NEGATIVE AFFECTIVITY IN CHILDREN

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Master of Science in Counseling

By
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ABSTRACT

Sixty-four children in grades 3, 5, and 7 from the Cabrillo Unified School District were assessed on three different personality measures: the Childhood Depression Inventory (CDI), the Piers-Harris Children's Self-Concept Scale, and a classroom sociometric scale. The three scales showed both pair-wise and multiple correlations among themselves. This intercorrelation among the three scales suggests the applicability of the Negative Affectivity construct (Tellegen, 1982; Watson & Clark, 1984) to children. Limitations of the study and suggestions for further research are discussed.
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Chapter I

INTRODUCTION

General Statement of the Problem

Can a valid and reliable assessment battery be developed to assess affective disorders in children?

Background of the Problem

Prior to 1970, research dedicated to exploring the etiology and manifestations of childhood depression was sparse and highly controversial. The majority of clinicians either ignored symptoms of childhood depression, or else treated the depressive symptoms as a behavior disorder (McKnew, Cytryn & Jahraes, 1983). The first papers on childhood depression were published by Rene Spitz (1945, 1946), who observed the profound withdrawal of institutionalized children. Spitz labeled these withdrawn children as suffering from "anaclitic depression" (Spitz, 1946), and claimed that "this expression would in an adult be described as depression" (Spitz, 1946, p. 316).

The clinical viewpoint which opposed the concept of childhood depression was typified by Herbert Rie. In 1966, he claimed that "...depression, namely, despair or hopelessness, is one of which children -- perhaps prior to the end of the latency years -- are incapable" (Rie, 1966,
p. 653). Furthermore, Rie claimed that the failure to specify diagnostic criteria, and the failure of symptoms to coincide with those of adult depression, brought about a conclusion that depression is not a form of child psychopathology. In further opposition to the concept of childhood depression, Therese Benedek (1975) directly refuted Spitz's 30-year-old claim that an anaclitic depression exists in hospitalized children. Because these children were not angry, did not cry, and had insufficient bodily perceptions to develop meaningful object relations, Benedek claimed that "hospitalism" was not a mental condition, and was not a depression (Benedek, 1975).

Since 1970, however, there has been an increasing surge of clinical recognition of childhood depressive disorders. Ling, Oftedal, and Weinberg (1970) conducted a study designed to identify and define depressive illness in youngsters. In a sample of 25 children (aged 4-16) who presented with severe headaches, 10 had a depressive disorder that could be recognized by specified criteria. The authors reported that mood change, social withdrawal, and self-deprecation were the most common symptoms. McConville, Boag, and Purohit (1973) described three types of childhood depression in a group of 6- to 13-year-old inpatients: (1) affectual depression, (2) negative self-esteem depression, and (3) guilt depression. Children 6 to 8 years old most commonly displayed
affectual depression, which was characterized by expressions of sadness, helplessness, and occasional hopelessness. Children who were in the 8 years old and older group most frequently expressed negative self-esteem depression, which included thoughts and feelings of worthlessness, being unloved and being used by other people. Guilt depression, although relatively uncommon when compared to the previous two depressions, became most common after age 11. This third group included children who felt that they were "wicked" and that they should be dead or killed.

Poznanski and Zrull (1970) attempted to describe "affective depression" in children. Based on their charts of 1,788 children, up to age 12, they claimed that the most frequent affective disturbance seen was a negative self-image. In an attempt to further legitimize the construct of childhood depression, Vranjesevic, Radojicid, Bumbasirevic, and Todorovic (1972) utilized terminology which closely coincided with descriptions of the adult syndrome: Negative affect, rejection, withdrawal, preoccupation with death or suicidal thoughts, etc.

Cytryn and McKnew (1974) described "acute," "chronic," and "masked" depression, with the masked variety as the most common form of depression in children. The authors further proposed that depressive mood and behavior were rare in children, and included hyperactivity,
aggressiveness, school failure, delinquency, and psychosomatic symptoms as signs of masked depression. However, McKnew, Cytryn, and Yahraes later concluded that masked depression was a more controversial clinical entity than they had previously envisioned (1983). They modified their view of masked depression by noting that "acting-out symptoms frequently will become an integral part of the depressive picture rather than a mask" (Cytryn, McKnew & Yahraes, 1983, p. 45).

Significance of the Problem

Although the syndrome of childhood depression has gained greater recognition from the mental health profession since 1970, the incidence of childhood depression among the general population has been studied by relatively few investigators. The first such prevalence study was conducted on the Isle of Wight (Rutter, Tizard, Yule, Graham & Whitmore, 1976). The authors reported that three out of 2,199 prepubertal children were depressed. Kashani and Simonds (1979) reported an incidence of 1.9% for depression, using DSM III criteria (1980). Kashani and Simonds (1979) also cited figures from other studies in which the rates ranged from 2.3 to 59%. A representative sample of 641 9-year-old New Zealand children was studied by Kashani et al. (1983). The methods used to assess the prevalence of depression included a parent questionnaire, a teacher report of school behavior, and
a child interview. The current prevalence of major and minor depression was estimated as 1.7% and 3.6%, respectively.

The wide variance in reported prevalence studies stems largely from the different diagnostic instruments used (Cytryn, McKnew, Zahn-Waxier & Gershon, 1986). In an attempt to develop a more precise operational definition for classifying depressed persons, Watson and Clark (1984), building on Tellegen's construct (1982), suggested the construct of Negative Affectivity. Individuals described as possessing high Negative Affectivity were viewed as tending to be distressed and upset, as well as having a negative self-concept. Conversely, those who were lower on Negative Affectivity were seen as relatively content and self-satisfied.

Hypothesizing that Watson and Clark's construct applied to children as well as to adults, Nagel (1986) conducted a study which utilized the following three scales to identify Negative Affectivity in children: (1) The Childhood Depression Inventory, (2) the Piers-Harris Children's Self-Concept Scale, and (3) the Matson Evaluation of Social Skills in Youngsters. Although this study did not statistically establish the existence of Negative Affectivity in children, the results suggested the possibility of a unifying construct in the assessment of childhood affective disorders.
Before there can be adequate treatment for childhood depression, early detection and diagnostic procedures must be developed. The present study will focus on further researching the identification of Negative Affectivity in children. With regard to the importance of identifying childhood depression, McKnew, Cytryn, and Yahraes (1983) emphasized that

Early detection and treatment of depressed children, before the depression becomes a way of life, is essential. Given timely and appropriate help, most depressed children can be helped to live a normal and productive life. (p. 167)
Chapter II

REVIEW OF THE LITERATURE

Introduction

Historically, both empirical and theoretical work on childhood depression has addressed the question of whether children can become depressed, and if so, what form the depression would take (Carlson & Garber, 1986). Chapter I of this study documented the mental health profession's gradual recognition of childhood depression since 1970. However, the absence of a generally agreed-upon and objective set of guidelines for classifying and measuring childhood depression has been a major obstacle to progress in the field. Consequently, in reviewing the literature leading to the present study, the following three areas will be discussed: (1) research which has attempted to classify childhood depression; (2) research which has attempted to investigate developmental aspects of childhood depression; and (3) research which has attempted to assess and measure childhood depression.

Classification of childhood depression

The classification of depression in children has proved extremely difficult, due largely to controversy regarding the clinical picture of childhood depression.
Cantwell (1983) has identified the following four major schools of thought in the literature, each espousing a different view on the depressive syndrome in children: (1) authors who have concluded that depression does not occur in prepubertal children; (2) authors who have concluded that depression exists in children, but that it is characterized by a unique set of symptoms that are not necessarily analogous to adult depressive symptoms; (3) authors who have concluded that depression exists in children, although the symptoms are "masked;" and (4) authors who have concluded that depression in children is analogous to adult depression.

Representatives of the first school of thought have concluded that depression as a clinical syndrome does not exist in children prior to puberty. Chapter I of this study focused upon those authors who have refuted the concept of childhood depression (Rie, 1966; Benedeck, 1975). Although this viewpoint has decreased in popularity, Lefkowitz and Burton (1978) have continued to propose that depressive symptoms constitute a transitory developmental phenomenon in children and will disappear over time. In reviewing the literature, Lefkowitz and Burton have concluded that many symptoms that are characteristic of depression commonly occur in normal children. Consequently, they concluded that clinical manifestations of childhood depression are not indicative of childhood
psychopathology. Furthermore, because no valid or reliable norm-referenced measures have been developed for assessing childhood depression, the concept of a depressive syndrome in children "rests largely on surmise" (Lefkowitz & Burton, 1978, p. 724).

Experts representing the second school of thought have concluded that depression does exist in children, but that it is characterized by a unique set of symptoms that are not necessarily analogous to adult depressive symptoms. This second school of thought has strongly criticized the recently prominent approach of diagnosing and classifying childhood depression utilizing adult criteria (Kashani et al., 1981). As a prime example, these authors have cited the Diagnostic and Statistical Manual of Mental Disorder's (DSM III) (American Psychiatric Association, 1980) failure to provide significantly different diagnostic categories for child and adult depressions. Similarly, a growing number of empirical studies of childhood depression have relied upon the use of unaltered Research Diagnostic Criteria (RDC) (Puig-Antich, 1980). In response to this trend, Cicchetti and Schneider-Rosen (1986) have stated that this research may be flawed for a number of reasons:

The criteria may be too narrow, excluding some cases that should be classified as depression. Some or all of those children who satisfy DSM III or RDC criteria
may have disorders whose etiology differs from that of adult depression (pp. 72-73).

An alternative approach to diagnosis and classification has been taken by other researchers in the field of childhood depression. These researchers have developed modified criteria for childhood depression "so that the essential features, rather than the associated features, are different from those required for the diagnosis of adult depression" (Cantwell, 1983, p. 12). Operational criteria for the diagnosis of childhood depression have been presented by Ling, Oftedal, and Weinberg (1970), Weinberg, Rutman, and Sullivan (1973), and Poznanski (1981).

A number of authors have developed classifications which are specifically "child-centered" (Carlson & Garber, 1986). Although these classifications have different names, they fall under three basic categories of depression: acute, chronic, and masked. (Both acute and chronic depression have been included here within the second school of thought, while masked depression has been included in the discussion of the third school of thought).

McKnew, Cytryn, and Yahraes (1983) have described acute, or simple, depression as the result of a precipitating traumatic event in the child's life, or in the lives of those close to the child.

Mother has had to go to the hospital, grandpa has
died, the family has moved, an especially favorite toy has disappeared—all these and many similar occurrences may precipitate an acute attack (McKnew, Cytryn, & Yahraes, 1983, p. 44).

The child's resulting depressive symptoms have been described as including a severe impairment of scholastic and social adjustment, disturbances of sleeping and eating, feelings of despair and hopelessness, and occasional suicidal thoughts or attempts. Similar descriptions of acute, pure, or simple depressions have been provided by Frommer (1968), Malmquist (1971), and Stack (1971).

Chronic depressions have been described as behavioral and affective manifestations in which depression and misery seem to be accounted for by longstanding deprivation of some form (Eisen, 1973; Frommer, 1968; Malmquist, 1971; McKnew, Cytryn, & Yahraes, 1983; Cantwell, 1983). McKnew, Cytryn and Yahraes (1983) have described the difference between acute and chronic depression as follows:

Children with chronic depression, in contrast to those with the acute type, have no immediate precipitating cause, their illness lasts longer, and there is a history of marginal social and emotional adjustment, of previous depressive episodes, and of depressive illness in close family members, particularly the mother (pp. 43-44).
Professionals who are members of the third school of thought have concluded that depression does exist in children, although the symptoms are "masked." Those who espouse this view have postulated that an underlying depression is responsible for the manifest behavior, which may include such diverse behaviors as conduct disorder, hyperactivity, enuresis, and somatic complaints (Cantwell, 1983). Toolen (1962) utilized the term "depressive equivalents," as he observed that a teenager "may deliberately mask his own feelings by a pretense of happiness and exhibit the picture of a smiling depression" (p. 407). Renshaw (1972) has drawn attention to promiscuity, academic failure, and drug abuse as depressive equivalents. Underlying depression has been found to exist in many of the pregnant teenagers referred to a psychiatrist (Lewis, Klerman, Jekel, & Curry, 1973). Kaufman, Makkay, and Zilback (1959) have described a "depressive core" in children with antisocial aggressive behaviors. Burks and Harrison (1962) have also cited aggressive behaviors as symptoms of masked depression, in which the aggressive behavior is used to ward off depression. Renshaw (1974) has claimed that fire setting is a means of acting out childhood depression. Furthermore, depressive equivalents such as anorexia nervosa and obesity syndromes have also been classified as a masked form of childhood depression (Malmquist, 1972).
Kovacs and Beck, who reviewed the literature on masked depression in 1977, concluded that the term was misleading and unnecessary. These authors claimed that many behaviors of children diagnosed as displaying masked depression were often presenting the same complaints as adult depressives. However, adults presenting such behaviors have not been referred to as "masking" depression. Kovacs and Beck (1977) thus concluded that the concept seems to have no clinical or heuristic significance and essentially signifies: (1) events that initiate referral, or (2) manifestations of a psychological disturbance acceptable or appropriate to that age category (p. 11).

Carlson and Cantwell's (1979) study of 102 child referrals to a psychiatric clinic further underscored the misleading label of masked depression. The authors concluded that "careful clinical evaluation revealed the true depressive syndrome. Thus, the overt behavior did not completely mask the depressive symptomatology" (p. 7).

Researchers who are involved with the fourth school of thought have concluded that depression in children is analogous to adult depression. Cantwell (1983) summarized this viewpoint as it was expressed at the Fourth Congress of the European Pedopsychiatrists in Stockholm in 1971.

The proponents of this school state that if one looks
for the clinical picture of depression in children in a way analogous to the way it has been looked for in adults, it can indeed by found. Moreover, they feel that it may be an underdiagnosed condition in childhood (p. 8).

The proceedings of this Congress were later published (Annell, 1972).

Developmental aspects of childhood depression

There have been numerous difficulties in the assessment of depression in children due to children's limited ability to describe the emotions they are feeling (Rutter, 1986). Language development is only one of the developmental aspects which has affected the assessment of childhood depression. Research has indicated that, as the age of the child increases, the frequency of depression changes. Rutter (1986) has delineated three developmental phases of childhood depression: (1) that which occurs during the first few years of life; (2) that which occurs after the age of 4 to 5, and before the onset of puberty; and (3) that which occurs during and after the onset of puberty.

Rene Spitz (1946) was the first researcher who attempted to describe a form of childhood depression during the first year of life. He described "anaclitic depression" as a syndrome which arose in institutionalized
children of about 6 to 12 months of age. This syndrome was attributed to the loss of the mother figure. Although few clinical accounts of depression in a young child have appeared in the literature (Harmen, Wagonfeld, & Emde, 1982), Spitz (1946) described depression as a common occurrence in institutional children. Freud and Burlingham (1974) reported that young children in the Hamstead nursery during World War II frequently grieved for their absent mothers. Similarly, Bowlby (1969, 1980) documented the protest-despair-detachment sequence seen in many toddlers admitted to hospitals or residential nurseries.

Malmquist (1975) concluded that children from 4 to 5 years of age to puberty make up the most frequently under-diagnosed group in terms of incidence of depression. In fact, depression has been observed to fall in frequency during middle childhood, only to rise again at the onset of puberty (Rutter, 1986). In opposition to this viewpoint of hidden latency-aged depression, McKnew, Cytryn, and Yahraes (1983) claimed that certain developmental factors emerging at the 5 to 6 year level actually facilitate the diagnosis of specific depressive disorders. These authors stated that the child's increased intellectual development, object stability, and language development all contribute towards an expression of depression. Although McKnew, Cytryn, and Yahraes (1983) did not make claims about the frequency of latency-aged depression,
Pearce (1977) suggested that the suppressed diagnosis of latency-aged depression is due to the changing manifestations of a growing child's symptoms, and not to a change in the frequency of depressive symptoms themselves.

The work of Rholes, Blackwell, Jordan, and Walters (1980) has suggested that developmental changes in children's attributional capabilities may play a role in the increased rate of depression after puberty. These authors hypothesized that younger children are less susceptible to feelings of helplessness, while adolescents are more prone to a pervasive sense of helplessness and hopelessness. Explanations for increased rates of adolescent depression have also emphasized developmental changes in children's emotions as they enter adolescence (Chandler, 1977), as well as in their ability to express affect, to be aware of emotions in others, and to appreciate the emotional connotations of social situations (Harris, Olthof, and Terwogt, 1981). This hypothesis of greater emotional awareness leading to a higher frequency of adolescent depression has found further support through the work of Helsel and Matson (1984). Helsel and Matson administered the Childhood Depression Inventory (CDI) to children of various age levels. They found that children aged 14 to 18 scored significantly higher than children aged 4 to 6 years. Because the CDI is a self-report scale, the adolescents' increased emotional awareness
may have contributed to their higher depression scores.

In opposition to the theory of variation of childhood depression at different age levels, Gardiner (1980) found no significant differences between age levels on the Children's Depression Scale. In addition, Weinberg, Rutman, Sullivan, Penick, and Dietz (1983) found no significant differences across age, sex, grade, or tested IQ. Furthermore, Nagel (1986) found no significant differences on the Childhood Depression Inventory (CDI) among children at the third, fifth, and seventh grade levels.

Assessment and measurement of childhood depression

In recent years, the assessment and measurement of childhood depression has entailed a growing emphasis on uniform clinical evaluations according to operationally defined criteria (Kovacs, 1986). The most specific tools for directly assessing the child himself or herself for depression have been developed in the following three areas: (1) interviews, (2) laboratory tests, and (3) children's self-rating scales.

Interview schedules have been developed that ensure a standard format and systematic information coverage for assessing childhood depression. Although numerous interview schedules have been developed for use by clinicians with parents of depressed children, most of these scales have provided versions which can be used
directly with the child subject. Examples of these inter-
view schedules have included the Schedule for Affective
Disorders and Schizophrenia--"Kiddie" version (K-SADS)
(Puig-Antich & Chambers, 1978), the Interview Schedule
for Children (ICS) (Kovacs, 1978), and the Diagnostic
Interview Schedule for Children and Adolescents (DICA)
(Herjawic, 1977). Both the K-SADS and the ISC were
designed with interview strategies which accommodate the
variable abilities of children to report about themselves.
For example, both schedules have utilized serial, graded
questions and actual, concrete examples of symptoms to
elicit the needed data. Both the K-SADS and the ISC have
appeared to be sensitive to children's difficulties in
estimating the severity or duration of symptoms. Kovacs
(1986), in reference to current semi-structured inter-
views for children, claimed that these scales "suggest
that apparently sophisticated constructs can be assessed
by the use of simple questions" (p. 458).

According to Cantwell (1983), psychological tests
which have been shown to be valid and reliable can be
considered to be laboratory tests. Furthermore, many
clinicians have claimed that projective psychological
tests provide diagnostic specificity similar to that shown
by biological validation laboratory measures (Cantwell,
1983). Cytryn and McKnew (1972), for example, have used
projective techniques to measure fantasy in school-age
children with depression. Furthermore, other projective tests, such as the CAT, TAT, and Rorschach, have been utilized to provide scores for depressive themes. However, Gittelman (1980), in reviewing the use of projective tests as measures of child psychopathology, concluded that they lack sufficient reliability and validity for use as differential diagnostic procedures.

Several children's self-rating scales have been developed within the last twelve years. The Children's Depression Inventory (CDI) was designed by Kovacs and Beck (1977) as a modification of the Beck Depression Inventory (Beck, 1974). The CDI was developed to measure the severity of depression in children aged 6 to 7 years and above. Helsel and Matson (1984) researched the CDI and found it to possess a satisfactory level of reliability. Lang and Tishner (1978) developed the Childhood Depression Scale (CDS), which consists of the following six subscales: (1) affective response, (2) social problems, (3) self-esteem, (4) preoccupation with own sickness and death, (5) guilt, and (6) pleasure. For the purposes of constructing the CDS, these six subscales constituted a definition of childhood depression (Tishner and Lang, 1983). Birleson (1981) has also developed a self-rating scale to measure childhood depression.

Recently, multiple scale assessments have been utilized in an attempt to assess childhood depression.
Helsel and Matson (1984) compared the CDI with the Matson Evaluation of Social Skills in Youngsters (MESSY). Upon finding a significant correlation between the two scales they concluded the following:

A greater emphasis on establishing batteries of assessments which can be used to evaluate a wide range of social and depressive behaviors in children is urgently needed (Helsel & Matson, 1984, p. 297).

In another study of multiple scale assessments (although utilizing an adult population), Watson and Clark (1984) found

a number of specific personality measures that, despite dissimilar names, nevertheless intercorrelate so highly that they must be considered measures of the same construct (p. 465).

The authors called this construct "Negative Affectivity" (NA), a construct first proposed by Tellegen (1982). Watson and Clark described NA as a mood-dispositional dimension reflecting pervasive individual differences in negative emotionality and self-concept.

Nagel (1986) conducted a study employing a multiple scale assessment of childhood depression similar to that used by Helsel and Matson (1984). Nagel attempted to establish a unifying concept of affective disorders in children by demonstrating significant correlations
between the CDI, the MESSY, and the Piers-Harris Children's Self-Concept Scale. He hypothesized that intercorrelations among these three scales would indicate the applicability of the negative affectivity construct (Watson & Clark, 1984) to children. Although Nagel found a strong correlation between the CDI and the Piers-Harris, he did not find significant correlations among the Messy and the other two scales. As possible explanations for his findings, Nagel cited numerous limitations of his study, including the small size of his sample, and the fact that teachers as well as the children themselves filled out the scales (Nagel, 1986).

Summary

Although a majority of researchers has acknowledged that depression does exist in children, debate has continued concerning the influence of development upon childhood depression, and concerning the relative effectiveness of various methods of assessing and measuring depression in children. Consequently, it was the purpose of the present study to measure affective disorders across three grade levels, using a multiple scale assessment battery. In addition, this study further investigated the applicability of the Negative Affectivity construct to children.
Chapter III

DESIGN

Specific Statement of the Problem

Do children demonstrate the construct of negative affectivity? Secondly, do scales measuring depression, self-concept, and classroom sociometric status intercorrelate in identifying negative affectivity in children? Thirdly, are there developmental or age-specific variables affecting youngsters' scores on these three classes of scales?

Hypotheses to Be Tested

Hypothesis I. There is a significant pair-wise correlational relationship among the three scales used for this experiment: The Childhood Depression Inventory, the Piers-Harris Children's Self-Concept Scale, and a classroom sociometric scale.

Hypothesis II. There is a significant multiple correlational relationship among the three administered scales.

Hypothesis III. There is a significant difference among the three grade levels on the scores of the administered scales.

Note: The hypotheses were tested in the null form,
and were rejected if the .01 level of significance was exceeded.

General Methodology

Permission to conduct this study was obtained initially from the superintendent of the school district. After the design for the study was approved by the superintendent, permission was obtained from the principals and classroom teachers at each of the targeted school sites. After receiving permission from the superintendent, principals, and teachers, informed consent letters were sent home to the parents or guardians of 126 children randomly selected to participate in the study (see population/sample section of Chapter III for details).

The sociometric scale was administered by the teachers of each of the targeted classrooms to the entire population (sample and non-sample) of each class. All teachers were contacted individually and briefed about the nature of the study; they were also given instructions for administering the sociometric scale. In addition, the teachers were provided with written instructions to be read to the children prior to scale administration. All classroom sociometric scales were administered within a three-day period.

After receiving parent/guardian written consent, the sample children were administered the Childhood
Depression Inventory (CDI) and the Piers-Harris Children's Self-Concept Scale (Piers-Harris). The children were administered the scales in groups based on their grade level and the school which they attended. The groups ranged in size from four to fourteen in number, with the group size determined by the number of approved children present on the day the scales were administered.

The children were excused from their classrooms during regular school hours, and met with the researcher in either the school library (when not in use) or an empty classroom. The children were seated at desks or tables, and were provided with pencils and copies of the CDI and the Piers-Harris. Before scale administration, a statement which described the purpose of the study was read to the children by the researcher. A copy of this statement is provided with this study (see Appendix A). After a few minutes to answer questions about the study, the directions were read verbatim by the researcher from both instruments. Time was allowed for questions, and it was emphasized that participation in the study was completely voluntary. Furthermore, the children were informed that their completed scales were to be kept in strict confidence, and would not be shared with their parents, classmates, or teachers. The CDI was administered first for all groups. Although oral administration is recommended for all scale items on both the CDI and the Piers-Harris,
all children in this study self-administered both scales. Self-administration was chosen to promote the atmosphere of confidentiality, and to facilitate greater self-disclosure. Consequently, each child was allowed to work individually, and to complete each scale at his/her own pace. Researcher assistance was provided if children had difficulty with answering a particular question, or if there were questions about the meaning of a test item.

Population/Sample

Three elementary schools and one middle school, all from the Cabrillo Unified School district in Half Moon Bay, were chosen to participate in this experiment. Two third-grade and two fifth-grade homeroom classes were selected from each elementary school, while six first-period seventh-grade classes were chosen from the middle school. Seven children were selected from each of these eighteen classrooms using a table of random numbers. Informed consent/permission slip letters (see Appendix B) were mailed to the parents/guardians of each selected child (N = 126). Each informed consent/permission slip letter included a stamped, self-addressed envelope for returning the permission slip. Approximately 55% of the parents granted consent for their children to participate in the study. However, because not all children were present on the days the CDI and Piers-Harris scales were
administered, a total study population of 64 was achieved.

Instruments Used

The children were assessed on three scales. The homeroom teachers administered the sociometric scale to each of the third- and fifth-grade classes, while the first-period teachers administered this scale to the seventh-grade classes. The CDI and the Piers-Harris scales were self-administered by the third-, fifth-, and seventh-grade children in the sample population.

Sociometric Scale. Sociometric scales, first developed and utilized by J. L. Moreno in 1915 (Toeman, 1949), were designed to give an objective picture of the relationships existing between the members of any group of people. The sociometric scale used in this study was designed by the researcher. Each of the six questions on the scale asked the child to nominate, from among his or her classmates, three children with whom he or she would choose, or not choose, to associate, in both work and social situations. After each child in a classroom completed the sociometric scale, the class results were tallied, and the popular, rejected, controversial, and neglected children were identified. The statistical average was 9 positive nominations and 9 negative nominations for each child in a classroom. However, as Evans (1966) noted, the nominations were distributed according
to a J-curve. Specifically, a few individuals, who were labeled "stars" by Evans, received a large number of choices, while most members of the group received few choices. Furthermore, there were far more under-chosen than over-chosen individuals. An identical distribution was noted for the rejected individuals in the classroom.

In one study at the elementary school level, the reliability of sociometric status scores (over different interval periods of sociometric test administration) yielded stability coefficients ranging from .60 to .90 (Witryol & Thompson, 1953). A previous study by Thompson and Powell (1951) yielded stability coefficients ranging from .85 to .92. The largest correlation coefficients were obtained over the one-week interval, and the smallest over the five-week interval. A study of the validity of sociometric choices with school-age children, when compared with behavioral observations, indicated close agreement for the children's first choice. The correlations were between .72 and .76 for the two observations sessions (Biehler, 1954). A copy of this scale, used for the purposes of this study, is provided in the appendix (see Appendix C).

Childhood Depression Inventory (CDI). The CDI is a measure of childhood depression which was developed by Maria Kovacs and Aaron T. Beck (1977). The CDI was developed to modify the format of the Beck Depression
Inventory for use with children ages 8-13. A total score of 9 was obtained as the average score for the nonpsychiatric population upon which the CDI was normed. William J. Helsel and Johnny L. Matson (1984) conducted a study on the internal structure of the 27-item CDI. The reported mean of their study, conducted with 216 northern Illinois students, was established as 7.79, with a standard deviation of 7.13. Helsel and Matson did not state reliability figures; however, they noted that the CDI was a reliable measure of childhood depression, and that several circumscribed subcomponents of childhood depression emerged. Their validity investigation found that the derived factors corresponded with the Type A and B forms of depression as described by Kendell (1976).

In order to replicate the CDI as it was utilized by Jeffrey Nagel (1986), item #9 was altered on the CDI. Specifically, the word "killing" was replaced with "hurting." A copy of this scale, used for the purposes of this study, is provided in the appendix (see Appendix D).

Piers-Harris Children's Self-Concept Scale. The Piers-Harris is a self-report questionnaire, and was designed to assess children's and adolescents' feelings about themselves (Piers, 1984). The scale presents 80 statements that tell how some people feel about themselves, and the children are asked to indicate whether each statement applies to themselves by giving "yes" or "no"
responses. The scale was developed for use with children aged 8 to 18 years, and was standardized on 1,183 children in grades 4 through 12 in one small Pennsylvania town (Piers, 1984). The mean of the normative sample was 51.84, with a standard deviation of 13.87. A median of 53.43 was also found. However, an accumulated sample of 3,692 normal school children from 14 independent studies (Piers, 1984) established a slightly higher mean of 55.2, with a standard deviation of 12.6. Test-retest reliability coefficients from numerous studies ranged from .62 to .96, and internal consistency estimates ranged from .85 to .93. Estimates of the content, criterion-related, and construct validity from numerous studies have also fallen within an acceptable range (Jeske, 1985). In addition to the total score, the scale provides for six cluster scores; these cluster scores accounted for 42% of the variance in the normative sample. The factors include: (1) Behavior, (2) Intellectual and School Status, (3) Physical Appearance and Attributes, (4) Anxiety, (5) Popularity, and (6) Happiness and Satisfaction. Norms and standard deviations are not provided for the cluster scores.

In order to replicate the Piers-Harris as utilized by Jeffrey Nagel (1986), item #73 was altered. The phrase "I have a good figure" was amended to "I have a good figure/body." A copy of this scale, used for the purposes of this study, is provided in Appendix E.
Data Analysis

The sociometric scale, CDI, and Piers-Harris were all hand-scored by the researcher. The calculation of the correlation matrix and the analysis of variance were performed with the Statistical Package for the Social Sciences (SPSS), located at CSUH's Computer Lab.

To investigate the pair-wise relationship among the scales (hypothesis I), a Pearson product-moment correlation matrix was constructed. A multiple correlation was calculated to establish the strength of the linear relationship among the three scales (hypothesis II). For the purposes of this study, the CDI was used as the dependent variable; the other two scales were used as predictors. To evaluate if differences in the scales existed as a function of grade level (hypothesis III), separate one-way analyses of variance (ANOVA) were performed for each administered scale.

For the purposes of data analysis, only the sociometric status scores of the study sample were used for statistical comparison. The entire sample and non-sample populations of the 18 classrooms completed the sociometric scale in order to provide accurate sociometric status scores for the sample population.
Chapter IV

RESULTS

Introduction

This chapter contains the results of the data analysis. The pair-wise correlational data are presented in Tables 1, 2, 3, and 4. The multiple correlational data are presented in Table 5. The descriptive statistics and the analysis of variance data are presented in Table 6.

Note: Because of the varying populations among the eighteen classrooms utilized, the sociometric data have been analyzed in percentage form.

Testing of the Hypotheses

Hypothesis I: There is a significant pair-wise correlational relationship among the three scales used for this experiment: the Childhood Depression Inventory, the Piers-Harris Children's Self-Concept Scale, and a classroom sociometric scale.

Table I presents the pair-wise correlations among the three scales for grade level 3. Inspection of Table 1 revealed a significant negative correlation (p < .01) between the CDI and the Piers-Harris total score. In addition, the negative sociometric score correlated positively (p < .001) with the total sociometric score, and
Table 1

Pair-Wise Correlations Among the Childhood Depression Inventory, Piers-Harris, and Sociometric Scale for Grade Level 3

<table>
<thead>
<tr>
<th></th>
<th>Pos Soc</th>
<th>Neg Soc</th>
<th>Total Soc</th>
<th>P-H Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI</td>
<td>-.3419</td>
<td>.2204</td>
<td>-.0643</td>
<td>-.5835*</td>
</tr>
<tr>
<td>Pos Soc</td>
<td>-.5084*</td>
<td>.3452</td>
<td></td>
<td>.2676</td>
</tr>
<tr>
<td>Neg Soc</td>
<td></td>
<td>.6325**</td>
<td></td>
<td>-.1891</td>
</tr>
<tr>
<td>Total Soc</td>
<td></td>
<td></td>
<td></td>
<td>.0252</td>
</tr>
</tbody>
</table>

*p < .01

**p < .001
the negative sociometric score correlated negatively
($p < .01$) with the positive sociometric score. In con-
clusion, the significant correlation between the CDI and
the Piers-Harris allowed the rejection of the null
hypothesis at the third-grade level. However, the first null
hypothesis was not rejected when considering the relation-
ship between the sociometric scale and the other two
administered scales.

Table 2 presents the pair-wise correlations among
the three scales for grade level 5. Inspection of Table 2
revealed that the Piers-Harris total score correlated
negatively with the following: The CDI ($p < .001$), the
negative sociometric score ($p < .01$), and the total socio-
metric score ($p < .01$). In addition, the CDI correlated
positively with both the negative sociometric score
($p < .01$) and the total sociometric score ($p < .001$). As
demonstrated at the third-grade level, several pair-wise
correlational relationships were demonstrated between the
positive, negative, and total sociometric scores. In
conclusion, the negative correlation between the CDI and
the Piers-Harris, the negative correlation between the
Piers-Harris and the sociometric scale, and the positive
correlation between the CDI and the sociometric scale
allowed the rejection of the first null hypothesis at the
fifth-grade level.
Table 2

Pair-Wise Correlations Among the Childhood Depression Inventory, Piers-Harris, and Sociometric Scale for Grade Level 5

<table>
<thead>
<tr>
<th></th>
<th>Pos Soc</th>
<th>Neg Soc</th>
<th>Total Soc</th>
<th>P-H Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI</td>
<td>-.1986</td>
<td>.6338*</td>
<td>.6617**</td>
<td>-.8235**</td>
</tr>
<tr>
<td>Pos Soc</td>
<td></td>
<td>-.5843*</td>
<td>-.0938</td>
<td>.2616</td>
</tr>
<tr>
<td>Neg Soc</td>
<td></td>
<td></td>
<td>.8626**</td>
<td>-.5715*</td>
</tr>
<tr>
<td>Total Soc</td>
<td></td>
<td></td>
<td></td>
<td>-.5421*</td>
</tr>
</tbody>
</table>

*p < .01

**p < .001
Table 3 presents the pair-wise correlations among the three scales for grade level 7. Inspection of Table 3 revealed that the Piers-Harris total score correlated negatively with both the CDI (p < .001) and the negative sociometric score (p < .001). Several pair-wise correlations were again demonstrated among the three sociometric scores. In conclusion, the negative correlation between the CDI and the Piers-Harris, and the negative correlation between the Piers-Harris and the sociometric scale allowed the rejection of the null hypothesis at the seventh-grade level. However, no significant relationship between the CDI and the sociometric scale was observed at this grade level.

Table 4 presents the pair-wise correlations among the three scales for grade levels 3, 5, and 7. Inspection of Table 4 revealed that the Piers-Harris correlated negatively with the following measures: The CDI (p < .001), the negative sociometric score (p < .001), and the total sociometric score (p < .01). Furthermore, the Piers-Harris correlated positively with the positive sociometric score (p < .01). In addition, the CDI correlated positively with both the negative (p < .001) and the total (p < .01) sociometric scores. As with the three individual grade level analyses, several pair-wise correlations were demonstrated among the three sociometric scores. In conclusion, the negative correlation between the CDI and the
Table 3

Pair-Wise Correlations Among the Childhood Depression Inventory, Piers-Harris, and Sociometric Scale for Grade Level 7

<table>
<thead>
<tr>
<th></th>
<th>Pos Soc</th>
<th>Neg Soc</th>
<th>Total Soc</th>
<th>P-H Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI</td>
<td>-.0641</td>
<td>.2582</td>
<td>.1977</td>
<td>-.7418**</td>
</tr>
<tr>
<td>Pos Soc</td>
<td>-.5061*</td>
<td>.0668</td>
<td>.8198**</td>
<td>-.6199**</td>
</tr>
<tr>
<td>Neg Soc</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Soc</td>
<td></td>
<td></td>
<td></td>
<td>-.4527</td>
</tr>
</tbody>
</table>

*p < .01

**p < .001
Table 4

Pair-Wise Correlations Among the Childhood Depression Inventory, Piers-Harris, and Sociometric Scale for Combined Grade Levels 3, 5, and 7

<table>
<thead>
<tr>
<th></th>
<th>Pos Soc</th>
<th>Neg Soc</th>
<th>Total Soc</th>
<th>P-H Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI</td>
<td>-.2059</td>
<td>.3870**</td>
<td>.2996*</td>
<td>-.7056**</td>
</tr>
<tr>
<td>Pos Soc</td>
<td>-.5125**</td>
<td>.1039</td>
<td>.2891*</td>
<td></td>
</tr>
<tr>
<td>Neg Soc</td>
<td></td>
<td>.7944**</td>
<td>-.5143**</td>
<td></td>
</tr>
<tr>
<td>Total Soc</td>
<td></td>
<td></td>
<td>-.3587*</td>
<td></td>
</tr>
</tbody>
</table>

*p < .01

**p < .001
Piers-Harris, the negative correlation between the Piers-Harris and the sociometric scale, and the positive correlation between the CDI and the sociometric scale allowed the rejection of the null hypothesis when grade levels 3, 5, and 7 were combined.

**Hypothesis II:** There is a significant multiple correlational relationship among the three administered scales.

Table 5 presents the multiple correlations among the three scales for grade levels 3, 5, and 7. Inspection of Table 5 revealed multiple correlations among the three scales ($p < .001$) at the fifth-, seventh-, and combined-grade levels. Consequently, the null hypothesis was rejected at these levels. However, the second null hypothesis was not rejected at the third-grade level.

**Hypothesis III:** There is a significant difference among the three grade levels on the scores of the administered scales.

Table 6 presents the means and standard deviations for the third-, fifth-, seventh-, and combined-grade levels. In addition, Table 6 shows the results of the one-way analyses of variance of the differences between the grade levels ($F$). Inspection of Table 6 revealed no significant differences among the three grade levels. Consequently, the third null hypothesis was not rejected.
Table 5

Multiple Correlations Among the Childhood Depression Inventory, Piers-Harris, and Sociometric Scale for Grade Levels 3, 5, 7, and Combined, With the CDI as the Dependent Variable

<table>
<thead>
<tr>
<th>Grade</th>
<th>Multiple R</th>
<th>R Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>.58346</td>
<td>.34043</td>
</tr>
<tr>
<td>5</td>
<td>.91626***</td>
<td>.83953</td>
</tr>
<tr>
<td>7</td>
<td>.79450***</td>
<td>.63123</td>
</tr>
<tr>
<td>Combined</td>
<td>.72645***</td>
<td>.52773</td>
</tr>
</tbody>
</table>

*p < .05

**p < .01

***p < .001
Table 6

Means, Standard Deviations (in Parentheses), and F Ratios for Grade Levels 3, 5, 7, and Combined

<table>
<thead>
<tr>
<th>Grade</th>
<th>CDI</th>
<th>P-H Tot</th>
<th>Pos Soc</th>
<th>Neg Soc</th>
<th>Total Soc</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>6.90</td>
<td>64.48</td>
<td>4.18</td>
<td>3.75</td>
<td>3.96</td>
</tr>
<tr>
<td></td>
<td>(5.45)</td>
<td>(9.66)</td>
<td>(3.01)</td>
<td>(3.66)</td>
<td>(1.68)</td>
</tr>
<tr>
<td>5</td>
<td>7.21</td>
<td>63.26</td>
<td>3.71</td>
<td>3.24</td>
<td>3.48</td>
</tr>
<tr>
<td></td>
<td>(7.04)</td>
<td>(10.34)</td>
<td>(2.65)</td>
<td>(5.17)</td>
<td>(2.12)</td>
</tr>
<tr>
<td>7</td>
<td>8.17</td>
<td>58.25</td>
<td>3.68</td>
<td>4.42</td>
<td>3.93</td>
</tr>
<tr>
<td></td>
<td>(5.07)</td>
<td>(12.77)</td>
<td>(2.63)</td>
<td>(5.68)</td>
<td>(2.24)</td>
</tr>
<tr>
<td>Comb.</td>
<td>7.47</td>
<td>61.78</td>
<td>3.85</td>
<td>3.85</td>
<td>3.81</td>
</tr>
<tr>
<td></td>
<td>(5.78)</td>
<td>(11.30)</td>
<td>(2.73)</td>
<td>(4.89)</td>
<td>(2.02)</td>
</tr>
</tbody>
</table>

F .288 1.995 .220 .308 .347

(df = 2,61)

*p < .05
Chapter V

SUMMARY

Discussion of Results

The descriptive statistics presented in Table 6 match closely the data previously obtained in the field (see Chapter III). The congruence of the data gathered in this study with those presented in the literature suggests that the present study is valid in terms of the scores obtained on the administered scales.

The following conclusions appear warranted based on the results of the data analyses:

1. There is a significant pair-wise correlational relationship among the Childhood Depression Inventory, the Piers-Harris Children's Self-Concept Scale, and a classroom sociometric scale. This intercorrelation among the three scales supports the applicability of the Negative Affectivity construct (Tellegen, 1982; Watson & Clark, 1984) to children. In order to obtain a more explicit picture, however, it is necessary to examine the scale intercorrelations individually at the three grade levels studied.

At the third-grade level, the CDI and the Piers-Harris showed a significant negative correlation; however, the sociometric scale did not show significant correlations with either the CDI or the Piers-Harris. This
pattern of correlations suggests that a third-grade child's sociometric status among his or her classroom peers may not relate significantly to that child's sense of depression or self-concept.

At the fifth-grade level, the CDI, Piers-Harris, and the sociometric scale all showed significant pair-wise correlations among themselves. These intercorrelations suggest that by the time a child is in the fifth grade, sociometric status among classroom peers is significantly related to that child's sense of depression and self-concept.

Again, at the seventh-grade level, the Piers-Harris correlated negatively with both the CDI and the sociometric scale. However, the CDI and the sociometric scale did not show a significant pair-wise correlation. It is possible that this failure of the CDI and the sociometric scale to correlate significantly can be explained by the multiple-classroom design of the seventh-grade curriculum. Specifically, because the seventh-grade subjects in this study attended several different classrooms during the day, it is possible that a seventh-grader's sociometric status in a single classroom may not interrelate with his or her overall sense of depression. That is, a child could be sociometrically unpopular in one or more classes, yet, at the same time, be quite sociometrically popular in other classes.
2. There is a significant multiple correlational relationship among the three administered scales at the fifth-, seventh-, and combined-grade levels. The lack of a significant multiple correlation at the third-grade level appears to have been due to inconsistent pair-wise correlations among the three scales. Furthermore, although the multiple correlations at the seventh- and combined-grade levels are significant, the sociometric scale did not contribute significantly to the variance accounted for in the CDI at either of these levels. This finding may be accounted for by the high pair-wise correlations found between the CDI and the Piers-Harris. Only at the fifth-grade level did the sociometric scale contribute significantly to the multiple correlation. Again, it is likely that this inconsistency between the fifth and seventh grades reflects the decreased significance of single-class sociometric status at the seventh-grade level.

3. There is not a significant difference among the three grade levels on the scores of the administered scales. This finding closely matches Nagel's finding (1986). This statistical similarity of scores suggests that there may be only minimal developmental differences among the three grade levels in their measured levels of depression, self-concept, and sociometric status.
Limitations of the Study

The sociometric findings at the seventh-grade level were confounded by the multiple-classroom design of the seventh-grade curriculum. The seventh-grade subjects in this study attended six to seven different classrooms during the day. Unlike the third- and fifth-graders, the seventh-graders had no true homeroom classroom, where each student was known by, and interacted extensively with, the majority of the other children in the classroom. Consequently, a seventh-grader's sociometric status in any one classroom may have had significantly less personal impact than the sociometric status of a fifth-grader's homeroom sociometric status.

Recommendations for Further Research

The design of the current study could be improved by including the fourth-, sixth-, and eighth-grade levels in the sample population. The inclusion of these additional grade levels would shed light upon the applicability of the Negative Affectivity construct to a wider and more inclusive range of age and grade levels.

Another advantageous design alteration would be to utilize a school setting where the sixth-, seventh-, and eight-graders attended a maximum of two or three different classrooms during the day. This reduced-classroom situation might well increase the significance of
measured classroom sociometric status at these three grade levels.

Finally, additional studies need to be conducted to research the intercorrelations among the various measures of childhood personality. Significant intercorrelations among these measures would lend additional credence to the claim that the Negative Affectivity construct applies not only to adults, but to children as well.


Appendix A

Purpose of Study Statement

1. Instructions to be given prior to children filling out the CDI and the Piers-Harris scales:
   Hello, my name is Mr. Stager. I am a college student from Hayward University, and I am conducting a study on the thoughts and feelings of children. I will be asking you some questions about yourself. There are no right or wrong answers to the questions, and you do not have to answer them if you don't want to.

2. Instructions to be given after the children have completed filling out the scales.
   If any of these questions have brought up unpleasant thoughts or feelings, you may remain here and talk about them with me. If you want to speak with me alone, just let me know and I will arrange a time to meet with you alone and to talk about your thoughts and feelings. If any time later on you want to speak with me about these questions, tell your teacher, and they will arrange a time for you to speak with me.
Dear Parents:

My name is Karl Stager. I am a graduate student at California State University, Hayward in the Clinical Child/School Psychology Program. I am currently working as a school psychologist intern in the Cabrillo Unified School District under the supervision of Dennis Riley and Judy Senning-Brown.

As part of my Master's thesis, I am conducting a survey of children in the 3rd, 5th, and 7th grades in the district. Your child has been randomly selected to participate in this survey on thoughts and feelings in children. Participation is completely voluntary, and I would gladly answer any questions you may have concerning this survey. I will be looking at three aspects of children's lives. Your child will participate in a peer sociometric survey in his or her classroom. In addition, your child will complete a self-concept scale (Piers Harris Children's Self Concept Scale), and a depression scale (Childhood Depression Inventory). The two scales take about 20 minutes to administer, and will be the only time taken away from your child's classroom instruction.

In accordance with Cabrillo Unified School District Board Policy, information regarding the attitudes or practices of a student or his/her family about sex, family life, morality, or religion shall not be solicited without consent of the parent or guardian. No such information will be solicited by this study. The information obtained will be held in strict confidence. The results of this study will give a better understanding of the relationship between how children think/feel about themselves and how they are viewed by their classmates. Furthermore, I am looking for a more precise method of identifying depression in children.

To work with your child, I need your written permission. I have attached (see below) a form for you to read and sign. Also, for your convenience, I am enclosing an addressed envelope for returning the form. If you have any questions about your child's participation in this study, please feel free to contact me at the District Office (726-5555). In addition, questions about your child's serving as a subject may be addressed to the Office of the Associate Vice President, Faculty Affairs and Research, California State University, Hayward (415/881-3022). Furthermore, your child is free to withdraw from the study at any time. I appreciate your and your child's participation, and I would gladly share the results of this study with you. Thank you for your assistance.

Karl Stager

(I give permission for my child ___________________________ to participate in the survey being conducted by Karl Stager, School Psychologist Intern.)

Signed: ___________________________ Date: ___________________________

Appendix B
Appendix C
PEER SOCIOMETRIC SCALE

1. Name 3 classmates you would choose to eat your lunch with.

   1. 
   2. 
   3. 

2. Name 3 classmates you would not choose to eat your lunch with.

   1. 
   2. 
   3. 

3. Name 3 classmates you would choose to work on a school project with you.

   1. 
   2. 
   3. 

4. Name 3 classmates you would not choose to work on a school project with you.

   1. 
   2. 
   3. 

5. Name 3 classmates you would choose to invite to a party at your home.

   1. 
   2. 
   3. 

6. Name 3 classmates you would not choose to invite to a party at your home.

   1. 
   2. 
   3.
Appendix D
CD INVENTORY

NAME: __________________________

DATE: __________________________

CASE: ____________

GROUP NUMBER

CASE 2 3 4 5

DATE 6 7 8 9 10 11

KIDS SOMETIMES HAVE DIFFERENT FEELINGS AND IDEAS.

THIS FORM LISTS THE FEELINGS AND IDEAS IN GROUPS. FROM EACH GROUP,
PICK ONE SENTENCE THAT DESCRIBES YOU BEST FOR THE PAST TWO WEEKS.
AFTER YOU PICK A SENTENCE FROM THE FIRST GROUP, GO ON TO THE NEXT
GROUP.

THERE IS NO RIGHT ANSWER OR WRONG ANSWER. JUST PICK THE SENTENCE THAT
BEST DESCRIBES THE WAY YOU HAVE BEEN RECENTLY. PUT A MARK LIKE THIS

X

NEXT TO YOUR ANSWER. PUT THE MARK IN THE BOX NEXT TO THE
SENTENCE THAT YOU PICK.

HERE IS AN EXAMPLE OF HOW THIS FORM WORKS. TRY IT. PUT A MARK NEXT
TO THE SENTENCE THAT DESCRIBES YOU BEST.

EXAMPLE:

□ □ □ □ □
I READ BOOKS ALL THE TIME
I READ BOOKS ONCE IN A WHILE
I NEVER READ BOOKS

Developed by M. Kovacs, The University of Pennsylvania School of Medicine, Philadelphia, Pa. 19104. Not to be used, quoted, or reproduced without permission.
Rev. 3/75; 2/76; 5/77; 7/77
REMEMBER, PICK OUT THE SENTENCES THAT DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

1. [ ] I AM SAD ONCE IN A WHILE
   [ ] I AM SAD MANY TIMES
   [ ] I AM SAD ALL THE TIME

2. [ ] NOTHING WILL EVER WORK OUT FOR ME
   [ ] I AM NOT SURE IF THINGS WILL WORK OUT FOR ME
   [ ] THINGS WILL WORK OUT FOR ME O.K.

3. [ ] I DO MOST THINGS O.K.
   [ ] I DO MANY THINGS WRONG
   [ ] I DO EVERYTHING WRONG

4. [ ] I HAVE FUN IN MANY THINGS
   [ ] I HAVE FUN IN SOME THINGS
   [ ] NOTHING IS FUN AT ALL

5. [ ] I AM BAD ALL THE TIME
   [ ] I AM BAD MANY TIMES
   [ ] I AM BAD ONCE, IN A WHILE

6. [ ] I THINK ABOUT BAD THINGS HAPPENING TO ME ONCE IN A WHILE
   [ ] I WORRY THAT BAD THINGS WILL HAPPEN TO ME
   [ ] I AM SURE THAT TERRIBLE THINGS WILL HAPPEN TO ME

7. [ ] I HATE MYSELF
   [ ] I DO NOT LIKE MYSELF
   [ ] I LIKE MYSELF
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<td>2.</td>
<td>MANY BAD THINGS ARE MY FAULT</td>
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<td>1.</td>
<td>I THINK ABOUT HURTING MYSELF BUT I WOULD NOT DO IT</td>
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<td>1.</td>
<td>I FEEL LIKE CRYING MANY DAYS</td>
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<td>1.</td>
<td>I FEEL LIKE CRYING ONCE IN A WHILE</td>
<td></td>
<td>1.</td>
<td>I LIKE BEING WITH PEOPLE</td>
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</table>
Remember, describe how you have been in the past two weeks.

16. □ 2 I have trouble sleeping every night
     □ 1 I have trouble sleeping many nights
     □ 0 I sleep pretty well

17. □ 0 I am tired once in a while
     □ 1 I am tired many days
     □ 2 I am tired all the time

18. □ 2 Most days I do not feel like eating
     □ 1 Many days I do not feel like eating
     □ 0 I eat pretty well

19. □ 0 I do not worry about aches and pains
     □ 1 I worry about aches and pains many times
     □ 2 I worry about aches and pains all the time

20. □ 0 I do not feel alone
     □ 1 I feel alone many times
     □ 2 I feel alone all the time

21. □ 2 I never have fun at school
     □ 1 I have fun at school only once in a while
     □ 0 I have fun at school many times

22. □ 0 I have plenty of friends
     □ 1 I have some friends but I wish I had more
     □ 2 I do not have any friends
23. [ ] MY SCHOOL WORK IS ALRIGHT
   [ ] MY SCHOOLWORK IS NOT AS GOOD AS BEFORE
   [1] I DO VERY BADLY IN SUBJECTS I USED TO BE GOOD IN

24. [ ] I CAN NEVER BE AS GOOD AS OTHER KIDS
   [ ] I CAN BE AS GOOD AS OTHER KIDS IF I WANT TO
   [0] I AM JUST AS GOOD AS OTHER KIDS

25. [ ] NOBODY REALLY LOVES ME
   [ ] I AM NOT SURE IF ANYBODY LOVES ME
   [0] I AM SURE THAT SOMEBODY LOVES ME

26. [ ] I USUALLY DO WHAT I AM TOLD
   [ ] I DO NOT DO WHAT I AM TOLD MOST TIMES
   [2] I NEVER DO WHAT I AM TOLD

27. [ ] I GET ALONG WITH PEOPLE
   [ ] I GET INTO FIGHTS MANY TIMES
   [2] I GET INTO FIGHTS ALL THE TIME

THE END
THANK YOU FOR FILLING OUT THIS FORM

TOTAL SCORE: ____________

ADMINISTRATION: 0. INDIVIDUAL
1. GROUP

TYPE: 0. INITIAL
1. RETEST

IF RETEST, INTERVAL IN DAYS (NAP=O)
APPENDIX E

THE PIERS-HARRIS
CHILDREN'S SELF CONCEPT SCALE

(The Way I Feel About Myself)

by

ELLEN V. PIERS, Ph.D.
and
DALE B. HARRIS, Ph.D.

Published by
Counselor Recordings and Tests

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NASHVILLE, TENNESSEE 37212
Here are a set of statements. Some of them are true of you and so you will circle the yes. Some are not true of you and so you will circle the no. Answer every question even if some are hard to decide, but do not circle both yes and no. Remember, circle the yes if the statement is generally like you, or circle the no if the statement is generally not like you. There are no right or wrong answers. Only you can tell us how you feel about yourself, so we hope you will mark the way you really feel inside.

1. My classmates make fun of me.........................yes no
2. I am a happy person........................................yes no
3. It is hard for me to make friends......................yes no
4. I am often sad..............................................yes no
5. I am smart................................................yes no
6. I am shy................................................yes no
7. I get nervous when the teacher calls on me..........yes no
8. My looks bother me......................................yes no
9. When I grow up, I will be an important person........yes no
10. I get worried when we have tests in school..........yes no
11. I am unpopular..........................................yes no
12. I am well behaved in school............................yes no
13. It is usually my fault when something goes wrong.....yes no
14. I cause trouble to my family............................yes no
15. I am strong...............................................yes no
16. I have good ideas........................................yes no
17. I am an important member of my family...............yes no
18. I usually want my own way..............................yes no
19. I am good at making things with my hands...........yes no
20. I give up easily........................................yes no
21. I am good in my school work ............................................. yes no
22. I do many bad things ..................................................... yes no
23. I can draw well ............................................................. yes no
24. I am good in music ......................................................... yes no
25. I behave badly at home ................................................... yes no
26. I am slow in finishing my school work ......................... yes no
27. I am an important member of my class ............................ yes no
28. I am nervous ............................................................... yes no
29. I have pretty eyes .......................................................... yes no
30. I can give a good report in front of the class .................. yes no
31. In school I am a dreamer ................................................ yes no
32. I pick on my brother(s) and sister(s) .............................. yes no
33. My friends like my ideas ................................................ yes no
34. I often get into trouble .................................................. yes no
35. I am obedient at home ................................................... yes no
36. I am lucky ................................................................. yes no
37. I worry a lot ............................................................... yes no
38. My parents expect too much of me ............................... yes no
39. I like being the way I am .............................................. yes no
40. I feel left out of things ............................................... yes no
41. I have nice hair............................................. yes no
42. I often volunteer in school .................................... yes no
43. I wish I were different ....................................... yes no
44. I sleep well at night......................................... yes no
45. I hate school................................................ yes no
46. I am among the last to be chosen for games ..................... yes no
47. I am sick a lot................................................ yes no
48. I am often mean to other people............................... yes no
49. My classmates in school think I have good ideas ................. yes no
50. I am unhappy................................................ yes no
51. I have many friends......................................... yes no
52. I am cheerful............................................... yes no
53. I am dumb about most things.................................. yes no
54. I am good looking........................................... yes no
55. I have lots of pep............................................ yes no
56. I get into a lot of fights...................................... yes no
57. I am popular with boys..................................... yes no
58. People pick on me.......................................... yes no
59. My family is disappointed in me............................. yes no
60. I have a pleasant face....................................... yes no
61. When I try to make something, everything seems to go wrong. yes  no
62. I am picked on at home .......................................... yes  no
63. I am a leader in games and sports ................................................................. yes  no
64. I am clumsy ................................................................................................. yes  no
65. In games and sports, I watch instead of play ........................................ yes  no
66. I forget what I learn ...................................................................................... yes  no
67. I am easy to get along with ................................................................. yes  no
68. I lose my temper easily .............................................................................. yes  no
69. I am popular with girls ................................................................................. yes  no
70. I am a good reader ........................................................................................ yes  no
71. I would rather work alone than with a group ......................................... yes  no
72. I like my brother (sister) ............................................................................. yes  no
73. I have a good figure/ or Body ........................................................................ yes  no
74. I am often afraid .......................................................................................... yes  no
75. I am always dropping or breaking things ............................................. yes  no
76. I can be trusted ............................................................................................. yes  no
77. I am different from other people ............................................................... yes  no
78. I think bad thoughts .................................................................................... yes  no
79. I cry easily ..................................................................................................... yes  no
80. I am a good person ....................................................................................... yes  no