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School Guidance Counsellors and Adolescent Depression

Part Two: Training Needs and a Workshop Targeted at School Counsellors

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Abstract

The first of these companion articles (Bulkeley, 2010a) described research from focus groups in Auckland and a questionnaire developed from this data about school counsellors' beliefs, knowledge, and practice regarding adolescent depression. This second article discusses training that school counsellors had previously undertaken which they believed helped them to work effectively with depressed students; their experiences of liaison with and referral to adolescent mental health services; as well as their perceived training needs in this area. Results from both the focus groups and the questionnaire are presented and discussed, together with some quotations from participants. Information from both sources was carefully considered and led to the development of a training workshop specifically designed for school counsellors and which the participants evaluated positively. This workshop covered assessment and screening for depression, and decisions about making appropriate referrals. To finish, I introduce some simple strategies for working effectively with depressed adolescents, referred to as "The Famous Five."

Keywords: school guidance counsellors, adolescent depression, training, strategies, Famous Five

In the first of two companion articles (Bulkeley, 2010a), I described results from research investigating the beliefs, knowledge, and practice of school counsellors regarding adolescent depression. Information was presented about the ways in which counsellors assessed depression, to whom they made referrals and on what basis, and

about aspects of safety and supervision. There was also discussion of the many ways in which counsellors worked with adolescents who showed signs of being depressed. In Part Two, consideration is now given to the education received by school counsellors, either initially or as later professional development, that they found to be helpful in their work with these students. Results from both focus groups and a nationwide questionnaire were crucial in the development of a training workshop specific to the needs of school counsellors.

As discussed in Part One, there are varied ways in which counsellors think about assessing young people who might be depressed. Many used tools such as HEADSS (Goldenring & Cohen, 1988) or the screening tools for Travellers (Dickinson, Coggan, & Bennett, 2003) or those taken from other training not specifically for depression. Most seemed to have learned from other counsellors or books rather than by undertaking training in the use of assessment inventories or tools.

> *I would say it's probably more picking up as I've gone along.*

These results led to the inclusion of an additional question especially designed to elicit information about professional education received in the area of adolescent depression. Responses were grouped into two parts: initial training in counselling and later training received.

Initial training

It was of concern that only 49 respondents out of 240 (20%) indicated that their initial training, whether at university or other tertiary institutions, was helpful for working with depressed adolescents. This means that 80% of school counsellors did not believe that their initial counsellor education prepared them for this part of their work. Some added that initial training had been very superficial in this area and so they had sought other professional development elsewhere to enable them to be adequately prepared for this work. There was no clarity about what was helpful in their initial training apart from two mentions of papers on general adolescent development.

Most counsellors reported receiving useful professional development around adolescent depression at some stage after their initial counselling training; 146 (almost 61%) gave a total of 217 responses about such training (see Table 1).

As can be seen, training provided by Child and Adolescent Mental Health Services (CAMHS) or the Ministry of Health, as well as specific Cognitive Behaviour Therapy (CBT) training, accounted for over ninety of these responses. It is notable that 21

Table 1. Main post-initial training providers mentioned

Provider	Frequency (N = 146)	Percentage
CAMHS/MoH	50	23
CBT	44	20
Narrative	22	10
MHS/SPINZ/HEADSS	21	10
Professional development	20	9
Individuals	14	6
IDT/art therapy	10	5
University mental health papers	8	4
Iwi/Māori	5	2
Others	23	11
Total	**217**	**100%**

reported that suicide prevention workshops, especially those offered by the Mental Health Foundation or the Suicide Prevention Information Network New Zealand (SPINZ), had been especially helpful in their work with depressed adolescents. HEADSS training (Goldenring & Cohen, 1988) was also valued. It certainly appears that school counsellors were seeking out appropriate professional development, but this was not always available.

CAMHS

Referrals

The focus group question that asked "How do you make decisions about referring on or cooperating with other professionals?" elicited useful information, not just about school counsellors' decisions, but also about the services to which they referred. As well as ensuring safety, there was an emphasis on wanting to do the right thing for their clients while keeping in balance the wishes of the young person and parents. A major reason for referrals to a CAMHS service was to ensure coverage in the event of a crisis or if the depression was severe.

> *Often I suppose if they are going to need medication I will refer on.*

Concerns of the participants

Many counsellors in the focus groups expressed concerns about some CAMHS services and clinicians. They reported occasions when client confidentiality was broken, when they or their clients experienced poor communication with staff, and when clients experienced long waits for appointments. Counsellors were also concerned about the limited approaches used by CAMHS clinicians, seemingly irrelevant lengthy assessments, and difficulties that arose regarding the use of interpreters. In addition, one widely expressed concern was that some CAMHS clinicians failed both to recognise and to value the experience and professional abilities of school counsellors.

> *Sometimes the so-called specialists or experts don't value your working knowledge that you've had over months. They don't acknowledge us as having a professional ability. They see us as lower down the level and not an equal in terms of therapy that clients get.*

The strength of this disquiet meant that I added a new section to the questionnaire that asked about the relationships between school guidance counsellors (SGCs) and CAMHS. One of these questions, which elicited a 92% response rate, was "How could the interface between SGCs and CAMHS services be improved?"

It was encouraging to learn that 50 of these counsellors (almost 23%) believed that their local CAMHS was already very good and no changes were needed. However, 98 (44%) mentioned that they wanted improved communication, respect,

Table 2: Desired improvements with CAMHS

Improvement Wanted	Frequency (N = 222)	Percentage
Better communication	65	29%
Very good/nothing needed	50	23%
Relationship/understanding	28	13%
Less time to appointment	18	8%
Different/more staff	16	7%
School visits	14	6%
Consult/liaison	10	5%
Collaboration	5	2%
Other	16	7%
Total	**222**	**100%**

or collaboration between themselves and their local CAMHS service. Others mentioned practical concerns such as shorter waiting times for appointments or having a School Liaison Team which visited and with whom relationships could be developed.

The final question about CAMHS was designed to try to discover which existing aspects of the service were most valued and appreciated. Eighty-two respondents (37%) appreciated the expertise available, 48 (22%) valued the service given, while 54 (almost 25%) mentioned consultation and collaboration. Only eight school counsellors reported that there was very little or nothing helpful.

Identified training needs

Strategies for working with depressed adolescents

Almost all focus group participants were clear that they wanted techniques and strategies to help them in their work, with information specifically tailored for them.

> *I could see the benefit of having some topics where there's an absolutely regular cycle of useful workshops for school counsellors and the issues tailored for them and this emphasis on some examples of ways of working.*

However, counsellors clearly stated that they did not need more information about adolescent depression, as CAMHS and other training providers had presented the facts. They wanted opportunities to develop their skills, rather than training, which was:

> *Just people talking and no time to practise.*

The following discussion among counsellors who worked in the same part of Auckland highlights this in an amusing fashion:

> A: *[CAMHS] have…run some rather desultory sessions…*
> B: *Desultory!*
> A: *…about some issues and the focus has been on giving a background about describing, for example, if it was anxiety…*
> C: *Oh they go through all the symptoms…*
> A: *…describing 12 different, you know sub sectors of anxiety…*
> B: *It's boring!*
> A: *…and then you know, five minutes on "What do we do now?" and "How do you operate?" and "How could we work together?"*

What counsellors wanted were effective ways of working, presented by those who worked with young people and were not simply academics.

> *I think we know about depression and suicide and at risk, but just knowing how to move. It's more about strategies: techniques and strategies.*
>
> *I like to go to a workshop to get a little bit of theory but mainly strategies, something to come home with, to try out.*
>
> *With real leading clinicians, like [researcher and clinician] Sally Merry.*

Some specified a need for more about CBT-type training.

> *I'd like to do something more on CBT, actually. I'm attracted to it, it's something I could identify with and use and I'd like to know more about it.*
>
> *…techniques, and strategies, it's knowing how to move them along so they get better, faster.*
>
> *I'm going tomorrow to [Massey University] Professor Merrick's CBT anxiety workshop. And I know it's just going to be straight techniques, strategies, this is how to do…which is the sort of stuff I want. This is where my interest is.*

Working cross-culturally

A second expressed need for professional development was in response to the change in the ethnic make-up in Auckland schools. There were requests for training about depression, as well as other mental health issues, in non-European cultures.

> *I'm always really keen for different opportunities to understand more about working with kids from cultures different from my own.*
>
> *I'd definitely like more professional development on working with Asian families.*

Recent training on Māori tikanga by Rawiri (David) Wharemate (kaumātua at Auckland's Werry Centre, a mental health training and resource centre) had been greatly appreciated.

> *[Rawiri] was great. He took us through the whole tangi process and now I understand how it's so just central and integral to that whole grief process…that whole process is just so therapeutic and so different from what we do.*

Participants also valued having access to Māori professionals who worked with adolescents and whānau. Several individuals were cited as being extremely helpful for referrals and for cultural supervision. Community support workers in CAMHS services were valued. In particular, if a Māori family was reluctant to access mainstream services, support workers could be the link.

> *…[name] who was at SAFE and she was absolutely fantastic, it definitely progressed the whole situation that we were dealing with.*
> *Certainly it's very good to refer Māori clients to Māori professionals and I'd do that.*

Information about medication

The third area of professional development requested by a few counsellors was the need for clear, authoritative information to help support adolescents who were on medication.

> *We haven't been trained in terms of the side effects of medication and the issues coming through about Aropax, the SSRIs. We've had to actually go and do that—self-train and build up a knowledge.*

These topics were followed up in the questionnaire, with 225 (94%) of school counsellors responding with a total of 531 requests. Overall 182 counsellors (83%) believed that specific training about adolescent depression could be beneficial. The areas of training requested are listed in Table 3. Ninety school counsellors (over 40%) requested further training about the identification and assessment of adolescent depression; 70 (32%) wanted help to access information, while 48 (22%) specified knowledge about dealing with crises or referring to CAMHS.

Table 3: Specific training requested

Type of Training	Frequency (N = 220)	Percentage
Research/treatment/practice/cases	182	83%
Identification/assessment	90	41%
Information (literature & electronic)	70	32%
Crisis/CAMHS/referrals	48	22%
General/anything	40	18%
Causes/understanding/context	30	14%
Drugs/medical information	25	11%
CBT	24	11%
Māori/cultural perspectives	13	6%
Others	9	4%
Total requests	**531**	**242%**

CBT

As CBT is known to be particularly effective with young people suffering from mild-to-moderate depression (Hoagwood & Erwin, 1997; Lewinsohn, Clarke, Hops, & Andrews, 1990; Phillips, Corcoran, & Grossman, 2003), data were analysed to see how often CBT was mentioned; 34 school counsellors had found past CBT training useful and 24 wanted CBT training. Many focus group participants had mentioned that CBT was helpful for a range of clients (Bulkeley, 2010b).

Delivery of training

While workshops were the favoured way of delivering training, there was mention of literature, the Internet, and interest groups as well.

> *Something that enables people actually to talk about their practice and apply a technique or an idea, strategy or a thought.*
>
> *These school counsellors' forums are great things, like the cluster meetings.*
>
> *Some Internet websites for school counsellors to be able to access. I think that's a great idea.*

While the idea of interest groups was enthusiastically discussed in one group, time was seen as a barrier to accessing regular training and follow-up.

> *A day workshop you leave buzzing but a week later it's very hard to hold on to maybe all of the things that you thought you're going to do, so an interest group perhaps.*
>
> *Not an interest group, because that to me means maybe six sessions, and I'd never find the time, but a workshop which is split so I would have a chance to have some experience and try to integrate it a bit and come back to follow up.…some sort of split sessions.*
>
> *An absolutely regular cycle of useful workshops for school counsellors and the issues tailored for them.*

One-day active, participatory professional development workshops, held locally during school terms, would appear to meet the needs of most school counsellors. These would focus on strategies and ways to work with depressed adolescents, based on sound recent research and presented by "competent clinicians." Overall, 218 counsellors (91%) believed that their schools would support attendance at further training events, especially if these were free or low cost.

Development and presentation of the workshops

I used the detailed information from focus groups and the survey to develop a workshop that focused on the training needs expressed by school counsellors. It was important to them that training was specific to their particular role in a school setting. The workshop was designed to match closely the reported needs, both in content and presentation. It aimed to offer additional knowledge and skills in the area of adolescent depression, to use didactic techniques that would be effective and enhance learning, including video clips, and to provide opportunities to practise new skills and to enable an accurate assessment of the process and content of the workshop to be evaluated by participants.

Four learning outcomes were established. These included an increased ability to carry out an initial assessment and accurately identify different levels of depression; knowledge of risk factors, and key questions to ask regarding suicidality and level of depression; confidence to make decisions about when to refer to CAMHS or other agencies; and knowledge of techniques and methods that are effective in working with depressed adolescents.

Ideally, to cover all that was requested, I had wanted to present two days of initial training with a further one-day follow-up session. However, experience gained from running the qualitative phase of the study as well as responses to the questionnaires indicated that many school counsellors would not be able to attend training requiring such a time commitment. The constraints affecting them also related to other issues, such as the lack of provision of relieving counsellors to cover absences in some schools, and many concerns around the valuing of the role of the school counsellor. In order to ensure as many as possible could attend and evaluate the training, I settled for a one-day workshop which was presented on two occasions. There were 37 participants—14 men and 23 women altogether. Over half had attended a focus group earlier in the study.

Content

Identification and symptoms of adolescent depression

Identification and symptoms of adolescent depression were described and discussed. Common symptoms include low mood, sadness, tearfulness, decrease in academic functioning, loss of interest in most activities, changes in patterns of sleeping and eating, weight loss or gain, hopelessness, poor concentration, guilt, low self-esteem, irritability, and behaviour problems, especially in young men. It was emphasised that many of these symptoms occur in young people who are not depressed. However, it is significant when there are several marked symptoms that have existed for some time

and are impacting on normal adolescent functioning. In that case, evidence of changes in the level of functioning is sought, as well as information about difficulties in relationships, activities, and academic performance that might suggest depression.

Causes of depression can be unclear, as situations, actions, thoughts and beliefs, and physical and emotional states all interact. While a small number of young people may have a genetic predisposition for depression (Cicchetti & Toth, 1998), for the majority the triggers are relationship break-ups, friendship problems, stresses at school (such as studies), bullying, teachers, family problems (such as parental separation, violence, or financial issues), loss and grief, illness or abuse (McNaughton, 2003; Merry, McDowell, Hetrick, Bir, & Muller, 2004).

Referrals

In general, there are two points for referral to CAMHS or a GP. First, after the initial meeting and screening, the student must be assessed for serious concerns about the level of depression, risk, complex factors, suicidality, or extreme hopelessness. Following the NICE Guideline (2005), the second most common time for referrals is likely to be after four to six counselling sessions if there are no signs of improvement, or indeed deterioration or other serious changes in the adolescent's situation. Where there are lower-level concerns, NICE recommends the strategy of "watchful waiting" (p. 36) and, if available, a non-directive supportive group or guided self-help may be all that is needed. Where depression is more severe, medication may be needed but always alongside some type of talk therapy such as regular counselling sessions.

When referring to another agency or CAMHS, it is important to be clear about identifying the concerns that have arisen and why the referral is being made at this time. As well as necessary background information, it is helpful to include details about your involvement and work with the student up to the present, as well as the results of any assessment tool used, and answers to specific questions around hopelessness and suicidal ideation. Referrals from counsellors that are clear and detailed are much more likely to ensure the best help for the student.

The "Famous Five" ways of working with depressed adolescents

The ideas that are included in this section came from a variety of sources and were adapted specifically for the work of school counsellors (Bulkeley, 2010b). They are offered as additions to other skills in a counsellor's kete, such as knowledge of counselling and depression; models of working; experience and philosophy; knowledge

of attachment, and of a client's previous difficulties and family circumstances; and the vital importance of therapeutic relationships and support in a variety of ways is emphasised. Since there were five helpful ways of working considered in the workshop, these began to be referred to as the "Famous Five." All quotations here are from workshop participants.

Activity scheduling

The first helpful way of working is activity scheduling—simply doing enjoyable things. The rationale is that keeping busy and having pleasurable, fun things to do can improve mood. Counsellors can help an adolescent to make a list of possible activities, and also see who else can be involved in that activity, which might include exercise, known to be efficacious in reducing depressive symptoms (Lawlor & Hopker, 2001). Suggestions given by participants included:

> *Just doing things.*
>
> *Encourage them to recognise when they are having fun.*
>
> *Brainstorm around how they had fun in the past, put it on paper, take it away, something concrete to look back on.*

Goal-setting

The second technique is goal-setting, where students are supported to reach specific, small, and measurable goals. The rationale is that when depression comes, it is hard to set goals, or carry them out, because of lack of motivation and energy, or because the goals may be too hard to achieve. Effective goals are SMART: Specific, Measurable, Achievable, Realistic, and Timely (Meyer, 2004). Goals are reviewed and progress is discussed. Some goals suggested at the workshops were:

> *Getting out of bed. To actually get out of bed and get to school is absolutely fabulous…a huge achievement.*
>
> *Getting to school on time.*
>
> *Getting to 50% of attendance.*

Cognitive restructuring

The key message of the third strategy, cognitive restructuring, is to replace "depressive" thinking with realistic thinking. There are two main theories about why depressive thinking can arise: Beck's cognitive triad—a negative view of self, events, and future (Beck, Rush, Shaw, & Emery, 1979)—and Seligman's (1975) learned helplessness—

"I'm not in control; nothing I do will make a difference." The rationale is that such thinking can be hard to shift as it may have been reinforced throughout life and have become automatic "negative thoughts."

Realistic thinking is being fair and accurate about yourself and the situation, looking at positives and negatives in a balanced way. It includes being accurate about the future and not exaggerating potential bad outcomes. Typical negative thoughts include filtering (where only the downside of everything is believed); exaggerating (where things are blown up often out of proportion); predicting failure (expecting the worst); feeling thoughts (where what we think depends on what we feel); setting yourself up to fail (expecting too much), and "Blame me" (where you feel responsible for everything that happens).

Working with students to help shift their thoughts involves assisting them in identifying thoughts and weighing up whether those thoughts are helpful or unhelpful. Evidence both supporting and refuting a negative thought is thoroughly investigated. Questions such as "Is it really true?" and "Am I jumping to conclusions?" help adolescents to check out their beliefs. Some counsellors gave examples of ways in which they were already using this strategy.

> *Drawing up a catalogue of absolutist terms…their language is actually riddled with always, never, etc.*
>
> *With alternative thoughts, sometimes if they can think "Oh well, it's a fake thought," I put a letter on school letterhead with an alternative thought—looks very impressive.*

Negative thoughts can be reframed as more helpful and cue cards can be useful reminders in replacing faulty cognitions.

Problem-solving

The fourth strategy is problem-solving, based on the rationale that problems can lead to depression and, once depression is present, it can often be very difficult to solve life problems (Hatcher, 2009). This means that problems can be perceived as more difficult than they actually are and people can get stuck trying to solve problems. Depression can also mean it is harder to put appropriate plans into action. Counsellors help students identify a specific problem and investigate it in detail in order to understand its nature, influence, and effects. Counsellors "coach" by exploring with students what can be done to solve the problem, and facilitate comparison and evaluation of the different solutions offered by the client. The positive and negative aspects of each

possibility are considered and students are encouraged to be aware of any potential safety issues. This helps adolescents to recognise the importance of considering and evaluating solutions, not just rushing ahead, and assists them to develop their decision-making skills and processes.

One counsellor was emphatic that, in his experience:

> *Teenagers don't always have a decision-making model. Successful adults all have a decision-making model.*

Relaxation techniques

The final strategy is the use of relaxation techniques, ranging from simple breathing to more in-depth visualisation. Weisz, Hawley and Doss (2004) believe that this can be the most effective of all techniques in helping with depression, anxiety, and other problems. Training students to use relaxation costs little, is easy to both teach and learn, and is portable. Adolescents frequently report liking the sense of control that they regain.

Using a combination of these five strategies should lead to improvement in mood after approximately four to six sessions. This can be measured by comparisons of mood, eating, sleeping, and general functioning, as well as changes measured by scales or self-reports. However, if this does not happen, or the situation deteriorates, then an adolescent may benefit from a referral to mental health services (NICE Guideline, 2005).

Evaluation of the workshops

The four learning outcomes for the workshop appeared to have been well-met with very positive evaluations on a five-point Likert scale (Likert, 1932). The highest mean scores were received for assessment and identification (3.84), decision-making (3.91), and ways of working (4.0). Thirty-six participants (97%) believed the workshop was relevant or very relevant, 30 (81%) said that it was likely or very likely to influence their work, and 34 (91%) were likely or very likely to use some of the new strategies learned. Results shown in Table 4 indicate that the workshop did appear to have been seen as very relevant and beneficial.

It was believed that the final two questions—asking whether the counsellors would attend similar training and whether they would recommend this training to colleagues—were likely to give an overall indication of the acceptability of the workshop. Thirty-five (94%) participants responded that they were likely or very

Table 4: Summary of relevance and benefits

Question	Mean Score (Max = 5)	Response (N = 37)
Relevance	4.71	37
Influence	4.2	36
Follow-up	4.29	35

likely both to recommend the workshop to others (4.51 mean score) and to attend a similar workshop themselves (4.3 mean score). The main benefits were seen as gaining practical ideas (51%) and the discussion or sharing of ideas with other school counsellors (38%).

Participants were also asked what they liked best about the workshop. The largest response, from 17 school counsellors (46%), mentioned that they enjoyed the interactive nature of the workshop. Eleven (31%) appreciated the breadth and pace of the presentation, and seven (20%) appreciated that the training specifically targeted school counsellors, while two enjoyed the opportunity to reflect on their practice. Additional responses showed that the pleasant surroundings of the University of Auckland Tāmaki Campus and adjacent café were appreciated. These responses about the venue and setting are backed by research indicating that adults do respond positively to comfortable physical environments, frequent breaks, snacks, and opportunities to collaborate with others in professional development sessions (Collins, 2004).

Conclusion

This research has shown that there was a clearly identified need for specific training to enable school counsellors to work more efficaciously with adolescents who may be depressed. Information obtained from focus groups in Auckland and a nationwide questionnaire indicated that most school counsellors did not believe that their initial counselling training had been particularly helpful in their work with depressed adolescents. Many had undertaken further training offered by a variety of providers. Some found workshops offered by CAMHS, the Mental Health Foundation, or SPINZ to be particularly helpful. It appears that school counsellors as a group are interested in finding training appropriate to their special work with adolescents, but this is not always available, especially outside main urban centres.

Training needs and ways of presenting such information were considered in detail and a workshop was specifically developed for school counsellors. It was encouraging to discover that once per term, the Canterbury District Health Board (CDHB) Youth Specialty Service offers school counsellors from Canterbury and the West Coast regular half-day trainings with a mental health focus. These are publicised early in the year to all school counsellors, are free of charge, attract 40 to 50 counsellors, and have been running for well over ten years. "We get the counsellors to do an evaluation each time, and it is rarely anything but positive" (B. Dunnachie, personal communication, 22 February 2006). There was mention of occasional training given by other CAMHS services, but generally this was not found to be of great benefit.

The professional development workshop discussed in this paper did more than just present ways of working with depressed adolescents. It also included detailed information about the screening and identification of adolescents for depression, and discussion of symptoms as well as some knowledge of risk assessment, based on research from the United Kingdom, New Zealand, and elsewhere. Considerable time was spent teaching about referrals in view of the concerns expressed that CAMHS teams did not always understand or acknowledge the experience of school counsellors. This was to ensure that referrals were appropriate, timely, and contained relevant information about the young person and the work carried out by the counsellor.

The "Famous Five" ideas offered additional knowledge to help counsellors work effectively with depressed adolescents. Discussions throughout the workshops indicated that many participants were using some of these ways already, as reflected in the selected quotations above.

Knowing the limited time for professional development available to many school counsellors meant that the training was delivered in one day, using a variety of methods. School counsellors particularly appreciated that the workshop was targeted to them in their special situation. They indicated they were likely to recommend these workshops to other counsellors and would themselves attend similar workshops in the future. Many remarked that they found it valuable to hear the comments of other school counsellors. This point had also emerged from participants in the focus groups. The workshop was evaluated positively and participants hoped that there would be further such training delivered throughout the country.

This research has shown that professional development that focuses on the needs expressed by a group of school counsellors is rated as relevant to their work and beneficial to them. It is hoped that future training events, whether offered by a DHB

or other providers, will meet the clear needs of school counsellors wishing to gain more knowledge about emerging mental health issues in many of the adolescents with whom they work. Further research could be carried out to investigate the level of CAMHS clinicians' understanding of and appreciation for the extensive training and experience that school counsellors bring to their practice. This might benefit the relationship between these two groups of professionals, both of whom work to enhance the mental and emotional wellbeing of the young people of Aotearoa New Zealand.

Glossary of Māori terms

kaumātua	elder
kete	basket
tikanga	Māori customs and traditional knowledge
whānau	extended family

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