to date have addressed the issue of children with internalizing disorders in the school setting. Even fewer have addressed the issue of teacher referral of children with such problems. This is one of the first comprehensive investigations of teachers’ beliefs and knowledge about school-based mental health services, and how these factors impact referral decisions. The referral rates of the children in the internalizing vignettes further illustrate the need for calling more attention to children exhibiting symptoms of anxiety and/or depression. Furthermore, this study shows that training may be a significant factor in teachers’ decisions to refer children with internalizing problems. Although Ines and Sacco (1992) showed that teacher training did not help in increasing correspondence between children’s self-reports of depressive symptoms, and teachers’ reports of their students’ symptoms, this study shows that teachers who are trained in depression may be more likely to identify and refer a child who is experiencing problems with the disorder. In addition, this study reveals the encouraging finding that the majority of teachers wish to receive additional training, regardless of their level of experience. The
number of mental health services available to children with anxiety and depression, and teacher beliefs about school-based mental health services do not appear to impact a teacher's decision to refer hypothetical children described as having internalizing problems. However, the majority of teachers believe that schools should provide parent education, teacher consultation, individual therapy, and group counseling to children in need. Further, it is possible that teachers sometimes refer children for additional school services simply to obtain more information, rather than as a step toward a change in placement, as Pugach determined in her investigation (1985). This possibility is also illustrated by some of the teachers' comments, expressing their desire to have a more active role in helping their students.

Overall, the findings in this study are encouraging and will hopefully motivate instructors of education to better prepare future teachers in dealing with children's mental health issues. In addition, school-based, mental health professionals may want to increase their efforts toward providing teachers with additional training in internalizing disorders. Previous studies have shown that teachers feel they are ill prepared in dealing with children who have emotional problems (e.g., Cheney & Barringer, 1995; Green et al., 1996). This study expands on this problem by confirming there is a lack of training and revealing teachers' desires toward receiving training, particularly in the internalizing disorders domain. Anxiety and depression are chronic problems and early intervention is critical. Teachers are willing to spend the time to learn more about how to identify children who may be experiencing such problems, and they can then refer their students to mental health professionals who can provide the necessary services.
Limitations of Current Study

Several limitations exist with the current study. First, hypothetical vignettes were used in assessing teachers’ referral decisions. Teachers’ reports about whether or not they would refer children in vignettes do not necessarily reflect their actual practice. An attempt to mitigate this problem was made by creating the question, “Approximately how many times in the past year have you referred a child similar to the one in the vignette?” However, it is possible that many teachers overlooked the part of the question “in the past year” because of some seemingly inflated numbers. For example, some teachers stated they had, within the last year, referred 10 children similar to one described in a vignette. Even if the resulting data had provided a more accurate picture of hypothetical referrals and actual referrals, there still remains the problem of reported actual referrals versus actual referrals.

Another limitation of this study is the fact that training was evaluated as either having received training or no training in the area of anxiety and depression. Assessing the nature of the training (depth and quality) is challenging, if not impossible in a survey. The fact that some teachers marked that they had received training but “very little” reflects the potential problem in truly understanding the relationship between teacher training in anxiety and depression, and referral of children with internalizing problems.

Finally, the teachers in this survey all teach in the state of Utah. Although the randomization of the sample resulted in a representation of diverse schools (e.g., urban vs. rural school districts), the results may not necessarily reflect what would be found in other
states. One issue specific to Utah is the low per pupil spending that possibly affects the availability of school-based mental health services to some degree. Utah ranked last in the nation in the 1999-2000 school year, with $4,036 per pupil. The president of the National Association of School Psychologists (NASP) conducted a survey and found that in Utah, the mean ratio of school psychologists to students is 1:1,726 (Thomas, 1999a). The total mean was 1:1,816. Although Utah’s ratio was not last in the nation, it was far from NASP’s recommended ratio of 1:1,000 (Thomas, 1999b).

Future Research

Initial quantitative data regarding teachers’ reports of their training, services available, and their beliefs about school-based mental health services are certainly important contributions. However, the potential factors involved in referral decisions likely vary widely between districts, and even between schools. Some teachers commented about their principal’s role in the referral process, and others commented on their frustration with the slow and ineffective referral system in their school. Perhaps research involving both qualitative and quantitative data at the school level will add to our understanding of the referral process for children with internalizing problems. Interviews with teachers examining potential factors involved in their referral decisions could provide a more in-depth analysis in this area. For example, an interview with a teacher could provide researchers with a better understanding of the quality of the children’s mental health training that teachers received. In addition to interviews, quantitative data regarding teachers’ actual referrals would be a valuable supplement. Of course, such
small-scale investigations would need to be replicated in a variety of settings in order to gain a more global perspective of the possible factors involved in teachers’ referral decisions with regard to internalizing children.

A difficult obstacle remains in offering mental health services to children: school funding is a problem, which affects provision of mental health services. Another exciting research area that is already taking shape is the collaboration between schools and community mental health centers. Building a bridge between this research area and the problem of the low referral rates of children with internalizing problems would be beneficial. Sharing resources might improve availability of services to all children, particularly for those who have, in the past, been sorely underidentified and do not easily call attention to themselves—those who suffer from symptoms of anxiety and depression.
REFERENCES


Mamlin, N., & Harris, K. (1998). Elementary teachers’ referral to special education in light of inclusion and prereferral: Every child is here to learn... but some of these children are in real trouble. *Journal of Educational Psychology, 90*, 385-396.


Appendix A:

Survey
CHILDREN'S MENTAL HEALTH QUESTIONNAIRE

Part I:

The following vignettes describe children in schools. Please carefully read each vignette and respond to the two questions that follow each one.

Vignette #1:

Joe is an 8-year-old boy. He is immature and disrupts the classroom often by arguing with his teachers, talking excessively and loudly, fidgeting with objects at his desk, and disobeying classroom rules. During breaks or outside of the classroom, Joe associates with a group of boys that tend to get into trouble. He has gotten into fights and some of his classmates have reported that he has been mean to them. He rarely finishes his school work and is getting poor grades.

Would you refer the child described in this vignette for additional school-based services?
1 = definitely not refer 2 = probably not refer 3 = probably refer 4 = definitely refer

Approximately how many times in the past year have you referred a child similar to the one described in the vignette? _________

If you were to seek consultation about a child similar to one of the children described in the vignette above, who would be most helpful to you? (Please rank order your responses)

____ School principal
____ Colleague (e.g. another teacher)
____ School psychologist
____ School counselor
____ Other (please specify) _______________________

Vignette #2:

Julie is an 8-year-old girl. She is immature for her age and seems to have difficulty staying still because she often fidgets with objects at her desk. She is also moody. She tends to hum in class or talk too much with her peers. As a result, she rarely finishes her school work and is getting poor grades. She is not popular with most of her peers; instead, she tends to associate with girls who get into trouble. When she is with those troublesome girls, she is more likely to misbehave or to argue with other peers.

Would you refer the child described in this vignette for additional school-based services?
1 = definitely not refer 2 = probably not refer 3 = probably refer 4 = definitely refer

Approximately how many times in the past year have you referred a child similar to the one described in the vignette? _________
If you were to seek consultation about a child similar to one of the children described in the vignette above, who would be most helpful to you? (Please rank order your responses)

____ School principal  ____ School counselor
____ Colleague (e.g. another teacher)  ____ Other (please specify) ____________
____ School psychologist

Vignette #3:
Mark is an 8-year-old boy. He works slowly in the classroom and as a result, often has to take his work home to complete. He seems to procrastinate often. This is partly due to his fear of making mistakes and oversensitivity to criticism, as he feels a need to do “perfect” work. He generally finishes his work and gets good grades, but it takes him much longer than his peers. In general, he is a child who withdraws from others, especially peers, and tends to keep things to himself.

Would you refer the child described in this vignette for additional school-based services?
1 = definitely not refer  2 = probably not refer  3 = probably refer  4 = definitely refer

Approximately how many times in the past year have you referred a child similar to the one described in the vignette? __________

If you were to seek consultation about a child similar to one of the children described in the vignette above, who would be most helpful to you? (Please rank order your responses)

____ School principal  ____ School counselor
____ Colleague (e.g. another teacher)  ____ Other (please specify) ____________
____ School psychologist

Vignette #4
Marie is an 8-year-old girl. She tends to seek excessive attention from her teacher. When she does not receive attention, she appears sad, withdraws, and makes self-critical statements, such as ‘No one likes me,’ and ‘I can’t do anything right.’ She is also overly anxious to please, so she is well-behaved in the classroom and gets good grades. Despite her successes, she often worries that she is disliked by her peers and teacher and that she will fail at things she tries to do.

Would you refer the child described in this vignette for additional school-based services?
1 = definitely not refer  2 = probably not refer  3 = probably refer  4 = definitely refer

Approximately how many times in the past year have you referred a child similar to the one described in the vignette? __________
If you were to seek consultation about a child similar to one of the children described in the vignette above, who would be most helpful to you? (Please rank order your responses)

____ School principal
____ Colleague (e.g. another teacher)
____ School psychologist
____ School counselor
____ Other (please specify) ________

Part II.

The following questions address the issue of children’s mental health issues and school services.

1. In your preservice training, in what areas did you receive information in your coursework concerning children’s mental health? (Please check all that apply)

____ Attention-Deficit Hyperactivity Disorder (ADHD)
____ Disruptive Behavior
____ Behavioral Interventions
____ Anxiety
____ Depression
____ Other (please specify) ________

2. Since you started teaching, have you received any staff development training concerning the following areas regarding children’s mental health? (Please check all that apply)

____ ADHD
____ Disruptive Behavior
____ Behavioral Interventions
____ Anxiety
____ Depression
____ Other (please specify) ________

3. Are there services available in your school district for children who have ADHD or other disruptive behavior problems but who do not qualify for special education services or Section 504 plans?

____ No       ____ Yes

4. If you marked yes for the previous question, what services are available in your school district for children who have ADHD or other disruptive behavior problems but who do not qualify for special education services or Section 504 plans? (Please check all that apply)

____ Teacher Consultation
____ Group Counseling (e.g., social skills)
____ Individual Counseling
____ Parent Education
____ Other (please specify) ________
____ Don’t know
5. Are there services available in your school district for children who have depression and/or anxiety but who do not qualify for special education services or Section 504 plans?

   _____ No  _____ Yes

6. If you marked yes for the previous question, what services are available in your school district for children who have depression and/or anxiety but who do not qualify for special education services or for Section 504 plans? (Please check all that apply)

   _____ Teacher Consultation  _____ Other (please specify) ____________________
   _____ Group Counseling (e.g., social skills) ________________________________
   _____ Individual Counseling  _____ Don’t know
   _____ Parent Education

7. Regarding children’s mental health issues, which of the following services do you feel schools should provide? (Please check all that apply)

   _____ Teacher Consultation  _____ Parent Education
   _____ Group Counseling (e.g., social skills)  _____ Other (please specify) ____________________
   _____ Individual Therapy

8. Would you be interested in receiving staff development training on children’s mental health issues?

   _____ No  _____ Yes

9. If you answered yes to the previous question, for what kinds of problems would you be interested in receiving training? (Please rank order)

   _____ ADHD  _____ Anxiety
   _____ Disruptive Behavior  _____ Other (please specify) ____________________
   _____ Depression
Part III.

Please take a moment to fill in the information requested below.

Demographic Information:

1. Gender..............................................  ___ Male  ___ Female

2. Race/Ethnicity.....................................  ___ Hispanic/Latino
  ___ White
  ___ Black /African-American
  ___ American Indian
  ___ Eskimo /Aleut
  ___ Asian/Pacific Islander
  ___ Other __________________________

3. Education (i.e., B.S., M.S.)..............

4. ....

5. Specialization/Certification.............

6. Grade level(s) you currently teach? ......

7. Number of years of teaching experience? ...

Your comments are important to us. Is there additional information regarding children’s mental health issues and school services that you feel we need to be aware of?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for your time in completing this survey.
Appendix B:

Cover Letter
Dear Teacher:

Children's mental health issues are impacting schools in many ways. As you are probably well aware, working with children who have mental health problems can be difficult. We are writing to request your participation in a study we are conducting that examines children's mental health issues with respect to the school environment and how these issues should be dealt with. Your response to this survey is critical in helping professionals gain a better understanding of how teachers view these difficulties. In addition, your responses will help in addressing the needs of teachers in working with children who have mental health problems.

Please complete the attached questionnaire and return it in the postage-paid envelope that has been provided. This questionnaire involves reading short vignettes of children and answering questions based on these vignettes. There are also two sections with questions regarding training and knowledge with regard to children's mental health issues. The average time to complete this survey is approximately 15 minutes. Although we urge you to participate in this study, your participation in this study is entirely voluntary. Returning a completed survey will be considered consent for participation in the study. If you choose not to participate, there will be no negative consequences. Your choice of whether or not to participate will in no way affect your job as a teacher.

All results obtained from this survey will be strictly confidential. Please do not put any identifying information on the survey. In order to encourage participation in this important study, we are offering the opportunity of entering a drawing for a $75.00 reward if you return your survey within two weeks. In addition to this opportunity, your response will make a significant contribution to the knowledge of other professionals as they join with you in working with children who have mental health problems. Once the deadline for the return of surveys has passed, your name will be removed from the mailing list and you will not be contacted again unless requested.

If you would like a copy of the results of this study, please enclose a separate note with your name and address. Results will be available once the study is complete, which should be in approximately six months.

If you have any questions regarding this study, please contact one of us at the above address or at the phone numbers listed below.

Thank you again for your participation in this important research study.

Sincerely,

Heather J. Clark  
Masters Student  
(435) 797-1460

Susan Crowley, Ph.D.  
Associate Professor  
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