Educators' Responses to Internalizing and Externalizing Symptomatology in Children: Implications for School Professionals

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Abstract

This study examined the relationship between educators' ratings (*N* = 182) of interpersonal attractiveness and rejection for children exhibiting internalizing and externalizing behaviors. Results revealed that internalizing behavior was perceived to be less interpersonally attractive but was not necessarily seen with greater levels of personal rejection. Externalizing behavior was perceived negatively on both interpersonal attractiveness and personal rejection measures. Ratings of personal rejection for externalizing behavior were greater than ratings of rejection for internalizing behavior. Implications as to the role of school counselors in providing specialized training, professional development, and consultation are addressed along with directions for future research.

Educators' Responses to Internalizing and Externalizing Symptomatology in Children: Implications for School Professionals

The responses and interpersonal interactions of educators with students may have significant implications for the etiology and maintenance of childhood behaviors (Henricsson & Rydell, 2004; Peterson, Wonderlich, Reaven, & Mullins, 1987). Acceptance, understanding, and the ability to establish positive relationships help build a solid foundation for all children. Children that develop warm, close, communicative relationships with their teachers have been found to be better adjusted overall as they progress through school (Birch & Ladd, 1998; Pianta, Steinberg, & Rollins, 1995). The research suggests, however, that children with internalizing (e.g., depressed mood, anxiety, avoidance of others) and externalizing (oppositional, defiant, aggressive, hyperactive) symptomatology have trouble establishing close communicative relationships that foster acceptance and understanding. For example, previous research has demonstrated that teachers find children with internalizing symptomatology less interpersonally attractive (Mullins, Chaney, Kiser, Nielsen, & Pace, 1998). Furthermore, it appears that teachers may perceive externalizing children both in a more rejecting manner and as less interpersonally attractive (Pace, Mullins, Beesley, Hill, & Carson, 1999). Mullins and colleagues (1995) suggested that the relationship between student self-reported symptomatology and negative social responding might increase over the course of the academic year. This evidence may further complicate identification of those students who may be in need of help.

Furthermore, socially aversive interpersonal experiences may foster emotional, behavioral, and social problems for some children (Henricsson & Rydell, 2004).

Children that display internalizing symptomatology may be depressed and overlooked in a classroom setting, especially if they are quiet or withdrawn. Children that display disruptive, acting-out behaviors are often removed from the classroom and, as such, tend to receive little support from educators (Little & Hudson, 1998; Nelson, 2000). Identification and early intervention for children with emotional and behavioral problems are essential to preventing chronic, long-term psychological, social, and educational difficulties (Cummings, Davies & Campbell, 2002). While educators are often placed in this position, they often have little or no training to assess emotional, behavioral, or other psychological difficulties in their students (Pianta, 1999; Stark, 1990).

Given the limited amount of research investigating externalizing symptomatology in children and the differences in the way educators relate to these children, it is important to understand how relationships with these students may either foster further distress or support positive adjustment. To aid in this understanding, the following hypotheses were proposed: (a) internalizing behavior (i.e., depressive symptomatology) would be associated with lower levels of interpersonal attractiveness compared to normal behavior; (b) externalizing behavior (i.e., inattentive and hyperactive symptomatology) would be associated with lower levels of interpersonal attractiveness and higher levels of personal rejection compared to normal behavior; and (c) externalizing behavior would be associated with higher levels of personal rejection compared to internalizing behavior.

Internalizing Symptomatology

A variety of disorders are characterized by internalizing symptoms. These include depression, anxiety, somatization, and social withdrawal. The scope of this research, however, has been limited to a more specific focus on childhood depression.

Many theorists have questioned the existence of depression in childhood. Commonly held conceptualizations include (a) depression cannot occur in children; (b) if depression exists in children, it is rare or occurs in "masked" form; and (c) childhood depression is a transitory developmental phenomenon or reflects a normal developmental stage (Kaslow & Rehm, 1985). However, recent assumptions regarding childhood depression suggest that it parallels adult depression (Clarizio, 1994; Schwartz, Gladstone, & Kazlow, 1998). The generally held consensus is that both childhood and adult depression present with similar affective, cognitive, physical, and motivational symptoms, although there may be age specific features (Schwartz, et al.).

According to recent research, the rate of major depressive disorders in children is higher than previously recognized (Campbell, 1998; Harrington, 1993). There are no definitive studies of the prevalence of depression in children (Achenbach & Edelbrock, 1981; Clarizio, 1994; Schwartz, et al., 1998). However, current studies suggest that 2%-5% of children in the general population and from 10%-50% of children in clinical populations meet the DSM-IV criteria for depressive disorder (Schwartz, et al.).

While recent studies have increased the understanding of childhood depression, their focus has largely been on cognitive and neurobiological factors without examining the interpersonal context of depression. This assumes to a large extent that the child's depression is somehow independent of their environment and is a limitation of the DSM

approach to diagnosis (Rehm & Sharp, 1996). According to Rehm and Sharp (1996), depression in children should be viewed in the context of family, peers, and school. This interpersonal context of depression may affect the onset of depression, the personal subjective experience of depression, and the behavioral manifestations and resolution of depression (Joiner & Coyne, 1999).

Behavioral and cognitive-behavioral models suggest a relationship between social skills deficits and depression (Spirito, Hart, Overholser, & Halverson, 1990). In a school setting, children who perceived themselves as less academically or socially competent were more likely to be depressed (Chan, 1997). Furthermore, children who indicated a higher level of self-reported depression were rated by their teachers as having more social skills deficits (Shah & Morgan, 1996). Since interpersonal factors and social skills deficits have been linked to the development of depressive disorders, interventions that address these deficits are a promising method of treatment (Sommers-Flanagan, Barrett-Hakanson, & Clark, 2000).

Externalizing Symptomatology

Externalizing symptomatology is characterized by problems that involve conflict with others (i.e., disorders of attention, defiance, aggression, etc.). For the purpose of this study, attention-deficit/hyperactivity disorder has been chosen as representative of disorders with externalizing features.

Attention-deficit/hyperactivity disorder (ADHD) is a complex disorder with multiple presentations and perhaps multiple etiologies and is one of the most studied disorders in existence (Culbertson & Krull, 1996). This serious disorder, affecting the cognitive, emotional, and social areas of a child's life, is thought to be mainly biologically based,

with early descriptions of the disorder occurring after brain injury were reported as early as the nineteenth century (Shaywitz & Shaywitz, 1988). Nevertheless, it has numerous potential etiologies (Barkley, 1997).

Not until the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) has an operational definition of attention deficit disorder (ADD) been specified in establishing guidelines for descriptors, age of onset, and duration of symptoms (Barkley, 1996). The name of the disorder was changed to ADHD with the DSM-III revision (APA, 1987), highlighting the elevated importance of hyperactivity as a symptom. With the DSM-IV-TR (APA, 2000), the criteria for ADHD expanded to include three separate subtypes: predominantly inattentive, predominantly hyperactive-impulsive, and combined type.

The typical features of ADHD are short attention span and impulsivity that are developmentally inappropriate. Children with this disorder may have severe or subtle impairments that persist for at least six months. Symptoms most commonly include over-reactivity to stimuli (noise, light, and temperature), crying constantly, staying awake, and frequent agitation. The prevalence of ADHD is approximately 3-4% of boys and 1-2% of girls (Hinshaw & Melnick, 1995).

Children with ADHD have problems with rule governed behavior and are at increased risk for problematic interactions with peers, teachers, and parents (Barkley, 1990). Given the influence of social interaction with peers and adults on the development of children, the child's social environment should be included as part of the assessment and potential treatment protocol, with social skills training as a significant part of any treatment model (Barkley).

Interpersonal Interaction Theory

Coyne's (1976) interpersonal interaction theory provides an interesting backdrop for understanding and exploring the potential contribution of social interaction to the maintenance of internalizing and externalizing symptomatology. Coyne explained the maintenance of psychological problems by examining the interpersonal consequences of emitting such behaviors. Coyne postulated that initially when individuals behave in a socially ineffective or disturbing manner, others respond with concern. However, if the symptomatology continues, they begin to harbor negative feelings of anger and resentment because they are unable to understand why the symptoms persist. These experiences result in rejection, avoidance, or criticism and serve as confirmation of the person's emotional or behavioral disturbance. Based on this model, a child with emotional or behavioral difficulties may become involved in a cycle of self and other rejection (Pace, et al., 1999). Failure to identify, assess, and provide appropriate interventions for difficulties observed in children may result in chronic, long-term problems with pervasive effects on psychological, social and academic development (Mash & Terdal, 1997).

Method

Participants

Elementary through high school counselors, teachers, and media specialists from a number of cities across a southwestern state were included in the study based on willingness to participate. The sample consisted of 182 participants (173 female and 7 male) ranging from 20 to 63 years old (M = 43.71, SD = 9.24). Ethnic composition of the sample was 148 (82.2%) Caucasian, 11 (6.1%) African American, 10 (5.6%) Native

American, 7 (3.9%) Hispanic, and 2 (1.1%) Asian American. When asked about level of education, a disproportionate number indicated they had received a master's degree or higher (74.4%) with a remaining 24.6% having college experience or a bachelor's degree. Over half of the educators (64.4%) reported a yearly family income of $41,000 or more, while 25.6% reported making between $31,000 and $40,000. Another 9.2% indicated a yearly family income of under $30,000. Ninety-two of the participants (51.1%) were school counselors who described themselves as actively involved in teaching, 63 (34.9%) were teachers, and 21 (11.7%) were media or library specialists, also actively involved in teaching. Of these, 77 (42.8%) were located at an elementary school, 28 (15.6%) at middle schools, and 19 (10.6%) at a high school. Another 39 (21.7%) reported being in a combination of school settings. The average years of overall teaching experience ranged from less than one to thirty-three years (M = 14.75, SD = 8.98). When asked to report current level of teaching satisfaction, the majority (76.1%) indicated a high level equal to or greater than 4 (M = 4.1, SD = .71) based on a 1 to 5 Likert scale.

Measures

A brief demographic questionnaire was included to obtain information on age, sex, ethnic identity, education, years taught, areas of instruction, and level of teaching satisfaction.

Teacher's Ratings of Student Interpersonal Attractiveness (TRIA; Pace, et al., 1999). This measure was designed to assess an overall impression of interpersonal attractiveness that includes physical, intellectual, and behavioral dimensions. The measure consists of 20 items rated by the teachers on a 7-point Likert scale to assess

perceptions of the interpersonal attractiveness of each child. Items are anchored with adjectives that represent the extremes of interpersonal characteristics (e.g., cute to plain; pleasant to unpleasant). Total scores may range from 20 to 140, with higher scores reflecting less interpersonal attractiveness. Coefficient alpha for this scale is .96 (Pace, et al.).

Teacher's Ratings of Personal Rejection toward Students (TRPR; Pace, et al., 1999), is a ten-item scale designed to measure teacher's attitudes toward students within the common types of interactions in school settings. Teachers are asked to indicate their willingness to interact with a child in specific types of activities (e.g., "sit beside him/her on a three hour bus trip," "take him/her to the zoo for a day"). Each item is rated on a 7-point Likert scale. The summed total of the ten items is used to measure personal rejection, with higher scores indicating greater personal rejection (Pace, et al.). Coefficient alpha was found to be .97 for this scale. Similar scales have been used successfully in previous research on teachers' social response to children (Mullins, Peterson, Wonderlich, & Reaven, 1986; Peterson, et al., 1987).

Video Tape Vignettes. Each video portrayed a male child actor (appearing approximately 10-12 years old, although his age was not specifically provided to participants in the study). In all three videos the child was filmed in the same setting, wore the same attire, and was interviewed by the same person. The child actor was Caucasian, appeared well groomed, had light brown hair, and did not wear glasses. He was dressed casually but neatly in a tee shirt and jeans, much as he would for school. The setting and background for the video appeared much like a school environment with the child actor working at a table.

All videos were made by the investigator of this study using a model from previous research in which a child actor is portrayed as having clinical symptomatology (i.e., Mullins, et al., 1986). Parallel scripts were followed in each video. The actor, although not a professional, portrayed a depressed child (internalizing symptomatology) in "Video A"; an inattentive and hyperactive child (externalizing symptomatology) in "Video B"; and a well functioning child (no obvious or apparent clinical symptomatology) in "Video C." To help validate the videos as accurate portrayals, five independent mental health professionals rated the videos for (a) level of believability and credibility of the tape, (b) level of clinical symptomatology (internalizing or externalizing) exhibited by the child, and (c) level to which a diagnosis could be made. This was measured using a 5-point Likert scale with higher scores indicating a greater level. The mental health workers rating the tapes were licensed psychologists (n = 2) or licensed professional counselors (n = 3). All described themselves as Caucasian. Three of the mental health professionals were males and two were females. They had a range of clinical experience from 2 years to 23 years (M = 9.8, SD = 8.23) and ranged in age from 26 to 42 years old (M = 37.2, SD = 9.63). Each scale rating and a total score of the three ratings were used to compute an interrater reliability coefficient. To compute the reliability coefficient, random effect was set for the rater with the measure effect fixed to obtain an alpha level or coefficient of agreement. For "Video A" (the depressed child condition), alpha was .88; for "Video B" (the inattentive and hyperactive child condition), alpha was .81; and for "Video C" (the well functioning child condition), alpha was .93. Although interrater reliability was higher for the depressed child condition, higher score ratings for level of clinical symptomatology and level to which a diagnosis could be

made were given for the inattentive and hyperactive child condition (*M* = 6.4, *SD* = .54) compared to the depressed child condition (*M* = 5.6, *SD* = .89). The well functioning child condition received the lowest score ratings for the same two scales (*M* = 2.4, *SD* = .54). These data support the reliability and validity of the videotape vignettes.

Procedure

Participants were drawn from a statewide conference for educators. These volunteers completed an informed consent form prior to participation. Subsequent to completing a brief demographic questionnaire, participants were randomly selected to view one of three video taped vignettes (approximately 3 minutes in length) in which a child actor portrayed as depressed (internalizing symptomatology), inattentive and hyperactive (externalizing symptomatology), or as well functioning (no obvious or apparent clinical symptomatology). Random selection was maintained by alternating the three different videotapes after every third person and beginning with a random draw. This maintained a relatively equal number of participants for each of the three conditions. Participants viewed only one of the three videotapes and were instructed to think about the child in the video from a personal point of view, apart from their professional attitudes as an educator, in order to elicit responses more indicative of a personal relationship. They were also asked not to discuss the content of the videotape with other potential study participants.

Results

Preliminary and Exploratory Analyses

Demographic variables were examined for group differences. Chi-square analyses of demographic data indicated that participants in each condition did not differ

significantly in terms of age, $F(2, 173) = .99$, $p = .37$; sex, $X^2(2, n = 178) = .316$, $p = .85$; ethnicity, $X^2(8, n = 178) = 12.57$, $p = .13$; grade or level currently teaching, $X^2(6, n = 163) = 7.68$, $p = .26$; or area of teaching or instruction, $X^2(4, n = 157) = 6.06$, $p = .19$. Furthermore, no differences between participants in each condition were found for variables of satisfaction with teaching, level of education, or years taught.

No a priori hypotheses were made about the relationship of demographic variables to the two teacher social responding variables. A series of one-way ANOVAs with a Bonferroni correction were used to compare the demographic variables of age, sex, ethnicity, education, years taught, grade level, area of instruction, certification areas, and satisfaction with teaching on the two social responding variables. No differences were found for age, ethnicity, level of education, area of teaching or instruction (i.e., teachers, counselors, or media specialists), grade level (i.e., elementary, middle school, high school, or combination), or satisfaction with teaching on either of the teacher social responding measures.

Demographic variables that were significant included sex of participant and years taught. Significant gender differences did occur on the TRPR, $F(1, 177) = 8.31$, $p = .004$, with males more rejecting of the child ($M = 48.42$) compared to females ($M = 34.03$). Years taught was also significant on both teacher social responding variables, TRIA, $F(4, 173) = 3.82$, $p = .005$, TRPR, $F(4, 174) = 4.07$, $p = .004$. A Tukey HSD post-hoc analysis revealed the greatest significant differences on the TRIA occurred between participants teaching one to five years ($n = 35$, $M = 65.94$) and those teaching six to eleven years ($n = 33$, $M = 81.88$). Similarly, the greatest significant differences on the TRPR occurred between educators with one to five years experience ($n = 35$, $M =$

27.71) and those with six to eleven years experience (*n* = 33, *M* = 39.0). Participants with one to five years experience found the child actor to be more interpersonally attractive and were less rejecting compared to those with six to eleven years experience.

Results from a zero-order correlation matrix in Table 1 shows the significant relationships among several demographic variables and the two social responding variables. As in past research (e.g., Pace, et al., 1999), the TRIA had a low but significant positive correlation with the TRPR.

Table 1

Correlations for Selected Demographic Variables and Teachers' Ratings of Interpersonal Attractiveness and Teachers' Ratings of Interpersonal Rejection

	TRIA	TRPR	Age	Years Taught
TRIA	1.00	.240**	-.195**	.053
TRPR		1.00	.112	.166*
Age			1.00	.584**
Years Taught				1.00

Note. TRIA = Teacher Ratings of Interpersonal Attractiveness; TRPR = Teacher Ratings of Interpersonal Rejection.
*$p < .05$. **$p < .01$.

Age was negatively correlated with the TRIA. As age of participant increased, scores on the TRIA decreased. In general terms, this suggests that as educators get older, their level of interpersonal attraction toward students tends to decrease. Years taught was significantly positively correlated with the TRPR, but not with the TRIA. In other words as years taught increased, so did levels of interpersonal rejection.

Primary Analyses

Since males accounted for only 3% of the entire sample, sex of participant was not used in the primary analyses. Analyses of variance procedures were used to examine differences in participant ratings of interpersonal attractiveness and personal rejection of the child actor based on condition. Results indicated a significant main effect for the child condition on the teachers ratings of interpersonal attractiveness, $F(2, 178) = 45.47$, $p = .000$ and for the teachers ratings of interpersonal rejection, $F(2, 179) = 12.48$, $p = .000$. A Tukey HSD post-hoc analysis indicated that the statistically significant differences in child condition occurred between all groups for the TRIA. The depressed child condition ($M = 86.81$) was viewed more negatively on interpersonal attractiveness compared to the other groups, followed by the ADHD child condition ($M = 73.79$) and the well functioning child condition ($M = 59.80$). For the TRPR, the post-hoc analysis indicated that the ADHD child condition ($M = 41.20$) was significantly perceived more negatively than the depressed child condition ($M = 32.45$) or the well functioning child condition ($M = 30.53$). Educators were therefore more rejecting of the ADHD child compared to the child in the other two conditions.

Table 2

Analyses of Variance on Teachers' Social Responding Variables Based on Condition

DV	Condition	*M*	*SD*	*df*	*F*	*p*
TRIA[a]				2	45.47	.000
	Depressed	86.81	16.20			
	ADHD	73.79	13.62			
	WF	59.80	16.67			
	Total	73.69	19.07			
TRPR[b]				2	12.48	.000
	Depressed	32.45	13.60			
	ADHD	41.20	11.03			
	WF	30.53	12.36			
	Total	34.69	13.17			

Note. TRIA = Teacher Ratings of Interpersonal Attractiveness; TRPR = Teacher Ratings of Interpersonal Rejection; WF = Well functioning. [a]Higher scores on the TRIA indicate less interpersonal attractiveness. [b]Higher scores on the TRPR indicate greater interpersonal rejection.

Discussion

Previous research in the area of student-teacher relationships has focused primarily on students' internalizing behaviors (e.g., Mullins, et al., 1986, Mullins, et al., 1998; Peterson, et al., 1987). Only recently has research been done to investigate how externalizing behaviors in children may also influence social responses in teachers (e.g., Pace, et al., 1999). The current study attempted to confirm findings from previous research based on educators' perceptions of internalizing children using a similar analogue study as a model (i.e., Mullins, et al., 1998) and also to build on existing research by investigating the relationship of educators' perceptions toward externalizing children.

It is of note that all of the proposed hypotheses were supported by the current study. Consistent with past research, the child portrayed as depressed was perceived by educators to be less interpersonally attractive than the child in the well functioning condition, yet was not necessarily seen with greater levels of personal rejection. Educators may have felt it was more acceptable to think of the depressed child as less interpersonally attractive, but believed it might be less socially desirable to reject interaction with a child that had depressive symptoms. Educators may also find the internalizing child less interpersonally attractive, but are reluctant to reject the child because he/she is not creating disturbances in the classroom.

Adding to this with the current study, the child portrayed with attention and hyperactive difficulties was perceived negatively on both social responding measures of interpersonal attractiveness and personal rejection when compared to the child in the well functioning condition. Also as hypothesized, levels of personal rejection for the externalizing child were greater than those for the internalizing child. This indicates that children's externalizing behaviors may elicit more powerful negative social responses from educators indicative of personal rejection (e.g., banishing the student to sit in the hallway or sending him/her to the principal's office). Thus in the school setting, children with a wide range of emotional and behavioral problems may be at increased risk for poor interpersonal relationships, but those with externalizing symptomatology have a greater risk for overt personal rejection (Pace, et al., 1999). Although the findings do not establish a causal link between internalizing and externalizing symptomatology in children and negative social responding, they are consistent with Coyne's (1976) interpersonal theory.

Of some surprise was the finding that the child portrayed with depressive symptomatology was seen as less interpersonally attractive than the child portrayed with ADHD symptomatology. This may be due to the interpersonal characteristics of the child that the TRIA helps to assess. The negative adjectives toward internalizing symptomatology may appear more pronounced on the measure than they would towards externalizing symptomatology, with descriptors such as unfriendly, unenjoyable, negative, dull, unsuccessful, and withdrawn. This phenomenon may also complement Coyne's (1976) theory of interpersonal interaction. In other words, the avoidance of others' psychological problems would be easier toward children exhibiting internalizing symptomatology than those exhibiting externalizing behavior. Likewise, this easier avoidance may unknowingly foster less interpersonal interaction with the internalizing child. For example, less teacher-student interaction may limit opportunities for support and intervention and may foster negative self and social perceptions by students.

Of note is the distinction in terminology between avoidance and rejection used to describe interactions between educators and students. Descriptors such as avoidance have been used to explain the relationship between educators' responses and internalizing symptomatology, while descriptors such as rejection have been used to explain the relationship between educators' response and externalizing symptomatology. Avoidance is a more passive process, and rejection is a more active one. It may be that the active process of negative social interaction (rejection) may have a more damaging influence on a child given the high level of potential conflict; a passive role of non-interaction (avoidance) and reduced attention may also further existing

difficulties. Such a pattern of effects has theoretical merit and is supported by empirical research on the effects of peer neglect (avoidance) and peer rejection among children and adolescents (see Bierman & Welsh, 1997 and Coie, Dodge, & Kupersmidt, 1990 for reviews of the childhood peer literature). In either situation (avoidance or rejection), children with emotional and behavioral problems may be at increased risk to become more distressed or impaired over time.

No research has been conducted to investigate how perceptions of interpersonal relationships with students may change over the years or the course of a career. However, in this study, educators with one to five years of experience viewed the child to be more interpersonally attractive and were less rejecting compared to those with six to eleven years experience. These findings may be due in part to educators' level of stress, perceptions that they can no longer make a difference, feelings of apathy, or degree of burnout. These demographic findings may be important and deserve additional research attention.

Limitations of the study include its analog nature, convenience sample (i.e., educators attending a professional conference), and the inherent difficulty in generalizing the findings to other educational settings. Although difficult to design and implement, future research needs to be continued (e.g., Pace, et al., 1999) within a classroom environment as a next step to confirm and validate the findings of this study. Although steps were taken to ensure validity of the videotape vignettes using consultation and interrater reliability measures of trained mental health professionals, the study used a child actor who portrayed as well functioning, with depressive symptomatology, and with ADHD symptomatology. Furthermore, a Caucasian male

subject was used in the videotapes, which poses some difficulty in generalization to female students or to other ethnic groups. In addition, the possibility exists that educators may associate externalizing behaviors with male students, since the disorder is diagnosed more frequently among males (APA, 2000).

Also, the sample was limited in terms of the number of male participants. While some indication of differences occurred between male and female participants on the social responding measures, adequate interpretations could not be made due to the small number of males in the sample (3%). Further research is needed to investigate potential differences in how male and female educators respond interpersonally to students.

This study suggests that there are specific types of behaviors that children may exhibit within a school setting that elicit negative social responses. These include externalizing behaviors that may involve inattentive and hyperactive (ADHD) symptomatology as well as internalizing behaviors that may involve depressive symptomatology. While it is known that some degree of externalizing and internalizing behaviors may overlap and coexist within the same child, this study only investigated the distinct symptomatologies associated with the two behavioral classifications. Therefore, future research needs to determine how a combination of these behaviors may be responsible for eliciting negative social responses. Also, research needs to determine how other specific types of externalizing and internalizing behaviors (e.g., oppositional defiant disorder and anxiety disorder) may elicit negative social responses.

This research, as well as previous studies, reveals that influential people in a child's life such as teachers and school counselors may hold negative perceptions of

children exhibiting internalizing or externalizing behaviors. Problem behaviors may elicit negative social responses from educators and may place children at risk for further psychological difficulties. However, a number of intervention strategies may be available to address the problems. Teacher and school counselor education programs could help increase awareness and knowledge of childhood disorders in order to facilitate identification and understanding of the symptoms of internalizing and externalizing behaviors and the related disorders that accompany them. This increased knowledge would allow educators to identify children with presenting symptomatology much earlier in the course of a psychological disorder and prevent difficulties from escalating in severity. Educators may also benefit from advanced training, professional development, and ongoing consultation to help them examine their beliefs about, reactions toward and expectations for students that exhibit emotional difficulties or behavioral problems (Bibou-Nakou, Kiosseoglou, & Stogiannidou, 2000; Pianta, 1999).

In addition, school counselors in particular are in a key position to provide, among other services, the following: (a) classroom guidance and small group intervention for students emphasizing relationship building skills, (b) training for teachers on the nature of negative social responding and on how to identify and manage internalizing and externalizing behaviors, (c) parenting support groups to educate families about the influences of negative social responses and strategies for helping children develop healthy interpersonal relationships, and (d) access to supplemental resources such as school psychologists, mental health counselors, social workers, school nurses, and community support. Finally, the overall school climate should be closely scrutinized to prevent labeling children (i.e., sad, lazy, wild, or bad)

that may give children a damaging sense of self (Childs, 1997).

Because certain behaviors exhibited by children elicit negative social responses, which in turn may lead to poor interpersonal relationships, it is important to make every effort to identify, prevent, and resolve any negative or lasting consequences before they develop or become ingrained. Children may then be able to develop warm, close, communicative relationships and be better adjusted as they progress through school.

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