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## A Study of Adolescent Depression Among Middle School Students

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**SAN JOSE STATE UNIVERSITY  
SCHOOL OF NURSING**

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The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Cristina Lee  
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# A STUDY OF ADOLESCENT DEPRESSION AMONG MIDDLE SCHOOL STUDENTS

## Abstract

Adolescent depression and teenage suicide should not be neglected and underestimated. While mental health is one of the ten health indicators that Healthy People 2010 is focused on, and there are goals for the health community to work on, statistics are showing that teenagers in a county in Northern California were at high risk for mental health problem. This study was an introductory screening of the depression level of 7<sup>th</sup> graders attending middle school, and explored sources of adolescent perceived stress and routes of assistance. Results of the study show that almost one in every five 7<sup>th</sup> graders has symptoms of depression, and Asian students have the highest prevalence and a higher level of depression. Although most students are aware of counseling services being offered at school, only a few students have used the service for personal reasons. School nurses can play an important role in assessment, intervention, and referrals for students at risk for mental health problems.

Key words: Depression, suicide, adolescents, middle school, stress, mental health.

## Introduction

The transitional stage of growing from childhood to adolescence is critical. These young adolescents go through an enormous change physically, cognitively, and emotionally. They are in a critical period where positive decisions and associations can lead to success in life, but at the same time, developmental changes and more unsupervised time creates opportunities for them to engage in risky behaviors (Lucile Packard Foundation for Children's Health [LPFCH], 2005).

Changes that may alter a pre-teenager's emotional health include a search for one's own identity, transitioning into the middle school environment, increase in peer pressure, more rigid and competitive grading system, the pressure of gaining more responsibilities and making important choices. If there is a lack of skill or knowledge in maintaining emotional balance, a young adolescent can be easily troubled; and if there is a consistent lack of awareness of the problem without assistance, a child can lose interest in daily activities and eventually develop depression. If problems persist, the result can be chronic depression.

According to the 2003-04 California Healthy Kid's Survey conducted in Santa Clara County, 23% of seventh grade students "felt so sad/hopeless almost everyday for two weeks" that they stopped doing some usual activities, just 1% less than the state average (LPFCH, 2005). According to the Santa Clara County Public Health Department [SCCPHD] (2004), more than 12% of Santa Clara County 7<sup>th</sup> graders reported having seriously considered suicide at least one time in the prior 12 months in 2004, and 6.6% of Santa Clara County 7<sup>th</sup> graders reported having attempted suicide at least one time in the prior 12 months during the same year. The suicide-related non-fatal injury hospitalization

rate for youth ages 13-15 in Santa Clara County in 2002 was double the rate for the same age group state-wide (SCCPHD, 2004). Santa Clara County ranks 54<sup>th</sup> out of California's 58 counties (with 58 being the worst) in the rate of adolescent self-inflicted injury (SCCPHD, 2004). One could conclude that teens in Santa Clara County are at high risk for mental health problems as evidenced by the above figures and fact.

#### Literature Review

Suicide rate ranked 5<sup>th</sup> in 5-14 year-olds in 2002, and ranked 3<sup>rd</sup> in 15-24 year-olds the same year in the U.S. (National Center for Health Statistics, 2005). Detecting signs of depression earlier can lead to a decreased incidence of suicide related fatalities. The federal government has developed Healthy People 2010 with goals to promote longevity and decrease disparities in health care. One of the ten leading health indicators to measure how well the nation is performing is mental health / illness. According to the U.S. Department of Health and Human Services [USDHHS] (2000), depression is the most common mental illness, and major depression is the leading cause of disability. The cost of direct and indirect treatment of depression, which includes suicide, lay and professional caregivers' time, and other losses such as reduced productivity, is estimated to be \$43 billion each year (Brock, Nguyen, Liu, Watkins, & Reutzel, 2005). One of the very important goals under the mental health key indicator of Healthy People 2010 is that the nation should work on reducing the percentage of youth who attempt suicide that require medical attention to 1% (USDHHS, 2000).

Adolescent depression is often difficult to recognize. The signs and symptoms that may be associated with depressive conflicts might be shown in psychosomatic symptoms such as stomachaches, headaches, and backaches, intense preoccupations with

the body, and fatigue symptoms (Siegler, 1997). Other depressive symptoms may include changes in behavior, school failure, substance abuse, antisocial behavior, social isolation, and family difficulties (Brock et al, 2005). Parents may not recognize these symptoms, although the child's constant complaining and lack of interest in family activities may be thought to be disruptive to family functioning (Wagner, 2003).

A study by deAnda, Bradley, Collada, Dunn, Dubota, et al. (1997) showed that middle school adolescents reported that school-related stressors were highest in frequency. Specific school-related stressors included teachers, school itself and schoolwork, and homework. Coping strategies to deal with stress were used infrequently and adolescents perceived their coping strategies to be ineffective in reducing stress (de Anda et al, 1997). Students spent most of their day in school and doing after-school activities, therefore, it could be estimated that the highest level of stress comes from school.

Pre-adolescents and adolescents also may not have developed efficient coping skills to deal with stress and pressure, thus possibly leading to a depressed state. Although there are many options for assistance, some adolescents believe that they can "tough it out" and handle the situation by themselves. Culp, Clyman, & Culp (1996) conducted a study of students in the 6<sup>th</sup> through 12<sup>th</sup> grades and found that the students who had depressive symptoms and did not seek help reported that they felt it was their responsibility to figure out their own problems. Students also believed that their problems were not that important, and they did not think they needed help. As adolescents progress through the changes of puberty and powerful hormonal influences, they may exhibit some of the characteristics as described by Siegler (1997) as being

anxious, rebellious, having depressive thoughts and feelings, and having extremes in mood.

With a lack of efficient coping skills and hesitance to ask for assistance, school personnel such as a school nurse, school counselor, and school psychologist are in an optimal position to provide assistance to students who may be exhibiting depressive symptoms. According to Gall, Pagano, Desmond, Perrin, & Murphy (2000), "schools can increase access to mental health services for children and adolescents by offering these services through school-based health centers" (p.292). Another strategy is to identify at risk students through school-wide screening programs. Gould, Marrocco, Kleinman, Thomas, Mostkoff, Cote, & et al (2005) showed that having high school students complete a suicide screening program did not increase the likelihood of suicidal ideation nor distress. The Children's Mental Health Screening and Prevention Act recommends increased screening for suicidality and mental illness (Gould et al, 2005).

Due to the increasing need to combat adolescent depression, decrease suicidal attempts, and to explore sources of adolescent perceived stress and routes of assistance, this study examined the depression levels of 7<sup>th</sup> graders in a middle school in Northern California. Research questions included: (1) What is the prevalence of depression among 7<sup>th</sup> grade students in a middle school in a Northern California county? (2) What are the subjective feelings about the sources of stress among students who have depressive symptoms as suggested by their scores on a depression screening tool? (3) What is the percentage of students who are utilizing counseling services at school? and (4) Do students feel like they are getting enough support when they need it? What are the most frequently used sources of support?

## Methodology

This descriptive study consisted of a convenience sample of 7<sup>th</sup> grade students in a middle school in Northern California. Consent letters were sent to 292 families who had agreed to receive mailings through the school district.

An anonymous survey using a quantitative questionnaire and a short qualitative questionnaire with demographics were used for data collection. The “Center for Epidemiological Studies Depression Scale for Children (CES-DC)” was used as a quantitative measure. The qualitative questionnaire consisted of a) demographics questions including gender (with a choice of male or female), ethnicity (with a choice of White [non-Hispanic], Asian American, Hispanic, African American, and other), b) three yes/no questions including: 1) Are you aware of counseling services available at school? 2) Have you ever seen a school counselor for any personal reason?, and 3) Do you feel that you have enough support when you need it? and c) four open-ended questions including: 1) If you have ever felt bothered, the major cause(s) are, 2) If you have ever felt down and unhappy, the major reason(s) are, 3) If you have ever felt sad, it is most likely because, and 4) What is your major source of support? An announcement that the survey was anonymous was emphasized when the surveys were distributed, and the information was also noted on the survey.

The CES-DC is a self-reporting survey consisting of 20 items with possible scores from zero to 60. It has a Likert-type scale for each item from zero being “not at all” to three being “a lot”, except for four items which are phrased positively with an opposite scoring. The developers of the tools have used a cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. The results of a study done by



Fendrich, Weissman, & Warner (1990) provided support for the reliability and validity of the CES-DC as a measure of depressive symptomatology, and it appears to be most valid as a measure of depression for girls and for adolescents aged 12 to 18. Faulstich, Carey, Ruggiero, Enyart, & Gresham (1986), concluded that the tool could be used for epidemiological research, especially for adolescent samples. And Myers & Winters (2002) also believed that the tool may have utility in community samples as first-stage screening instruments. Because the tool was developed by a government agency and is in the public domain, a permission to use the tool from the developers was not necessary.

Following approval by the university Institutional Review Board, consent was obtained from the school district's superintendent to obtain mailing information for all 7<sup>th</sup> grade families, and consent was obtained from the middle school's principal to use the school site for the study. All families had to complete an emergency card at the beginning of the school year and they had to indicate if they wanted to receive mailings from groups such as Parent Teacher Association (PTA) etc. Two hundred and ninety two families were identified who had agreed to receive mailings, therefore the student's names and addresses were obtained, and consent letters were mailed. Parents who agreed that their children could participate in the study returned a consent form in a prepaid envelope, and indicated if they desired to be notified if their children had scores that would be indicative of having depressive symptoms.

The study was conducted over a 2-day period after a school-wide 7<sup>th</sup> grade vision screening program. Students who had been identified to complete the survey were escorted to a private area after their vision screening to complete the survey. Numbers were used to identify each student to maintain anonymity and confidentiality. Only the

researcher had access to the coding system. The students had to return the completed survey to an envelope, and a bookmark with resources from school and outside agencies was given to them.

## Results

What is the prevalence of depression among 7<sup>th</sup> grade students in a Northern California County? Students who had a score of 15 or above would be considered to have depression symptoms. Out of the 62 subjects who had completed the survey, 12 students (19.4%); 5 female and 7 male, had a score of 15 or above. Five female students (41.7%) had scores ranging from 15 to 43, with a mean of 31.6, and seven male students (58.3%) had scores ranging from 18-48, with a mean of 25.7. (Table 1).

Demographic data showed that out of the 62 subjects who had completed the survey, 33 were male (53.2%), and 29 were female (46.8%). There were 35 Caucasian students (56.5%), 25 Asian students (40.3%), 1 Hispanic student (1.6%), and 1 student who was listed under "other" (1.6%). (Table 2).

There were six Caucasian students among the group of 12 students who were indicative of having depressive symptoms; they had a range of scores between 18 to 43, with a mean of 26.8. Five Asian students had a range of scores between 15 to 48, with a mean of 30.6; and one Hispanic student had a score of 24. Six out of a total of 35 Caucasian students (17.1%) had scores indicative of depressive symptoms, 5 out of 25 Asian students (20%) had scores indicative of depressive symptoms, and there was only 1 Hispanic student who had completed the survey and had a positive score. (Table 1).

Results related to the second research question: What are some of the possible causes of depression among students who have depressive symptoms as suggested by their scores? included the following:

Twelve students were identified as having depressive symptoms, but four students did not complete an answer to the three open-ended questions of the possible causes of sadness. The other eight students had answers ranging from “no friends around”, “my friends did not like me”, “family problems at home”, and “I didn’t sleep at all”. A few students had also listed “school”, or other school-related problems such as “bullying”, “other mean kids”, and “work”. For those eight students who may have had difficulty in interpersonal relationships as evidenced by their answers, their scores ranged from 18 to 48, with a mean of 31.9. Therefore, it may suggest that in addition to the school-related stress, having difficulty in interpersonal relationships may be related to depression and that could be an area to focus on for intervention strategy.

What is the percentage of students who are utilizing counseling services at school? When students were asked if they are aware of counseling services that is available at school, 59 out of 62 students (95.2%) answered yes, and only three students (4.8%) answered no. When students were asked if they have ever seen a school counselor for any personal reason, 11 out of 62 students (17.7%) answered yes, and 51 out of 62 students (82.3%) answered no. (Table 4). This indicates that there are resources available to them but not been well used. Therefore school counselors may want to focus on strategy such as being more proactive in advertising their services in school, and mingle with students during “normal hanging-out” hours such as lunch time.

Do students feel like they are getting enough support when they need it? What are the sources? When students were asked if they feel that they have enough support when they need it, 55 out of 62 students (88.7%) answered yes, and seven students (11.3%) answered no. (Table 4). Out of the seven students who answered no, five students (71.4%) had a score which may be indicative of having depressive symptoms.

Students had to complete the major sources of support and most of the students had indicated that their “friends” and “family” were their major support system. A few students had used “teachers” and a sibling as an answer, and even fewer students had used “myself” as an answer or no support. (Table 5).

Three of the 12 students (25%) had either used self or no supportive system at all. Eight out of 12 students who were identified as having depressive symptoms had written “parents” or “family” as their major support system, five wrote “friends”, two wrote “teachers”, one wrote “myself”, and two did not write anything. Because this question was an open-ended question, students could respond with more than one answer and some did. (Table 5)

### Discussion

Sixty two out of 292 consents were returned. The response rate of 21.2% was considered a reasonable response rate. Of major concern was that 19.4% of the students in the survey had scores indicative of depressive symptoms, or almost one out of every five students. The result is comparable to the county-wide data showing that 23% of 7<sup>th</sup> grade students felt sad / hopeless when they completed the California Healthy Kids survey in 2003-04.

After studying the sample's ethnicity distribution, it is noted that it is similar to the school district's Powerschool report of student's ethnicity distribution, which shows 45.3% Caucasian students, 48.9% Asian-American students, 1.3% Hispanic students, and 4.6% "other" students. Therefore the sample is representative of the entire 7<sup>th</sup> grade.

Although more male students (21.2%) had been identified as having a higher incidence of symptoms than female students (17.2%), female students had a higher mean score (31.6) than male students (25.7), which supported the data from other studies (Gall et al, 2000; de Anda et al, 1997) that female students have more depressive symptoms than male students. The reason for more male students being identified with depressive symptoms than female students in this study group is not clear. However, it could be due to the nature of the survey being a self-reported study.

A unique finding in this study was that Asian students had the highest mean score of depression (30.6). Also, the single Hispanic student had a score indicative of depressive symptoms, but the Asian students had the highest percentage (20%) of students among the same ethnic group with depressive symptoms. Asian students have given the public the impression of being hard workers and high achievers. However, because there is a lack of research addressing depression in the Asian students, it is impossible to compare any findings or to hypothesize a correlation of academic stress and depression. Continued research regarding depression in the adolescent Asian population is needed.

After analyzing the quantitative data from the CES-DC, it was noted that there are four questions in the tool that provided significant information. Six out of 62

students (almost 10%) had scored a “3” (“a lot” / “not at all” if the question is phrased positively) on three of the questions, and 9 out of 62 students (14.5%) had scored a “3” on one of the questions. After comparing the answers of the 62 subjects in general and the answers of the 12 identified students whose score indicated depressive symptoms, a definite problem was identified. When asked, “I didn’t sleep as well as I usually sleep during the past week”, six students checked “a lot”, and all six of these students had scores that may indicate that they have depressive symptoms (Table 3). Therefore, it is very important that parents, school teachers, and school nurses are attentive to students who appear to be sleep-deprived. Also, educating adolescents about the importance of sharing their feelings and problems, and informing them about different available resources is important as well. The importance of educating adolescents about depression could also be a major focus. It will be interesting to find out in future studies about students’ perception of “support” and the sources of support that they feel most comfortable and most needed.

Although the majority of the students (95%) stated that they were aware of counseling services available at school, most of the students (82%) reported that they had not seen a school counselor for any personal reason. Students might not believe that they needed an “outside” adult assistance as evidenced by the high number of students (88.7%) reported that they have enough support when they needed it, yet most of those students reported having their family and friends as being the major support system. The result of this finding could lead the school nurse into an active role of educating parents about depression, and a proactive role in screening students and drawing attention in this “prohibited” topic of adolescent depression. Parent’s awareness of the importance of

having counselors at school may also need to be emphasized since the funding for counselors at school are fully sponsored by educational foundation being supported by parents' donation.

At the end of the study, parents were notified that their children had symptoms of depression and information about a community agency was provided to all of them. Three out of 12 parents who had children with depressive symptoms had contacted the researcher after and requested information regarding the survey and the results.

#### Limitation of the study

Because of a lack of human resources and the survey could only be done during P.E. period per agreement on the parent's consent, the survey had to be conducted over a two-day period in order for the researcher to screen all the 7<sup>th</sup> grade students, there could be a chance that some of the students who had completed the survey might have revealed the content of the survey to other students who had not taken the survey yet. Future considerations should be taken into account if more resources are available.

The CES-DC had been recommended to be used in community samples as a first-stage screening instrument only, and according to Fendrich, Weissman & Warner (1990), "it should not be used as a substitute for clinical diagnosis" (p.549). Students who had scores which indicated that they had depressive symptoms would need further evaluation and testing by professionals, and parents should understand the importance of that. An effort had been made to emphasize that by follow-up letters to the parents from the researcher.

## Conclusion

Adolescent depression could lead to attempted suicide, and fatalities without early intervention. Students in this study were identified to feel “so sad/ hopeless” (23%), score high in suicide thoughts (more than 12%) and attempted suicide (6.6%), and more efforts need to be done to bring the figures of attempted suicide down to the goal of 1% as listed in Healthy People 2010. Screening can increase parental awareness of mental health issues in the pre-adolescent and adolescent populations. Also, more school outreach programs should be in place to provide mental health education and counseling and assistance to all students in general, and different resources from schools and the community can be introduced as well.

## Implications for school nursing practice

Because students spend an equal amount of time at school and at home, an effort should be made from the student, parents, and school personnel if a student is showing signs and symptoms of depression. There should be increased awareness of mental health problems through education, effective communication, collaboration, trust and partnership to create a successful environment with a goal of providing the best care.

Education plays a vital role for the student, parents, and school personnel. Student should understand that they should not be fighting the battle alone. Even though most adolescents believe that they need to handle their own problems, it is questionable from an outsider’s point of view if they are capable of doing so; therefore educating youth about expected developmental changes and the problems that may result is an obvious need (Culp, Clyman, & Culp, 1995). Students also need to learn different coping



strategies and methods to handle stress and difficult situations. Teachers, counselors, school administrators, and school social workers can collaborate, teach and reinforce positive coping strategies (de Anza et al, 1997). A cognitive-behavioral therapy based program called the Penn Resiliency program was developed and tested by Freres, Gillham, Reivich, & Shatte (2002) in a group of middle school students, the program contained an intrapersonally oriented cognitive component and an interpersonally oriented social-program solving component. The program had proven to be an effective intervention for the reduction and prevention of depressive symptoms in middle school aged students with different ethnic backgrounds and settings. School nurses can identify and share established intervention programs based on research data to implement evidence based practice.

Besides learning about the developmental changes and characteristics of adolescence, parents also need to be educated on the signs and symptoms of adolescent depression and to monitor for changes in behavior that may require medical attention. Promoting awareness and educating parents through student screening, school health newsletters, speakers at PTA meetings, and school functions may be an effective strategy to assist parents to be more sensitive to mental health issues and cultural implications.

School nurses need to maintain and update their knowledge of signs and symptoms of depression, and increasing awareness of cultural differences as well. Through daily interactions with students, school nurses can develop trust and create communication channels with the students. School nurses should be supportive and sensitive to student's needs and be non-judgmental. Increasing the availability of programs to educate school nurses about mental health assessments and interventions

would be effective. A program developed by Hootman, Houck, & King (2002) to enhance school nurses' abilities to identify students with mental health problems and to implement early intervention was proven effective and was highly recommended. School nurses also need to be aware and be familiar with referral procedures and various resources at school and in the community. The school nurse can also act as a liaison between the student, the parent, and community resources as well as providing valuable insight to families in need.

Effective communication does not only refer to communication skills but the flow of communication between all the involved parties. If parents only communicate with the physician and blocks out information to the school in fear of embarrassment or stigma, then comprehensive care cannot be provided. Different school personnel including teachers, counselors, school nurses, school psychologists, and other parties who are involved with individual cases should also communicate among each other and exchange valuable information that should be kept confidential as well. Collaboration can produce more positive outcomes for students at risk of mental health problems.

Once the student, parents, and school personnel have the knowledge, the skills for intervention, and effective communication, then trust and partnership will eventually develop and the relationship will become harmonious, and there also comes a three-dimensional success in assisting adolescent depression.

Table 1. Descriptive characteristics of 7<sup>th</sup> grade students who are indicative of depressive symptoms (N=12)

<b>Gender</b>	<b># of students (% with N=12)</b>	<b>Mean scores</b>	<b>Range</b>	<b>% depressed among identified group</b>
<i>Female</i>	5 (41.7%)	31.6 ±	15-43	17.2 % (N=29)
<i>Male</i>	7 (58.3%)	25.7 ±	18-48	21.2% (N=33)
<b>Ethnicity</b>	<b># of students</b>	<b>Mean scores</b>	<b>Range</b>	<b>% depressed among identified group</b>
<i>White (non-Hispanic)</i>	6 (50%)	26.8 ±	18-43	17.1% (N=35)
<i>Asian American</i>	5 (42%)	30.6 ±	15-48	20% (N=25)
<i>Hispanic</i>	1 (8%)	24 ±	n/a	100% (N=1)

Table 2. Descriptive characteristics of the sample - 7<sup>th</sup> grade students

(N=62)

<b>Gender</b>	<b># of students (%)</b>
<i>Female</i>	29 (47%)
<i>Male</i>	33 (53%)

<b>Ethnicity</b>	<b># of students (%)</b>
<i>White (non-Hispanic)</i>	35 (56.5%)
<i>Asian American</i>	25 (40.3%)
<i>Hispanic</i>	1 (1.6%)
<i>African American</i>	0
<i>Other</i>	1 (1.6%)

Table 3. Significant finding in CES-DC – question items with extreme answer

Question	# of students who scored a "3**" (N=62)	# of depressive students who scored a "3**" (% among identified group of 12)
* "I felt like I was just as good as other kids"	6	1 (16.7%)
"I felt like I was too tired to do things"	6	4 (66.7%)
* "I felt like something good was going to happen"	9	3 (33.3%)
"I didn't sleep as well as I usually sleep"	6	6 (100%)

\* indicates a positively phrased question

\*\* 3= "a lot" / "not at all" if the question is positively phrased

Table 4. Students' interpretation of counseling service and support (N=62)

**1. Are you aware of counseling services available at school?***Yes 59 (95.2%)**No 3 (4.8%)***2. Have you ever seen a school counselor for any personal reason?***Yes 11 (17.7%)**No 51 (82.3%)***3. Do you feel that you have enough support when you need it?***Yes 55 (88.7%)**No 7 (11.3%)*

Table 5. Interpretation of sources of support from students who are indicative of having depressive symptoms (N=12)

Sources of support	# of students
“parents” / “family”	8
“friends”	5
“teachers”	2
“myself”	1
“none”	2

\*Students may have more than one answer

*(Note: 3 out of 12 students [25%] had either no supportive system or use “myself” as a supportive system)*

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