School Counselor Development Program (SCDP) for the Treatment of Adolescent Depression and Suicidality: A Pilot Study

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Abstract

The School Counselor Development Program (SCDP) was developed as a continuing education intervention for middle school counselors in the New York City Department of Education, focusing on six mental health issues relevant to their work with students. A pilot study was run with 21 New York City Public School counselors. This paper focuses on one of the six modules, dealing with the depression and suicidality of students. The training consisted of a short didactic portion focusing on skills training, extensive role-play practice, and a concluding discussion. A repeated measures design was used with counselors self-assessing confidence before and after the training. It showed a moderately significant increase in counselors' confidence in dealing with suicidal students and a significant increase in their confidence in dealing with depressed students. Implications for counselors, limitations of the study, and future research are discussed.

School Counselor Development Program (SCDP) for the Treatment of Adolescent Depression and Suicidality: A Pilot Study

Suicide and depression have an enormous impact on youth. In 2004, suicide was the third leading cause of death for children aged 10 to 14 (Center for Disease Control and Prevention (CDC), 2005). Among several minority groups, including Hispanic and American Indian, adolescents are at an even greater risk (CDC, 2005; Zayas, Lester, Cabassa, & Fortuna, 2005). Symptoms of depression, such as feeling sad or hopeless, are very common, and they are severe enough in over one fourth of high school students to interfere with their daily lives (Eaton et al., 2006). Beyond simply feeling depressed, 16.9% of high school students have seriously considered attempting suicide, 8.4% have attempted suicide, and one fourth of these attempts were so serious they required medical treatment (Eaton et al., 2006). Every day, students are hampered by these problems to a degree that is limiting their ability to learn and harming their lives. As children and adolescents spend the majority of their waking life in school, it is the schools' responsibility to protect the emotional and academic well-being of their students.

Schools are legally responsible for the well-being of their students while these students are enrolled in their schools. Several courts have ruled that school counselors have a legal obligation to protect students if "they foresee, or should have foreseen that the student was potentially dangerous to himself or herself" (King, Price, & Telljohann, 2000, p. 260). Thus, counselors and schools have a legal imperative to be prepared for suicidal crises. As schools function *in loco parentis*, they must ultimately be responsible for the safety and well-being of students, and the legal system has made this clear.

Beyond the legal imperative, however, the ability to assist a student has been found to be very important to counselors: 82% of school counselors felt very strongly that “one of the most important things I could ever do would be to prevent a suicidal student from committing suicide” (King, Price, Telljohann, & Wahl, 1999, p 463). Falls and Nichter (2007, p. 15) found that one main reason individuals become school counselors is “they believe they can make a difference” in students’ lives. Along with legal reasons, school counselors have personal and ethical reasons to want to help students who are struggling, and one major area in which students are struggling is with depressed feelings and thoughts of suicide.

As helping professionals with long-term exposure to students, school counselors are in a unique position to provide assistance. While counselors have a great many students under their care, they have the ability to keep close tabs on students via teachers, peers, and counselor visibility. This continuity of presence allows school counselors to develop strong, trusting relationships with students. Despite this unique opportunity counselors have to prevent student suicide, counselors are still faced with suicidal students. Hermann (2002) found that, during their tenure, 74% of high school counselors had encountered at least one student who attempted suicide. For many reasons, school counselors need to have the skills necessary to assess, help, and refer depressed and suicidal students.

Counselor Self Confidence

Unfortunately, many counselors do not feel prepared to meet this challenge. Allen et al. (2002) found that school counselors feel less than adequately prepared to deal with crisis situations, such as suicidal students. They also found that over one third

of the counselors had received no training in crisis intervention. Just over one third of the counselors surveyed felt confident that they could recognize a student at risk of attempting suicide, and fewer than half felt they could even discuss with other teachers and counselors whether or not a student was at risk (King et al., 1999). However, in follow-up research, King and colleagues (2000) found that this lack of confidence was not fully related to actual knowledge or ability. The vast majority of counselors responded correctly to questions about what to do during a suicidal crisis, as well as after a suicide completion. Most also correctly recognized many of the risk factors for a student potentially attempting suicide. While counselors were reasonably knowledgeable regarding suicidal students, they lacked confidence in their abilities.

Even though the vast majority of counselors have had some previous training in dealing with adolescent suicide, it is still one of the most widely desired areas for further training (Coder, Nelson, & Aylward, 1991; Allen et al., 2002). This lack of confidence can be ameliorated with continuing education and supervision (Leach & Stoltenberg, 1997). For example, Hermann (2002) found that counselors who participated in suicide prevention training felt more prepared to handle such issues. In fact, Melchert, Hays, Wiljanen, and Kolocek's (1996) study suggested that training can yield increases in confidence and competence beyond what is offered by clinical experience.

Counselors' self confidence is vital to their ability to successfully perform their duties. Larson and Daniels (1998) found a positive correlation between counseling performance and self confidence. Additionally, Urbani et al. (2002) found that increasing self confidence was necessary to improve both counseling performance and clinical judgment, and Al-Damarki (2004) showed a correlation between self efficacy and use of

higher order counseling skills. Finally Curry (2007) noted the particular importance of self confidence for counselors, due to the abstract nature of their duties. The lack of concrete goals makes it particularly important to have an internal motivator, specifically the belief that one is progressing in the correct direction.

In addition to a lack of training, counselors also may feel impeded by a lack of cooperation from other school personnel (Roberts-Dobie & Donatelle, 2007). Sutton and Fall (1995) found that supportive administrators and faculty were the strongest predictor of counselor self confidence. This suggests that while training school counselors to deal with adolescent depression and suicidality may increase their confidence to do so effectively, additional measures should include educating other school staff as well as training counselors in effective collaboration techniques with teachers and other school personnel.

School Counselor Development Program

The School Counselor Development Program (SCDP) was developed as a continuing education intervention program for middle school counselors in the New York City Department of Education. The training covers six topics: collaborating effectively with teachers, administration, and other school personnel; aiding the development of Emotionally Responsive Classrooms; contemporary theories of adolescent development and the role of aggression in school; the specific needs of over-age students; adolescent depression and suicide; and grief and bereavement. These module topics were chosen by combining a review of the literature on the skills beneficial to guidance counselors (e.g. Adelman & Taylor, 2002; King et al., 1999) with collaboration between professionals in the field and supervisors of direct student services in the schools.

Each module followed the same training structure, combining didactic, discussion-based, and role-play practice teaching techniques. The didactic portion consisted of relevant background, research, and theory on the topic being discussed, as well as the specific skills. It is important to note that the SCDP is a skills-based program, and the major objective is for school counselors to learn and practice specific skills. During this didactic section, targeted discussions about the actual experiences of the school counselors were used to put each skill into the context of their actual day-to-day duties.

Following the didactic/discussion-based training, the school counselors split into small groups of 4-6 to role-play the skills they learned. Role-plays were used to reinforce the learned skills, as role-play and discussion require a deep level of information processing, which results in easier memory access and information that is more resistant to change (Cacioppo, Petty, Kao, & Rodriguez, 1986), and role-plays are a vital aspect of crisis intervention training (Gilliland & James, 1997). Each role-play group was led by a psychology graduate student from the research team, who facilitated the role-play scenarios, gave immediate feedback to the counselors, and helped the counselors to give each other constructive feedback. The graduate students spent significant time researching and preparing the six modules, gaining expertise in these narrow fields. The principal investigator, a licensed psychologist, ‘floated’ between groups to assist and answer any clinical questions that came up during the role play sessions. The role-plays incorporated actual situations encountered by each of the school counselors in the group, in order to make sure the role play sessions were beneficial. The counselors practiced the newly-learned skills with another counselor or

the facilitator who role-played the part of the student in the group. Each module concluded with the principal investigator facilitating a discussion with the school counselors about the skills, the role-play practice scenarios, and application within the schools. The counselors discussed what they found particularly beneficial during the role-plays, as well as what was challenging for them. The research team could then reinforce their use of the skills and remind them of the key points from the training. This also was a chance to give feedback to the group as a whole, describing particularly positive discussions in the small groups, as well as common difficulties, and to solidify the skills training with the school counselors.

Depression and suicidality module

The current study focused on a single module of the training, dealing with adolescent depression and suicide. The counselors were taught the signs of depression categorized into two groups. General signs and symptoms of depression, as enumerated in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), such as sad mood, anhedonia, changes in eating or sleeping behavior, and feelings of guilt or worthlessness, were discussed first (American Psychiatric Association [APA], 2000). These were distinguished from adolescent-specific traits, such as decreased effort at school, somatic complaints, truancy, recklessness, and irritability (Capuzzi & Gross, 2004). This distinction was made explicit, as many of the signs of depression in children and adolescents do not correspond directly to the general DSM-IV symptoms of depression.

Common myths of suicide were also described. Some of those myths included the notion that suicide happens without warning, it is impossible to stop a person intent

on committing suicide, and women commit suicide more often than men. In actuality, people often attempt to get help from those around them before attempting suicide, suicidal crises tend to be short-lived, and while women *attempt* suicide more often than men, men *complete* four times more often than women (Capuzzi, 1994). The warning signs for suicidality were discussed; pointing out that a previous attempt is the best predictor of future attempts (Capuzzi & Gross, 2004). Other signs discussed in the training included marked changes in the adolescent's behavior or lifestyle, such as sleeping pattern, achievement in school, friend group, or putting affairs in order; and at-risk internal traits, such as hopelessness, isolation, poor problem solving skills, poor communication skills, and depression.

The specific skills taught during this module focused on the direct assessment of suicidality by asking the student "Are you thinking of hurting yourself?", and counseling skills related to helping actively depressed or suicidal adolescents through their crisis. Assessment skills were related to understanding the difference between suicidal ideation and intent, as well as identifying whether the student has a plan and means to achieving the plan to harm him- or herself. After assessment, the school counselor could use skills to continue to build rapport with the student and address the depression or suicidality directly (Capuzzi & Gross, 2004). The skills taught included general counseling skills, such as active listening and eliciting change talk (Center for Nonviolent Communication, 2005; Ivey, 1988), geared specifically toward depressed adolescents.

The role-play section of the module began with the graduate student research team member introducing that he or she would role-play a student coming to the

counselor under differing depressed and/or suicidal situations. Specific situations were devised in collaboration with the group itself, in order to mimic real situations the counselors had faced or felt they might face. Some of the presentations included a student who was angry about being in the office and responded belligerently to the counselor; a student who was noticeably sad, barely interacting with the counselor; and a student who was punitively silent, refusing to discuss anything with the counselor. Each of these situations required different approaches, but the skills of assessment and counseling could be applied equally to each.

The concluding discussion provided an opportunity for the counselors to discuss the assessment and counseling skills that were most difficult for them. The discussion also gave the counselors a chance to debrief after practicing very stressful situations. Asking about suicidality directly and succinctly was reinforced and emphasized.

The purpose of this pilot study was to begin to examine the effectiveness of the depression and suicidality module of the SCDP, on increasing middle school counselors' confidence in dealing with depressed and suicidal students. The researchers hypothesized that, following the training, school counselors would feel more confident when working with these students. The prevalence and severity of suicidality and depression demand counselors' competence in the best practice procedures and confidence in their ability to carry out those skills. Ultimately, if effective, the SCDP intervention will lead to school counselors feeling more confident and satisfied in their own skills and thus, better serving their student populations.

Method

Participants

Middle school guidance counselors from an urban region of the New York City Department of Education were recruited as part of a continuing education effort coordinated in collaboration with Teachers College, Columbia University. Each of the 26 schools serving students in sixth through eighth grade in the region was invited to send one school counselor for the three-day continuing education program. In total, 26 counselors participated in the SCDP program.

Each of the 26 school counselors was invited to participate in the current study. The procedures were explained and the school counselors were informed that they would not be precluded from the training if they decided not to participate in the study. The counselors were not given inducements to participate, beyond the opportunity to further their education. Informed consent forms were provided to all school counselors, which explained the procedures, and those who wished to be part of the study signed and returned one copy, keeping one copy for themselves. Included in the informed consent description was an explanation of the confidentiality of their responses. The counselors' responses were aggregated, and not reported individually. Their pretests and posttests were identified by number only, with their personal information removed. Their responses were kept in locked file cabinets in the researcher's office. The approval of Teachers College's IRB was also described, as was the fact that the study posed minimal risk of harm to them. Potential benefits both to the school counselors and the students they serve were highlighted in the informed consent document.

Those school counselors who attended the training, wished to participate, and completed both pretest and posttest assessments were included in the results. This yielded a sample of 21 counselors; 18 were female and three were male. The median time in their current position was eight years, ranging from less than one to 23, and the median years of education specifically targeted at counseling was 4.5. While all school counselors served in a middle school (grades 6-8), five served schools with younger students as well, one 5th-8th grade, and four Kindergarten-8th grade.

Design

A quasi-experimental repeated measures design was used, in which the counselors self-rated their confidence on a number of variables, including their confidence in dealing with the suicidality of a student and students with depression on a pre-test. They then participated in the SCDP program, and they rated their confidence on the same variables on a post-test. Paired samples t-tests were used to compare the pretests and posttests. Fisher's g was run to check if the data were distributed approximately normally, as this is an unbiased test of skew (Fisher, 1970). Power tests were used to examine the effect size of moderately significant results. As this was a pilot study to examine if there was any evidence that the SCDP module may be effective, no control group was used.

Measures

A researcher-constructed, self-administered questionnaire was given to the participants as a pretest and a posttest to evaluate counselor self-confidence; a ten-point Likert-type scale was used for all ratings, except for the evaluations of the module and the training, which used a five-point Likert-type scale. Again, due to the pilot nature

of this study, no measure of validation was conducted. The surveys included five sections in total. The three utilized in the current study are detailed below.

Demographic Information. This section was included only on the pre-test. It asked participants to respond to several questions about their background and training. The length of time they have been at their current position and their years of education were assessed with open-ended questions. Forced-choice questions were also included regarding their employment position (guidance counselor, school social worker, and other) and which grade levels they work with (6-8 and/or 9-12).

Confidence. This section was included on the pre-test and post-test, examining the counselors' confidence in 20 areas of their work adapted from the Counselor Self-Efficacy Scale (Melchert et al., 1996). They were asked 13 questions about their confidence, responding with rankings of 1 (no confidence) through 10 (highly confident). The first seven questions dealt with students with a variety of issues, including some that were addressed in other modules. The next six questions asked about their confidence in making referrals, dealing with teachers, parents, and administration, and providing information to teachers about mental health issues. They were then asked seven questions about their confidence in different counseling situations, consulting with staff, and other job tasks that they are required to perform in their positions. The items, “How confident do you feel in dealing with the suicidality of a student?” and “How confident do you feel in dealing with students with depression?” are used in the current study.

Workshop Evaluation. This section was included only on the post-test, and included a 5-point Likert-type scale to rate the perceived usefulness of each module

individually and the training as a whole, from 1 (Not at all useful) to 5 (Very useful). A section was provided for open-ended comments on each module as well as the entire training. The school counselors were also asked to indicate whether or not they would recommend the SCDP workshops to their colleagues.

Procedures

Each of the six modules of the SCDP workshop was three hours long, and was divided into three main sections, the didactic and discussion-based portion lasting approximately 30 minutes, the role-play practice session lasting 2 hours, and the concluding discussion lasting approximately 30 minutes. Two modules were presented once a week resulting in three total training days over a three week period. The workshops were run by the principal investigator, who is a New York State Licensed Psychologist, and assisted by graduate students in clinical or counseling psychology. Each graduate student co-led one of the six modules with the Principal Investigator. The procedures below describe the adolescent depression and suicide module, which was one of the three-hour modules.

Didactic Portion. The principal investigator led the didactic portion, with the assistance of a graduate student research team member, the secondary presenter. The training was designed to be as interactive as possible, in order to involve the counselors, to help them process the information thoroughly, and to relate the presentation to their specific experience and knowledge. A white board was used at the front of the room to record the counselors' ideas and to emphasize points throughout the training.

The didactic portion began with an introduction to the topic of depression and suicide, recognizing the difficulty of discussing the topic, and stressing the importance of discussing it despite the difficulty. A short review of the current research, and background information on suicide and depression was provided.

As previously stated, the rest of the didactic portion focused on presenting the general and adolescent-specific signs and symptoms of depression, myths and facts about suicidality, and specific skills in assessment and individual counseling of depressed and suicidal adolescents, focusing on the importance of asking students directly and succinctly if they were considering harming themselves.

Role-Play. During the role-play section the counselors split into small groups with one graduate student moderating each group. The principal investigator moved from group to group to provide feedback and answer questions specific to counseling, as well as more in-depth or difficult questions. The graduate student moderator portrayed a middle school student who was depressed or suicidal, while the counselor worked with the student, practicing the specific skills they had just learned. Several varied scenarios were presented, allowing the counselors to deal with students who were depressed, suicidal, angry, and other variations of depression and suicidality. After a short 'counseling session,' the other counselors in the group and the group leader gave the counselor feedback on his or her use of the taught skills. After discussing the first scenario and the counselor's performance, a second counselor was given a different scenario, and the practice continued.

Group Discussion. The last half hour consisted of a group discussion with the counselors describing how it felt to use these new skills, what worked well for them, and

what was more difficult. The presenters also re-emphasized the main points of the training (See Wright, Blount, and Emmert-Aronson (2007) for further workshop details).

Data Analysis

Analyses consisted of a paired samples t-tests, pairing the pretest and the posttest (Mendenhall, Beaver, & Beaver, 2006). Findings in which $.05 < p < .1$ were considered moderately significant in light of the small sample size and pilot nature of this study. Because of the lack of power this small sample size caused, effect sizes calculated with Cohen's d were also reported. Many authors have argued for the importance of effect size, even over significance tests (e.g. Thalheimer & Cook, 2002; Thompson 1998).

Results

From the full survey, two measures of the counselors' confidence were examined: dealing with the suicidality of a student and dealing with students with depression. The skew statistics ranged from -.552 to .230. None of these scores indicated significantly skewed data (Myers & Well, 2003), and paired samples t-tests were run.

On the pretest, school counselors rated their confidence in dealing with several specific student situations on a Likert-type scale ranging from "1 (not confident)" to "10 (highly confident)." The pretest mean (and standard deviation) of the counselors' confidence in dealing with the suicidality of a student was 6.29 (2.261), ranging from two to 10. Their confidence in dealing with a student with depression was 6.10 (2.364), ranging from one to nine (See Table 1).

Table 1

	Possible Range	Min	Max	Median	Mean	Std Dev
Suicidality	1-10	2	10	7	6.29	2.261
Suicidality, post	1-10	5	10	8	7.14	1.493
Depression	1-10	1	9	6	6.10	2.364
Depression, post	1-10	5	10	8	7.57	1.165
Module evaluation	1-5	4	5	5	4.62	0.498
Training evaluation	1-5	4	5	5	4.81	0.402

Counselors' confidence in dealing with the suicidality of a student showed moderate improvement, from a mean score of 6.29 on the pre-test to 7.14 on the post-test, $t(20) = 1.788$, $p = .089$. The effect size is $d = .455$. Their confidence in dealing with depression showed significant improvement, from a mean of 6.10 to 7.57, $t(20) = 3.277$, $p < .0038$). The effect size is $d = .808$. Using the smaller of these two effect sizes to calculate a power analysis yields a power of .51 (Faul, Erdfelder, Lang, & Buchner, 2007). According to Cohen (1988) a power of .8 is desirous in order to reliably detect significant results. With an effect size of .455, a modest sample of 40 participants would yield this power.

In terms of the subjective evaluation of how useful the school counselors felt the training was, the counselors were given 5- point Likert-type scales for each of the modules and the overall training. The average evaluation (and standard deviation) of the usefulness of the depression and suicidality module was 4.62 (.498). The entire training (all six modules together) received a rating of 4.81 (.402) (See Table 1).

Additionally, when asked whether or not they would recommend the SCDP training to their colleagues, 100% of respondents indicated that they would recommend it.

Discussion

School counselors tend to lack confidence in recognizing students who are suicidal (King et al., 1999). They have also demonstrated a desire for more continuing education, particularly in regard to adolescent suicide (Coder, Nelson, & Aylward, 1991; King & Smith, 2000). This study found that a skills-based training program that primarily utilized role-play practice increased school counselors' confidence in dealing with students with depression. While the suicidality confidence measure was only moderately significant, this merits further study, as it did show a medium effect size, d=.4436 (Cohen, 1988).

Implications

This pilot study has shown that a single, three-hour, skills-based training session can yield an increase in school counselors' confidence in dealing with students' depression and suicidality. The risks of not addressing depression and suicidality are grave—even life and death. Moreover, in addition to the individual student, the suicide of a classmate can have profound negative effects on the entire student population, as well as school faculty and staff (Gilliam, 1994). Given these risks, the cost of ongoing training seems not only worth the benefits of the continuing education, but ongoing training and supervision seems imperative to the well-being of the students (as well as the mental health of the counselors) (Malley & Kush, 1994; Page, Pietrzak, & Sutton, 2001; Reeves & Seber, 2004). The SCDP intervention is one brief and easy way to ensure that school counselors' skills are adequately. This means that school districts

can effectively and efficiently train their counselors, and that counselors can address their lack of confidence in these two crucial areas.

Limitations

As this was a repeated measures design with no control group, the increase in confidence may be due to factors other than the educational component of the training, limiting the internal validity. For example, the increased attention of the training may have led to the increase in confidence. As this was a pilot study with a small sample of counselors from one urban region of the New York City Public Schools the generalizability and external validity are also limited. Additionally the researcher-constructed questionnaire has not been evaluated for reliability.

Future Research

Larger studies of more geographically diverse samples utilizing control groups are necessary to examine generalizability and causality. These studies would also allow for analysis of the reliability of the questionnaire, and comparison with established measures such as the Counselor Self-Efficacy Scale. Future studies should also examine variations in both the didactic portion and specific role-play scenarios to compare the effectiveness of distinct trials. More broadly, do the skills training and role-plays translate into actual school counselor behavior change, and does that change persist over time?

Conclusion

As many as 8% of adolescents suffer from Major Depressive Disorder, and the prevalence of adolescent suicide is increasing; at the same time, approximately 70% of children who need mental health services are not receiving them (U.S. Department of

Health and Human Services, 1999). Of those students who do receive services, the vast majority receive those services from their school, making schools “the primary providers of mental health services for children” (Hoagwood & Erwin, 1997, p.435). While counselors have many roles, including more and more administrative tasks, they are in a unique position to assist students. A small increase in support, particularly in skills-based training, can show a large benefit in counselors’ confidence in their abilities to help students. The current pilot study provides evidence for the SCDP as a potentially promising intervention to improve school counselors’ confidence in dealing with depressed and suicidal teens, meriting further investigation.

References

Al-Damarki, F. R. (2004). Counselor training, anxiety, and counseling self-efficacy: Implications for training psychology students from the United Arab Emirates University. Social *Behavior and Personality, 32*(5), 429-439.

Adelman, H. S., & Taylor, L. (2002). School counselors and school reform: New directions. *Professional School Counseling, 5*(4), 235-248.

Allen, M., Burt, K., Bryan, E., Carter, D., Orsi, R., & Durkan, L. (2002). School counselors' preparation for and participation in crisis intervention. *Professional School Counseling*, *6*(2), 96-104.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*. (Revised 4th ed.). Washington, DC: American Psychiatric Association.

Cacioppo, J. T., Petty, R. E., Kao, C. F., & Rodriguez, R. (1986). Central and peripheral routes to persuasion. *Journal of Personality and Social Psychology, 51,* 1032-1043.

Capuzzi, D. (1994). *Suicide prevention in the schools: Guidelines for middle and high school settings.* Alexandria, VA: American Counseling Association.

Capuzzi, D. & Gross, D. (Eds.). (2004). *Youth at risk: A prevention resource for counselors, teachers and parents* (4th ed.). Upper Saddle River, NJ: Pearson Merrill/Prentice Hall.

Centers for Disease Control and Prevention. (2005). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. National Center for Injury Prevention and Control, CDC. (producer). Retrieved August 20, 2007, from www.cdc.gov/ncipc/wisqars/default.htm

Center for Nonviolent Communication. (2005). *What is nonviolent communication?* Retrieved February 8, 2007, from http://www.cnvc.org/nvc.htm

Coder, T. L., Nelson, R. E., & Aylward, L. K. (1991). Suicide among secondary students. *School Counselor, 38*, 358-361.

Cohen, J. (1988). *Statistical power analysis for behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Curry, J.R. (2007) *An investigation of the relationship between counseling self-efficacy and counselor wellness among counselor education students.* Ph.D. dissertation, University of Central Florida, United States -- Florida. Retrieved May 14, 2008, from Dissertations & Theses: Full Text database. (Publication No. AAT 3256914).

Eaton, D. K., Kann, L., Kinchen, S., Ross, J., Hawkins, J., Harris, W.A., et al. (2006). Youth risk behavior surveillance - United States, 2005. *Morbidity and Mortality Weekly Report, 55*(5), 1-108.

Falls, L., & Nichter, M. (2007). The voices of high school counselors: Lived experience of job stress. *Journal of School Counseling, 5*(13). Retrieved November 27, 2007, from http://www.jsc.montana.edu/articles/v5n13.pdf

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39,* 175-191.

Fisher, R.A. (1970). *Statistical methods for research workers* (14th ed.). Edinburgh, Scotland: Oliver & Boyd.

Gilliam, W.S. (1994, November). *Issues in student suicide and sudden death postvention: Best practices in school crisis response.* Paper presented at the

Annual Meeting of the Mid-South Educational Research Association, Nashville, TN.

Gilliland, B. E., & James, R. K. (1997). Crisis intervention strategies (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Hermann, M. A. (2002). A study of legal issues encountered by school counselors and perceptions of their preparedness to respond to legal challenges. *Professional School Counseling, 6*(1), 12-19.

Hoagwood, K., & Erwin, H. D. (1997). Effectiveness of school-based mental health services for children: A 10-year research review. *Journal of Child and Family Studies, 6*(4), 435-451.

Ivey, A. E. (1988). *Intentional interviewing and counseling: Facilitating client development* (2nd ed.). Pacific Grove, California: Brooks/Cole Publishing Company.

King, K. A., Price, J. H., Telljohann, S. K., & Wahl, J. (1999). How confident do high school counselors feel in recognizing students at risk for suicide? *American Journal of Health Behavior, 23*(6), 457-467.

King, K. A., Price, J. H., & Telljohann, S. K. (2000). Preventing adolescent suicide: do high school counselors know the risk factors? *Professional School Counseling, 3*(4), 255-263.

King, K. A., & Smith, J. (2000). Project SOAR: A training program to increase school counselor's knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health, 70*(10), 402-407.

Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26,* 179-218.

Leach, M. M., & Stoltenberg, C. D. (1997). Self-efficacy and counselor development: Testing the integrated developmental model. *Counselor Education & Supervision, 37*(2), 115-125.

Malley, P. B., & Kush, F. (1994). School-based adolescent suicide prevention and intervention programs: A survey. *School Counselor, 42*(2), 130-137.

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counselor development with a measure of counseling self-efficacy. *Journal of Counseling and Development, 74*, 640-644.

Mendenhall, W., Beaver, R. J., & Beaver, B. M. (2006). *Introduction to probability and statistics* (12th ed.). Belmont, California: Thomson Brooks/Cole.

Miller, W. R., & Rollnick, S. (Eds.). (2002). *Motivational interviewing: Preparing people to change addictive behavior* (2nd ed.). New York: Guilford Press.

Myers, J. L., & Well, A. D. (2003). *Research design and statistical analysis* (2nd ed.). Mahwah, New Jersey: Lawrence Erlbaum Associates.

Page, B., Pietrzak, D., & Sutton, J. (2001). National survey of school counselor supervision. *Counselor Education and Supervision, 41*(2)*,* 142-150.

Reeves, A., & Seber, P. (2004). When a client is suicidal. *Counseling & Psychotherapy Research Journal, 4*(2), 27-31.

Roberts-Dobie, S., & Donatelle, R. J. (2007). School counselors and student self-injury. *Journal of School Health, 77*(5), 257-264.

Sutton Jr., J. M., & Fall, M. (1995). The relationship of school climate factors to counselor self-efficacy. *Journal of Counseling & Development, 73*(3), 331-337.

Thalheimer, W., & Cook, S. (2002). *How to calculate effect sizes from published research articles: A simplified methodology.* Retrieved March, 22, 2008, from http://work-learning.com/effect_sizes.htm

Thompson, B., (1998). Statistical significance and effect size reporting: Portrait of a possible future. *Research in the Schools, 5*(2), 33-38.

Urbani, S., Smith, M. R., Maddux, C. D., Smaby, M. H., Torres-Rivera, E., & Crews, J. (2002). Skills-based training and counseling self-efficacy. *Counselor Education & Supervision, 42*(2)*,* 92-106.

U.S. Department of Health and Human Services. (1999) *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Wright, A. J., Blount, M. C., & Emmert-Aronson, B. O. (2007). *School Counselor Development Program (SCDP): Adolescent depression and suicidality.* New York: Teachers College.

Zayas L. H., Lester R. J., Cabassa L. J., & Fortuna L. R. (2005). Why do so many Latina teens attempt suicide? A conceptual model for research. *American Journal of Orthopsychiatry, 75*(2), 275-287.

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