Child and Adolescent Depression and Suicide: The Role of the School Counselor in Assessment and Treatment

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Suicide is the third leading cause of adolescent death in the United States. This alarming statistic has been widely studied and debated for years. It has become a consensus that because adolescents spend more than a third of their time in school, suicide intervention strategies must be put into place school-wide. There has also been “heightened awareness of the need for effective crisis intervention in public schools” (Allen et al., 2002, p. 96) nationwide. Kennedy (1999) feels that teaching students about violence and prevention is just as important as teaching them to read and write.

More of the responsibility for adolescent suicide prevention is being given to school counselors. There is also a greater need for school counselors to be able to recognize the warning signs and plan effective prevention strategies. According to a study by King, Price, Telljohann, and Wahl (1999) only one in three counselors actually feels confident in identifying students at risk. They suggested that counselors at the university level focus more attention on developing the skills to distinguish those students at risk.

The 1999 Surgeon General’s Report suggests that counseling may be the key factor in adolescent suicide prevention; yet, many potential victims are going unnoticed. “Less than one third of the suicidal adolescents receive psychological or emotional counseling - in other words more than two thirds do not receive such counseling” (Pirkis et al., 2003, p. 391).

Research has suggested many approaches to a comprehensive guidance program designed around adolescent suicide prevention. Kahn (2000) proposed a solution-focused approach along with consultation, “shifting traditional emphasis from problems and deficits to solutions and strengths” (p. 248). Several coping strategies were suggested by Kan (1999), including: developing a comprehensive school guidance program, prevention and rehabilitation techniques, making use of outreach, advocacy, and consultation services, crisis intervention and crisis management teams, as well as conflict resolution strategies.

In his 2001 research on developing adolescent suicide prevention programs, King suggested that students and school professionals be trained in recognizing the warning signs of suicide. He concluded “effective school suicide prevention programs should be structured enough to provide school professionals with guidelines to follow when dealing with this issue, but flexible enough to allow for the proper handling of unique situations” (p. 136).

King (2001) and Kennedy (1999) both suggested a three level prevention program: primary (prevention), secondary (intervention), and tertiary (post-intervention). Primary prevention is aimed at improving students’ coping skills, increasing awareness, and identifying the warning signs. The secondary intervention step is to ensure a quick and appropriate response to suicide threats or attempts and to make timely referrals. The tertiary step ensures quick and appropriate action if a suicide has been completed or attempted, minimizes trauma, and decreases the chances of peers glorifying or emulating the act.

Suicide prevention programs may also be needed for certain elementary and middle school populations. Results from a 1988 survey of 123 elementary school counselors in Kansas follow: 187 students considered suicide, 26 attempted suicide, and one male fifth grade student committed suicide using a gun. Counselors observed the following behaviors in order of prevalence in students who attempted suicide: depression; suicide threats; defiant and aggressive behavior; decline in academic performance; and changes in personal appearance, attendance, and friendships, respectively. The death of a family member occurred prior to the suicide attempt in 2% of the instances (Nelson & Crawford, 1990). It is possible that more startling results would be obtained from a current survey of elementary and middle school counselors, especially in communities experiencing socioeconomic stress.

Local Suicide Prevention Program

In response to the alarming national statistics on adolescent suicide, the Muscogee County School District in Columbus, Georgia screens all ninth grade students for depression and suicide risk. The suicide prevention program, Life Works®, is coordinated through the Guidance Services department. The program requires school counselors to attend several days of in-service training to learn how to identify and assess students who are depressed and potentially suicidal.

Once this training is completed, school counselors, along with mental health colleagues from the
community, participate in a yearly program that screens all ninth grade students for depression and suicide risk. Using an approach prescribed by Life Works®, the team visits a school and shows a suicide prevention film to all ninth graders. Students are then guided through a risk assessment that includes relevant questions, the most pertinent one being “have you ever considered suicide?” The team scores the assessments, and students are ranked in a hierarchy according to suicide risk. Students determined to be at a low to moderate risk for suicide are provided counseling services within the school. However, parents are contacted and an emergency mental health referral is made if the risk for suicide is high.

School counselors request that parents sign a contract stating that will seek immediate services. The school counselor contacts parents 24 hours after the referral to ensure the child is receiving mental health services. For parents who refuse to follow through, the Department of Family and Children Services is utilized to ensure the safety of the child (Y. Jones, personal communication, December 1, 2004).

**Prevalence of Depression in U.S. Youth**

Since suicide is often linked to depression, the prevalence of depression in children and adolescents is an area of concern. According to the National Mental Health Association (NMHA, 2004), one in every 33 children, or 2.5% of children, and approximately 8.3% of adolescents may suffer from depression. The NMHA further reports that young people who have suffered one episode of major depression are in danger of suffering another episode within the next five years and that almost two-thirds of children with mental health problems do not receive needed professional assistance.

Sung and Kirchner (2000) state the prevalence of major depressive disorder in U.S. youth as being one percent of the preschool population, two percent of the elementary population, and five to eight percent of the adolescent population. According to Lawrence Kerns, approximately six million youth in the United States experience depression in some form (Black, 1996).

**Causes and Risk Factors for Depression**

When considering possible causes of depression, Sung and Kirchner (2000) stress the importance of ruling out possible medical causes. Neurochemical and hormonal imbalances, among other conditions, can trigger depressive symptoms. Thus, school counselors should be aware of common signs of medical disorders that trigger depression and refer parents to a physician when medical disorders are suspected.

In some cases, depression may have multiple causes rather than directly linked to a single factor in a child’s life. Many authors have identified common causes and risk factors, and the school counselor should become familiar with these. The NMHA (2004) reports that youth experiencing stress or a loss and those who have conduct, learning, or attention disorders suffer higher rates of depression. The data suggests a link between depression and low self-esteem related to below standard academic performance. Sung and Kirchner (2000) have related below standard school performance as a risk factor for depression.

Stiles and Kottman (1990) cite that the majority of depressed and suicidal youth are responding to the loss of a loved one, an important object, or a sense of security. Ramsey (1994) states that depression in children can be a consequence of parental depression. She lists several possible causes of depression: genetic factors, a significant loss, and failure to meet goals or standards set by self, parents, or significant others. Depression may also be triggered by frustration, social setbacks, illness, death of a loved one, failure, or conflict with significant others or authority (Ramsey, 1994, p. 2).

According to AtHealth.com (2004), children with major depression often have a family history of depression. AtHealth.com lists the following risk factors for depression: loss of a parent or loved one, cigarette use, stress, child abuse or neglect, chronic illness such as diabetes, the failure of a romance, traumas such as natural disasters, and conduct/attention/learning disorders.

Nugent (2000) reports that gifted students and those with perfectionist tendencies are also at-risk for depression. She cites some of the disabling and self-destructive effects of perfectionism as underachievement, eating disorders, substance abuse, obsessive-compulsive traits, psychosomatic disorders, depression, and suicide (Nugent, 2000, p. 2). She encourages gifted teachers to be aware of signs of disabling perfectionism in the classroom.

**Symptoms of Depression**

Sung and Kirchner (2000) list common signs of depression in youth as low self-esteem, depressed mood, irritability, guilt, anger, suicidal thoughts, and attempted suicide. The NMHA (2004) encourages parents, teachers, and school counselors to be aware of symptoms of depression in children and adolesc-
cents. These symptoms include absenteeism and low academic achievement, motivation, energy, or enthusiasm. Additional signs listed by NMHA include disruptions in sleep and eating patterns, low self-esteem, loss of interest in friends and hobbies, anger, conflict with authority, substance abuse, and contemplating death or suicide. McChristie (n.d.) lists additional symptoms of childhood depression as anhedonia, delinquent behavior, and sexual promiscuity.

Strauss, Forehand, and Frame (1984) conducted a study using a sample of fifth grade students in a rural Georgia county. The goal of their study was to verify the concurrent validity of the Children's Depression Inventory (CDI) by comparing student scores on this assessment to self-reports, teacher reports, and peer reports of characteristics associated with depression. The team concluded that students with high CDI scores also exhibited traits often associated with depression: poor self-esteem, unassertive behavior, poor social interactions, attention deficits, low academic performance, and anxiety.

### Diagnostic Screening

The University of Michigan Depression Center (UMDC) stresses the importance of assessing youth for depression since untreated depression can lead to suicide. Early identification and prompt treatment of depression can prevent harmful outcomes such as academic underachievement, low self-esteem, damaged interpersonal relations, drug abuse, risk-taking, and suicide (University of Michigan Depression Center, 2005).

Several authors mention diagnostic tools for assessing depression in children and adolescents. These include the Children's Depression Inventory (Strauss et al., 1984); the Depression and Anxiety in Youth Scale (Brooke, 1995); the Reynolds Adolescent Depression Scale and Reynolds Child Depression Scale (Ramsey, 1994); and the Adapted-SAD PERSONS for use with children and adolescents (Juhnke, 1996).

As suggested by Brooke (1995), the school counselor should consider the following testing issues prior to administration: validity, normative samples, reliability, and ease of score interpretation. Brooke (1995) also mentions the following testing issues in her review of the Depression and Anxiety in Youth Scale: time required for administration, the appropriateness of group versus individual administration, qualifications for administration, how acquiescent response patterns are detected, and the reliability with special student populations.

### Counselor Interventions and Treatments

Ramsey (1994) emphasizes the need to assess depression levels and the potential for suicide. The A-SAD PERSONS assessment is a tool that allows school counselors to make appropriate referrals for students at high risk for suicide (Juhnke, 1996). Once depression has been diagnosed, Sung and Kirchner (2000) encourage a timely referral and collaboration with mental health professionals to reduce chances of academic failure and, more importantly, suicide. While the school counselor may provide adjunct treatment for high-risk students, mental health professionals are more qualified to deliver the intensive treatment required for clinical, crisis, and even chronic depression.

Ramsey (1994) proposes interventions school counselors can use to treat specific manifestations of depression such as social withdrawal, aggressive behavior, and low self-esteem. For the child with low self-esteem, supportive counseling, parent training, role-playing, and child participation in non-threatening group activities can be beneficial. Using techniques such as play therapy, sentence-completion exercises, drawing, and diaries encourages students to express their concerns. She emphasizes the importance of helping students set achievable goals and discussing/rehearsing more adaptive behaviors. These students benefit from reflecting on their positive attributes and from opportunities to achieve personal and interpersonal success (Ramsey, 1994, p. 5). Thus, school counselors can collaborate with parents and teachers to encourage such opportunities for student success.

For students who are less social, Ramsey (1994) suggests using active listening skills and projective interventions such as puppets, art, music therapy, journal writing, and pets. To increase the social interactions, she suggests involving children in small group activities with other children, social skills training, and helping parents and teachers create environments conducive to improved social relations.

Black (1996) echoes Sung and Kirchner's (2000) emphasis on making timely referrals to specialists or psychiatrists in cases of clinical depression. She cites that these specialists typically use family, psychodynamic, or cognitive-behavioral approaches to combat severe cases of depression. In less severe depression, the school counselor may also use cognitive-behavioral therapy to help students replace distorted expectations of self and others with more realistic expectations (Black, 1996).
Mutual-storytelling may be used to help depressed children process the underlying feelings or situations contributing to depression. In mutual storytelling, the counselor requests the child create a story and the counselor carefully analyzes the content (including situations, characters, and metaphors) to gain insight into the child’s concerns. The counselor then shares a story similar to the child’s (i.e., using the child’s characters and metaphors) to demonstrate more effective methods of problem resolution. The ultimate goal is to help the child gain insight into more effective ways of coping with difficult situations and conflicts (Stiles & Kottman, 1990).

Stiles and Kottman (1990) stress these considerations for using the technique: the child must be at least five years old and cognitively able to create stories; the counselor must develop rapport prior to using the technique; and, the counselor must strive to understand metaphors used by the child and consciously use them in retelling the story. They further emphasize that mutual-storytelling should not be used with children who have expressive communication disorders or cognitive impairments, and they state that more empirical evidence is needed to support the benefits of this technique.

Summary

Depression and suicide in children and adolescents are forces that all school counselors will face at some point in their career. These forces are not bound by socioeconomic status, race, ethnicity, religion, gender, or any other cultural factor. School counselors must be aware that even socially and academically successful children with supportive families are at risk for suicide if they experience a significant loss or perceived failure to meet internally or externally imposed standards.

The counselor must advocate for depression and suicide-risk screenings to identify students most at risk of suffering severe psychosocial harm from depression. Whereas some students may be effectively treated within the school, others will need immediate referrals to community mental health agencies. There must be collaboration among the mental health professionals, the schools, parents, and community to identify appropriate diagnostic assessments and to develop hierarchical treatment plans that correlate with the varying degrees of depression experienced by students. Coordination among parents, teachers, the community, and counselors may mean developing workshops focusing on the risk factors and symptoms associated with depression. These workshops would promote awareness and hopefully prevent suicide among our youth.

The school counselor has many options for helping students replace depressive symptoms with more hopeful and adaptive feelings, perceptions, thoughts, and behaviors. Regardless of whether the school counselor provides primary or adjunctive treatment, she/he plays a primary role in identifying at-risk youth and ensuring they receive the most appropriate care.

References


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