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Inter-informant agreement and childhood depression.

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INTER-INFORMANT AGREEMENT AND CHILDHOOD DEPRESSION

by

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ABSTRACT

In the present study, the influence of several variables on parent-child agreement for child, mother, and father reports of child functioning were investigated. Variables included the specificity of the depression measure used, child self-reports of global self-worth, and parent reported pathology. Harter's (Harter, Marold, & Whitesell, 1991) model of the mediational role of self-worth as a risk factor of depression and suicidal ideation was also examined. This model was originally developed for use with adolescents but was tested with elementary school age children in this study. Ninety-two elementary school children (9 to 12 years of age), their mothers, and a subgroup of their fathers completed parent and child versions of the Self-Perception Profile for Children (SPPC: Harter, 1985a), the Social Support Scale for Children and Adolescents (SSSC: Harter, 1985b), the Dimensions of Depression Profile for Children and Adolescents (DDPC: Harter & Nowakowski, 1987), and the Children's Depression Inventory (CDI: Kovacs, 1992). Parents also provided self-reports of depression by completing the Beck Depression Inventory (BDI: Beck & Steer, 1987). Compared to previous research (e.g., see Achenbach, McConaughy, & Howell, 1987), agreement was not improved for children and mothers, children and fathers, or mothers and fathers. For example, the domain specific nature of the DDPC

did not result in an improvement in agreement between informants over the more global CDI. In addition, children with low global self-worth and their parents were not observed to report greater parent-child agreement compared to children and their parents with high global self-worth on the SPPC, SSSC, DDPC, and CDI. While parent self-reports of depression on the BDI were positively related to parent reports of child functioning on two measures of depression, they were not related to child self-reports. Last, child and mother reports provided partial support for Harter's model of self-worth and risk factors associated with depression and suicidal ideation. These results support the use of child self-reports in the assessment process and in school-based screening programs for the early identification of children at risk for depression or other school related difficulties.

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Introduction

The study of childhood depression continues to be an area of child psychopathology fraught with discrepancies (Kazdin, 1988). Consensus regarding the primary symptoms of this disorder has not yet been achieved. For example, according to DSM-III-R the primary or essential symptoms of depression include depressed affect and anhedonia (DSM-III-R; American Psychiatric Association, 1987; see also DSM-IV Draft Criteria; American Psychiatric Association, 1993). Other researchers consider that self-deprecatory ideation (e.g., low self-worth) should be included as a primary symptom of depression (e.g., see Poznanski, 1982a; Weinberg, Rutman, Sullivan, Penick, & Dietz, 1973). Concern has also been expressed regarding children's abilities to accurately report on their symptoms. In addition, comparisons between parent and child reports generally reflect limited agreement for the presence and severity of childhood depressive symptoms (e.g., see Achenbach, McConaughy, & Howell, 1987).

In this review, the literature available on parent-child agreement will be explored in some detail. In addition, Harter's model of the determinants and mediational role of self-worth and related research studies will be reviewed (e.g., see Harter, Marold, & Whitesell, 1991). Finally, a study which attempted to establish predictors of

parent-child agreement using this model will be summarized.

Childhood Depression: Inter-Informant Agreement

The assessment of childhood depression has progressed from an emphasis on parental reports to increased attention to child self-reports. However, this approach is not without difficulties as discrepancies in the information provided by children and their parents is common. Discussion of this phenomenon will be the primary focus of this section.

Traditionally, the assessment and diagnosis of child psychiatric disorders has depended on information (e.g., interviews, rating scales) completed by the child's parents (Costello, 1986; Edelbrock, Costello, Dulcan, Conover, & Kalas, 1986; Kazdin & Petti, 1982). An evolving trend has been the increasing reliance on children as valuable informants regarding their own feelings, behaviours, and social relationships (Edelbrock et al., 1986). However, it is frequently noted that informants disagree about the presence, severity, and duration of a child's symptoms (e.g., Carlson & Cantwell, 1980; Costello, 1986).

According to Weissman et al. (1987), Rutter and Graham were the first to report this pattern of low parent-adolescent agreement, and this trend has continued (e.g., see Rutter & Graham, 1968; Rutter, Graham, Chadwick, & Yule 1976). For example, Rutter et al. (1976) reported disagreements between parents and adolescents on ratings of severity of depression, with adolescents reporting more

severe symptomatology. Disagreements have also been reported in some studies with middle school age and younger children, regardless of their sample classification (i.e., psychiatric inpatient, psychiatric outpatient, elementary school children, or children of parents with an affective disorder) (e.g., see Angold, Weissman et al., 1987; Edelbrock, Costello, Dulcan, Kalas, & Conover, 1985; Herjanic & Reich, 1982; Lefkowitz & Tesiny, 1985; Martini, Strayhorn, & Puig-Antich, 1990; Mokros, Poznanski, Grossman, & Freeman, 1987; Moretti, Fine, Haley, & Marriage, 1985; Weissman, Orvaschel, & Padian, 1980).

Discrepancies also exist between adults' self-reports and evaluations made by family members. For example, family members of adult patients have been observed to underestimate the severity of depressive symptoms (Orvaschel, Thompson, Belanger, Prusoff, & Kidd, 1982), a finding consistent for adolescents (e.g., see Rutter et al., 1976) and children (e.g., see Angold et al., 1987). Also consistent with some child self-reports (Kazdin, Esveldt-Dawson, Unis, & Rancurello, 1983a; Kazdin, French, & Unis, 1983b; Kazdin, French, Unis, & Esveldt-Dawson, 1983c) some adults may minimize symptoms when self-reporting (Prusoff, Klerman, & Paykel, 1972; Carroll, Fielding, & Blashki, 1973).

Typically, discrepancies between parent and child reports fall within one of the following areas. First,

children either report more depressive symptomatology (e.g., see Edelbrock et al., 1986; Mokros et al., 1987), or less depressive symptomatology than do their parents (e.g., see Kazdin et al., 1983a, b, c). Second, parent-child agreement tends to be better for items assessing easily observable behaviours than for internal feelings or experiences (Edelbrock et al., 1986). Finally, age may impact on agreement, with greater agreement reported for 14 to 18-year-olds than for 10 to 13 and 6 to 9-year-olds (Edelbrock et al., 1986).

Generally, limited agreement between informants is considered to mean informant inaccuracy. However, Achenbach et al. (1987) suggest an alternative explanation for the observed low pattern of agreement between informants. In a comprehensive review of studies assessing inter-informant agreement, they determined that differences between the role and ecologies of informants accounted for the observed discrepancies between informants. For example, Achenbach et al. (1987) reported that comparisons of ratings provided by similar individuals (e.g., teacher-teacher or parent-parent) reflected higher agreement (mean $\underline{r}$ = .60) than did ratings provided by individuals occupying different roles or ecologies in the child's life (e.g., parent-teacher, $\underline{r}$ = .27). Low levels of agreement were also reported for comparisons involving the child (e.g., parent-child, $\underline{r}$ = .25; teacher-child, $\underline{r}$ = .20; peer-child, $\underline{r}$ = .26:

Achenbach et al., 1987). Thus, the authors concluded that while each informant is capable of providing valid information about the child's behaviour, discrepancies are expected given the different roles and environments of each respondent.

Even though parent-child reports reveal limited agreement, children are increasingly involved in the assessment process. In the following sections, the importance of child self-report measures and possible reasons why discrepancies exist between parent-child reports will be explored.

Self-Report Measures

Self-report measures play a crucial role in the assessment, diagnosis, and treatment formulation of children and adults alike (Apter, Orvaschel, Laseg, Moses, & Tyano, 1989). Self-reports are particularly important for those areas of human behaviour that are subjective, internal, and least observable (Martin, 1988). However, the influx of self-report measures assessing depression has raised an important issue regarding the extent to which children are able or willing to self-report on their depressive symptoms (Kazdin, 1988). For example, children may deny depressive symptoms or they may not be able to make subtle discriminations regarding symptom presence, intensity, and duration (Kazdin, 1988). To address these concerns, child self-reports are frequently compared with assessments

provided by parents, and occasionally, teachers and peers as well (e.g., see Achenbach et al., 1987 for a review). Parent, teacher, and peer sources of information may be utilized to provide a more comprehensive analysis of a child's behaviour in a variety of settings including the home, school, or neighbourhood (Hoier & Kerr, 1988). For example, teachers may identify depressive features not accessible to parents, or not reported by children themselves, while peers may provide independent validation of parent, teacher, and self ratings (Hoier & Kerr, 1988). In addition, comparisons are computed in an attempt to determine how best to integrate information provided by each informant (Hodges & Seigel, 1985), and whether additional information is gained by a multi-method, multi-informant perspective (Kazdin, 1988). Finally, parent, teacher, and peer sources of information are frequently used to confirm (or disconfirm) the child's own information (Hoier & Kerr, 1988).

Reasons Given For the Lack of Agreement Between Informants

Discrepancies in reporting between children and parents and other informants has resulted in controversy regarding the accuracy and importance of child self-reports. Most researchers consider that the parent, usually the mother, is the most reliable source of both factual information and information on the duration and onset of symptoms (Orvaschel, Weissman, Padian, & Lowe, 1981; Puig-Antich &

Gittelman, 1982). This position is often predicated on the assumption that children are unable to report on selected aspects of their overall functioning (e.g., eating disturbances, irritability, chronology of symptom onset: Kazdin et al., 1983c; Poznanski, Cook, & Carroll, 1979; Puig-Antich & Gittelman, 1982). Second, children are sometimes viewed as underestimating the severity of their distress in relation to parent reports (Kazdin et al., 1983a, b, c).

Limited agreement may occur because parents and children endorse different aspects of a child's dysfunction, not because one is more or less accurate (Saylor, Finch, Baskin, Furey, & Kelley, 1984). Differences in perspective could be due to differential access to internal states, attention to different features of depression, or individual differences in the weighting of various symptoms (Birelson, 1981). Also, parents and children may possess different schema or definitions for words used during interviews or on rating scales (Angold, 1988). In addition, parents may guess at what a clinician or researcher is inquiring about and respond on the basis of a depressive syndrome while a child may respond to each question on an individual basis (Angold, 1988).

Agreement may also be hampered by an underlying bias, or reluctance to admit, that children experience depression (Anthony & Cytryn, 1977). Parents may also focus more on

those behaviours that they perceive as disruptive or disturbing (e.g., irritability, temper tantrums, obstinacy), rather than focusing on behaviours that their child may perceive as disturbing (Cytryn, McKnew, & Bunney, 1980; Edelbrock et al., 1986; Moretti et al., 1985; Orvaschel et al., 1981). In addition, parents may interpret affective problems as behaviour problems (Kashani, Orvaschel, Burk, & Reid, 1985). Finally, parental psychopathology may impact on a parent's ability to perceive or report child symptoms (Poznanski, 1982b; Reynolds, Anderson, & Bartell, 1985).

Parents as Informants. As mentioned previously, mothers' reports are typically relied upon to provide information about their child's functioning. However, a growing trend has been to question the accuracy of these reports, especially when the mother is believed to be depressed herself (e.g., see Richters, 1992). According to Richters (1992), it is commonly assumed that depressed mothers over-report problem behaviours in their children and that this over-reporting is a product of the parent's own depression. Several models have been proposed to explain the relationship between maternal depression, family stressors, and maternal perceptions of child behaviour. However, as with parent-child agreements, discrepancies exist in the findings reported. Some depressed mothers report more symptomatology than their children (Brody & Forehand, 1986), while others report less (Kashani et al., 1985). It is

uncertain whether these discrepancies reflect maternal distortions as a result of maternal depression in the one case, or greater sensitivity to, and accuracy in reporting child behaviours in the other (e.g., see Richters, 1992).

Children as Informants. Most hypotheses that focus on "child" variables to explain poor agreement between informants deal with children's limitations in cognitive and emotional development due to their young age. For example, developmental status may influence the child's capacity to comprehend the interview process, maintain attention, and articulate responses (Gutterman, O'Brien, & Young, 1987). In addition, most authors approach developmental differences in terms of age differences rather than in terms of cognitive or emotional development, which further limits our understanding of how developmental status may impact on self-reporting of depression (e.g., see Edelbrock et al., 1986).

Other explanations related to children's assumed inability to respond accurately to measures of depression include observations that children are less able to perceive symptom severity or make fine discriminations between symptoms (Kazdin, 1983c), or that they are able to perceive their symptoms but are protective of themselves when reporting to parents or clinicians (Treiber & Mabe, 1987). Poznanski (1982b) suggests that this latter problem may arise because children have been scolded or otherwise

reprimanded for behaviours or self-statements regarding their irritability or other disturbances. In addition, children may try to hide the intensity of negative feelings from others and to present a positive front (Poznanski, 1982b). Alternatively, young children (e.g., preschoolers) may deny sad feelings in an attempt to maintain a psychological distance from their sadness (Glasberg & Aboud, 1982). Although not typically addressed, the child's degree of psychiatric disturbance could also impact on their ability to self-report.

Much attention has been focused on children's inabilities to complete self-report measures of depression. However, literature in the growing fields of emotional understanding and self development suggests that children may have more capabilities in comprehending and communicating information about themselves than previously recognized.

Literature pertinent to emotion and self development will be presented in the following section. Then, a more detailed analysis of different models of self-concept will be considered, with special emphasis given to Harter's model of the determinants and mediational role of self-worth (e.g., see Harter et al., 1991).

Emotional Development in Children

This section will provide a review of recent literature in the area of children's developing understanding and

awareness of emotion concepts. Considerable research is accumulating attesting to children's abilities to identify and talk about emotions in themselves and others. For example, Bretherton and Beeghly (1982), and Dunn, Bretherton, and Munn (1987) report that by approximately 28 months of age, toddlers are able to talk about the feeling states experienced by themselves and others, and to discuss the causes and consequences of these feelings. In addition, Harter and Whitesell (1989) report that by age four, children can sort facial photographs of the six basic emotions into piles of "good" and "bad" feelings, and provide adequate descriptions of each (i.e., happy, love, sadness, anger, fear, surprise). Brody and Harrison (1987) investigated children's abilities to match and label a wide variety of emotional responses depicted by story characters. They determined that while preschool age and third and fourth grade children could match a large number of emotions, all children had difficulty labelling the emotions. These authors suggest that even young children may possess the ability to understand complex emotional situations despite their inability to generate specific emotion labels (Brody & Harrison, 1987).

Numerous investigators have documented preschool age and older children's abilities to infer emotional responses, causes, and consequences of emotional reactions in story characters (e.g., see Zelko, Duncan, Barden, Garber, &

Masters, 1986). In addition, Fabes, Eisenberg, McCormick, and Wilson (1988) documented that preschool age children were able to use this causal information to implement appropriate and effective "help" strategies to ameliorate peers' emotional distress.

Several authors have examined children's understanding of their own emotions. For example, Harris, Olthof, and Terwogt (1981) were interested in the extent to which children (ages 6, 11, and 15 years) would cite bodily, situational, or mentalistic cues in identifying their emotional responses. While all children used physiological or behavioral cues equally often, younger children relied on situational cues more often and rarely recognized or acknowledged the private or inner, mental aspects of emotions (Harris et al., 1981). These authors concluded that for young children (i.e., six year olds) emotion knowledge is comprised of two parts, an external display and a situational or external causal agent. Older children possess an additional component, knowledge of inner mental states when determining their own feelings.

A developing awareness of internal causes of emotion is also paralleled by changes in the awareness of and increasing ability to mask or strategically control emotional expressions (e.g., see Harter & Whitesell, 1989). Strategic control also implies an awareness of the impact of different emotions on the self and others (Terwogt & Olthof,

1989). Although young children (i.e., six year olds) are aware that emotions may be masked or re-directed, the mechanisms by which this may be achieved are primarily external (Harris et al., 1981). For example, changing the external facial display or changing the situation are strategies used by young children to alter emotional experiences. Older children possess a more adult-like model of emotional control, realizing that internal mental or cognitive states may be altered to effect a change in emotional state (Harris et al., 1981).

A developmental trend has also been documented in children's abilities to acknowledge the simultaneous experience of two or more emotions (Harter & Whitesell, 1989). For example, five year olds deny the simultaneous existence of emotions, but acknowledge that two emotions may exist sequentially. By age seven, children acknowledge the simultaneous existence of two emotions, but only if they possess the same valence (e.g., positive). By approximately age ten, children are able to appreciate the simultaneous experience of emotions of differing valence (Harter & Whitesell, 1989).

The social context may also be influential in directing and determining a child's knowledge or understanding of emotions (e.g., see Saarni, 1989). For example, the ability to experience the emotions of pride and shame requires the internalization of parental and societal values. Harter and

Whitesell (1989) determined that four and five year olds were unable to offer plausible, verbal examples of these emotions, while six to seven year olds could. However, this latter age group did not include references to the self when providing examples (e.g., parent feels proud if child ...) while eight year olds did (Harter & Whitesell, 1989).

In summary, it is apparent that children possess some ability to identify and conceptualize emotional experiences in both themselves and others. However, this ability is influenced by the age of the child and the type of emotional experience being investigated. Several developmental trends are also evident, with pre-adolescent children acknowledging the ability to experience more than one emotion at a time and identifying internal or psychological causes for some, if not all emotions.

Developmental acquisitions in the area of emotion knowledge are also paralleled by similar acquisitions in children's knowledge about the self. In the next section, children's knowledge about the self will be examined from a developmental perspective.

Self Development in Children

Emotion knowledge and self development share a number of developmental similarities. For example, the ability of toddlers to talk about the feeling states of themselves and others is considered indicative of an awareness of self (Bretherton & Beeghly, 1982). Also, awareness of the self

progresses from the recognition of physical, overt characteristics and possessions (e.g., has brown hair, owns a bike) to a more internal and conceptually based perspective (e.g., being popular, intelligent: Harter, 1985c; Stone & Lemanek, 1990; Rosenberg, 1986). This trend parallels the shift from a reliance on facial expressions and situational cues to internal representations as a way of understanding the emotions of the self (e.g., see Harris et al., 1981). The following section will examine in more detail the development of the self. A summary of emotion and self development in relation to child self-reports will then be presented.

According to Lewis (1986), development of a concept of self requires knowledge of the self as an agent of action, recognition of the self as separate from others, and an awareness of internal states. These abilities appear developed by approximately age two (e.g., see Lewis, 1986; Stone & Lemanek, 1990 for a review). The self-concept continues to develop over the life span, becoming more complex and differentiated with age (Rosenberg, 1986). For example, both Harter (1989) and Rosenberg (1986) have identified changes in children's self-concept with increasing age. Preschool age children typically describe the self in terms of easily observable, physical attributes, actions, and possessions (e.g., has blue eyes, can swim, owns a basketball: Harter, 1989). During childhood and

adolescence, descriptors of the self are organized into increasingly more abstract and conceptually based trait-like terms (e.g., attractive, athletic: Harter, 1989). Rosenberg (1986) has further clarified this distinction, suggesting that children move from a social exterior or focus on overt, visible aspects of the self to a psychological interior and the incorporation of thoughts and feelings into the self-concept. In addition, children move from a reliance on interpersonal linkages (e.g., have mother, father) to interpersonal sentiments (e.g., possess feelings for others) in describing the self (Rosenberg, 1986).

The self also becomes more differentiated with age. This differentiation is reflected in the greater number of domain specific judgments children make about the self. For example, Harter and Pike (1984) determined that preschool age children were able to make reliable judgments about two broad domains of behaviour (i.e., general competence, social acceptance). By age eight, this ability has increased to include five domains (i.e., Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, Behavioral Conduct: Harter, 1985a). Differences in accuracy have also been noted, with preschool age children generally providing overly-positive self-evaluations (Harter, 1990). By age eight, children are believed to rely on comparisons with others, feedback, and past experiences of successes and failures when making self-judgments (Harter, 1990).

In conjunction with self-concept acquisition is an increasing awareness of the role of others in the observation and evaluation of the self. According to Selman (1980), children between the ages of six and eight become more aware that others (e.g., parents, peers) observe and evaluate the self. However, they are not able to appreciate the perspective of others until approximately ages eight to ten. With age, children become increasingly able to incorporate the perceptions and evaluations of others into their own self-concept, to evaluate the self in terms of the standards and expectations of others, and to internalize these standards as their own (Selman, 1980). By age ten to twelve, children can examine the self from their own and another's perspective simultaneously. During these latter two stages, children also compare themselves to others, and according to Harter (1988), this act of social comparison provides the child with information regarding her/his competency or self-adequacy.

Intimately linked with the self-concept is the construct of self-esteem (Rosenberg, 1986). Self-esteem or self-worth generally refers to feelings of self-acceptance, self-liking, and self-respect (Rosenberg, 1986). Although evaluative judgments about the self's abilities and characteristics contribute to self-esteem, these judgments are not identical with or exclusively responsible for the experience of self-esteem (Rosenberg, 1986). Developmental

differences have been reported in children's abilities to evaluate self-esteem. According to Harter (1990), this ability develops around the eighth year.

In summary, during the years between eight and twelve there appears to be marked changes in children's emotional and self knowledge. Children increasingly rely on internal cues to understand their own and others' emotional experiences. Similar shifts occur in their understanding and knowledge about the self. Children also become more aware of the impact of others on their self-evaluations of competency and feelings of self-worth. One benefit of these developmental advances, according to Stone and Lemanek (1990), is children's improving abilities to complete self-report measures.

Relationship of Emotion Knowledge and Self Knowledge to Self-Reports of Depression

As reviewed above, children make considerable gains in emotional development and self knowledge and should be able to provide reliable and valid information regarding their thoughts and feelings (Stone & Lemanek, 1990). However, several caveats are in order. For example, Brody and Harrison (1987) observed that although preschool and latency age children could match examples of different emotions, even children in grade four had difficulty providing labels for some of the emotions. Second, although latency age children are developmentally capable of providing valid

accounts of their thoughts and feelings, their responses to self-report measures may reflect socially desirable responses (Stone & Lemanek, 1990). Finally, Harter (1988) drawing on the writings of Anna Freud (1965) has suggested that latency age children may not normally engage in the process of self-reflection. In fact, Harter (1988) does not believe that this process becomes fully operational until adolescence. This lack of self-reflection may impact on children's self-reports in some, as yet, undetermined way.

Even given the potential liabilities of children to report on their internal experiences, sufficient evidence exists to warrant further exploration of this phenomenon. In the following sections, different models of self-concept will be discussed, with special attention given to the model proposed by Harter (e.g., see Harter, 1986; Harter & Marold 1990; Harter et al., 1991). The relationship between childhood depression and Harter's model will then be considered.

Models of Self-Worth

A number of different conceptual models of the self have been developed. One similarity across all models is the emphasis on self-evaluations or judgments about the competency or adequacy of the self (Harter, 1985c). Some authors approach the self-concept from a unitary perspective (e.g., see Coopersmith, 1967). For example, evaluations of the self across a number of different domains (e.g., family,

school, peers) are grouped together as a single construct of the self (Coopersmith, 1967). In this approach, no distinction is made between the contributions of judgments of domain specific abilities and feelings of self-worth to the individual's overall sense of self (Harter, 1990).

Rosenberg (1979) and Harter (1985c) believe that various attributes or characteristics of the self contribute differentially to the individual's overall judgment of self-worth. Rather than examining the relationship between self-evaluations and self-worth, Rosenberg has focused primarily on the individual's perceptions of global self-worth (e.g., general life satisfaction, positive feelings towards the self). He has determined that children and adolescents who report low self-worth also report feelings of depression and anxiety.

Harter (1986) has proposed an alternate approach to the self which underscores the importance of both global judgments of self-worth as well as evaluations of domain-specific competencies. As an assessment tool for her approach, Harter (1985a) has developed a self-report measure of perceived competence and global self-worth. The Self Perception Profile for Children (SPPC) assesses self-evaluations of competence in five discrete domains (e.g., Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, and Behavioral Conduct) and Global Self-Worth. In addition, Harter (1985c) believes that

the self is not a static entity but undergoes change with develcpment. As such, she includes an increasing number of domains in her measures of perceived competence for children, adolescents, and adults (e.g. see Harter, 1985a; Harter & Pike, 1984). Harter has incorporated her work on the self-concept into a model of the determinants and mediational role of self-worth (Harter et al., 1991). This model will be examined in some detail in the following section.

The Determinants and Mediational Role of Self-Worth

Harter and associates have given considerable attention to the determinants and mediational role of self-worth (Harter & Marold, 1990; Harter, et al., 1991). Harter's (Harter, 1986) original goal was to identify the determinants or antecedents of self-worth and to examine the functional role of self-worth in mediating affect along the dimension from cheerful to sad. She has since made numerous modifications to her model and is currently pursuing potential risk factors associated with adolescent suicidal ideation (Harter & Marold, 1990; Harter et al., 1991). This aspect of her model is predicated on the increasing emphasis of cognitive features associated with depression, especially those involving negative self-evaluations (e.g., see Poznanski, 1982a; Weinberg et al., 1973). Harter's model of the determinants and mediational role of self-worth is summarized below.

Some of the constructs included in Harter's model are based on the formulations of William James (1892, cited in Harter, 1986) and Charles Horton Cooley (1902, cited in Harter, 1986). James (1892) postulated that global self-esteem was related to an individual's judgment of competence in discrete domains or areas of behaviour and the importance of success they attached to these domains. He further reasoned that individuals judge success in some domains to be more important than success in other domains. Competence, or lack there of, in domains judged important to the individual was suggested to affect self-worth.

Harter (1985a) has attempted to operationalize James' formulations by developing a companion measure to the SPPC. The Importance Rating Scale (IRS) asks children to evaluate how important each of the five domains of the SPPC is to how they feel about themselves as a person. Comparisons are then made between the children's ratings of importance and ratings of competence for each of the SPPC domains. Harter and Marold (1990) have determined that judgments of competence in domains where success is considered important strongly predicts global self-worth (r = .70) while competence in domains considered unimportant is more weakly related to self-worth (r = .30: Harter & Marold, 1990).

A second postulate of James' predicted that discrepancies between ratings of importance and perceived competence would also affect judgments of self-worth. For

example, when importance scores are larger than perceived competence scores, low self-worth is predicted (Harter, 1986). Harter (1986) compared importance and competence scores for each of the five domains of the SPPC for three groups of children in grades 5 and 6 with high, medium, and low self-worth. She determined that children with low self-worth had the largest discrepancy between ratings of importance and competence while children with high self-worth had the smallest discrepancy. The relationship between discrepancy scores and self-worth for this sample was $r = -.76$. This relationship suggests that lack of competence in domains considered to be important to the self may impact negatively on self-worth.

Harter has extended her application of the importance of success in discrete domains to parents and peers as well. According to adolescent self-reports, feelings of competence in the domains of Scholastic Competence and Behavioral Conduct are judged to be more important to parents than are competencies in the three other domains of the SPPC. In contrast, success in the domains of Social Acceptance, Athletic Competence, and Physical Appearance are judged to be more important to peers. Harter and Marold (1990) defined these two constellations of domains as self-concept clusters one and two, respectively. An examination of the relationship between these two clusters and self-worth indicates that competence in domains considered important to

parents and peers is predictive of self-worth (r = .50 to r = .60: Harter & Marold, 1990).

Based on James' formulations, Harter (1986) has also explored the ability of children to protect or enhance their feelings of self-worth. Harter has documented two potential strategies associated with self-enhancement or protection: (a) the ability to discount the importance of domains in which one is judged to perform incompetently; and (b) the over-estimation of competence in domains judged to be important. For example, Harter (1986) observed that, unlike children with high self-worth, children with low self-worth were less likely to discount those domains in which they perceived themselves to be less competent. In fact, these children seemed to judge their least competent domain as equal in importance to their most competent domain. From these results, Harter suggests that the ability to discount the importance of domains in which one is not competent is strongly related to one's overall sense of self-worth.

Another strategy related to self-protection or enhancement involves the ability to inflate one's sense of competence in domains considered important (Harter, 1986). Child-teacher comparisons of perceived competence were evaluated for groups of high and low self-worth children. Children with high self-worth were observed to rate themselves as slightly more competent across domains of high and low competence than did their teachers. Children with

low self-worth did not inflate their feelings of competence and tended to rate themselves less competently in their least competent domain when compared to their teachers. Although the magnitude of the discrepancies was not large, Harter (1986) suggests that children with low self-worth may evidence a systematic bias to judge themselves, especially in their least competent domain, more harshly than do others.

Cooley's formulations about the self suggest that the self is a social construction, based on the perceived opinions of significant others (Harter, 1986). Cooley suggested that social support, in the form of positive regard from significant others, would be predictive of self-worth. To assess this assumption, Harter developed the Social Support Scale for Children and Adolescents (SSSC: Harter, 1985b). The SSSC is a self-report scale designed to measure children's perceptions of the opinions of others about the self (e.g., do significant others acknowledge their worth, treat them like a person, listen to them?) across four domains of support (e.g., Teachers, Parents, Classmates, and Close Friends). Harter and Marold (1990) determined that perceived positive regard from both parents and peers was highly predictive of self-worth (average r = .60).

Relationship of Self-Worth to Affect. Harter has also focused attention on the relationship between self-worth and

self-reported affect (e.g., see Renouf & Harter, 1990). To examine this relationship, Harter and associates (Harter & Nowakowski, 1987) developed a self-report depression inventory, the Dimensions of Depression Scale for Children and Adolescents (DDPC). The DDPC was designed to assess five theoretically derived dimensions of childhood depression: Mood/Affect, Self-Worth, Energy/Interest, Self-Blame, and Suicidal Ideation (Harter & Nowakowski, 1987). Correlations between self-worth and affect, along a continuum from cheerful to depressed, as assessed by the DDPC Mood/Affect subscale indicated a strong positive relationship (r = .70 to .82: Harter & Marold, 1990; Renouf & Harter, 1990). This finding suggests that older children and adolescents with low self-worth report depressed affect, while those with high self-worth report cheerfulness (Renouf & Harter, 1990). In addition, factor analysis of the DDPC revealed a four factor solution, with Self-Worth and Mood/Affect defining one factor. According to Renouf and Harter (1990) this observation suggests that the degree to which one is sad or depressed is highly related to one's general attitude towards the self. Renouf and Harter (1990) also found that changes in affect and self-worth were highly related over a twelve month period in their sample of adolescents. For example, those adolescents who became depressed over the school year also reported lowered self-worth scores. These authors argue that their findings support the relationship

between self-deprecatory ideation (i.e., low self-worth) and depression.

Subsequent to Renouf and Harter (1990), Harter (e.g., see Harter & Marold, 1990; Harter et al., 1991) added a new subscale to the DDPC, a general hopelessness subscale. The General Hopelessness subscale assesses hopelessness about the future. Correlations between this subscale, Self-Worth, and Mood/Affect have revealed high intercorrelations (e.g., Self-Worth and Mood/Affect, r = .82; Self-Worth and Hopelessness, r = .83; and Hopelessness and Mood/Affect, r = .77: Harter et al., 1991). Because of the observed high intercorrelations, Harter and Marold (1990) have suggested that these three constructs be combined to represent a single factor. This factor has been labelled the Depression Composite and frequently replaces self-worth as a mediator of behaviour in her model (Harter et al., 1991). In addition, Harter et al. (1991) have determined that any one of the constructs comprising the Depression Composite can be used in their model of the predictors of suicidal ideation with adolescent populations.

Finally, Harter (Harter & Nowakowski, 1987) examined the relationship between the Mood/Affect subscale of the DDPC and the Children's Depression Inventory (CDI: Kovacs, 1992) and three other subscales of the DDPC believed to assess primary symptoms of childhood depression (i.e., Self-Worth, Energy/Interest, Self-Blame). The CDI is a derivative

of the Beck Depression Inventory and assesses a wide variety of symptoms associated with childhood depression (Kovacs, 1992). Harter and Nowakowski (1987) determined that correlations between Mood/Affect and Self-Worth, Mood/Affect and Energy/Interest, and Mood/Affect and Self-Blame ranged from r = .47 to r = .75, and were greater than those between the CDI and these three subscales (r = .28 to r = .40). Harter and Nowakowski (1987) attributed this finding to the observation that the CDI comprises a mixture of both primary and secondary symptoms of depression. Harter concluded that the Mood/Affect subscale was more highly related to other, theoretically derived constructs of depression as tapped by the DDPC than was the CDI.

Discussion of Harter's Model of the Determinants and Mediational Role of Self-Worth

The culmination of Harter's work has resulted in a model of the determinants and mediational role of self-worth in adolescents. Harter's model suggests that numerous constructs such as perceived competence in specific domains, importance of success in those domains, importance of those domains to parents and peers, and perceived social support from significant others may impact on an individual's feelings of global self-worth which in turn impacts on their behaviour. This model can be further broken down into four separate components: (1) constructs that impact on perceived support from peers; (2) constructs that impact on perceived

support from parents; (3) constructs that impact on an individual's mood and feelings of self-worth (i.e., the Depression Composite); and (4) constructs that impact on suicidal ideation. For example, feelings of sadness, low global self-worth, and limited parent support are considered to be predictive of suicidal ideation in adolescents (Harter et al., 1991). Constructs believed to impact on the Depression Composite (DC) include feelings of competence associated with the two self-concept clusters, Scholastic Competence-Behavioral Conduct (SBC), and Athletic Competence-Social-Acceptance-Physical Appearance (ASP) as well as perceptions of peer and parent support. Harter has also explored feelings of hopelessness at achieving competency in domains judged important to the self, and feelings of hopelessness at obtaining support from significant others as impacting on the Depression Composite (Harter et al., 1991).

Harter (e.g., see Harter & Marold, 1990; Harter et al., 1991) has documented empirical support for this model with adolescents from a normative sample. She has determined that the Depression Composite, comprised of low self-worth, depressed affect, and general hopelessness acts as a mediator between domain specific judgments of competence and social support and suicidal ideation. The value of this model is considerable as it provides a framework within which to identify potential precursors of suicidal

behaviour.

Relationship of Harter's Model to Childhood Depression

Harter's model has a number of interesting implications for childhood depression. Of primary significance is the relationship between feelings of self-worth and affect. Typically, children and adolescents who report low self-worth also report sad or depressed feelings (Renouf & Harter, 1990). This observation provides support for the relationship between negative self-evaluations and depression suggested by various authors (e.g., see Kovacs & Beck, 1977; Kaslow, Rehm & Seigel, 1984).

Self-worth may also influence the accuracy of child self-reports. For example, greater congruence was reported for teacher and child assessments of competence for a group of children with low self-worth (Harter, 1986). This finding was replicated with a group of children identified to be depressed by their classroom teachers (Harter, 1986). Harter (1986) suggests that depressed children may be quite realistic in the assessment of their strengths and weaknesses. The observation that children with low self-worth may provide more realistic appraisals of their competencies may also apply to measures of internal or covert behaviours (i.e., thoughts, feelings) typically associated with depression. As such, it is hypothesized here that children who report low self-worth should also demonstrate more congruence with parent reports of

depression than do children with high self-worth.

Finally, Harter's model illuminates the importance of identifying children who may experience low self-worth as these children may also be at risk for depression, feelings of hopelessness, and suicidal ideation as they approach and reach adolescence. The model also enables identification of the potential risk factors or antecedents (e.g., lack of competence in domains considered important; lack of social support from family or friends) associated with depression and possible suicidal ideation. Although suicide completion is believed to be rare among elementary school age children, there is a dramatic increase in completion rates in adolescence (Pfeffer, 1988). This trend strongly argues for the identification of factors prior to adolescence that may lead to suicidal ideation and behaviour during adolescence (Asarnow, 1992).

The Present Study

The first goal of the present study was to examine a number of variables that might be related to parent-child agreement. These variables included the specificity of the self-report measure used, the child variable of self-worth, and the parent variable, degree of parent depression. Currently, little is known about situational or personal factors that might impact on parent-child agreement. For example, agreement between informants may be improved if a

few discrete symptom areas are assessed in detail. The first hypothesis was that the specificity of a measure of childhood depression would impact positively on parent-child agreement. Alternatively, the personal characteristics of informants, such as child feelings of self-worth or parental depression were considered as having a possible impact on agreement. Thus, the second hypothesis addressed whether parent-child agreement would be greater for children with low global self-worth as compared to children with high global self-worth; the third hypothesis was that a positive relationship would be found between parent self-reports of depression and parent reports of depression in their children.

A final interest of the present study was the applicability of Harter's model of the determinants and mediational role of self-worth with elementary school age children. Support for Harter's model may provide an avenue for the early identification and intervention for children at risk for depression and suicidal ideation. The fourth hypothesis, therefore, was that child self-reports and parent reports of child functioning in elementary school age children would support Harter's model.

Hypothesis I. According to Harter (Harter & Nowakowski, 1987), the DDPC assesses five discrete or primary symptom areas of childhood depression. In contrast, the CDI (Kovacs,

1992) taps depressive symptoms that encompass both primary and secondary symptoms and may identify children at risk for a number of different problems but not necessarily those children most at risk for depression (Harter & Nowakowski, 1987). The specificity of discrete symptom areas, as assessed by the DDPC, may be related to higher levels of parent-child agreement. Thus, it was hypothesized that parent-child agreement would be greater for the domain-specific subscales of the DDPC than for the CDI. In addition, the direction and magnitude of child and parent reports on these measures was examined.

Hypothesis II. Based on Harter's (1986) observation that agreement between teachers and children was higher for children with low self-worth, it was predicted that children who reported low global self-worth on the SPPC would demonstrate greater parent-child agreement for the global CDI score and the subscales of Harter's three measures (i.e., SPPC, SSSC, DDPC) than children with high global self-worth.

Hypothesis III. The relationship between parental depression and parent and child reports of child functioning on the Depression Composite (DC) and CDI total score were explored. A positive relationship was expected between level of self-reported parental depression and parent reports of

child functioning on the DC and the CDI. In addition, a positive relationship was expected between level of self-reported parental depression and child self-reports of depression on the DC and the CDI.

Hypothesis IV. Although most of Harter's measures (i.e., SPPC, SSSC, DDPC) are designed for use with latency age children, Harter and associates (e.g., see Harter et al., 1991) have tested her model most extensively with adolescents. The applicability of this model to younger age children is important in terms of the early identification of children at risk for low self-worth, depression, and suicidal ideation. The application of this model to children in grades 4 through 6 was explored using child self-reports and parent reports. It was hypothesized that child and parent reports would provide support for Harter's model.

CHAPTER II

METHOD

Subjects

A total of 103 children (55 female, 48 male) in grades 4, 5, and 6, 92 female caregivers, and 43 male caregivers participated in the study. The children were drawn from regular education classes in eight Roman Catholic elementary schools in south-western Ontario. Across schools, the number of child-caregiver participants varied from 4 to 22 percent, with an average participation rate of 11 percent. Four families, or four percent of the sample were dropped from the study because of incomplete parent data; seven families, or seven percent of the sample had two children who participated in the study. Only one child from each family was included in all analyses. These exclusions resulted in 92 children (49 female and 43 male), 92 female caregivers, and 39 male caregivers who participated in the study. Of the 92 children, 53 comprised child-female caregiver dyads, while 39 comprised child-female caregiver-male caregiver triads. The number, grade, gender, and mean age of the children, and participation by dyad or triad is presented in Table 1.

Demographic Characteristics of the Caregivers. All adult participants were asked to complete a Background Information Form (BIF) (See Appendix A). Information on non-participating male caregivers (N = 53) was obtained from the

Table 1

Number of Children, Their Grade, Gender, Mean Age, and Participation by Female and Male Caregivers

Grade	Gender	Number of Children		Age (yr mn)	Caregiver: Female Only (Dyad)	Caregiver: Female & Male (Triad)	
4	Girls	16	M	9-6	7	9	
			SD	0-5			
4	Boys	18	M	9-8	10	8	
			SD	0-9			
Total					17	17	34
5	Girls	16	M	10-4	12	4	
			SD	0-4			
5	Boys	16	M	10-5	11	5	
			SD	0-4			
Total					23	9	32
6	Girls	17	M	11-7	7	10	
			SD	0-4			
6	Boys	9	M	11-4	6	3	
			SD	0-3			
Total					13	13	26
Total					53	39	92

Note: Male caregivers did not participate independently of female caregivers, thus the number of male caregivers equals the number of female-male caregiver pairs who participated.

female caregiver; information on the participating male caregiver (N = 39) was obtained from the male caregiver. Ninety-eight percent of the female caregivers and 90% of the participating male caregivers were biological parents of the children; the remaining respondents were either adoptive, step- or grand-parents. In addition, 80% of the female and 95% of the participating male caregivers were married, while the remainder of the sample were either separated, divorced, living common-law, or widowed. A majority of the respondents were Caucasian (90% female, 92% male) with Hispanic, African-Canadian, and other ethnicities comprising the rest. See Table 2 for Marital Relationship and Relationship of the Caregiver to the Child Informants, and Table 3 for Ethnicity of the Caregivers.

A majority of the participating adult sample reported either full or part time employment (females: 24% part time, 41% full time; males: 90% full time), with the remainder reporting either unemployment (females: 33%; males: 8%) or no information (females: 2%; males: 2%). Most female and approximately half of the male adult respondents reported completing high school or receiving some college or university training (females: 29.3% high school, 53.3% college or university; males: 18.5% high school, 18.5% college or university). Table 4 summarizes the Educational Status of the Caregivers. Table 5 presents the Socio-Economic Status (SES) of the adult respondents based on

Table 2

Marital Relationship and Relationship of the Caregiver to the Child Informants

	Female Participant N = 92		Male Non-Participant N = 53		Male Participant N = 39	
	Freq.	(%)	Freq.	(%)	Freq.	(%)
Marital Relationship						
Married	73	(79.3)	28	(52.8)	35	(90.0)
Divorced	7	(7.6)	1	(1.9)	1	(2.5)
Separated	6	(6.5)	0	(0.0)	2	(5.5)
Single	0	(0.0)	0	(0.0)	0	(0.0)
Common-Law	4	(4.3)	2	(3.8)	1	(2.2)
Widowed	2	(2.2)	0	(0.0)	0	(0.0)
No Response	0	(0.0)	22	(41.5)	0	(0.0)
Total	92	(100.0)	53	(100.0)	39	(100.0)
Relationship to Child Informants						
Biological	90	(98.0)	24	(45.3)	35	(90.0)
Adoptive	1	(1.0)	1	(1.9)	1	(2.5)
Step-parent	0	(0.0)	5	(9.4)	2	(5.0)
Grandparent	1	(1.0)	0	(0.0)	1	(2.5)
No Information	0	(0.0)	23	(43.4)	0	(0.0)
Total	92	(100.0)	53	(100.0)	39	(100.0)

Table 3

Ethnicity of the Caregivers

	Female Participant	Male Non-Participant	Male Participant
	N = 92	N = 53	N = 39
Ethnicity	Freq. (%)	Freq. (%)	Freq. (%)
Caucasian	82 (89.1)	28 (52.8)	36 (92.3)
African-Canadian	0 (0.0)	0 (0.0)	1 (2.5)
Hispanic	1 (1.1)	0 (0.0)	0 (0.0)
Other	4 (4.3)	0 (0.0)	1 (2.5)
No Information	5 (5.4)	25 (47.2)	1 (2.5)
Total	92 (100.0)	53 (100.0)	39 (100.0)

Table 4

Educational Status of the Caregivers

Educational Status	Female Participant N = 92 Freq. (%)	Male Non-Participant N = 53 Freq. (%)	Male Participant N = 39 Freq. (%)
Less than 7 years	1 (1.1)	0 (0.0)	0 (0.0)
Grade 7-9	5 (5.4)	1 (1.9)	1 (2.5)
Grade 10-12	4 (4.3)	10 (18.9)	11 (28.2)
High School Diploma	27 (29.3)	10 (18.9)	7 (18.0)
Some College, University	23 (25.0)	3 (5.6)	7 (18.0)
College, University Degree	26 (28.3)	3 (5.6)	4 (10.3)
Graduate Work or Degree	5 (5.4)	0 (0.0)	8 (20.5)
No Information	1 (1.1)	26 (49.1)	1 (2.5)
Total	92 (100.0)	53 (100.0)	39 (100.0)

Table 5

Socio-Economic Status (SES) of the Caregivers

SES	Frequency	(%)
I	10	(10.9)
II	14	(15.2)
III	21	(22.8)
IV	11	(12.0)
V	4	(4.3)
No Information	32	(34.8)
Total	92	(100.0)

Note: SES computed using Hollingshead's (1975) criteria

I = Major business and professional;
II = Medium business, minor professional, technical;
III = Skilled craftsmen, clerical, sales workers;
IV = Machine operators, semi-skilled workers;
V = Unskilled labourers, menial service workers

Hollingshead's (1975) criteria. SES was determined for each family based on educational and occupational information provided by the female caregivers for themselves and their non-participating spouse (N = 53), and by female caregivers and their participating spouse (N = 39). A majority of the sample reported an SES equivalent to level III or greater (e.g., Skilled Craftsmen, Clerical, or Sales Workers: Hollingshead, 1975). Mean income level for the sample was approximately $48,000. Thirty-two percent of the sample reported an income between $10,000.00 to $40,000.00; 27% reported an income between $41,000.00 to $50,000.00; and 39% reported an income greater than $51,000.00.

Last, twenty-five families reported receiving some form of counselling services concurrently or in the past. The number and recipients of these counselling services are presented in Table 6.

Measures

The following questionnaires were used in the present study. Children completed the Self-Perception Profile for Children (SPPC: Harter, 1985a), the Social Support Scale for Children and Adolescents (SSSC: Harter, 1985b), the Dimensions of Depression Scale for Children and Adolescents (DDPC: Harter & Nowakowski, 1987), and the Children's Depression Inventory (CDI: Kovacs, 1992). Children also completed a cover sheet requesting their name, grade, and

Table 6

Number of Families Who Received Counselling Services

	Freq. (%)
No counselling	65 (70.7)
Counselling	25 (27.2)
No Response	2 (2.2)
Total	92 (100.0)

Recipients of Counselling Services

	Freq. (%)
Adult Female	8 (32.0)
Adult Male	1 (4.0)
Child	2 (8.0)
Mother-Child Dyad	6 (24.0)
Mother-Father-Child Triad	1 (4.0)
Mother-Father Dyad	5 (20.0)
No Response	2 (8.0)
Total	25 (100.0)

birthdate (See Appendix B). Parents completed the Parent Rating Scale (PRS: Harter, 1985a), a companion measure to the SPPC. Modifications were made to the wording of the SSSC, DDPC, and CDI questionnaires so that parents could evaluate their children on these measures (See Appendix C, D, and E, for a sample of items comprising the SSSC-P, DDPC-P and CDI-P). Written permission was obtained from Dr. Harter and from the publishers of the CDI to make these alterations. Parents also completed the Beck Depression Inventory (BDI: Beck & Steer, 1987).

Self-Perception Profile for Children (SPPC). The SPPC represents a revision of the Perceived Competence Scale for Children (Harter, 1982) and taps children's domain-specific judgments of their competency or self-adequacy in five areas plus feelings of global self-worth. Scholastic Competence measures children's perceptions of their competence in school related activities; Social Acceptance measures the degree to which children feel accepted by peers, feel popular, and have friends; Athletic Competence measures items related to sports and outdoor games; Physical Appearance measures the degree to which children are happy with their outward appearance (i.e., height, weight, face, hair); Behavioral Conduct measures children's perceptions of the way they behave and do the things they are supposed to do; and Global Self-Worth measures the extent to which children like themselves as a person and feel happy about

the way they are leading their life.

Each subscale consists of six items with half of the items worded such that the first part of the statement reflects high competence or adequacy. Item scores ranging from one to four are averaged for each domain. High item/domain scores reflect competency while low scores reflect inadequacy. Separate scores for each subscale permit a profile analysis of each child's evaluative judgments. Items are presented in a repeating order throughout the SPPC (i.e., Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, Behavioral Conduct, Global Self-Worth).

Item presentation uses a structured alternative format which presents two contrasting descriptions of child behaviour. After reading an item, children decide which child is most like them, the one described in the first part of the statement or the one described in the second part of the statement (e.g., see Harter, 1985a). After selecting the statement that is most true for them, they then decide whether this statement is only sort of true or really true for them. This question format was designed to overcome socially desirable responding as well as to legitimize either choice by allowing the child to identify with existing groups of children (Harter, 1985a).

The SPPC may be administered individually or in groups. Items are read aloud and children are reminded to select

only one response option per statement. The questionnaire completed by the child is entitled What I Am Like and is designed for children in grades three through six. Parents completed the Parent Rating Scale (PRS: Harter, 1985a), a companion measure to the SPPC for comparison purposes.

Psychometric data for samples of elementary (grades 3-6) and junior high school (grades 6-8) children indicate acceptable internal consistency (Cronbach's Alpha: range .71 [Behavioral Conduct] to .86 [Athletic Competence]) (Harter, 1985a). Intercorrelations between domain specific-subscales indicated two clusters, Scholastic Competence and Behavioral Conduct ($\underline{r}$ = .29 to $\underline{r}$ = .58) and Social Acceptance, Athletic Competence, and Physical Appearance ($\underline{r}$ = .29 to $\underline{r}$ = .53). Self-Worth also correlated more highly with Physical Appearance ($\underline{r}$ = .62 to $\underline{r}$ = .73) than with the other subscales ($\underline{r}$ = .30 to $\underline{r}$ = .64). Factor analysis revealed a five factor structure corresponding to the five domain-specific subscales of the SPPC.

Parent Rating Scale (PRS). The PRS parallels the SPPC and asks parents to rate children's actual behaviour across five domains of competence (Harter, 1985a). Previous testing has indicated that three items per domain are sufficient to obtain highly reliable judgments. Items are worded, listed, and scored in the same manner as the SPPC. This scale can be used with other adults (e.g., teachers, therapists, etc.)

Social Support Scale for Children and Adolescents (SSSC). The SSSC assesses the degree to which children perceive that significant others care for them as a person and like them the way they are (Harter, 1985b). The SSSC taps four areas of perceived support and positive regard. Parent Support assesses the extent to which children feel their parents understand them and want to hear about their problems; Classmate Support assesses whether classmates are friendly and don't make fun of them; Teacher Support assesses the extent to which teachers help them do their best and are fair to them. These three subscales assume that these people exist in the child's life. In contrast, the Close Friend subscale does not make this assumption and asks whether the child has a close friend they can tell their problems to and who they can complain to about things that bother them.

Individual scale composition and administration follows the format for the SPPC. Each subscale consists of six items; half are worded such that the first part of the statement reflects positive regard and are presented using the structured alternative format; item scores range from one to four with a score of one representing lack of positive regard; scores are averaged for each domain and items are presented in a repeating order throughout the SSSC. The questionnaire completed by the child is entitled People in My Life and is designed for children in grades

three through eight. To allow comparisons between parents and children, the SSSC was modified for use in the present study (Social Support Scale for Children and Adolescents-Parent Form, SSSC-P). The questionnaire completed by parents was entitled People in My Child's Life and a subset of items is presented in Appendix C.

Psychometric data for samples of elementary (grades 3-6) and junior high school (grades 6-8) children indicate acceptable internal consistency (Cronbach's Alpha: range .72 [Close Friend] to .88 [Parent]) (Harter, 1985b). Factor analysis revealed a three factor solution (Parent, Teacher, Classmate-Close Friend) for the younger children and a four factor solution for the older children (Parent, Teacher, Classmate, and Close Friend). Intercorrelations ranged from r = .27 (Teacher-Close Friend) to r = .57 (Classmate-Close Friend) with the majority in the low to moderate range (r = .30 to r = .43). The high intercorrelation between the Classmate-Close Friend subscales for the younger children is consistent with the factor analysis results. Convergent validity was also demonstrated between reports of Classmate Support and Social Acceptance as measured by the SPPC (r = .62, grade 3-6; r = .69, grade 6-8).

Dimensions of Depression Profile for Children and Adolescents (DDPC). The DDPC (Harter & Nowakowski, 1987) assesses the following domains: Mood/Affect, which measures the extent to which children feel cheerful and happy versus

sad and depressed; Self-Blame, which measures whether children blame themselves when things do not go right, or feel that it is their fault when things go wrong; Self-Worth, which measures the degree to which children like themselves as a person; Energy/Interest, which measures the degree to which children feel they have the energy to do things, feel wide awake, and find it easy to get up in the morning; and Suicidal Ideation, which measures the extent to which children think about killing themselves, do not care if they die, and want to commit suicide.

Individual scale composition and administration follows the format for the SPPC and SSSC. Each subscale consists of six items; half are worded such that the first part of the statement reflects positive experiences or feelings; items are presented using the structured alternative format; item scores range from one to four with a score of one representing a negative experience or feeling; item scores are averaged for each domain; and items are presented in a repeating order throughout the DDPC (i.e., Mood/Affect, Self-Blame, Self-Worth, Energy/Interest, and Suicidal Ideation). The questionnaire completed by the child is entitled What's True For Me and is designed for children in grades three through eight. A modified version of the DDPC, the Dimensions of Depression Profile for Children and Adolescents-Parent Form (DDPC-P) was created for comparison purposes (See Appendix D). The measure completed by parents

was entitled What's True For My Child.

Psychometric data for samples of elementary (grades 3-6) and junior high school (grades 6-8) children indicate acceptable internal consistency (Cronbach's Alpha: range .72 [Energy/Interest] to .90 [Suicidal Ideation]) (Harter & Nowakowski, 1987). Intercorrelations ranged from r = .75 to r = .82 for the Self-Worth and Mood/Affect subscales, and from r = .50 to r = .65 for the other domains. Factor analysis revealed a four factor solution, with Mood/Affect and Self-Worth defining a single factor and the other three subscales representing separate factors. Validity indices indicate adequate convergent validity, construct validity, and discriminant validity (Harter & Nowakowski, 1987).

Children's Depression Inventory (CDI). The CDI, a derivative of the Beck Depression Inventory (Beck, 1967), is a 27 item self-report symptom-oriented scale designed for children and adolescents between 8 and 17 years (Kovacs, 1992). Items sample behaviours associated with childhood depression (e.g., disturbed mood, hedonic capacity, self-evaluations, and vegetative functions) and provide three response options keyed from 0 to 2, in the direction of increasing severity. Total symptom scores range from 0 to 54.

The CDI was initially designed for individual administration in clinical research settings. However, the CDI has been group-administered by researchers and teachers

without difficulties (Reynolds et al., 1985). All CDI items and response options are read aloud. Children are encouraged to read along silently with the researcher. For older children, oral administration can be discontinued once task comprehension is determined. Children are reminded throughout the administration to respond to each item on the basis of their feelings and ideas over the last two weeks. Parents completed a modified version of the CDI, the Children's Depression Inventory-Parent Form (CDI-P) for comparison purposes (See Appendix E).

Using psychiatric (PS), pediatric medical (PM) and Canadian school populations (CS), Kovacs (e.g., see Kovacs, 1985 for a review) found the CDI had adequate internal consistency estimates (Cronbach's Alpha .70 to .86), item-total score correlations (PS: $\underline{r}$ = .29 to $\underline{r}$ = .62; CS: $\underline{r}$ = .31 to $\underline{r}$ = .54), and test-retest reliability (PM: $\underline{r}$ = .82; PM; CS: $\underline{r}$ = .72) (Kovacs, 1985). Factor analysis revealed a single factor solution for the CS group (see Kovacs, 1985). Concurrent validity was demonstrated with the Children's Manifest Anxiety Scale ($\underline{r}$ = .65, $\underline{p}$<.0001) and the Self-Esteem Inventory ($\underline{r}$ = .59, $\underline{p}$<.0001) in a psychiatric sample (Kovacs, 1985). While the CDI appears unable to discriminate between normative children and a heterogeneous psychiatric population, Kovacs et al., (1984) reported that the scale was successful in discriminating between certain DSM-III categories (e.g., Major Depressive

Disorder (MDD) versus MDD in partial remission; MDD versus Adjustment Disorder).

Beck Depression Inventory (BDI). The BDI is a 21 item self-report measure of adult depression (Beck & Steer, 1987). Items assess cognitive, affective, vegetative, and somatic symptoms and are rated on a four point scale from 0 to 3, in the direction of increasing severity. Total symptom scores range from 0 to 63. Parents completed the BDI as part of the questionnaire package.

Beck and Steer (1987) report high internal consistency estimates for the BDI with both clinical and nonclinical populations (Cronbach's Alpha .86 and .81, respectively). Although not designed to discriminate across different psychiatric diagnoses, the BDI has been shown to discriminate between Dysthymic and MDD (Steer, Beck, Brown & Berchick, 1987) and between MDD and Generalized Anxiety Disorders (Steer, Beck, Riskind, & Brown, 1986).

Procedure

After clearance was received from the University of Windsor Psychology Department Ethics Committee, school superintendents in south-western Ontario (N = 4) were contacted by mail to request that schools in their respective districts participate in the study. After approval was obtained from one school board, school principals were contacted by mail and through a follow-up

phone call to request their participation in the present study (N = 16). School superintendents and principals received an information package containing all information to be distributed to parents including letters of recruitment and copies of the questionnaires.

Principals/schools that agreed to participate (N = 8) distributed information letters and consent forms to all children in grades four through six (See Appendices F, G, and H, for Letter of Introduction to Parents/Guardians, Parent's/Guardian's Information Sheet, and Parent's/Guardian's Consent Form). After written consent was obtained from parents, a package containing Parent Instructions (See Appendix I), the Background Information Form (BIF) and the five questionnaires (PRS, CDI-P, DDPC-P, SSSC-P, BDI) was mailed to their homes. Parents completed one of two questionnaire orders that were counterbalanced across parent and child gender (Order 1: BIF, PRS, CDI-P, DDPC-P, SSSC-P or Order 2: BIF, PRS, DDPC-P, CDI-P, SSSC-P). In families in which both parents/care-givers participated, respondents were asked not to collaborate when completing the questionnaires and all parents were asked not to discuss item content with their child prior to the child's participation. Parents were requested to complete the questionnaires and return them within a two week period. Follow-up calls were made to some parents to remind them to return the completed packages. Children did not participate

in the study until parents returned their completed questionnaires.

Children were administered the SPPC, CDI, DDPC, and SSSC in a group setting in their respective schools. Group size ranged from one to 17 children and varied as a function of the number of children participating per school, the number of children in attendance on the day of testing, and principal preferences for the least number of visits to the school. In some cases, children completed the measures individually because they had been absent from school during the scheduled group administration. All questionnaires were completed in one session which was approximately 45 to 60 minutes in length.

The order of administration of the questionnaires completed by the children was also counterbalanced across gender and schools where possible. Children either completed the SPPC, CDI, followed by the DDPC and SSSC (Order 1) or the SPPC, DDPC, followed by the CDI and SSSC (Order 2). Equal numbers of children completed each of the two orders. However, differences occurred in the number of boys and girls at each grade level who completed either Order 1 or Order 2. Table 7 summarizes this information.

Prior to completing the questionnaires, children read and signed an assent form and were given the opportunity to withdraw from the study (See Appendix J). No children withdrew from the study. Standardized administration

Table 7

Grade, Gender, and Number of Children Who Completed Questionnaire Order One Versus Questionnaire Order Two

Grade	4		5		6		
Gender	Girls	Boys	Girls	Boys	Girls	Boys	Total
Order 1	9	9	8	10	7	3	46
Order 2	7	9	8	6	10	6	46
Total	16	18	16	16	17	9	92

procedures were followed. Instructions and individual items were read aloud and children were encouraged to read along silently at their desks (See Appendix K). Upon completion of the questionnaires, children were given a thank-you note to take home to their parents indicating the date of their participation in the study (See Appendix L).

Two people (the author and a graduate student assistant) were present for all group administrations greater than four children. The assistant helped in the seating of the children, handing out questionnaires, answering students' questions, and ensuring that children answered all questionnaire items.

All questionnaires completed by children, mothers, and fathers were coded with an identification number that was used to identify children who may be experiencing emotional distress. Twenty-five children, 13 girls and 12 boys were identified by child self-report to be at risk for childhood depression (See Table 8). These children were divided into two groups, those who met stringent clinical criteria for depression on the CDI (Subgroup 1 [SG1]) and those who met more liberal criteria on the CDI (Subgroup 2 [SG2]). Consideration was also given to the child's scores on the Mood/Affect (MA) and Suicidal Ideation (SI) subscales of the DDPC. While Harter and Nowakowski (1987) do not provide guidelines for the identification of children at risk for depression, Harter et al. (1991) used a cut-off score equal

Table 8

Grade, Gender, and Subgroup Classification for Children Considered to be at Risk for Depression (N = 25)

Grade	4		5		6		
Gender	Girls	Boys	Girls	Boys	Girls	Boys	Total
SG I	2	3	1	2	1	0	9
SG II	2	3	5	3	3	0	16
Total	4	6	6	5	4	0	25

to 2.6 on the Mood/Affect and Suicidal Ideation subscales to identify children at risk for depression and suicidal ideation.

SG1 (N = 9) had scores equal to or greater than 23 on the CDI; this score is equivalent to a Standard Score (SS) of 70 for girls and a SS of 67 for boys aged 7-12 years, and is considered to be "very much above average" (Kovacs, 1992). Kovacs (1992) recommends using a SS equal to 70 to identify children at risk for depression from low base rate groups, such as elementary school children. Seven of these children also reported scores one or more standard deviations below the mean on the Mood/Affect (M = 3.18, SD = 0.76) and SI (M = 3.41, SD = 0.72) subscales. Children in SG2 (N = 16) had scores between 15 and 22 on the CDI and six children had scores one or more standard deviations below the mean on the Mood/Affect and Suicidal Ideation subscales.

The liberal criteria for SG2 were adopted because (a) the nature of the data collection did not permit individualized contact or the clarification of the children's responses; (b) the DDPC has not been used extensively with children; and (c) both the CDI and DDPC were designed to be used as screening measures.

Parents were informed by phone and a follow-up letter if their child was identified to be at risk for depression (See Appendix M). Parents were encouraged to obtain a more thorough assessment of their child's functioning through a

mental health professional. In addition, some parents (N = 8) requested that a referral be made to their child's principal by completing a second consent form (See Appendix N).

CHAPTER III

RESULTS

Overview of Analyses

Analyses included intercorrelations and multivariate analyses (e.g., MANOVA, multiple regression). Independent variables included: (a) informant (child, mother, father); and (b) global self-worth (high, low). Dependent variables included the subscales of: (a) the Self Perception Profile for Children (SPPC); (b) the Parent Rating Scale (PRS); (c) the Social Support Scale for Children and Adolescents (SSSC); (d) the SSSC completed by parents (SSSC-P); (e) the Dimensions of Depression Profile for Children and Adolescents (DDPC); (f) the DDPC completed by parents (DDPC-P); (g) the Children's Depression Inventory (CDI); (h) the CDI completed by parents (CDI-P); and (i) the Beck Depression Inventory (BDI). All analyses were computed using SPSS (Norusis, 1990).

First, preliminary analyses were conducted. Separate oneway MANOVAs were computed to determine the effects of child and parent characteristics on the questionnaire scores. Second, descriptive statistics, as well as paired and between groups MANOVAs were computed to determine if parents and children differed in the magnitude and direction of their ratings on the questionnaires. Descriptive information is presented separately for Hypothesis I and II below. The total or subscale scores on the questionnaires

were the dependent variables, and informant or group membership was the independent variable for the respective MANOVAs. In addition, because different numbers of mothers (N = 92) and fathers (N = 39) participated in the study, and a subgroup of children was identified to be at risk for depression (N = 25), a decision was made to divide the sample into four different groups. These groups consisted of: (a) the total sample of children (N = 92) and their mothers (N = 92); (b) the subgroup of children whose fathers participated (N = 39), their mothers (N = 39), and fathers (N = 39); (c) the subgroup of children identified to be at risk for depression (N = 25), their mothers (N = 25), and fathers (N = 10); and (d) the subgroup of children not identified to be at risk for depression (N = 67), their mothers (N = 67), and fathers (N = 29).

To test the first hypothesis that parent-child agreement would be greater for the domain specific subscales of the DDPC than for the CDI, Pearson product-moment correlations were computed and presented in a correlation matrix to evaluate inter-rater reliability between informants on the measures of depression. Significance tests were computed to determine if correlations were significantly different from zero, and from other correlations in the matrix (e.g., see Ferguson, 1976; Horvath, 1985). The dependent variables were the subscale

scores on the DDPC and the total score on the CDI.

The second hypothesis examined whether inter-rater reliability was affected by child reports of global self-worth. Children were assigned to one of two levels of global self-worth (i.e., high, low) and agreement between parents and children was examined using Pearson product moment correlations and significance tests. Separate correlation matrices were computed for: (a) the subscale scores of the Self-Perception Profile for Children (SPPC) and the Parent Rating Scale (PRS); (b) the Social Support Scale for Children and Adolescents completed by the children and their parents (SSSC and SSSC-P); and (c) the Dimensions of Depression Profile for Children and Adolescents (DDPC and DDPC-P) and the Children's Depression Inventory (CDI and CDI-P) completed by the children and their parents.

The third hypothesis predicted that parent self-reports of depression would correlate significantly with child self-reports and parent reports of child depression. Multiple regressions were computed with parent self-reports of depression as the independent or predictor variable and child self-reports or parent reports of child functioning on the Depression Composite and CDI total score as the dependent variables.

Finally, the fourth hypothesis explored the validity of a model of the determinants and mediational role of self-worth for elementary school age children (e.g., see Harter

et al., 1991). Multiple regressions were used to test this hypothesis. Composite variables were created following Harter's model (Harter et al., 1991) and included the: (a) Scholastic Competence/Behavioral Conduct subscales cluster (SBC) from the SPPC/PRS; (b) Athletic Competence/Social Acceptance/Physical Appearance subscales cluster (ASP) from the SPPC/PRS; (c) Classmate/Close Friend Support subscales cluster (SS) from the SSSC/SSSC-P; (d) Parent Support (PS) subscale from the SSSC; and (e) the Depression Composite (DC) comprised of the Mood/Affect and Self-Worth subscales of the DDPC/DDPC-P. Four regressions were computed for each group of informants (i.e., children, mothers, and fathers): (1) the SBC and ASP were entered as the predictor variables and PS was entered as the dependent variable; (2) the SBC and ASP were entered as the predictor variables and SS was entered as the dependent variable; (3) the SBC, PS, SS, and ASP were entered as the predictor variables and the DC was entered as the dependent variable; and (4) the DC, PS, and SBC were entered as the predictor variables and Suicidal Ideation (SI) was entered as the dependent variable.

Examination of the Data

Prior to analyses, each subscale or total score variable was examined for missing data, normality, and violations of the assumptions of multivariate analyses. Subscale or total scores were examined separately for children, mothers, and fathers.

One mother and father dyad did not complete the SSSC-P for their child; one father did not complete the BDI. Missing data on individual questionnaire items were replaced using the mean value for that subscale or total score for that informant (e.g., see Tabachnick & Fidell, 1989). Analysis of the normality distributions for each subscale or total score revealed that most of the obtained data were skewed. Outliers were also identified. The presence of outliers and skewed data were attributed to the phenomenon of child reported depression. Thus, the data were not transformed.

The presence of multivariate outliers can influence the magnitude and significance of the correlation coefficient, as well as influence the slope of the regression line. Influence statistics, (e.g., DFBETA, Cook's D, and Leverage) were computed for bivariate and multivariate analyses to identify informants that might impact on the obtained results (e.g., see Hamilton, 1992). Influential cases reflected children who had met the previously described criteria for being at risk for depression. Hamilton (1992) recommends conducting two sets of analyses and reporting results with and without the influential cases, where relevant. In this study the removal of influential cases and outliers did not affect the outcome of analyses in hypotheses I through IV. Thus, all reported results below include influential cases and outliers.

Reliability - Internal Consistency

Table 9 presents reliability coefficients for each subscale or total score for each questionnaire for children, mothers, and fathers, where applicable (Coefficient alpha: Cronbach, 1951, cited in Anastasi, 1982). All subscale or total scores possess a moderate to high degree of reliability (.64 (PRS-Physical Appearance) to .94 (Child self-report-CDI)) across all informants. Obtained reliability coefficients were also consistent with those reported for the SPPC (Harter, 1985a), the SSSC (Harter, 1985b), the DDPC (Harter & Nowakowski, 1987), the CDI (Kovacs, 1992), and the BDI (Beck & Steer, 1987) for child and adult informants, respectively.

Preliminary Analyses: Influence of Child and Parent Characteristics

MANOVAs were performed to evaluate the effects of informant characteristics on the subscale or total scores of the questionnaires used. Separate oneway MANOVAs were computed with child grade (3), child gender (2), participation in counselling (2), order of completion of the depression measures for children (2), and socio-economic status (6) as the independent variables. The following were the dependent variables: (a) SPPC/PRS (Global Self-Worth, Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, and Behavioral Conduct subscale scores); (b) SSSC/SSSC-P (Parent Support, Classmate

Table 9

Reliability Coefficients by Informant for Each Subscale or Total Score

Subscale or Total Score	Author of Measure	Informant Children	Mothers	Fathers
SPPC/PRS [a]				
Scholastic Comp.	.82	.89	.77	.68
Social Acceptance	.75	.87	.81	.81
Athletic Comp.	.81	.78	.76	.87
Physical Appearance	.76	.81	.64	.67
Behavioral Conduct	.73	.86	.79	.84
Global Self-Worth [b]	.78	.85	---	---
SSSC/SSSC-P [c]				
Parent Support	.78	.80	.71	.70
Classmate Support	.74	.83	.85	.80
Teacher Support	.82	.79	.90	.78
Friend Support	.74	.87	.91	.75
DDPC/DDPC-P [d]				
Mood/Affect	.86	.90	.89	.89
Self-Blame	.76	.76	.86	.82
Self-Worth	.84	.85	.86	.87
Energy/Interest	.72	.75	.80	.80
Suicidal Ideation	---	.88	.80	.79

(table continues)

Table 9 continues

Subscale or Total Score	Author of Measure	Informant		
		Children	Mothers	Fathers
CDI/CDI-P [e]				
CDI	.71-.89	.94	.86	.82
BDI [f]				
BDI	.86	---	.89	.72

[a] Harter, 1985a. [b] Mothers and fathers were not administered this subscale. [c] Harter, 1985b. One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers. [d] Harter & Nowakowski, 1987. Harter and Nowakowski (1987) do not report reliability coefficients for this subscale for elementary school age children. [e] Kovacs, 1992. [f] Beck & Steer, 1987. One father did not complete this questionnaire; thus N = 38. Children were not administered this measure.

Support, Teacher Support, Close Friend Support subscale scores); (c) DDPC/DDPC-P (Mood/Affect, Self-Blame, Self-Worth, Energy/Interest, Suicidal Ideation subscale scores); and (d) total scores on the CDI/CDI-P and BDI. Each MANOVA was computed separately for child, mother, and father informants.

The results of the MANOVAs are presented in Appendix O. Pillai's criterion was used to evaluate all MANOVAs in this study since it is considered to be more robust when violations of the assumption of normality are suspected and cell sizes are unequal (Tabachnick & Fidell, 1989). The MANOVAs indicated no significant effects for child grade or participation in counselling for child, mother, or father informants. A child gender effect was found for the SPPC/PRS for all informants (Child Multivariate F (6,85) = 3.32; p <.01; Mother Multivariate F (5,86) = 4.24; p <.01; Father Multivariate F (5,33) = 3.78; p <.01). Univariate significance was obtained for the Behavioral Conduct subscale score across all informants, with girls being rated as more behaviorally competent than boys (Child self-report: Girls M = 3.06, Boys M = 2.84; Mother report: Girls M = 3.51, Boys M = 3.19; Father report: Girls M = 3.57, Boys M = 2.30). Children and mothers reported a univariate effect for the Athletic Competence subscale score, with boys rated as more athletically competent than girls (Child self-report: Girls M = 2.68, Boys M = 3.04; Mother report: Girls

M = 2.81, Boys M = 3.11). Mothers and fathers also reported a significant univariate effect for the Scholastic Competence subscale score, with girls rated as more scholastically competent than boys (Mother report: Girls M = 3.33, Boys M = 2.93; Father report: Girls M = 3.35, Boys M = 2.79).

Mothers reported a significant multivariate effect for Order on the DDPC-P/CDI-P (Multivariate F (7,84) = 2.92; p <.01). Univariate effects revealed that mothers reported less self-blame in their children when they completed the DDPC-P after the CDI-P (Order 1: M = 3.02; Order 2: M = 2.77) and that their children had more energy to do things when they completed the DDPC-P before the CDI-P (Order 1: M = 3.34; Order 2: M = 3.56). These findings are difficult to interpret and do not suggest a systematic effect for completing the DDPC-P before or after completing the CDI-P for mothers.

A significant multivariate effect was also observed for children on the SSSC for SES (Multivariate F (20,276) = 1.91, p <.05). Univariate significance was obtained for the Classmate Support, Teacher Support, and Close Friend Support subscales of the SSSC (See Appendix O). These findings were difficult to interpret given the large number of SES levels (See Table 5) and the absence of a linear trend in the mean scores across the subscales.

In summary, these results indicate minimal influence of

informant or family characteristics on the obtained subscale or total scores of the measures used. The significant effect for child gender on the measure of child competence (i.e., SPPC/PRS) supports general findings that girls and boys are believed to differ in terms of their academic, behavioral, and athletic performance within the school setting. The absence of a grade or consistent gender effect across informants and questionnaires suggests that elementary school age children in grades 4 through 6 may comprise a fairly homogeneous group in terms of their adaptive and academic functioning. This finding also warrants collapsing the sample across grade and gender in all subsequent analyses.

Hypothesis I

In this hypothesis the effects of the specificity of a measure of childhood depression on parent-child agreement was examined. Hypothesis I will be presented in three sections: (1) descriptive statistics and paired and between groups MANOVAs; (2) correlation matrices for the total sample of children and mothers; and (3) correlation matrices for the subgroup of children and mothers with fathers/ spouses who participated in the study.

Descriptive Statistics. The following section presents descriptive statistics for the total sample of children (N = 92), their mothers (N = 92), and fathers (N = 39); for the subgroup of children identified to be at risk for

depression (N = 25), their mothers (N = 25), and fathers (N = 10); and for the subgroup of children not at risk for depression (N = 67), their mothers (N = 67), and fathers (N = 29).

The means and standard deviations for each respondent for each subscale or total score for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, CDI/CDI-P, and BDI for the total sample of children are presented in Table 10. Because preliminary analyses revealed no significant differences as a function of grade and only a significant effect for child gender on the SPPC, no grade or gender differences will be reported here. For the total sample of children, the mean subscale scores of the SPPC, SSSC, and DDPC are comparable to those reported by Harter (1985a; 1985b), and Harter and Nowakowski (1987) for children in grades 4 through 6. Similarly, the mean CDI score reported by children in this sample (M = 9.72, SD = 10.53) is comparable to that reported by Kovacs (1992) for normative 7 to 12 year old girls and boys (M = 10.5, SD = 7.3). Mean scores reported by mothers and fathers were similar to those reported by the children (See Table 10).

To evaluate differences in the magnitude and direction of child functioning, comparisons between children's and mothers' reports, children's and fathers' reports, and mothers' and fathers' reports were computed using paired MANOVAs. The subscale scores of the SPPC/PRS, SSSC/SSSC-P,

Table 10

Means and Standard Deviations for the SPPC/PRS, SSSC-SSSC-P, DDPC/DDPC-P, CDI/CDI-P, and BDI for the Authors' Samples and the Total Sample of Children, Mothers, and Fathers

Subscale or Total Score		Author of Measure	Informant: Children	Informant: Mothers	Informant: Fathers
SPPC/PRS [a]		N = 167	N = 92	N = 92	N = 39
Scholastic Competence	M	2.82	2.88	3.14	3.12
	SD	0.66	0.86	0.69	0.74
Social Acceptance	M	2.88	2.91	3.32	3.42
	SD	0.73	0.83	0.64	0.60
Athletic Competence	M	2.85	2.85	2.95	3.12
	SD	0.73	0.71	0.59	0.57
Physical Appearance	M	2.85	2.84	3.76	3.80
	SD	0.72	0.79	0.37	0.37
Behavioral Conduct	M	3.00	2.84	3.36	3.32
	SD	0.54	0.75	0.71	0.69
Global [b] Self-Worth	M	3.04	3.11	---	---
	SD	0.69	0.75	---	---
SSSC/SSSC-P [c]		N = 235	N = 92	N = 91	N = 38
Parent Support	M	3.42	3.51	3.64	3.74
	SD	0.64	0.60	0.38	0.31
Classmate Support	M	2.94	3.07	3.35	3.43
	SD	0.65	0.69	0.56	0.41
Teacher Support	M	3.11	3.28	3.44	3.45
	SD	0.67	0.66	0.53	0.44
Friend Support	M	3.07	3.43	3.24	3.41
	SD	0.66	0.67	0.57	0.45

(table continues)

Table 10 continues

Subscale or Total Measure		Author of Measure	Informants: Children	Mothers	Fathers
DDPC/DDPC-P [d]		N = 176	N = 92	N = 92	N = 39
Mood/ Affect	M	3.08	3.18	3.44	3.61
	SD	0.69	0.76	0.52	0.41
Self-Blame	M	2.59	2.70	2.89	3.09
	SD	0.67	0.66	0.60	0.55
Self-Worth	M	3.04	3.09	3.25	3.47
	SD	0.70	0.75	0.56	0.48
Energy/ Interest	M	3.16	3.07	3.45	3.47
	SD	0.59	0.65	0.48	0.49
Suicidal Ideation	M	---	3.41	3.79	3.81
	SD	---	0.72	0.36	0.33
CDI/CDI-P [e]		N = 1266	N = 92	N = 92	N = 39
CDI	M	10.5	9.72	4.82	3.56
	SD	7.3	10.53	5.11	3.66
BDI [f]		---	---	N = 92	N = 38
BDI	M	---	---	7.46	3.66
	SD	---	---	7.05	3.43

Note. Means presented for the SPPC and the DDPC are average means based on means provided separately for boys and girls in grades 4, 5, and 6. For comparison purposes, these means were computed by the present author.

[a] Harter, 1985a. [b] Mothers and fathers were not administered this subscale. [c] Harter, 1985b. One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers. [d] Harter & Nowakowski, 1987. Harter and Nowakowski (1987) do not report means for this subscale for elementary school age children. [e] Kovacs, 1992. [f] Beck & Steer, 1987. Beck and Steer (1987) do not include means for normative adult populations. One father did not complete this questionnaire; thus N = 38. Children were not administered this questionnaire.

DDPC/DDPC-P and CDI/CDI-P were the variables of interest. Low mean scores on the SPPC/PRS, SSSC/SSSC-P and DDPC/DDPC-P are indicative of less perceived self-competence, less social support, and more depressive symptomatology, respectively. In contrast, high scores on the CDI/CDI-P are indicative of more depressive symptomatology. Table 11 presents the results of these analyses.

A significant multivariate effect was found for the self-competence (SPPC/PRS), social support (SSSC/SSSC-P), and depression measures (DDPC/DDPC-P and CDI/CDI-P) for children and mothers, and for children and fathers (See Table 11). The direction of these differences indicated that children consistently reported less self-competence, less social support, and more emotional distress than did either of their parents. This observation was consistent for the CDI total score and for the subscale scores of the SPPC, SSSC, and the DDPC, with the exception of the Close Friend Support subscale of the SSSC. On this subscale, children reported receiving more support from close friends than did father reports (See Table 10). Mothers and fathers did not differ in their evaluation of child functioning on any of the questionnaires.

Table 12 presents the means and standard deviations for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P and CDI/CDI-P for children, mothers, and fathers for the subgroup of children identified to be at risk for depression and for the subgroup

Table 11

Paired Multivariate Comparisons for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for the Total 2Sample of Children, Mothers, and Fathers

	Comparison Pairs		
	Child/Mother N = 92	Child/Father N = 39	Mother/Father N = 39
SPPC/PRS			
Multi F [a]	24.98***	8.67***	1.02
df	(5,87)	(5,34)	(5,34)
SSSC/SSSC-P [b]			
Multi F	4.73**	4.60**	0.49
df	(4,87)	(4,34)	(4,34)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	6.12***	4.66**	0.72
df	(6,86)	(6,33)	(6,33)

[a] Multivariate F [b] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

* = p <.05. ** = p <.01. *** = p <.001

Table 12

Means and Standard Deviations for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for Children, Mothers, and Fathers for the Children at Risk Subgroup (N = 25) and for the Children Not at Risk Subgroup (N = 67)

Subscale or Total Score		Children		Informant Mothers		Fathers	
		At Risk	Not At Risk	At Risk	Not At Risk	At Risk	Not At Risk
SPPC/PRS		N=25	N=67	N=25	N=67	N=10	N=29
Scholastic Competence	M	2.23	3.12	2.92	3.23	2.73	3.25
	SD	0.94	0.69	0.61	0.70	0.93	0.62
Social Acceptance	M	2.29	3.14	3.15	3.39	3.20	3.49
	SD	0.76	0.74	0.61	0.64	0.69	0.55
Athletic Competence	M	2.46	2.99	2.87	2.98	2.93	3.18
	SD	0.74	0.64	0.47	0.63	0.58	0.57
Physical Appearance	M	2.06	3.13	3.61	3.81	3.67	3.85
	SD	0.61	0.63	0.50	0.30	0.44	0.34
Behavioral Conduct	M	2.21	3.08	3.07	3.47	3.03	3.41
	SD	0.55	0.65	0.71	0.69	0.73	0.66
Global [a] Self-Worth	M	2.27	3.42	---	---	---	---
	SD	0.66	0.50	---	---	---	---
SSSC/SSSC-P [b]		N=25	N=67	N=24	N=67	N=09	N=29
Parent Support	M	3.01	3.69	3.60	3.65	3.72	3.75
	SD	0.69	0.44	0.31	0.41	0.36	0.29
Classmate Support	M	2.50	3.28	3.10	3.29	3.26	3.48
	SD	0.69	0.57	0.50	0.58	0.48	0.38
Teacher Support	M	2.92	3.41	3.28	3.50	3.22	3.52
	SD	0.77	0.56	0.59	0.51	0.47	0.41
Friend Support	M	3.15	3.53	3.35	3.34	3.35	3.43
	SD	0.68	0.63	0.46	0.60	0.55	0.42

(table continues)

Table 12 continues

Subscale or Total Score		Informant: Children		Mothers		Fathers	
		At Risk	Not At Risk	At Risk	Not At Risk	At Risk	Not At Risk
DDPC/DDPC-P		N=25	N=67	N=25	N=67	N=10	N=29
Mood/ Affect	M	2.38	3.48	3.31	3.49	3.48	3.65
	SD	0.76	0.51	0.59	0.50	0.43	0.40
Self-Blame	M	2.17	2.90	2.86	2.91	2.75	3.21
	SD	0.56	0.59	0.62	0.60	0.59	0.49
Self-Worth	M	2.29	3.39	3.13	3.30	3.25	3.55
	SD	0.73	0.49	0.65	0.53	0.57	0.43
Energy/ Interest	M	2.61	3.25	3.39	3.48	3.38	3.49
	SD	0.62	0.57	0.48	0.48	0.49	0.49
Suicidal Ideation	M	2.74	3.66	3.71	3.82	3.67	3.86
	SD	0.81	0.50	0.38	0.35	0.34	0.31
CDI/CDI-P		N=25	N=67	N=25	N=67	N=10	N=29
	M	23.52	4.57	6.20	4.30	5.10	3.03
	SD	10.48	3.73	5.74	4.80	5.93	2.40

[a] Mothers and fathers were not administered this subscale.
[b] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

of children not identified to be at risk for depression. The mean total CDI score reported by the subgroup of depressed children (M = 21.96, SD = 10.92) is comparable to the cutoff score of 23 recommended by Kovacs (1992) for the identification of emotional distress in normative populations of children. A visual comparison of the means revealed that the subgroup of depressed children reported less self-competency, less social support, and more depressive symptoms than the subgroup of children not at risk for depression. This effect was also noted for reports provided by mothers and fathers on most subscales.

To determine whether children identified to be at risk for depression provided significantly different assessments of their functioning on the SPPC, SSSC, DDPC, and CDI from either their mothers or fathers, paired MANOVAs were computed. Table 13 presents the results of these analyses. Children consistently provided more negative estimates of their functioning on the SPPC, SSSC, DDPC, and CDI than did their mothers. Children and fathers differed only on the subscale scores of the SPPC/PRS, the DDPC/DDPC-P, and the CDI/CDI-P total score. No differences were observed between mothers or fathers reports for this group of children. This finding, with the exception of the SSSC for children and fathers, parallels that obtained for the total sample of children, mothers, and fathers.

Between group MANOVAs were also computed to determine

Table 13

Paired Multivariate Comparisons for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for Children, Mothers, and Fathers for the Children at Risk Subgroup (N = 25) and for the Children Not at Risk Subgroup (N = 67)

Subgroup of Children at Risk for Depression

	Comparison Pairs		
	Child/Mother N = 25	Child/Father N = 10	Mother/Father N = 10
SPPC/PRS			
Multi F [a]	20.39***	9.09*	2.00
df	(5,20)	(5,5)	(5,5)
SSSC/SSSC-P [b]			
Multi F	7.68***	1.55	0.59
df	(4,20)	(4,5)	(4,5)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	10.88***	84.34***	0.73
df	(6,19)	(6,4)	(6,4)

Subgroup of Children Not at Risk for Depression

	Comparison Pairs		
	Child/Mother N = 67	Child/Father N = 29	Mother/Father N = 29
SPPC/PRS			
Multi F	17.76***	5.50**	1.04
df	(5,62)	(5,24)	(5,24)

(table continues)

Table 13 continues

	Comparison Pairs		
	Child/Mother N = 67	Child/Father N = 29	Mother/Father N = 29
SSSC/SSSC-P			
Multi F	3.20*	3.37*	0.70
df	(4,63)	(4,25)	(4,25)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	2.83*	2.50	0.65
df	(6,61)	(6,23)	(6,23)

[a] Multivariate F. [b] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

* = p <.05. ** = p <.01. *** = p <.001.

whether the children, mothers, and fathers of children at risk for childhood depression reported more distress on the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P than the children, mothers, and fathers of children not at risk for depression. See Table 14 for a summary of these analyses. Significant multivariate effects were observed only between the two groups of children on each of the questionnaire subscales. An examination of the multivariate and univariate F's indicated that children in the depressed subgroup reported significantly less self-competence on all subscales of the SPPC, less social support on all subscales of the SSSC, and more depressive symptoms on the DDPC and CDI. Mothers and fathers provided similar estimates of their child's functioning, whether that child was assigned to the depressed subgroup or not.

In summary, children provided more negative assessments of themselves than did their mothers or fathers across all questionnaires administered. These differences were significant and were observed for the total group of children and for a subgroup of children identified to be at risk for depression. Children also appeared to respond consistently across measures, with depressed children reporting less social support and fewer feelings of competency than did children not considered to be at risk for depression. These findings suggest that parents may over-estimate child functioning relative to child self

Table 14

Multivariate Comparisons for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P For Children, Mothers, and Fathers for the Children At Risk Subgroup (N = 25) and the Children Not At Risk Subgroup (N = 67)

	Comparison Pairs		
	Child Reports (N = 25/67)	Mother Reports (N = 25/67)	Father Reports (N = 10/29)
SPPC/PRS			
Multi F [a]	16.15***	1.90	1.21
df	(6,85)	(5,86)	(5,33)
Univariate F			
SC	24.59***	3.75	4.00
SA	24.28***	2.66	1.85
AC	11.41***	0.67	1.43
PA	53.24***	5.44*	1.85
BC	32.23***	6.08*	2.35
GSW [b]	78.66***	---	---
df	(1,90)	(1,90)	(1,37)
SSSC/SSSC-P [c]			
Multi F	11.23***	1.35	1.60
df	(4,87)	(4,86)	(4,33)
Univariate F			
PS	30.82***	0.39	0.04
CS	30.34***	2.16	2.09
TS	11.22***	3.05	3.42
FS	6.53*	0.01	0.18
df	(1,90)	(1,89)	(1,36)

(table continues)

Table 14 continues

	Comparison Pairs		
	Child Reports (N = 25/67)	Mother Reports (N = 25/67)	Father Reports (N = 10/29)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	29.33***	0.57	1.25
df	(6,85)	(6,85)	(6,32)
Univariate F			
MA	63.88***	2.15	1.22
SB	28.59***	0.11	5.92*
SW	68.57***	1.76	2.95
EI	21.40***	0.52	0.38
SI	43.62***	1.95	2.63
CDI	165.68***	2.56	2.46
df	(1,90)	(1,90)	(1,37)

Note. SC = Scholastic Competence. SA = Social Acceptance. AC = Athletic Competence. PA = Physical Appearance. BC = Behavioral Conduct. PS = Parent Support. CS = Classmate Support. TS = Teacher Support. FS = Close Friend Support. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory.

[a] Multivariate F. [b] Mothers and fathers were not administered this subscale. [c] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

* = p <.05. ** = p <.01. *** = p <.001.

reports as parent reports did not differentiate between the two groups of children. Alternatively, parents may not be aware of, or receptive to, signals of child distress.

Intercorrelations for Child-Mother Dyads (N = 92). The first question addressed by this study involved the degree of correspondence between child and mother reports of child functioning on two screening measures of childhood depression, the DDPC/DDPC-P and the CDI/CDI-P (See Table 15). First, convergence for the same questionnaire subscales or total score completed by different informants was examined (underlined coefficients), followed by an examination of the pattern of correlations for different measures completed by different informants.

Children and mothers provided significant convergent estimates of the child's functioning on the Mood/Affect (MA), Self-Worth (SW), and Energy/Interest (EI) subscales of the DDPC and the total score of the CDI. Although these coefficients were low (Mood/Affect: r = .20, p <.05; Self-Worth: r = .32, p <.01; Energy/Interest: r = .21, p <.05; CDI: r = .29, p <.01), they are in keeping with previous results (e.g., see Achenbach et al., 1987 for a review). To determine if convergence between informants was significantly different for the subscale scores of the DDPC than for the CDI, t-tests for correlated samples were computed following the procedure outlined in Ferguson (1976). Convergence on the CDI was compared with convergence

Table 15

Intercorrelations for the DDPC/DDPC-P and CDI/CDI-P for Child-Mother Dyads (N = 92)

Informants:	Children					
	CDI	MA	SB	SW	EI	SI
Mothers						
CDI	.29**	-.29**	-.22*	-.32**	-.30**	-.23*
MA	-.21*	.20*	.16	.22*	.25**	.11
SB	.01	.01	-.03	.02	.04	-.06
SW	-.29**	.22*	.17	.32**	.31**	.25**
EI	-.06	-.00	.11	.07	.21*	-.06
SI	-.11	.14	.12	.15	-.05	-.06

Note. CDI = Children's Depression Inventory. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. Underlined coefficients are coefficients for the same measure completed by different informants.

* = p <.05. ** = p <.01.

on the Mood/Affect, Self-Worth, and Energy/Interest subscales separately. None of these comparisons were significantly different ($p > .05$) suggesting that mother-child agreement was not facilitated by the domain specific subscales of the DDPC for this sample of children. Examination of the remaining correlation coefficients revealed that mother reports on the CDI-P correlated significantly with child reports on the five subscales of the DDPC ($p < .05$). Second, mother reports on the Self-Worth subscale correlated significantly with child reports on the CDI and all but the Self-Blame subscale of the DDPC. Third, mother reports on the Mood/Affect scale also correlated significantly with child self-reports on the CDI and the Self-Worth and Energy/Interest subscales of the DDPC. This observation suggests that, for mothers, the CDI-P, Self-Worth, and Mood/Affect subscales may function in a similar manner in the identification of child difficulties.

In summary, only three of the five subscale scores of the DDPC achieved convergence between children and mothers ($p < .05$). Second, no differences were observed in the magnitude of the convergence between these subscale scores and the CDI. This suggests that the domain specific nature of the DDPC does not necessarily result in better parent-child agreement compared to the CDI.

Intercorrelations for Child-Mother-Father Triads (N = 39). Table 16 presents the intercorrelations for children

Table 16

Intercorrelations for the DDPC/DDPC-P and CDI/CDI-P for Child-Mother-Father Triads (N = 39)

Informants:	Children					
	CDI	MA	SB	SW	EI	SI
Mothers						
CDI	.43**	-.42**	-.30*	-.43**	-.43**	-.26
MA	-.17	.14	.01	.20	.32*	.09
SB	-.11	.07	-.06	.14	.11	-.02
SW	-.40**	.34*	.21	.43**	.40**	.37**
EI	.01	-.14	-.09	-.18	.21	-.22
SI	-.05	.12	-.07	.05	-.01	-.07

Informants:	Children					
	CDI	MA	SB	SW	EI	SI
Fathers						
CDI	.63**	-.58**	-.20	-.41**	-.45**	-.45**
MA	-.17	-.02	.09	-.05	.07	.13
SB	-.29*	.13	.10	.08	-.06	.24
SW	-.38**	.18	.25	.25	.30*	.36*
EI	-.12	.02	.24	-.00	.11	.16
SI	-.24	.13	.27	.22	.15	.36**

(table continues)

Table 16 continues

Informants:	Mothers					
	CDI	MA	SB	SW	EI	SI
Fathers						
CDI	.62**	-.24	-.27*	-.47**	.02	-.15
MA	.01	.13	.10	.04	.14	-.03
SB	-.05	.03	.27*	.08	-.20	.08
SW	-.29	.26	.23	.37*	.06	.01
EI	.05	-.15	-.15	-.04	-.01	-.15
SI	-.18	.17	.34*	.33*	.08	.13

Note. CDI = Children's Depression Inventory. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. Underlined coefficients are coefficients for the same measure completed by different informants.

* = $p < .05$. ** = $p < .01$.

and mothers, children and fathers, and mothers and fathers for the DDPC/DDPC-P subscales and CDI/CDI-P total score. Examination of the correlation coefficients for the same measures completed by children and mothers, children and fathers, and mothers and fathers revealed variable results. Significant correlations were noted for: (a) children and mothers on the CDI (r = .43, p <.01) and Self-Worth subscale (r = .43, p <.01); (b) children and fathers on the CDI (r = .63, p <.01) and Suicidal Ideation subscale (r = .36, p <.01); and (c) mothers and fathers on the CDI (r = .62, p <.01), the Self-Blame (r = .27, p <.05), and Self-Worth (r = .37, p <.05) subscales of the DDPC.

Correlated t-tests of the difference between significant convergent coefficients were computed separately for children and mothers, children and fathers, and mothers and fathers. Convergence on the CDI was determined to be significantly different from convergence on the Suicidal Ideation subscale for children and fathers (t (35) = 1.69, p <.05). However, the direction of this difference was opposite to that predicted, with the magnitude of the correlation coefficient being greater for the CDI (r = .63, p <.01) than for the Suicidal Ideation subscale (r = .36, p <.05). Convergence was also observed to be significantly greater for the CDI (r = .62, p <.01) than for the Self-Blame subscale (r = .27, p <.05) for mothers and fathers (t (35) = 2.30, p <.01). All other comparisons failed to

achieve significance $p > .05$).

Correlated t-tests were also computed to determine whether convergence was greater for one pair of informants compared to another pair (e.g., child-mother versus child-father reports). Convergence was observed to be significantly greater for child and father dyads than for mother and father dyads (t (35) = 1.76, $p < .05$) on the CDI total score only.

Examination of the remaining correlation coefficients revealed large significant correlations between: (a) mother reports on the CDI and child reports on all but the Suicidal Ideation subscale of the DDPC; (b) mother reports on the Self-Worth subscale and child reports on all but the Self-Blame subscale of the DDPC; and (c) father reports on the CDI and child reports on all but the Self-Blame subscale of the DDPC. These findings are similar to those observed for the total sample of children and mothers (N = 92).

In conclusion, the one consistent finding for this subgroup of informants was convergence on the CDI, followed by convergence on the Self-Worth subscale for children and mothers, and mothers and fathers. Mother and father reports on the CDI also correlated significantly with child reports on most of the DDPC subscales. Differences were observed in the magnitude of convergence for comparisons involving the CDI with the Suicidal Ideation and Self-Blame subscales of the DDPC for children and fathers and mothers and fathers,

respectively. However, these differences were in the opposite direction to that predicted, with convergence being greater for the CDI than for the two DDPC subscales.

Summary

Overall, the results of the intercorrelations and the t-tests for differences between correlated coefficients for the CDI and the DDPC subscales did not support hypothesis 1. The CDI total score and the Self-Worth subscale score of the DDPC were the two measures most likely to achieve convergence between informants. Convergence was typically low to moderate for children and mothers, and moderate to high for children and fathers, and mothers and fathers. This observation is consistent with previous literature (e.g., Kazdin et al., 1983a, b, c; Reynolds et al., 1985; Treiber & Mabe, 1987). In addition, comparisons of the differences between significant coefficients using t-tests revealed that the magnitude of convergence was greater for the CDI than for the Suicidal Ideation subscale for children and fathers and greater for the CDI than for the Self-Blame subscale for mothers and fathers. Thus it appears that for this sample of children and parents, the domain specific nature of the DDPC subscales did not facilitate parent-child agreement.

Hypothesis II

A second goal of this study was to examine the effects of child reported global self-worth on parent-child agreement. Based on Harter's (1986) observations that

children with low self-worth provided more realistic appraisals of their competency, it was predicted that children with low global self-worth and their parents would demonstrate greater parent-child agreement for the subscales of Harter's three measures, the SPPC/PRS, SSSC/SSSC-P, and DDPC/DDPC-P and for the more global score of the CDI/CDI-P than children with high global self-worth and their parents.

Descriptive Statistics. Child self-reports on the global self-worth subscale score of the SPPC were used to assign children to either the low or high global self-worth group. Children with scores falling below the mean (M = 3.11) were assigned to the low global self-worth group and had scores between 1.00 and 3.10 (N = 42); children in the high global self-worth group had scores between 3.11 and 4.00 (N = 50). Table 17 presents the grade and gender distribution for these children. Table 18 presents the means and standard deviations for the subscales of the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P total score as reported by children, mothers, and fathers for these two groups. Separate oneway MANOVAs indicated significant multivariate effects for the SPPC, SSSC, DDPC, and CDI for the child informants (See Table 19). Examination of the univariate effects revealed that low global self-worth children consistently reported lower means scores on the subscale scores of the SPPC, SSSC, and DDPC, and a higher mean score on the CDI than did the high global self-worth

Table 17

Grade and Gender Distribution for Children with Low Versus High Global Self Worth

Grade	4		5		6		
Gender	Girls	Boys	Girls	Boys	Girls	Boys	Total
Low GSW	5	9	10	7	7	4	42
High GSW	11	9	6	9	10	5	30
Total	16	16	16	16	17	9	92

Note. GSW = Global Self-Worth.

Table 18

Means and Standard Deviations for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for Children, Mothers, and Fathers for Children with Low and High Global Self Worth

Subscale or Total Score		Informants: Children		Mothers		Fathers	
		Low GSW	High GSW	Low GSW	High GSW	Low GSW	High GSW
SPPC/PRS		N=42	N=50	N=42	N=50	N=16	N=23
SC	M	2.50	3.20	3.08	3.20	3.08	3.14
	SD	0.92	0.66	0.75	0.64	0.76	0.73
SA	M	2.56	3.21	3.18	3.44	3.33	3.48
	SD	0.75	0.79	0.66	0.60	0.66	0.54
AC	M	2.62	3.04	2.94	2.95	3.08	3.14
	SD	0.72	0.64	0.59	0.59	0.64	0.54
PA	M	2.33	3.27	3.74	3.77	3.85	3.77
	SD	0.65	0.61	0.41	0.33	0.32	0.41
BC	M	2.44	3.18	3.13	3.55	3.17	3.42
	SD	0.70	0.62	0.84	0.53	0.83	0.56
SSSC/SSSC-P[a]		N=42	N=50	N=41	N=50	N=15	N=23
PS	M	3.18	3.78	3.58	3.69	3.76	3.73
	SD	0.67	0.36	0.38	0.38	0.26	0.34
CS	M	2.69	3.38	3.21	3.27	3.39	3.46
	SD	0.67	0.54	0.51	0.61	0.39	0.43
TS	M	3.03	3.49	3.41	3.47	3.53	3.40
	SD	0.69	0.55	0.55	0.52	0.38	0.47
FS	M	3.21	3.61	3.36	3.33	3.46	3.38
	SD	0.67	0.61	0.51	0.61	0.55	0.38

(table continues)

Table 18 continues

Subscale or Total Score		Informants: Children		Mothers		Fathers	
		Low GSW	High GSW	Low GSW	High GSW	Low GSW	High GSW
DDPC/CDI & DDPC-P/CDI-P		N=42	N=50	N=42	N=50	N=16	N=23
MA	M	2.63	3.63	3.35	3.52	3.68	3.56
	SD	0.71	0.43	0.57	0.48	0.37	0.44
SB	M	2.33	3.02	2.97	2.83	3.03	3.14
	SD	0.51	0.61	0.60	0.61	0.62	0.51
SW	M	2.54	3.56	3.14	3.35	3.42	3.51
	SD	0.64	0.45	0.66	0.45	0.52	0.46
EI	M	2.69	3.40	3.41	3.49	3.49	3.45
	SD	0.60	0.49	0.48	0.48	0.44	0.53
SI	M	3.05	3.72	3.79	3.79	3.78	3.83
	SD	0.80	0.47	0.37	0.35	0.34	0.32
CDI	M	16.19	4.28	6.31	3.56	4.94	2.61
	SD	12.17	4.00	6.23	3.53	4.75	2.33

Note. GSW = Global Self-Worth. SC = Scholastic Competence. SA = Social Acceptance. AC = Athletic Competence. PA = Physical Appearance. BC = Behavioral Conduct. PS = Parent Support. CS = Classmate Support. TS = Teacher Support. FS = Close Friend Support. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory.

[a] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

Table 19

Multivariate Comparisons of Children with Low and High Global Self Worth for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for Children, Mothers, and Fathers

	Comparison Pairs		
	Child Reports (N = 42/50)	Mother Reports (N = 42/50)	Father Reports (N = 16/23)
SPPC/PRS			
Multi F [a]	14.91***	2.51*	0.64
df	(5,86)	(5,86)	(5,33)
Univariate F			
SC	17.68***	0.70	0.06
SA	16.52***	3.84	0.55
AC	8.64**	0.01	0.11
PA	51.62***	0.21	0.50
BC	28.78***	8.21**	1.29
df	(1,90)	(1,90)	(1,37)
SSSC/SSSC-P [b]			
Multi F	10.41***	0.62	0.68
df	(4,87)	(4,86)	(4,33)
Univariate F			
PS	30.69***	1.97	0.05
CS	29.09***	0.28	0.24
TS	12.46***	0.28	0.85
FS	9.05**	0.06	0.28
df	(1,90)	(1,89)	(1,36)

(table continues)

Table 19 continues

	Comparison Pairs		
	Child Reports (N = 42/50)	Mother Reports (N = 42/50)	Father Reports (N = 16/23)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	17.00***	2.26*	1.45
df	(6,85)	(6,85)	(6,32)
Univariate F			
CDI	42.52***	7.05**	4.13*
MA	68.61***	2.35	0.79
SB	34.27***	1.27	0.35
SW	80.61***	3.06	0.33
EI	39.70***	0.54	0.06
SI	24.89***	0.00	0.17
df	(1,90)	(1,90)	(1,37)

Note. SC = Scholastic Competence. SA = Social Acceptance. AC = Athletic Competence. PA = Physical Appearance. BC = Behavioral Conduct. PS = Parent Support. CS = Classmate Support. TS = Teacher Support. FS = Close Friend Support. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory.

[a] Multivariate F. [b] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

* = p <.05. ** = p <.01. *** = p <.001

children. Low mean scores on the SPPC, SSSC, and DDPC subscales represent less perceived competence, less social support and more depressive symptomatology, respectively, while high mean scores on the CDI reflects more depressive symptomatology. Similar findings were reported for the SPPC (Harter, 1986) and the DDPC (Harter et al., 1991) for groups of children with low global self-worth.

Separate oneway MANOVAs revealed that mother's reports were significantly different for the two groups of children on only the PRS (Multivariate F (5,86) = 2.51, p <.05) and DDPC-P/CDI-P (Multivariate F (6,85) = 2.26, p <.05). However, the only univariate effect to reach significance for the PRS was the Behavioral Conduct subscale and the only univariate effect to reach significance for the DDPC-P/CDI-P was the CDI-P total score. In both cases, mothers described children with low global self-worth as behaving less competently and experiencing more depressive symptoms than children with high global self-worth. Father reports were not significantly different for either group of children (See Table 19).

Paired MANOVAs were also computed to determine whether children and parents within each group provided similar estimates of their child's functioning. Table 20 presents a summary of this analysis. Comparisons involving children with mothers, and children with fathers revealed that low global self-worth children reported significantly lower

Table 20

Paired Multivariate Comparisons for Child-Mother, Child-Father, and Mother-Father Reports on the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for Children with Low and High Global Self-Worth

Children With Low Global Self Worth

	Comparison Pairs		
	Child/Mother (N = 42)	Child/Father (N = 16)	Mother/Father (N = 16)
SPPC/PRS			
Multi F [a]	29.02*** (5,37)	15.28*** (5,11)	0.59 (5,11)
SSSC/SSSC-P [b]			
Multi F	9.74*** (4,37)	5.38* (4,11)	0.11 (4,11)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	13.08*** (6,36)	8.51** (6,10)	0.69 (6,10)

Children With High Global Self Worth

	Child/Mother (N = 50)	Child/Father (N = 23)	Mother/Father (N = 23)
SPPC/PRS			
Multi F	11.07*** (5,45)	2.76 (5,18)	0.43 (5,18)

(table continues)

Table 20 continues

	Child/Mother (N = 50)	Child/Father (N = 23)	Mother/Father (N = 23)
SSSC/SSSC-P			
Multi F	3.34* (4,46)	7.98*** (4,19)	0.40 (4,19)
DDPC/DDPC-P and CDI/CDI-P			
Multi F	2.85* (6,44)	1.52 (6,17)	0.64 (6,17)

[a] Multivariate F. [b] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

* = p <.05. ** = p <.01. *** = p <.001.

estimates of their functioning on all measures than did their mothers or fathers. No differences were observed between mother and father reports for the low global self-worth children (See Table 20).

High global self-worth child self-reports were significantly different from mother reports on the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P. However, a visual examination of the means (See Table 18) revealed that high global self-worth children reported higher mean scores on the Athletic Competence subscale of the SPPC, the Parent Support, Classmate Support, Teacher Support, and Close Friend Support subscales of the SSSC, and the Mood/Affect, Self-Blame, and Self-Worth subscales of the DDPC than did their mothers. High global self-worth children and their fathers differed only on the SSSC/SSSC-P (Multivariate F (4,19) = 7.98, p <.01), with children reporting higher mean social support on the Parent Support, Teacher Support, and Close Friend Support subscales than did their fathers. The pattern of mean scores for the children and parents in the high global self-worth group is difficult to interpret. However, Harter (1986) suggests that children with high global self-worth may inflate their feelings of competency in an effort to maintain their positive feelings of self-worth. It is possible that this phenomenon may be occurring for this group of children for some of the domains tapped by the questionnaires. No differences were observed between

mother and father reports on any of the measures for the high global self-worth children.

Intercorrelations for Children with Low Global Self-Worth and High Global Self-Worth. Intercorrelations were computed for the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P measures for children and their parents in the low global self-worth and high global self-worth groups separately.

SPPC/PRS. Significant correlation coefficients were noted for children and mothers for the Scholastic Competence, Athletic Competence, and Behavioral Conduct subscales for children in the low and high global self-worth subgroups (See Tables 21 and 22). As well, high global self-worth children and their mothers provided similar estimates on the Physical Appearance subscale. Children and fathers in the low global self-worth group also provided convergent estimates on the Scholastic Competence, Athletic Competence, and Behavioral Conduct subscales, while children and fathers in the high self-worth group provided convergent responses on the Scholastic Competence and Athletic Competence subscales only. Mothers and fathers reported convergence on all but the Physical Appearance subscale for both groups of children.

To determine if the above coefficients for the group of low global self-worth children were significantly different from those of the high global self-worth children,

Table 21

Intercorrelations for the SPPC/PRS for Children, Mothers, and Fathers for the Subgroup of Children with Low Global Self Worth (N = 42)

Informants:	Children				
	SC	SA	AC	PA	BC
Mothers					
SC	.31*	.27	.11	.17	.24
SA	.36*	.28	.26	.19	.24
AC	.25	.38*	.45**	.37*	.16
PA	.16	-.04	.19	.00	.36*
BC	.17	.04	-.06	-.04	.36*

Informants:	Children				
	SC	SA	AC	PA	BC
Fathers					
SC	.51*	.15	.18	-.03	.50*
SA	.51*	.47	.34	.52*	.12
AC	.24	.22	.72**	.26	.04
PA	.20	.11	-.24	.29	.06
BC	.28	.28	-.04	.02	.56*

(table continues)

Table 21 continues

Informants:	Mothers				
	SC	SA	AC	PA	BC
Fathers					
SC	.61*	-.11	-.09	.55*	.66**
SA	-.10	.81**	.48	-.27	-.11
AC	-.28	.40	.71**	-.21	-.41
PA	.03	.01	.08	.29	.16
BC	.80**	-.17	-.15	.40	.80**

Note. SC = Scholastic Competence. SA = Social Acceptance. AC = Athletic Competence. PA = Physical Appearance. BC = Behavioral Conduct. Underlined coefficients are coefficients for the same measure completed by different informants.

* = $p < .05$. ** = $p < .01$

Table 22

Intercorrelations for the SPPC/PRS for Children, Mothers, and Fathers for the Subgroup of Children with High Global Self Worth (N = 50)

Informants:	Children				
	SC	SA	AC	PA	BC
Mothers					
SC	.59**	.10	.19	.04	.16
SA	-.07	.27	.01	.04	-.31*
AC	.27	-.02	.34*	.29*	-.27
PA	.05	-.09	-.07	.28*	-.15
BC	.30*	.06	.02	-.14	.36*

Informants:	Children				
	SC	SA	AC	PA	BC
Fathers					
SC	.54**	.17	.06	.41	.47*
SA	.52*	.34	.25	.35	-.02
AC	.15	.48*	.42*	.28	-.06
PA	.24	.68**	.26	.25	.30
BC	.07	-.09	-.08	.03	.32

(table continues)

Table 22 continues

Informants:	Mothers				
	SC	SA	AC	PA	BC
Fathers					
SC	.75**	.04	-.12	.37	.40
SA	.31	.49*	.66**	.41	.21
AC	.18	.45*	.49*	.18	.08
PA	.42*	.14	.30	.19	.11
BC	.58**	-.09	-.19	.03	.47*

Note. SC = Scholastic Competence. SA = Social Acceptance. AC = Athletic Competence. PA = Physical Appearance. BC = Behavioral Conduct. Underlined coefficients are coefficients for the same measure completed by different informants.

a = $p < .05$. ** = $p < .01$

Fisher's Z tests comparing correlation coefficients for independent samples were computed (e.g., see Horvath, 1985). Comparisons between children and mothers in the low global self-worth group and the children and mothers in the high global self-worth group revealed no significant differences for convergence on the Scholastic Competence, Athletic Competence, Physical Appearance, and Behavioral Conduct subscales of the SPPC/PRS ($p > .05$). Similarly, comparisons between children and fathers, and mothers and fathers for each subgroup of global self-worth children were nonsignificant ($p > .05$). Thus, the observed pattern of convergence for the subscales of SPPC/PRS did not support the second hypothesis that parent-child agreement would be better for children with low global self-worth.

SSSC/SSSC-P. An examination of the correlation coefficients revealed convergence for children and mothers on the Classmate Support and Teacher Support subscales and convergence for children and fathers on the Classmate Support subscale only for children with low global self-worth (See Table 23). Convergence was observed for the Classmate Support and Close Friend Support subscales for children and mothers, on the Teacher Support subscale for children and fathers, and on the Teacher Support and Close Friend Support subscales for mothers and fathers for children with high global self-worth (See Table 24).

Comparisons of the correlation coefficients for the

Table 23

Intercorrelations for the SSSC/SSSC-P [a] for Children, Mothers, and Fathers for the Subgroup of Children with Low Global Self Worth (N = 42)

Informants:	Children			
	PS	CS	TS	FS
Mothers				
PS	.28	.37*	.36*	.32*
CS	.12	.65**	.13	.30
TS	.14	.07	.49**	-.12
FS	.08	.31	.24	.22

Informants:	Children			
	PS	CS	TS	FS
Fathers				
PS	.12	.31	.05	.26
CS	.41	.57*	-.38	.01
TS	.26	.26	.31	.00
FS	.43	.67**	.02	.42

(table continues)

Table 23 continues

Informants: Mothers

	PS	CS	TS	FS
Fathers				
PS	.24	.22	-.30	.13
CS	-.06	.16	-.10	-.27
TS	.08	-.03	.22	.38
FS	.29	.18	-.40	.11

Note. PS = Parent Support. CS = Classmate Support. TS = Teacher Support. FS = Close Friend Support. Underlined coefficients are coefficients for the same measure completed by different informants.

[a] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers.

* = p <.05. ** = p <.01.

Table 24

Intercorrelations for the SSSC/SSSC-P for Children, Mothers, and Fathers for the Subgroup of Children with High Global Self Worth (N = 50)

Informants:	Children			
	PS	CS	TS	FS
Mothers				
PS	-.02	-.05	.07	.19
CS	-.11	.50**	.01	.32*
TS	-.19	-.14	.05	-.13
FS	-.10	.32*	-.20	.40**
Informants:	**Children**			
	PS	CS	TS	FS
Fathers				
PS	-.06	.28	-.15	-.20
CS	.19	.39	.05	.02
TS	.32	.41	.44*	.36
FS	.19	.38	.17	.21

(table continues)

Table 24 continues

Informants:	Mothers			
	PS	CS	TS	FS
Fathers				
PS	.00	.20	.13	.24
CS	.09	.29	.20	.15
TS	.35	.56**	.42*	.20
FS	.04	.19	.15	.46*

Note. PS = Parent Support. CS = Classmate Support. TS = Teacher Support. FS = Close Friend Support. Underlined coefficients are coefficients for the same measure completed by different informants.

* = $p < .05$. ** = $p < .01$.

same measures completed by different pairs of informants using Fisher's Z tests indicated that children and mothers in the low global self-worth group reported greater convergence on the Teacher Support subscale than did the children and mothers in the high global self-worth group (t (90) = 2.28, p <.05). This suggests that this subgroup of children and mothers demonstrated greater inter-rater reliability on the Teacher Support subscale. None of the other comparisons between children and fathers and mothers and fathers for the two groups of global self-worth children on the SSSC/SSSC-P were significantly different (p >.05).

DDPC/DDPC-P and CDI/CDI-P. Convergence was noted for children and mothers on the Self-Blame subscale, for children and fathers on the CDI and Self-Worth subscale, and for mothers and fathers on the CDI, Self-Blame, and Self-Worth subscales of the DDPC for children in the low global self-worth group (See Table 25). Children in the high global self-worth group demonstrated convergence on the CDI for children and mothers, on the Suicidal Ideation subscale for children and fathers, and on the CDI for mothers and fathers (See Table 26). Fisher's Z test comparisons between the significant coefficients for each pair of informants for the two groups of children indicated no significant differences.

Table 25

Intercorrelations for the DDPC/DDPC-P and CDI/CDI-P for Children, Mothers, and Fathers for the Subgroup of Children with Low Global Self Worth (N = 42)

Informants:	Children					
	CDI	MA	SB	SW	EI	SI
Mothers						
CDI	.16	-.09	-.16	-.14	-.16	-.12
MA	-.17	.14	.22	.17	.24	.03
SB	-.12	.14	.31*	.23	.26	.05
SW	-.24	.13	.16	.29	.23	.25
EI	-.00	-.21	.02	-.01	.13	-.19
SI	-.14	.20	.26	.23	-.04	-.10
Informants:	**Children**					
	CDI	MA	SB	SW	EI	SI
Fathers						
CDI	.67**	-.60*	-.30	-.37	-.45	-.51*
MA	-.17	-.02	-.05	.09	.07	.13
SB	-.46	.19	.39	.33	.27	.28
SW	-.52*	.25	.40	.51*	.52*	.37
EI	-.12	-.06	.20	.10	-.16	-.20
SI	-.21	-.02	.19	.34	.38	.14

(table continues)

Table 25 continues

Informants:		Mothers				
	CDI	MA	SB	SW	EI	SI
Fathers						
CDI	.55*	-.26	-.20	-.42	.01	-.16
MA	.01	.13	-.10	.04	.14	-.03
SB	-.30	.28	.61*	.31	.07	.13
SW	-.53*	.39	.54*	.50*	.09	.01
EI	-.06	-.21	.11	.03	-.02	-.22
SI	-.33	.22	.63**	.39	.01	-.02

Note. CDI = Children's Depression Inventory. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory. Underlined coefficients are coefficients for the same measure completed by different informants.

* = $p < .05$. ** = $p < .01$.

Table 26

Intercorrelations for the DDPC/DDPC-P and CDI/CDI-P for Children, Mothers, and Fathers for the Subgroup of Children with High Global Self Worth (N = 50)

Informants:	Children					
	CDI	MA	SB	SW	EI	SI
Mothers						
CDI	.30*	-.32*	-.03	-.31*	-.24	-.14
MA	-.16	.10	-.01	.14	.16	.04
SB	-.00	.11	-.14	.04	.01	-.08
SW	-.24	.16	.02	.24	.28*	.08
EI	-.08	.12	.13	.05	.28	-.01
SI	-.13	.17	.04	.16	-.08	-.03

Informants:	Children					
	CDI	MA	SB	SW	EI	SI
Fathers						
CDI	.26	-.33	.19	-.06	-.26	-.10
MA	-.22	.10	.10	-.20	.06	.32
SB	.02	-.05	-.14	-.42*	-.47*	.16
SW	-.22	.03	.14	-.06	.11	.34
EI	-.26	.20	.35	-.03	.34	.57**
SI	-.31	.30	.33	.10	-.06	.62**

(table continues)

Table 26 continues

Informants:		Mothers				
	CDI	MA	SB	SW	EI	SI
Fathers						
CDI	.68**	-.21	-.41	-.46*	-.10	-.19
MA	.11	.14	-.07	.10	.11	-.00
SB	.46*	-.21	-.07	-.32	-.36	.04
SW	.07	.15	-.06	.19	.09	.01
EI	.17	-.12	-.32	-.11	-.01	-.10
SI	.04	.13	.10	.26	.14	.27

Note. CDI = Children's Depression Inventory. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory. Underlined coefficients are coefficients for the same measure completed by different informants.

* = $p < .05$. ** = $p < .01$.

Summary

Contrary to Harter's (1986) observation that children with low global self-worth demonstrated greater convergence with teacher ratings for the SPPC/PRS, low global self-worth children and their parents did not differ from high global self-worth children and their parents on the subscales of the SPPC/PRS, DDPC/DDPC-P, CDI/CDI-P, and the SSSC/SSSC-P with the exception of the Teacher Support subscale in the present study. Harter's use of more stringent criteria to identify children with low global self-worth may explain the differences obtained between these two studies. Further research using more stringent criteria may help clarify whether the variable of global self-worth facilitates agreement between children and their parents for measures of competency, social support, and depression.

Hypothesis III

This hypothesis examined the effects of parent reported depression on child self-reports and parent reported depression on parent reports of child functioning for two measures of childhood depression. Separate regressions were computed with scores on the BDI entered as the predictor variables and scores on either the Depression Composite (DC) or total CDI score generated by child, mother, and father informants entered as the dependent variable. The Depression Composite was computed by taking the average of the Self-Worth (SW) and Mood/Affect (MA) subscale scores of the DDPC

for each informant. Table 27 presents the correlations for the BDI, Depression Composite, and CDI for child, mother, and father informants. Comparisons of the magnitude of the correlation coefficients for mother reports on the BDI with: (a) mother reports on the Depression Composite; and (b) mother reports on the CDI using correlated t-tests indicated no significant differences. No differences were observed in the magnitude of these correlation coefficients for fathers as well. In addition, no differences were observed in the magnitude of the correlation coefficients comparing mother reports with father reports for these coefficients.

Descriptive Statistics. Mother reports of depression on the BDI ranged from 0.00 to 34.00 (M = 7.46, SD = 7.05), fathers's scores ranged from 0.00 to 15.00 (M = 3.66, SD = 3.44). Twenty-three mothers (25% of the sample) reported minimal to severe symptoms compared to two fathers (5% of the sample) (See Beck and Steer (1987) for diagnostic criteria). Of the total sample of parents who participated, only four mothers and one father reported depressive symptoms in their children (i.e., score equal to or greater than 15 on the CDI). Of these five children, only two reported experiencing depressive symptoms themselves. Seven mothers who reported minimal to severe symptoms on the BDI had children who also reported depressive symptoms on the CDI.

Table 27

Correlations Between Parent BDI Scores and the Depression Composite and CDI/CDI-P for Child, Mother, and Father Informants

Informants	Children		Mothers	
	DC	CDI	DC	CDI
Mother BDI	-.14	.04	-.36**	.37**

Informants	Children		Fathers	
	DC	CDI	DC	CDI
Father BDI [a]	-.14	.22	-.35*	.26

Note. DC = Depression Composite. CDI = Children's Depression Inventory. BDI = Beck Depression Inventory.

[a] One father did not complete this questionnaire; thus N = 38 for fathers.

* = p <.05. ** = p <.01

Predicting the Depression Composite from the BDI. Mother and father reports of depression on the BDI did not predict child self-reports on the Depression Composite (See Table 28). However, mother reports on the BDI predicted mother reports of child functioning on the Depression Composite (R = .36, F (1,90) = 13.75, p <.001), and father reports on the BDI predicted father reports of child functioning on the Depression Composite (R = .35, F (1,36) = 5.10, p <.05).

Predicting the CDI from the BDI. Child self-reports on the CDI were not predicted by either mother or father reports of depression on the BDI. Mother reports of depression on the BDI did predict mother reports of child functioning on the CDI (R = .37, F (1,90) = 14.05, p <.001), but father reports did not predict father reports on the CDI (See Table 28).

Summary. The outcome of this analysis suggests that there is a relationship between parent reports of depression and parent perceptions of child functioning. However, parent reported difficulties were not related to child self-reports.

Hypothesis IV

The final goal of this study predicted that support would be found for a sequential model of the determinants and mediational role of self-worth in elementary school age children. Harter's (Harter et al., 1991) model represents a

Table 28

Summary of Regression Analyses with Mother and Father Reports on the BDI [a] as the Predictor Variable

Dependent Variable: Depression Composite

	R	R^2	F	b	SEb
Informants					
Child	.14	.02	1.83 (1,90)	-.01	.01
Mother	.36	.13	13.75** (1,90)	-.03	.01
Child	.14	.02	0.68 (1,36)	-.03	.03
Father	.35	.12	5.10* (1,36)	-.04	.02
Dependent Variable: CDI					
Informants					
Child	.04	.00	0.12 (1,90)	.05	.16
Mother	.37	.14	14.05** (1,90)	.27	.07
Child	.22	.05	1.83 (1,36)	.61	.45
Father	.26	.07	2.60 (1,36)	.28	.17

Note. R = Multiple R. R^2 = Multiple R Squared. b = Unstandardized Regression Coefficient. SEb = Standard Error of the Regression Coefficient.

[a] One father did not complete this questionnaire; thus N = 38 for fathers.

* = $p < .05$. ** = $p < .01$. ** = $p < .001$.

sequential, multistage attempt to identify the antecedents and mediational role of self-worth and risk factors associated with suicidal ideation. Harter's model is divided into four components or stages (a) the impact of Scholastic Competence/Behavioral Conduct (SBC) and Athletic Competence/Social Acceptance/Physical Appearance (ASP) on perceptions of Parent Support (PS); (b) the impact of SBC and ASP on perceptions of School Support (SS); (c) the impact of SBC, ASP, PS, and SS on the Depression Composite (DC); and (d) the impact of the DC, PS, and SBC on Suicidal Ideation (SI) (See Harter et al., 1991 for a complete description of this model). At the last stage, there are more variables than enter the model; for example, Athletic Competence/Social Acceptance/Physical Appearance (ASP) and School Support (SS) are not evaluated as predictors of Suicidal Ideation (SI) in Regression IV. The exclusion of these variables is based on empirical testing to determine which variables contribute to the most parsimonious model of self-worth (e.g., see Harter et al., 1991).

Harter's complete model was not used in the present study as she incorporates: (a) judgments of the importance of success on the subscales of the SPPC (which is measured by the Importance Rating Scale [IRS: Hater, 1985a]); and judgments of hopefulness/hopelessness about (b) the future; (c) of achieving competency in domains considered important to the self; and (d) of achieving social support from

significant others. The IRS was not used in the present study as its use would have resulted in restrictions in the number of child self-reports that could be included in the regression analyses. Constructs relating to hopelessness were not assessed for the elementary school age children because Harter (1989) has indicated that the ability to make judgements about the future does not fully develop until after puberty. Also, these tests have been developed for use with adolescent populations (Harter et al., 1991) and are currently unpublished. However, they are available from the author upon request.

To evaluate Harter's model, four separate regressions were computed for each group of informants (i.e., children, mothers, and fathers). The following composite variables were included: (a) Scholastic Competence/Behavioral Conduct (SBC) which represents the average of the Scholastic Competence (SC) plus Behavioral Conduct (BC) subscale scores of the SPPC; (b) Athletic Competence/Social Acceptance/Physical Appearance (ASP), which represents the average of the Athletic Competence (AC) plus Social Acceptance (SA) plus Physical Appearance (PA) subscale scores of the SPPC; (c) School Support (SS), computed by averaging the Classmate Support (CS) plus Close Friend Support (FS) subscale scores of the SSSC; (d) the Parent Support (PS) subscale of the SSSC; and (e) the Depression Composite (DC) formed by computing the average of the Self-

Worth (SW) plus the Mood/Affect (MA) subscale scores of the DDPC. The first regression examined Parent Support (PS) as the dependent variable and SBC and ASP as the predictor variables. The second regression examined School Support (SS) as the dependent variable and SBC and ASP as the predictor variables. The third regression used the Depression Composite (DC) as the dependent variable and the following as the predictor variables: SBC, PS, ASP, and SS. The fourth regression examined Suicidal Ideation (SI) as the dependent variable and the DC, SBC, and PS composite scores as the predictor variables.

Last, following procedures outlined in Pedhazur (1982), the goodness of fit of the complete model including ASP and SS as predictors of SI was compared to the goodness of fit of the more parsimonious model which excluded these two variables from Regression IV. Both of these models are based on empirical testing using Harter's proposed models (e.g., see Harter et al., 1991). Goodness of fit tests are reported for child and mother generated data only due to the small sample of fathers who participated.

Descriptive Statistics. The means and standard deviations for each composite variable for each informant are presented in Table 29. Table 30 presents correlation matrices for each variable in the regression analyses, for each informant.

Table 29

Means and Standard Deviations for the Composite Variables for Harter's Model of Self-Worth for Children, Mothers, and Fathers

Composite Variables		Informants: Children N = 92	Mothers N = 92	Fathers N = 39
PS [a]	M	3.51	3.64	3.74
	SD	0.60	0.38	0.31
SS [b]	M	3.25	3.29	3.42
	SD	0.61	0.49	0.38
SBC	M	2.86	3.25	3.22
	SD	0.68	0.63	0.64
ASP	M	2.87	3.34	3.45
	SD	0.61	0.39	0.40
DC	M	3.13	3.35	3.54
	SD	0.72	0.51	0.43
SI	M	3.41	3.79	3.81
	SD	0.72	0.36	0.33

Note. PS = Parent Support. SS = School Support. SBC = Scholastic Competence/Behavioral Conduct. ASP = Athletic Competence/Social Acceptance/Physical Appearance. DC = Depression Composite.SI = Suicidal Ideation.

[a] One mother and one father did not complete the subscales comprising this composite score; thus N = 91 for mothers and N = 38 for fathers. [b] One mother and one father did not complete the subscale comprising this composite score; thus N = 91 for mothers and N = 38 for fathers.

Table 30

Correlation Matrices for the Composite Variables for Harter's Model of Self-Worth for Children, Mothers, and Fathers

Child Report

	DC	SBC	ASP	SS	PS	SI
DC						
SBC	.70**					
ASP	.73**	.57**				
SS	.62**	.52**	.55**			
PS	.67**	.56**	.39**	.63**		
SI	.77**	.57**	.58**	.61**	.73**	

Mother Report

	DC	SBC	ASP	SS [a]	PS [a]	SI
DC						
SBC	.50**					
ASP	.49**	.32**				
SS	.47**	.22*	.50**			
PS	.42**	.37**	.24*	.37**		
SI	.53**	.19	.40**	.38**	.39**	

Father Report

	DC	SBC	ASP	SS [b]	PS [b]	SI
DC						
SBC	.51**					
ASP	.51**	.13				
SS	.72**	.60**	.51**			
PS	.48**	.43**	.49**	.69**		
SI	.66**	.58**	.42**	.71**	.61**	

Note. DC = Depression Composite. SBC = Scholastic Competence/Behavioral Conduct. ASP = Athletic Competence/Social Acceptance/Physical Appearance. SS = School Support. PS = Parent Support. SI = Suicidal Ideation.
[a] One mother did not complete the subscales comprising these composite scores; thus N = 91 for mothers. [b] One father did not complete the subscales comprising these composite scores; thus N = 38 for fathers.
* = p <.05. ** = p <.01

Examination of Harter's Model of the Antecedents and Mediators of Self-Worth. Partial support was found for Harter's model (Harter et al., 1991) using child generated data. The first regression equation was significant, (R = .57, F (2,89) = 21.51, p <.001); however, only the composite variable Scholastic Competence/Behavioral Conduct (SBC) was predictive of Parent Support (PS) (See Table 31). The second regression was fully supported (R = .60, F (2,89) = 25.30, p <.001) by the entry of both the Athletic Competence/Social Acceptance/Physical Appearance (ASP) and Scholastic Competence/Behavioral Conduct (SBC) variables to perceptions of School Support (SS). Partial prediction of the Depression Composite (DC) was also obtained in the third regression (R = .86, F (4,87) = 63.51, p <.001) by the entry of the Parent Support (PS), Athletic Competence/Social Acceptance/Physical Appearance (ASP), and Scholastic Competence/Behavioral Conduct (SBC) variables. Last, partial support was demonstrated for the fourth regression (R = .82, F (3,88) = 62.31, p <.001). However, only the Depression Composite (DC) and the Parent Support (PS) variables contributed unique variance to the prediction of Suicidal Ideation (SI). Model testing (Pedhazur, 1982) indicated a fit between the proposed model and the data for this sample of children (χ^2 (3, N = 92) = 1.22, p >.05). Figure 1 presents Harter's sequential, multistage model; reported coefficients are standardized beta coefficients.

Table 31

Summary of Regression Analyses Using Harter's Model of Self-Worth for Children, Mothers, and Fathers

R	R^2	F	Pred. Var.	b	SEb	Unique Variance	F
Child Report							
Regression I: Dependent Variable = Parent Support							
.57	.33	21.51*** (2,89)	ASP	.10	.10	.01	1.03
			SBC	.44	.09	.17	22.65*** (1,90)
Regression II: Dependent Variable = School Support							
.60	.36	25.30*** (2,89)	ASP	.37	.10	.10	13.44***
			SBC	.27	.09	.06	8.62** (1,90)
Regression III: Dependent Variable = Depression Composite							
.86	.74	63.51*** (4,87)	PS	.40	.09	.06	19.85***
			ASP	.52	.08	.11	38.50***
			SBC	.26	.08	.03	10.82**
			SS	.05	.09	.00	0.31 (1,90)
Regression IV: Dependent Variable = Suicidal Ideation							
.82	.68	62.31*** (3,88)	PS	.48	.10	.08	23.07***
			SBC	-.01	.10	.00	0.02
			DC	.51	.10	.10	28.34*** (1,90)

(table continues)

Table 31 continues

R	R^2	F	Pred. Var.	b	SEb	Unique Variance	F
Mother Report							
Regression I: Dependent Variable = Parent Support							
.39	.15	7.95** (2,88)	ASP	.14	.10	.02	1.83
			SBC	.20	.07	.09	9.77**
							(1,90)
Regression II: Dependent Variable = School Support							
.51	.26	15.33*** (2,88)	ASP	.60	.12	.21	25.10***
			SBC	.05	.08	.00	0.41
							(1,90)
Regression III: Dependent Variable = Depression Composite							
.66	.44	16.57*** (4,86)	PS [a]	.23	.12	.02	3.71
			ASP	.33	.12	.05	6.90*
			SBC	.24	.08	.06	9.78**
			SS [a]	.22	.10	.03	4.74*
							(1,90)
Regression IV: Dependent Variable = Suicidal Ideation							
.58	.33	14.35*** (3,87)	PS [a]	.22	.09	.04	5.51*
			SBC	-.08	.06	.01	1.90
			DC	.35	.07	.18	22.87***
							(1,90)

(table continues)

Table 31 continues

R	R^2	F	Pred. Var.	b	SEb	Unique Variance	F
Father Report							
Regression I: Dependent Variable = Parent Support							
.58	.34	9.00** (2,35)	ASP	.31	.11	.15	8.03**
			SBC	.17	.08	.10	5.38* (1,37)
Regression II: Dependent Variable = School Support							
.70	.50	17.26*** (2,35)	ASP	.36	.12	.14	9.43**
			SBC	.34	.08	.24	16.36*** (1,37)
Regression III: Dependent Variable = Depression Composite							
.78	.60	12.52*** (4,33)	PS [b]	-.13	.22	.00	0.35
			ASP	.23	.10	.05	4.55*
			SBC	.25	.14	.04	3.12
			SS [b]	.55	.20	.09	7.52** (1,37)
Regression IV: Dependent Variable = Suicidal Ideation							
.81	.66	22.16*** (3,34)	PS [b]	.32	.12	.07	6.72*
			SBC	.25	.07	.11	11.35**
			DC	.19	.10	.04	3.70 (1,37)

Note. R = Multiple R. R^2 = Multiple R Squared. Pred. = Predictor Variables. b = Unstandardized Regression Coefficient. SEb = Standard Error of the Regression Coefficient. PS = Parent Support. SS = School Support. SBC = Scholastic Competence/Behavioral Conduct. ASP = Athletic Competence/Social Acceptance/Physical Appearance.
[a] One mother did not complete the subscales comprising these composite scores; thus N = 91 for mothers. [b] One father did not complete the subscales comprising these composite scores; thus N = 38 for fathers.
* = p <.05. ** = p <.01. *** = p <.001.

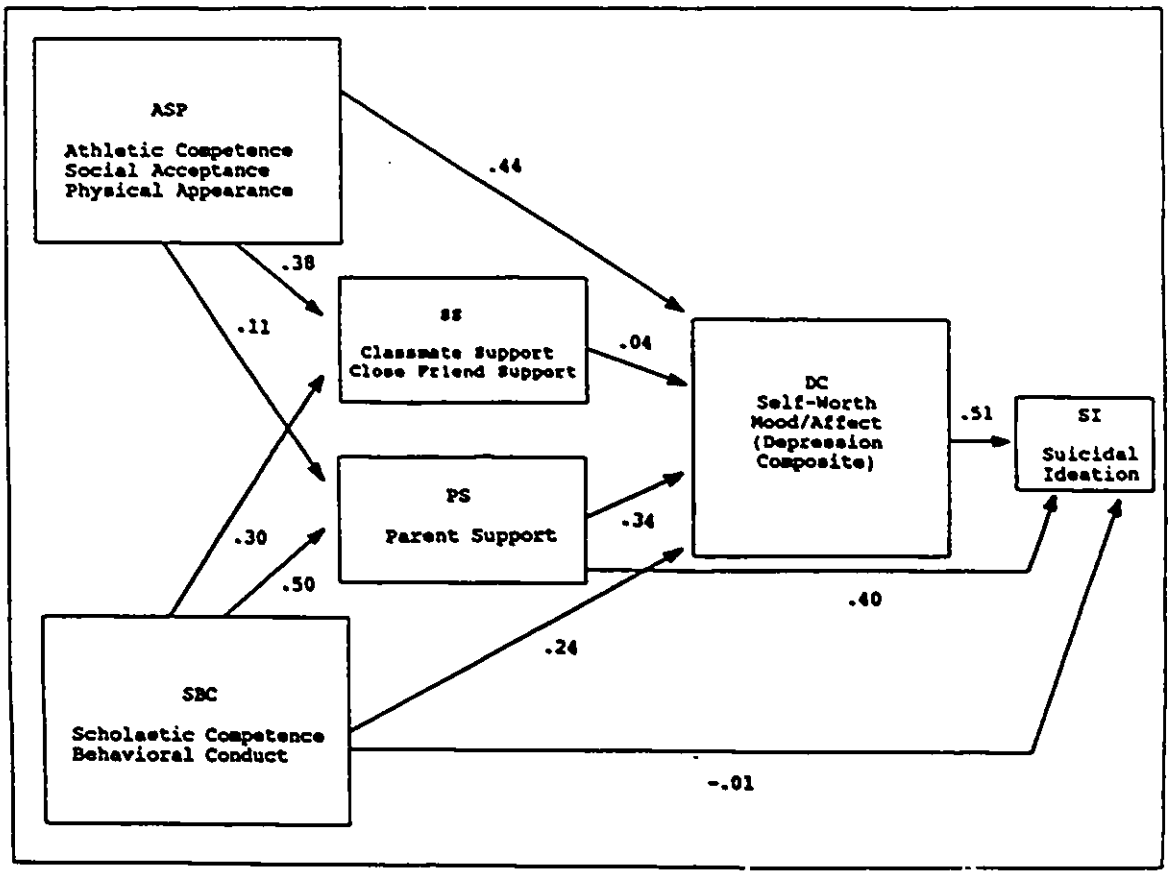

Figure 1. Model of the determinants and mediational role of self-worth, including standardized beta coefficients for child self-reports.

Mother data also provided partial support for Harter's model (See Figure 2). Regression I resulted in a significant solution (R = .39, F (2,88) = 7.95, p <.001) with the composite variable Scholastic Competence/Behavioral Conduct (BC) contributing unique variance to the equation (See Table 31). Partial support was also obtained for regressions II (R = .51, F (2,88) = 15.57, p <.001) and III (R = .66, F (4,86) = 16.57, p <.001). Differences were noted in the combination of variables that contributed to the significance of each equation compared to those reported by the children in this study and by Harter et al. (1991). Partial support was also demonstrated for the fourth regression (R = .58, F (3,87) = 14.35, p <.001) but only the Depression Composite (DC) and Parent Support (PS) variables contributed unique variance to this solution. This solution was similar to that generated by the child data. Mother data was also determined to provide a fit of the model described (χ^2 (3, N = 92) = 1.78, p >.05).

Regressions were computed for the father data. However, caution is warranted when interpreting the outcome of these results because of the small number of fathers who participated (N = 39) and the subsequent restrictions imposed by multivariate analyses with small sample sizes.

Father data were also observed to support Harter's model (See Figure 3). However, some of the predictor variables contributing unique variance to these equations

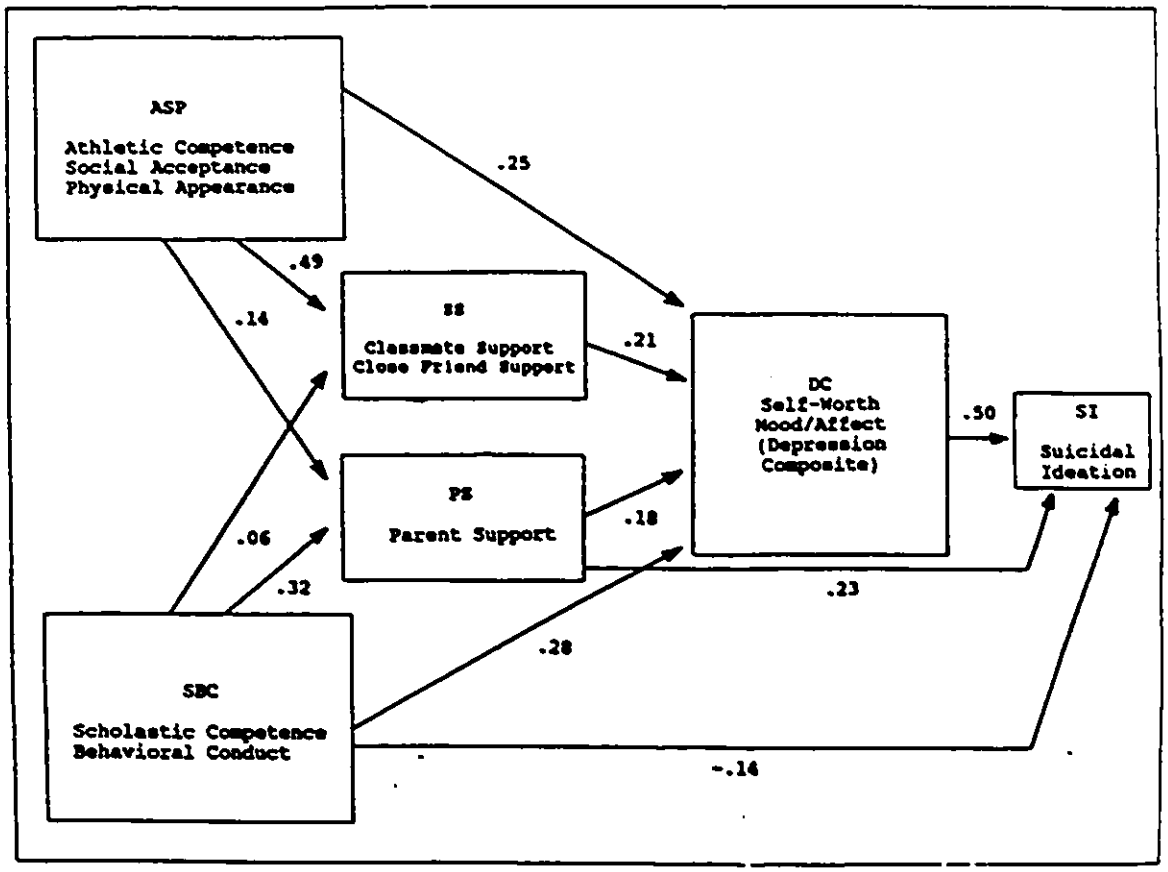

Figure 2. Model of the determinants and mediational role of self-worth, including standardized beta coefficients for mother reports.

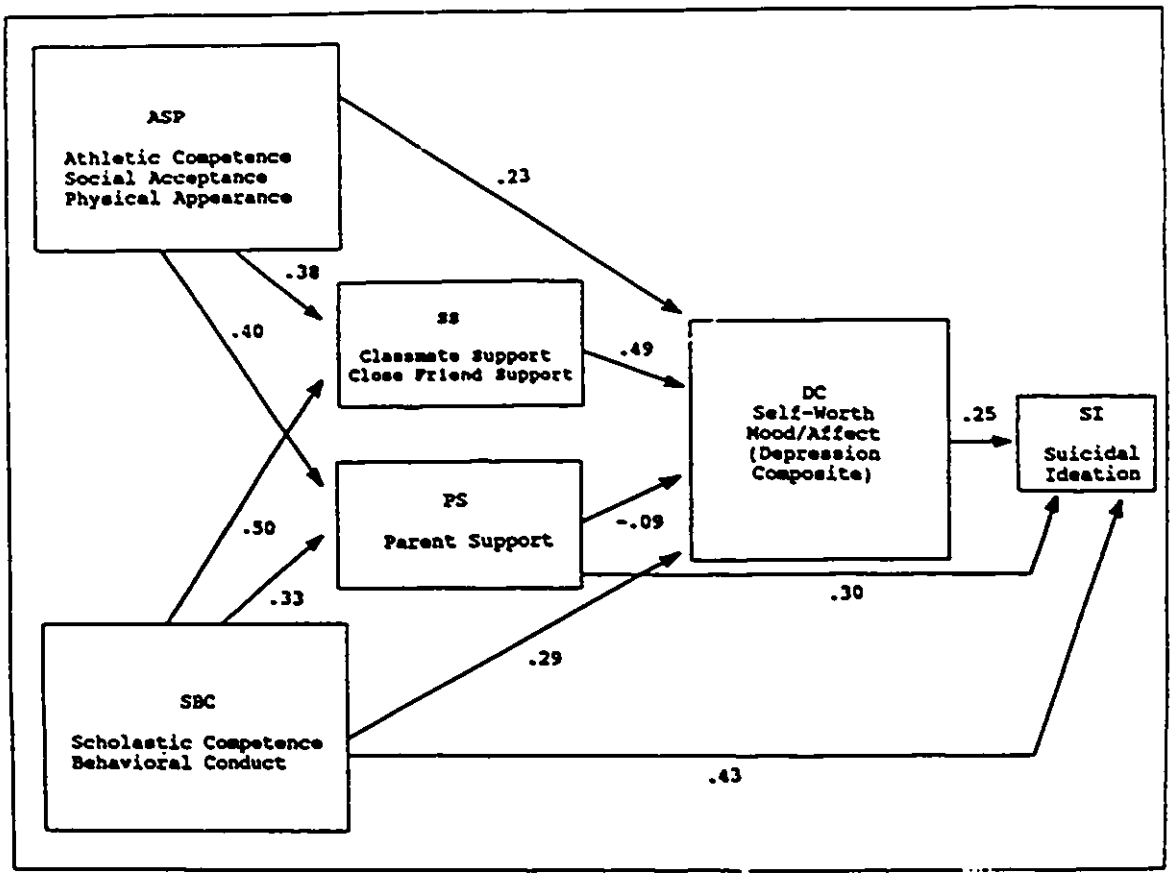

Figure 3. Model of the determinants and mediational role of self-worth, including standardized beta coefficients for father reports.

were different than those generated by the children and mothers in this study. Most noteworthy was the failure of the Depression Composite to contribute unique variance to the fourth regression (See Table 31). A goodness of fit test was not computed for the fathers due to the concerns raised above.

Summary. The results of these analyses provide partial support for Harter's model using both child and mother generated information. Father reports were less consistent and more difficult to interpret. It is possible that fathers may emphasize different aspects of child functioning in determining risk for suicidal ideation.

Summary of the Results

The first goal was to compare parent-child agreement on measures of childhood depression. The first hypothesis predicted that better parent-child agreement would be found for the discrete symptom areas of depression as assessed by the DDPC than for a more global measure of depression, the CDI. In fact, contrary to expectations, agreement on the CDI was significantly better than agreement on the Suicidal Ideation subscale for children and fathers and significantly better than agreement on the Self-Blame subscale for mothers and fathers. Last, while convergence between informants was minimal for the subscales of the DDPC, both mother and father reports on the CDI-P were significantly correlated with child self-reports on most subscales of the DDPC.

The second hypothesis predicted that parent-child agreement would be greater for a subgroup of children identified to have low self-worth compared to a subgroup of children with high self-worth. This expectation was not supported by the results. Differences were observed in the pattern of correlation coefficients that obtained significance between the two groups of children for the SPPC/PRS, SSSC, DDPC, and CDI. However, a comparison of these coefficients using Fisher's Z tests for independent samples indicated no differences in parent-child agreement, with the exception of the Teacher Support subscale of the SSSC.

The third hypothesis stated that parent self-reports of depression would be positively related to child self-reports and parent reports of child depression. The results of this study indicated that mother and father self-reports of depression were positively correlated with parent reports of child functioning. However, mother and father reports were not correlated with child self-reports of depression.

The fourth hypothesis predicted that support would be found for Harter's model of the determinants and mediational role of self-worth in elementary school age children. Partial support was obtained for this model, suggesting that child self-reports and mothers' reports of child functioning can be utilized to determine potential risk factors associated with suicidal ideation in children.

CHAPTER IV

DISCUSSION

The results of the present study suggest that it may not be advantageous to pursue variables that could impact on parent-child agreement. Researchers and clinicians alike may have to accept that agreement between different pairs of informants will be in the low to moderate range. A more fruitful endeavour may be to investigate schema held by children and adolescents regarding the construct "depression" and to develop more efficacious measures of childhood depression that are related to later maladaptive behaviours including suicidal ideation in adolescence.

A discussion of the findings for each hypothesis is presented separately in the following section. This is followed by a summary of the implications for using child self-reports and some possible directions for future research.

Hypothesis I. For hypothesis I, the degree of relationship between child self-reports and parent reports of child functioning on two measures of childhood depression was investigated. The CDI represents a global measure of childhood depression which assesses both primary and secondary symptoms, while the DDPC is a domain-specific or primary symptom measure of childhood depression (Harter & Nowakowski, 1987). For hypothesis I, the prediction was that parent-child agreement would be greater for the domain-

specific subscales of the DDPC than for the CDI. Obtained results were contrary to expectations. Low to moderate agreement was observed between children and mothers, children and fathers, and mothers and fathers on the CDI total score for both the total sample of children (N = 92) and for the subgroup of children with both mothers and fathers participating (N = 39). Convergence, (or agreement between informants), failed to reach significance for most of the DDPC subscales across the different pairs of informants, with the exception of the Self-Worth subscale. Convergence was noted on the Self-Worth subscale for children and mothers for the total sample of children; for children and mothers for the subgroup of children with both parents participating; and for mothers and fathers for the subgroup of children with both parents participating. Correlated t-tests to determine whether convergence was greater for the subscales of the DDPC than for the CDI revealed either no differences in the magnitude of convergence, or that convergence was greater for the CDI than for the DDPC subscales.

These results are disappointing for two reasons. First, convergence was not achieved for a majority of the DDPC subscales, suggesting that children and parents did not provide similar estimates of child functioning on this measure. Second, the lack of convergence for the DDPC subscales limited the number of possible comparisons that

could be made between these subscales and the CDI.

The absence of agreement between informants for the DDPC subscales may reflect the more subjective and evaluative nature of the items on this measure. For example, children are asked to read each item, to compare themselves to two groups of children, and to decide which group is most like them. One group of children describes a more positive or adaptive attribute and the other group describes a more negative or maladaptive attribute (e.g., "some kids feel happy about things in their life BUT other kids feel sad about how their life is going"). According to Harter & Nowakowski (1987), this response format is effective because it legitimizes either choice and allows the child to identify with existing groups of children. Also, it does not require that children endorse "I" statements or make direct statements about the self (Harter & Nowakowski, 1987). In contrast, the CDI asks children to endorse "I" statements. Another difference between these two measures appears to be in the nature of the judgments required. The DDPC appears to ask children to make evaluative judgments about their feelings and experiences (e.g., "Some kids are unhappy a lot of the time BUT other kids are pretty happy a lot of the time"), while the CDI asks children to endorse both internally experienced feeling states (e.g., "I feel sad once in a while") and descriptors of actual behaviours (e.g., "I do most things O.K."). It is possible that parents

may be better able to respond to the more direct statements of the CDI parent version than to a child's possible interpretations or perceptions of experiences or feeling states on the DDPC. For example, parents may find it easier to endorse statements that reflect actual behaviours with which they may have had some experience (e.g., "My child cannot make up her/his mind about things"), rather than guess at a child's self-evaluation of his or her inner experiences (e.g., "Some kids wish they were different BUT other kids like the way they are"). Thus, the more evaluative and subjective nature of the DDPC may have hampered parent-child agreement because parents would not be expected to have access to a child's evaluations of internal experiences. In contrast, the CDI, which taps both subjective and overt manifestations of depressive symptoms could be expected to show greater agreement between informants.

Related to the evaluative and subjective nature of the DDPC is the undifferentiated content of some items. For example, a child may "wish that they were different", but only the child knows in which way she or he wishes this difference to occur (i.e., to be taller, to be more friendly or popular, etc.). In contrast, some items on the CDI are more concrete (e.g., "I have to push myself many times to do my school-work"). While a child may have no difficulty responding to both types of items, an adult may feel more

competent in answering the CDI than the DDPC.

This explanation may clarify why children and parents failed to reach convergence on most of the DDPC subscale scores but demonstrated low to moderate inter-relationships between child reports on most of the DDPC subscale scores and mother and father reports on the CDI-P (See Tables 15 and 16). As suggested earlier, the CDI-P may be more user friendly for parents than the DDPC-P, while children can self-report using either measure of depression. This observation suggests that, overall, children and parents were reporting similar behaviours or experiences. Also, because the CDI is a downward extension of the BDI, parents may feel more comfortable or competent in responding to the various items. Item content on the CDI, while determined to be relevant to childhood depression, may still reflect adult-like experiences. In contrast, the DDPC was designed specifically for children and attempts to state depressive experiences in a way that is uniquely geared to children (e.g., "Some kids don't have the energy to do the things they are supposed to do BUT other kids really do feel like doing the things they have to do each day").

Parent-child agreement may also be affected by the wording of the items on the parent forms of the CDI and DDPC. In this study, items were re-worded so that parents could respond according to their perceptions of their child's feelings and behaviours. In a similar study using

only the CDI, Garber (1983) asked parents to respond on the basis of how they believed their child felt. These differences in wording, while subtle, could affect parent-child agreement, especially for subjective or covert experiences.

A number of additional issues related to parent-child agreement and child self-reports emerged from the testing of hypothesis I and are addressed next. These include the low to moderate estimates of convergence typically observed between informants, the magnitude and direction of symptom severity reported by different informants, the identification of a subgroup of children considered to be at risk for depression, and the use of the DDPC as a screening measure of childhood depression.

Convergence and Degree of Symptom Severity. Typically, discrepancies are reported in the literature between children and their mothers regarding agreement and symptom severity on measures of childhood depression. Consistent with other studies (e.g., see Achenbach et al., 1987 for a review), low to moderate intercorrelations were found between informants for the CDI total score and for the Self-Worth subscale score of the DDPC. This pattern of low to moderate agreement for these measures is comparable with reports in the literature, whether the children are inpatients (Kazdin et al., 1983a, b, c,), outpatients (Treiber & Mabe, 1987), or elementary school children

(Reynolds et al., 1985), and whether the measure of interest is a psychiatric interview (Edelbrock et al., 1986), clinician rating scale (Kazdin et al., 1983a, b, c; Mokros et al., 1987), parent report behaviour questionnaire (Leon, Kendall, & Garber, 1980; Reynolds et al., 1985), or child self-report measure (Kazdin et al., 1983a, b, c; Weissman et al., 1980). Second, contrary to reports provided by Kazdin et al. (1983a, b, c) for psychiatric children and by Treiber and Mabe (1987) for outpatient children, children in this sample provided more negative estimates of their overall functioning than did their mothers and fathers. This observation was consistent across each questionnaire (i.e., SPPC, SSSC, DDPC, CDI) for the total sample of children (N = 92) and for the subgroup of children identified to be at risk for depression (N = 25).

Other researchers have reported similar, contradictory findings. For example, Edelbrock et al. (1986) observed that psychiatric inpatient and outpatient children reported more depressive symptoms on the DISC, a structured psychiatric interview, than did their mothers. However, Mokros et al. (1987) found no difference between child and mother reports for their clinic sample, but observed the nonclinic children to report more emotional distress than did their mothers on the Children's Depression Rating Scale.

Numerous explanations exist for the differences in symptom severity reported by children and parents on

measures of depression, including the possibility that children may have exaggerated or over-reported symptom occurrence and severity. However, child self-reports were determined to be reliable and meaningful (e.g., see Internal Reliability-Internal Consistency estimates, Table 9). Second, when children reported difficulties in one area of functioning (i.e., depression), they also reported problems in other areas as well (i.e., perceptions of competency, social support). Third, child self-reports resulted in the identification of a subgroup of children considered to be at risk for depression; mother and father reports resulted in the identification of a smaller subgroup of children. (Please see the following section for a more detailed discussion of this issue). These observations suggest that parents may not be sensitive to the full scope of emotional, academic, or social difficulties experienced by their children; this raises the possibility that parents may underestimate the existence or extent of these difficulties. For example, Moretti et al. (1985) observed that parent comments reflected a lack of knowledge or awareness of their children's distress. Also, parents may view childhood as a time of innocence and goodwill (Anthony & Cytryn, 1977) and thus fail to realize that their children may be experiencing emotional problems.

Typically, parents report more overt or externalizing difficulties and fewer covert or internalizing problems in

their children (Herjanic & Reich, 1982). Although overt behaviour problems were not examined in this study, the finding that parents reported fewer depressive symptoms is consistent with some of the literature (e.g., see Edelbrock et al., 1986). Differences in symptom severity may also be attributed to different schema held by children and parents. For example, children may interpret a symptom to be problematic and to cause them intense distress, whereas parents may minimize or underestimate the impact of the symptom to the child's overall functioning (Angold, 1988). In such cases, this could result in minimal agreement between informants.

Last, it is possible that differences in the magnitude of child and parent reported symptoms may be idiosyncratic to the sample of children being studied (e.g., see Mokros et al., 1987). However, there does appear to be a trend for psychiatric referred children to report less symptomatology and for non-referred children to report more symptoms in relation to parent reports.

Child Reports of Depression. A small percentage of children were determined to be at risk for depression based on child self-reports. Using stringent criteria outlined by Kovacs (1992), 10% of the sample (N = 9) was determined to be at risk; adoption of more liberal criteria resulted in 25 children or 27% of the sample identified to be at risk. It should be remembered that the CDI is designed to be a

screening measure for childhood depression, not a diagnostic instrument. The number of children identified to be at risk for depression in this study using liberal criteria was slightly greater than prevalence rates (2 to 20%) (Kazdin, 1988) for both normative (e.g., see Kashani et al., 1983) and clinic referred children in the United States (Puig-Antich & Gittelman, 1982) and for normative children in Ontario (approximately 10% for emotional disorders which reflect a combination of anxiety, affective, and obsessive compulsive symptoms using DSM-III criteria) (e.g., see Offord, Boyle, Fleming, Blum, & Grant, 1989). Prevalence rates of childhood depression can, however, be affected by the type of assessment measure used, the child population being interviewed, and the diagnostic criteria used (Fleming & Offord 1989; Kazdin, 1988).

In the present study, no opportunity existed for the clarification of the children's responses on the two measures of depression. However, informal observations made by the author and/or the graduate assistant identified six of the 25 children as exhibiting behavioral or emotional problems during the group administration of the questionnaires. Interestingly, only four mothers and one father reported depression in their children that met the more liberal criteria used in this study (i.e., CDI score equal to or greater than 15). Comparison of child and parent reports revealed overlap between one mother and her child

and one father and his child. During telephone contacts with parents to inform them of the possibility of their children requiring mental health follow-up, seventeen parents either indicated that their child was already receiving some form of assistance or that they were aware that their child was experiencing difficulties and mentioned the antecedent (e.g., divorce, death of a family member, or sibling conflict). These responses lend credence to the children's self-reports on the CDI, but raise the question of why parents did not report more depressive symptoms in their children if they were aware of difficulties. A possible explanation for this is that children experiencing depressive symptoms are under-identified during the elementary school years.

Psychometric Properties of the DDPC. Although not an explicit goal of the present study, support was obtained for the DDPC as a self-report measure of childhood depression. The DDPC was designed to assess theoretically derived dimensions of depression believed to occur in children and adolescents (e.g., affect, motivation) with special attention given to feelings of self-worth and self-deprecatory ideation (Harter & Nowakowski, 1987). The CDI, in comparison, was modeled after the BDI and reflects symptom overlap between adults, adolescents, and children (Kovacs & Beck, 1977). Certainly, the DDPC possesses content and face validity. In addition, internal reliability-

consistency estimates for the children, mothers, and fathers in this study (see Table 9) suggests that the five DDPC subscales contain homogeneous item content. Last, moderate to high intercorrelations between the CDI and each of the five subscales of the DDPC were observed for children and mothers (See Appendix P). In fact, the largest correlations were observed between the CDI and the Mood/Affect and Self-Worth subscales for children, mothers, and fathers. These results suggest that the DDPC may well function as an alternate self-report measure of depression. While further validation of the DDPC with both normative and clinical groups of children is necessary, it appears to be potentially useful as a screening measure of childhood depression.

Hypothesis II. For hypothesis II, children with low global self-worth and their parents were compared to children with high global self-worth and their parents to determine if low global self-worth children and their parents provided more congruent assessments of child functioning. Contrary to predictions, dividing the total sample of children into two groups on the basis of child reported global self-worth did not facilitate inter-informant agreement. Low to moderate convergence was noted for children and mothers on the Scholastic Competence, Athletic Competence, and Behavioral Conduct subscales of the SPPC/PRS for both the low and high global self-worth groups

of children. Moderate to high convergence was noted for children and fathers and mothers and fathers for both groups of children on these same subscales. However, inter-informant agreement for the group of low global self-worth children was not significantly greater than for the group of high global self-worth children. Inter-informant agreement for the SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P was similarly not improved by dividing the sample into low and high global self-worth groups, with the exception of the Teacher Support subscale of the SSSC/SSSC-P. Thus, the results of the present study were inconsistent with Harter's observation that teacher ratings and child self-reports were more congruent for children with low global self-worth than for children with high global self-worth (Harter, 1986).

In the present study, child and parent reports for low and high global self-worth groups of children were compared on the SPPC, SSSC, DDPC, and CDI. In contrast, Harter (1986) compared child and teacher reports and found greater convergence on a measure of perceived competence (i.e., SPPC) for a subgroup of children with low global self-worth. The differences in these two findings could be related to the teacher's greater experience with, and opportunity to observe, compare, and evaluate children. Thus the teachers in Harter's study may have been more practised in evaluating children than the parents who participated in the present study.

Alternatively, the inclusion of teacher ratings or grade reports in the present study could have provided an additional standard against which to compare both child and parent reports, and to determine whether children with low global self-worth provided more congruent or realistic appraisals of their competencies than did children with high global self-worth. For example, the SPPC asks children about their competencies in a number of school related domains (i.e., Scholastic Competence, Social Acceptance, Athletic Competence, Behavioral Conduct), while the SSSC asks about teacher and school (i.e., classmate and close friend) relationships. These domains reflect areas that are often part of the school curriculum and require ongoing evaluation by teachers. Thus the inclusion of teacher generated information may have helped to clarify the results of this study.

The use of teacher ratings as a "gold standard" (Richters, 1992) against which to compare child or parent ratings implies that there are tangible measures of childhood behaviour, and that some informants may have better access to this information. In addition to teachers, some authors have suggested using fathers as a gold standard against which to compare mother reports. Arguably, the fathers who participated in the present study could be considered to represent such a standard. The assumption that teachers or fathers can function as a gold standard ignores

the possibility that ratings completed by these informants may be as fallible as the ratings completed by children or their mothers. For example, teachers as well as parents may be less likely to notice symptoms of depression and social withdrawal than the more overt behaviour disorders such as Conduct Disorder or Attention Deficit Hyperactivity Disorder (Stavrakaki, Williams, Walker, Roberts, & Kotsopoulos, 1991). Alternatively, teachers and parents may misinterpret affective problems as behaviour problems (Kashani et al., 1985) or report only those behaviours that they perceive as disruptive or disturbing (Cytryn et al., 1980). Also, it is conceivable that informants will differ in their assessment of the child depending on the nature of their relationship and the frequency of their contact with the child (Achenbach et al., 1987).

The assumption that children with low global self-worth will provide more congruent responses with adult ratings is related to the theory of "depressive realism" (e.g., see Altmann & Gotlib, 1988). This position suggests that depressed individuals provide more realistic appraisals of the self than do non-depressed persons. This is in contrast to some cognitive theories of depression which suggest that depressed individuals make cognitive distortions that are related to a more negative or pessimistic view of the self (e.g., see Beck, 1967). Empirical support has been demonstrated for both depressive realism (Altmann & Gotlib,

1988) and cognitive distortions in children (Asarnow, Carlson, & Guthrie, 1987; Kendall, Stark, & Adam, 1990). For example, Altmann and Gotlib (1988) reported that children who rated themselves as depressed on the CDI also perceived themselves as less socially adept on the SPPC and were observed to demonstrate social skills deficits during periods of free play. These authors suggested that the negative self-appraisals of the depressed children represented actual difficulties and provided support for the position of depressive realism. In contrast, Kendall et al. (1990) reported that depressed children distorted their self-perceptions on a measure of competence similar to the SPPC relative to teacher reports, and that teacher reports correlated more highly with the self-reports of the non-depressed children.

The results of the present study do little to clarify this issue. However, an interesting avenue for further research involves the possibility that both depressive realism and cognitive distortions occur differentially in various subgroups of depressed children. For example, Asarnow et al. (1987) observed that depressed children reported negative self-perceptions on the Scholastic Competence and Global Self-Worth subscales of the SPPC. In contrast, Asarnow and Bates (1988) observed a second sample of depressed children to report negative self-perceptions on all subscales of the SPPC. Asarnow and Bates (1988) suggest

that the observed discrepancies between these two studies reflects not only the heterogeneity of depressive disorders in children, but the presence of subgroups of children who may distort self-perceptions on some, but not all domains. In a related vein, Mullins, Peterson, Wonderlich, and Reaven (1986) suggest that depressed children who realistically view themselves negatively may elicit negative reactions from others which serves to reinforce their negative self-perceptions.

It may be the case then, that when children fail in some area of skill acquisition, a pattern similar to a self-fulfilling prophecy may be established, where negative self-perceptions are validated and reinforced by others which in turn results in a further loss of self-worth and increased negative self-appraisals. Thus, what began as cognitive realism may evolve into cognitive distortion. In the long run, it may by more fruitful to focus on such self-perceptions and personal experiences of competency and self-worth, rather than merely attempting to determine the accuracy of children's self-reports.

Hypothesis III

For hypothesis III, a relationship between parent self-reports on the BDI and parent reports of child functioning on the CDI and the Depression Composite, (comprised of the Mood/Affect and Self-Worth subscales of the DDPC) was predicted. Both mother and father reports on the BDI were

significantly related to parent reports on the Depression Composite but only mother reports or the BDI were significantly related to mother reports on the CDI. Contrary to expectations, no relationship was found between mother and father reports on the BDI and child self-reports on the CDI and Depression Composite.

The general interpretation of the relationship between self-reports of parental, usually maternal, depression and parent reports of child depression is that depressed parents over-report (or report more) child depressive symptoms in relation to their own pathology than do non-depressed parents (Richters, 1992). For example, Moretti et al. (1985) reported a significant relationship between parent self-reports on the BDI and parent reports of child depression on the Children's Depression Scale (r = .44, p <.02). These authors suggested that parents may project their own distress onto their children and thus provide a biased assessment of their child's functioning. In contrast, Ivens and Rehm (1988) found no relationship between maternal reports on the BDI and maternal reports of child depression on the K-SADS. However, a relationship was found for paternal reports on the BDI and paternal reports of child depression on the K-SADS (e.g., r = -.29, p <.05). Ivens and Rehm (1988) concluded that maternal depression did not influence maternal reports of child functioning and that the observed relationship for fathers was of little practical

significance. They also reported the mean score on the BDI for both mothers (M = 10.6, SD = 7.4) and fathers (M = 6.0, SD = 6.7). These scores are comparable to the mean scores obtained by the parents in the present study (Mothers: M = 7.46, SD = 7.05; Fathers: M = 3.66, SD = 3.43) and correspond to minimal and no depressive symptoms, respectively (see Beck & Steer (1987) for diagnostic criteria). Scores equal to or greater than 15 on the BDI have been suggested for the identification of depressive symptoms in normative adults (Sundberg, 1985). Thus, as Ivens and Rehm (1988) suggest, the observed relationship between parent BDI scores and parent ratings of child functioning may have little practical significance, especially when the adult population being studied is not clinically depressed.

Also of interest in the present study is the significant relationship found between father reports on the BDI and father reports on the Depression Composite (DC) and an absence of a significant relationship between the BDI and CDI-P for fathers. As mentioned previously (see Chapter III: Results), no significant difference was observed in the magnitude of these two correlation coefficients. Most likely then, the lack of a significant relationship between the BDI and the CDI-P was due to the small number of fathers who participated in this study. This suggests that the observed relationship between parental self-reports and parent

reports of child functioning may be an artifact of the assessment process rather than the influence of parental pathology on parent reports of child functioning in this study.

In contrast to the above findings, Conrad and Hammen (1989) determined that depressed mothers' reports of child functioning on the Child Behaviour Checklist Externalizing and Internalizing Scales differentiated between children with or without a diagnosis of depression while non-depressed maternal reports did not (See also Angold et al., 1987; Weissman et al., 1987). Conrad and Hammen (1989) suggest that this finding could be related to depressive realism in which depressed individuals provide more realistic appraisals of events and attributes than do non-depressed individuals. As an alternative interpretation, Weissman et al. (1987) suggested that non-depressed mothers may have misperceived or under-reported depressive symptoms in their children.

The controversy whether depressed parents are more or less accurate than non-depressed parents in reporting child functioning is similar to the debate as to whether children are more or less reliable than their parents in providing self-reports. Strategies to help clarify whether depressed mothers are more or less reliable than non-depressed mothers have included using a second informant, such as fathers or teachers against which to compare maternal reports (e.g.,

see Richters, 1992). However, as mentioned in the previous section (see Hypothesis II), this approach is not without difficulty. Finally, examining one group of informants as more or less reliable than another group does little to address the issue of bidirectional influences on behaviour. It is conceivable that children's depressive symptoms and parents' difficulties in alleviating these symptoms may contribute to parent self-reports of depressive symptoms, rather than the commonly accepted viewpoint that maternal depression results in parenting difficulties, children's misbehaviour, and the perception by mothers of increased behavioral and affective problems in their children.

Hypothesis IV

For hypothesis IV, the application of a model of the antecedents and mediational role of self-worth in elementary school age children was examined (e.g., see Harter et al., 1991). Partial support was obtained for this four stage sequential model using child self-reports and mother reports. Differences were noted between the solutions generated by adolescent subjects (e.g., see Harter et al., 1991) and the elementary school age children participating in this study. For example, school support was not found to contribute to the prediction of the Depression Composite in this group of children. Hartup (1978) has suggested that different sources of social support may have a differential impact on adjustment at different ages. Dubow, Tisak,

Causey, Hryshko, and Reid, (1991) suggest that peer support may have more impact in older children and adolescents than in younger children. Also, parent support may be more important to younger age children, and it is not until adolescence that friendships with classmates and close friends takes on more significance as a mediator of feelings of self-worth and suicidal ideation.

Scholastic Competence/Behavioral Conduct contributed to the prediction of perceived parental support (see Regression I), however, this variable had no impact on suicidal thoughts. This finding is contrary to predictions made by Harter (Harter et al., 1991). While children may view academic and behavioral success as an important component of parental support, success in these domains may not yet impact on children's thoughts of suicide.

Harter's model provides an important first step in identifying potential developmental processes that contribute to feelings of low self-worth, negative mood, and suicidal ideation in young children. These developmental processes include feelings of incompetence in academic and social domains and feelings of limited support from parents, classmates, and close friends. Theoretical and empirical support for Harter's (Harter et al., 1991) model can be found in the child depression and child development literature. For example, Blechman, McEnroe, Carella, & Audette (1986) reported that children who were rated as

academically and socially incompetent by their peers and teachers had higher self-reports and peer reports of depression. Coopersmith (1967) also reported a relationship between academic success and self-worth, with children experiencing academic difficulties reporting feelings of low self-worth. Lefkowitz and Tesiny (1980) report that the best predictor of child self-reported depression are peer ratings of unpopularity and poor social skills development. Similarly, Jacobsen, Lahey, and Strauss, (1983) determined that poor peer relationships were related to child self-reports of depressive symptoms. Last, Rubin (1983) observed that preschoolers who are unpopular are at risk for developing social, educational, and mental health problems. This observation parallels the developmental processes included in Harter's model.

The study and application of Harter's model to elementary school age children offers a number of benefits to clinicians and researchers. For example, Harter's (Harter et al., 1991) model represents a potentially quick and effective means to identify children from normative populations who might be at risk for depression, suicidal ideation, or both. The early detection of children at risk is important because of the relationship between learning problems, social withdrawal, and suicide attempts in children experiencing emotional distress (Stavrakaki et al., 1991) and the increased risk of suicide in adolescence

(Asarnow, 1992). Screening, using child self-reports, is also important given the intrapsychic nature of emotional disorders and because these disorders are less likely to be detected by parents or teachers than are more overt behavioral disorders such as Attention Deficit Hyperactivity Disorder or Conduct Disorder (Stavrakaki et al., 1991).

The identification of the antecedents of low self-worth and risk factors associated with suicidal ideation also provides information for determining treatment intervention strategies. For example, a child reporting a lack of social acceptance and limited peer support may benefit from a social skills development program which also focuses on negative self-evaluations. Also, because not all children may report difficulties in the various competency and social support domains, Harter's model permits the selective identification of target areas for intervention.

Another benefit of this model may be the ability to follow children considered to be at risk for depression. Longitudinal studies may help to determine: (a) whether these children respond to treatment interventions; (b) whether different interventions are more or less effective; and (c) whether children reporting depressive symptomatology in childhood continue to report difficulties in adolescence.

Last, Harter's model represents a linear interpretation of the possible causal factors of childhood depression in that negative self-perceptions and perceptions of limited

social support are seen as contributing to the development of depressive symptomatology (Harter et al., 1991). Alternatively, depression itself may cause or result in academic and social deficits and negative self-perceptions. However, a third explanation exists. Additional factors, such as a biological or genetic predisposition, environmental vulnerability (e.g., being raised by a depressed parent), daily or chronic life stressors or some other factor(s) may contribute to the development and maintenance of childhood depression. Further research is therefore necessary to clarify the ontogeny of childhood depression.

Implications for Child Self-Reports

The results of this study provide evidence for including child self-report measures of depression in the assessment process since child self-reports were found to be reliable and meaningful (see Table 9). In addition, child self-reports were used to identify two clinically relevant subgroups of children in this study: those children who reported depressive symptoms on the CDI, and those children who reported low global self-worth on the SPPC. Last, child self-reports contributed significantly to the identification of a model of the antecedents and mediational role of self worth.

Prior research (see Achenbach et al., 1987) has demonstrated that agreement between different pairs of

informants is often low to moderate, and is affected by the environments that the different informants occupy (i.e., the home, school, community). Also, it appears that parents may focus more on overt or easily observable behaviours than on those of an intrapsychic nature (Cytryn et al., 1980). It is also conceivable that parents and teachers may not detect problems in shy, withdrawn, or sad children until their distress impacts negatively on their academic and social development (Stavrakaki et al., 1991).

While many authors advocate the use of multiple informants, questions still exist as to the reliability or meaningfulness of the information obtained, and how to combine this information into a coherent whole (Greenbaum, Prange, & Dedrick, 1992; Kazdin, 1988). For example, Stanger and Lewis (1992) determined that information gathered from the children, parents, and teachers in their study was not interchangeable. Achenbach et al. (1987) also support the need to gather information from multiple sources as the nature of the child's difficulties may change as a function of the environment and the individuals with whom the child interacts. Thus, the use of multiple and diverse informants (i.e., children, parents, teachers, peers) may increase the reliability and validity of the assessment information obtained by corroborating information gathered by different sources (Hoier & Kerr, 1988). Last, perhaps the most convincing argument for including children in the assessment

process is that parents may not always be aware of the thoughts and feelings of their children, especially where suicidal behaviour is concerned (e.g., see Kashani, Goddard, & Reid, 1989).

Future Directions

The present study differed from that of Harter et al. (1991) in two important ways. One, this study examined the applicability of Harter's model of the antecedents and mediational role of self-worth with elementary school age children. Second, children in this study were asked to complete the Suicidal Ideation subscale of the DDPC. While the rate of suicide is low in elementary school children, the rate increases dramatically in adolescence (Pfeffer, 1988). The early identification and intervention with children considered to be at risk for depression and suicide during childhood may help offset problems during adolescence. This study represents a first step in exploring the usefulness and applicability of the Suicidal Ideation subscale and Harter's model with younger children. However, continued research is required.

Related to the correlates of suicidal ideation identified by Harter et al. (1991) is the variable of hopelessness. Harter (1989) has suggested that the ability to make judgements about the future does not fully develop until after puberty. However, other researchers have demonstrated that elementary school age children can make

reliable and meaningful judgements on measures of hopelessness (e.g., see Asarnow et al., 1987; Kazdin, Rodgers, & Colbus, 1986). While there is some debate whether elevated depression scores or feelings of hopelessness scores are better predictors of suicide attempts, the inclusion of the suicidal ideation variable with elementary school age children will further the understanding of the etiology and maintenance of childhood depression.

Harter's model represents a linear interpretation of the possible causal factors of childhood depression. Verification of the unidirectionality of this model requires continued application of this model with normative and clinical groups of children using longitudinal or sequential designs. Longitudinal and sequential designs offer opportunities to assess: (a) the stability of the proposed antecedents or risk factors associated with childhood depression; (b) whether these antecedents and associated symptoms lessen or worsen with changes in age and developmental status; and (c) whether additional variables come into play over time. For example, Renouf and Harter (1990) reported that some adolescents experienced changes in their feelings of self-worth and mood over a twelve month period. Some adolescents reported increased feelings of self-worth while others reported a loss of self-worth and feelings of sadness and depression. Longitudinal and sequential designs may help clarify why these changes

occurred.

Second, while empirical testing of Harter's model (see Harter et al., 1991) indicates that the variables of Self-Worth, Mood/Affect and Hopelessness are all interchangeable with the Depression Composite in predicting suicidal ideation, Harter (see Harter 1990) has identified two subgroups of adolescents for which this pattern may not be applicable. For example, some adolescents report experiencing feelings of low self-worth followed by feelings of sadness or depression; another subgroup reported experiencing the opposite. Conceivably, these differences may have implications for the etiology and treatment interventions associated with childhood depression.

Also, while Harter's model offers a comprehensive analysis of potential risk factors, other researchers have looked at the role of daily hassles or chronic stressors in predicting depressive symptoms. These variables have been implicated in the etiology and maintenance of adult and child depression (Dubow et al., 1991). Thus, while Harter's model provides us with information regarding the potential antecedents of childhood depression, additional research is required to determine whether these variables are indeed predictors and whether or not they represent an exhaustive list.

Last, it is generally accepted that depression as a single diagnosed difficulty in children is relatively rare

(Fleming & Offord, 1990). More often, childhood depression is associated with other childhood diagnoses such as Attention Deficit Hyperactivity Disorder, Conduct Disorder, or Learning Disabilities. It is possible that the risk factors that Harter has identified may also be concomitants or associated features of these disorders. Thus, Harter's model may reflect a more generalized model of childhood difficulties rather than specifically explaining the developmental course of childhood depression. An additional avenue of research, therefore, would be to apply Harter's model to a priori diagnosed groups of children (i.e., Attention Deficit Hyperactivity Disorder, Conduct Disorder, or Learning Disabilities with and without depressive features) to evaluate the effectiveness of this model.

In conclusion, Harter's model represents a significant contribution to our understanding of the potential etiology and maintenance factors associated with childhood depression. In addition, her model offers numerous possibilities for future research endeavours.

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Appendix A

Parent's/Guardian's Background Information Form

Code _____

1. Today's Date: year _____ month _____ day _____

2. Child's date of birth: year _____ month _____ day _____

3. Child's grade: Grade 4 _____ Grade 5 _____ Grade 6 ____

4. Relationship of child to female caregiver (MOTHER/GUARDIAN) and/or male caregiver (FATHER/GUARDIAN) currently living in the home

	Mother/Guardian	Father/Guardian
1) Biological parent	_____	_____
2) Adoptive parent	_____	_____
3) Step-parent	_____	_____
4) Foster Parent	_____	_____
5) Legal Guardian	_____	_____
6) Not Present	_____	_____
7) Other _____	_____	_____

5. Person Completing Form: Mother _____ Father _____

6. Have you or any other member of your family ever received psychological counselling or services? _____ Yes _____ No.
If yes, please describe:

	Child	Mother	Father
1) who received services	_____	_____	_____
2) type of service received	_____	_____	_____
3) approximate dates of service	_____	_____	_____

7. Marital Status:

	Mother	Father
1) married	_____	_____
2) divorced	_____	_____
3) separated	_____	_____
4) single	_____	_____
5) living together	_____	_____
6) widowed	_____	_____

8. Ethnicity:

	Mother	Father
1) Caucasian	_____	_____
2) Black	_____	_____
3) Hispanic	_____	_____
4) Asian/Pacific	_____	_____
5) Native	_____	_____
6) Other _____	_____	_____

9. Are you currently employed?

	Mother	Father
Full time	_____	_____
Part time	_____	_____

10. What is/was your occupation? _____ Mother
_____ Father

11. Please mark the highest level of schooling you have achieved.

	Mother	Father
1) Less than 7 years	_____	_____
2) Some junior high school. Please indicate grade obtained (E.g., Grade 7, 8, 9)	_____	_____
3) Some high school. Please indicate grade obtained (E.g., Grade 10,11,12,)	_____	_____
4) Graduated from high school or equivalent HS diploma	_____	_____
5) Some college or university. Please indicate number of years.	_____	_____
6) Graduated from college or university. Please indicate degree(s).	_____	_____
7) Some work beyond Bachelor's degree.	_____	_____
8) Finished graduate degree. Degree(s)	_____	_____

12. What is the approximate income bracket of your family?

1) _____ less than 10,000	2) _____ 10,000 - 20,000
3) _____ 21,000 - 30,000	4) _____ 31,000 - 40,000
5) _____ 41,000 - 50,000	6) _____ over 50,000

Thank-you

Alison Crocker, M.A.

Appendix B

Cover Sheet

Study of Children's Thoughts and Feelings

Code _____

Name _____

Boy _____ Girl _____ Grade _____ Age _____

Birthday _____ (Year, Month, Day)

Appendix C

Sample Items from the Four Subscales of the Social Support Scale for Children and Adolescents - Parent Form

PEOPLE IN MY CHILD'S LIFE (SSSC-P)

	Really True for My Child	Sort of True for My Child				Sort of True for My Child	Really True for My Child
1.	☐	☐	Some kids have parents who *don't* really *understand* them	BUT	Other kids have parents who really *do* understand them.	☐	☐
2.	☐	☐	Some kids have classmates who like them the way they are	BUT	Other kids have classmates who wish they were *different*.	☐	☐
3.	☐	☐	Some kids have a teacher who *helps* them if they are *upset* and have a problem	BUT	Other kids *don't* have a teacher who helps them if they are upset and have a problem.	☐	☐
4.	☐	☐	Some kids have a close friend who they can tell *problems* to	BUT	Other kids *don't* have a close friend who they can tell problems to.	☐	☐

Note. Item 1 is from the Parent Support subscale (PS), item 2 is from the Classmate Support subscale (CS), item 3 is from the Teacher Support subscale (TS), and item 4 is from the Close Friend Support subscale (FS). Items altered and reproduced with permission from Susan Harter, Denver, Colorado, 1993.

Appendix D

Sample Items from the Five Subscales of the Dimensions of Depression Profile for Children and Adolescents - Parent Form

WHAT'S TRUE FOR MY CHILD (DDPC-P)

	Really True for My Child	Sort of True for My Child				Sort of True for My Child	Really True for My Child
1.	☐	☐	Some kids are *unhappy* a lot of the time	BUT	Other kids are pretty *happy* a lot of the time	☐	☐
2.	☐	☐	Some kids *don't* blame themselves for things that go wrong	BUT	Other kids *do* blame themselves for things that go wrong	☐	☐
3.	☐	☐	Some kids wish they were *different*	BUT	Other kids *like* the way they are	☐	☐
4.	☐	☐	Some kids *don't* have a lot of energy to do things children their age like to do	BUT	Other kids *do* seem to have enough energy to do things children their age like to do	☐	☐
5.	☐	☐	Some kids don't really care if they live or die	BUT	Other kids do care if they live or die	☐	☐

Note. Item 1 is from the Mood/Affect subscale (M/A), item 2 is from the Self-Blame subscale (SB), item 3 is from the Self-Worth subscale (SW), item 4 is from the Energy/Interest subscale (E/I), item 5 is from the Suicidal Ideation subscale (SI). Items altered and reproduced with permission from Susan Harter, Denver, Colorado, 1993.

Appendix E

Sample Items from the Children's Depression Inventory - Parent Form

CDI - PARENT/GUARDIAN RATING FORM (CDI-P)

For each group of items, please pick the one sentence that best describes your child for the past two weeks. Please put a checkmark next to the sentence you select.

1. _____ My child is sad once in a while
_____ My child is sad many times
_____ My child is sad all the time

2. _____ My child feels nothing will ever work out for him/her
_____ My child is not sure if things will work out for him/her
_____ Things will work out for my child O.K.

3. _____ My child does most things O.K.
_____ My child does many things wrong
_____ My child does everything wrong

9. _____ My child does not think about killing herself/himself
_____ My child thinks about killing herself/himself but would not do it
_____ My child wants to kill herself/himself

13. _____ My child cannot make up her/his mind about things
_____ My child finds it hard to make up her/his mind about things
_____ My child makes up her/his mind about things easily

15. _____ My child feels she/he has to push herself/himself all the time to do her/his schoolwork
_____ My child feels she/he has to push herself/himself many times to do her/his schoolwork
_____ My child feels doing schoolwork is not a big problem

Note. Items altered and reproduced by permission of Multi-Health Systems Inc., 65 Overlea Blvd., Toronto, Ontario, M4H 1P1, (800) 268-6011.

Appendix F

Letter of Introduction to Parents/Guardians

Study of Children's Thoughts and Feelings

September 1992

Dear Parent(s)/Guardian(s)

I am writing to request your permission to allow your child to participate in a study that will be conducted in his/her school. Your principal and the School Board have kindly given their permission for this research to take place.

This study will be looking at how children feel about themselves. I have included an Information Sheet on the reverse describing my study and what you and your child will be asked to do if you agree to participate.

This study is being conducted as part of the requirements for my doctorate degree in psychology at the University of Windsor. I will be asking children in grades four through six and their parents/guardians to participate.

Involvement in this study will be voluntary and you or your child may withdraw at any time. If you and your child would like to participate in this study, please read the Information Sheet on the reverse side of this page and sign the enclosed Consent Form. You may keep the Information Sheet. Please seal the signed consent form in the envelope addressed to myself and have your child return it to his or her school.

Please be assured that all information I receive from you and your child will remain confidential. At no time will your name or the name of your child, or school be identified in written reports of the study findings. The results of this study will be discussed with my academic supervisor and committee; a summary of this study may be published.

If you require any further information about the study, please do not hesitate to contact me at the University of Windsor (253-4232, Ext. 2218). I will be pleased to answer any questions you may have.

Sincerely,

Alison Crocker, M.A.

Appendix G

Parent's/Guardian's Information Sheet

Study of Children's Thoughts and Feelings

Purpose: This is a study about how children feel about themselves.

What Participants Do: If you and your child agree to participate in this study, your child will be asked to complete five questionnaires about his or her thoughts and feelings. The questionnaires will be administered in small groups by myself and one assistant in your child's school. The questionnaires will take approximately one hour to finish. You will also be asked to complete a Background Information sheet and four similar questionnaires about how you think your child feels about himself/herself, and one about how you feel about yourself. These questionnaires will be mailed to you and take approximately one hour to complete. If your spouse agrees, he or she will be asked to complete the questionnaires at home as well.

The questionnaires will be sent to you first. If, after receiving your questionnaires, you decide that you and your child no longer wish to participate, you may drop out of the study. If you change your mind about participating, you will be asked to return the unused questionnaires in a stamped, self-addressed envelope.

Your child will not be given the opportunity to participate in the study until after I receive your responses. After your child has completed the questionnaires at school he or she will be sent home with a note notifying you of the day and date of completion. You may want to take this opportunity to discuss the study with your child. Please do not discuss the different types of questions prior to this point.

Participant's Rights: It is possible that in filling out the questionnaires, you or your child may be reminded of some negative feelings or problems that your child has experienced. If for any reason you or your child do not wish to continue participating once the study is underway, you and your child will be free to drop out at any time.

Some of the questionnaires used in this study were designed to be screening tools to identify children who might be experiencing an emotional disturbance. It is encumbent upon me to inform you if it appears that your child may be distressed. I will also notify your school psychologist or social worker with your consent. Because some of these questionnaires are still being researched and some of them have not been used extensively to date, inaccuracies in the information obtained may result. In addition, some children who are experiencing emotional distress may not be identified by these questionnaires because they rely on self-report information. A thorough assessment provided by a licensed psychologist would be necessary to determine if your child was emotionally distressed. If you feel that your child may need psychological services, some community resources are provided below:

Catholic Family Service Bureau
677 Victoria Avenue
Windsor, Ontario
N9A 4N3
519-254-5164

Regional Children's Centre, Windsor Western Hospital
1453 Prince Road
Windsor, Ontario
N9C 3Z4
519-257-5215

The paperwork for this project will be kept confidential. Your names will not appear on any of the questionnaires or in any reports of this study. Although children's names will not appear on any of the questionnaires, their responses will be identified by a code number. This code number will allow me to identify those children who may be experiencing emotional distress.

You may ask questions about the procedure of the study at any time and your questions will be answered.

Feedback: Once the study has been completed, you may receive a copy of the results if you wish. Please leave your name and mailing address on the back of the consent form if you wish to receive a copy of the results.

This research has been cleared by the Ethics Committee of the Psychology Department at the University of Windsor, and that any concerns about the procedures may be reported to that committee (Chair: Dr. Ron Frisch, 253-4232, Ext. 7012), or to the Office of Research Services (253-4232, Ext. 3916). Your School Board and school principal have also cleared the procedure for this study.

If you have any questions about participating or would like further information about the study results, please feel free to contact me at any time. You may also contact my advisor, Dr. Julie Hakim-Larson.

Alison D. Crocker, M.A.
Department of Psychology,
University of Windsor
(519) 253-4232, Ext. 2218

Dr. Julie Hakim-Larson
Department of Psychology,
University of Windsor
(519) 253-4232, Ext. 2241

Appendix H

Parent's/Guardian's Consent Form

Study of Children's Thoughts and Feelings

Purpose: This is a study about how children feel about themselves.

What Participants Do: If you and your child agree to participate in this study, your child will be asked to complete five questionnaires about his or her thoughts and feelings. The questionnaires will be administered in small groups by myself and one assistant in your child's school. The questionnaires will take approximately one hour to finish. You will also be asked to complete a Background Information sheet and four similar questionnaires about how you think your child feels about himself/herself, and one about how you feel about yourself. These questionnaires will be mailed to you and take approximately one hour to complete. If your spouse agrees, he or she will be asked to complete the questionnaires at home as well.

The questionnaires will be sent to you first. If, after receiving your questionnaires, you decide that you and your child no longer wish to participate, you may drop out of the study. If you change your mind about participating, you will be asked to return the unused questionnaires in a stamped, self-addressed envelope.

Your child will not be given the opportunity to participate in the study until after I receive your responses. After your child has completed the questionnaires at school he or she will be sent home with a note notifying you of the day and date of completion. You may want to take this opportunity to discuss the study with your child. Please do not discuss the different types of questions prior to this point.

Participant's Rights: It is possible that in filling out the questionnaires, you or your child may be reminded of some negative feelings or problems that your child has experienced. If for any reason you or your child do not wish to continue participating once the study is underway, you and your child will be free to drop out at any time.

Some of the questionnaires used in this study were designed to be screening tools to identify children who might be experiencing an emotional disturbance. It is encumbent upon me to inform you if it appears that your child may be distressed. I will also notify your school psychologist or social worker with your consent. Because some of these

questionnaires are still being researched and some of them have not been used extensively to date, inaccuracies in the information obtained may result. In addition, some children who are experiencing emotional distress may not be identified by these questionnaires because they rely on self-report information. A thorough assessment provided by a licensed psychologist would be necessary to determine if your child was emotionally distressed. If you feel that your child may need psychological services, some community resources are provided below:

Catholic Family Service Bureau
677 Victoria Avenue
Windsor, Ontario
N9A 4N3
519-254-5164

Regional Children's Centre, Windsor Western Hospital
1453 Prince Road
Windsor, Ontario
N9C 3Z4
519-257-5215

The paperwork for this project will be kept confidential. Your names will not appear on any of the questionnaires or in any reports of this study. Although children's names will not appear on any of the questionnaires, their responses will be identified by a code number. This code number will allow me to identify those children who may be experiencing emotional distress.

You may ask questions about the procedure of the study at any time and your questions will be answered.

Feedback: Once the study has been completed, you may receive a copy of the results if you wish. Please leave your name and mailing address on the back of the consent form if you wish to receive a copy of the results.

This research has been cleared by the Ethics Committee of the Psychology Department at the University of Windsor, and that any concerns about the procedures may be reported to that committee (Chair: Dr. Ron Frisch, 253-4232, Ext. 7012), or to the Office of Research Services (253-4232, Ext. 3916). Your School Board and school principal have also cleared the procedure for this study.

If you have any questions about participating or would like further information about the study results, please feel free to contact me at any time. You may also contact my advisor, Dr. Julie Hakim-Larson.

Alison D. Crocker, M.A.
Department of Psychology,
University of Windsor
(519) 253-4232, Ext. 2218

Dr. Julie Hakim-Larson
Department of Psychology,
University of Windsor
(519) 253-4232, Ext. 2241

I, _____ HAVE READ THIS CONSENT
(parent/guardian please print name)

FORM AND GIVE PERMISSION TO _____
(please print child's name)

TO PARTICIPATE IN THIS STUDY _____ .
(signature/relationship to child)

Date _____

I, _____ HAVE READ THIS CONSENT
(child's mother/guardian please print name)

FORM AND AGREE TO PARTICIPATE IN THIS STUDY

_____ Date _____ .
(mother's/guardian's signature)

I, _____ HAVE READ THIS CONSENT
(child's father/guardian please print name)

FORM AND AGREE TO PARTICIPATE IN THIS STUDY

_____ Date _____ .
(father's/guardian's signature)

The questionnaires can be mailed to this address:

_____

Telephone number where you may be reached _____

Yes, _____ I wish to receive a copy of the results of this study.

Appendix I

Instructions To Parents/Guardians

Study of Children's Thoughts and Feelings

This booklet contains a Background Information Form, four questionnaires that ask about your child's thoughts and feelings and one that asks about your thoughts and feelings, the BDI. The names of these questionnaires are:

1. Background Information Form
2. Parent/Guardian Rating Scale of Child's Behaviour
3. People in My Child's Life
4. What's True for My Child
5. CDI-Parent/Guardian Form
6. BDI

The questionnaires may be arranged in a different order than listed above.

Please complete the Background Information Form by checking off the appropriate boxes.

For the following questionnaires, Parent/Guardian Rating Scale of Child's Behaviour, People in My Child's Life and What's True for My Child please read each item carefully and decide if your child is most like the child described on the left, or most like the child described on the right. Then determine if this statement is only sort of true for your child or really true for your child. Place a checkmark in the box that corresponds to the statement you select. Please select only one box for each item.

For the CDI-Parent/Guardian Form, please read each group of items carefully and pick the one sentence that best describes your child for the past two weeks. Please put a checkmark next to the sentence you select.

The BDI uses a similar format to the CDI-Parent/Guardian Form. Please read each group of statements carefully and circle the one statement in each group that best describes the way you have been feeling in the past week, including today.

Please return the completed questionnaires in the stamped, pre-addressed envelope provided as soon as possible. Your child will not be asked to answer these questions until after your information is received. Please do not discuss the different types of questions until everyone in your family (e.g., child, spouse) has completed the questionnaires. Your child will be sent home with a note

indicating the date that they participated in the study. You may want to take this opportunity to discuss the study and the types of questions asked with your family.

Thank you for your time and cooperation in completing these questionnaires.

Alison D. Crocker, M.A.

Appendix J

Child Assent Form

Study of Children's Thoughts and Feelings

I would like to know if you would like to help me out today. What I will ask you to do is to read some questions with me and then answer them. There are five different questionnaires to answer. These questions have no right or wrong answers. I want you to know that I will not be telling your teachers or parents or any of the other children what you answer.

When I'm finished talking with all the children I'd like to see, I will write up a big project. My teachers will read it and it might be put in a book but no one will know who the children are that helped me out.

Sometimes, children have problems that make them feel sad or unhappy. If I think some of the kids who answer my questions have a problem, I will need to tell their parents and some other people who can help them.

Your Mom and/or Dad has given permission for you to answer these questions today. Do you think you would like to help me out by answering the questions. You don't have to if you don't want to -- you won't get into any trouble if you say "No", it's up to you. What would you like to do?"

If you would like to help me out, please sign your name on the line below. You don't have to answer the questions if you don't want to and you can stop any time if you decide that you don't want to keep going once we get started.

Name _____ Date _____

Appendix K

Instructions Read Aloud to the Children

Study of Children's Thoughts and Feelings

Child Introduction

Hi, my name is Alison Crocker and this is my assistant _____. We are students at the University of Windsor. I am doing a project about the different kinds of thoughts and feelings that children have.

Child Assent

I would like to know if you would like to help me out today. What I will ask you to do is to read some questions with me and then answer them. There are five different questionnaires to answer. These questions have no right or wrong answers. I want you to know that I will not be telling your teachers or parents or any of the other children what you answer.

When I'm finished talking with all the children I'd like to see, I will write up a big project. My teachers will read it and it might be put in a book but no one will know who the children are that helped me out.

Sometimes children have problems that make them feel sad or unhappy. If I think some of the kids who answer my questions have a problem, I will need to tell their parents and some other people who can help them.

Your Mom and/or Dad has given permission for you to answer these questions today. Do you think you would like to help me out by answering the questions. You don't have to if you don't want to -- you won't get into any trouble if you say "No", it's up to you. What would you like to do?"

If you would like to help me out, please sign your name on the line below. You don't have to answer the questions if you don't want to and you can stop any time if you decide that you don't want to keep going once we get started.

Instructions to the Child

Before we begin answering the questions about your thoughts and feelings we need to complete the first page of your booklets. Please print your name, age, birthday, what grade you are in and circle whether you are a boy or a girl.

Now I am going to read you some sentences that ask about your thoughts and feelings. I am interested in which of these statements is most true for you. There are no right or wrong answers. Since kids are very different from one another, each of you will be putting down something different.

There are five different sets of questions. The first group of questions we will answer is called <u>What I Am Like</u>.

First let me explain how these questions work. There is a sample question at the top, marked (a). I'll read it out loud and you follow along with me. (Examiner reads sample question). This question talks about two kinds of kids, and we want to know which kids are most like you.

So, what I want you to decide first is whether you are more like the kids on the left side who would rather play outdoors, or whether you are more like the kids on the right side who would rather watch T.V. Don't mark anything yet, but first decide which kind of kid is most like you, and go to that side of the sentence.

Now, the second thing I want you to think about, now that you have decided which kind of kids are most like you, is to decide whether that is only <u>sort of true for you</u>, or <u>really true for you</u>. If it's only sort of true, then put an X in the box under sort of true, if it's really true for you, then put an X in that box, under really true.

For each sentence you only check <u>one</u> box. Sometimes, it will be on one side of the page, another time it will be on the other side of the page, but you can only check one box for each sentence. You don't check both sides, just the one side most like you.

OK, that one was just for practice. Now we have some more sentences which I'm going to read out loud. For each one, just check one box, the one that goes with what is true for you, what you are most like.

The next group of questions we will answer is called

<u>How Important Are These Things To How You Feel About Yourself As A Person</u>

These questions are answered the same way as the ones you just answered.

The next group of questions we will answer is called

What's True For Me.

These questions are also answered in the same way.

The next group of questions we will answer is called the CDI.

This group of questions looks different from the others but it is also about the different kinds of feelings and thoughts kids have. Let me show you how this one works.

This questionnaire lists the feelings and ideas in groups. From each group, pick the one sentence that describes you BEST for the past two weeks. After you pick a sentence from the first group, we will go on to the next group.

Here is an example of how this form works. Try it. Put a mark next to the sentence that describes you BEST.

Remember, pick out the sentences that describe you best in the PAST TWO WEEKS.

The last group of questions we will answer is called

People In My Life.

These questions are answered in the same way as the questions for the first three questionnaires.

Appendix L

Thank-You Note

Study of Children's Thoughts and Feelings

Your child _____ (name) completed a number of questions asking about their thoughts and feelings on _____ (day, month, year). You may want to take this opportunity to discuss this study and the questions that were asked with your child.

I would like to thank you and your child for taking the time to participate in my study.

Sincerely,

Alison D. Crocker, M.A.

Appendix M

Letter to Parent's/Guardian's of Children at Risk for Depression

Study of Children's Thoughts and Feelings

Dear

Thank you for participating in my study investigating "How Children Feel About Themselves".

Part of my responsibility in conducting this study is to inform parents if I think that their child may be experiencing emotional distress. After looking at your child's responses to the various questionnaire items, it is possible that your child may be feeling sad or unhappy about him/herself. Also, some of your child's responses indicate that your child may sometimes think about hurting him/herself.

Although your child's responses suggest that s/he may feel sad, it is important to remember that some of these questionnaires are still being researched and that some of them have not been used extensively with children to date. As such, it is possible that inaccuracies in the information obtained may result.

If you are concerned that your child may feel sad or unhappy, a thorough assessment provided by a mental health professional would be necessary to determine if your child is emotionally distressed. If you feel that your child may benefit from psychological services, some community resources that you can contact are listed below. You can also contact a mental health professional listed under the heading "Psychologists", "Social Workers" or "Social Service Organizations" in the yellow pages. Or, you can call the "Children's Services Council of Windsor-Essex County" at 519-256-2391. In addition, you can contact your school principal and/or social worker and discuss your concerns with them.

Catholic Family Service Bureau
677 Victoria Avenue
Windsor, Ontario
N9A 4N3
519-254-5164

Regional Children's Centre, Windsor Western Hospital
1453 Prince Road
Windsor, Ontario
N9C 3Z4
519-257-5215

Alternatively, I can contact your child's school principal. If you would like me to contact your child's school principal, please complete the enclosed consent form and return it to me in the stamped, self-addressed envelope.

Sincerely,

Alison D. Crocker, M.A.

Appendix N

Parent's/Guardian's Consent Form for Children at Risk for Depression

Study of Children's Thoughts and Feelings

I understand that the results of Ms. Crocker's study show that my child may be feeling sad or unhappy and may sometimes think about hurting him/herself.

I am aware that although my child's responses suggest that s/he may feel sad, it is important to remember that some of the questionnaires used in Ms. Crocker's study are still being researched and that some of them have not been used extensively with children to date. As such, it is possible that inaccuracies in the information obtained about my child may result.

I understand that Ms. Crocker will inform the school principal that my child's overall responses to the questionnaires used in this study are indicative of a child who may be experiencing emotional distress and that my child might benefit from a thorough assessment. The purpose of this assessment would be to determine if my child was feeling sad or unhappy and to consider if my child might benefit from counselling or therapy.

I also understand that Ms. Crocker will not be showing or discussing my child's individual responses to the questionnaires with the staff members from my child's school.

Yes, _____ would like Ms.
(parent's/guardian's name)

Crocker to contact the school principal of _____

_____
child's name

and inform him/her that my child may be experiencing some emotional distress.

_____ _____
Parent's/Guardian's Signature Date

Appendix O

The Effects of Child and Parent Characteristics on the Factor Scores of the SPPC/PRS, SSSC/SSSC-P, DDPC/DDPC-P, and CDI/CDI-P for Child, Mother, and Father Informants

Measure: SPPC/PRS

Demographic Character.	Informants		
Grade	Child	Mother	Father
Multi F [a]	1.11	1.04	0.41
df	(12,170)	(10,172)	(10,66)
Univariate F			
GSW	0.87	-- [b]	-- [b]
SC	0.59	1.30	0.74
SA	3.19*	1.15	0.16
AC	0.74	0.03	0.05
PA	0.63	1.49	0.42
BC	0.09	0.33	0.18
df	(2,89)	(2,89)	(2,36)
Gender	Child	Mother	Father
Multi F	3.32**	4.24**	3.78**
df	(6,85)	(5,86)	(5,33)
Univariate F			
GSW	0.24	-- [b]	-- [b]
SC	0.001	8.44**	6.12*
SA	0.05	1.06	0.12
AC	6.09**	6.25*	2.53
PA	0.01	0.48	3.94
BC	9.39**	4.94*	8.86**
df	(1,90)	(1,90)	(1.37)

(table continues)

Demographic Character.	Informants		
Couns.	Child	Mother	Father
Multi F	0.24	0.66	0.49
df	(6,83)	(5,84)	(5,33)
Univariate F			
GSW	0.80	-- [b]	-- [b]
SC	0.28	3.02	0.22
SA	0.61	0.04	0.69
AC	0.002	0.08	2.18
PA	0.29	0.00	0.22
BC	1.01	1.01	0.01
df	(1,88)	(1,88)	(1,37)
SES	Child	Mother	Father
Multi F	1.42	1.13	0.41
df	(25,326)	(25,306)	(25,109)
Univariate F			
GSW	1.87	-- [b]	-- [b]
SC	1.76	1.65	0.31
SA	2.01*	2.13	0.47
AC	1.80	1.27	0.19
PA	0.28	0.78	0.21
BC	1.87	1.09	0.38
df	(5,86)	(5,86)	(5,33)

(table continues)

Measure: SSSC/SSSC-P [c]

Demographic Character.	Informants		
Grade	Child	Mother	Father
Multi F	1.33	0.94	0.60
df	(8,174)	(8,172)	(8,66)
Univariate F			
PS	0.20	0.66	0.24
CS	0.71	1.05	0.12
TS	0.60	1.00	0.70
FS	2.57	0.02	0.01
df	(2,89)	(2,88)	(2,35)
Gender	Child	Mother	Father
Multi F	0.67	0.87	1.22
df	(4,87)	(4,86)	(4,33)
Univariate F			
PS	1.47	0.00	4.03
CS	0.06	2.88	3.07
TS	0.37	0.45	3.12
FS	1.42	0.53	3.55
df	(1,90)	(1,89)	(1,36)

(table continues)

Demographic Character.	Informants		
Couns	Child	Mother	Father
Multi F	1.47	1.47	0.41
df	(4,84)	(4,84)	(4,33)
Univariate F			
PS	1.42	1.42	0.62
CS	0.30	0.30	0.00
TS	1.14	1.14	0.18
FS	2.08	2.07	0.06
df	(1,87)	(1,87)	(1,36)
SES	Child	Mother	Father
Multi F	1.91*	1.16	0.86
df	(20,276)	(20,272)	(20,97)
Univariate F			
PS	1.17	1.30	1.21
CS	3.77**	2.12	0.61
TS	2.70*	0.25	0.78
FS	3.62**	0.30	2.54*
df	(5,86)	(5,85)	(5,32)

(table continues)

Measure: DDPC/DDPC-P, CDI/CDI-P, BDI [d]

Demographic Character.	Informants		
Grade	Child	Mother	Father
Multi F	1.20	1.02	1.25
df	(12,170)	(14,168)	(14,60)
Univariate F			
MA	4.39*	0.44	0.61
SB	3.88*	0.75	0.36
SW	2.38	0.40	0.28
EI	2.50	0.12	2.21
SI	1.10	1.24	0.18
CDI	2.03	1.40	2.55
BDI	--	1.31	0.44
df	(2,89)	(2,89)	(2,35)
Gender	Child	Mother	Father
Multi F	0.71	1.48	1.47
df	(6,85)	(7,84)	(7,30)
Univariate F			
MA	0.74	0.03	1.60
SB	0.00	0.76	0.11
SW	0.21	1.16	2.28
EI	0.50	0.35	0.82
SI	2.34	2.70	2.80
CDI	0.21	0.10	0.00
BDI	--	0.13	6.82**
df	(1,90)	(1,90)	(1,36)

(table continues)

Demographic Character.	Informants		
Order	Child	Mother	Father
Multi F	1.76	2.92**	1.70
df	(6,85)	(7,84)	(7,30)
Univariate F			
MA	0.13	0.18	1.01
SB	3.46	4.00*	0.01
SW	0.06	0.00	0.03
EI	0.00	4.90*	6.39**
SI	0.11	0.28	0.02
CDI	0.86	1.00	2.20
BDI	--	1.41	0.41
df	(1,90)	(1,90)	(1,36)
Couns	Child	Mother	Father
Multi F	0.70	1.37	1.55
df	(6,83)	(7,82)	(7,30)
Univariate F			
MA	0.00	1.92	0.75
SB	1.84	0.03	2.93
SW	0.02	1.60	0.00
EI	0.26	0.05	0.63
SI	0.68	0.29	0.46
CDI	0.32	0.67	0.15
BDI	--	3.48	2.46
df	(1,88)	(1,88)	(1,36)

(table continues)

Demographic Character.	Informants		
SES	Child	Mother	Father
Multi F	1.22	1.09	0.60
df	(30,326)	(35,339)	(35,112)
Univariate F			
MA	2.63*	0.60	0.89
SB	1.13	0.47	0.60
SW	2.94*	0.89	0.49
EI	0.51	0.99	0.10
SI	2.44*	0.46	0.60
CDI	1.74	1.31	0.16
BDI	--	0.82	0.64
df	(5,86)	(5,86)	(5,32)

Note. GSW = Global Self-Worth. SC = Scholastic Competence. SA = Social Acceptance. AC = Athletic Competence. PA = Physical Appearance. BC = Behavioral Conduct. PS = Parent Support. CS = Classmate Support. TS = Teacher Support. FS = Close Friend Support. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory. BDI = Beck Depression Inventory. Couns = Received Counselling

[a] Multivariate F. [b] Mothers and fathers were not administered this subscale. [c] One mother and one father did not complete this questionnaire; thus N = 91 for mothers and N = 38 for fathers. [d] One father did not complete this questionnaire; thus N = 38 for fathers. Children did not complete this questionnaire.

* = $p<.05$. ** = $p<.01$.

Appendix P

Intercorrelations Between the CDI and the Subscales of the DDPC for Children, Mothers, and Fathers

Child Report

	MA	SB	SW	EI	SI
CDI	-.80**	-.50**	-.79**	-.62**	-.76**

Mother Report

	MA	SB	SW	EI	SI
CDI	-.62**	-.33**	-.71**	-.37**	-.40**

Father Report

	MA	SB	SW	EI	SI
CDI	-.16	-.22	-.45**	.00	-.24

Note. MA = Mood/Affect. SB = Self-Blame. SW = Self-Worth. EI = Energy/Interest. SI = Suicidal Ideation. CDI = Children's Depression Inventory.

* = $p<.05$. ** = $p<.01$

VITA AUCTORIS

1960 Born in LLandrindod Wells, Wales, England.

1984 Graduated with the degree of Honours Bachelor of Arts (Psychology) from the University of Winnipeg, Winnipeg, Manitoba.

1989 Graduated with the degree of Master of Arts (Child Clinical Psychology) from the University of Windsor.

1994 Completed Doctoral degree in January 1994.