SCHOOL COUNSELORS' REFERRAL PRACTICES OF CHILDREN

WITH INTERNALIZING SYMPTOMS

by

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ABSTRACT

School Counselors' Referral Practices of Children with Internalizing Symptoms

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This project proposed to examine school counselors' knowledge of and experiences with internalizing issues in children. The sample included all elementary and middle/secondary school counselors employed in Utah. The measure used in the present study was a questionnaire adapted from a study by Green, Clopton, and Pope. Analyses revealed that few elementary school counselors would meet with a student struggling with internalizing symptoms, but many would meet with the students' teacher(s) and parents. Overall, fewer secondary school counselors endorsed the presented responses as compared to elementary school counselors. More than half of both elementary and secondary school counselors indicated they had encountered one to five students struggling with internalizing issues during the past year. The knowledge gained from this research highlights changes that need to be made to preservice and
inservice training of school counselors in order to aid in the identification and intervention of internalizing disorders in students.
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Kelly Hughes
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>II. REVIEW OF THE RELATED LITERATURE</td>
<td>5</td>
</tr>
<tr>
<td>Internalizing Disorders</td>
<td>5</td>
</tr>
<tr>
<td>Elementary and Secondary School Counselors</td>
<td>14</td>
</tr>
<tr>
<td>Conclusion</td>
<td>27</td>
</tr>
<tr>
<td>III. METHODS</td>
<td>28</td>
</tr>
<tr>
<td>Data Collection</td>
<td>28</td>
</tr>
<tr>
<td>Participants</td>
<td>28</td>
</tr>
<tr>
<td>Measure</td>
<td>29</td>
</tr>
<tr>
<td>Procedure</td>
<td>32</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>34</td>
</tr>
<tr>
<td>Primary Analysis</td>
<td>34</td>
</tr>
<tr>
<td>Research Questions</td>
<td>41</td>
</tr>
<tr>
<td>V. DISCUSSION</td>
<td>56</td>
</tr>
<tr>
<td>Summary of Findings</td>
<td>56</td>
</tr>
<tr>
<td>Limitations</td>
<td>64</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>65</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>68</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>75</td>
</tr>
<tr>
<td>Appendix A: Cover Letter</td>
<td>76</td>
</tr>
</tbody>
</table>
Appendix B: Elementary School Counselor Questionnaire ................................ 78
Appendix C: Middle/Secondary School Counselor Questionnaire.................. 84
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Educational Degree</td>
<td>35</td>
</tr>
<tr>
<td>2. Field of Study</td>
<td>36</td>
</tr>
<tr>
<td>3. Certification</td>
<td>36</td>
</tr>
<tr>
<td>4. Summary of Demographics</td>
<td>38</td>
</tr>
<tr>
<td>5. Training Received in Children’s Mental Health</td>
<td>42</td>
</tr>
<tr>
<td>6. Modal Rankings for Type of Desired Training</td>
<td>47</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Unfortunately, some children experience childhood as a time of unhappiness, anxiety, withdrawal, and hopelessness. Research has shown the prevalence rate of depression to range from 0.4-2.5% in children and 0.4-8.3% in adolescents (Birmaher et al., 1996). Other research has shown prevalence rates of depression as high as 20% in school-aged children (Hart, 1991). These rates of depression have been steadily increasing, suggesting that with each passing year more and more children suffer from depression.

Children who experience episodes of depression and anxiety tend to have difficulty in school achievement and interpersonal relationships (Birmaher et al., 1996). These difficulties include poor concentration, irritability, low grades, decreased social or peer functioning, and general withdrawal (Hart, 1991). Variables such as low socioeconomic status, family turmoil, and stressful life events are common life situations that are associated with depression in children as well (Birmaher et al.). Unfortunately, symptoms of depression and anxiety often go undetected and untreated, resulting in lasting, severe disturbance throughout the child’s life (Reynolds, 1990).

Additionally, suicidal ideation and suicide attempts are associated with depressive symptoms in children and tend to parallel the prevalence rates of depression (Birmaher et al., 1996; Kovacs, Goldston, & Gatsonis, 1993). Despite potential difficulties in tracking suicide deaths in children, suicidal behaviors have been shown to be increasing as well (Matter & Matter, 1984).
Despite children's apparent need for mental health services, they are the most underserved population in mental health services (La Greca, 1992). "In general, it is estimated that 12-15% of youth under the age of 18 experience emotional and behavioral problems serious enough to justify treatment" (Weisberg, Caplan, & Sivo, 1989 as sited in Rice & Leffert, 1997, p. 25). Alarmingly, 70-90% of children who need some type of intervention do not receive treatment (Cicchetti & Toth, 1998; Rice & Leffert). Although shocking, these types of statistics will hopefully work as a springboard to motivate mental health professionals to reform this distressing state in which many children find themselves. The ominous threat of physical, emotional, and fatal harm of society's children demands urgent attention, prevention, and intervention by the capable adults who closely interact with them on a daily basis.

Children spend nearly one half of their days in school, making schools the ideal environment in which to identify and intervene with children's mental health problems. This places school counselors in a pivotal role as frontline mental health professionals and educators (Bailey, Deery, Gehrke, Perry, & Whitledge, 1989). Master's-level trained professionals (school counselors, counselors) should be relied upon to recognize and make recommendations regarding children exhibiting social-emotional problems, including depression and anxiety, within the school environment. However, at least three major problems exist in terms of relying on school counselors to assist children who experience mental distress. First, not all schools are required to employ a school counselor due to differing state laws. Second, current research examining the knowledge base and experience of school counselors with internalizing disorders in
children is extremely limited. Third, lack of research on internalizing disorders (e.g., major depressive disorder, dysthymic disorder, anxiety disorders) makes it increasingly difficult to identify specific disorders in children. It was not until recent decades that research on internalizing disorders in childhood and adolescence began to proliferate (Cicchetti & Toth, 1998). This research has shed light on the fact that depressive disorders in particular are the most serious psychopathological disorders due to their tendency to persist across the life span (Merrell, 1994), association with suicide, and effect on interpersonal, familial, and peer relationships (Cicchetti & Toth).

Because children’s mental health problems tend to be under-diagnosed and under-treated, it is of utmost importance to ensure that the professionals who have daily contact with them possess the necessary skills to intervene and help these children. This project examined school counselor’s knowledge of and experiences with mental health issues in children specific to internalizing disorders. The knowledge gained from this research highlight changes that need to be made to preservice and inservice training of school counselors in order to aid in the identification and intervention of internalizing disorders in children who so rarely receive the help they need.

As previously stated, school counselors are the frontline mental health professionals in the schools, necessitating the need for adequate training regarding children’s mental health needs. Unfortunately, the lack of research makes it unclear whether or not school counselors are being adequately trained in this critical area. Further, the lack of research on school counselor’s experience with children’s mental health issues in the schools punctuates the need for further exploration and study. This
problem is particularly important in light of the increasing prevalence rates of suicide and depression and anxiety symptoms in children. To begin to remedy the gap in the research, the present study sought to ascertain Utah school counselors' knowledge of children's mental health concerns, particularly focusing on internalizing disorders. The focus is on internalizing disorders because this group of disorders is typically manifested covertly, have high rates of comorbidity, and can result in suicide. This study also sought to determine the influences of Utah school counselors' decisions to refer children exhibiting symptoms of depression or anxiety. The following questions were specifically addressed in this study:

1. In what types of children's mental health issues have school counselors received training?

2. In what types of children's mental health problems do school counselors want more training?

3. Is there a relationship between the type of training school counselors have received and their willingness to refer children with internalizing problems?

4. Is there a relationship between school counselors' decision to refer children exhibiting internalizing disorder symptoms and the reported availability of services for these children within the school?

5. Is there a relationship between the willingness of school counselors to refer children with internalizing problems and their opinions of whether schools should provide a variety of services for children with such problems?
CHAPTER II

REVIEW OF THE RELATED LITERATURE

The review of literature outlines research conducted on childhood internalizing disorders, including details regarding prevalence rates, stability, comorbidity, symptom presentation, gender differences, and suicide. The role of elementary and secondary school counselors within the school environment will be explored. Finally, school counselor training and educator licensure requirements will be reviewed, as well as research on school counselors' experience with emotional problems in children.

Internalizing Disorders

Definition

"[I]nternalizing [disorders] represent a useful heuristic for the general description and categorization of a relatively broad set of psychological disturbances," including among others, major depressive disorder (MDD), dysthymic disorder (DD), panic disorder, specific phobia, generalized anxiety disorder, and separation anxiety disorder (Reynolds, 1990, p. 139-140). This study will describe pertinent aspects of internalizing disorders in children, but will not outline details of each specific internalizing disorder. The broad category of internalizing disorders is targeted because studies often fail to specify which specific disorders they examined, and merely describe results of a plethora of disorders included within the internalizing disorder heuristic.
Prevalence

Research on internalizing disorders in children has proliferated in the past decade, thus providing invaluable information about these insidious disorders. Many studies have revealed prevalence rates of depression ranging from 0.4-2.5% in children and 0.4-8.3% in adolescents (Birmaher et al., 1996; Fleming & Offord, 1990; Kashani et al., 1987; Lewinsohn, Clarke, Seeley, & Rohde, 1994). However, other studies have detected depression rates in children in the general population to be as high as 10-15% at any point in time (Nolen-Hoeksema, Girgus, & Seligman, 1986; Smucker, Craighead, Craighead, & Green, 1986). Research further demonstrates that depressive disorder rates tend to triple from childhood to adolescence (Daleiden, Vasey, & Brown, 1999; Flemming & Offord, 1990). For example, Kashani, Orvaschel, Rosenberg, and Reid (1989) determined depression rates in 8- and 12-year-old children to be 1.5% and depression rates in 17-year-olds to be 5.7%. Rutter, Graham, Chadwick, and Yule (1976) demonstrated that depression rates tripled from childhood (age 9 and 10) to adolescence (age 13 and 14) as well. Three large scale epidemiological studies that utilized retrospectively reported data similarly found rates of depression in children up to age 9 as relatively low; whereas, depression in 9- to 19-year-olds rose dramatically (Burke, Burke, Regier, & Rae, 1990; Kessler et al., 1994; Lewinsohn et al., 1986 as cited in Lewinsohn et al., 1994).

Ialongo, Edelsohn, Werthamer-Larsson, Crockett, and Kellam (1994, 1995) found a “crude estimate” of anxiety disorder prevalence in adolescents to be approximately 2.5% and in children (mean age of 6.6) to be 2.5% as well. On the other
hand, Kashani and Orvaschel (1988) found 6-month prevalence rates of anxiety in 14- to 16-year-olds to be at 8.7% when including the criterion of “clinically significant functional impairment requiring intervention,” and an astonishing rate of 17.3% when not including this criterion (i.e., no clinically significant impairment). Kashani and Orvaschel (1990) further reported anxiety rates of 15.7% and 21.4% for 12- and 17-year-olds, respectively.

As illustrated, prevalence rates of internalizing disorders appear to be quite high in children and adolescents, even though particular studies have demonstrated wide variability in this population (i.e., Ialongo et al., 1994, 1995; Smucker et al., 1986). These discrepancies can be due to several factors including the operational definition of disorders (caseness), measures used to assess the presence of disorders, the source reporting the disorder, and the particular sample investigated. Additionally, many studies of depression and anxiety in children and adolescents utilize samples from schools and typically do not include students who have dropped out, have poor school attendance, or who are institutionalized, thus possibly underestimate the already astoundingly high prevalence rates. Despite inconsistencies in the literature regarding prevalence rates of internalizing disorders, it is evident that an inordinate number of young people experience high levels of emotional distress and are desperate for intervention.

Stability

Early intervention for children and adolescents with internalizing disorders is imperative because the presence of these disorders has tremendous implications for the
future functioning of the individual. It was once believed that psychiatric disorders in children were transient phenomena that would remit over time. Currently, internalizing disorders are understood to be stable over time and to serve as risk factors for other future psychiatric dysfunction. Research examining depressive disorders has demonstrated that the average duration of a MDD episode is 7 to 9 months with a recurrence rate of 40% within two years and 70% within five years (Birmaher et al., 1996). Children who are exposed to a highly conflictive family environment tend to have even higher recurrence rates. Another study assessing adolescents (mean age of 15) with depression upon the initial assessment, found that 39% had an anxiety disorder and 69% had recurrent MDD at a 7-year reassessment (Rao et al., 1995). Kovacs and Devlin (1998) further demonstrated that emotional problems tend to persist or recur in over 60% of children and adolescents with previous emotional difficulties. Several other studies have shown similar results emphasizing the recurrence of depressive disorders and refuting the notion that these disorders are temporary phases of childhood (Harrington, Fudge, Rutter, Pickles, & Hill, 1990; Kovacs, Gatsonis, Paulauskas, & Richards, 1989; Rao et al.). The stability of depressive problems highlights the need for accurate identification so that early intervention and treatment may be carried out in a timely manner, thus preventing future development or recurrence of other affective disorders (Kovacs, Akiskal, Gatsonis, & Parrone, 1994).

Anxiety disorders have also been found to be relatively stable over time. Ialongo and colleagues (1995) reported the presence and severity (i.e., below, at, or above clinical cutoff) of anxiety disorders in first-grade children to be stable over a 4-
month interval. Symptoms of anxiety in first grade have further been found to predict significant anxiety symptoms and adaptive functioning in the fifth grade (Ialongo et al., 1995). Similarly, when a sample of 151 children (ages 2 to 15) were examined at a 4- to 5-year follow-up screening, 24% continued to have the originally diagnosed internalizing disorder and 42% were diagnosed with an anxious or depressive disorder different from that with which they originally presented (Cantwell & Baker, 1989). In a longitudinal study by Offord et al. (1992) involving a random sample of 881 children (ages 4 to 12), 10.8% were diagnosed with an internalizing disorder. Four years after this diagnosis, 26.2% continued to suffer from that disorder. Furthermore, of the original 10.8% diagnosed with an internalizing disorder, 14% developed hyperactivity and 18.2% developed conduct disorder at the 4-year followup. Similar findings have been reported in other longitudinal studies (Cantwell & Baker, 1989; Flament et al., 1990; Last, Perrin, Hersen, & Kazdin, 1996; Leonard et al., 1993).

The aforementioned research demonstrates that internalizing disorders in children tend to be recurrent and relatively stable over time. Therefore, they should not be viewed as transient phases, but as chronic disorders that necessitate immediate attention in order to prevent future emotional problems and psychiatric disturbance.

Comorbidity

Another major impact of anxiety and depression on current and future functioning of the individual is their high frequency of comorbidity with other internalizing disorders. Kovacs et al. (1989) examined a sample of 104 children (mean age of 11.2) with diagnosed MDD and/or DD and found that 41-44% had a concomitant
anxiety disorder, two thirds of which developed the anxiety disorder prior to the depressive disorder(s). Orvaschel, Lewinsohn, and Seeley (1995) similarly found two thirds of their sample of children and adolescents with anxiety disorders to later develop MDD. A review conducted by Brady and Kendall (1992) found comorbid rates of anxiety and depression to range from 15.9-61.9% in children and adolescents. Many other researchers have found high concurrence rates of anxiety and depressive disorders in children as well (Cicchetti & Toth, 1998; Cole, Peeke, Martin, Truglio, & Seroczynski, 1998; Kashani et al., 1987; Kovacs & Devlin, 1998; Ollendick & King, 1994). The high comorbidity of anxiety and depression may in part be due to the similarity of symptoms across these disorders, but it also suggests that children who are diagnosed with either an anxiety or depressive disorder are at great risk of developing another disabling disorder. Moreover, “in general, comorbid diagnoses appear to enhance the risk for recurrent depression and to affect the duration of the depressive episode, suicide attempts, functional outcome, response to treatment, and the use of mental health services” (Birahmer et al., 1996; Kovacs et al., 1994 as cited in Cicchetti & Toth, 1998, p. 223-224).

Symptoms

One of the most salient challenges professionals face regarding the identification of internalizing disorders in children and adolescents is their covert symptom presentation. The core symptoms of internalizing disorders are viewed as innerdirected and are often unobservable. These emotional disturbances include excessive worry, muscle tension, irritability, sleep disturbance, fatigue, difficulty concentrating, low self-
esteem, sadness, suicidal ideation, and feelings of hopelessness. Children who suffer from an internalizing disorder may feel unloved, angry, self-conscious, tense, and hypersensitive (Birmaher et al., 1996; Strauss, 1988). Additionally, the detection of internalizing disorders may be further complicated in children who are already viewed as shy or withdrawn (Reynolds, 1992).

Anxiety and depression in children and adolescents has been associated with social difficulties as well. Anxiety is specifically correlated with problematic peer interactions, including social withdrawal, overall low rates of peer interactions, unpopularity within the peer group, and dependence on adults in social environments. Depression in nonclinical samples of children and adolescents was also associated with unpopularity. Depressed students were further viewed by teachers and peers as more withdrawn and less likable and attractive (Strauss, 1988). The social difficulties experienced by children with internalizing symptoms may be further complicated by low socioeconomic status, stressful life events, and family turmoil that are often associated with internalizing disorders (Birmaher et al., 1996).

The ability of professionals to detect internalizing disorders in children and adolescents is greatly impacted by students’ covert symptom presentation, social withdrawal and ineptness, and the students’ tendency to be viewed as unattractive by peers and teachers. These children may be viewed differently as compared to their peers, but they seldom receive the intervention needed to relieve their psychological distress and to prevent future severe disturbance (Reynolds, 1990).
Suicide

The most detrimental effects of depression on children and adolescents include suicide, suicidal ideation, and suicide attempts. It has been demonstrated that a large proportion of children and adolescents suffer from depressive disorders. Further, children and adolescents who struggle with depression have been found to evidence suicidal ideation and attempts (Myers et al., 1991; Ryan et al., 1987), and suicidal children have high depression rates (Brent et al., 1986; Robbins & Alessi, 1985). Similarly, children who complete suicide tend to have positive histories of depressive disorders. In fact, Shaffer and colleagues (1996) found mood disorders to be the most common predictor of suicide completion in teenagers. On the other hand, every child who suffers from depression will not necessarily evidence suicidal thoughts or behaviors, and every child who attempts suicide will not have a history of depression. However, suicide ideation and attempts are closely associated with depression, thus warranting attention to depression in children and adolescents (Reynolds, 1990; Reynolds & Mazza, 1990, as cited in Reynolds, 1992).

Each decade the rate of adolescent suicide has risen. In fact, adolescent suicide rates have doubled over the past 10 years, tripled over the past 20 years (Wellman, 1984, as cited in Nelson & Crawford, 1990), and quadrupled since 1950 (Brent et al., 1988; Lewinsohn et al., 1993b, as cited in Birmaher et al., 1996). According to the Centers for Disease Control and Prevention (CDC, 2002), more adolescents and young adults lost their lives to suicide in 1998, than to AIDS, heart disease, birth defects, cancer, stroke, influenza, pneumonia, and chronic lung disease combined. The Utah
Office of Vital Records and Statistics (2002) reported that in the year 2000, 294 suicides were committed in Utah. Of these 294 suicides, 20.8% were committed by individuals between 15 and 24 years of age. In the United States, this age group committed 12.7% of suicides in 1999 (American Association of Suicidology, 2001). The CDC (2002) of Utah not only reported higher percentages of young people committing suicide when compared to the U.S., but also ranked suicide to be the second leading cause of death of individuals aged 10-14 and 15-24 as compared to the national ranking of third from 1996-1998. It is apparent that child and adolescent suicide in Utah continues to be of particular concern due to its high prevalence in such a young population of individuals. Most surprising is that the alarming rate of self-inflicted death of Utah children does not appear to be decreasing, further necessitating the need for intervention.

The detrimental affects of suicide and suicide attempts as associated with depression in children and adolescents illustrate the tremendous need for early identification and intervention with emotional disturbance in this young population. The possibility of death coupled with the high prevalence, stability, likelihood of comorbidity, and covert symptom presentation of internalizing disorders in school-age children draws attention to the need for frontline mental health professionals to have adequate training and skills to intervene with such a despondent group of young people.

Conclusions

Anxiety and depression are consistently found to be among the most common psychiatric diagnoses in children and adolescents. For example, Kashani et al. (1987)
examined a community sample of 150 adolescents (14-16 years of age) and found 18.7% to have at least one psychiatric disorder with anxiety (8.7%) and depressive disorders (8.0%) among the most common diagnoses. Despite the relatively large numbers of children who suffer from internalizing disorders, they make up a population that is too frequently overlooked and thus continue through life with disorders that can be quite disabling. The high prevalence rates, relative stability over time, comorbidity, covert symptom presentation, and association with suicide make internalizing disorders difficult, yet imperative to identify in society’s valuable youth. The most obvious environment within which to identify and intervene with such emotional disturbance is the school. Unfortunately, school counselors, like many professionals, who have the opportunity to detect emotional disturbances in children often fail to do so. This failure to detect internalizing problems in students could be due to a number of factors including counselor’s perceived roles, preservice or inservice training, experience, and attitudes.

Elementary and Secondary School Counselors

This next section of the literature review examines elementary and secondary school counselors. Specifically, school counselors’ role within the schools, training, and certification requirements will be addressed. Additionally, research regarding school counselors’ experience with emotional disturbance in students will be explored. Finally, the implication of school counselors as frontline mental health professionals for children and adolescents suffering from internalizing disorders will be discussed.
Training

Relatively little research has examined the level of school counselor preparedness in detecting and intervening with children and adolescents suffering from mental health disorders. The research that does exist suggests that school counselors receive very little education on childhood psychopathology. For example, Ibrahim and Thompson (1982) conducted a study of 50 randomly selected state universities that offer secondary school counselor programs. Forty-three universities responded to a questionnaire requesting graduate bulletins, master’s curriculum, and a list of required courses. Of the 43 participating, 29 responded with bulletins and master’s curriculum, but only 10 responded with information on required courses. Core curriculum courses pertaining to adolescent development and psychology and abnormal psychology were included in 7% and 3% of programs, respectively. When assessing elective courses, psychology (i.e., abnormal, social, psychological adaptation, psychological aspects of disability, and personality theories) ranked fifth out of 13 possible areas of electives. Despite the low rate of response in the required courses section of the questionnaire, findings suggest that education pertaining to adolescent psychological and emotional problems was not a priority in secondary school counselor training when the survey was conducted.

Sisson and Bullis (1992) examined the opinions of practicing elementary, middle/junior-high, and secondary school counselors in Oregon with regard to important educational domains in graduate counseling programs based on their past and current experience working in schools. The authors included several specific items
under the five broad domains of knowledge and information, counseling skills, abilities related to counselor role and function, consultation skills, and personal and professional issues. The items were ranked with regard to perceived importance. When examining the respondents aggregately, the highest ranked item in each of the aforementioned domains included counseling theories, personal problems, development of counseling and guidance programs, consultation with teachers about individual students, and self-understanding, respectively. The lowest ranked item in each domain included research and evaluation, play therapy, using computers, consultation with community professionals, and research and evaluation respectively. Of note is that many of the elementary, middle/junior-high, and secondary school counselors' rankings significantly differed. Statistically significant differences were found between the three groups of participants in six of the eight items of the knowledge and information domain, in five of the eight items of the counseling skills domain, in eight of the nine items represented in the abilities related to counselor role and function domain, and in five of the six consultation skills items. Based on these findings, it was apparent that although elementary, middle/junior-high, and secondary school counselors had some similar rankings, the discrepancies suggested the possible need for separate preparation programs at each level. Individualized training for school counselors employed at varying levels of education would help ensure they are trained to handle issues specific to their population of students.

*Educator Licensure*

Educator licensure requirements for school counselors are dependent upon the
particular state within which the individual wishes to practice and can greatly affect the
type of training received. The present study will focus on certification requirements in
the state of Utah. School counselor training requirements in Utah programs are based
on requirements specified by the Utah State Board of Education. The Utah State Board
of Education supports three levels of licensure for school counselors practicing within
the state of Utah. Level I is a Provisional Endorsement that requires the individual to be
formally admitted into an approved program, recommended for licensure by that
institution, have completed all requirements specified by the Utah State Board of
Education ("Standards for Approval of Programs for the Preparation of School
Counselors"), and have completed a practicum experience. An individual licensed with
the Level I Provisional Endorsement may only practice as a counselor for three years,
after which he/she must meet requirements for the Level II certificate. The Level II, or
Basic Certificate, requires the individual to have completed all of the requirements for
the Level I certificate and complete an approved 600-hour field experience or
internship. If the individual has a minimum of two years of previous counseling or
teaching experience, he/she is required to complete a 400-hour field experience. In
order to receive the Level II certification, the individual must also have received a
master's degree in school counseling or a related field and must be recommended for
the certification by an approved institution. The Level III certificate, or Standard
Certificate, is awarded to those individuals who have completed all requirements as
specified for the Level II certification, completed a minimum of two years of experience
as a school counselor with the Level II certificate, and been recommended by the
superintendent of his/her employing school district for the Level III certificate.

Utah further requires prospective school counselors to complete a background check, but does not require any prior professional teaching or counseling experience and does not require an examination in order to receive any certification. Additionally, Utah requires that school counselors function at the secondary grade level (Grades 9-12) with a goal of one counselor to every 400 students, and has recently proposed, but does not mandate, that counselors work in elementary or middle schools (Grades K-8; American Counseling Association, 2001). Given the aforementioned prevalence rates of internalizing disorders in children, it seems imperative that school counselors be required at the elementary school level.

The Role of the School Counselor

Elementary and secondary school counselors play different roles within the schools. In fact, the perceived necessity of elementary school counselors is dependent upon legislation of each state. Only 17 states had required counselors in elementary schools by 1989 (Glosoff & Koprowicz, 1990, as cited in Hardesty & Dillard, 1994). On the other hand, secondary school counselors are viewed by all states as essential components in the education system. This difference may be due to several factors including the relative newness of the elementary school counseling profession and the perceived importance of the elementary school counselor. Secondary school counselors traditionally function as vocational counselors, whereas elementary school counselors tend to focus on academic, vocational, and emotional development of students. The emphasis on development may not yet be viewed as an essential aspect of education or
as an appropriate area of focus for the educational system (Hardesty & Dillard, 1994).

Howard (1989) conducted a study comparing counseling activities of elementary and secondary school counselors. Findings from this study demonstrated that both elementary and secondary school counselors spent the largest portion of their time counseling students. However, elementary and secondary school counselors differed with regard to their second and third most important counseling activities. Elementary school counselors indicated working with teachers and carrying out classroom guidance activities as their second and third, respectively; whereas, secondary school counselors listed academic counseling and career counseling.

Hardesty and Dillard (1994) expanded this study by examining the differing roles of elementary ($n = 141$), middle ($n = 88$), and secondary school counselors ($n = 140$) from Kentucky. They administered a questionnaire outlining 17 activities (including an “other” category) that were to be ranked in order of amount of time spent in each. The six activities related to counseling of the student were drug counseling, relationship counseling, rape counseling, family relations counseling, abuse counseling, and suicide prevention. Some of the noncounseling activities included consulting with faculty, coordinating programs, student scheduling, and completing paperwork. Three of the six counseling activities were ranked within the top five for elementary and middle school counselors; whereas, none of these activities were ranked in the top five for secondary school counselors.

Several studies have demonstrated that school counselors can positively impact students who have been identified as having emotional and behavioral struggles. For
instance, school counselors have been found to increase positive attitudes and decrease inappropriate behaviors, including hostility and aggression (Baker & Gerler, 2001; Omizo, Hershberger, & Omizo, 1988). School counselors have demonstrated that they can effectively teach social skills (Verduyn, Lord, & Forrest, 1990), which is often an issue with children who are depressed or anxious (Strauss, 1988). Furthermore, school counselors have been found to be able to prevent suicide in students, particularly when implementing prevention programs with young students (Jones, 2001).

These findings demonstrate that more time may be devoted to counseling activities in the elementary and middle school level than at the secondary level. It is further concluded that elementary and secondary school counselors differ in the amount of time they spend in various activities. However, these studies indicate that both elementary and secondary school counselors spend the majority of their time counseling students about personal issues. Additionally, it is apparent that school counselors are capable of intervening and consequently having a positive impact on emotional and behavioral struggles in students. Unfortunately, school counselors cannot intervene with students if they do not detect that there is a problem, which is often the case.

*Elementary school counselors' role in the school system.* It is difficult to assess elementary school counselors with regard to their effectiveness in prevention, detection, and early intervention of emotional disturbances in children due to the dearth of literature in this area. Researchers have explored teachers’ expectations of elementary school counselors (Madak & Gieni, 1991) and have discussed the role of elementary school counselors (Humes & Hohenshil, 1987; Pardeck & Pardeck, 1989), but very few
studies have conducted research (i.e., questionnaire, survey) regarding actual roles as reported by elementary school counselors. Approximately four studies exist that specifically examine elementary school counselors' role in the school system. Unfortunately, the most recent study found in this review was published in 1993 (Carroll, 1993).

Although Furlong, Atkinson, and Janof's (1979) study of elementary school counselors' perceptions of actual and ideal roles in the school was conducted in the late 1970s, it offers valuable insight to current elementary school counselor roles and is confirmed by more recent studies. Furlong et al. surveyed the amount of time elementary school counselors in California actually spend in specified roles (i.e., counseling, program planning, career development, referral) versus the amount of time they would like to spend in each role. Results showed the top five current activities in descending order, as counseling, consultation, pupil appraisal, parent help, and referral. The highest ranked ideal-role was counseling, followed by consultation, parent help, change agent, pupil appraisal, and referral. Elementary school counselors reported counseling, including individual and small groups, to occupy the majority of their time and said that research or evaluation studies are their least conducted and preferred activity. Despite some differences in the order of importance, actual versus ideal elementary school counselor roles were quite similar. As noted previously, Howard (1989) similarly found counseling elementary students to be school counselors' first priority.

Morse and Russell (1988) found larger discrepancies between actual and ideal
roles. They found that the top ranked activity in both actual and ideal roles involved consultation. Furthermore, actual elementary school counselor roles included individual counseling in two of the five highest ranked items and consulting in 3 of the 5 highest ranked items. In contrast, the participants ranked their ideal roles as involving group counseling in four of the five highest ranked responses. It is apparent that these counselors were involved in some counseling activities, but perceived group counseling to be a large need, and thus would have liked to offer more group counseling opportunities for the students.

In the most recent study, Carroll (1993) examined elementary school counselors' actual perceived roles and preparation experiences versus ideal roles and preparation. Questions pertained to the role and preparation areas of coordinator, consultant, counselor, teacher, and manager. Carroll's survey did not focus on a ranking of roles as previous studies have, but instead discussed discrepancies between actual versus ideal activities. Coordinator, consultant, and counselor roles were the most congruent in terms of both being listed as actual and ideal roles. However, the specific areas of group work with children and parents, special needs referrals, and conducting inservice trainings were disparate with regard to actual and ideal activities. The roles of teacher and manager (i.e., program evaluation) resulted in the largest discrepancies between actual and ideal roles. Furthermore, the finding that counselors were not evaluating their program is consistent with Furlong et al. (1979). In conclusion, Caroll's study shows that elementary school counselors demonstrate congruence with many of their actual and ideal roles. Due to the lack of a rank order system, it is impossible to
determine which activities elementary school counselors believe are the most important or necessary.

*Secondary school counselors' role in the school system.* A dearth of research similarly exists in the area of secondary school counselors and their role within the schools especially with regard to students' mental health. The few studies that examine secondary school counselor roles touch on the importance of research in this crucial area that has the potential to significantly impact the lives of adolescents across the country. Bonebrake and Borgers (1984) examined junior high and middle school counselors' opinions of their ideal role within the schools. Ideal role was defined as the participants' opinions of those tasks deemed appropriate for counselors. School counselors were asked to rank 15 counselor tasks that were organized into the four groups of counseling, coordinating, consulting, and problem areas, based on a Likert scale indicating the ideal amount of emphasis they would like to give to each task. With regard to counseling, the junior high and middle school counselors ranked individual counseling as their first ideal role and group counseling as the seventh ideal role. Teacher consultant, student assessment, parent consultant, evaluation of guidance, and referral services were ranked 2 through 6, respectively. Findings suggest that these school counselors view individual counseling as the most important ideal activity to be involved in. Unfortunately, Bonebrake and Borgers did not examine the school counselor's actual role within the school, thus providing nothing with which to compare the counselor's ideal activities.

Howard (1989) assessed actual time versus ideal time that secondary school
counselors spend in particular activities. Results indicated that secondary school
counselors reportedly spent more than 50% of their time counseling students and
making schedules. The counselors further indicated that ideally they should be primarily
focused on counseling students regarding academic and personal issues.

Based on the few studies offering insight into actual versus ideal roles of
secondary school counselors, it appears that individual counseling is an important
priority for these professionals. However, despite some knowledge about actual versus
ideal role, school counselors’ specific role within the school system is not always clear.
Further research is needed to confirm these findings and to examine more specific role
requirements of school counselors. The present study sought to help expand the
literature on school counselors’ role specifically pertaining to internalizing issues in
students.

School Counselors and Internalizing Disorders in Students

Some individuals within the school system may believe that it is not the school
counselor’s role to detect and intervene with childhood affective disorders. However,
others highlight the important role school counselors can maintain with the school
environment. For example, Hart (1991, p. 277-278) believed that

although it is not within the scope of duties of school counselors to provide a
clinical diagnosis or to actually treat [internalizing disorders], there is much that
can be done within school settings to moderate, remediate, and even effectively
rehabilitate [internalizing] symptoms (pp. 277-278)

in children and adolescents. Schools represent institutions that have the most contact
with the largest number of children and adolescents from the community. In fact,
students may spend an average of one third of each weekday and thousands of hours of their lives in school. The school environment provides an ideal setting in which school counselors can detect and possibly prevent emotional disturbances in students. However, very little research has examined school counselors' role in the prevention, detection, and intervention of internalizing disorders in children and adolescents. Unfortunately, research that does exist tends to provide conflicting findings and at times exhibits significant methodological shortcomings.

Peterson, Wonderlich, Reaven, and Mullins (1987) conducted one of the few studies examining school personnel responses to depression in students that included elementary and secondary school counselors. Participants included 77 counselors, principals, and teachers from elementary and secondary schools who were attending a workshop on the impact of childhood emotional disturbance on school educators. Each participant completed a demographics measure and viewed one of four films depicting a depressed, not depressed, stressed, or not stressed nine-year-old girl. The participants also completed a rating scale before and after viewing the films, which required them to rate their own current level of anxiety (1, anxious or tense to 9, calm or peaceful) and depression (1, depressed or sad to 9, happy). They were then asked to complete several measures designed to assess their reaction to the child depicted in the film. Results demonstrate that educators would treat the depressed and stressed child differently than they would treat other children, and would view these children "...as having more current and future negative behavior, and as having less potential for future positive behavior" (p. 55). Additional negative attitudes toward the depressed child included
being rated as less attractive. It is evident that the participants were able to detect a difference in behavior between the “depressed” and “not depressed” child. However, the negative views of attractiveness and current and future functioning may serve to maintain the depression if these attitudes were to be conveyed to the child. It should be noted that perceived reactions to a depressed child might not reflect actual reactions of the participants if they were able to personally interact with the depressed student.

Maag, Rutherford, and Parks (1988) were interested in the ability of secondary school guidance counselors \((n = 30)\), regular classroom teachers \((n = 30)\), and special education teachers \((n = 30)\) to identify symptoms of adolescent depression. A questionnaire-interview method revealed that school counselors identified more characteristics of adolescent depression overall and identified more covert or cognitive symptoms (i.e., low self-esteem) than did regular classroom and special education teachers. Although many factors could contributed to this finding, the level of training completed by the school professional may have an impact on knowledge related to emotional disturbance in students.

Other researchers have studied the perceptions of teachers versus mental health professionals with regard to behavioral or adjustment problems in students. Unfortunately, these studies did not include school counselors, however it should be noted that in each study, the mental health professionals were better able to detect possible adjustment problems including the severity or urgency of those problems (Sack & Sack, 1974; Vidoni, Fleming, & Mintz, 1983; Wall & Pryzwansky, 1985). Based on these studies, it seems that higher levels of education better prepare mental health
professionals to effectively detect behavioral and emotional problems in students. This further suggests that school counselors may be more efficacious in the prevention, detection, and intervention of internalizing symptoms in children and adolescents if they were to receive more training in the areas of psychopathology and treatment (i.e., individual and group counseling).

Conclusion

Based on current literature, it is evident that many children and adolescents experience symptoms of internalizing disorders including depression and anxiety. Unfortunately, these students often do not receive intervention or treatment and thus, continue through life with often disabling disorders. The presence of affective disorders in childhood has been shown to put children and adolescents at risk for future severe disturbance. Furthermore, when examining the most timely and effective manner in which to identify these children, school counselors seem to be the most readily accessible and convenient resources. Unfortunately, the role of elementary and secondary school counselors within the schools seems to be unclear and vague. Research indicates that school counselors possess more advanced abilities to detect internalizing symptoms in students than their less educated colleagues. This offers promising evidence for the value of implementing courses on childhood and adolescent mental health (i.e., psychopathology, early intervention) to help ensure that school counselors will be better equipped to detect emotional disturbance in youth.
CHAPTER III

METHOD

Data Collection

This study utilized an extant data set collected through a grant from the Bureau of Research Services at Utah State University awarded to Susan Crowley, Ph.D., principal investigator. The funding was obtained in November of 2000.

Participants

The target population for this study consisted of all elementary and middle/secondary school counselors working at schools in the state of Utah. Participants were initially recruited during two days of a school counseling conference in Provo, Utah at Brigham Young University in May of 2001. As a result of this recruitment, 58 questionnaires were completed and returned by middle/secondary school counselors. The remaining school counselor participants were recruited for the study by asking for address labels from the Utah State Office of Education. Approximately 950 school counselors work in the state of Utah, all of which were mailed a questionnaire for this study. The first mailing resulted in the completion of 94 elementary school counselor questionnaires and 175 middle/secondary school counselor questionnaires (271 total). A reminder postcard was then sent out to the individuals who had not yet returned the questionnaire. After this mailing, 68 completed questionnaires were received, which included 31 elementary questionnaires and 37 middle/secondary questionnaires.
Response rates included 45% of the elementary school counselors and 41% of the middle/secondary school counselors working in the state of Utah. This response rate is above average based on the expected 30% (Black & Champion, 1976; Meyers & Grossen, 1974), and is close to the 50% maximum expected response rate for mailed surveys (Bailey, 1978). Furthermore, several surveys were returned with a note stating that the school counselor had received two surveys due to being employed at more than one school. It is thus speculated that the overall 41.6% response rate is a low estimate.

Measure

The measure used in the present study was a questionnaire adapted from a study by Green, Clopton, and Pope (1996). The survey was originally intended for teachers and consisted of four vignettes, describing externalizing and internalizing problems in hypothetical children, each followed by several yes/no and multiple choice questions. The current study is based on the use of two versions of the survey, one for elementary school counselors (see Appendix B) and one for middle and secondary school counselors (see Appendix C). A small pilot study was conducted using one elementary school counselor and two secondary school counselors. These individuals completed the prospective surveys and made comments on recommended changes to be made. Changes were then made according to these recommendations. For instance, additional lines were added to “other” responses to give respondents adequate room to comment. Additionally, the wording of the question following each vignette was changed to eliminate confusion as suggested (i.e., from “would you refer the child described in this
vignette for additional school-based services," to "use the following rating system to respond to the question below").

Both versions of the survey (secondary school counselors and middle/secondary school counselors) consist of three parts: Part I including vignettes followed by questions, Part II consisting of questions about children's mental health and school services, and Part III, demographic information (see Appendix A). Part I of each version consists of four vignettes. Two vignettes describe a male and female exhibiting internalizing symptoms and two describe a male and female exhibiting externalizing symptoms. For purposes of this study, only the responses to the internalizing vignettes will be examined. The elementary school counselor version contains the vignettes from the Green et al. (1996) study. These vignettes were modified for the middle/secondary school counselor version to describe emotional and behavioral problems of 14-year-old children. This modification was made to increase the relevance of the vignettes for middle and secondary school counselors. The descriptions of emotional and behavioral problems were taken from the Teacher’s Report Form for Ages 5-18 of the Child Behavior Checklist (CBCL-TRF; Achenbach, 1991). For example, the male internalizing vignette was changed from "he works slowly in the classroom and as a result, often has to take his work home to complete" in the elementary version, to "struggles to finish his homework on time" in the secondary version of the questionnaire.

Each vignette is followed by two questions in Part I of the questionnaire. One asks the participants to rate a list of five options (meet with this child’s teacher(s), meet
with this child’s parents, see this child once, see this child on a continuing basis, refer
this child to a psychologist) that describe how they would respond to the child described
in the vignette. They are to rate these options on a Likert scale of 1 (definitely not) to 4
(definitely). The second question asks, “Approximately how many times in the past year
have you consulted about a child similar to (child’s name), as described in the vignette.”

Part II of the questionnaire asks nine questions regarding children’s mental
health and school services. The section begins with two questions regarding the
participants’ preservice and staff development training. A list of children’s mental
health problems (attention deficit hyperactivity disorder [ADHD], anxiety, suicide,
aggressive behavior, and so forth) is provided and the participants are asked to place a
check next to areas in which they received preservice training and staff development
training. The third question asks participants to indicate whether or not services in the
participant’s school district are available for children who have externalizing disorders.
The fourth question asks participants to check which services are available. Questions
five and six are identical to questions three and four but ask about children with
internalizing disorders as opposed to externalizing disorders. Question seven asks,
“Regarding children’s mental health issues, which of the following services do you feel
schools should provide? (Please check all that apply).” This is followed by a yes/no
inquiry about the participant’s interest “in receiving staff development training on
children’s mental health issues.” The final question in Part II asks, “If you answered yes
to the previous question, for what kinds of problems would you be interested in
receiving training? (Please rank order).” The problems to be rank ordered include
ADHD/attention deficit disorder (ADD), anxiety, depression, suicide, disruptive behavior, behavioral interventions, and other.

Part III of the questionnaire asks for demographic information, including the participant’s gender, education and field of study, specialization/certification, current school(s) served, and number of years of counseling experience. This is followed by questions concerning the average percent of time spent performing particular tasks (assessing children, counseling children, consulting with teachers, administration/scheduling, etc.) and the ideal average percent of time performing these tasks. Space for additional comments is provided as well (see Appendix A for complete survey).

Each questionnaire was accompanied by a detailed letter explaining the purpose of the study, informed consent, confidentiality, incentives for participating, as well as a contact person for questions (see Appendix A). Participation in the study was explained as being completely voluntary with no negative consequences resulting from declining participation. Consent was assumed upon the completion and returning of the questionnaire. Adding to current knowledge and literature in this area as well as being entered in a drawing for $50 were incentives for participating in the study.

Procedure

Data were collected at a school counseling conference in Provo, Utah. A table was set up at this conference next to the registration table, and included a sign reading, “USU RESEARCH.” An incentive of being entered in a drawing for $50.00 was advertised as well. A one-page flyer advertising the need for school counselors to
participate in the study as well as information regarding the $50 drawing was placed in the
counselor's registration packets that were received by attendees the morning of each
county conference day. A separate demographics page asking for the individual's name,
address, telephone number, and e-mail address was attached to each survey, as well as a
cover letter introducing the investigators and explaining the importance of the research.
Two slips of paper containing the survey number were also included on the
demographics page. One slip was given to the participant and the other was entered into
the drawing. A $50 drawing took place at the end of the lunch break each day. Data
were collected during the first 2 days of the 3-day conference.

A cover letter, survey, and return envelope was mailed to each of the remaining
elementary and secondary school counselors in the state of Utah. The participants were
asked to complete and return the surveys within two weeks of receiving them. Every
school counselor who returned a completed survey was entered in a drawing for $50 as
well. Follow-up postcards were mailed to individuals who did not return the survey
within two weeks of the initial mailing.
CHAPTER IV
RESULTS

This section provides results of data analyses organized by the research questions presented in Chapter I. Preliminary analyses were first conducted to obtain descriptive information (e.g., degree, field of study, number of years of counseling experience) for the participants. The preliminary analyses are followed by results of statistical calculations guided by research questions. Finally, additional analyses are presented on further information obtained from the survey that was found to be of importance (i.e., responses to questions following each vignette based on a Likert scale). The data were analyzed separately for elementary and secondary school counselors and then integrated and summarized to broadly include all school counselors.

Preliminary Analysis

Prior to addressing the research questions for the present study, preliminary analyses were conducted to better describe the participants and to investigate whether the data would support further substantive analyses. Preliminary analyses included descriptive statistics found in Part III of the survey. Statistics were computed for elementary and secondary school counselors as separate groups, as well as for the combined sample. Several items in the demographic section of the survey were open-ended and consequently resulted in a broad range of responses (e.g., educational degree, years of counseling experience). To better make sense of the information provided, the
data were collapsed into conceptually meaningful groups. Variables for which the data were collapsed included educational degree, field of study, type of certification, number of schools served, and number of years of counseling experience.

The categories into which the data for educational degree were organized are presented in Table 1. Specifically, the participants reported 10 different educational degrees. These degrees were combined to form three main categories of bachelor’s degree, master’s degree, and doctoral degree. The categories into which the data for field of study and type of certification were organized are presented in Tables 2 and 3. Participants reported 21 different fields of study and 32 different types of certification. For both variables, three broad categories of school counseling, psychology, and education/administration were developed to represent the specific areas reported.

Participants further reported serving a range of 1 to 15 schools with the majority of participants (over 90%) serving three or fewer schools. Therefore, the number of schools served was broken down to either one to three schools served, or greater than three schools served. Participants similarly varied greatly with regard to their number of years of counseling experience (1 to 35 years). To better manage this large variation,

Table 1

*Educational Degree*

<table>
<thead>
<tr>
<th>Collapsed category</th>
<th>Participant responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s degree</td>
<td>B.S., B.A., B.S.+</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>M.S., M.A., M.Ed., M.A.Ed., SSW</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>Ph.D., Ed.D.</td>
</tr>
</tbody>
</table>
Table 2

Field of Study

<table>
<thead>
<tr>
<th>Field of study</th>
<th>Participant response</th>
</tr>
</thead>
<tbody>
<tr>
<td>School counseling</td>
<td>Counseling, School Counseling, Educational Counseling, Social Work, Vocational Rehabilitation Counseling, Guidance Counseling, Marriage and Family Therapy, Counseling Psychology, Family Studies</td>
</tr>
<tr>
<td>Psychology</td>
<td>School Psychology, Educational Psychology, Psychology</td>
</tr>
<tr>
<td>Education/administration</td>
<td>Special Education, Educational Administration, Administration, Secondary Education, Educational Leadership, Education, PE/Health/Behavioral Science/Science, Science/Mental Health, Elementary or Secondary Education</td>
</tr>
</tbody>
</table>

Table 3

Certification

<table>
<thead>
<tr>
<th>Certification</th>
<th>Participant response</th>
</tr>
</thead>
<tbody>
<tr>
<td>School counseling</td>
<td>Marriage and Family Therapy, School Counseling, Guidance Counseling, Counseling, LCSW/LSSW, School Social Work, Educational Counseling, K-12, Drug/Alcohol Rehabilitation, LPC, Reality Therapy, Early Childhood, LSAC, Counseling Psychology</td>
</tr>
<tr>
<td>Psychology</td>
<td>Psychology, School Psychology, Educational Psychology</td>
</tr>
<tr>
<td>Education/administration</td>
<td>ESL, Special Education, Speech/Language, PE/Math/Social Science/Science, Educational/Mental, Professional Educator License, Elementary Education, Secondary Education, Administration, Learning Disabilities, Criminology, Resource, Communication Disorders</td>
</tr>
</tbody>
</table>

years of counseling experience was divided into four ranges including, 1 to 5, 6 to 10, 11 to 15, and greater than 15 years of counseling experience.
Descriptive Information for Elementary School Counselors

The following descriptive information pertains to participants working as professionals in the role of elementary school counselor within the state of Utah. The data are presented in Table 4. In total, 125 elementary school counselors were included in the study. The majority of these participants were female (75.8%). The education level of participants was primarily at the master's degree level (85.2%), with relatively few participants having a bachelor's (2.5%) or doctoral (12.3%) degree. Three (2.4%) participants failed to record their educational degree. Of the participants who recorded their field of study (18.4% did not respond), most either obtained a degree in school counseling (45.1%), or in psychology (51.0%), with a few participants obtaining degrees in the field of education/administration (3.9%). Several elementary school counselors (12.8%) recorded a second field of study, with the majority specifying that their second degree was in psychology (68.8%).

Most participants (84.8%) further noted that they had received certification in a particular area, with several (15.2%) recording two certifications. More than half of elementary school counselors (67.9%) reported being certified in school counseling. Over one fifth (22.7%) noted a certification in psychology, with the remaining participants (9.4%) specifying certifications in education/administration. The majority of participants (89.5%) who reported a second certification were certified in psychology or education/administration, with few (10.5%) having a second certification in school counseling. With regard to the number of schools served, the vast majority of elementary school counselors (90.4%) who responded to this question noted serving up
Table 4

Summary of Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Elementary school counselors (N = 125)</th>
<th>Secondary school counselors (N = 270)</th>
<th>Combined elementary and secondary school counselors (N = 395)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Gender</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>94</td>
<td>75.8</td>
<td>172</td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
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<td>97</td>
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<tr>
<td>Educational degree</td>
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<tr>
<td>Bachelor's</td>
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<tr>
<td>Master's</td>
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<tr>
<td>Doctorate</td>
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<tr>
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<td>46</td>
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<td>143</td>
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<tr>
<td>Psychology</td>
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<td>51.0</td>
<td>79</td>
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<tr>
<td>Education/administration</td>
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<td>14</td>
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<td>Second field of study</td>
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<tr>
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<td>7</td>
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<td>68.8</td>
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<tr>
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<td>12.5</td>
<td>12</td>
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<td>Psychology</td>
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<tr>
<td>Education/administration</td>
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<tr>
<td>Second certification</td>
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<tr>
<td>School counseling</td>
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<tr>
<td>Education/administration</td>
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<td>42.1</td>
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<td>Number of schools served</td>
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<td>Years counseling experience</td>
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<td>55</td>
</tr>
</tbody>
</table>

Note. Percentages based on the number of participants who responded to each individual question. The number of respondents for each question ranged from 19 to 124 for elementary school counselors and from 29 to 269 for secondary school counselors.
to three schools (4.8% did not respond). The majority of the elementary school counselors further reported their number of years of professional experience (98.4%), with almost half (42.2%) having up to 5 years of experience and approximately one quarter (23.6%) with either 6 to 10 years of experience or greater than 15 years of experience. Relatively few participants (10.6%) had 11 to 15 years of counseling experience.

**Descriptive Information for Secondary School Counselors**

Results for secondary school counselors are also presented in Table 4. A total of 270 individuals working as secondary school counselors in the state of Utah participated in this study. Female respondents \( n = 172; 63.9\% \) outnumbered male respondents \( n = 97; 36.1\% \) by almost two to one. All but four (1.5%) respondents noted their educational degree, with the majority (95.9%) obtaining master's degrees. Two hundred thirty-six (87.4%) secondary school counselors reported their field of study with 39 (14.4%) indicating two fields of study. More than half (60.6%) of the respondents studied school counseling with over one third (33.5%) studying psychology. Of those who indicated a second field of study, approximately half (51.3%) indicated also studying psychology, with one third (30.8%) studying education/administration. Relatively few (17.9%) secondary school counselors revealed their second field of study to be school counseling, presumably because so many counselors noted this field as their primary area of study.

Of the secondary school counselors who noted their type of certification
the majority obtained certifications in school counseling (88.9%), with few obtaining certifications in psychology (1.0%) or education/administration (10.1%).

Alternately, a small number of participants (10.7%) noted a second certification, with more than half (62.1%) having a second certification in education/administration. The vast majority of secondary school counselor respondents (99.2%) revealed that they serve one to three schools (6.7% did not indicate the number of schools served). Almost all (99.3%) secondary school counselors indicated their number of years of professional experience, with most (70.2%) of them having between one and 10 years of experience. Several others (20.5%) noted having more than 15 years of counseling experience.

Descriptive Information for Elementary and Secondary School Counselors Combined

Data for the combined elementary and secondary school counselor sample are also presented in Table 4. A total of 395 school counselors participated in this study. The total sample was comprised of more than twice as many females (67.7%) as males (32.2%). The majority (92.5%) reported obtaining master’s level degrees, with relatively few having bachelor’s (1.8%) or doctoral (5.7%) degrees. Just over half of the participants (55.9%) studied school counseling with a number of them studying psychology (38.8%). Of the school counselors who noted a second field of study (13.9%), approximately half (56.4%) of those also studied psychology. Just over three quarters (77%) of the participants reported being certified in a particular area. The majority of school counselors noted certifications in school counseling (81.6%). Of the few who recorded a second certification (12.2%), about half were also certified in
education/administration (54.2%). Almost all participants (93.3%) further revealed the number of schools they currently serve, with the majority (97.8%) serving one to three schools. All but four participants further reported their number of years of professional experience. Well over half of school counselors (68.8%) reported having 1 to 10 years of professional experience. Almost a quarter of respondents (21.5%) revealed having more than 15 years of professional experience.

Research Questions

*Training Received in Children’s Mental Health*

The first research question asked about the types of children’s mental health issues in which school counselors have received training. Data to answer this question were drawn from questions 1 and 2 in Part II of the survey. Question 1 provided a list of children’s mental health issues and asked respondents to check all that apply in responding to the question, “In your preservice training, in what areas did you receive information in your coursework concerning children’s mental health.” Question 2 similarly provided a list of children’s mental health issues and asked respondents to check all that apply in response to the question, “since you started practicing, have you received any staff development training concerning the following areas regarding children’s mental health.” The list of children’s mental health issues that followed questions 1 and 2 included ADHD/ADD, anxiety, depression, suicide, disruptive behavior, aggressive behavior, behavioral interventions, and other. Data for the first research question were analyzed separately for elementary and secondary school
counselors and then combined for all school counselors. These data are presented in Table 5.

*Elementary school counselors.* The areas of preservice and staff development training listed in questions 1 and 2 in Part II of the survey can be categorized as internalizing issues (e.g., anxiety, depression, suicide), externalizing issues (e.g., ADHD/ADD, disruptive behavior, aggressive behavior), and behavioral intervention. With regard to preservice training, analyses revealed that 70.4% of elementary school counselor participants received preservice training on anxiety. Over 80% also received preservice training on depression (82.4%) and suicide (83.2%). Concerning externalizing issues, approximately 70% received training on ADHD and disruptive behavior, and 67.2% received training on aggressive behavior. More than three quarters

Table 5

*Training Received in Children’s Mental Health*

<table>
<thead>
<tr>
<th>Type of training received</th>
<th>Elementary school counselors $(N = 125)$</th>
<th>Secondary school counselors $(N = 269)$</th>
<th>Combined elementary and secondary school counselors $(N = 394)$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre$^a$</td>
<td>In$^b$</td>
<td>Pre</td>
</tr>
<tr>
<td>Internalizing issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>88</td>
<td>70.4</td>
<td>76</td>
</tr>
<tr>
<td>Depression</td>
<td>103</td>
<td>82.4</td>
<td>89</td>
</tr>
<tr>
<td>Suicide</td>
<td>104</td>
<td>83.2</td>
<td>102</td>
</tr>
<tr>
<td>Externalizing issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>89</td>
<td>71.2</td>
<td>108</td>
</tr>
<tr>
<td>Disruptive behavior</td>
<td>88</td>
<td>70.4</td>
<td>92</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>84</td>
<td>67.2</td>
<td>90</td>
</tr>
<tr>
<td>Behavioral intervention</td>
<td>95</td>
<td>76.0</td>
<td>105</td>
</tr>
</tbody>
</table>

$^a$ Pre- signifies preservice training.

$^b$ In- signifies staff development or inservice training.
(76.0%) of elementary school counselors also received preservice training on behavioral interventions with children.

Over half of the elementary school counselor respondents reported that they had received staff development training at the time of the survey completion on internalizing and externalizing mental health areas, as well as on behavioral interventions. Specifically, 60.8% received staff development training on anxiety, 71.2% on depression, and 81.6% on suicide. Respondents noted receiving staff development training in the externalizing areas of ADHD (86.4%), disruptive behavior (73.6%), and aggressive behavior (72.0%), as well as in behavioral interventions (84.0%). The largest number of elementary school counselors reported staff development training in the area of ADHD, with the least number of counselors receiving training on childhood anxiety; although, approximately two-thirds received some training in childhood anxiety.

Secondary school counselors. The number of secondary school counselors who received preservice training in the specific areas of childhood mental health as presented in the survey was comparable to that of elementary school counselors. Well over half of secondary school counselors received preservice training on anxiety (71.4%), with 84.8% receiving staff development training on depression and suicide. With regard to externalizing problems, over 60% of secondary school counselors received preservice training on ADHD, disruptive behavior, and aggressive behavior. The majority of secondary school counselors (80.7%) further noted being trained in behavioral interventions prior to their professional employment. Preservice training on
ADHD represented the largest difference in preservice training between secondary and elementary school counselors. However, this difference was only 6.1% (anxiety: 1.0%, depression: 2.4%, suicide: 1.6%, disruptive behavior: 2.7%, aggressive behavior: 4.0%, behavioral interventions: 4.7%). Elementary and secondary school counselors differed very little (from 1.0- 4.7%) in their preservice training on anxiety, depression, suicide, disruptive behavior, aggressive behavior, and on behavioral interventions.

Elementary and secondary school counselors differed more significantly in their staff development training than in their preservice training. For instance, 44.6% of secondary school counselors received staff development training on anxiety versus the 60.8% of elementary school counselors who received training in this area. However, the number of secondary school counselors trained at the staff development level on depression (74.0%) and suicide (85.5%) is similar to elementary school counselors trained in these areas. In general, the number of secondary school counselors who received staff development training in externalizing problems was lower than the number of elementary counselors trained in this area. Specifically, 76.2% were trained on issues related to ADHD, 61.3% on disruptive behavior, and 56.9% on aggressive behaviors. A large difference was further found with respect to training on behavioral interventions with 66.9% of secondary school counselors versus 84.0% of elementary school counselors being trained in this area. Overall, elementary and secondary school counselors differ more in their staff development training than they do with regard to preservice training. This difference may be reflective of their different roles within the school system.
Elementary and secondary school counselors combined. When examining the combined elementary and secondary school counselor sample, analyses revealed that for internalizing issues, 71.1% of school counselors received preservice training in anxiety, with a larger portion of individuals being trained in depression (84.0%) and suicide (84.3%). With regard to externalizing issues, between 60 and 70% of the sample were trained on ADHD (67.0%), disruptive behaviors (68.5%), and aggressive behaviors (64.5%). A similar number of school counselors reported being trained on behavioral interventions (79.2%).

Analyses of staff development training demonstrated that similar numbers of school counselors were trained on the internalizing issue of suicide (84.3%); whereas, only 49.7% of school counselors received staff development training on anxiety and 73.1% on depression. Similar numbers of school counselors were trained at the staff development level on disruptive behavior (65.2%) and aggressive behavior (61.7) as with the preservice training level; whereas, over 10% more individuals were trained on ADHD (79.4%) during staff development than during preservice training.

Desire for Additional Training in Children’s Mental Health

The second research question sought to ascertain the types of children’s mental health problems in which school counselors would like additional training. Data to answer the second research question was taken from questions 8 and 9 in Part II of the survey. Question 8 asked school counselors if they would be interested in receiving staff development training on children’s mental health issues and provided a “yes” and
“no” option to check. Question 9 stated, “If you answered yes to the previous question, for what kinds of problems would you be interested in receiving training? (Please rank order).” A list specifying the mental health issues of ADHD/ADD, anxiety, depression, suicide, disruptive behavior, and behavioral interventions was provided. After examining individual responses to question 9, it became apparent that many respondents did not make note of the rank order direction and merely placed a check next to each area in which they were interested in receiving training. In order to make sense of these responses, check marks were recorded as “yes” responses and items left blank were coded as “no” responses. The data from participants who rank ordered their responses were analyzed separately from the data of participants who provided check marks.

Elementary school counselors. Of the elementary school counselors who placed checks next to the areas in which they would be interested in receiving further training, the majority (92.3%) noted that they would be interested in receiving additional training in children’s mental health issues. Between 60% and 70% of respondents noted an interest in further training in the externalizing areas of ADHD (66.7%) and disruptive behavior (67.8%), and in the area of behavioral interventions (62.1%). A slightly higher percentage of elementary school counselors reported a strong interest in obtaining supplementary training in the internalizing areas of anxiety (79.3%) and depression (74.7%). Just over half of the respondents who checked their areas of interest indicated a desire for further training in suicide (58.6%).

Thirty-one (24.8%) of the elementary school counselor sample rank ordered their responses as question 9 of Part II of the survey requested. The modal rank for each
specified area will be discussed here. For complete analysis results see Table 6.

Concerning areas in the externalizing domain, the modal ranking for ADHD was third with 25.8% of respondents endorsing this ranking. The modal ranking for disruptive behavior was second and third with a similar 25.8% ranking disruptive behavior as their second choice and 25.8% ranking it as their third choice in training area preference.

Behavioral interventions were ranked as the number one choice for the largest number of respondents (41.9%). With regard to internalizing issues, over one quarter of elementary school counselors revealed anxiety (29.0%) and depression (25.8%) to be their fourth choices for further training, with 54.8% placing suicide as their sixth choice.

**Secondary school counselors.** When considering only the secondary school counselors who placed checks next to the children’s mental health issues in which they want further training, the majority (91.8%) reported that they would be interested in additional training. Similar numbers of secondary school counselors indicated a desire

### Table 6

**Modal Rankings for Type of Desired Training**

<table>
<thead>
<tr>
<th>Type of training desired</th>
<th>Elementary school counselors (N = 31)</th>
<th>Secondary school counselors (N = 54)</th>
<th>Elementary and secondary school counselors (N = 85)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Modal rank</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Internalizing issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>4</td>
<td>9</td>
<td>29.0</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>8</td>
<td>25.8</td>
</tr>
<tr>
<td>Suicide</td>
<td>6</td>
<td>17</td>
<td>54.8</td>
</tr>
<tr>
<td>Externalizing issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD</td>
<td>3</td>
<td>8</td>
<td>25.8</td>
</tr>
<tr>
<td>Disruptive behavior</td>
<td>2</td>
<td>8</td>
<td>25.8</td>
</tr>
<tr>
<td>Behavioral interventions</td>
<td>1</td>
<td>13</td>
<td>41.9</td>
</tr>
</tbody>
</table>

*Note.* Percentages based on the number of participants who responded to each individual question. The number of respondents for each question was 31 for elementary school counselors and ranged from 49 to 54 for secondary school counselors and from 77 to 85 for elementary and secondary school counselors combined.
for additional training in each area as compared to elementary school counselors. The differences between the two groups ranged from 0.8-10.0%. Nearly three quarters of the respondents indicated that they would be strongly interested in receiving further training in the externalizing area of disruptive behavior (73.6%). Similar numbers of respondents indicated interest in learning about behavioral interventions (72.1%), with fewer expressing interest in ADHD (62.9%). With regard to internalizing issues, 70.1% indicated an interest in further training in anxiety and depression. Fewer secondary school counselors included suicide (59.4%) in their areas of interest, which is surprising given the high rate of suicide in individuals aged 15 to 24 (Utah Office of Vital Records and Statistics, 2002). Over half of the respondents noted interest in receiving supplementary training in all specified areas of children’s mental health.

Fifty-four (20.0%) of the secondary school counselor respondents rank ordered their responses as indicated by the survey question. The modal rank for each specified area will be discussed. For complete analysis results see Table 6. The internalizing areas were modally ranked as sixth for anxiety (25.0%), first for depression (30.2%), and fifth for suicide (29.4%). Externalizing areas revealed the modal rankings of sixth for ADHD (29.6%) second for disruptive behavior (26.9%). Behavioral interventions were also modally ranked as first (24.5%). When just examining the rank ordered responses, it appeared that the largest number of secondary school counselors were most interested in learning more about depression; whereas the largest number of elementary school counselors were most interested in learning about behavioral interventions.

*Elementary and secondary school counselors combined.* After analyzing the
combined elementary and secondary school counselor sample, it was discovered that 91.9% \((n = 274)\) indicated an interest in additional training on children’s mental health issues. When examining just those who placed checks next to their areas of interest, over 60% indicated a desire for further training on disruptive behavior, anxiety, depression, and behavioral interventions. Over 50% of respondents noted an interest in additional training on ADHD and suicide.

Furthermore, a total of 85 school counselors rank ordered their responses. Depression (27.4%) and behavioral interventions (32.5%) both received a modal ranking of one. Disruptive behavior ranked second (26.5%), anxiety ranked fifth (19.3%), and suicide (29.3%) and ADHD (23.5%) both received a modal ranking of six (refer to Table 6 for a list of modal rankings).

The Relationship Between Educational Training and Willingness to Refer

Research question 3 asked about the relationship between the type of training school counselors have and their willingness to refer children with internalizing problems to a psychologist. In order to answer this question, answers to willingness to refer to a psychologist on vignette #3 and #4 (Part I of survey) were compared with school counselors’ field of study (question 2, Part III of survey) in a one-way ANOVA. School counselors’ willingness to refer to a psychologist was also compared with their preservice and staff development training (questions 1 and 2, Part II of survey). Respondents were asked to answer questions following each vignette using a Likert scale of 1 (definitely not) to 4 (definitely). In order to meaningfully interpret the data,
the responses to the question about referring the child in the vignette to a psychologist were collapsed to signify a response of yes or no. Similarly, only four (3.9%) elementary school counselors and 14 (5.9%) secondary school counselors indicated their field of study to be in the area of education/administration; thus, these individuals were removed from analyses. Furthermore, participants' responses to preservice and staff development training were collapsed to indicate three main categories of neither training in anxiety nor depression, either training in anxiety or in depression, and training in both anxiety and depression. Each category could include training (or lack thereof) on either the preservice or staff development level. Significance levels for each ANOVA was set at .05. Effect sizes were also calculated for each ANOVA, utilizing eta squared ($\eta^2$) for each factor. According to Cohen (1969), effect sizes of .10 to .24 are small, .25 to .39 are medium, and .40 and higher are large effects. Effect sizes that are larger than .33 are considered to have practical significance (Gall, Borg, & Gall, 1996).

**Elementary school counselors.** A one-way ANOVA revealed that the relationship between willingness to refer to a psychologist for vignette #3 ($F = 1.044; p < .310$) and #4 ($F = .687; p < .410$) and field of study were not statistically significant. An effect size was calculated using eta squared ($\eta$) and indicated a small effect for vignette #3 ($\eta^2 = .01$) and vignette #4 ($\eta^2 = .01$).

A one-way ANOVA indicated that the relationship between willingness to refer and preservice/staff development training was statistically significant for vignette #3 ($F = 3.67; p < .03$), but not for vignette #4 ($F = 2.48; p < .09$). However, the effect sizes for both vignettes were quite small (vignette #3: $\eta^2 = .07$; vignette #4: $\eta^2 = .05$).
Secondary school counselors. A one-way ANOVA was computed to determine the relationship between willingness to refer and field of study. Analyses revealed no statistically significant relationship between willingness to refer and field of study for vignette #3 ($F = 1.12; p < .29$) and for vignette #4 ($F = .511; p < .476$). The effect size found for vignette #3 ($\eta^2 = .01$) was small. The effect size for vignette #4 ($\eta^2 = .003$) was small as well.

The results of the one-way ANOVA examining the relationship between willingness to refer and preservice/staff development training, revealed no statistically significant relationship for vignette #4 ($F = .01; p < .988$) or for vignette #3 ($F = .16; p < .85$). The effect sizes for this analysis were similarly quite small (vignette #3: $\eta^2 = .0001$; vignette #4: $\eta^2 = .001$).

Relationship Between Reported Availability of Services and Willingness to Refer

The fourth research question inquired about the relationship between school counselors’ willingness to refer students with internalizing problems to a psychologist and the reported availability of services for these students, who do not qualify for special education services. General descriptive statistics revealed that 90.3% of elementary school counselors and 77.8% of secondary school counselors reported that some services are available for individuals with internalizing issues like those described in the vignettes. Of the 90.3% of elementary school counselors reporting available services for these students, well over half indicated available teacher consultation (83.8%), group counseling (87.4%), individual counseling (94.6%), and parent
education (67.6%). Of the 77.8% of secondary school counselors who said services are available for these secondary school students, over half similarly indicated available teacher consultation (61.4%), group counseling (70.9%), and individual counseling (85.0%). However, only 46.9% indicated available parent education. In order to determine if this reported availability of services impacts school counselors’ referral practices, ANOVAs were calculated utilizing a significance level of .05. Effect size was also calculated utilizing eta squared ($\eta^2$).

Elementary school counselors. The one-way ANOVA revealed no significant relationship between willingness to refer and reported availability of services within the school for vignette #3 ($F = 1.11; p < .295$) or vignette #4 ($F = .436; p < .51$). The effect size estimates found for both vignette #3 ($\eta^2 = .01$) and #4 ($\eta^2 = .005$) were quite small.

Secondary school counselors. The one-way ANOVA calculated with the secondary school counselor data indicated similar results as found for elementary school counselors. No significant effect was found between willingness to refer and the reported availability of services for these students for either

Relationship Between Willingness to Refer and Opinions of Services to be Provided

The last research question addressed the relationship between school counselors’ decisions to refer students with internalizing problems to a psychologist and the school counselors’ opinions of whether schools should provide a variety of services for these students. ANOVAs were calculated for both the elementary and secondary school counselor samples to determine the relationship between willingness to refer and
opinions of whether schools should provide teacher consultation, group counseling, individual therapy, and parent education. A significance level of .05 was used. Effect sizes were similarly calculated utilizing eta squared (η²).

**Elementary school counselors.** The results of the one-way ANOVAs for the elementary school counselor data revealed no significant relationship between willingness to refer on, either vignette #3 or #4 and teacher consultation (vignette #3: F = .71, p < .40; η² = .007; vignette #4: F = .22; p < .64; η² = .002), group counseling (vignette #3: F = 1.52; p < .22; η² = .015; vignette #4: F = .47; p < .49; η² = .005), individual therapy (vignette #3: F = 1.74; p < .19; η² = .018; vignette #4: F = .46; p < .50; η² = .005), or parent education (vignette #3: F = 2.45; p < .12; η² = .025; vignette #4: F = 3.02; p < .09; η² = .031). Effect sizes for every relationship were small.

**Secondary school counselors.** Similar results were found with regard to the secondary school counselor data. No significant relationship was revealed between willingness to refer on either vignette #3 or #4 and teacher consultation (vignette #3: F = 2.10; p < .15; η² = .009; vignette #4: F = .63; p < .43; η² = .003), group counseling (vignette #3: F = 3.06; p < .08; η² = .013; vignette #4: F = 1.53; p < .22; η² = .007), individual therapy (vignette #3: F = 1.82; p < .67; η² = .001; vignette #4: F = .084; p < .772; η² = .000), or parent education (vignette #3: F = .085; p < .77; η² = .000; vignette #4: F = .006; p < .94; η² = .000).
Experience with Children's Mental Health Issues

As previously indicated, for purposes of this study only information pertaining to internalizing issues and demographic information from the survey was analyzed. Therefore, vignettes #3 and #4 were of particular interest. Vignette #3 depicted a male student exhibiting symptoms of anxiety and depression and vignette #4 depicted a female student exhibiting symptoms of anxiety and depression. Responses to questions following vignette #3 revealed that 96.7% of elementary school counselors would meet with the student's teacher, 85.2% would meet with his parents, 63.5% would see him one time, and 74.8% would see the student on a continuous basis. Additionally, elementary school counselors reported that they had consulted about 5.67 similar children on average ($SD = 5.66$) within the past year. School counselors noted a minimum of 0 and a maximum of 30 children consulted about who were similar to the male depicted in the vignette. However, the majority (67.2%) reported consulting about 1 to 5 children within the past year.

Responses to questions pertaining to vignette #4 were similar with 97.6% of elementary school counselors indicating they would meet with the student's teacher and 85.2% would meet with her parents. However, more elementary school counselors noted they would see the student one time (68.8%) or on a continuing basis (78.9%) as compared to secondary school counselors. Elementary school counselors consulted about or encountered an average of 7.22 children similar to the girl described in the vignette within the past year. They encountered a minimum of 0 and a maximum of 90 similar children, with the majority (59.9%) encountering 1 to 5 similar children and
many (23.5%) encountering 6 to 10 similar children within the past year. The number of elementary school counselors who responded to questions following vignette #3 ranged from 96 to 123 and those who answered questions pertaining to vignette #4 ranged from 93 to 123.

With regard to vignette #3, analyses revealed that 73.4% of secondary school counselors would reportedly meet with the student’s teacher, 78.5% would meet with his parents, 67.6% would see him one time, and 66.9% would see him on a continuous basis. Secondary school counselors indicated that they had consulted about or encountered an average of 5.71 ($SD = 8.67$) students similar to the boy described in the vignette during the past year. They further indicated a minimum of 0 and a maximum of 70 similar students encountered, with the majority (61.1%) indicating they encountered 1 to 5 students. Consistently fewer secondary school counselors indicated they would respond to the female student’s symptoms (vignette #4) in the manner indicated (i.e., meet with teacher, see on continuous basis). Specifically, 66.1% secondary school counselors indicated they would meet with her teacher, 66.9% would meet with her parents, 67.8% would see this student one time, and 70.4% would see her on a continuous basis. Secondary school counselors revealed that they encountered an average of 6.24 ($SD = 9.01$) students similar to the girl described in the vignette. The noted a minimum of 0 and a maximum of 100 similar students consulted about during the past year with the majority (58.2%) indicating they consulted about 1 to 5 similar students and many (24.0%) consulting about 6 to 10 similar students within the past year.
CHAPTER V
DISCUSSION

The major objective of the present study was to ascertain information regarding school counselors' knowledge about and experience with children's mental health issues, particularly focusing on internalizing disorders. Another goal was to obtain general demographic and descriptive information relative to school counselors in order to add to our currently limited knowledge about school counselors in general. The present study specifically examined school counselors' training experiences as well as investigated the relationship between various factors and school counselors' referral practices. This chapter includes a discussion and summarization of the results obtained from descriptive information and research questions based upon the school counselor survey, as well as incorporating and making connections to existing research. It is specifically organized to highlight training, referral, and experience issues. This summarization further includes comments made by school counselor respondents that provide invaluable qualitative information reflecting school counselors' individual experiences and needs.

Summary of Findings

Training

With regard to preservice training, similar numbers of elementary and secondary school counselors reported receiving training on anxiety, depression, and suicide. Although over 70% receiving training on anxiety and over 80% receiving training on
depression and suicide seems like relatively high percentages, it is still of concern to realize that up to 30% of participant elementary and secondary school counselors did not report receiving preservice training in these important internalizing disorder areas. More elementary school counselors received inservice training on anxiety than secondary school counselors and similar numbers of elementary and secondary school counselors received staff development training on depression and suicide. Differences in staff development training between elementary and secondary school counselors would be expected based on research demonstrating them to have differing roles within the school system (American School Counselor Association, 2002). For example, Hardesty and Dillard (1994) found that elementary and middle school counselors reported that they devote more time in counseling activities than secondary school counselors. Of course this does not negate the need for the training of all school counselors in the identification of internalizing disorders in students.

Although it is hoped that ultimately all school counselors would eventually receive some staff development training on anxiety, depression, and suicide, there are likely individuals working as school counselors who never receive training on specific internalizing issues with which children struggle. Internalizing problems represent some of the most difficult mental health issues to identify in children due to their covert symptom presentation (Birmaher et al., 1996). The tendency to overlook students struggling with such issues, the demonstrated high rates of depression and anxiety in children, and the propensity for prevalence rates of such disorders to triple from childhood to adolescence underscore the profound need for school counselors to be
adequately trained as frontline mental health professionals to detect and intervene with these children (Daleiden et al., 1999; Fleming & Offord, 1990; Kashani & Orvaschel, 1988, 1990).

Unfortunately, when asked to rank order the areas in which they desired further training, elementary school counselors’ top three choices did not include internalizing issues. Secondary school counselors’ however, indicated depression as their top modal ranking. Behavioral intervention was also ranked as number one. Anxiety and suicide were ranked as some of the least desired areas in which to receive additional training. Secondary school counselors’ increased interest in depression may reflect the increased rates of depression in adolescence, therefore increasing the demand for detection and intervention with depression in this group of students (Daleiden et al., 1999; Fleming & Offord, 1990; Kashani et al., 1989; Rutter et al., 1976). Conversely, elementary school counselors may not be identifying internalizing symptoms in as many young students as secondary school counselors due to lower rates of depression in children. Nevertheless, the overwhelming rates of internalizing disorders in children suggest the need for an increased emphasis on training to identify covert symptoms that may signify or lead to disabling internalizing disorders.

Training issues are further implicated with regard to school counselors reported field of education, degree, and type of certification. Despite working under the common occupational title of school counselor (as indicated by a list of school counselors obtained from the Utah State Office of Education), participants reported receiving educational training in various areas as well as having varying degrees and
specializations or certifications. To illustrate this wide variation, school counselors indicated a range of 21 different fields of study (i.e., school counseling, social work, administration, education, marriage and family therapy), nine educational degrees (i.e., B.S., MSW, M.A., Ed.D.), and 32 different specializations or certifications (i.e., counseling, LCSW, professional educator, drug/alcohol rehabilitation, administration). With such large variations in training it is impossible to ensure that all individuals working as school counselors have the education and skills to detect internalizing disorders in students.

Ibrahim and Thompson (1982) found that only 3% of secondary school counselor graduate programs surveyed required core curriculum courses pertaining to psychology and abnormal psychology. They did not specify particular areas of psychological training, but it could be assumed that mental health issues, including some internalizing issues, would be discussed in a psychology or abnormal psychology course. The present study found that at least 70% of school counselors received some preservice training on internalizing issues, illustrating today's increased standards of education (i.e., Counsel for Accreditation of Counseling and Related Educational Programs requirements of accredited programs). However, this should not overshadow the finding that approximately 30% of participants reported no preservice training on internalizing issues. Ensuring that all school counselors receive training on internalizing disorders prior to working as professionals remains a concern.

It is not surprising that many school counselors do not receive preservice training on internalizing issues given the wide range of educational experience, degrees,
and certifications they indorsed. Utah school districts not only employ certified school counselors, but also employ other individuals (social workers, marriage and family therapists, psychologists) to act as and carry out school counselor functions. A further problem is that many states do not require school counselors to be trained at a Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) accredited program nor do many require that school counselors pass an examination prior to being granted certification. For instance, Utah does not require that individuals obtain a master’s degree from an accredited school counseling and guidance program. It does not require individuals to pass an examination, and it does not require any specific experience outside of university degree requirements. Requiring prospective school counselors to pass a comprehensive examination may help to ensure at least a minimum knowledge base to detect internalizing issues in students. Increased stringency in certification requirements and standardization of training would enable Utah school districts to ensure that school counselors are adequately trained to carry out their position requirements. Requiring prospective school counselors to pass a comprehensive examination and establishing minimum accepted educational experiences (as CACREP requires), with regard to specific classes and practical experience, would help to ensure a higher level of preparedness for professional school counselors. Specifically, this would ensure that school counselors are adequately trained to detect and intervene with internalizing symptoms in students.

Referral

The present study examined several questions pertaining to school counselors’
referral practices, including the relationship between school counselors' willingness to refer to a psychologist and the type of training received (field of study), reported availability of services, and opinions of whether school should provide a variety of services. No relationship was found between field of study and willingness to refer to a psychologist. Similarly, educational background did not have a significant effect on school counselors' willingness to refer students exhibiting internalizing symptoms to a psychologist. For elementary school counselor respondents a significant relationship was found between willingness to refer the boy described in vignette #3 and preservice/staff development training. However, the effect size for the relationship was quite small ($\eta = .07$), suggesting little practical significance. No relationship was found between educational background and willingness to refer for vignette #4 or for vignette #3 or #4 for secondary school counselor respondents.

These findings suggest that preservice or staff development training in the areas of anxiety or depression has no effect on school counselors' willingness to refer students similar to those depicted in the vignettes to a psychologist. It could be speculated that school counselors would refer students with more serious symptoms of anxiety or depression (i.e., panic attack, verbal suicide threat) because these students would be more disruptive, thus demand more attention, and necessitate more involved treatment consisting of more than a few counseling sessions that school counselors may not have the time, resources, or training to carry out. School counselors may also view themselves as the only available resource for these students, and thus do not refer students out. Furthermore, the students depicted in the vignettes were not described as
exhibiting particularly alarming symptoms (e.g., procrastinates, oversensitive to
criticism, self-critical, worries) that would necessitate such an involved response.
However, as noted previously, internalizing disorder symptoms tend to be quite covert.
Therefore, troublesome yet seemingly benign symptoms should not be overlooked as
they may signify more severe, covert issues.

The perceived availability of services for children who have depression and/or
anxiety but who do not qualify for special education services has no apparent impact on
school counselors decisions of whether or not to refer them to a psychologist. This
finding could be due to the fact that several school counselors noted on the survey that
they are not allowed to refer to a psychologist, but that they can suggest to parents to
take their child to see a psychologist. Another explanation could be that school
counselors actually provide the services for these students, thus making a referral to a
psychologist unnecessary.

Again no relationship was found between school counselors' opinions about
whether schools should provide a variety of services for students and their willingness
to refer to a psychologist. The services school counselors were asked to indicate as
services that schools should provide (teacher consultation, group counseling, individual
therapy, parent education) were similar to those that respondents were asked to mark
following each vignette (meet with this child's teacher, meet with this child's parents,
see this child once, see this child on a continuing basis) as indicators of how they would
respond to the described student. As will be discussed in the following section, school
counselors indicated that they would themselves meet with the child's teacher and
parents, see the child once, and see the child on a continuing basis (i.e., individual/group therapy). It seems as if the lack of a relationship between these two variables may be due to the fact that many school counselors provide the majority of these services themselves, and thus would not need to refer to a school psychologist. Conversely, many school counselors noted on the survey that they do not have as much time as they perceive they need to provide such services because much of their time is consumed by administrative tasks. This anecdotal information suggests that school counselors may not have the resources to provide these offered services.

**Experience**

The most important survey questions pertaining to school counselors' experience with internalizing issues in students were the questions that followed each vignette. Responses to these questions suggested that school counselors would in fact respond in some way to children displaying internalizing symptoms. The most endorsed responses were meeting with the student's teacher and parents. About 70% also noted they would meet with the students once or on a continuing basis. Conversely, 30% did not indicate that they would meet with the students once or on a continuing basis. If 30% of school counselors do not investigate symptoms of depression or anxiety with the student personally, they could miss an important opportunity to intervene at an early stage of development with a student who may be struggling.

Furthermore, the majority of school counselors indicated that they had only worked with 1 to 5 children similar to those described in the vignettes within the past year. Given the 475,269 students enrolled in Utah schools in 2001, this number seems
quite low. Several elementary school counselors indicated on their surveys that they work at more than one school and are not employed full time. They iterated a need for more elementary school counselors to be employed in general and for elementary school counselors to be employed at only one school so that they can devote more time to students in need. Given the low number of students exhibiting internalizing symptoms worked with in a 1-year time period and given that school counselors indicated being overworked and having to share their time across several schools, it is not surprising that students with covert internalizing symptoms are often overlooked. It would be beneficial if school counselors engaged in less administrative tasks and focused more of their time and training on detecting internalizing issues in students.

Limitations

There were several limitations in the current study. First, some survey questions proved to be somewhat confusing. Specifically, school counselors were asked to indicate after each vignette if they would “see this child once” and if they would “see this child on a continuing basis.” Given the similar percentages of school counselors who indicated they would see the child once and see the child on a continuing basis, it is suspected that respondents may have been confused as to whether they should indicate seeing the child once if they thought they would see him/her on a continuing basis. It may have been beneficial to ask school counselors to indicate if they would “see this child one time only.” Additionally, the majority of school counselors misread or failed to read the instructions to rank order their responses to question 9 on Part II of the
In order to make sense of the data, responses that were rank ordered were analyzed separately from those that had checks next to areas of interest. This resulted in a relatively small sample size with regard to those who actually rank ordered their responses. It may have helped to place rank order questions in a separate section of the survey to avoid confusion in responding.

This survey obtained quantitative information with regard to the examination of school counselors' educational training. It is difficult to make recommendations for educational changes when the quality of information disseminated during individuals' educational experiences is not known. Variations like spending one week discussing internalizing issues versus devoting an entire semester to the subject could not be taken into account. Such variations could potentially make a difference in school counselors' abilities to detect internalizing symptoms in students. It may have been informative if school counselors were asked to indicate the number of classes/seminars devoted to internalizing problems or how prepared they felt they were in detecting and intervening with such disorders when beginning their careers.

Additionally, the sample for this study included those school counselors who are employed in school districts within the state of Utah. As previously noted, certification requirements for school counselors are state dependent, and thus this sample may not be representative of school counselors working in other states.

Recommendations for Future Research

Despite some continued ambiguity as to school counselors' role within the
school system, school counselors are consistently sited as the primary mental health professional responsible for providing students with individual and group counseling when needed (American School Counselor Association, 2002; Humes & Hohenshil, 1987; Utah State Office of Education, 1992). As such, it is imperative that school counselors receive adequate training in graduate programs in order to ensure their preparedness to detect and intervene with students experiencing internalizing issues (i.e., depression, anxiety, suicidal ideation). The current study found that many professionals work as a “school counselor” within the school system, but come from varying educational backgrounds, and thus have varying exposure to children’s mental health issues during their preservice training. Future research should examine current state requirements for school counselor certification as well as the extent and quality of training school counselors receive with regard to internalizing disorders within graduate programs.

Virtually no research exists that has examined referral practices of school counselors. As demonstrated by the present study, it is somewhat difficult to ascertain what influences school counselors’ referral decisions. Research based on more qualitative approaches (i.e., short answer questions, structured interviews) may help to increase our understanding of how school counselors decide which students would be better served by a psychologist or outside mental health agency.

The value of school counselors, particularly at the elementary level, is no longer a question (Gerler, 1985). School counselors have consistently been shown to make positive impacts on students’ academic achievement (Hadley, 1988; Lee, 1993),
discipline problems, attitude (Baker & Gerler, 2001; Omizo et al., 1988), social skills (Verduyn et al., 1990), and on violence (Commission for the Prevention of Youth Violence, 2000) and suicide prevention (Jones, 2001). With the increasing emphasis on early detection and intervention with regard to mental health issues in children, it is becoming increasingly important to ensure that frontline mental health professionals receive adequate training to prepare them to effectively identify and provide services for (or refer) students struggling with mental health issues, and specifically internalizing issues.
REFERENCES


APPENDICES
Appendix A

Cover Letter
Dear Mental Health Guidance Specialist,

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 feedback and participation in a study we are conducting that examines children's mental health issues in the schools. Your response to this survey is critical in helping professionals gain a better understanding of how mental health guidance specialists view these difficulties. In addition, your responses will help in addressing the needs of mental health guidance specialists working in the schools with children who have mental health problems.

Please complete the attached questionnaire. 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 mental health guidance specialist.

All results obtained from this survey will be strictly confidential and will be stored in a secure facility. Participant names will be numerically coded in order to ensure confidentiality, and access to the data will be limited to the primary investigator and the research assistant. Please do not put any identifying information on the survey itself. Participation in this study involves minimal risk. In order to encourage participation in this important study, we are offering the opportunity of entering a drawing for $50.00, 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. This knowledge will help to improve pre-service and in-service training of mental health guidance specialists and thus, will better the service provided to children with mental health needs.

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.

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,

Kelly Hughes, B.A.
Research Assistant
(435) 797-3059

Susan Crowley, Ph.D.
Primary Investigator
(435) 797-1251
Appendix B

Elementary School Counselor Questionnaire
The following vignettes describe children who are experiencing problems in schools. Please carefully read each vignette and respond to the questions that follow each one. As a school counselor, assume you have been consulted by a teacher about students similar to those described and have complete parental consent to proceed as you see fit.

**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.

Use the following rating system to respond to the question below:

1 = definitely not 2 = probably not 3 = probably 4 = definitely

Would you:

- meet with this child's teacher(s)?
- meet with this child's parents?
- see this child once?
- see this child on a continuing basis?
- refer this child to a psychologist?

Other (please specify) ________________

Approximately how many times in the past year have you consulted about a child similar to Joe, as described in the vignette? ______

**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.

Use the following rating system to respond to the question below:

1 = definitely not 2 = probably not 3 = probably 4 = definitely

Would you:

- meet with this child's teacher(s)?
- meet with this child's parents?
- see this child once?
- see this child on a continuing basis?
- refer this child to a psychologist?

Other (please specify) ________________

Approximately how many times in the past year have you consulted about a child similar to Julie, as described in the vignette? ______
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.

Use the following rating system to respond to the question below:
1 = definitely not  2 = probably not  3 = probably  4 = definitely

Would you:
_____ meet with this child’s teacher(s)?
_____ meet with this child’s parents?
_____ see this child once?
_____ see this child on a continuing basis?
_____ refer this child to a psychologist?

Other (please specify) __________________________

Approximately how many times in the past year have you consulted about a child similar to Mark, as described in the vignette? ________

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, 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.

Use the following rating system to respond to the question below:
1 = definitely not  2 = probably not  3 = probably  4 = definitely

Would you:
_____ meet with this child’s teacher(s)?
_____ meet with this child’s parents?
_____ see this child once?
_____ see this child on a continuing basis?
_____ refer this child to a psychologist?

Other (please specify) __________________________

Approximately how many times in the past year have you consulted about a child similar to Marie as described in the vignette? ________

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

_____ School principal
_____ Colleague (e.g., another school counselor)
_____ School psychologist

Other (please specify) __________________________
Part II.

The following questions address the issue of children’s mental health 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) and/or Attention-Deficit Disorder (ADD)
   - Anxiety
   - Depression
   - Suicide
   - Disruptive behavior
   - Aggressive behavior
   - Behavioral interventions
   - Other (please specify)

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

   - ADHD/ADD
   - Anxiety
   - Depression
   - Suicide
   - Disruptive behavior
   - Aggressive behavior
   - Behavioral interventions
   - Other (please specify)

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

   - No
   - Yes (In your opinion, how effective are these services? __ good __ fair __ poor)

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? (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?

   - No
   - Yes (In your opinion, how effective are these services? __ good __ fair __ poor)

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? (Please check all that apply)

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

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/ADD
- Anxiety
- Depression
- Suicide
- Disruptive Behavior

- Behavioral interventions
- Other (please specify)

Part III.

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

Demographic Information:

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

2. Education (i.e., B.S., M.S.) and field of study..............................

3. Specialization/Certification..............................

4. Current school(s) served..............................

5. Number of years of counseling experience..............................

Estimate the average percent of time you do spend:

1. Assessing children (i.e., curriculum based tests, classroom observation)
2. Counseling children:
   - individually
   - in a group setting
   - in the classroom
3. Consulting with teachers
4. Administration/Scheduling
5. Meeting with parents
6. Other (please specify)..............................
Estimate the average percent of time you would like to spend:

1. _____ Assessing children (i.e., curriculum based tests, classroom observation)
2. Counseling children:
   _____ individually
   _____ in a group setting
   _____ in the classroom
3. _____ Consulting with teachers
4. _____ Administration/Scheduling
5. _____ Meeting with parents
6. _____ Other (please specify) ____________________

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.

Please return the survey to:

Utah State University
Department of Psychology
2810 Old Main Hill
Logan, UT 84322-2810
Appendix C

Middle/Secondary School Counselor Questionnaire
CHILDREN'S MENTAL HEALTH QUESTIONNAIRE—MIDDLE/SECONDARY
Part I:

The following vignettes describe children who are experiencing problems in school. Please carefully read each vignette and respond to the questions that follow each one. As a school counselor, assume you have been consulted by a teacher about students similar to those described and have complete parental consent to proceed as you see fit.

Vignette #1:

Joe is a 14-year-old boy. He is disruptive in the classroom, often argues with his teachers, and disobeys school rules. Joe consistently talks during class time, distracting his peers. During breaks or outside of class, Joe associates with a group of boys that tend to get into trouble. He has gotten into fights and is regarded as mean and inconsiderate by many of his peers. Joe rarely finishes his homework, is getting poor grades, and has a poor attendance record.

Use the following rating system to respond to the question below:

1 = definitely not 2 = probably not 3 = probably 4 = definitely

Would you:

- meet with this child's teacher(s)?
- meet with this child’s parents?
- see this child once?
- see this child on a continuing basis?
- refer this child to a psychologist?
- Other (please specify) ____________________________

Approximately how many times in the past year have you consulted about a child similar to Joe, as described in the vignette? __________

Vignette #2:

Julie is a 14 year-old girl. She is inattentive during classes and talks excessively with her peers. Julie is also considered moody and sometimes hums during class. She rarely completes homework assignments and is consequently getting poor grades. She is not popular with most of her peers; instead, she "hangs out" with girls who get into trouble and often skip school. When with her friends, Julie is more argumentative with teachers and school personnel, and more likely to violate school rules.

Use the following rating system to respond to the question below:

1 = definitely not 2 = probably not 3 = probably 4 = definitely

Would you:

- meet with this child's teacher(s)?
- meet with this child’s parents?
- see this child once?
- see this child on a continuing basis?
- refer this child to a psychologist?
- Other (please specify) ____________________________

Approximately how many times in the past year have you consulted about a child similar to Julie, as described in the vignette? __________
Vignette #3:
Mark is a 14 year-old boy. He reportedly has a fear of making mistakes and is over-sensitive to criticism, feeling like he needs to do "perfect" work. As a consequence, Mark procrastinates often and struggles to finish his homework on time. He generally finishes his work and gets good grades, but typically spends more time on assignments than his peers. In general, he is withdrawn from others, especially peers, and tends to keep things to himself.

Use the following rating system to respond to the question below:
1 = definitely not 2 = probably not 3 = probably 4 = definitely

Would you:
_____ meet with this child's teacher(s)?
_____ meet with this child's parents?
_____ see this child once?
_____ see this child on a continuing basis?
_____ refer this child to a psychologist?

Approximately how many times in the past year have you consulted about a child similar to Mark, as described in the vignette? ________

Vignette #4
Marie is a 14 year-old girl. She often seeks excessive attention from her teachers and appears sad and withdrawn when she does not receive it. Marie often makes self-critical statements to teachers and peers, such as 'No one likes me,' and 'I can't do anything right.' She is also overly anxious to please others and very compliant. Marie is well-behaved in the classroom, and gets good grades. Despite her successes, she often worries that she is generally disliked and that she will fail at things she tries to do.

Use the following rating system to respond to the question below:
1 = definitely not 2 = probably not 3 = probably 4 = definitely

Would you:
_____ meet with this child's teacher(s)?
_____ meet with this child's parents?
_____ see this child once?
_____ see this child on a continuing basis?
_____ refer this child to a psychologist?

Approximately how many times in the past year have you consulted about a child similar to Marie as described in the vignette? ________

If you were to seek consultation about a child similar to one of the children described in the vignettes above, who would be most helpful to you? (Please rank order your responses)
_____ School principal
_____ School psychologist
_____ Colleague (e.g. another school counselor)
_____ Other (please specify)
Part II.

The following questions address the issue of children's mental health 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) and/or Attention-Deficit Disorder (ADD)
   - Anxiety
   - Depression
   - Suicide
   - Disruptive behavior
   - Aggressive behavior
   - Behavioral interventions
   - Other (please specify)

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

   - ADHD/ADD
   - Anxiety
   - Depression
   - Suicide
   - Disruptive behavior
   - Aggressive behavior
   - Behavioral interventions
   - Other (please specify)

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

   - No
   - Yes (In your opinion, how effective are these services? ___ good ___ fair ___ poor)

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? (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?

   - No
   - Yes (In your opinion, how effective are these services? ___ good ___ fair ___ poor)

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? (Please check all that apply)

   - Teacher Consultation
   - Group Counseling (e.g., social skills)
   - Individual Counseling
   - Parent Education
   - Other (please specify)
   - Don't know
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
____ Group Counseling (e.g., social skills)
____ Individual Therapy
____ Parent Education
____ Other (please specify)

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/ADD
____ Anxiety
____ Depression
____ Suicide
____ Disruptive Behavior
____ Behavioral interventions
____ Other (please specify)

Part III.

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

Demographic Information:

6. Gender ..................................................... ____ Male ____ Female

7. Education (i.e., B.S., M.S.) and field of study .................................................................

8. Specialization/Certification .................................................................

9. Current school(s) served .................................................................

10. Number of years of counseling experience .................................................................

Estimate the average percent of time you do spend:

1. _____ Assessing children (i.e., curriculum based tests, classroom observation)

2. Counseling children:
   _____ individually
   _____ in a group setting
   _____ in the classroom

3. _____ Consulting with teachers

4. _____ Administration/Scheduling

5. _____ Meeting with parents

6. _____ Other (please specify) __________________________
Estimate the average percent of time you would like to spend:

1. _____ Assessing children (i.e., curriculum based tests, classroom observation)
2. Counseling children:
   _____ individually
   _____ in a group setting
   _____ in the classroom
3. _____ Consulting with teachers
4. _____ Administration/Scheduling
5. _____ Meeting with parents
6. _____ Other (please specify) ____________________

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. Please return the completed survey to the address listed below:

Utah State University
Department of Psychology
2810 Old Main Hill
Logan, UT 84322-2810