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The effectiveness of teachers to recognize the symptoms of depression for their depressive students

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Abstract

This study evaluated the effectiveness of teachers' recognizing the symptoms of depression in their students. The study was conducted with 209 teachers from four (high) schools in Eskisehir. For data collection using a two-stage procedure. The first was a short questionnaire designed by the researcher to elicit information about teachers' individual attitudes towards adolescent depression. Secondly, teachers completed the "Student in Need Questionnaire". Questionnaire presented to participants five brief vignettes of young people. Data were evaluated through frequencies, percentages, ratios, chi-square statistics. Teachers more likely make a 'depressed' diagnosis correctly on depressed vignettes.

Keywords: Depression; teachers; adolescence; attitudes to depression; depression vignetness.

1. Introduction

Depressive symptoms are common among adolescents. According to the World Health Organization, depression is the number one cause of disability, and will be the second most important disorder by 2020. In terms of burden of disease (e.g., disability and mortality) (Murray and Lopez, 1996). At any given time, between 8% and 20% of the adolescent population reports experiencing depressive symptomatology (Lewinsohn, Rode & Seeley, 1998). Given that depression is significantly linked to poor adaptation during adolescence –for example, poor academic performance, school difficulties and substance abuse (Rickert, Wiemann & Berenson, 2000;Lewinsohn *et al.*,1998). Depression is strongly associated with suicide which is the second most common cause of death among 15–24 year olds (Flisher, 1999). Against this background of increasing concern about youth suicide, the countries have set ambitious targets for prevention. However, a number of well-conducted depression prevention programmes (Shochet et al., 2001; Spence, Sheffield, & Donovan, 2003), when evaluated, have had disappointingly small sustained effects (Andrews, Szabo, & Burns, 2002). An alternative strategy might be to enhance early recognition of established depression in the community. Adolescents spend a lot of time in school, and school settings can pose social and academic challenges. Spirito, Stark, Grace and Stamoulis (1991) have noted that when young adolescents are asked to name the most upsetting events during the last month, school events are consistently among the three most common problems mentioned. It has been suggested that the primary setting for the identification of

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depression in adolescence may be the school (Maag, Rutherford, and Parks, 1988). Teachers are well placed to observe some of the hallmarks of depression in this age group, e.g. irritability, social withdrawal and cognitive decline (Puura et al., 1998), which otherwise may be dismissed as teenage moodiness, ill temper or laziness. Moor et al. (2007) made a systematic evaluation showed that training teachers with a educational package about depression did not improve their ability to recognize their depressed pupils. Burns and Rapee (2006)examined the mental health literacy of a group of adolescents, with particular reference to their ability to recognize symptoms of depression in their peers. 202 Australian adolescents showed a mixed ağabeylity to correctly recognize and label depression, although they were able to differentiate depressed and nondepressed scenarios. Recognizing depressive illness in adolescence is one of the main public health challenges for adolescent mental health services Schools also have a ready-made referral pathway which accesses parents, community mental health professionals and specialized mental health services for their pupils. If teachers can gain a better understanding of the nature of depression and how to recognize it, they are in an ideal position to take appropriate steps to facilitate treatment through this established triage system (Kent, Vostanis, & Feehan, 1995).

1.1 The aim of the study

The aim of the current study was to extend current knowledge about mental health literacy into a teacher group. Moreover, the intention was to use a vignette-based questionnaire that required respondents whenever possible to generate their own thoughts and beliefs, rather than to select answers from a pool. The study presented respondents with vignettes of more than one depressed person and sought to tease out knowledge of depression by comparing the depression vignettes with two other vignettes of non-clinically depressed adolescents and to what extent do teachers report depressive illness in their pupils.

2. Method

2.1.Setting

Eskisehir is a semirural province situated in the western part of Turkey, with a population of about 705,000. The socio economic level of the city is average compared with other cities of the country. There are significant disparities in the socioeconomic characteristics of the quarters of the city. The city includes 2 universities and has a cosmopolitan structure in Turkey .

2.2.Participants

The study was conducted with 209 teachers from four (high) schools in Eskisehir. 139 were female and 70 were male of the sample. Selection was on the basis of the willingness and ability of the school to conduct the study within the research time frame and on the availability of an adequate number of teachers.The identified schools broadly represented the demographic range of high schools.

2.3.Instruments

2.3.1.Questionnaire Attitudes Towards Adolescent Depression

The first was a short questionnaire designed by the researcher to elicit information about teachers' individual attitudes towards adolescent depression. Teachers had reported that they were not confident with the degree of certainty implied by 'probably' and preferred the wider definition of risk, i.e. possibly/probably.

2.3.2.The Student in Need Questionnaire

The Student in Need Questionnaire was developed specifically for this study. After a brief general introduction and some demographic questions, the questionnaire presented to participants five brief vignettes of young people going through a range of life difficulties and their responses to the difficulties. Participants were asked to answer questions about how worried they were about each young person in the vignettes; what they ''think is the matter''

with each person; what parts of the vignettes were the strongest hints that the young person was experiencing emotional difficulties; how long they thought it would take for each young person to feel better; and who they thought the young person needed help from to cope with their problems. Unlike many other questionnaires used in the study of mental health literacy, the Student in Need questionnaire avoided giving participants multiple-choice answers to questions. Rather, it asked respondents to generate their own answers. In two of the five vignettes (Emel ve Tarkan) there was strong evidence that the focus character had significant signs of depression, with each having at least five symptoms of a Major Depressive Episode, as described in the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV: American Psychiatric Association, 1994). Psychomotor agitation was not included in this study as there is evidence that this symptom is not a common presentation in adolescent depression (Patton, Coffey, Posterino, Carlin, & Wolfe, 2000), getting caught by parents when drunk (Jale) and the death of an elderly relative (Kaan). While these vignettes presented signs of sadness and distress, there was not evidence of significant depressive symptomatology..

2.4.Procedure

Teachers completed two measures. The first was a short questionnaire designed by the researcher to elicit information about teachers' individual attitudes towards adolescent depression. In the second, teachers were asked to complete the "Student in Need Questionnaire". Consent forms were sent to principals of all schools in requesting permission for their teachers to participate. All teachers were asked to complete the Student in Need questionnaire during school time. Teachers took up to 30 min to complete these questionnaires without consultation and the questionnaires were collected by the research on completion

2.5.Legal Ethical Consent

Ethical permission for the study was obtained prior to collecting data by contacting and receiving approval from the appropriate principals of schools, Participants were assured of the confidentiality of their responses and provided informed verbal consent. Assent was obtained from the teachers themselves. The teachers also returned the forms whether consent was given or withheld.

2.6.Statistical Analyses

The Statistical Package for Social Sciences (SPSS) version16.0 was used to enter and analyze the data on a personal computer. Data were evaluated through frequencies, percentages, ratios, chi-square statistics.The measure for statistical significance was established a priority as p,.05

3. Results (Findings)

Respondents were asked for each vignette 'what do you think is the matter' with each character. The question was left deliberately open-ended to allow participants to create their own 'diagnosis' for each character. Responses were coded according to the presence of identified key words. Responses were coded as ''Depressed'' in the presence of the words 'depressed/depression' or 'suicide/suicidal'. The absence of any such words was coded as ''Non-Depressed''. It was anticipated that respondents might use a broad vocabulary to describe the 'depressed' state, The only other depression synonym was 'sad' and in the overwhelming majority of cases this asused only to describe Kaan's response to the death of his grandmother. Frequencies of each code, by sex are shown in Table 1.

Table 1.Number of participants who labeled characters as ''depressed''

	Total N (percentage)	Male N Percentage	Female N Percentage	Chi-square (x2) for gender difference
Tarkan	72 (34%)	50 (35.5%)	22(31.0%)	1.10[a]
Jale	21 (9.9 %)	15(10.6 %)	6 (8.5%)	4.20[a]
Emel	87(41.0%)	62(44.0%)	25 (35.2%)	1.84[a]
Kaan	29(13.7%)	17 (12.1%)	12(16.9%)	6.21[a]

[a]Sig different ($p<0.01$) between male and female on x^2 analysis.

Of the respondents, 87% labelled Emel as depressed while 72% labelled Tarkan as depressed. In both these vignettes males were significantly more likely than females to make a 'depressed' diagnosis. The non-depressed vignettes were rated as 'depressed' less frequently than the depressed vignettes and did not show a significant difference in response between males and females.

Do teachers express greater worry for students showing signs of depression than those who do not?

Participants indicated their 'worry about' each vignette character according to a five-point scale, ranging from 1 (''not at all worried'') to 5 (''extremely worried''). Extremly worried scores were collapsed to produce frequencies of each code, by sex are shown in Table 2.

Table 2. Frequencies and Percentage scores for degree of extremly worried concern by vignette type across males and females

	Total N Percentage %	Male N Percentage %	Female N Percentage%	Chi-square (x2) for gender difference
Tarkan	106 (50.7%)	24 (34.3%)	82(59.0%)	21.89[a]
Jale	84 (40.2%)	22 (31.4%)	62 (44.6%)	12.17[a]
Emel	95 (45.5%)	26 (37.1%)	69 (49.6%)	12.69[a]
Kaan	36(17.2%)	13 (18.6%)	23(16.5%)	2.41[a]

[a]Sig different ($p<0.01$) between male and female on x^2 analysis.

Extremly worried scores for each subject across the two depressed vignettes and the two 'nondepressed 'vignettes. Overall, teachers showed greater concern for the cases in the 'depressed' vignettes and females showed more overall concern than did boys. Data are presented in Table 2.

Do teachers perceive their students' with depressive symptoms as taking longer to recover than those without depressive symptoms?

Table 3. Frequencies and Percentage scores reflecting the estimated time for recovery by vignette type across males and females

	To Get Better A Few Days			To Get Better More Than A Few Months			
	Total N Percentage%	Male N Percentage%	Female N Percentage%	Total N Percentage %	Male N Percentage%	Female N Percentage%	Chi-square (x2)
Tarkan	1 (.5%)	1 (1.5%)	0 (.0%)	126 (60.9)	37(54.4%)	89 (64.0%)	8.96[a]
Jale	7 (3.3%)	2(2.9%)	5(3.6%)	96 (46.6%)	31(45.6%)	65(47.1%)	9.47[a]
Emel	7 (3.4%)	6(8.8%)	1(.7%)	103 (49.3%)	27 (38.6%)	76(54.7%)	6.36[a]
Kaan	10 (5.0%)	5(7.4%)	5(3.7%)	36(17.8%)	9(13.2%)	27 (20.1%)	4.34[a]

[a]Sig different ($p<0.01$) between male and female on x^2 analysis.

For each vignette, respondents were asked how long they thought it would take for each character to 'get better' using a five-point scale from 1 (''a few days'') to 4 (''more than a few months''). Scores for each participant were then collapsed to create separate frequencies and percentages of "to get better a few days" and "to get better more than a few months" among the two extreme terms of ''Time Until Better'' scores for the depressed vignettes and for the nondepressed vignettes. To examine differences between the 'time until better' scores for depressed vs. non-depressed vignettes was Overall, adolescents felt that cases in the 'depressed' vignettes would take longer to get better and females reported that cases overall would take longer to get beter than did males. Data are presented in Table 3.

Who do young people recommend their depressed peers seek help from?

Participants were asked to respond to the question ''Do you think (name) needs help from another person to cope with his/her problem?'' For the depressed scenarios of Tarkan and Emel, respondents answered''yes'' in 94% and 82% of cases, respectively. For the non-depressed scenarios, 80% indicated ''yes'' for Jale, 46% for Kaan. If they answered affirmatively they were also asked to state whose help was needed. Responses for the two depressed vignettes were tallied and combined to give the results as listed in Table 4.

Table 4.Recommended source of help for 'depressed' vignettes

Help source	Psychologist	Psychiatrist	Counselor	Family	Teacher	Friends
Tarkan	73 (44%)	12 (7.2%)	46 (27.7%)	5 (3.0%)	16 (9.6%)	14 (8.4%)
Jale	39 (28.5%)	14 (10.2%)	31 (22.6%)	20 (14.6%)	12 (8.8%)	21(15.3%)
Emel	55 (38.7%)	14 (9.9%)	36 (25.4%)	6 (4.2%)	15(10.6%)	16(11.3%)
Kaan	13 (15.7%)	3 (3.6%)	19 (22.9%)	28 (33.7%)	7 (8.4%)	13(15.7%)

The''Counsellor'' category included mention of the terms 'counsellor', 'counselling' and 'school counsellor'. 'Friend', 'mates' and 'peers' were combined into the ''Friends'' category. The''Family'' category included the responses of 'family', 'parents', relatives' and 'siblings/brother/sister'. Use of specific terms 'psychologist' or'psychiatrist' while use of the more were afforded their own categories. Respondents identified the category ''psychologist'' as the most common type of help they thought was required for the characters in the depressed vignettes, followed by counsellor and then'family/relatives'.

Teachers' attitudes towards adolescent depression?

Table 5 shows the results for the teachers' Attitude Questionnaire. There were attitudinal response of teachers in five of the ten questions. Teachers felt more confident in their knowledge of depression (55.5%), more confident in their ability to recognize depression (55.5%) and they don't belive the school can cope with depressed pupils (51.9%). Female scores were higher than male scores.

Table 5. Attitude Questionnaire: teachers' attitudes to depression

	Agreeing		
Question	**Female N %**	**Male N %**	**Total N %**
1. I feel confident about my knowledge of depressive symptoms	81(38.8%)	35 (16.7%)	116 (55.5%)
2. I feel confident about recognizing a pupil with depression	80 (38.3%)	36 (17.2%)	116 (55.5%)
3. I think school is an unsuitable place for recognizing depression	53 (25.4%)	27 (12.9%)	80 (38.3%)
4. I know what questions to ask a pupil to ascertain their state of mind	46 (22%)	32 (15.3%)	78 (37.3%)
5. I think schools cannot cope with depressed pupils	73 (35.1%)	35 (16.8%)	108 (51.9%)

4. Discussion

The aim of the current study was to assess the 'mental health literacy' of high school teachers, with specific interest in their knowledge of depression. Overall, the results revealed a mixed level of knowledge in relation to their ability to 'label' depression and to identify the key symptoms. The fact that there was such a marked difference across the sample between the labelling response of the two 'depressed vignettes' of Emel and Tarkan (87% and 72%, respectively) suggests that combination of presenting symptoms and the context within which they are presented may be important for teachers. The vignette of Emel included the very blunt comments of suicidal intent and feelings of worthlessness, which were also the two most highly noted 'symptoms' by respondents. The finding also seems to challenge the emphasis placed upon schools' introduction of other health promotion initiatives (Spence, 2002). However, it is important to note that the model of depression taught in the educational package was based on psychiatric concepts with which most teachers were unlikely to be familiar. In the absence of such obvious symptoms there appears little ability to label the signs together as 'depression'. The ability of teachers to 'label' depression is not just an academic exercise. It is likely to increase a young person's urgency for seeking help and who they seek help from. On the other hand, the fact that over 94% of teachers reported that the 'depressed' cases needed to get help from another person indicated that they had some level of knowledge of the extent of their difficulties. Respondents identified the category ''psychologist'' as the most common type of help they thought was required for the characters in the depressed vignettes, followed by counsellor and then'family/relatives'. Interestingly the common recommendation to see a psychologist was in marked contrast to the recommendation to access either psychology or psychiatry, a finding that has been echoed in actual use patterns among teachers (Andrews, Henderson, & Hall, 2001). According to results of Attitude Questionaire, teachers felt more confident in their knowledge of depression (55.5%), more confident in their ability to recognize depression (55.5%) and they don't belive the school can cope with depressed pupils (51.9%) Moor, et all (2007) research finding clearly indicates that teachers' ability to identify their depressed pupils was not improved by the

educational intervention. Unrecognized depression remained unrecognized. The limitation to the study was the different rates of participation of male female teachers, but the fact that males were less likely to participate than females makes the identified gender differences difficult to interpret.

5. Conclusion and Recommendation

5.1 Conclusions

The results revealed a mixed level of knowledge in relation to their ability to 'label' depression and to identify the key symptoms. The fact that there was such a marked difference across the sample between the labelling response of the two 'depressed vignettes'

5.2 Recommendation

This research needs to be replicated in other populations reflecting broader socioeconomic and ethnic diversity.A further challenge for mental health literacy research is to understand what the public actually mean when they identify a person as 'depressed'. Psychologists and psychiatrists, by and large, have a shared understanding of the term ''depression'', which is articulated in documents such as DSM-IV and ICD-10. An important next step in raising mental health literacy in the community is to ensure that the public share meanings with mental health professionals as well as with each other.

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed). Washington, DC: American Psychiatric Association.

Andrews, G., Szabo, M., & Burns, J. (2002). Preventing major depression in young people. *British Journal ofPsychiatry*, 181,460–462.

Burns,J.,Rapee,R.(2006) Adolescent mental health literacy: Young people's knowledge of depression and help seeking. *Journal of Adolescence* 29 ,225–239.

Flisher, A. J. (1999). Annotation: Mood disorder in suicidal children and adolescents. Recent developments. *Journal ofChild Psychology and Psychiatry and Allied Disciplines*, 40(3), 315–324.

Kent, L., Vostanis, P., & Feehan, C. (1997). Detection of major and minor depression in children and adolescents:Evaluation of the mood and feelings questionnaire. Journal of Child Psychology and Psychiatry and Allied Disciplines, 38(5), 565–573.

Lewinsohn, P. M., Gotlib, I. H. & Seeley, J. R. (1995). Adolescentpsychopathology: IV. Specificity of psychosocial risk factors for depression and substance abuse in older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *34*,1221–1229.

Lewinsohn, P. M., Rohde, P. & Seeley, J. R. (1998). Major depressive disorder in older adolescents: Prevalence, risk factors, and clinical implications. *Clinical Psychology Review*, *18*, 765–794.

Maag, J. W., Rutherford, R. B., Jr., & Parks, B. T. (1988). Secondary school professionals' ability to identify depression in adolescents. *Adolescence*, 23(89), 73–82.

Moor, S.,Maguire A., McQueen H., Wells J. E.,Elton R., Wrate.R, and Blair C. (2007). Improving the recognition of depression in adolescence:Can we teach the teachers? *Journal of Adolescence* 30 ,81–95.

Murray, C. J. L., and Lopez, A. D. (1996). The Global Burden of Disease, Harvard University Press, Cambridge, MA.

Patton, G. C., Coffey, C., Posterino, M., Carlin, J. B., & Wolfe, R. (2000). Adolescent depressive disorder: a population-based study of ICD-10 symptoms. Australian and New Zealand Journal of Psychiatry, 34,741–747.

Puura, K., Almqvist, F., Piha, J., Moilanen, I., Tamminen, T., Kumpulainen, K., et al. (1998). Children with symptoms of depression—What do the adults see? *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 39(4),577–585.

Rickert, V. I., Wiemann, C. M. & Berenson, A. B. (2000). Ethnicdifferences in depressive symptomatology among young women.*Obstetrics & Gynecology*, *95*, 55–60.

Shochet, I. M., Dadds, M. R., Holland, D., Whitefield, K., Harnett, P. H., & Osgarby, S. M. (2001). The efficacy of a universal school-based program to prevent adolescent depression. *Journal of Clinical Child Psychology*, 30(3),303–315.

Spence, S. H., Sheffield, J. K., & Donovan, C. L. (2003). Preventing adolescent depression: An evaluation of the problem solving for life program. *Journal of Consulting and Clinical Psychology*, 71(1), 3–13.

Spence, S. (2002). Preventing adolescent depression: Fantasy or reality. Paper presented at the Australasian Society for Psychiatric Research, Canberra, Australia.

Spirito, A. Stark, L. J., Grace, N. & Stamoulis, D. (1991). Common problems and coping strategies reported in childhood and earlyadolescence. *Journal of Youth and Adolescence*, *20*, 531–544.

Ruacan,/Ruacan,. (2002): Transition to Sustainability in 21.century. Science and Technology Addition. www.tuba.gov.tr. 25.06.2003

Yıldırım, A, ve Şimşek, H. (2006). Qualitative research methods in social sciences. Extended fifth edition, Ankara: Seçkin Press.