Emotional difficulties in children with behaviour difficulties, within special education schools.

by

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Abstract

The aim of this study is to identify and address whether the symptoms of depression, anxiety and trauma are higher in children with behaviour difficulties than those in the general population of the same age and gender. A group of 22 children aged 8 – 13 of both genders participated in the research. The sample selected attend a special needs school for children classed as having behaviour difficulties. These children have been removed from mainstream education due to their behaviour. Literature points to the fact that the symptoms of depression, anxiety and trauma can affect the behaviour and academic ability of children. There is however very limited literature available on children with behaviour difficulties. The children completed a Child Depression Inventory, Multidimensional Anxiety Scale, and Trauma Symptoms Checklist for Children. The teacher and parents of these children completed a Conners behaviour checklist to establish a baseline of behaviour for these children. The asTTle academic records of the children were accessed from the school's database to establish a baseline of academic achievement for these children in comparison to the general population. The research conducted indicated mixed results both indicating that children in these special needs school have both higher and similar rates of symptoms of depression, anxiety and trauma.

Dedication

I dedicate this thesis to my darling wife and my little angel. Thank you for being my rock, inspiration and support. For being there for me when I needed it most. Thanks for the sacrifice of time and effort. But most of all thanks for Monique my biggest blessing of all. I do this all for you.

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This would not have been possible without the help from a range of people.

- Firstly I would like to acknowledge and thank my parents for the multiple sacrifices that they have made in their lifetime for me. I know that without you both I would not have been where I am today. I also know that nothing can repay you for all of this, but I am truly deeply grateful.

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Literature Review

1.1 Introduction

People, no matter their age, who conduct themselves in a socially unacceptable manner, are a large problem for every member of that society. This is no different for children; every situation they find themselves in has a set of behaviours that is deemed appropriate for the situation. If a child steps out of these boundaries, his/her behaviour is frowned upon.

Behaviour can be seen as a language; it can be explained that people behaving in a certain manner are expressing their emotions through their behaviour. This would indicate that an individual's emotional state explains his/her behaviour. This would mean that if a person is on an emotional low his/her behaviour would be different to his/her behaviour if he/she were on an emotional high.

Children who continually behave in this manner usually end up being removed from the school environment. These children are often sent to a school, which has the ability to cater for the needs of these children. These schools are not just there to maintain a set of behaviours but also to modify

the unacceptable behaviour into acceptable behaviour, which will enable these children to return to a mainstream school.

What came to the fore when observing these children is that they appear to be weighed down by stress and seem to carry a lot of emotional baggage with them. They seem emotionally charged and on edge - in other words emotionally overburdened which is often transferred into their behaviour.

Based on observations and discussions with the staff at these schools, the emotional drain that the children within these schools experience seems much larger than that experienced by children in the general population of the same age. It is therefore often understandable, yet not acceptable, for these children to behave in these emotionally driven behaviour outbursts.

Behaviour outbursts come in a range of ways: there can be oppositional or deviant behaviour or it could be verbal or physical aggression. Behavioural outburst could involve running away or self-isolation. Many of these go hand in hand with one another but are different entities. Not all children's behaviour patterns will be the same.

There are many factors that influence the behaviour of children. Some of the factors that influence the behaviour of children are their environment and the people they associate with. There are also internal structures that influence the behaviour of children. The following chapter aims to discuss

some of these in a broad sense but take an in-depth look at the impact of emotional difficulties on behaviour especially the symptoms of depression, anxiety and trauma.

1.2 The Relationship between behaviour difficulties and emotional problems.

Emotional difficulties manifest themselves in a range of ways dependent on emotion, situation and individual. Some of these are behavioural others are academic; while some of them are not manifested in any way visible to the naked eye. There are however some common threads that are exhibited by many individuals who face these emotional difficulties.

Karustis, Power, Rescorla, Eiraldi and Gallagher (2000) explain that children who experience emotional difficulties often experience social problems. One of the main social problems that the children face is aggression towards peers. These behaviours are one of the main contributing factors to children being removed from mainstream education. Karustis, Power, Rescorla, Eiraldi and Gallagher (2000) also explain that these children often find it much harder to except their peers and so they find it hard to mingle with children of their own age. This can be seen as a double-edged sword as some of the children do not like their peers and often most of these children's peers do not like them either.

Reinke, Splett, Robeson & Offutt (2009), explain that children who exhibits behaviour problems at a very young age have a higher risk of academic underachievement, peer rejection, substance abuse, and delinquency. They also explained that research has identified that children who exhibit aggressive behaviour at school are at higher risk for later conduct disorder, anxiety disorders, depressive disorder, and antisocial behaviour (Reinke, Splett, Robeson & Offutt, 2009),

1.3 Environmental factors influencing behaviour

Emotional difficulties are not the only cause of behaviour difficulties in children. There is a very wide range of contributing factors that could lead to a child behaving in an antisocial manner. One of these factors that can influence the behaviour of children is environmental factors. Environmental factors include the environment within which these children live in at home as well as other environments they find themselves in i.e. school and social circles. This means that the individuals that the children associate with are classed as an influential factor within the environment of the children (Reinke, Splett, Robeson & Offutt, 2009).

Situations can impact on the lives of children, which in turn can make children behave in a manner that can be seen as socially unacceptable. Children gather cues from their environment. They use these cues to establish how they should behave. There are times when children behave in ways that the rest of society sees as unacceptable and strange. This can

provide for difficult times as a child may misread a situation or not know how exactly how to respond to the situation.

Dodge, Lansford, Burks, Bates, Pettit, Fontaine, and Price (2003), suggests that parent child relationship and peer rejection is the most researcher areas in children with behaviour difficulties. They explain that research has been done to establish the impact of parent – child relationships and how different children respond to this (Dodge, Lansford, Burks, Bates, Pettit, Fontaine, and Price, 2003). The research indicates that these relationships with parents greatly impact on the social/behavioural development of children. Peer rejection also has a major impact on the development of behaviour difficulties in children (Dodge, Lansford, Burks, Bates, Pettit, Fontaine, and Price, 2003). It is explained that children who exhibit minor behaviour problems at a young age get worse if their peers reject them. It is also proven that the younger the child when the rejection occurs the worse their behaviour gets.

Ary, Duncan, Duncan & Hops (1999) & Reinke, Splett, Robeson & Offutt, (2009), explain that parent and peer influences shape a child's behaviour. Reinke, Splett, Robeson & Offutt, (2009), state that parents are the most influential factor in the development of behavioural problems in children. Ary, Duncan, Duncan & Hops (1999) state that parents that are inconsistent and harsh often have a profound impact on their children. Stormont (2001) explains that these children who have parents that are more controlling often exhibit stable behaviour problems. Amato and Rivera, (1999) state

that previous research has indicated that the relationship between fathers and children in particular have an impact on the behaviour of children. Their research however, indicates that paternal involvement is not necessarily a predictor of positive behaviour in children. There are other contributing factors that have an impact too (Amato and Rivera, 1999).

She also explains that these children with stable behaviour problems where more intense and harder to control at school (Stormont, 2001). This can often lead to children becoming very insecure and lead to them becoming aggressive at a very young age. These children who have behaviour difficulties often surround themselves with other children who are similar to them (Ary, Duncan, Duncan & Hops, 1999). This is a very negative situation as these children reinforce each other's negative behaviour. They encourage each other and so their behaviour escalates to higher levels constantly.

1.4 Other factors influencing behaviour

As mentioned earlier there are many factors that influence the behaviour of children. Some of these may be based on external factors and other will be rooted in internal factors.

Ehrler, Evans & McGee (1999), explain that personality traits have a significant impact on the behaviour of an individual. They explain that specific traits, or a combination of traits could be the explanation for the

way certain children behave (Ehrler, Evans & McGee, 1999). This could be an explanation of the behaviour seen within these schools. Personality disorders have a significant impact on how children interpret situations, how they respond to situations and the situations that they create themselves.

Attention deficit hyperactive disorder is often associated with behaviour difficulties amongst children (Karustis, Power, Rescorla, Eiraldi and Gallagher, 2000; & Marc & Crundwell, 2005). Marc & Crundwell, (2005) state that behaviour problems have been highlighted as the main factor in identifying ADHD. .

Riva, Lyon, and Heefner (1995), explain that many children who have a learning disability often experience behaviour problems as well. They also explain that many children who are classed as having a behaviour problem are in actual fact a case of undiagnosed learning disability (Riva, Lyon & Heefner, 1995)

Dodge, Lansford, Burks, Pettit, Fontaine & Price (2003), indicate that the child suffering from peer rejection can cause behaviour problems. This is significant as many children get rejected by their peers due to their behaviour, and their behaviour is often caused by being rejected.

Fussell, Macias and Saylor (2005) have indicated that children who suffer from a learning difficulty often suffer from social difficulties and therefore

have a problem interacting appropriately with their peers and adults. Furthermore, research has also found that children who suffer from Attention Deficit Hyperactive Disorder and a learning difficulty have a very high rate of social difficulties that also influence behavioural development (Fussell, Macias and Saylor, 2005).

Fussell, Macias and Saylor (2005) also explain that sibling relationships have a profound effect on the social and behavioural development of individuals. Lambie (2005) also explains that ethnic background influences how the family responds to one another as well as others including those in the school setting. Therefore it is clear that behaviour can be driven by ethnical expectation and beliefs. This is important to remember as the children in these schools come from a range of ethnical backgrounds.

1.5 Relationship between academic underachievement and emotional difficulties

According to Riva, Lyon, and Heefner (1995), research has shown that children who suffer from a learning difficulty often experience elevated levels of emotional problems. Research indicates that children's academic achievement can often be greatly influenced by their emotional well-being.

Karustis, Power, Rescorla, Eiraldi and Gallagher (2000) point to the fact that most students who suffer from emotional difficulties will underachieve

in their academic work. This could be due to the fact that academic work can take a back seat to some of the other problems faced by these children.

Depression, anxiety and trauma greatly influence the academic achievement of children within schools. These factors will be discussed at a later stage.

1.6 Environmental factors influencing academic achievement

Lambie (2005) explains that there are many factors that influence children's academic achievement at school. One of these is cultural difference. Certain cultures may have a different way of measuring success and so the academic achievement of the children from this specific culture may not be deemed important.

Socio-economic status is the next point identified by Lambie (2005) as a major contributor to the academic under-achievement of certain children. Lambie (2005) explains that children who come from a lower socio-economic background may not believe that there are opportunities for them to reach higher goals. Therefore they are not motivated to fully apply themselves to academic work.

The emotional state of the parents is another factor that influences the academic achievement of children. Lambie (2005) highlights that children carry the emotional state of their parents to school. Carrying this extra

burden can greatly influence the academic achievement of the children, as schoolwork just does not seem that important.

1.7 Other factors influencing academic achievement

According to Raynish (2007), research indicates that divorce has a profound effect on the academic achievement of children. There are a very large number of divorces taking place in modern day society. This identifies the possibility that a large number of children will be underachieving in their academic work at school.

Raynish (2007), identifies that these problems occur not just due to the fact that these children are experiencing emotional torment due to the divorce, but physically they are impacted as time with parents as well as financial status in the household undergoes a change.

As can be seen from the above mentioned literature there is a wide range of factors affecting the emotional states of children, the behaviour of children and their academic achievement. For the purpose of this research a closer look will be taken at three emotional factors that have been identified to greatly affect both children's behaviour and their academic achievement. These three factors are the symptoms of depression, anxiety and trauma. The literature based on these three factors will be discussed below.

Leung, Yeung and Wang (2009), found that children who do not have parental support are prone to more academic anxiety and stress, which has a profound impact on the academic achievement of the children. They also explain that this is in part due to the fact that when individuals know they do not have any or limited support the burden of anxiety becomes more. This lack of support often influences the children to have a lower academic self-concept and so they believe that they cannot achieve academically.

1.8 Depression

When meeting the children from the special need schools the impression is created that they are carrying the world on their shoulders. The emotional states of this population, however, rarely get formally assessed. The fact that the emotional well being of these children is not assessed is very interesting as teachers often comment that these children are emotionally detached or immature for their age. The literature indicates that teachers often overlook emotional difficulties, like depression. Teachers find it hard to comprehend the fact that children may suffer from these forms of problems (Barrett and Waterfield, 1997). This often leads to teachers not being willing to admit that children may suffer from these emotional issues.

Research has shown that children with behaviour difficulties often suffer from depression; in actual fact they are much more likely than the average child in the general population to be exhibiting these behaviours (Schloss,

Sher &Wisniewski, 1994). This is due to the fact that children externalise their feelings of depression, taking out their depressive emotional states on the outside world, rather than internalising the depression as adults do (Lebrun, 2007, & Schaffer, & Waslick, 2002). Semrud-Clikeman,

Fine & Butcher (2007) state that children, who fall into the age group researched, exhibit their depressive symptoms through external behaviours such as temper outbursts, physical aggression and distractibility. This is often a vicious circle where the children feel depressed and so they behave in an "inappropriate" way because they are annoyed at life. This behaviour makes the children feel even more depressed which means the cycle is never ending (Schaffer, & Waslick, 2002).

As mentioned earlier these children often get excluded from certain educational situations due to their behaviour. This would mean that if the child were depressed and got excluded, the self-defeating prophecy that the world is an unfair and unjust place, which is out to harm them, gets fulfilled. This plays into the cycle of depression, however, teachers in mainstream education cannot be expected to compromise the education of the class based on the behaviour of one individual.

Depression is often a vicious cycle in which children are trapped, from which escape seems impossible (Schaffer, & Waslick, 2002). They also state that failure at school can be the cause of depression in children, and conversely depression could also be the cause of failure at school for these

children. Therefore it is essential that the issue of depression gets addressed as this information is used to identify and address any other underlying issues that may be present. Reijntjes, Stegge & Terwogt (2006) state that children are often alienated from their peers, which causes depression as peers play a very important role in the lives of young people.

However, the fact that these children are depressed would be one of the main contributing factors to them getting even more alienated from their social group. The children at these special needs schools often do not allow people to get close to them as they are fearful of the impact that these external individuals can have on their lives. Children who are depressed also do not seem to have the skills to overcome the issues in their lives and so they seem to plummet deeper into a depressive state (Reijntjes, Stegge & Terwogt, 2006). Varma (1984) explains that children who suffer from the symptoms of depression often come across as being restless and may seem to be inattentive to tasks.

Anderson, Kelly, Klaas, Russell, Daharsh, and Vogel (2009) explain many children who suffer from a physical disability suffer from depression and anxiety. This needs to be taken into consideration when testing the children, as a physical disability could be the cause of their depression.

Fröjd, Nissenin, Pelkonen, Marttunen, Kovisto, Kaltiala-Heino (2008) explain that depression in children is often associated with difficulties in

social relationships with peers and adults, concentration at school and school performance in general.

1.9 Anxiety

Kearney & Bensaheb (2007), Van Gastel and Ferdinand (2008), and Downing (2007), explain that anxiety is one of the most common psychological disorders amongst children in the world today. They also explain that anxiety disorders are one of the most debilitating disorders a child can ever face. A wide range of research findings point to the fact that when children suffer from symptoms of anxiety they have an elevated risk of having social difficulties within their daily lives (Chansky & Kendall, 1997; Strauss, Frame & Forehand, 1987; Strauss, Lahey, Frick, Frame & Hynd, 1988 in McClure & Nowicki, 2001; & Downing, 2007).

These difficulties often involve both their peers and the adults within their lives. It is therefore indicated that children who suffer from anxiety can behave in a socially inappropriate manner that will get them into trouble with their teacher and peers. This form of antisocial behaviour is widely observed in the children who attend these special needs schools. These children behave in a socially unacceptable manner as they are anxious and at that point they would like to alleviate those feelings of anxiety. They often feel that the world is a very dangerous place and so they make sure that others could not hurt them, by letting them get close to them. This often relates to both these children's peers and the adults within their lives.

It also has to be mentioned that these children often have full right to feeling these emotions of anxiety as many of them come from environments where these fears are real and justifiable, as they come from emotionally charged environments.

Hussain and Kashani (1992) explain that within New Zealand girls, aged eleven have a much higher rate of general anxiety. This, however, is not the case for panic disorder where boys are more represented than girls. This is very interesting as the majority of the children who attend these schools are boys.

The interaction between peers is also essential for future development into well-balanced individuals. Because many of the children in these special needs schools alienate themselves from the rest of their peers, they deny themselves the opportunity to develop into well-balanced individuals. Reijntjes, Stegge & Terwogt, (2006) also explain that children face many problematic situations while interacting with their peers and by working through these situations children acquire the necessary skills, which enable them to cope in future life. It is clear that many of these individuals need assistance and support to overcome these issues.

1.10 Trauma

Traumatic events occur in each and every person's life and can be defined as "events, which are outside the realm of day to day experiences"

(Tunnecliffe, 1996). According to Lanktree, Gilbert, Briere, Taylor, Chen, Maida & Saltzman (2008), trauma can lead to anxiety, depression, posttraumatic stress, oppositional disorder and dissociation (Guterman, Cameron, & Hahm, 2003, Ford, 2002, & Lanktree, Briere, & Zaidi, 1991). The only concern with this is that events that one person considers traumatic may be seen by others as normal. Even if a range of people experience an event as traumatic it will affect all of them differently and some may be traumatised and others not. Tunnecliffe, (1996), explains that this is one of the main difficulties faced by adults hoping to determine whether a child has been affected by a certain event.

There are, however, certain characteristics that children who suffer from trauma exhibit. However, children can exhibit all, some or none of these behaviours. Research has proven that most children-suffering trauma exhibit at least one of these behaviours. Children suffering from trauma are often immature in comparison to children of a similar age (Tunnecliffe, 1996). At school these children also often have a low work output rate and generally under-perform in their academic work.

One of the major symptoms experienced by children who suffer from trauma is that they have social difficulties that are often manifested in aggressive behaviour or withdrawal from both peers and adults (Tunnecliffe, 1996). Both these scenarios inevitably lead to these children being alienated and isolated from their peers. This isolation leads to other emotional difficulties, which just further drive these children's negative

attitude towards life in general. These children also often gravitate between the states of aggressive behaviour and withdrawal, which can make diagnosis exceptionally difficult. Due to this fact, many of these children are often misdiagnosed.

1.11 Aim of Research

The aims of the research include the following:

- to determine what the literature says about the symptoms of depression, anxiety and trauma in children aged 8-13;
- to determine how these symptoms of depression, anxiety and trauma affect the behaviour of children aged 8-13;
- to determine by means of the Child Depression Inventory (CDI), Multidimensional Anxiety Scale for Children (MASC), Trauma Symptom Checklist for Children-Alternative (TSCC-A) and Conners Rating Scale whether an increased rate of symptoms is exhibited in the sample group; and
- to determine whether children who attend special need schools due to behaviour difficulties exhibit higher symptoms of depression, anxiety and trauma in comparison with their counterparts in the general population of the same age and gender.

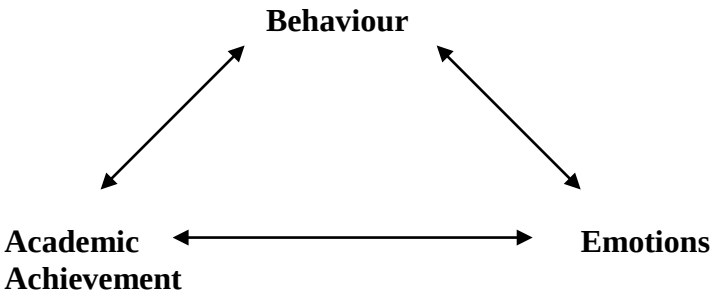
1.12 Hypothesis for Research

1) Children in special education schools suffer higher symptoms of depression, anxiety, and trauma, than children within the normative population.

2) Children in these special education schools achieve lower academically than the general population in New Zealand.

3) Children will exhibit higher levels of oppositional behaviour & cognitive difficulties as measured by the Conners rating scale revised, in comparison with the normative population.

4) There is a relationship between emotional difficulties, behaviour problems and low academic achievement.



1.13 Conclusion

Literature indicates there is a broad range of factors that influence the behaviour, emotional state and academic achievement of children in

modern day society. For the purpose of this research the emphasis will be on the symptoms of depression, anxiety and trauma.

Chapter Two

Methodology

2.1 Introduction

This chapter will aim to provide a detailed description of the organisation as well as the participants who participated in the research. The method used to collect the data for the research will also be highlighted and discussed. It will identify and discuss the process and procedures used and followed, as well as discussing how the psychological measures were applied.

2.2 Setting

There are two of these special needs schools within New Zealand, however only one will be used for the research, as the other is currently participating in other research. These schools cater for children who fall in the age range of 7 – 13. Students of both genders attend these schools and they come from all over New Zealand. This specific school runs with support from the Baptist church and so the children participate in Bible studies on a weekly basis.

The children who attend these schools have all participated in mainstream education within the New Zealand system, however their behaviour has

been classed as antisocial and intervention within the mainstream schools has proven ineffective. The children who attend these schools have been stood down or expelled from a range of mainstream schools. The behaviour of these children is classed, as being too severe to deal with in mainstream education therefore the move to the special needs school.

These children are often physically and verbally abusive towards both their peers and the adults in their lives. The presence of one of these children within a classroom can severely impact on the education of the whole class. These children are often time consuming and so overbearing that other children within the class often miss out on quality educational time. All of these children have been provided with resources and assistance, within mainstream education, to assist them with their behaviour and academic issues that they exhibit. They also often get excluded from activities within mainstream schools, as these activities may be classed as being too un-structured, which holds the belief that these children will not be able to maintain their behaviour. This can often have a profound effect on these children, as this exclusion often fuels their anti-social behaviour towards school.

Due to these children's behaviour many of them achieve academically below their chronological age. Many mix with individuals who can be classed as having antisocial behaviour. This often means that they are involved in traumatic situations, which could have a great impact on the children. The proposed research will aim to identify whether children

within this special needs school are more likely to exhibit symptoms of depression, anxiety and trauma, than children of a similar age within the general population.

The school where the research is being conducted has 5 classrooms with a primary educated teacher in them. Every classroom also has one or two teacher aids that assist the teachers in their classrooms. The classroom is based on year groups rather than ability levels. The children attend school from 9 am to 3 pm Monday to Friday. At 3pm the children return to the residential facility of the school. When within the residential programme the children have physical programmes as well as other activities. The children go to bed between 8-9 pm and wake at 7 am again. The children are then assisted to get ready to go to school at 9 am.

2.3 Participants

The entrance criteria into the research are based on the fact that these children have met the criteria to attend this school. Therefore, all the children who attend the school were approached to participate in the research.

2.3.1 Children

The children participating in the research were all aged 8 – 13 years. A grand total of 26 children were approached to participate in the research.

Of the 26 children one child's parents declined due to personal reasons. There were 3 children whose parents did not complete the consent process and so these children were eliminated from the test group. There were a total of 22 children who completed all the tests and fully participated in the research. The test group consisted of 2 girls and 20 boys. The group consisted of 15 children who fell between the ages of 8 – 10 and 7 in the 11-13 years age range. These children came from all over the north island of New Zealand. There was also a very wide range of cultures within this test group.

The children whose parents/caregivers granted consent for their child to participate were provided with an information and consent form of their own. The children's information sheets were divided into three groups based on their age. The three age levels were 7-10, 10-12 and 13 (See Appendix D). This division was purely made to deliver the language in each information sheet at a level that would be understandable to children of the appropriate age groups.

The children completed the tests in pairs with the researcher. The children were under no circumstances allowed to communicate with one another and did not sit close enough to one another to allow them to see each other's work. The children completed all three assessment tools in succession and in the following order: first the CDI, then MASC, and finally the TSCC-A.

The researcher alone conducted all of these tests. The children were removed from their school activity and went into a room, which was separated, from the rest of the children. It was quiet, but still safe for both researcher and children as there were many staff members around. They however couldn't see the answer the children provided or hear any of the questions asked within the room. The room is also monitored by surveillance cameras, which record images but has no audio feed. This maintains the confidentiality of the children as no one could establish what they had answered.

Total Children	**Boys**	**Girls**
22	20	2
(100%)	*(90.91%)*	*(9.09%)*

Table 2.3.1.1 illustrating gender make-up of the test group.

Age	**8**	**9**	**10**	**11**	**12**	**13**
Number Of children	2	2	4	6	3	5
	(9.09%)	*(9.09%)*	*(18.18%)*	*(27.27%)*	*(13.64%)*	*(22.73%)*

Table 2.3.1.2 distribution of ages for the test group.

Total Children	**Pacific Islander**	**Maori**	**European**	**Asian**	**Other**
22	10	11	7	2	1
(100%)	*(45.45%)*	*(50.00%)*	*(31.82%)*	*(9.09%)*	*(4.55%)*

Table 2.3.1.3 Ethnical make up of the test group. The total of student's ethnical identification goes above 100% as some of the children associate with more than one culture.

Five of the children had Child Youth and Family involvement, however all the children stay with family members and have contact with their parents and siblings on a daily basis when they are not attending the residential school.

2.3.2 Teachers

All the teachers at this school have been trained as primary school teachers. They have extensive knowledge and understanding of the New Zealand Curriculum.

Once consent had been obtained from the parent/caregivers and children, consent was also obtained from the teacher of every child. The teachers were also provided with an information sheet (See Appendix E).

Every child's teacher completed a Conner's Behaviour Checklist for the child. This was done to establish a baseline of behaviour for the children at these schools. This baseline was then compared to a normative sample based on the general population. Teachers were given the Conner's

behaviour checklist and they went away and completed it in their own time. The Conner's behaviour checklist teacher forms were then returned to the researcher.

2.3.3 Parents

After ethics had been obtained every parent/caregiver was provided with information sheets that discussed the process and context of the research. From there on consent was obtained from the parents and/or caregivers of the children within the school (See Appendix B and C). The consent entailed that the parents were willing to participate in the research; they gave consent for their child to participate in the research as well as allowing the researcher access to the children's academic data from the school database.

The parent/s or caregivers of every child completed a Conner's Behaviour Checklist. This was done to establish a baseline of behaviour for the children at these schools. This baseline is then compared to a normative sample based on the general population.

The parents were asked to complete a Conner's Behaviour checklist for their child based on the child's behaviour at home. Most parents completed the Conners at home. If they had any questions these were directed to the researcher who answered them promptly.

2.4 Measures

There are three assessment tools that will be used to identify the presence of the symptoms of depression, anxiety and trauma, namely the Child Depression Inventory (CDI), the Multidimensional Anxiety Scale for Children (MASC) and the Trauma Symptom Checklist for Children Alternative (TSCC-A).

The children will complete a Child Depression Inventory (CDI) and the Trauma. Symptom Checklist for Children Alternative (TSCC-A). Depression is one of the scales measured by the TSCC-A. The CDI is one of the most widely used psychological assessment tools for the assessment of depression in children (Carey, Faulstich, Gresham, Ruggiero & Enyart, 1987, & Samm, Värnik, Tooding, Sisask, Kõlves & von Knorring, 2008). This tool is easy to use for participants and the researcher alike. . The CDI has also been translated into a range of other languages. Charman & Pervova (2000) explain that the internal consistency of the CDI for identifying depressive symptomatology in children is high if the CDI is the non-translated version. For the purpose of this research the un-translated version will be used, as all the children are English speaking. This would be beneficial to the research conducted, as the CDI used is not translated into another language.

The Child Depression Inventory (CDI) is a globally used depression scale for children. The CDI is used over a wide range of settings in New

Zealand on a regular basis. It is used with a range of other methods to form a diagnosis; however the CDI should not be used on its own to formulate a diagnosis but should be a part of the assessment towards a diagnosis.

The Multidimensional Anxiety Scale for Children (MASC) and the Trauma Symptom Checklist for Children Alternative (TSCC-A) both measure anxiety within children. The MASC is a self-report measure and according to Kearney & Bensaheb (2007), it is essential to use self-reports when assessing children's anxiety or any internal mood for that matter, as it is important to hear the child's voice. The MASC is an age-appropriate test for the children participating in the research and it is easy to use for both the researcher and the participants.

The MASC is a good choice as it covers a wide range of anxiety related symptomatology and is relatively brief. It also has high levels of test-retest reliability as well as internal reliability. The measure shows consistency and stability, which makes it a good measure to use (Baldwin & Dadds, 2007, March, Sullivan & Parker, 1999 & Kearney & Bensaheb 2007). Ivarsson (2006), states that the MASC has shown to have global reliability and validity. The measure also has a large amount of normative data that can be used to compare the children in the study to the general population. March, Sullivan, Parker, Stallings and Conners (1997) explain that the MASC showed good to excellent test-retest reliability as well as internal reliability.

The TSCC-A is the only scale that measures symptoms of trauma, and a range of trauma, and it has the ability to report the under- and over-identification of trauma (Nilsson, Wadsby & Svedin, 2008). . The TSCC-A is standardised in both clinical and non-clinical samples. Using this assessment tool is essential for this population of children as they are often exposed to traumatic events within their lives. Quite often these children not only come from traumatic backgrounds at home, but they also often surround themselves with individuals that are prone to violence and other anti-social behaviour.

The Conner's Behaviour Checklist is one of the most widely used global rating scales in the world today (Conners, 1977). Every child's teacher completed a Conner's Behaviour Checklist for the child. This was done to establish a baseline of behaviour for the children at these schools. This baseline is then compared to a normative sample based on the general population. Teachers were given the Conner's behaviour checklist and they went away and completed it in their own time. The Conner's behaviour checklist teacher forms were then returned to the researcher.

The parent/s or caregivers of every child completed a Conner's Behaviour Checklist. This was done to establish a baseline of behaviour for the children at these schools. This baseline is then compared to a normative sample based on the general population.

The parents were asked to complete a Conner's Behaviour checklist for their child based on the child's behaviour at home. Most parents completed the Conners at home. If they had any questions these were directed to the researcher who answered them promptly.

The children's *asTTle* academic data was also obtained from the school. Based on observation and anecdotal data it is clear that *asTTle* is one of the most used standardised assessment tools within New Zealand. Schools use this test package, which covers a range of curriculum areas, to identify where their children fall in comparison with the New Zealand mean. The *asTTle* also identifies the areas that need work, to enable the child to make age appropriate progress. The *asTTle* score for the test group's children was obtained from the schools database, for the purpose of establishing if the children in the test group score lower academically that children of the same age in the general population.

2.5 Ethical Considerations

There were many ethical issues to consider in conducting this research with this population. One of the main considerations that were addressed was the fact that these children are already labelled as having a 'behaviour problem' and therefore another label could be detrimental to the mental health of the children. It is therefore stipulated throughout the research (consent forms, information sheets and any other information) that the research aims to identify the symptoms of depression rather than label

children with the disorder. Not only is it foolish to believe that a diagnosis can be made by using one or two psychological assessment tools, but it would also not benefit the children nor the research.

The cultural expectations of the children and their families had to be considered. This lead to the support of a Maori and Pacific Island expert being sought to assist the researcher with any cultural issues that may arise within the research. This was done as most of the children participating in the research are from Maori or Pacific Island descent. The Maori and Pacific Island experts advised and informed the researcher throughout the research process. They explained certain cultural beliefs and wants for the researcher as well as the process that the researcher needed to follow in working with individuals from these specific cultures. These experts have been consulted at every stage of the research process.

Other tests were looked at and the Trauma Symptom Checklist for Children (TSCC) was initially selected but due to the fact that it contained questions that measured sexual trauma, the alternative form was rather used. The TSCC-A includes all other forms of trauma as per the TSCC-A. The reason behind excluding sexual trauma was based on the concern that children will be emotionally distressed as a result of these questions.

The safety of the children and the researcher had to be taken into consideration and so children were tested in pairs. It was however not

possible for the children to communicate with one another or see each other's answers.

2.6 Research Design

The research is quantitative in nature and four psychological assessment tools and an academic standardised assessment tool will be used to collect the data. The data collected will then be correlated with the data of the normative data used in the development of these assessment tools.

This research will look at the relationship/correlation between the three variables tested. The three variables are the behaviour of the children, the emotional state of the children and the academic achievement of these children. The Pearson correlation will be used to identify direction (positive or negative) and the strength of the relationship of the variables (Pallant, 2001). Identifying this is very important, as it will expose the magnitude if any of the impact that the variables have on one another. The confidence interval will be determined and then used to establish whether or not the data collected will fall with in the significant range.

2.7 Conclusion

As seen in this chapter it is a very involved process that includes a wide range of individuals and assessment tools. This is essential as it provides the researcher with a broad range of data. This broad range of data is

necessary, as it will mean that the research will provide a more holistic view of the test group.

Chapter Three

Results

3.1 Introduction

In this chapter the test results for the CDI, MASC and TSCC will be presented.

3.2 Child Depression Inventory (CDI)

The normative data used in the CDI is based on a sample size of 1266 children, whose ages range between 7 and 16(Kovacs, M. 1992).

The CDI has five scales as well as a total CDI measure which looks at the overall score of the five scales. The five sub-scales are negative mood, interpersonal problems, ineffectiveness, anhedonia, and negative mood. These five scales cover a wide range of some of the most common emotional states experienced by children. The measure just evaluates the degree to which a child is experiencing these emotions in comparison to the general population of the same age and gender.

The child depression inventory manual has clearly defined levels based on the T-Score achieved by the children in comparison with their raw score on the test. This can be seen in table 3.1, which indicates the severity of

depressive symptoms a child experiences based on the score a child received on the CDI scales.

Table 3.1
Interpretive guidelines for T-scores for the CDI

T-Score	Guideline*
Above 70	Very much above average
66 to 70	Much above average
61 to 65	Above average
56 to 60	Slightly above average
45 to 55	Average
40 to 44	Slightly below average
35 to 39	Below average
30 to 34	Much below average
Below 30	Very much below average

*compared to children of a similar age and gender in the normative sample

Source: Kovacs, M. Children's Depression Inventory Manual, 1992: 16

The test group's range of T-scores for the Total CDI scale fell between 38 and 84 with a mean score of 54.73. Based on the mean of the T-score the test confidence interval (95%) is between 50.55 and 58.91. This indicates that any score that falls outside of these two scores would be statistically significant.

When looking at the mean score (54.73) for the CDI total and comparing it to the interpretive tool for the CDI (table 3.1), it is clear that the mean for the CDI falls within the average range. When looking at the individual score for the children in the test group it is clear that 3 (13.64%) children fall within the "very much above average" category. When looking at the confidence interval it is clear that 6 (27.27%) children score where statistically significant, indicating the 6 children within the group score much higher in comparison to a child of the same age and gender within

the normative sample. It is clear then that 72.73 % of children within the test group did not score that much different to their counterparts within the normative sample, in actual fact they fall within the average range.

This indicates that according to the CDI most of the children within this special needs school do not suffer abnormally high levels of symptoms of depression.

3.3 Multidimensional Anxiety Scale for Children (MASC)

The MASC is one of the most widely used anxiety assessment tools with children today (Kearney & Bensaheb, 2007). The MASC measures and then categorises data according to age and gender. It has a range of normative data, which had been gathered from the general population. A sample of 2698 children and adolescents were used to determine the norm data (March, 1997). The tool consists of an overall measure, which in turn consists of five scales; there is then however six sub categories that divide the MASC in to smaller parts. Each one of these sub categories measures a specific symptom (field of anxiety).

Table 3.2
Interpretive guidelines for T-scores for the MASC

T-Score	Guideline*
Above 70	Very much above average
66 to 70	Much above average
61 to 65	Above average
56 to 60	Slightly above average
45 to 55	Average
40 to 44	Slightly below average
35 to 39	Below average
30 to 34	Much below average
Below 30	Very much below average

*compared to children of a similar age and gender in the normative sample

The test group's range of T-scores for the Total MASC scale fell between 42 and 77 with a mean score of 58.41. Based on the mean T-score the test confidence interval is between 54.23 and 62.59 this indicates that any score that falls outside of these two scores would be statistically significant.

When looking at the T-scores of the test group on the MASC and using the interpretive tool (table 3.2), there are 6 (27.27%) children who fall within the "very much above average" bracket. In comparison when looking at the confidence interval, 8 (36.36%) individuals fall within the clinically significant range. When looking at the separation scale of the MASC, it is however important to indicate that the mean, of the test group, for this scale lies between "above average" and "much above average". Looking at the individual scores for the children on the separation scale indicates that 9 (40.91%) individuals fall within the "much above average" category. Along with this there are 2 (9.09%) individuals that fall within the "above average category".

This indicates that 50 % of the test group falls above the score that would be classed as average. This is however even more concerning due to the fact that all of these children have been separated from their families, to enable them to attend the school.

3.4 Trauma Symptom Checklist for Children Alternative (TSCC-A)

The Trauma Symptom Checklist for Children Alternative is a widely used psychological measure that is used to assess trauma in children. The alternative version does not assess sexual trauma in children but covers the basis of other trauma. All of the normative data is based on data collected from 3,008 children and adolescents from the general population (Briere, J. 1996).

The TSCC-A measures 5 scales namely: anxiety, depression, anger, posttraumatic stress and dissociation. Dissociation is divided into two parts, which report on overt dissociation and fantasy. There is also a measure that indicates whether children are over- or under-stating their trauma. On both these scales none of these children achieved higher than the T-score of 6, which falls within the mean range when including the standard deviation. The results of the T-Sore intervals can get interpreted as presented in Table 3.3.

Table 3.3
Interpretive guidelines for T-scores for the TSCC-A

T-Score	Interpretation
65+	Clinically Significant
60 - 64	Significant
50 - 59	Average

When looking at the T-score for the anxiety scale the test group's scores fall between 35 and 100 with a mean of 61.14. The scores for the depression scale ranges between 37 and 90 with a mean of 60.32. The mean for the anger scale is 56.59 with the test group's scores ranging between 37 and 70. The Posttraumatic stress scale's score range between 36 and 80 with a mean of 60.95. The last scale on the TSCC-A is the dissociation scale. The test group's scores range from 41 to 84 with a mean score of 61.36.

When looking at the means of the scales of the TSCC-A all of the scales except the anger scale fall within the "significant" range. This then indicates that the consideration needs to be made to identify whether the children deliberately skewed their results on the other test conducted, as the TSCC-A also assesses symptoms of anxiety and depression.

When looking at the individual children for the anxiety scale it is significant to identify that 10 (45.45%) children fall within the

"significant" range or higher and of the 10 (45.45%) children 8 (36.36%) children fall within the "clinically significant" range.

It is also important to identify that 10 (45.45%) children also fall in the "significant" range or higher of the depression scale. Again of the 10 (45.45%) another 8 (36.36%) children (not all the same children as in the anxiety scale) fall within the "clinically significant" range.

Even more significant is that 12 (54.55%) of the children (not the necessarily the same children as above) fall with in the "significant" range or higher for the PTSD scale. Of the 12 children, 9 (40.91%) fall within the "clinically significant" range.

3.5 Conners Behaviour Checklist

As mentioned earlier both the parents and the teachers of the children participating in the research completed a Conners rating scale-revised.

Table 3.4 indicates the interpretive guideline for the T-scores and the percentiles.

Table 3.4
Interpretive Guidelines for T-Scores and Percentiles for the Conners Rating Scale – Revised

T-Score	%ile	Guideline
70+	98+	Markedly Atypical (Indicate Significant Problem)
66-70	95-98	Moderately Atypical (Indicate Significant Problem)
61-65	86-94	Mildly Atypical (Possible Significant Problem)
56-60	74-85	Slightly Atypical (Borderline: Should raise concern)
45-55	27-73	Average(Typical Score: Should not raise concern)
40-44	16-26	Slightly Atypical (Low Scores are good not a concern)
35-39	6-15	Mildly Atypical (Low Scores are good not a concern)
30-34	2-5	Moderately Atypical (Low Scores are good not a concern)
<30	<2	Markedly Atypical (Low Scores are good not a concern)

The test group's T-scores on the oppositional scale of the Conners rating scale-parent range between 54 and 89 with a mean score of 69.36.

The Conners Rating Scales-Revised Teacher Form measures four areas of behaviour. These areas are oppositional, cognition, hyperactivity and ADHD. Figure 3.1 shows the average of the total T-scores of each of these areas as provided by the teachers. The norms are also shown for children of the same age and gender within the normative sample. As can be seen the children in the test group scored higher in all the areas of the Conners test as rated by their parents.

Both the teachers and the parents Conners' Rating Scale show that these children have very high rates of oppositional, cognitive, hyperactivity and ADHD behaviour as can be seen in Figure 3.1 and 3.2.

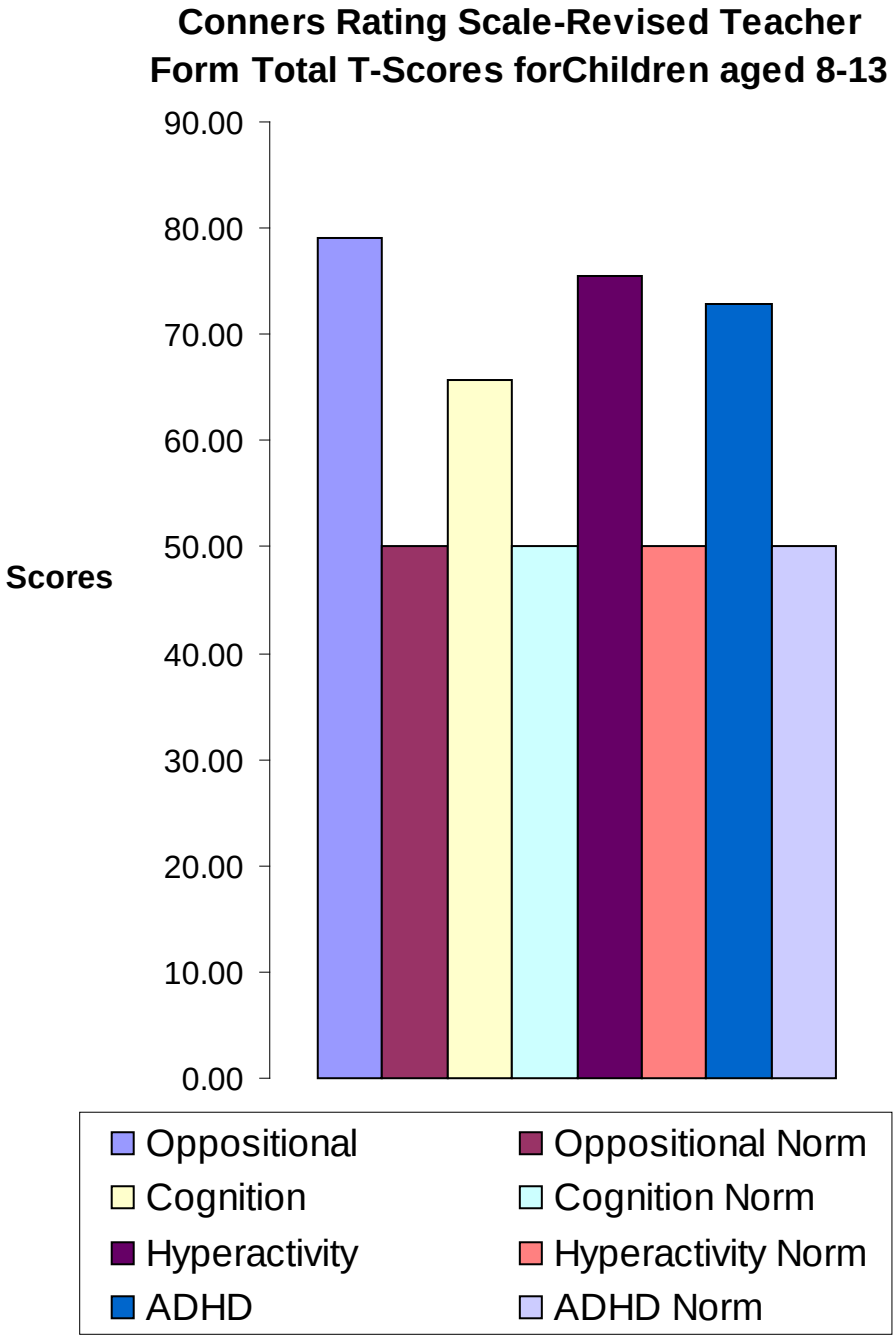


Figure 3.1: The Conner's Rating Scale-Revised Teacher Form for children of a similar age.

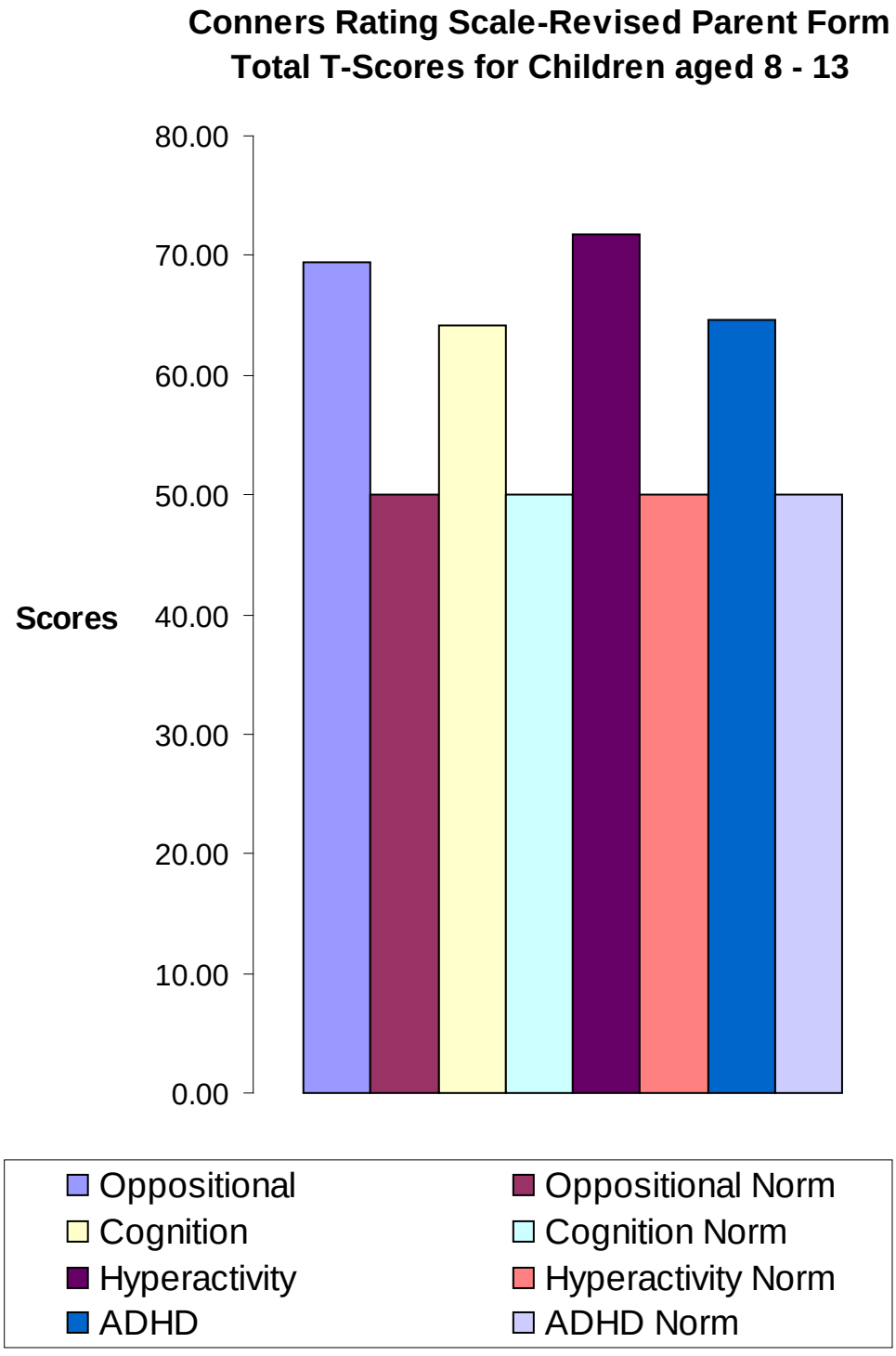


Figure 3.2: The Conner's Rating Scale-Revised Parent Form for children of a similar age.

The Conners Rating Scale-Revised Parent Form measures the same areas as the Conners Rating Scale Revised Teacher Form. As can be seen in figure 4.2 the children scored significantly higher in all areas than the mean score for the general population. It is evident that the score in both figure 4.1 and figure 4.2 shows a similar discrepancy between the scores of the test group and the mean score for the general popultion.

3.6 AsTTle

When comparing the test group's *asTTle* results for reading, it appears that one child scored above the New Zealand mean for their age. There are 6 children who scored below the New Zealand mean, but who were closer than 100 points from the New Zealand mean. There are, however, 15 students who scored significantly lower than their counterparts of the same age in the New Zealand population. These children scored more than 100 points less than that of the mean, and in some cases closer to 200 points below the mean.

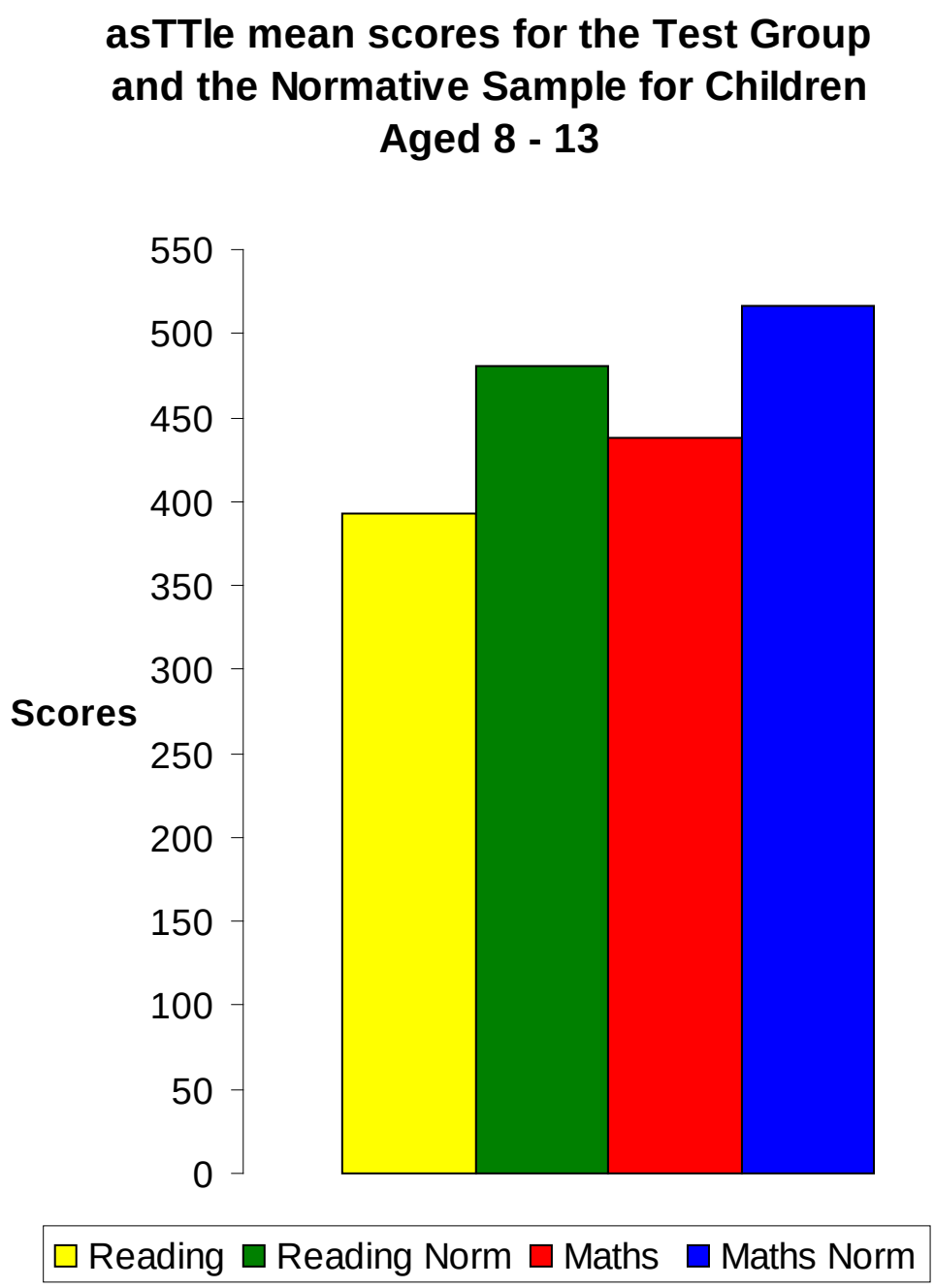


Figure 3.3: asTTle result for the test group and normative sample for maths and reading

By comparing the *asTTle* mathematics results for the test group, it appears that 3 children scored above the New Zealand mean and 3 children scored less than 100 points below the New Zealand mean. There are, however, 16 children who scored more than 100 points less than the mean with scores as high as 250 points below the New Zealand mean.

As can be seen in the preceding discussion the children in the test group show significantly lower achievement rates on the asTTle standardised assessment tool. It is clear that every child, bar a few, shows a significant academic deficit in comparison to the general population.

3.7 Conclusion

This chapter has clearly identified some interesting results and these will be further discussed in detail in the following chapter.

Chapter 4

Discussion and Conclusion

4.1 Introduction

This chapter will aim to summarise and conclude the previous chapters as well as looking forward to possible steps that could be taken in future to further develop this research.

From the data collected and discussed above it is indicated that children in special education schools may suffer higher symptoms of depression and anxiety, due to the fact that there is a discrepancy between the findings of the different tests. It is however clear from the TSCC-A that these children exhibit higher symptoms of trauma, than children within the normative population.

The *asTTle* data indicated that the children in these special education schools do achieve lower academically than the general population in New Zealand.

The Conners rating scale did identify on both the parent and teacher forms that the children within these special need schools exhibit higher levels of oppositional behaviour and cognitive difficulties. However it is also

indicated that these children score significantly higher on the hyperactivity and ADHD Scales as well.

The data tends to indicate that there is a relationship between behaviour problems and emotional difficulties. The results involving emotional difficulties are mixed as the TSCC-A clearly indicates that these children tend to exhibit higher symptoms of all the emotional difficulties proposed. These findings are not completely supported by the data collected on both the CDI and the MASC.

The data points to the fact that children within these special educational schools may indeed suffer from higher rates of symptoms of depression and anxiety, as well as clearly indicating that most of the children at these schools suffer symptoms of trauma. Further research needs to be done to concrete these findings either way. It is clear that a relationship between behaviour and academic achievement does exist and careful consideration needs to be given to this relationship.

4.2 Depression

It is evident from the data presented in chapter 3 and chapter 4 that the children in the test groups have higher levels of depressive symptoms. This will have a significant impact not only on their behaviour but their, academic and social ability. Therefore, it is evident that a programme that assists the children in addressing their depressive symptoms will be highly

beneficial as it will equip them with the necessary tools to address some of their issues giving them the power back and so encouraging them to believe in their own ability.

These children will behave in a way that is seen as inappropriate, as the baseline behaviour would be significantly different to that of the general population. This is due to the fact that children often externalise feelings of depression. This would mean that they see the world as a dangerous place against which they need to protect themselves. This would indicate that the children would not be able to focus on changing their behaviour, as they will be trapped in the vicious cycle of depression.

4.3 Anxiety

Anxiety is a mixed bag as on many scales the children scored the same as the average. This, however, is not true for the separation panic scale where the children in the test group scored much higher than average.

The children also scored above average for the social anxiety scale and the total anxiety scale but not as much as the separation panic scale. There are, however, reservations held as the children scored in the significant range for the anxiety scale as measured by the TSCC-A.

It is therefore suggested that in future research anxiety be assessed again. A programme to assist the children in dealing with their separation panic

will be beneficial to them. It is essential to establish whether these children are truly exhibiting higher symptoms, as these symptoms of anxiety would influence the behaviour of these children significantly.

4.4 Trauma

As can be seen from the discussion and interpretation in chapter 4 and 5, the children within this special needs school score high on the TSCC-A scales. The children scored "average and above" constantly achieving a score that is classed as "significant" and then the children scored in the clinically significant range of the dissociation fantasy scale.

The only scale that the children did not achieve above average is the anger scale. This is ironic as the children who go to this school are normally classified as having an 'anger problem'. It is clear that the children at this school will benefit from a programme that addresses these issues.

As mentioned earlier the high rates of symptoms of trauma can lead to depression, anxiety, anger, oppositional behaviour and a wide range of other mental health issues. This would indicate that the symptoms of trauma need to be addressed, as these symptoms could lead to a wide range of issues for these children. These symptoms would also limit the work that the schools are all ready doing, with the programmes that they are currently running.

It is clear from this data that a large number of children fall above the average score for most of the scales measured by the TSCC-A. This shows again that significant consideration needs to be taken to see whether the children have not purposely skewed the measurements of the CDI and the MASC.

4.5 Final word

Overall it can be seen that there are concerns about the high levels of symptoms of trauma and depression. This would greatly impact on the social development of these children. The levels of symptoms of anxiety are not as clear-cut; however there are some concerns as many of the children still scored high individually of the MASC and the average level for all children on the TSCC-A is very high.

The hypothesis stated at the start of this piece of work has been proven as semi correct. The research has indicated that the children who attend this special needs school have significantly higher rates of symptoms of depression and trauma. Anxiety on the other hand was shown to be significantly higher according to the TSCC-A but only average according to the MASC.

Future research could include reassessing the symptoms of anxiety in children within special need schools. Research could also be done on the relationship between trauma and the symptoms of anxiety and depression

those children within special need schools experience. The development of a programme to address these symptoms of trauma and depression would also be beneficial for the children within this school.

The behaviour would significantly be impacting on the academic achievement of the child. The rating scales indicate that teaching these children in a mainstream setting can be difficult as they scored high on all the scales. Many of these things can be seen as just putting up a front to protect themselves from harm, as they may believe that the world is a dangerous place. It is also important to address their issues, which would minimise some of these behaviours.

These children are lacking in a range of areas and if something is not done about their behaviour they will never catch up on the academic deficit.

One of the main limitations of this study is that only one school participated in the research. It would have been better if more schools participated in the research. Another limitation is the fact that four parents did not give permission for their children to participate in the research. If the children purposely influenced the test answers this would have skewed the test outcome, which would directly impact the results and therefore implicate whether the hypothesis be proven or not.

Reference List

Amato, P. R., & Rivera, F. (1999). Paternal Involvement and Children's Behavior Problems. *Journal of Marriage and Family*, 61 (2), 375-384.

Anderson, C., Kelly, E., Klaas, S. J., Russell, H., Daharsh, E& Vogel, L. C. (2009). Anxiety and depression in children and adolescents with spinal cord injuries.

Ary, D. V., Duncan, T. E., Duncan, S. C. & Hops, H. (1999). Adolescent problem behavior: the influence of parents and peers. *Behavior Research and Therapy, 37(3), 217-230.*

Baldwin J. S., & Dadds, M. R. (2007). Reliability and validity of parent and child versions of the multidimensional anxiety scale for children in community samples. *Journal of the American academy of child and adolescent psychiatry*. 46 (2), 252 – 260.

Barrett, M., & Waterfield, J. (1997). The hidden factor: an educational perspective of depression in learning. In K. N., Dewivedi & V. P., Varma (Eds.). *Depression in children and adolescents* (pp.106-124). United Kingdom: Athenaeum Press Ltd.

Carey, M. P., Faulstich, M.E., Gresham, F.M., Ruggiero, L., & Enyart, P. (1987). Children's Depression Inventory: Construct and Discriminant Validity Across Clinical and Nonreferred (Control) Populations. *Journal of Consulting and Clinical Psychology.* 55 (5), 755-761.

Chansky, T. E., & Kendall, P. C. (1997). *Anxiety disorders in youth: cognitive-behavioural interventions.* Boston: Allyn and Bacon.

Charman, T., & Pervova, I. (2000). The internal structure of the child depression inventory in Russian and UK Schoolchildren. *Journal of youth and adolescents*. 30 (1), 40-51.

Conners, C., K. (1977). *Conners' rating scales-revised: Technical manual.* New York: Multi-Health Systems Inc.

Dodge, K. A., Lansford, J. E., Burks, V. S., Pettit, G. S., Fontaine, R., & Price, J. M. (2003). Peer Rejection and Social Information-Processing Factors in the Development of Aggressive Behaviour Problems in Children. *Journal of child development,* 74 (2), 374-393.

Downing, J. A., (2007). *Students with emotional and behavioural problems. Assessment, management, and intervention strategies*. New Jersey: Pearson.

Ehrler, D. J., Evans, J. G., and McGee, R. L. (1999). Extending the big five theory into childhood: a preliminary investigation into the relationship between big-five personality traits and behaviour problems in children. *Psychology in the Schools*, 36(6), 451-458.

Ford, J. D. (2002). Traumatic victimization in childhood and persistent problems with oppositional defiance. *Journal of Aggression, Maltreatment and Trauma*, 6, 25–58.

Fröjd, S. A., Nissenin, E. S., Pelkonen, M. U. I., Marttunen, M. J., Kovisto, A., and Kaltiala-Heino, R. (2008). Depression and school performance in middle adolescent boys and girls. Journal of Adolescence 31, 485–498.

Fussell, J. J., Macias, M. M., and Saylor, C. F. (2005). Social Skills and Behavior Problems in Children with Disabilities with and without Siblings. *Child psychiatry and human development.* 36(2), 227-241.

Guterman, N. B., Cameron, M., & Hahm, H. C. (2003). Community violence exposure and associated behavior problems among children and adolescents in residential treatment. *Journal of Aggression, Maltreatment & Trauma, 6*, 111–135.

Hussain, S. A. & Kashani, J. H. (1992) *Anxiety disorders in children and adolescents*. Washington DC: American Psychiatric Press.

Ivarsson T. (2006). Normative data for the multidimensional anxiety scale for children (MASC) in Swedish adolescents. *Nordic Journal of Psychiatry*. 60, 107 – 114.

Karustis, J. L., Power, T. J., Rescorla, L. A., Eiraldi, R. B., & Gallagher, P. R. (2000). Anxiety and depression in children with ADHD: Unique associations with academic and social functioning. *Journal of Attention Disorders*, 4, 133-149.

Kearney, C.A., & Bensaheb, A. (2007). Assessing anxiety disorders in children and adolescents. In S.R. Smith & L. Handler (Eds.), *The clinical assessment of children and adolescents: A practitioner's guide* (pp. 467-483). Mahwah, NJ: Lawrence Erlbaum.

Lambie, R. (2005). At-risk students and environmental factors. In Lambie, R. *Family systems within educational context*. Denver: Love publishing company.

Lanktree, C. B., Briere, J., & Zaidi, L. Y. (1991). Incidence and impacts of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse & Neglect*, *15*, 447–453.

Lanktree, C. B., Gilbert, A. M., Briere, J., Taylor, N., Chen, K., Maida, C. A., & Saltzman, W. R. (2008). Multi-informant assessment of maltreated children: Convergent and discriminant validity of the TSCC and TSCYC. *Child abuse and neglect.* 32, 621-625.

Lebrun, M. (2007). Student depression: *A silent crisis in our schools and communities*. Maryland: Rowman & Littlefield Education.

Leung, G. S. M., Yeung, K. C., and Wang, D. F. K. (2009). Academic stressors and anxiety in children: the role of paternal support. *Journal of child and family studies.* 19, 90-100.

Marc, R. & Crundwell, A. (2005). An Initial Investigation of the Impact of Self-Regulation and Emotionality on Behaviour Problems in Children With ADHD. *Canadian Journal of School Psychology.* 20 (1/2), 62-74.

March, J. S., Sullivan, K. S., & Parker, J. (1999). Test-Retest reliability of the multidimensional anxiety scale for children. *Journal of anxiety disorders.* 13 (4), 348 – 358.

Nilsson, D., Wadsby, M. & Svedin, C. G. (2008). The psychometric properties of the trauma symptom checklist for children (TSCC) in a sample of Swedish children. *Child Abuse & Neglect.* 32, 627-636.

March, J. S., Sullivan, M. P. H., Parker, D. A., Stallings, P., and Conners, C. K. (1997). The Multidimensional anxiety scale for children (MASC): Factor, structure and reliability. *American academy if child and adolescent psychology,* 36(4), 554 – 565.

Pallant, J. (2001). *SPSS survival manual*. Victoria: McPherson printing group.

Raynish, A. (2007). *The Price of divorce.* In partial fulfillment of the requirements For the degree of Masters in Education.

Reinke, W. M., Splett, J. D., Robeson, E. N., and Offutt, C. A. (2009). Combining school and family interventions for the prevention and early intervention of disruptive behaviour problems in children: a public health perspective. *Psychology in the Schools*, 46(1), 33-43.

Reijntjes, A., Stegge, H., and Terwogt, M. M. (2006). Children's coping with peer rejection: The role of depressive symptoms, social competence, and gender. *Infant and Child Development.* 15(1), 89-107.

Riva, M. T., Lyon, M. A., & Heefner, A. S. (1995). *Internalising and externalising behaviour problems in children with and without identified learning problems*. Paper presented at the annual convention of the rocky mountain psychological association. Boulder, Colorado.

Samm, A., Värnik, A., Tooding, L., Sisask, S., Kõlves, K., & von Knorring, A. (2008). Children's Depression Inventory in Estonia Single items and factor structure by age and gender. *European Child and Adolescent Psychiatry,* 17, 162-170.

Schaffer, D. & Waslick, B. D. (2002). *The many faces of depression in children and adolescents*. Washington: American Psychiatric Publishing Inc.

Schloss, P., Sher, H., &Wisniewski, L. (1994). Depression in special education populations. In W. M., Reynolds & H. E., Johnston (Eds.). *Handbook of depression in children and adolescents* (pp.445- 460). New York: Plenum Press.

Semrud-Clikeman, M., Fine, J. G., & Butcher, B. (2007). The assessment of depression in children and adolescents. In S. R., Smith & L., Handler (Eds.). *The clinical assessment of children and adolescents: a practitioner's handbook***.** New Jersey: Lawrence Erlbaum Associates.

Strauss, C. C., Frame, C. L., & Forehand, R. L. (1987). Psychosocial impairment associated with anxiety in children. *Journal of Clinical Child Psychology*, 16, 235-239.

Strauss C. C., Lahey B. B., Frick P., Frame C. L., Hynd G. W., (1988). Peer social status of children with anxiety disorders. *Journal of consulting and clinical psychology.* 56 (1), 137-141.

Tunnecliffe, L. (1996). *Children affected by trauma. A guide for parents, teachers, ambulance, rescue and emergency medical personnel*. WA: Bayside Books.

Van Gastel W., & Ferdinand, R., F. (2008), Screening capacity of the multidimensional anxiety scale for children (MASC) for DSM-IV anxiety disorder. *Depression and Anxiety*, 25, 1046-1052.

Varma, V. P. (Ed.). (1984). *Anxiety in children*. London: Croom Helm.

Appendix A:

School information and Consent Form

Dear Madame/Sir,

I am writing to you in concerns to the research project that we have discussed earlier on. I will just again outline the form/nature of the research.

I intend using the children at the special needs residential schools with in New Zealand. The amount of children that will be used may very as it is dependent on the amount of children available. A range of self-report psychological assessments will be conducted with every child to assess the levels of Depression and Anxiety. The children will all complete a Child Depression Inventory (CDI), also a Multidimensional Anxiety Scale for Children (MASC) and a Trauma Symptom Checklist for Children (TSCC). Assessments will also be done to observe the impact on the children's behaviour and their academic ability, to measure this all children will be academically accessed using the *asTTLe* program and their parents and teachers will complete a Conner's Behaviour Checklist. Confidentiality will be maintained at all time and feedback can/will be provided to the parents/caregivers and the school if so desired.

It is also requested that I will be allowed access to the asTTle database, as the individual data concerning the child's academic achievement in mathematics, reading and writing. This data will be used to identify the impact if any of the children that may be caused by one or a range of the above mentioned symptoms.

It would now be appreciate if you could sign a consent form stating that I, Bernard G. Niehaus have discussed the research with you and that you have give consent to use some of the children attending, Your School and that I can now go forth and gain informed consent from the parents/caregivers of those children selected for the research.

Kind regards
Bernard G. Niehaus

I, _____ Principal of _____ hereby give permission to Bernard G. Niehaus to use some of the children within my school, subject to parental consent, for his research. I also grant him access to the schools academic database, which would allow him access to individual children's academic records.

_____ _____

Signature

Appendix B:

Parent Information and Consent Form

Emotional difficulties in children with behaviour difficulties, within special education schools.

PARENTAL INFORMATION SHEET

Introduction

My name is Bernie Niehaus, I am a qualified teacher, but currently I have returned to Massey University to further my studies in the field of Psychology. I do still however relieve teach on the odd occasion. I am researching the above-mentioned topic as a part of my Masters Degree in Psychology. Mei Williams and Richard Fletcher are Psychology Lecturers, at Massey University and they will be supervising this research project.

The research will involve children from a special needs school in Auckland, to see whether children at these schools suffer from the symptoms associated with Depression, Anxiety, and Post-Trauma that affect their learning and behaviour at school. It is hoped that the research will enhance the services that children receive at the school in future and will benefit them to move forward and return to mainstream education. In doing this the hope would be that the findings in the research could benefit the community, families and the children themselves in future. It would be appreciated it if you would grant consent for your child to take part in the study and that some of your child's academic data may be used, which is stored by the school. The children who participate in the research will be asked to complete some questions in a questionnaire for me. If you do agree for your child to take part in the study I would also like to invite you to contribute to the research. You as the parent/caregiver of the child will be asked to complete a questionnaire asking about the behaviour and other issues affecting your child at home. Your child's teacher will also be asked

similar questions about your child's behaviour in the classroom and at school.

At the school the children complete a range of academic assessments to see how they are progressing in their learning. This assessment information is kept on the computer database of the school. I seek your permission to have access to this data. This data will only include the academic records of your child in the subject areas of Mathematics, Reading and Writing.

All the data collected will be kept confidential and no data will be able to be traced back to any specific child or their family. There is an exception though and this is that if your child discloses that they themselves or somebody else could be in danger; this will need to be discussed with the individual caseworker of the child at the school.

Project procedure:

- You need to sign the consent form before your child can participate in the research. The researcher will work closely with the teachers and staff to ensure that the children are comfortable should they take part in the study.
- You will need to sign a consent form that you wish to take part in the study and for me to access your child's academic records at the special need school.
- If you decide to take part in the study, you will be asked to complete a questionnaire asking about your child's behaviour and other concerns at home at the initial Individual Planning (IP) meeting for your child. This should take about 15 minutes to complete.
- A summary of the research will be available for you to access, via the school, from the researcher Bernie Niehaus.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during the study;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.

Please feel free to contact Bernie Niehaus, Mei Williams or Richard Fletcher for more clarification of the research.

Contact details are as follows:

Researcher

Bernie Niehaus

Email: talktobernie99@hotmail.com

Supervisors

Mei Williams

Email: m.w.williams@massey.ac.nz

Phone: 09 414 0800 ext 41222

Richard Fletcher

Email: R.B.Fletcher@massey.ac.nz

Phone: 09 414 0800 ext 41213

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/042. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz

Emotional difficulties in children with behaviour difficulties, within special education schools.

PARENTAL CONCENT FORM

I _____have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree that my child _____ can participate in this study under the conditions set out in the Information Sheet. I also grant the researcher access to my child's academic data as stored on database by the school.

In granting consent:

- I agree for my child to take part in the research.
- I agree to take part in the research.
- I agree that you may access my child's data from the school's database

Signature: ..... **Date:** .....

Full Name

(Please print in block letters) .....

Appendix C:

Caregiver Information and Consent Forms

Emotional difficulties in children with behaviour difficulties, within special education school

CAREGIVER INFORMATION SHEET

Introduction

My name is Bernie Niehaus, I am a qualified teacher, but currently I have returned to Massey University to further my studies in the field of Psychology. I do, however, still relieve teach on the odd occasion. I am researching the abovementioned topic as a part of my Masters Degree in Psychology. Mei Williams and Richard Fletcher are Psychology Lecturers, at Massey University and they will be supervising this research project.

The research will involve children from a special needs school in Auckland to see whether children at these schools suffer symptoms associated with Depression, Anxiety, and Post-Trauma, which could affect their learning and behaviour at school. It is hoped that the research will enhance the services that children receive at these school in future and benefit them to move forward and return to mainstream education and in doing this the hope would be that the findings in the research can benefit the community, families an the children themselves in future.

It is understood that you are the primary caregiver of a child whom has been identified as a possible candidate within this research. I would appreciate it if you would grant consent for your/the child to take part in the study and that we may use some of your/the child's academic data, which is stored by the school. The children who participate in the research will be asked to complete some questions in a questionnaire for me. If you do agree for your/the child to take part in the study I would also like to invite you to contribute to the research. You as the parent/caregiver of the child will be asked to complete a questionnaire asking about the behaviour and other issues affecting your/the child at home. Your/The child's teacher

will also be asked similar questions about your/the child's behaviour in the classroom and at school.

The children at the school complete a range of academic assessments to see how they are progressing in their learning. This assessment information is kept on the computer database of the school. I seek your permission to have access to this data. This data will only include the academic records of your/the child in the subject areas of Mathematics, Reading and Writing.

All the data collected will be kept confidential and no data will be able to be traced back to any specific child or their family. There is an exception though and this is that if your child discloses that they themselves or somebody else could be in danger; this will need to be discussed with the individual caseworker of the child at the school.

Project procedure:

- You need to sign the consent form before your child can participate in the research. The researcher will work closely with the teachers and staff to ensure that the children are comfortable should they take part in the study.
- You will need to sign a consent form that you wish to take part in the study and for me to access your child's academic records at the special need school.
- If you decide to take part in the study, you will be asked to complete a questionnaire about your child's behaviour and other concerns at home at the initial Individual Planning (IP) meeting for your child. This should take about 15 minutes to complete.
- A summary of the research will be available for you to access, via the school, from the researcher Bernie Niehaus.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;

- withdraw from the study at any time;
- ask any questions about the study at any time during the study;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.

Please feel free to contact Bernie Niehaus, Mei Williams or Richard Fletcher for more clarification of the research.

Contact details are as follows:

Researcher

Bernie Niehaus

Email: talktobernie99@hotmail.com

Supervisors

Mei Williams

Email: m.w.williams@massey.ac.nz

Phone: 09 414 0800 ext 41222

Richard Fletcher

Email: R.B.Fletcher@massey.ac.nz

Phone: 09 414 0800 ext 41213

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/042.If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz

Emotional difficulties in children with behaviour difficulties, within special education schools.

CAREGIVER CONSENT FORM

I _____have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree that my child _____ can participate in this study under the conditions set out in the Information Sheet. I also grant the researcher access to my child's academic data as stored on database by the school.

In granting consent:

- I agree for my child to take part in the research.
- I agree to take part in the research.
- I agree that you may access my child's data from the school's database

Signature: ..... **Date:** .....

Full Name

(Please print in block letters) .....

Appendix D:

Child Information and Consent Forms

(All Ages)

Emotional difficulties in children with behaviour difficulties, within special education school.

CHILD (7-10) INFORMATION SHEET

Introduction

My name is Bernie Niehaus. I am studying at Massey University but I am a teacher and still do some teaching. I am going to look at how Children in Residential Schools feel. I am doing this as a part of my Masters Degree in Psychology. Mei Williams and Richard Fletcher, Psychology Lecturers, at Massey University will be looking after the work I do in this study.

The study will need you to answer some questions. The questions have no right or wrong answer and only asks how you are feeling. You all do test at the school and I will have a look at them. Your Mum and Dad and Teachers will also be asked questions about how they think you behave and feel. I will be the only person that knows your answer to the tests, but if you tell me that you or somebody else is going to get hurt I will have to make sure that you tell your caseworker at the school.

All the your answers and the answers of your Mum and Dad and your Teacher will then be used to try and help the residential schools help children who come to schools even more. Because this will help children like you, I would like you to help me by doing these tests. To do this you need to sign a form that says you are happy to do the tests.

Project procedure:

- Your Mum and Dad/caregivers will sign a form to say that it is alright for you to do these tests.
- You, need to sign the forms that say you will do the tests.

- Nobody should feel unsafe at any time during the study, but if you do you can talk to your teacher or me, Bernie Niehaus.

If you have any questions just ask me, Bernie Niehaus, or you teacher so that they can ask me.

Participants Rights

You do not have to take part in this study. If you agree to take part in the study, you have the right to:

- Say that you do not want to answer a question;
- You can leave the study at any time.
- You can ask any questions about the study at any time you like

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/042 *(insert application number).* If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Emotional difficulties in children with behaviour difficulties, within special education school.

CHILD (10-12) INFORMATION SHEET

Introduction

My name is Bernie Niehaus. I am studying at Massey University but I am a teacher and still do some teaching. I am going to look at how Children in Residential Schools feel. I am doing this as a part of my Masters Degree in Psychology. Mei Williams and Richard Fletcher, Psychology Lecturers, at Massey University will be looking after the work I do in this study.

The study will need you to answer some questions on some tests. The questions have no right or wrong answer and only asks how you are feeling. You already do some test, about schoolwork at the school and I would like to have a look at them to help me even more. Your parents and teachers will also be asked to take part in the study and will be asked questions about what they think about your behaviour and how you feel. All of your answers on the tests will be kept secret so that nobody will know what you said. This is however not true if you tell me that you or anybody else might be in danger. If this happens I will have to tell your caseworker at your school.

All the answers to the tests, which you, your parents and your teacher have done, will then be used to try and help the residential schools help children who come and stay there even more. Because this study will help children like you, I would like you to take a part in it. To do this you need to sign a form that says you agree to do these tests.

Project procedure:

- Your parents/caregivers will sign a form to say that it is alright for you to take part.
- You will need to sign the forms that say they will take part in the study.
- You will do the tests.
- Nobody should feel unsafe at any time during the study, but if you do you can talk to your teacher or me, Bernie Niehaus.

If you have any questions just ask me, Bernie Niehaus or your teacher so that they can ask me.

Participants Rights

You do not have to take part in this study. If you agree to take part in the study, you have the right to:

- Say that you do not want to answer a question;
- You can leave the study at any time.
- You can ask any questions about the study at any time you like

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/042 *(insert application number).* If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Emotional difficulties in children with behaviour difficulties, within special education school.

CHILD (13) INFORMATION SHEET

Introduction

My name is Bernie Niehaus. I am studying at Massey University but I am a teacher and still do some teaching. I am going to look at how Children in Residential Schools feel, such as if they are sad or happy, or if there are some things that children are scared of, and whether this makes it hard for them to learn at school. I am doing this as a part of my Masters Degree in Psychology. Mei Williams and Richard Fletcher, Psychology Lecturers, at Massey University will be looking after the work I do in this study.

The study will need you to answer some questions on a questionnaire. The questions have no right or wrong answer and only ask how you are feeling. You will also need do some tests at the school to see how you are doing in your schoolwork. Your parents and teachers will also be asked to take part in the study and will be asked questions about your behaviour and how you feel too. All the information that you give to the researcher (Me, Bernie Niehaus) will be kept secret so that nobody will know what you said. This is however not true if the information you give to the researcher shows that you or anybody else might be in danger. If this happens the researcher will have to tell your caseworker at your school.

All the information from you, your parents and your teacher will then be used to try and help the residential schools help children who come to schools even more. Because this study will help children like you, I would like you to take a part in it. To do this you need to sign a form that says you agree to take part in it.

Project procedure:

- Your parents/caregivers will sign a form to say that it is alright for you to take part.
- You, your parents and teachers will need to sign the forms that say they will take part in the study.
- Nobody should feel unsafe at any time during the study, but if you do you can talk to your teacher or me, Bernie Niehaus.

If you have any questions just ask me, Bernie Niehaus or you teacher so that they can ask me.

Participants Rights

You do not have to take part in this study. If you agree to take part in the study, you have the right to:

- Say that you do not want to answer a question;
- You can leave the study at any time.
- You can ask any questions about the study at any time you like

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/042 *(insert application number).* If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Emotional difficulties in children with behaviour difficulties, within special education school

CHILD CONSENT FORM (ALL AGES)

I have read the Information Sheet and somebody has talked to me about what will happen in the study. My questions have been answered and I know that I can ask more questions at any time.

I agree to take part in this study under the rules set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name –

Please Print in Block Letters .....

Appendix E:

Teacher Information Sheet

Emotional difficulties in children with behaviour difficulties, within special education schools.

TEACHER INFORMATION SHEET

Introduction

My name is Bernie Niehaus, I am a qualified teacher, but currently I have returned to Massey University to further my studies in the field of Psychology. I do, however, still relieve teach on the odd occasion. I am researching the above-mentioned topic as a part of my Masters Degree in Psychology. Mei Williams and Richard Fletcher are Psychology Lecturers, at Massey University and they will be supervising this research project.

The research will involve children from a special needs school in Auckland to see whether children at these schools suffer from Depression, Anxiety, and Post-Traumatic Stress Disorder, that could affect their learning and behaviour at school. It is hoped that the research will enhance the services that children receive at these school and benefit them to move forward and return to mainstream education. The belief is that the research will also help the families and the communities in which they live. I would appreciate it if you would grant consent to take part in the study. The children who participate in the research will be asked to complete some questions in a questionnaire for me. If you agree to participate in the research, you as the teacher of the child will be asked to complete a questionnaire about the behaviour and other issues affecting the child at school. The child's parents will also be asked similar questions about the child's behaviour at home. The parents/Caregivers of the children participating in the research will also consent that their child's academic records as stored on the asTTle database may be accessed to further support the research conducted.

All the data collected will be kept confidential and no data will be able to be traced back to any specific child or their family.

Project procedure:

- You will need to sign a consent form that you wish to take part in the study.
- If you decide to take part in the study, you will be asked to complete a questionnaire about the child's behaviour and other concerns at school, at a time when is convenient for you. This should take about 15 minutes to complete.
- A summary of the research will be available for you to access, via the school, from the researcher Bernie Niehaus.

Participants Rights

You are under no obligation to accept this invitation. If, however, you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- ask any questions about the study at any time during the study;
- provide information on the understanding that your name will not be used;
- be given access to a summary of the project findings when it is concluded.

Please feel free to contact Bernie Niehaus, Mei Williams or Richard Fletcher for more clarification of the research.

Contact details are as follows:

Researcher

Bernie Niehaus

Supervisors

Mei Williams

Email: talktobernie99@hotmail.com

m.w.williams@massey.ac.nz

Email:

Phone: 09 414 0800 ext 41222

Richard Fletcher

Email:

R.B.Fletcher@massey.ac.nz

Phone: 09 414 0800 ext 41213

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 09/042. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Emotional difficulties in children with behaviour difficulties, within special education schools.

TEACHER CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name

(Please print in block letters) .....

Appendix F:

Maori Expert Consent Form

This is to confirm that I, _____ have been explained the research proposed by Bernard G. Niehaus. I hereby agree to provide the researcher with assistance concerning the Maori students involved in the research. I will advise the researcher of the customs, beliefs and cultural expectations that will/could be upheld by the participants and their families. If there are some issues that need further specific assistance I will refer the researcher on to individuals that will be able to assist him.

_____ _____

Signature Date

Appendix G:

Pacific Island Expert Consent Form

This is to confirm that I, _____ have been explained the research proposed by Bernard G. Niehaus. I hereby agree to provide the researcher with assistance concerning the Pacific Island students involved in the research. I will advise the researcher of the customs, beliefs and cultural expectations that will/could be upheld by the participants and their families. If there are some issues that need further specific assistance I will refer the researcher on to individuals that will be able to assist him.

_____ _____

Signature Date