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School Guidance Counsellors and Adolescent Depression

Part One: Beliefs, Knowledge and Practice

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Abstract

Adolescent depression is a significant problem in New Zealand. Although school guidance counsellors are ideally placed to identify, assess, and treat adolescents, they are rarely included in mental health research. This article discusses findings from research that used qualitative and quantitative methods to investigate school counsellors' understandings of and knowledge about adolescent depression. Data from focus groups were organised into two main categories, "Beliefs and Knowledge" and "Practice." These themes were further investigated in a nation-wide questionnaire, concerning aspects such as identification, assessment, safety, referrals, ways of working, and training needs. School counsellors are generally knowledgeable about causes and different presentations of depression, but know less about assessment and referrals. Most work in an eclectic manner, with the therapeutic relationship being the basis of counselling. This study will be useful to school counsellors as well as others who work with adolescents.

Keywords: **school guidance counsellors, adolescent depression, assessment, referral, youth mental health services**

Adolescent depression

Adolescent depression is a major problem throughout the world. It has been estimated that up to one quarter of adolescents have had at least one clinically significant episode of depression by the age of 18 (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). In New Zealand, the Dunedin Multidisciplinary Health and Development Study reported a significantly large increase in depressive rates for females aged 15 to 18 compared to younger adolescents (Hankin et al., 1998). More recently, findings from

the Youth2000 Survey indicated that around 60% of young females and 40% of young males are likely to have times when they experience depressive symptoms (Adolescent Health Research Group, 2003).[1] In total, 14% of students (9.0% of males and 18.3% of females) reported levels of depression that were considered serious and in need of professional assistance. For females, episodes of depressed mood were highest at age 15 years (Fleming, 2003). The follow-up Youth'07 survey indicated a slight decrease, with 15% of female and 7% of male students reporting significant depressive symptoms (Adolescent Health Research Group, 2008).

Depression in adolescents usually follows a more variable course and is characterised by more interpersonal difficulties than it does in adults (Kovacs, 1996, 2001; Parker & Roy, 2001). Depression in young people is frequently associated with poor academic performance, dysfunction in social relationships, suicide attempts, and completed suicide (Horowitz & Garber, 2006; Obeidallah & Earls, 1999; Petersen et al., 1993). Somatic complaints, nervousness, and substance abuse may also indicate depressed mood (Garrison et al., 1997; Gudex, 1994; Rice & Leffert, 1997; Wight, SepÚlveda, & Aneshensel, 2004).

The presence of depressive symptoms during adolescence has significant effects on healthy development in areas such as relationships with family and friends, part-time work, and maintaining balance in various aspects of life (ACE Evaluation and Publications, 2002; Birmaher, Brent, & Benson, 1998; Field, Diego, & Sanders, 2001). An overview of the Christchurch Health and Development Study data suggests that early onset of depression, before the age of 16, leads to a significantly increased risk of subsequent depressive episodes (Fergusson & Horwood, 2001).

Most adolescents spend considerable time in school. Almost all secondary schools in New Zealand have a counsellor available for students (Besley, 2001; Crowe, 2006; Payne & Lang, 2009). School counsellors deal with a variety of issues, including emotional and behavioural difficulties, and emerging mental health problems. In a survey undertaken in the late 1990s, 56% of school counsellors rated depression as the most serious problem for the students with whom they worked (Manthei, 1999).

In 2003, 10% of referrals to Child and Adolescent Mental Health Services (CAMHS) were from the education sector (Ramage et al., 2005). However, not all young people with depression need to be seen by CAMHS, so it is wise to make better use of community resources already regularly accessed by adolescents. School counsellors can be considered as key consultation/liaison partners of mental health services (Fortune & Clarkson, 2006).

School students are unlikely to access general practitioners to seek help when feeling depressed (Brown, 2005; Denny, Balhorn, Lawrence, & Cosgriff, 2005; Gledhill, Kramer, Iliffe, & Garralda, 2003; Sawyer et al., 2001). School counsellors are therefore ideally positioned for early identification of mental health problems and intervention with young people (Auger, 2005; Black, 1996: Evans, Van Velsor, & Schumacher, 2002; Maag, Rutherford Jr, & Parks, 1988; NICE Guideline, 2005). It is therefore important for counsellors to be aware of the prevalence of depression, to consider the possibility of depressive disorder when seeing adolescents, and to be skilled in the identification of indicators of depression.

Results from a small exploratory study with school counsellors in South Auckland (Bulkeley, 2002) suggested that the number of adolescents with depressive symptoms seen by counsellors in schools was smaller than would be expected from community-based research (Birmaher, Ryan, Williamson, Brent, & Kaufman, 1996; Lewinsohn et al., 1993; Manthei, 1999). This led to questioning why this should be. Did school counsellors not believe in adolescent depression, or was it a matter of difficulty with its identification? These questions became the basis of the current research to investigate school counsellors' beliefs, knowledge and practice in relation to adolescent depression.

Focus groups and a nationwide questionnaire

The first stage of the research was conducted in Auckland by recruiting school counsellors to take part in focus groups to investigate how they assessed and worked with depressed adolescents. Information from these groups contributed to the development of a widely distributed questionnaire, "Adolescent Depression and the School Counsellor." This enabled key issues to be followed up and ensured that the study would be national rather than solely Auckland-based. The main results of both stages are presented in this article. From these results, a one-day pilot workshop on identification, referral, and effective ways of working was developed and presented to school counsellors in Auckland. This workshop was evaluated and will be discussed in a subsequent article.

Increased rates of depression are reported for young people aged 13 years and older, and the differential rate between boys and girls becomes more marked at this age (Fergusson & Horwood, 2001; Ge, Lorenz, Conger, Elder, & Simons, 1994; Hoffman, Baldwin, & Cerbone, 2003). Therefore, this research was conducted with school counsellors who worked with students in Years 9 and above.

Focus groups

Ninety-nine schools in the Auckland region have students in Year 9 or above. Of these, 77 schools employed 116 counsellors either full-time or part-time at the time of the study. The remaining 22 schools referred students to external agencies or had other systems in place. Initially, school principals were contacted by post with information sheets and consent forms. Forty-nine principals (64%) returned consent forms and the 75 counsellors in those schools were then contacted, with 58 (77%) returning consent forms and 52 (69%) attending one of nine focus groups that were conducted in different parts of the city.

Demographic information

Three-quarters of the 52 participants in the focus groups were female, 65% were over 50 years old, and 94% over 40 years old. Almost 85% (84.5%) identified as European ("NZ or Other European"), while 11.5% were of Asian ethnicity and 4% were Māori. Almost three-quarters had postgraduate qualifications in counselling and only one had no formal qualification. Twenty-six counsellors (50%) had been in the job for more than a decade, and almost 80% for more than six years.

Discussion in focus groups

Ten possible topics were chosen as being likely to encourage discussion (Figure 1). These provided a basic structure for the groups and enabled comparisons across groups.

Using a general inductive approach (Thomas, 2003), data were systematically analysed and a thematic map developed with two main categories: "Beliefs and Knowledge" (which covered causes, negative connotations, and different presentations) and "Practice" (assessment, referrals, effective therapy, systems, and training needs). These are shown in Figure 2.

Figure 1: Interview Guide

1) What are your beliefs about adolescent depression?
2) What do you know about adolescent depression?
3) What about Māori rangatahi?
4) What experience do you have working with depressed young people?
5) How do you make decisions about referring on or cooperating with other professionals?
6) What training have you had in assessment for adolescent depression?
7) Tell me about the ways you work with depressed young people?
8) What about Māori young people?
9) What are your views on Cognitive Behaviour Therapy (CBT) and Interpersonal Psychotherapy (IPT)?
10) Would you be interested in a short course of CBT to help your work with depressed adolescents?

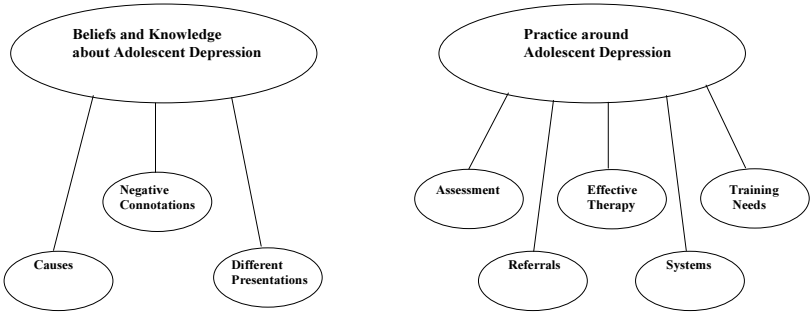

Figure 2: Thematic Map Showing Categories and Main Themes

Questionnaire

The main themes arising from the qualitative study were investigated in greater depth in a self-completion paper questionnaire sent to schools throughout New Zealand. This had 25 items (15 open-ended questions and ten multi-choice items) seeking to gather information about the identification of adolescent depression, ways of working with depressed adolescents, relationships with other services, and training needs. Results presented here give strength to the data collected in the focus groups and provide relevant information on key issues.

Information about which New Zealand schools were likely to employ a counsellor was obtained through the website Te Kete Ipurangi (Ministry of Education, 2000), school websites, and personal information. Once again, all initial contact was made through school principals, to whom all consent forms and information were sent by post. In total, 362 schools were contacted and 180 consent forms (almost 50%) were returned from a wide range of urban and rural schools throughout the country. The total number of counsellors eligible to participate numbered 455, and of those, 240 returned questionnaires (53%). Questionnaires were anonymous and no school or counsellor was identified. Demographic data provided were, however, remarkably similar to that collected from focus groups.

Results

Beliefs and knowledge about adolescent depression

Information obtained from focus groups showed that these school counsellors clearly believe that adolescent depression is real and definitely exists. They saw it as quite common among teenagers:

…something they seem to be pretty familiar with, being depressed.

However, many counsellors commented that depression was not understood by teachers and that many parents minimised it. In particular, this was felt to occur in higher-decile areas where a common parental attitude was expressed as:

God, they've got it good; what have they to be depressed about?

You think you've got a hard life? Go down to Otara.

Counsellors appeared to believe that depression could be represented on a continuum of severity, and made decisions to use the label "depression" at different places according to their different understandings.

Two areas of interest emerged: prevalence and societal attitudes. Some counsellors believed that the pressures of modern life meant more adolescents were depressed.

I think it's probably underestimated.

I guess over the last seven or eight years, there seems to be more cases. Would that be fair comment?

However, others wondered if there was an actual increase or if depression was now being identified more often.

I'm suspecting that more cases are emerging for me because I'm getting better at recognising when it's present.

There were some strong beliefs that the attitudes of society made it hard for certain young people with depressive symptoms to be understood.

Sometimes young people have to convince an adult that it's something serious.

People have a good handle on what adult depression is, but not adolescent depression.

Table 1: Ways in which school counsellors identify depression (N = 240)

Identification by	Frequency	Percentage
What they say	226	94%
Behaviour changes	224	93%
Sadness or tearfulness	216	90%
Physical signs	08	87%
Other ways	147	61%

Ways of identifying adolescent depression were followed up in the questionnaire and the results are presented in Table 1. Most counsellors responded that they used several indicators, in particular what the adolescent said (94%) and behavioural changes (93%).

Causes of depression

Many school counsellors were very knowledgeable about the signs and causes of adolescent depression.

> *Confusions and anxieties and social difficulties can actually cause the depression.*

Other ideas mentioned appeared to relate depression to the students' psychosocial circumstances, such as broken relationships, parental separation, abuse, or immigration. The link between physical and psychological well-being was also discussed.

> *I think I am querying more about the physical causes too than I used to, especially with girls.*

Several counsellors reported that their understanding of depression was limited to information from easily available resources. In particular, the Mental Health Foundation's guide to adolescent depression (Mental Health Foundation, 1997), commonly referred to as "The Green Book," was mentioned by several as useful and accessible. Those who had undertaken Ministry of Education training about suicide prevention reported that the publication *Young People at Risk of Suicide: A Guide for Schools* (Ministry of Education & National Health Committee, 1998), was now available online and was also helpful in assessing depression.

> *I did bring along the guide for schools, which is probably where I got most of my good quality understanding of the condition.*

One participant descriptively named those occasions when several events stacked up together and caused great distress as "the pancake effect."

> *There's also what I call the pancake effect that adolescents experience but they also do it to themselves, they go, you know, my cat's died and I've got an exam and my best friend's worried. They pile it up on themselves.*

The pile-up or convergence of stressful events can intensify an adolescent's distress (Agee & Dickinson, 2008). It was unclear if all counsellors knew of the potential effects of this for depressed clients.

Negative connotations

Group discussions around the concerns of labelling and stigma were often lively and passionate. Beliefs varied as to whether giving a label of depression actually was helpful to students or not. Some counsellors believed that certain students saw it as negative.

> *I said something like, "Oh, it sort of sounds a bit like you're feeling a bit depressed," and her reaction was quite negative to the use of the word.*

Others used the term with caution because of the stigma and fear attached to the word. However, some parents and staff were said to feel positive about the term.

> *Staff are often relieved there is a label.*
>
> *I'd like to say how wonderful it is when you've got parents that don't have all this thing about stigma and who get in behind and are supportive.*

Different presentations

Considerable discussion took place about how depression could present in a variety of forms. I will focus here on two of the major themes: ethnicity and gender. Some counsellors were reluctant to generalise or stereotype, so it was at times not clear what they actually believed about certain topics.

Māori rangatahi

Results of the Youth2000 survey (Adolescent Health Research Group, 2004) indicated that more young Māori reported significant levels of depression than did the general population. Focus groups discussed presentation and working with Māori in terms of whānau involvement, Māori services, and understanding a Māori perspective on health, as well as societal and school pressures.

> *I just know there's a range of beliefs around health and the interconnectedness of mental, spiritual, physical health, whether that family operates in a tikanga Māori way or…a conventional Western model.*

Some counsellors commented that Māori students were under-reported in visits to the counselling department, and also tended to be under-represented among their clients.

> *There are many fewer Māori coming to counselling.*

Conversely, others saw many rangatahi. This seemed to depend on the area of Auckland and the decile level of the school.

> *We have about 50% of our Māori students come to our department. And that's been consistent in my time, over the years.*

Table 2: Are there differences between Māori and non-Māori? (N = 224)

Answer	Frequency	Percentage
Yes	93	39%
No	91	38%
Possibly	12	5%
Too few to comment	26	11%
Only work with Māori	2	1%
Total	**224**	**94%**

There was some indication that counsellors believed there were differences but were unable to be specific.

> *I think there's a very significant difference; I just can't quite verbalise what it is.*

However, counsellors clearly understood the importance of whānau for rangatahi, and acknowledged traditional ways of healing as well as spirituality. Positive changes for rangatahi occurred at schools that embraced supportive programmes and had more Māori staff, mentoring, and links with local marae. These comments were further investigated in the questionnaire by asking about beliefs in differences of Māori self-presentation. Results are presented in Table 2.

Responses to this question suggested that there was indeed confusion and uncertainty among school counsellors about Māori adolescents' self-presentation. Differences mentioned included the reluctance of Māori students to come to counselling (13%), levels of whānau involvement (13%), more anger shown (12%), talking less (10%), and being more spiritual (6%). There appeared to be a marked need for accurate information to be available; since only 1% of school counsellors who responded to the questionnaire identified as Māori, those of other ethnicities will inevitably work with rangatahi.

Pacific Island students

Initial findings from Youth2000 about Pacific adolescents were similar to those for Māori youth (Adolescent Health Research Group, 2004). In most focus groups in the current study, participants mentioned socioeconomic and cultural issues that could lead to depression and could present as behaviour problems among Pasifika students.

> *Working in a lower decile school with a lot of Polynesian students, I've never ceased to be amazed how much baggage some students actually carry around with them.*

One counsellor summed up by saying that although many Pasifika students had difficult lives, they were often resilient and coped well.

> *I mean, we have students who might be entitled to be stuck in grief or depression, you know, because their lives are really hard; they're trotting along with life as if everything is fine.*

Asian students

While emphasising that "Asian" is not a homogeneous term, counsellors expressed their belief that many Asian parents did not recognise depression, thus making it difficult to work for change.

> *They'd rather say, "That's lazy, that's not depression."*
>
> *Often with Korean parents, you know they'll listen and you'll talk about some of the developmental steps of teenagers and try to mediate, but I personally have found there's very little middle ground there.*

Language and cultural barriers for Asian students were also noted, especially for recent immigrants.

> *It's very hard to talk to young people at any depth because of the language difficulty.*

All groups discussed the frequent psychosomatic presentations of depression among Asian students.

> *So much of the psychological is interpreted in the medical or physical way.*

This was closely linked with ideas of shame in their cultures and the stigma of mental illness.

> *With Asian families, there's so much stigma around mental health issues.*
>
> *I've heard the word shame floating around quite a bit.*

Gender

Concerns were expressed that young men present differently and have less access to support than young women.

> *I think that it's much easier to get support from outside agencies for a girl than it often is for a boy.*

Male counsellors in particular believed that depression could underlie much of the typical acting-out behaviours of young men.

> *I think there are many young males entering our discipline statistics who have got…depression.*

One male participant was adamant that until there is more self-disclosure about feelings and the normalisation of depression, boys would not understand how common depression is and that it could have positive features, such as being a learning experience.

> *Let's look at depression as a teacher…an excellent opportunity for growth.*

Working with adolescent depression

The second major theme concerned the practice of school counsellors across various aspects of adolescent depression.

Assessment

At the time of this research, I was working in a youth health service and so was particularly interested in how depression was assessed. One counsellor commented on my use of the term assessment.

> *I think the language of your question is actually quite important when you talk about what we have been taught about assessment. And that is not what we were taught in counselling training.*

However, even if school counsellors did not like using the term assessment, this was in fact what they did. All reported being interested in identifying a range of factors, such as behaviour changes, and the length of time a student had felt "down."

> *I've got a sort of set of criteria, a checklist that I go through. Just in the general discussion. I'll cover most of the points.*

Of interest was that most counsellors did not use standardised assessment tools.

> *I don't use anything like a specific assessment tool,*

with one exception being the counsellor quoted below:

> *I like to do a Reynolds Scale…because I've got that very clear measurement of "this is their score, so they're in the high-risk range."*

Some counsellors used assessments not specifically designed to screen for depression.

> *The HEADSS assessment's quite a good one to go through too, I find that really useful.*

Table 3: Main assessment tools used by school guidance counsellors (N = 153)

Name of Tool	Frequency	Percentage
BDI	39	25%
"My own"	34	22%
MHF	24	16%
MoE & NHC "YPARS" checklist	22	14%
DSM	16	10%
CES-D	12	8%
HEADSS	8	5%
CDI	3	2%
Other	56	37%
Total	**214**	**139%**

Abbreviations: **BDI** = Beck Depression Inventory; **MHF** = Mental Health Foundation; **MoE** = Ministry of Education; **NHC** = National Health Committee; **"YPARS"** = *Young People at Risk of Suicide*; **DSM** = Diagnostic and Statistical Manual of Mental Disorders; **CES-D** = Center for Epidemiologic Studies Depression Scale, National Institute for Mental Health; ***HEADSS*** = Home and Environment, Education and Employment, Activities, Drugs, Sexuality, Suicide/Depression; **CDI** = Child Depression Inventory

> *Travellers' screening gives you a lot of information about which kids are at risk and we can go through and check.*

Others mentioned assessment tools that had been discovered through training or via colleagues. Often these were anonymous or adapted and so could not identified.

> *I think it turned up in a book somewhere and I thought, "Well, that's good," and photocopied it.*

Some counsellors had thought deeply about the issues of criteria in the assessment of adolescent depression. One stated a desire for clear criteria to assist in identification and screening.

> *Perhaps there needs to be some more work done around the identification of adolescent depression.*

While data from the questionnaire generally supported the findings from the focus groups, one major difference was that 69% of counsellors reported current or previous use of a screening tool or checklist. The most frequently named (25%) was the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Details are shown in Table 3.

While several inventories were mentioned by only one or two individuals, 22% used a checklist that they had developed themselves, as had been mentioned in the focus groups. It would therefore appear that assessment of adolescent depression in schools is not at all standardised, and this became a topic to cover in the training workshop.

Referrals

In the focus groups, the main reason counsellors gave for making referrals was to ensure coverage in the event of a crisis. However, they wanted to obtain a good service for their clients.

> *For me, it's often that gut-feel thing. I'm really worried about this kid because things aren't right on a lot of levels and this has been going on for more than just a couple of weeks and there's that sense of helplessness.*

Referrals were made to three groups: CAMHS, family doctors, and other agencies.

CAMHS

Most counsellors would refer severely depressed students directly to CAMHS:

> *…certainly if there is self-harm involved or attempts have been made.*

It was frequently mentioned that it could take some time to get families "on board" with the referral, which was very stressful.

> *When you've got someone who you know needs to have the support of CAMHS, and the parents are really negative about it, it actually puts us in a terrible position.*

In many cases this related to the stigma of being involved with a mental health service.

The focus group findings about referral to CAMHS were supported by the questionnaire results indicating that 225 counsellors (94%) referred depressed adolescents to CAMHS. However, 32% mentioned that they would like a clear, structured assessment tool to help make good referrals. Recent changes in CAMHS, such as the introduction of school consultation-liaison services and training opportunities offered, had made counsellors feel more valued as fellow professionals. Still, referrals could be difficult for a variety of reasons. An identifiable contact person with whom they could build a relationship was greatly appreciated.

> *I find being able to call the duty counsellor and discuss it with them as well is really, really helpful because they can often ask some quite pivotal questions that I might not have thought of.*

Counsellors reported some unsatisfactory dealings with CAMHS, in particular the referral and assessment process that could make them feel disempowered, as well as the emphasis on a medical model.

> *But once you get involved in a system like that, you get captured. Maybe that's an emotive word, but you become a part of a process of the way that they do things.*
>
> *And I think that is part of why we have this difficulty of working with CAMHS, because they expect us to report to them in their language.*
>
> *They're different; they're a medical model, working with those structures that they have to.*

Family doctors

Focus group participants were clear that referring to a general medical practitioner (GP) seemed less threatening to a family than a CAMHS referral.

> *Referral to GP is rather harmless. It's about checking certain things that we cannot know without those checks.*

This was confirmed in questionnaire results, where 80% reported that they referred to a GP. This was most likely to happen if the adolescent had a regular GP and the family was supportive. Many counsellors believed that antidepressant medication could help.

> *I also used to be really against medication, after training, but again, I've seen such miraculous results from it that I would never be against it. But I approach it cautiously.*

However, reservations were expressed that some GPs seemed to prescribe medication almost automatically.

> *Because GPs will see them for fifteen minutes and whack them on Prozac.*

Other services

When families could afford it, school counsellors were happy to refer to private clinicians. However, the high cost made this impossible for the majority of families.

> *CAMHS is the option that's mostly taken up, but because I'm in a high-decile school they also have the availability of psychiatrists in private practice.*

Questionnaire results gave more details and are presented in Table 4.

Table 4: Who do school counsellors refer to? (N = 240)

Refer to:	Frequency	Percentage
CAMHS	225	94%
GPs	190	80%
Agencies	136	57%
Māori services	32	55%
Other services	39	16%
Total	**722**	

Counsellors made referrals to 21 different services or individuals, including private psychologists, therapists, psychiatrists, Group Special Education, drug and alcohol services, youth workers, and health services. These are often the same services that refer school students to school counsellors.

Safety and supervision

The matter of safety was followed up in the questionnaire by asking about cover during school holidays. Some counsellor-participants indicated multiple possibilities. Seventy per cent of counsellors would refer to CAMHS, 55% to counselling agencies, while 42% enabled students to contact them in some way. Almost a quarter involved the adolescent's family, while others suggested help lines or crisis teams, or made safety plans.

I asked whether school counsellors received specific supervision when working with depressed adolescents. Sixty-one per cent reported that they received supervision from a counsellor or psychotherapist, 9% had regular supervision from a CAMHS clinician or a psychologist in private practice, while a further 20% indicated that alongside regular supervision, they had additional input (either regular supervision or occasional consultation) from a mental health clinician. Of concern was that 4% received very little or no supervision. Cost, availability, and schools' lack of willingness to release them for supervision were mentioned as barriers.

Effective therapy

Group discussions around effective therapy with depressed adolescents were strongly influenced by core beliefs that all clients were different, generalisation was rarely helpful, and that no assumptions should be made.

> *Never, never, never go with assumptions based on what you have read or heard about that particular cultural group because there are such vast differences.*

Table 5: Main ways of working with depressed adolescents (N = 240)

Ways of Working	Frequency	Percentage
Talking	228	95%
Coping strategies	223	93%
Family and friends	211	83%
Writing	195	81%
Psychosocial education	176	73%
Activities/homework	141	59%
Interactive ways	127	53%
Using props	89	37%
Advice	71	22%
Narrative	24	10%
Referral on	21	9%
CBT	18	8%
Other therapeutic ways	62	26%
Total	**1586**	

The relationship between counsellor and client was considered the most important aspect of therapy.

> *It's all about the relationship.*

Once this relationship had been established, in what ways did counsellors work with depressed adolescents? Almost all focus group participants expressed a belief that an eclectic approach was best. One counsellor challenged the consensus in her group and emphasised a behavioural approach. There was some support for this.

> *I always work much less in a Rogerian way and much more in a behavioural way with depression. Linking back to past episodes and what did you do and emphasising the doing and the behaviours.*

The questionnaire asked directly for information about ways in which counsellors worked with depressed adolescents. All 240 respondents answered this question, giving 1586 answers, which are presented in Table 5. A variety of ways are mentioned, supporting the qualitative data that school counsellors work in an eclectic manner

While activity-scheduling and making lifestyle changes were recognised as important by several counsellors at the focus groups, it was not clear if this was identified as Cognitive Behavioural Therapy (CBT). However, many talked of using CBT alongside other methods.

> *…a bit of CBT will be mixed in.*

Comments about the usefulness of CBT approaches were made frequently. In general, counsellors believed there were two particularly beneficial aspects of a CBT approach. The first was helpful ways of challenging negative thoughts:

> *[By] looking at their thoughts, helpful thoughts, unhelpful thoughts, often they'll catastrophise a lot of the times, identifying their thought patterns and how that might be adding to how they're feeling.*

The second was enabling the adolescents to have something positive to take away.

> *You've got a sense of a concrete thought that they can take away with them when they've used CBT.*

CBT was seen as helpful to a wide range of young people, especially boys. The focus on thoughts was appreciated.

> *It has a place with boys because they're not into feelings.*

Helpful ideas and strategies from CBT workbooks and resources were often used without formal training.

> *I have used a programme that was designed for primary schools which talks about an invading thought, and when the invading thought comes in, matching it with a challenger thought.*
>
> *There's some good adolescent CBT material actually around at the moment. I've found the Think Good, Feel Good book, that's a good one, and aspects of the Friends manual from Australia. It's practical, good stuff.*

Initially, several counsellors had not liked CBT but their opinion changed once they had seen how successful it could be.

> *I've become more accepting that it's the extremes of the thoughts, the alls or nothings, the blacks and the whites, and the "It's only me."*
>
> *I've had students walk out and go, to paraphrase them, "I know what's happening inside my head now."*

Many school counsellors have the necessary skills to work effectively with high-risk students, but there is a perception within the profession that heavy workloads can reduce the time available for these students. It is interesting that questionnaire results

found that 93% reported meeting weekly with a depressed adolescent, and most indicated they would meet as often as needed. Over 60% of school counsellors would see a young person as long as was needed, generally two to three months.

Systems

Counsellors frequently mentioned the importance of working with the systems of which young people are a part. This included safety plans and support networks as well as links with the family or school staff.

> *Perhaps education is needed for staff not just about recognising but also continuing to support over a long period.*

Questionnaire results indicated that 83% of counsellors involved students' families and friends in their work.

Discussion

The qualitative findings that school counsellors were largely eclectic in their approach to working with depressed adolescents were strongly supported by questionnaire data. Few reported using a solely CBT approach, but participants clearly stated they used many CBT techniques along with other methods.

However, there was some uncertainty and disquiet around assessment and referrals to CAMHS, in part related to different philosophical views of depression and its meaning. Guidelines in the United Kingdom suggest that if watchful waiting or non-directive supportive therapy were unsuccessful in assisting recovery, then referral to CAMHS would be encouraged after two to three months (NICE Guideline, 2005). If there was ongoing active counselling, and no changes were seen or some deterioration occurred, then a referral should be made sooner. Results from this study indicated that referrals did not always happen within this timeframe, for while some school counsellors referred quickly, others waited for some weeks or months. In part this may be related to concerns about mental health services, in particular the stigma felt by some families. Therefore, it appeared that training was needed to support decision-making and referrals.

It is interesting to note that over 60% of school counsellors would see a young person as long as was needed, generally two to three months. This is longer than the four to six sessions believed to signify best practice (Lewinsohn, Clarke, Hops, & Andrews, 1990) and is worth further investigation, especially as school counsellors have such a heavy workload.

The information gathered about depression and Māori rangatahi indicated that for many counsellors there was a real need for further knowledge and understanding in this area. Of course, it is important that counsellors ascertain to what extent Māori young people and their whānau embrace traditional beliefs, as this varies enormously, which will have an impact on the efficacy of various ways of working.

The questionnaires were successful in eliciting information and in almost every case supported the qualitative findings. Information presented here indicates that New Zealand school counsellors are generally a well-trained and experienced group of professionals, knowledgeable about many aspects of adolescent depression such as the range of causes and presentations. However, some counsellors knew that their knowledge of adolescent depression was inadequate, and were keen to learn more. It was also evident in some group discussions that the ways in which adolescents may deal with the convergence of distressing events were not well-understood.

The basis of counsellors' work is seen as being the therapeutic relationship, with any additional techniques used to build on this relationship. The second article in this series, which will be published in a future issue of the Journal, will focus on perceived training needs and the development, presentation, and evaluation of a training workshop on the identification and assessment of adolescent depression, making referrals, and simple yet effective strategies for intervention. There could be a role for CAMHS in providing appropriate training to the school counsellors in this area.

Note

1 Youth2000 was the first national youth health and well-being survey in New Zealand. A total of 9699 secondary students aged 13–18 participated. Questions were asked about home and family; culture and ethnicity; schooling; physical, emotional and sexual health; substance use; injury; violence; exercise, and activities. Youth'07 was a follow-up study conducted some years later, with 9107 students surveyed.

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