COGNITIVE BEHAVIORAL THERAPY IN K–12 SCHOOL SETTINGS




A PRACTITIONER'S TOOLKIT

DIANA JOYCE-BEAULIEU
MICHAEL L. SULKOWSKI

SPRINGER PUBLISHING COMPANY

Cognitive Behavioral Therapy in K–12 School Settings

Diana Joyce-Beaulieu, PhD, NCSP, is a faculty member in the National Association of School Psychologists–approved and American Psychological Association–accredited School Psychology Program at the University of Florida, Gainesville, Florida. She has taught numerous graduate courses, including topics in developmental psychopathology and diagnosis, as well as social–emotional assessment and interventions. She is a licensed psychologist and nationally certified school psychologist with supervision responsibilities for graduate-student practical experiences across several school districts and clinical sites. Her research interests include professional development issues and behavioral/conduct disorders. Her publications include two books and numerous peer-reviewed chapters and articles. She also has served as co-principal investigator for two professional development grants to research training models for multitiered systems of support, including applications of cognitive behavioral therapy in the school setting.

Michael L. Sulkowski, PhD, NCSP, is a faculty member in the National Association of School Psychologists–approved and American Psychological Association–accredited School Psychology Program at the University of Arizona, Tucson, Arizona. He also maintains a private practice in Tucson, Arizona, in which he treats children, adolescents, and adults using evidence-based psychotherapies, such as cognitive behavioral therapy. He is a licensed psychologist and is nationally certified as a school psychologist. His research focuses on the use of evidence-based interventions for children with mood and anxiety disorders as well as on supporting the emotional and behavioral needs of vulnerable or at-risk populations. To date, he has published over 35 articles in peer-reviewed journals and his research has been highlighted by the receipt of awards from the American Psychological Association and the National Association of School Psychologists.

Cognitive Behavioral Therapy in K–12 School Settings

A PRACTITIONER'S TOOLKIT

Diana Joyce-Beaulieu, PhD, NCSP

Michael L. Sulkowski, PhD, NCSP

SPRINGER PUBLISHING COMPANY
NEW YORK

Springer Publishing Company, LLC
11 West 42nd Street
New York, NY 10036
www.springerpub.com

Acquisitions Editor: Nancy S. Hale
Composition: diacriTech

ISBN: 978-0-8261-9638-5
e-book ISBN: 978-0-8261-9639-2
Appendix ancillary ISBN: 978-0-8261-2892-8

The Appendix is available for download at www.springerpub.com/joyce-beaulieu

15 16 17 18 / 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Joyce-Beaulieu, Diana, author.
Cognitive behavioral therapy in K–12 school settings : a practitioner's toolkit / Diana Joyce-Beaulieu, Michael L. Sulkowski.
p.; cm.
Includes bibliographical references and index.
ISBN 978-0-8261-9638-5 — ISBN 978-0-8261-9639-2 (eISBN) — ISBN 978-0-8261-2892-8 (Appendix ancillary ISBN)
I. Sulkowski, Michael L., author. II. Title.
[DNLM: 1. Cognitive Therapy—methods. 2. Counseling—methods. 3. Adolescent. 4. Child. 5. School Health Services. WS 350.2]
RJ505.C63
618.92'891425—dc23
2014042826

Printed in the United States of America by McNaughton & Gunn.

This book is dedicated to my father, Donald Ray Joyce, who taught us by example to think positively, to interact with others respectfully and compassionately, and to live with a noble purpose. His life exemplifies the psychological principles of mental wellness elucidated throughout this manual. I also am immensely grateful to my husband, David Beaulieu, for his effervescent demeanor, nurturing spirit, and supportive encouragement during this endeavor.
—Diana Joyce-Beaulieu

I dedicate this book to my mother and father, Marge and Lee Sulkowski, who have instilled the virtues of serving others in me; it is also dedicated to my unbelievably empathetic and supportive partner, Brooke Finley. I am grateful for the love and support these individuals have provided me while completing this text.
—Michael L. Sulkowski

Lastly, we dedicate this book to our colleague and friend, Dr. Thomas Oakland. His positive and profound impact on the profession, and on our lives personally, will never be forgotten.
—Diana Joyce-Beaulieu and Michael L. Sulkowski

Contents

Contributors

Janise Parker, MEd School Psychology Doctoral Intern, University of Florida, Gainesville, Florida

Lee Purvis, BS School Psychology Doctoral Student, University of Florida, Gainesville, Florida

Olivia Soutullo, MEd School Psychology Doctoral Student, University of Florida, Gainesville, Florida

Foreword

Stated simply, primary and secondary schooling serves three broad purposes: to promote foundational academic knowledge, to promote social and emotional development, and to encourage the attainment of a high school degree. Approximately 20% of children and youth evidence chronic social and emotional problems that attenuate their academic development and thus place them on a path that frequently leads to leaving school early. They need and generally benefit from the provision of mental health services.

Schools, especially public schools, are most likely to be the provider of mental health services to children and adolescents. Other community or private practice providers offer fewer services, often at an unaffordable cost. Moreover, schools constitute the ideal setting in which to provide mental health services. School personnel who are trained to provide these services (e.g., counselors, school psychologists, school social workers) generally are available on-site. Additionally, school settings provide an ideal context in which to acquire, practice, and attain needed social and emotional skills and behaviors in an effective and efficient manner. I cannot imagine a more suitable climate for attaining these skills.

The provision of mental health services in schools is guided by many legal and professional standards. Key provisions of the federal Individuals with Disabilities Education Improvement Act provide legal standards for the availability of mental health services. Criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,* that pertain to children and youth promote an understanding of professional standards governing diagnosis. Both sets of standards underscore the importance of mental health services being guided by evidence-based intervention practices. The practice of cognitive behavioral therapy (CBT) meets these standards.

The content and organization of this book reflect the authors' extensive experiences in providing mental health services to children and youth within an educational context. Both have practiced as school psychologists, are highly regarded professors, and are accomplished scholars. The authors' extensive experiences providing CBT enable them to clearly describe its many therapeutic methods, align the methods with prevailing mental health disorders, and thus assist mental health practitioners in selecting and using those methods based on their evidence of effectiveness. The content in the book's many tables promotes comprehension

and its many exhibits promote applications. Thus, readers acquire foundational knowledge and methods with proven effectiveness in helping children and youth overcome mental health disorders. The authors are to be commended for their contribution to the promotion of mental health services to children and youth through this important book.

Thomas Oakland, PhD, ABPP, ABPN
Emeritus Professor, University of Florida
Honorary Professor, University of Hong Kong
President, International Foundation for Children's Education
Past President, International Association of Applied Psychology's
Division of Psychological Assessment and Evaluation

Preface

In *Cognitive Behavioral Therapy in K–12 School Settings: A Practitioner's Toolkit*, we have attempted to provide practitioners with an easily accessible and practical guide for implementing basic cognitive behavioral therapy (CBT) counseling strategies in K–12 school settings. Because of the unmet mental health needs displayed by millions of students in these settings and the advancements in the training and provision of school mental health services during the past couple of decades, school-based mental health professionals, such as counselors, school psychologists, social workers, and others, are increasingly being asked to provide evidence-based counseling and intervention services such as CBT. Therefore, to address this need, the current text provides an overview of methods used to conduct effective CBT interventions in school settings. Whether the reader is a graduate student in training, beginning a career in counseling, or a seasoned practitioner, this workbook can serve as an easy how-to guide because it offers numerous counseling activities and examples as well as forms to use when structuring session discussions.

The content covered in this text is nested within contemporary school-based service-delivery models, such as response-to-intervention (RtI) and multitiered systems of support (MTSS), which are becoming more commonly adopted and implemented in K–12 schools. In Chapter 1, this workbook first describes the need for mental health services in schools, noting the diagnoses most prevalent among school-age children, and then reviews progress-monitoring instruments for measuring counseling outcomes. The second chapter provides core components of CBT, including psychoeducation, cognitive restructuring for common thinking distortions, relaxation training, contingent reinforcement, and modern technology applications in CBT. A quick review of issues related to case conceptualization and contraindications for CBT are also provided in Chapter 2. Chapters 3 and 4 discuss symptoms of internalizing disorders and specialized CBT applications for internalizers. Chapters 5 and 6 provide symptom reviews for externalizers and counseling considerations for externalizing challenges. In addition, sample reports are included in Chapters 7 and 8 as templates for busy practitioners who need documentation of counseling outcomes or services rendered. The Appendix offers multiple reproducible student activity forms and resources. **The Appendix containing these forms and resources is also available for download from Springer Publishing Company's website. To download, go to www.springerpub.com/joyce-beaulieu.**

This book differs from many extant CBT guides and workbooks in that it is designed for the busy practitioner who primarily works in K–12 school settings and must balance a range of different roles and responsibilities. Thus, this book is not a comprehensive review of theory; rather, it aims to serve as a workbook that can be used to help practitioners get better acclimated with CBT and then integrate this therapeutic approach into their own regular practice. From decades of study, a wealth of research is available that supports the efficacy of CBT for treating various disorders and forms of psychopathology in youths, and this research has been applied and referenced in the construction of this text. Because of its format and the content, it is our hope that this book will be both engaging and useful for practitioners who work with students in K–12 school settings. We have found the strategies discussed in this text to have great utility in our own practice, and we trust that you will as well.

Acknowledgments

The foundational knowledge, research, and clinical expertise reviewed in this book are an invaluable gift from past and present visionaries who have dedicated their lives to meeting the mental health needs of others. Their research and legacy of scholarship have made the techniques discussed in this text possible. Thus, we are both grateful and humbled while we stand on the shoulders of great giants.

We are especially appreciative of the dedicated and scholarly contributions to this manuscript from Janise Parker, who coauthored Chapter 4, and Olivia Soutullo and Lee Purvis, who coauthored Chapter 3. It also has been a pleasure to work with Nancy S. Hale, who is the editorial director of social sciences at Springer Publishing Company. Her personal warmth and professional support, from guiding the original proposal to facilitating the final publication, have brought this project to fruition. Thank you!

Share
Cognitive Behavioral Therapy in K–12 School Settings: A Practitioner's Toolkit

PART I

Introduction to Cognitive Behavioral Therapy

ONE

Effectively Integrating CBT Counseling Into School Services

As noted in the Individuals with Disabilities Education Improvement Act (IDEIA, 2004, Part 300 A, Section 300.34 [c][2]), highly qualified school professionals with appropriate training, such as guidance counselors, psychologists, school psychologists, and social workers, are ideally positioned to be the first-line providers of counseling services to children and youth. With training in mental health issues and counseling techniques, these related-service school personnel have valuable expertise to contribute in serving children with mental health needs (American School Counselor Association, 2014; Center for Mental Health in Schools at UCLA, 2014; Joyce-Beaulieu & Rossen, 2014; National Association of School Psychologists, 2010; School Social Work Association, 2014).

Their training also includes an understanding of how to integrate services in educational institutions, child development and learning models, as well as in effective intervention design. Essentially, these personnel often know the most about psychology in schools and how to assist students who can benefit from receiving psychological services. The convergence of expertise in knowing each of these areas provides these professionals with the potential to synergize highly effective cognitive behavioral therapy (CBT) services within the intervention structure of schools. In other words, school support service providers are well positioned to tailor the provision of CBT to students who can benefit from these services as well as to then nest them within existing service-delivery frameworks at school.

The delivery of school-based counseling also is unique in that it removes many of the barriers to services, such as missed appointments due to transportation challenges, the hardship of lost employment time for parents, and the financial strain on families to pay for private mental health treatment.

Moreover, integrating counseling as a key component of school intervention service delivery can be highly beneficial for students because children are available multiple days per week to receive these services. Counseling plans also can be coupled with classroom behavior strategies to foster generalization of skills and a plethora of opportunities exist for teachers to reinforce concepts within their classrooms throughout the day. Additionally, school-based service delivery offers many opportunities to observe and monitor newly learned strategies in an authentic setting,

which can help ensure that lasting behavioral changes are achieved. Research suggests that providing school-based mental health services also can reduce disparities in the utilization of mental health services among minority youth (Cummings, Ponce, & Mays, 2010) given that school systems provide equal access to services regardless of the financial resources of families.

A report from the U.S. surgeon general estimates that 20% of school-age children experience mental health problems in any given year and nearly 10% to 15% of these students will suffer significant impairment in their ability to learn, be successful at school, make and keep friends, and maintain positive relationships with their caregivers because of these problems (Merikangas et al., 2010; United States Department of Health and Human Services [USDHHS], 2000). Thus, to prevent millions of students from experiencing negative outcomes at school and beyond, effective counseling and mental health services need to be much more widely available to students. Unfortunately, within the general population, 25% to 30% of students in the United States will not successfully graduate from high school, as every 9 seconds a student drops out of school. These data are even more devastating for vulnerable students with mental health needs. For students receiving services for emotional disturbance under IDEIA, the dropout rate (i.e., 44%) is higher than in any other disability category, including those with intellectual disabilities (United States Department of Education [USDOE], 2012). For African American and Latino American minority youth, the dropout rates are even higher, at nearly 50% (Greene & Winters, 2005). Among U.S. students who drop out, a significant portion experience mental health challenges, including stressful life circumstances and adjustment issues, throughout their education that could benefit from counseling. Lastly, mental health issues among youth are a global problem that extends well beyond the boundaries of the United States and thus intervention is likely to be a prevalent need among newly immigrating students as well. In this regard, a study by the World Health Organization indicates that mental health problems account for nearly half of all disabilities internationally among individuals between the ages of 10 and 24 (Gore et al., 2011). The provision of high-quality and targeted counseling interventions can assist these students to stay in school and to complete their education. Collectively, these findings highlight a critical need to provide mental health interventions to at-risk students before their problems become pervasive or chronic.

Schools and school-based mental health professionals can have a significant impact in addressing the unmet emotional, behavioral, and mental health needs of youth. Research indicates that the majority of youth (i.e., 70% to 80%) who do receive mental health services access these services through their local school districts (Hoagwood & Erwin, 1997; Rones & Hoagwood, 2000). Based on these data, the American Academy of Pediatrics (2004) has advocated for the provision of more school-based mental health services, noting the benefits of better access to assessment/evaluation and treatment or intervention compliance. Additionally, through the surgeon general's national agenda, mental health services are considered a national priority for all children, including intervention research and behavioral support delivered within the school. In particular, students from underrepresented groups, those living in poverty, and those with disabilities present with vulnerabilities that warrant considerations for early school-based intervention services (USDHHS, 2000, 2001).

Counseling in schools can come in many forms and it can be tailored to support a wide variety of developmental concerns. In elementary school, first-tier counseling services often include addressing systems-wide issues related to bullying

prevention, character values, stress reduction, prosocial life skills, and consulting on educational issues. Second-tier counseling services often provide small-group and individual counseling for friendship groups for new or shy students, self-esteem building, teaching self-regulation in regard to classroom rules or expectations, peer mediation, conflict resolution, grief counseling, organization skills, understanding body changes as puberty approaches, addressing abuse or family crisis, and advising on personal hygiene or appropriate social boundaries. Addressing all of these needs generally involves explicitly teaching skills to the child through counseling strategies or collaborating with the family to improve temporary life stressors. In middle and high school, first-tier systems-wide counseling services may include life-skills training, bullying prevention, substance use prevention, as well as consulting as a member of leadership teams on educational issues. Second-tier, short-term, or individualized counseling interventions for older students often address increasing interpersonal communication skills, goal setting, social skills, and career planning. All of these counseling functions noted are vital in schools. However, for students with the most pervasive and severe mental health disorders, the services noted previously may not be adequate, as these students require more extensive and formalized therapeutic approaches, such as CBT, to address social and emotional dysfunction. Therefore, because of the importance of understanding the problems encountered by these youth, the next section reviews mental health diagnoses and subsequent chapters describe how CBT strategies can be tailored and applied to address problems encountered by youth who display particular internalizing and externalizing disorders.

DSM-5 CHILD AND ADOLESCENT DIAGNOSES AND AGE OF ONSET

A brief overview of the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5;* American Psychiatric Association [APA], 2013) diagnoses that are common to school-age children is provided in this section as these are the students most likely to require more intensive or therapeutic counseling interventions, such as CBT. Additionally, a wealth of research over the past few decades indicates that very specific components of CBT are well suited and effective for treating many of these specific disorders or forms of psychopathology; however, the exact same CBT components are not equally effective for each type of diagnosis. For example, exposure and response prevention (E/RP), a type of therapy that falls under the CBT umbrella and involves facing one's fears while abstaining from engaging in anxiety-reductive compulsions, has been found to be a first-line treatment for obsessive-compulsive disorder in children (Jordan, Reid, Mariaskin, Augusto, & Sulkowski, 2012). In contrast, the same CBT method of E/RP could be contraindicated for a child with conduct disorder. Thus, being aware of specific symptoms of these disorders can assist in planning CBT sessions to focus on the correct targeted skills, avoiding both wasted time and counterproductive methods (Poitevien, Sloan, & Joyce, 2014; Soutullo, Palma, & Joyce, 2014; Sulkowski, Joyce, & Storch, 2011).

Research suggests that over one half of all lifetime mental health diagnoses first manifest during childhood/adolescence, and up to three fourths of all syndromes emerge before age 24 (Kessler et al., 2005). The early emergence of a wide range of mental health issues is illustrated in Table 1.1, which provides a review of the newly published *DSM-5* (APA, 2013). Therefore, it is important for counselors to consult the *DSM-5* when they are seeking to better understand the students they work

TABLE 1.1 Common *DSM-5* Psychiatric Disorders With Typical Age of Initial Diagnosis

DSM-5 Disorders—Prevalence Rate and Typical Age-of-Onset Range	Percentage	Childhood											Adolescent						Postsecondary						Gender
Age		2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
ADHD	5.0																								> M
Adjustment	5.0–20																								?
Anorexia Nervosa	0.4																								> F
Antisocial Personality	0.2–3.3																								> M
Autism Spectrum	1.0																								> M
Avoidant Personality	2.4																								> M
Bipolar I	0.6																								> M
Bipolar II	0.3																								M = F
Borderline Personality	1.6–5.9																								> F
Bulimia Nervosa	1.0–1.5																								> F
Conduct	2.0–10																								> M
Cyclothymic	0.4–1.0																								M = F
Disruptive Mood Dysregulation	2.0–5.0																								> M
Excoriation (skin picking)	1.4																								> F
Histrionic Personality	1.8																								> F
Generalized Anxiety	0.9																								> F
Hoarding	2.0–6.0																								> M
Intermittent Explosive	2.7																								> M
Major Depressive	7.0																								> F
Narcissistic Personality	≤ 6.2																								> M

Obsessive-Compulsive	1.2																							> M
Obsessive-Compulsive Personality	2.1–7.9																							> M
Oppositional Defiant	1.0–11.0																							> M
Panic	2.0–3.0																							> F
Paranoid Personality	2.3–4.4																							> M
Persistent Depressive	0.5																							?
Posttraumatic Stress	8.7																							> F
Reactive Attachment	?																							?
Schizoid Personality	3.1–4.9																							> M
Schizophrenia	0.3–0.7																							> M
Schizotypal Personality	4.6																							> M
Selective Mutism	0.03–1.0																							M = F
Separation Anxiety	1.6–4.0																							M = F
Social Anxiety	7.0																							> F
Somatic Symptom	5.0–7.0																							> F
Specific Phobia	5.0–16																							> F
Tourette's	3.0–8.0																							> M
Trichotillomania (hairpulling)	1.0–2.0																							> F

Note: Data in this table are based on *DSM-5* prevalence, development, and course information related to childhood through early adulthood, unless data were available only for adults. Neurocognitive and substance use disorders are excluded. Light grey shading indicates Pre-K to 12th grade; dark grey shading denotes college age.
?, unknown based on *DSM-5*; gender data (M, male; F, female); ADHD, attention deficit hyperactivity disorder.

with, conceptualize their treatment plans, and enhance their understanding of potential factors that may influence an individual's psychiatric presentation (Joyce-Beaulieu & Sulkowski, in press).

Elementary behavior specialists, counselors, and school psychologists are likely to receive initial teacher referrals for disorders during specific educational windows depending on the developmental course of specific syndromes. Because of this, practitioners who are in elementary schools may encounter significantly different needs from those who are primarily servicing students and others in secondary education settings (see Table 1.1). Additionally, teacher and parent referrals during the initial emergence of mental health needs may require the provision of both assessment and intervention services, whereas needs that are recognized in later educational years may be primarily intervention focused to ameliorate or diminish the negative effects of needs that have already been identified. With appropriate intervention, some disorders seem to resolve within a prescribed time frame (e.g., reactive attachment disorder), whereas others are more episodic based on stressors and temporal factors (e.g., adjustment disorders, major depressive disorder, posttraumatic stress disorder) that can reoccur along with negative life events throughout a student's educational years. Symptoms of other mental health disorders are chronic in nature (e.g., attention deficit hyperactivity disorder [ADHD], autism spectrum disorder, persistent depressive disorder, and schizophrenia) and they may require more sustained school and even community services throughout their educational experience. The following list denotes disorders that are most likely to occur first during specific grades and are more likely to be treated initially by counselors in those school levels.

- Preschool or elementary school: ADHD, autism spectrum disorder, reactive attachment disorder, selective mutism, separation anxiety, specific phobia, and Tourette's disorder
- Middle/high school: Excoriation (skin picking) disorder, social anxiety disorder, and trichotillomania (compulsive hairpulling)
- Postsecondary/college: Antisocial personality disorder, avoidant personality disorder, bipolar type I disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, obsessive-compulsive personality disorder, and paranoid personality disorder

Other disorders are more variable in their onset range with onset ages that span from childhood to adolescence or preadulthood. These disorders include the following: adjustment disorder, anorexia nervosa, bulimia nervosa, conduct disorder, disruptive mood dysregulation disorder, generalized anxiety disorder, hoarding disorder, major depressive disorder, obsessive-compulsive disorder, oppositional defiant disorder, panic disorder, persistent depressive mood disorder, posttraumatic stress disorder, schizoid personality disorder, schizophrenia, schizotypal personality disorder, separation anxiety disorder, and somatic symptom disorder. Because the onset of these disorders spans many different academic years and school levels, practitioners serving children of all ages will likely need counseling skills to help students who are affected by these disorders.

Regarding the goal of helping students with disorders that present late in their youth or carry over into their young-adult years, specific mental health supports and transition services are often needed. School-based mental health service providers may be involved with formal efforts to prepare students with mental health needs for successful entrance into postsecondary education settings and related opportunities

through their participation in federally mandated transition planning efforts (Joyce & Grapin, 2012; Joyce-Beaulieu & Grapin, 2014; Sulkowski & Joyce, 2012).

Beginning at age 16, written transition supports are legally mandated and written into the individualized education plans of students with disabilities (USDOE, 2011). Depending on the student, these supports may include counseling interventions that build self-efficacy, mental health wellness, and/or self-advocacy for continuing mental health supports in college or in workplace transitions. Services for students with disabilities also extend to direct service provision in postsecondary education mental health centers and college disability centers for traditional college enrollment. Now more than ever, the lines are blurred between high school and college as 70% of high schools offer dual enrollment, typically from ninth grade or higher (although some states, such as Arizona, have no age limit), thus increasing the number of adolescent-aged students who receive instruction in college settings for at least part of the day (National Research Center for Career and Technical Education, 2010; USDOE, 2013). Therefore, some counseling for high school students may occur within the postsecondary institution in which they are dual enrolled.

Counseling Within Multitiered Systems of Support in Schools

Although a wide range of mental health services are available through community agencies and private practitioners, a review of the status of national mental health care for youth indicates those services are most often accessed in a fragmented and noncomprehensive manner. This has often resulted in low effectiveness, especially for more chronic or severe mental health problems (USDHHS, 2000). Response to intervention (RtI) and multitiered systems of support (MTSS) are models of school-based service delivery that have evolved over the past two decades to provide schools with the infrastructure to offer a continuum of multifaceted counseling and behavioral supports to students who display a range of academic, behavioral, and mental health needs (National Association of State Directors of Special Education, 2008a, 2008b; Sulkowski & Michael, 2014; Sulkowski, Wingfield, Jones, & Coulter, 2011).

The overarching RtI/MTSS frameworks incorporate a multitiered approach to service delivery to help students at varied levels of need. At the first tier of service-delivery (Tier I), general emotional and behavioral health as well as preventive universal or school-wide services are delivered to meet the needs of approximately 80% to 85% of students. At the second tier (Tier II), interventions are provided for students who display needs that cannot be adequately addressed by Tier I services alone and are at risk for academic failure or other negative outcomes. Tier II services are predicted to serve 5% to 15% of the population and these services are designed as short-term, low-intensity interventions that may be structured around a protocol or prescribed curricula and they often are provided once or twice a week for 6- to 12-week periods as well as in group settings. Tier II interventions tend to address more common student needs and may include elements of CBT or CBT strategies as needed (e.g., relaxation training, identifying negative emotional states), although other methods may be employed as well. Examples might include friendship groups, social skills training groups, self-esteem building exercises, or conflict-resolution strategies. When students respond well to the intervention, a problem-solving team may decide to close intervention. If it is determined that a more intensive intervention is needed, students are provided more individualized, longer term, and often more frequent intervention. This third tier often supports 1% to 5% of the student

population. Examples might include a semester or more of CBT therapy sessions, two or more times per week, to address depression or a sequence of anger management/self-regulation interventions.

Students requiring Tier III services often have a multifaceted support plan that may include other behavioral interventions in addition to counseling (e.g., mentoring, behavior plans with daily behavior report cards). For students with needs that require sustained intervention, special education eligibility may be considered with a classification of emotional disturbance (ED). Once identified, individuals needing emotional disturbance services may continue to require a structured counseling regimen for multiple years in addition to supplemental mental health supports (e.g., behavior modification, outside counseling or family therapy coupled with school counseling, and sometimes psychopharmacology). A quick review of behavioral modification strategies that school personnel can utilize to supplement or enhance multifaceted interventions is noted in Table 1.2.

TABLE 1.2 Behavior Modification Strategies

Technique	Description and Goals	Key Points for Implementation
Shaping	Shaping is utilized to encourage an individual to exhibit a target behavior by reinforcing successive approximations of that behavior over time. It is best applied when there is a large gap between a student's current behaviors and the desired behaviors.	■ Identify target or desired behavior goal. ■ Identify a behavior in the individual's present repertoire as a starting point for reinforcement. ■ Select an appropriate reinforcer. ■ Create a sequence of successive approximations of the behavior. ■ Reward successive approximations of the behavior until the child arrives at the target behavior. ■ For example, if targeting completing math worksheets, start by rewarding completion of one item, then two items, etc., to completion.
Fading	Fading is used to encourage an individual to demonstrate a target behavior across multiple settings. This is accomplished by gradually changing one setting, in which the behavior already occurs, to a second setting. *Note: This technique calls for changes in settings rather than changes in behaviors.*	■ Identify the setting in which the behavior is already occurring. ■ Identify a setting in which the behavior should occur (i.e., target environment). ■ Create a sequence of successive approximations of the target environment. ■ Use a token economy to reward the display of appropriate behaviors in the target setting as the child progresses through this sequence. ■ For example, if a child learns to control anxiety in counseling sessions but cries when in class, gradually increase number of persons in counseling activities, until she or he is more comfortable with others, then move to classroom full of students.
Chaining	Chaining is used to encourage the student to exhibit a series of related behaviors (i.e., to strengthen a sequence of new responses that ultimately elicit the target behavior). Chaining can also be used to weaken maladaptive behavior patterns.	■ Identify response patterns in the old behavior chain, starting back far enough to include responses that prompt the undesired behavior. ■ Write a new behavior chain that prompts the target behavior.

(*continued*)

TABLE 1.2 Behavior Modification Strategies (*continued*)

Technique	Description and Goals	Key Points for Implementation
		■ Model the new behavior chain and have the child follow the new sequence. ■ Reinforce the child for successfully implementing the new chain. ■ For example, if a student is chronically late from lunch, teach a new response (e.g., clean lunch tray up earlier, quicker route back to class), model and remind her; if she or he forgets, walk back to cafeteria and rehearse.
Contingency contracting	Contingency contracting is used to increase the occurrence of a low-frequency behavior. In this technique, permission to engage in high-frequency behaviors is made contingent on the performance of a low-frequency behavior.	■ Establish a contract to determine the terms of contingency between the low- and high-frequency behaviors. ■ Reward the child frequently with smaller amounts of the preferred or high-frequency activity and only after he or she has executed the low-frequency behavior (i.e., do not provide noncontingent reinforcement). ■ For example, give 10 minutes of preferred computer time for 1 hour of work completion.
Token reinforcement	The purpose of token reinforcement is to increase the occurrence of desirable behaviors and/or to decrease the occurrence of problematic behaviors by systematically reinforcing the goal behavior.	■ Identify and define problematic behaviors as well as appropriate replacement behaviors. ■ Identify tokens, feasible reinforcers, and a schedule of reinforcement. ■ Provide reinforcers when desired behavior occurs. Implement a response cost when inappropriate behaviors are exhibited. ■ For example, a child earns tokens toward a reinforcer for work completed; not turning in assignments could result in token reduction.
Replacement behavior training	Replacement behavior training is used to teach new behaviors and skills that can be used in place of problematic behaviors.	■ Identify and define the problematic behavior. ■ Identify and teach the individual replacement behaviors. This may require modeling and opportunities for student practice. ■ Implement schedule of reinforcement for replacement behaviors. ■ For example, each time a student prone to impulsive anger says "excuse me" or uses an "I" statement, offer points toward earning a reinforcer.
Interdependent group-oriented contingency management	This technique is a group management system that reinforces the behaviors of a group as a whole. The goal of this strategy is to increase appropriate behaviors while simultaneously decreasing classroom disruptions; groups also may persuade individuals to cooperate.	■ Divide the class into groups or teams. ■ Model appropriate behaviors and instruct students to role-play behavior. ■ Identify a group reinforcer (e.g., points, reward). ■ Post a visual representation of points earned or lost. ■ Reinforce the winning team at predetermined intervals. ■ For example, groups caught displaying good social skills earn points (e.g., helping others, quiet group projects, saying "thank you").

(*continued*)

TABLE 1.2 Behavior Modification Strategies (*continued*)

Technique	Description and Goals	Key Points for Implementation
Precorrection and prompting	This technique is designed to encourage the display of appropriate or desirable behaviors, especially when it is likely that the individual will need reminders to do so.	■ Identify the context in which problem behaviors typically occur and clarify behavioral expectations for that setting. ■ Define/model expected behaviors, have student role-play behavior. ■ Provide reinforcement for appropriate behaviors. ■ Provide cuing and prompting as needed for appropriate behaviors. ■ For example, prompting a withdrawn student to join a group or cuing the student on introductory comments (e.g., "say hello to Juan").
Differential reinforcement of alternative or incompatible behavior	The purpose of this technique is to weaken maladaptive behaviors by simultaneously strengthening an incompatible or competing response.	■ Identify and define the problematic behavior. ■ Identify a competing behavior (i.e., one that will be incompatible with the problem behavior). ■ Reinforce occurrences of the competing behavior while ignoring or redirecting the student when the problematic behavior occurs. ■ For example, when targeting classroom running, reward in-seat behavior or walking behaviors.
Self-monitoring	Self-monitoring is used to increase the individual's awareness of his or her behaviors and to encourage him or her to self-regulate while working toward a goal.	■ Identify target behavior to be monitored. ■ Set intervention goals as well as time frame for goal. ■ Provide child with a cuing graphic, list, or behavior chart. ■ Define and describe steps for self-monitoring the behavior and model them for the student. ■ For example, a shy student might mark his or her own behavior chart each time he or she initiates a conversation with someone; try to increase total interactions each day or weekly.
Self-reinforcement	This technique is used to encourage students to reinforce their own appropriate behaviors with either tangible or intangible rewards.	■ Identify an appropriate reinforcer. ■ Determine contingencies for earning the reinforcer. ■ Describe and model steps for earning and accessing the reinforcer. ■ For example, student can self-initiate a 2-minute Internet surfing break after 30 minutes of work completion in the library.

Source: Alberto and Troutman (2012); Kaplan and Carter (1995).

Progress Monitoring

A key factor in well-implemented RtI/MTSS intervention models is the mandate for data-based decision making and the utilization of progress-monitoring measures to track student outcomes. Progress monitoring offers a number of benefits, including feedback to the counselors on how well interventions are working, information to decide when goals are met and therefore when counseling can be ended, as well as guidance on when students may require more intense services or multifaceted intervention plans. This section reviews several easy methods for collecting progress-monitoring data on the effectiveness of counseling interventions:

knowledge/skill testing, subjective units of distress (SUDs) data, naturally occurring school performance data, observational data, daily behavioral report cards, behavior rating scales, and the new *DSM-5* cross-cutting symptomology measures. In Chapters 7 and 8 there also are several sample counseling reports that include examples of the progress-monitoring methods discussed in this section.

Best practices associated with psychoeducational assessment involve employing a multifaceted approach that includes gathering information across multiple settings, at multiple times, and from multiple sources, using multiple data-collection methods (American Psychological Association, 2014; Saklofske, Joyce, Sulkowski, & Climie, 2013). Although originally written for comprehensive test design, these principles also are valuable for conducting brief intervention outcome-related measurements, such as posttreatment assessments. By acquiring data across multiple settings, personnel can ensure that the student is applying the new skills throughout the day and generalizing to other contexts outside of the therapy sessions. This data provides strong evidence that a student has adopted the new strategies and the counseling has had positive impact. A benefit of gathering information multiple times is to establish that new knowledge or improved emotional mood is stable. For example, by measuring a child's feelings of anxiousness across several sessions and establishing a period of time that the stress remains low can indicate stable improvement and perhaps a good rationale for closing the intervention; whereas one session of not feeling anxious does not provide enough information to determine whether intervention should be withdrawn. Additionally, if the first measures are made prior to the counseling, the data will provide information on the student's baseline level of functioning in a particular domain (e.g., anxiety, social skills) that can be compared to later levels of functioning that are assessed during or after treatment to provide stronger evidence of improvement. By collecting information on a student's level of functioning across multiple sources (e.g., teacher, parent, self-report), possible rater biases can be controlled. For example, a parent's overly optimistic perceptions of his or her child may not be supported by data provided by another caregiver or by adults at school. Of course, to rule out or control for rater biases high-quality rating measures are needed. These include validity scales that alert practitioners to inconsistent or overly negative/positive rating patterns. Through measuring multiple variables, practitioners can ensure that complex sets of skills are thoroughly assessed before recommendations to change or discontinue services are made. An example of this might include measuring both the child's knowledge of new relaxation techniques and positive self-affirmations as well as obtaining his or her self-rated feelings of anger. These data coupled with observations of her or his use of the relaxation techniques in a natural setting (i.e., in class when frustrated, on the playground when provoked by peers) and decreasing discipline referrals for angry outbursts would offer a well-rounded set of data for intervention decision making that would be consistent with an RtI model of assessment and service delivery.

Traditionally, intervention effectiveness decisions have relied on anecdotal evidence (e.g., teacher report of improvement), which subsequently left unanswered questions about whether reported changes were stable, enduring, adequately learned, and generalizable to other settings, thus transportable to other contexts or applicable in similar situations that the student may encounter. Fortunately, there are many quick and easy progress-monitoring methods available that offer greater validity and reliability than anecdotal reports. The following sections offer a brief

review of counseling progress-monitoring methods with the understanding that the practitioner's choice of specific methods (or combinations of measures) will depend on the complexity of the presenting problems displayed by the student and the targeted goals of CBT.

Knowledge/Skills Testing

Often through the CBT process, a number of new skills are taught. These skills might include being able to identify and describe one's feelings, employing self-calming and relaxation techniques (e.g., diaphragmatic breathing, progressive muscle relaxation), challenging negative self-talk or cognitive distortions, interacting more effectively with peers, or becoming more assertive in getting one's need met in a prosocial manner. The student's awareness of these skills can provide a good comparison of pre- and posttest knowledge. For example, this might occur by having the counselor inquire during the first session as to how many (and what) self-calming techniques a student knows or how many (and what) feeling words he or she can recall and pair with facial expressions (e.g., sad, mad, angry). When measuring this knowledge, it is important to have the child recall without providing him or her with cues that can give away answers or simply stating his or her opinion of how many new strategies he or she has acquired. Having the child demonstrate the skill also is a strong measure of knowledge acquisition.

Figure 1.1 illustrates pre- and posttest progress-monitoring data for a small-group application of CBT addressing test anxiety. In general, the goal of the CBT sessions was to provide support for the four students who had similar needs. Teacher referrals indicated that the students became very anxious prior to important tests and they also had been observed to voice maladaptive and self-deprecating statements when they were presented with tests. These statements were as follows: "I'm

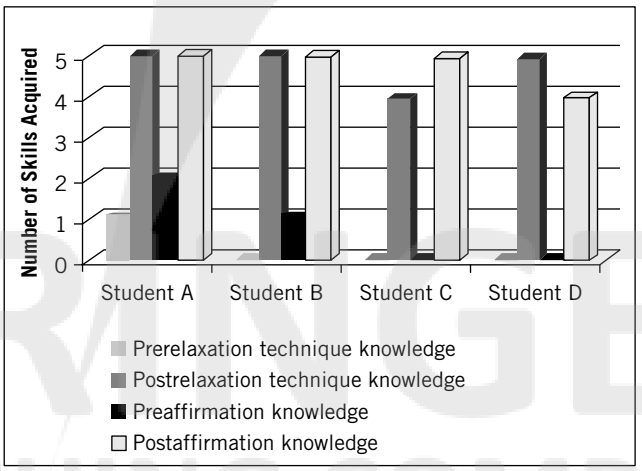


Figure 1.1 Knowledge acquisition progress-monitoring sample. Cognitive behavioral therapy test anxiety group, pre- and posttest knowledge of five relaxation and five positive self-affirmations taught.

never good at tests" (overgeneralizing), "That test is gonna be impossibly hard" (fortune-telling), and "I'm just stupid" (labeling). Counseling sessions addressed several of the cognitive distortions displayed by the students by teaching the students to identify and employ more adaptive positive self-affirmations as replacement thoughts.

The replacement thoughts that the students in the aforementioned example came up with and began to apply to challenge their cognitive distortions included: "I've passed tests before and I can do it again," "This test might be hard but I can give it my best. If I don't get the grade I want, I can try harder for the next test," and "Sometimes I may feel stupid but everyone does. I actually do quite well at school sometimes." As one can see, all of the replacement self-affirmations are more adaptive, objective, and rational than were the cognitive distortions that they used to harbor. Additionally, these statements are not overly Pollyannaish or unreasonably or illogically optimistic. Instead, they provide relief by reducing students' use of negative thoughts as opposed to artificially inflating their use of positive ones.

In addition to cognitive restructuring, several relaxation skills were taught to help the students manage their anxious feelings associated with being tested (e.g., imagining a calm place, diaphragmatic or belly breathing, progressive muscle relaxation or systematically tensing and releasing muscles, counting backward slowly from 10, and taking a 5-second break to close their eyes). It is important to note that not all relaxation strategies work for all people and some people even experience heightened anxiety when they try to implement these strategies. Therefore, a counselor may need to coach students through the use and application of several of these strategies to discover which ones will benefit particular students the most and which ones should be abandoned.

In this example provided in Figure 1.1, student A knew one relaxation strategy at the beginning of the CBT sessions and the other students did not know any of these strategies. However, all of the students acquired knowledge of various relaxation techniques by the end of the intervention. Prior to intervention, students A and B reported that they periodically employed one to two positive self-affirmations, whereas students C and D did not employ any of these thoughts. By the end of the intervention, all students had replacement affirmations they could apply when they felt anxiety associated with having to take tests. The change in knowledge of the aforementioned skills by students across the time that they received interventions suggests an improvement in their knowledge. However, it does not indicate that they effectively used or benefited from these skills. Thus, to assess the former, other measures, such as conducting direct observations and behavior rating scales, could be a good supplement to determining whether the interventions were effective for each child. If it is determined that some students have acquired knowledge of the aforementioned skills but still are not effectively applying them as evidenced by the continued display of self-defeating statements, highly anxious body language during testing, or elevated self-report ratings of anxiety, reteaching the skills or implementing supplemental intervention strategies (e.g., behavior management incentive plan) might be warranted. Chapter 8 includes two comprehensive CBT case examples and reports that utilize pre- and posttest knowledge as counseling outcome data to more fully elucidate the methods discussed in this chapter (see Jim and Fisher cases).

Subjective Units of Distress

Subjective units of distress (SUDs) measurement is simply based on self-reported feelings (e.g., anxiousness, fear, and anger) that individuals experience in the moment when asked. The method can be utilized for a number of counseling purposes but is often applied during behavioral exposures to assess the degree of anxiety that an individual is experiencing when facing a feared situation or stimulus. A more detailed explanation for the procedure of using SUDs is provided in the section on the exposure/response prevention therapy technique in Chapter 4; however, a basic review of this process is worth mentioning in this chapter. The student and the therapist can work together to help create the SUDs scale and it can have a wide or small range of points (e.g., 1 to 100, 1 to 10). For younger children, it may be helpful to use a smaller number of points and to provide descriptors on the scale adjacent to the numbers that the student chooses to make it personally more meaningful (e.g., "10 = freaking out," "4 = a little scared," 1 = "easy"). However, for assessing and interpreting progress-monitoring data, it will be important to report the scale number rather than the qualitative descriptors. Additionally, using pictorial representations may assist younger students in conceptualizing the scale (e.g., thermometers, rulers, rising stars). Pictorial themes may be especially appealing if they reflect the child's personal interests (e.g., sports, animals, rockets blasting off). Two samples of pictorial feelings scales for younger students are provided in the Appendix (see Appendix, Exhibit 1.1 Subjective Units of Distress Scale: Feeling Thermometer, and Exhibit 1.2 Subjective Units of Distress Scale: What I Feel Inside forms).

SUDs data can be collected at each session, across the duration of intervention at select points (e.g., every 3 weeks), or multiple times within a session (particularly when ERP is occurring). Figure 1.2 provides an example of SUDs progress-monitoring data on an anxiety scale with a range of 1 to 100 (100 = extremely high anxiety, 0 = absolute calm). This example reflects self-reported SUDs scale measurement every 5 minutes across five exposure counseling sessions. In this example, an adolescent student was afraid of crowds or being in dense groups of people

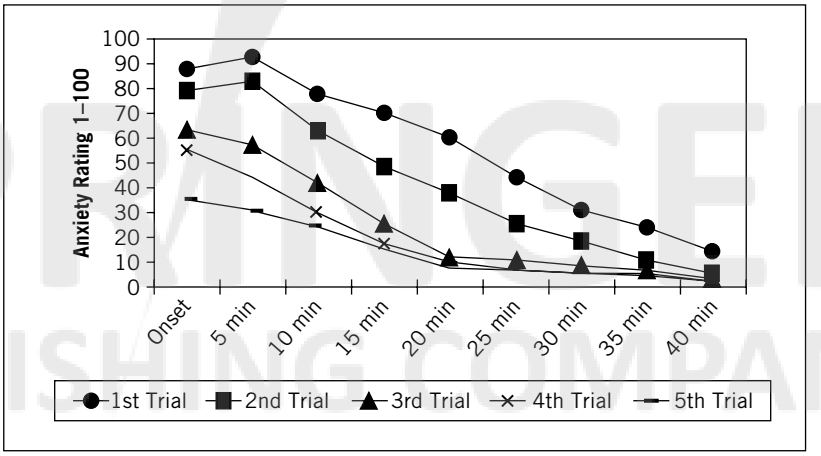


Figure 1.2 Subjective units of distress data progress-monitoring sample; exposures to crowded situations at school.

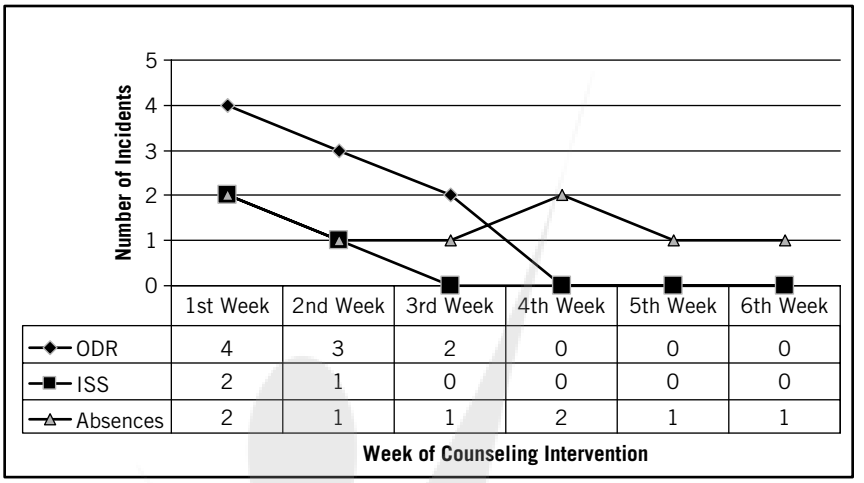
(e.g., in crowded hallways). This fear resulted in him avoiding the cafeteria, missing required auditorium meetings, and avoiding participating in large-group activities (e.g., band practice).

Prior to engaging in the counseling intervention, the student and the school psychologist worked together to come up with a hierarchy of feared situations and the student agreed to confront these situations. Therapy was first structured to have the student confront his anxious thoughts associated with being in crowded places through engaging in imaginal exposures. Then a series of graduated in vivo (i.e., in real life) exposures (e.g., sitting in back of cafeteria during lunch, joining a band practice, attending the all-school meeting in the auditorium) were attempted, with the counselor accompanying and monitoring the student's self-reported stress level. According to the student's subjective report, his level of initial anxiety was a 90/100 SUDs during the first exposure trial. However, his anxiety decreased to significantly lower levels with each subsequent exposure trial (i.e., 80/100, 63/100, 58/100, 37/100). Additionally, the pattern of data within each session indicated that the student's SUDs quickly dropped within about 5 to 10 minutes after exposure, which is relatively common for many youth with anxiety problems. During trials three to five, the student reported low distress via his SUDs ratings at 15 minutes postexposure. Overall, these data indicate the student is responding favorably to E/RP and benefiting from treatment as evidenced by reductions in overall distress at the outset of each exposure session as well as reductions in distress following each exposure. Sample reports utilizing SUDs as a progress-monitoring measure are included in Chapters 7 and 8 (see Carlos and Jim cases).

Naturally Occurring School Data

A number of readily available sources of behavioral data can be easily accessed by school-based mental health practitioners. Often these data are directly related to the counseling referral concerns and the preferred outcomes that are desired post intervention. As an example, for students with externalizing or acting-out behavioral problems, important and relevant school data to track include office discipline referrals (ODR), in-school suspensions (ISS), and incidents of out-of-school (OSS) suspensions. For youth with the aforementioned problems and a significant discipline history, counseling strategies often aim to foster self-regulation, anger-management, or conflict-resolution skills, which, if successfully learned and applied, likely will result in reductions in ODR, ISS, and OSS incidents. Similarly, for students who are disengaged academically, display fragmented or low rates of school attendance, or who have a history of school avoidance, attendance data, number of days tardy, rates of work completion, grades, and credit deficiencies are easily accessible data sources that can help with measuring the efficacy of intervention. As a third example, for anxious students with high numbers of unjustified nurse visits and unnecessary requests to go home for somatic complaints (i.e., headaches, stomach pains), their nurse-visit data can be tracked across the counseling intervention sessions to show improvements. Nurse visits are logged daily, thus are easy to access and naturally occurring data within school systems.

Figure 1.3 provides an example of using naturally occurring school data for progress monitoring during the course of counseling intervention. To assess therapeutic progress, ODR, ISS, and school absences were reviewed as these data were tracked by schools as part of their general operating procedures and readily available



	1st Week	2nd Week	3rd Week	4th Week	5th Week	6th Week
ODR	4	3	2	0	0	0
ISS	2	1	0	0	0	0
Absences	2	1	1	2	1	1

Figure 1.3 Naturally occurring school data progress-monitoring sample.
ISS, in-school suspensions; ODR, office discipline referrals.

for review. The counseling sessions aimed to address impulse control difficulties in a student that resulted in numerous altercations with other students, disciplinary referrals, and subsequent school avoidant problems.

To help this student, cognitive restructuring was provided to challenge two cognitive distortions: jumping to negative conclusions and mind reading. In addition, anger management skills were taught that aimed to increase the student's emotional regulation skills and the use of "I" statements were taught to help him communicate his needs better in a nonoffensive manner. Lastly, the student was taught conflict-resolution skills (i.e., generating nonaggressive yet effective solutions for addressing interpersonal conflicts). Counseling for this student was individualized and it was delivered two times a week for 6 weeks for a total of 12 sessions. Additionally, motivational issues related to school attendance were addressed. Data indicate the student's ODR and ISS incidents steadily diminished to zero incidents post intervention so counseling appears to have had a positive effect, at least on part of the goals for better self-regulation. However, absences were not greatly improved during the intervention time frame; and thus, additional interventions to address attendance were warranted. A sample report utilizing naturally occurring school data (i.e., attendance, tardies) for progress monitoring can be found in Chapter 7 (see Brittany case).

Observational Data

School-based mental health professionals are highly familiar with observational data as this data is often requested by teachers who are trying to better understand puzzling or maladaptive student behaviors, physicians who are diagnosing ADHD or monitoring medication effects, as well as parents who have concerns regarding the interpersonal actions of their children. Observational data also can be utilized to measure counseling outcomes. Examples might include pre- and postintervention data for on-task behaviors when the goals of counseling are addressing self-regulation, attention, frustration tolerance, withdrawal, or work completion. Several factors

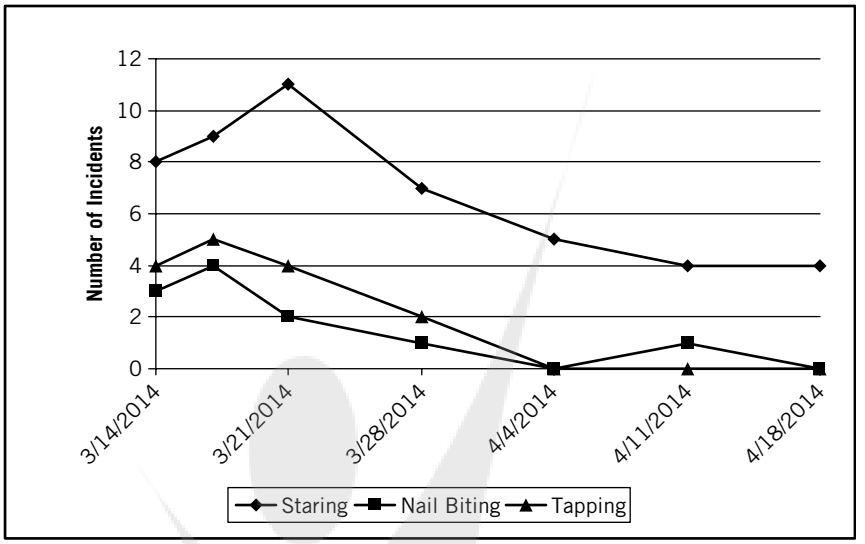


Figure 1.4 Observational data progress-monitoring sample; frequency of maladaptive behaviors during math quizzes.

can increase the utility of observational data: assuring that baseline functioning is documented for comparison to intervention measures, collecting samples across classes and times of day, as well as establishing peer comparisons.

An example of observational data is noted in Figure 1.4 for an anxious student with a history of maladaptive test behaviors that included significant nail biting, loud finger tapping, and staring episodes. These behaviors were interfering with his test performance and a goal of counseling was to challenge his cognitive distortions associated with catastrophizing: "I'll never pass math," "I can't get answers right on math tests," and "I'll never graduate or go to college without math." Further, a second goal was to teach him more appropriate replacement strategies that he could employ when he was anxious (e.g., relaxation techniques, positive self-affirmations). Results of this case study indicate that the student improved because he displayed fewer maladaptive behaviors related to his test anxiety. Chapter 7 provides a sample report that incorporates observational data as a counseling outcome measure (see Amia case).

Daily Behavioral Report Cards

Daily behavioral report cards are often utilized as a behavioral modification strategy and they involve identifying a few observable and objectively defined target behaviors that are positively phrased that the child strives to achieve each day. Examples might include: "Sally will raise her hand before asking questions" or "Juan turns in his homework at the beginning of each class." The child may be asked to have each teacher throughout the day note whether the behavioral goal is achieved. Usually this strategy requires a parent review and/or signature at the end of the day and it is tied to a specific reward if a certain number of points are earned. Often rewards can be delivered at both home and school to ensure the generalizability of the plan across settings as well as the presentation of desired behaviors. Rewards may be tangible objects or preferred activities and they are coupled with praise and recognition for

demonstrating positive or desired behaviors. The goals are set to be obtainable 75% or more of the time and the criterion for reward is moved up as the child reaches his or her behavioral goals. When used as counseling outcome data, the results from daily behavioral report cards may be confounded with the behavioral management/incentive effects. In other words, changes to behavior plans and related contingencies may make it challenging to generalize from these plans across different time points. However, it is not uncommon for students with high needs to require multifaceted interventions and coupling more than one method of support with the counseling effort is often a necessary strategy.

An example of a daily behavioral report card is included in Figure 1.5. The child's referral concern was task avoidance due to the student's perfectionistic tendencies, resulting in immediately giving up or stopping a task if he felt he might make a mistake. Counseling targeted challenging an all-or-nothing thinking cognitive distortion and it involved conducting behavioral exposures (i.e., managing distress associated with submitting less than perfect papers). Counseling also was coupled with a behavior plan that rewarded completed work as well as compliance with requests to try the work (even if it was not perfect). As reflected in the daily behavior report card, the goal was to complete at least six tasks per day and to comply at least six times daily with teacher requests to attempt work. Counseling was provided twice weekly for 6 weeks and results showed notable improvement by the third week. Chapter 7 provides a case example and sample report utilizing daily behavioral report card data for progress monitoring (see Amia case).

Behavioral Rating Scales

Rating scales come in a wide variety of formats and degrees of complexity, and they may or may not have norm-referenced scores. Four basic types of behavior rating scales have obvious utility for progress monitoring associated with implementing CBT in the schools:

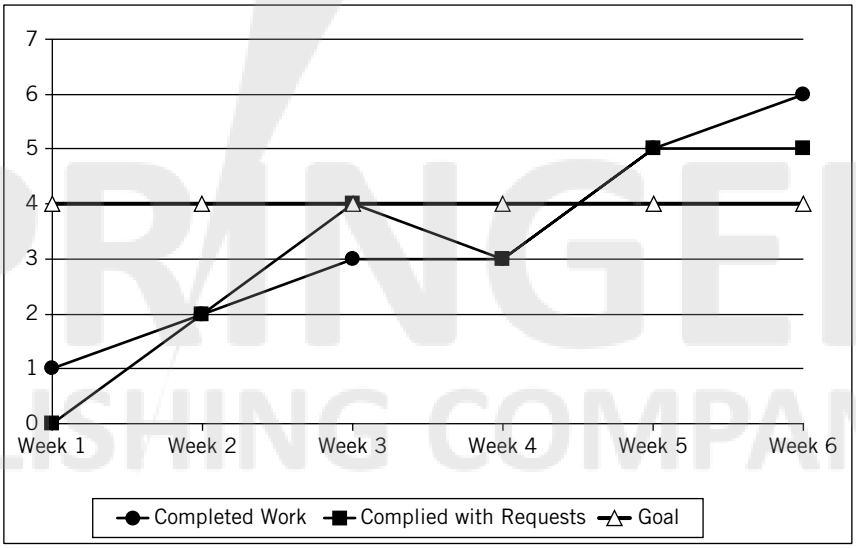


Figure 1.5 Daily behavioral report card progress-monitoring sample.

- Omnibus measures that sample psychopathology across a number of internalizing and externalizing domains and allow comparison to a nationally representative sample of children. The Behavioral Assessment System for Children–Second Edition (BASC-2) is one example of an omnibus measure that has multiple mental health scales (e.g., anxiety, depression, withdrawal, somatization, social stress, aggression, attention; Reynolds & Kamphaus, 2004). Although not necessarily intended to be used as a repeated measure of progress over a short period of time (e.g., instructions often ask for ratings of behavior over the past several weeks), this type of measure offers clinical norms and can be useful for measuring progress even within students who fall in the clinical range. A limitation of omnibus measures is often their length, as many have over 100 items.
- A second generation of rating scales emerged several years ago to provide quick options for Tier I screening in RtI/MTSS models. These measures typically contain 10 to 20 items and offer a single *T*-score that can be compared to national norms for identifying emotionally at-risk students. The Behavioral and Emotional Screening System (BESS) and the Conners 3 Global Index (Conners 3 GI) are examples of rating screener measures (Conners, 2008). These instruments can be used repeatedly to track progress; however, one limitation of these measures is that they only give one global score rather than tracking progress on specific symptoms.
- Third-generation rating scales have recently added progress-monitoring forms that are short/quick measures addressing targeted areas of intervention need. They are norm referenced and designed for repeated measures over short periods of time. Many also offer scoring and tracking software that create intervention progress-monitoring graphs. Examples include the BASC-2 progress-monitoring forms (e.g., externalizing and ADHD problems, social withdrawal, internalizing problems, and adaptive skills), Conners 3 ADHD Index (Conners 3 AI), the Children's Depression Inventory–2nd Edition Short (CDI-2), the Social Skills Improvement System (SSIS), as well as short versions of the Anger Regulation and Expression Scales (ARES-S; Conners, 2008; DiGiuseppe & Tafrate, 2011; Gresham & Elliot, 2008; Kovacs, 2004; Reynolds & Kamphaus, 2009).
- Self-made Likert scales can be created by the counselor to specifically target questions for the student and they can be highly individualized. Decisions made based on data collected with these scales must be made with caution, as they lack norm-referenced comparison information. Figure 1.6 provides an example of a therapist-created Likert survey with specific questions based on targeted counseling goals and teacher-reported referral needs. Counseling intervention report samples utilizing norm-referenced rating scale data can be found in Chapter 8 (see Jim, Fisher, and Amitola cases).

DSM-5 Cross-Cutting Symptomology Measures

For the first time, the new *DSM-5* manual offers a series of freely accessible measures of psychiatric symptoms that also can be used as progress-monitoring measures. The measures can be downloaded and reproduced without charge by clinicians for use with their patients from the APA's *DSM-5* website (www.psychiatry.org/practice/

TEST-TAKING SURVEY	Never	Sometimes	Always
1. Tests make me nervous.	1	2	3
2. I have to read questions over and over.	1	2	3
3. I have trouble concentrating during a test.	1	2	3
4. My mind goes blank during the test.	1	2	3
5. My head or stomach hurts before a test.	1	2	3
6. I worry about what grade I will get on a test.	1	2	3
7. My hands get shaky during a test.	1	2	3
8. During a test I forget things I knew before.	1	2	3
9. I don't sleep well the night before a big test.	1	2	3
10. I usually feel sick on the day of a test.	1	2	3

Figure 1.6 Test anxiety Likert scale progress-monitoring sample.

dsm/dsm5/online-assessment-measures). Forms include ages 6 through adult and offer self-ratings, parent ratings, and some clinician ratings. The following categories are available:

- Level 1 cross-cutting symptom measure includes adult symptom self-report (i.e., ages 18 and older), parent/guardian measures for ages 6 to 17, and child self-report measures (i.e., ages 11 to 17) with 25 items across 12 domains: depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use.
- Level 2 cross-cutting symptom measures include several brief adult (i.e., age 18 and older), parent-report (i.e., ages 6 to 17), and child self-report (i.e., ages 11 to 17) symptom domain-specific measures (e.g., depression, anger, mania, anxiety).
- Disorder-specific severity measures—these measures offer symptom severity ratings for several syndromes (e.g., depression, separation anxiety disorder, social anxiety) that may be particularly important to diagnosis criteria where severity specifiers are indicated. Adult, child, and clinician-rated forms are available.
- Disability measures—these measures are based on the World Health Organization Disability Assessment Schedule 2.0 (WHODAS-2; World Health Organization, 2010). They include 36 items and assess disability impact across six domains: understanding/communicating, getting around, self-care, getting along with others, daily life activities, and integration/participation in society.
- Personality inventories—personality inventories are provided for adult (i.e., age 18 and older), child (i.e., ages 11 to 17), and parent report (i.e., ages 6 to 17). Five personality domains are included (i.e., negative affect, detachment, antagonism, disinhibition, and psychoticism).

- Additionally, the *DSM-5* site offers early development and home background interview forms as well as cultural formulation interviews that may be helpful during the case conceptualization stage of planning for CBT sessions. An example of *DSM-5* rating data (i.e., level 2 cross-cutting measure for somatic symptoms and severity measure for separation anxiety disorder) is included in the sample report for Brittany in Chapter 7.

CBT EFFICACY IN SCHOOL-BASED APPLICATIONS

There are many different theoretical orientations for counseling; however, CBT is one of the most effective approaches as noted by the American Psychological Association's Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1998). CBT has a long history of empirical support among clinical service providers for helping students with ADHD, anxiety, OCD, PTSD, panic attacks, and phobias (Albano & Kendall, 2002; Kendall, 2006; Salloum, Sulkowski, Sirrine, & Storch, 2009).

CBT also has been successfully adapted to provision of services within school settings for a wide range of disorders, including depression, anxiety, ODD, posttraumatic stress disorder, and obsessive-compulsive disorder (Creed, Reisweber, & Beck, 2012; Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007). Research indicates that the efficacy of CBT extends across a range of school settings serving diverse student populations (Mychailyszyn, Méndez, & Kendall, 2010; Neil & Christensen, 2009). For example, Ginsburg, Becker, Kingery, and Nichols (2008) found CBT services delivered in school-based mental health clinics were highly efficacious for high-risk populations of inner-city schools.

In addition to direct positive mental health outcomes, CBT intervention also has been shown to improve school academic performance. In a nonmanualized CBT intervention study that delivered 14 weeks of counseling to high school students, attendance was improved, discipline referral rates were lowered, and one half of the participants had higher grade point averages following services (Michael et al., 2013). A national review of school-based counseling literature found that positive impact was also documented for improving general social competency, reading and math scores, as well as personal engagement and commitment to school success (Foster et al., 2005). Given the number of CBT studies illustrating intervention effectiveness in school-based intervention across many mental health needs, tools for successful application of CBT methods are essential for practitioners. Chapter 2 provides a review of the core CBT components.

REFERENCES

Albano, A. M., & Kendall, P. C. (2002). Cognitive behavioural therapy for children and adolescents with anxiety disorders: Clinical research advances. *International Review of Psychiatry*, *14*, 129–134.

Alberto, P. A., & Troutman, A. C. (2012). *Applied behavior analysis for teachers*. New York, NY: Pearson Higher Ed.

American Academy of Pediatrics, Policy Statement. (2004). School-based mental health services. *Pediatrics*, *113*(6), 1839–1844.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2014). *The standards for educational and psychological testing*. Washington, DC: Author.

American School Counselor Association. (2014). *The professional school counselor and student mental health*. Retrieved from http://www.schoolcounselor.org/asca/media/asca/PositionStatements/PS_StudentMentalHealth.pdf

Center for Mental Health in Schools at UCLA. (2014). *Mental health in schools: New roles for school nurses*. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/nurses/unit1.pdf

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., . . . & Woody, S. R. (1998). Update on empirically validated therapies, II. *Clinical Psychologist*, *51*, 3–16.

Conners, C. K. (2008). *Conners 3rd edition (Conners 3)*. North Tonawanda, NJ: Multi-Health System.

Creed, T. A., Reisweber, J., & Beck, A. T. (2012). *Cognitive therapy for adolescents in school settings*. New York, NY: Guilford Press.

Cummings, J., Ponce, N., & Mays, V. (2010). Comparing racial/ethnic differences in mental health service use among high-need adolescent populations across clinical and school-based settings. *Journal of Adolescent Health*, *46*, 603–606.

DiGiuseppe, R., & Tafrate, R. C. (2011). *Anger Regulation and Expression Scale (ARES): Technical manual*. North Tonawanda, NY: Multi-Health Systems.

Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School mental health services in the United States, 2002–2003*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Ginsburg, G. S., Becker, K. D., Kingery, J. N., & Nichols, T. (2008). Transporting CBT for childhood anxiety disorders into inner-city school-based mental health clinics. *Cognitive and Behavioral Practice*, *15*, 148–158.

Gore, F. M., Bloem, P. J., Patton, G. C., Ferguson, J., Joseph, V., Coffey, C., . . . & Mathers, C. D. (2011). Global burden of disease in young people aged 10–24 years: A systematic analysis. *Lancet*, *377*, 2093–2102.

Greene, J. P., & Winters, M. (2005). *Public high school graduation and college readiness: 1991–2002*. New York, NY: Manhattan Institute for Policy Research.

Gresham, F., & Elliott, S. N. (2008). *Social Skills Improvement System (SSIS) rating scales*. Bloomington, MN: Pearson Assessments.

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*, 435–451.

Individuals with Disabilities Education Improvement Act, 20 U.S.C. § 1400 *et seq.* (2004).

Jordan, C., Reid, A. M., Mariaskin, A., Augusto, B., & Sulkowski, M. L. (2012). First-line treatment for pediatric obsessive-compulsive disorder. *Journal of Contemporary Psychotherapy*, *42*, 243–248.

Joyce, D., & Grapin, S. (2012). School psychologists' role in facilitating successful postsecondary transitions for students with disabilities. *Communique'*, *41*, 1–22.

Joyce-Beaulieu, D., & Grapin, S. (2014). Facilitating successful transitions for high school students with mental health needs: Practical recommendations for school personnel. *Phi Delta Kappan*, *96*(4), 29–33.

Joyce-Beaulieu, D., & Rossen, E. (2014). Preparation of school psychologists in the United States. *International Journal of School and Educational Psychology*, *2*, 1–6.

Joyce-Beaulieu, D., & Sulkowski, M. (in press). The *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition* (*DSM-5*) model of impairment. In S. Goldstein & J. A. Naglieri (Eds.). *Handbook of impairment* (2nd ed.). New York, NY: Springer.

Kaplan, J. S., & Carter, J. (1995). *Beyond behavior modification: A cognitive-behavioral approach to behavior management in the school* (3rd ed.). Austin, TX: Pro-Ed.

Kendall, P. C. (2006). *Child and adolescent therapy: Cognitive-behavioral procedures* (3rd ed.). New York, NY: Guilford Press.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 593–602.

Kovacs, M. (2004). *Children's Depression Inventory, Second Edition (CDI-2)*. Toronto, Canada: Multi-Health Systems.

Masia-Warner, C., Fisher, P. H., Shrout, P. E., Rathor, S., & Klein, R. G. (2007). Treating adolescents with social anxiety disorder in school: An attention control trial. *Journal of Child Psychology and Psychiatry*, *48*, 676–686.

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., . . . Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, *49*, 980–989.

Michael, K. D., Albright, A., Jameson, J. P., Sale, R., Massey, C., Kirk, A., & Egan, T. (2013). Does cognitive behavioral therapy in the context of a rural school mental health program have an impact on academic outcomes? *Advances in School Mental Health Promotion*, *6*, 247–262.

Mychailyszyn, M. P., Méndez, J. L., & Kendall, P. C. (2010). School functioning in youth with and without anxiety disorders: Comparisons by diagnosis and comorbidity. *School Psychology Review*, *39*, 106–121.

National Association of School Psychologists. (2010). *Model for comprehensive and integrated school psychological services*. Bethesda, MD: Author.

National Association of State Directors of Special Education. (2008a). *Response-to-intervention: Blueprint for implementation—District level*. Alexandria, VA: Author.

National Association of State Directors of Special Education. (2008b). *Response-to-intervention: Blueprint for implementation—School building level*. Alexandria, VA: Author.

National Research Center for Career and Technical Education. (2010). *Programs of study: Year 2 joint technical report*. Louisville, KY: Author.

Neil, A. L., & Christensen, H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. *Clinical Psychology Review*, *29*, 208–215.

Poitevien, C. Sloan, A., & Joyce, D. (2014). The new *DSM-5* and interventions for autism spectrum disorder: What school psychologists need to know. *Florida Association of School Psychologists Newsletter, 40*(2), 38–43.

Reynolds, C. R., & Kamphuas, R. (2004). *Behavior assessment system for children* (2nd ed.). Bloomington, MN: Pearson Assessments.

Reynolds, C. R., & Kamphuas, R. (2009). *BASC-2 progress monitor*. Bloomington, MN: Pearson Assessments.

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, *3*, 223–241.

Saklofske, D. H., Joyce, D. J., Sulkowski, M. L., & Climie, E. (2013). Models of personality assessment for children and adolescents. In C. R. Reynolds (Ed.), *The Oxford handbook of child psychological assessment* (pp. 348–365). New York, NY: Oxford University Press.

Salloum, A., Sulkowski, M. L., Sirrine, E., & Storch, E. A. (2009). Overcoming barriers to using empirically supported therapies to treat childhood anxiety disorders in social work practice. *Child and Adolescent Social Work Journal*, *26*, 259–273.

School Social Work Association. (2014). *School social workers' role in addressing students' mental health needs and increasing academic achievement*. Retrieved from http://sswaa.org/displaycommon.cfm?an=1&subarticlenbr=600

Soutullo, O., Palma, L., & Joyce, D. (2014). *DSM-5* depression symptoms and interventions: What school psychologists need to know. *Florida Association of School Psychologists Newsletter, 40*, 34–47.

Sulkowski, M., & Joyce, D. (2012). School psychology goes to college: The emerging role of school psychology in college communities. *Psychology in the Schools*, *49*, 809–815.

Sulkowski, M. L., Joyce, D. K., & Storch, E. A. (2011). Treating childhood anxiety in schools: Service delivery in a response-to-intervention paradigm. *Journal of Child and Family Studies*, *21*, 938–947.

Sulkowski, M. L., & Michael, K. (2014). Meeting the mental health needs of homeless students in schools: A multi-tiered system of support framework. *Children and Youth Services Review*, *44*, 145–151.

Sulkowski, M. L., Wingfield, R. J., Jones, D., & Coulter, W. A. (2011). Response to intervention and interdisciplinary collaboration: Joining hands to support children and families. *Journal of Applied School Psychology*, *27*, 1–16.

United States Department of Education. (2011). *Questions and answers on secondary transition*. Retrieved from http://idea.ed.gov/explore/view/p/,root,dynamic,QaCorner,10

United States Department of Education. (2012). *Thirty-first annual report to Congress on the implementation of the Individuals with Disabilities Education Act*. Jessup, MD: Author.

United States Department of Education, National Center for Education Statistics. (2013). *Digest of education statistics, 2012* (NCES 2014-015). Washington, DC: Author.

United States Department of Health and Human Services. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda*. Washington, DC: The National Institute of Mental Health, Office of Communications and Public Liaison.

United States Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to 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.

World Health Organization. (2010). *Measuring health and disability: Manual for WHO disability assessment schedule – WHODAS 2.0*. Geneva, Switzerland: Author.

TWO

What Is Cognitive Behavioral Therapy?

The cognitive behavioral therapy (CBT) model of counseling simply proposes that a person's thoughts mediate his or her emotions and behavioral responses to life circumstances and events, which in turn affects both short- and long-term consequences for the individual (Kendall, 2006). CBT theory has its origins in the work of these pioneers: A. T. Beck (1991), J. S. Beck (1995, 2011), his daughter, and Albert Ellis (1991). The contributions of A. T. Beck include a framework for understanding automatic thoughts (and sometimes images) that occur spontaneously in people's thinking. For persons with maladaptive automatic thoughts, the theme or content could foster mental health symptoms. For example, for a person whose instinctive thoughts are always fear, dread, or lurking danger, anxiety ensues. For persons prone to hostility, automatic maladaptive thoughts might include perceived injustice, entitlement, or feeling threatened. His daughter, Judith Beck, further delineated the applied aspects of cognitive therapy through her internationally acclaimed textbooks on the topic. Ellis's contributions through rational–emotive therapy included conceptualizing beliefs with which persons interpret circumstances as either rational or irrational. Rational beliefs would lead to a healthier, well-balanced perspective, whereas irrational beliefs would foster social and emotional disorders. Most important, the aforementioned perspectives are confident in the ability to change thought patterns through a logical process of helping individuals find evidence to determine whether their automatic thoughts are true or false.

When thoughts are positive and adaptive, better behavioral choices are made and, subsequently, better outcomes result. By nature, positive outcomes are reinforcing and likely to be repeated, thus the skill of making good choices becomes better developed. For example, if a student is notified of a test, one possible initial thought is, "I need to make a plan to study." If the student follows through on this thought and does study, it is probable over time that this behavior will foster better academic outcomes. These principles also apply to negative thought patterns in that the more often maladaptive or irrational thoughts are applied, the more likely they will become instinctive and repeated. As maladaptive behaviors are repeated they become habits and set up a cycle of reoccurring negative consequences. As an example, a child may hear the same message noted previously regarding a test at school

and automatically thinks, "I hate tests, I can't make a good grade, I am stupid." These types of internal thoughts are likely to suppress the energy to study and the problem-solving skills necessary to make a meaningful plan. Consequently, the student who creates a pattern of defeated thinking over time is unlikely to perform well on tests. In turn, not performing well on tests solidifies an expectation that she or he will not make a good grade and the unhealthy thinking pattern strengthens.

Cognitive behavioral therapy methods have been demonstrated to help individuals recognize the reciprocal relationship among their own emotions, thoughts, and behaviors and make lasting positive changes (Butler, Chapman, Forman, & Beck, 2006; Chambless & Ollendick, 2001). CBT also offers a variety of strategies to interrupt negative sequences and replace feelings, thoughts, and behavior choices with more adaptive mechanisms. Although CBT is often applied for persons with significant mental health needs, it also can be effective for enhancing the lives of children who do not have diagnoses but rather exhibit stress or mild dysfunction. Indeed at some time everyone is susceptible to negative thoughts. It is also important to note that emotions and thoughts are not dichotomous (i.e., good or bad) but rather they exist along a continuum. Therefore, the level of therapy needed will differ by individuals and be strongly influenced by their constellation of symptoms and individual life stressors. For example, a child may experience mild test anxiety to full panic attacks and the counseling intervention design would need to reflect the differing levels of need. For the purposes of this text, the discussion of CBT is reviewed in lieu of applications for mild to moderate counseling needs often provided within the school context. Incidences of severe psychopathology or trauma symptoms will require more in-depth CBT training and skills as well as a multifaceted approach to treatment that often involves multiple service providers. This text is not intended to be a guide for CBT applications in life-threatening or severe symptomology cases or as a substitute for the required level of training to address those issues.

In the broadest definition, cognitive behavioral therapy can encompass a plethora of cognitive or thinking strategies as well as traditional behavioral techniques. One of the challenges for counselors will be the ability to select components that most appropriately target specific needs and to adapt the counseling plan as new information or needs emerge. The rest of this chapter will discuss core CBT methods, including psychoeducation, cognitive restructuring, relaxation training, thought journaling, contingency reinforcement, low-intensity CBT options, and case conceptualization. A more detailed explanation of specific in-depth needs by diagnoses and syndromes is provided in Chapters 3 through 6.

In beginning the discussion of CBT techniques it is important to distinguish a few CBT terms. Students can present with cognitive deficiencies that are based on a lack of information, which creates misperceptions that a child accepts as accurate or cognitive distortions that are misdirected thinking patterns created by the student (Mennuti, Christner, & Freeman, 2012). Psychoeducation may be the best remedy for cognitive deficiencies, whereas cognitive reframing may best address the need to challenge and realign cognitive distortions. Students can also present with skill deficiencies or skill dysfunctions. A skill deficiency can benefit from explicit instruction (e.g., social skills training), whereas a skill dysfunction may benefit most from additional practice with corrective feedback and planned generalization opportunities, such as contingency management.

PSYCHOEDUCATION

Psychoeducation is one strategy used to address *cognitive deficiency* or a lack of accurate information that can have a negative impact. Within the broader social context of mental health there is often a stigma and negative connotation associated with a psychiatric diagnosis, atypical behavior, and in some cases even participation in counseling services. Additionally, families do not always have access to rigorous scientific reviews of syndromes and effective interventions. Thus, it is easy for parents and their children with behavior challenges and/or mental health diagnoses to misunderstand their own symptoms, risk factors, and prognosis. It also is common for children to feel their diagnosis is insurmountable or overwhelming. Part of the psychoeducational component within a CBT context includes providing accurate information to the child and parents regarding the nature of disorders and challenging behaviors. Parents may misunderstand symptoms as "bad" behavior without fully appreciating the complex physiological influences. Some children may feel powerless and one of the goals of psychoeducation is to empower them. This concept may be expressed as "taking charge of my ADHD [attention deficit hyperactivity disorder]," "kicking my anxiety away," or "I'm more than OCD [obsessive-compulsive disorder], it doesn't rule me." Psychoeducation also involves teaching students and their families about the interventions, both its purposes and implementation, especially if parents will be asked to extend the strategies to the home. In addition, to sharing *Diagnostic and Statistical Manual of Mental Disorders,* 5th ed. (*DSM-5*; American Psychiatric Press [APA], 2013) information with parents, there are a wide range of nationally funded resources for specific behavioral needs and interventions with empirical rigor that clinicians can share with families as part of the psychoeducation process. Table 2.1 lists national child/adolescent mental health centers that provide empirically supported intervention resources.

COGNITIVE RESTRUCTURING

The very first step in the process of cognitive restructuring is to identify the student's maladaptive thought patterns. A number of thinking fallacies and distortions are delineated in CBT literature and the counselor's ability to recognize these as well as to provide explanations that students understand to build their personal insight into their own thinking will be a key component of cognitive restructuring (J. S. Beck, 2011; Kendall, 2006; Stallard, 2002). Initially, identifying distortions (also called thinking errors) will involve gathering information from parents, teachers, and others on the referral concerns for the child, including any statements that are clearly unhealthy. For example, teachers may describe the helpless and hopeless thinking patterns of a student with depression as giving up easily, stating he/she "can't do anything right so why should I try" or noting the pervasive negative attitude (e.g., "School is just boring, useless, and will never get better."). Additional support for a hypothesis of helpless and hopeless thinking could be the behavioral descriptors (e.g., "She shuts down and hides her face if she thinks work is hard." "He shrugs his shoulders, looks defeated, and scuffles away when asked a question."). Alternately, a student with oppositional defiant disorder may be described as "always blaming others for his mood," "arguing with teachers in a judging tone,"

TABLE 2.1 National Child/Adolescent Mental Health Centers With Empirically Supported Intervention Resources

National Resource Center	Website
American Psychological Association	www.effectivechildtherapy.com
Association for Behavioral and Cognitive Therapies	www.abct.org/home
Autism Speaks	www.autismspeaks.org
Center for Autism and Related Disorders	www.centerforautism.com
Center for the Study of Violence Prevention	www.colorado.edu/cspv/publications/otherblueprints.html
Centers for Disease Control and Prevention	www.cdc.gov/ncbddd/tourette
Collaborative for Academic, Social, and Emotional Learning, Safe and Sound: An Educational Leader's Guide to Evidence-Based Social and Emotional Learning Programs	www.casel.org
International OCD Foundation	www.ocfoundation.org
National Academy of Child and Adolescent Psychiatry	www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/FAQ.aspx#cdfaq3
National Autism Center	www.nationalautismcenter.org/learning/guides.php
National Child Traumatic Stress Network	www.nctsnet.org/resources/topics/treatments-that-work/promising-practices
National Dissemination Center for Children with Disabilities	nichcy.org
National Education Association	www.nea.org/home/neabullyfree.htm
National Institute on Mental Health	www.nimh.nih.gov
National Resource Center on ADHD	help4adhd.org/aboutus.cfm
National Tourette Syndrome Association	www.tsa-usa.org
Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs	aspe.hhs.gov/hsp/PositiveYouthDev99/index.htm
Substance Abuse and Mental Health Services Administration (SAMHSA): Exemplary Substance Abuse and Mental Health Programs; School Violence Prevention Initiative Matrix of Evidence-Based Prevention Interventions	nrepp.samhsa.gov
What Works Clearinghouse	http://ies.ed.gov/ncee/wwc

or "always tells others how he thinks they should behave." Behaviors may include yelling, hovering over others with an angry look, and arrogance. Together the descriptors lend support for blaming and defiant thinking patterns. The quotations in each of these examples are very distinct messages from children regarding the thoughts that are blocking their success. A trained therapist has the opportunity to identify the category of misdirected thought and begin to reframe the child's thinking pattern. Student interviews should also be a key component in determining

counseling needs. The student interview process continues throughout sessions as new information will emerge over time and in response to events that occur in their lives during the intervention period.

Sentence Completion and If/Then Questionnaires

In those cases when youth struggle with articulating thoughts, a sentence completion technique may be helpful in eliciting responses. Sentence completions can be created by the counselor to include both innocuous questions mixed with select topic areas the counselor would like to explore. It is often advisable to start the exercise with a few items that are easy to answer and nonthreatening before asking questions related to core issues (e.g., anger, withdrawal) that may be uncomfortable for the child. Additionally, the language utilized will need to be developmentally appropriate and sensitive to the student's reading level. Although sentence completion is generally filled out by the student, for those with less willingness to write or less ability to write, the items could also be read and the counselor can complete the responses. Utilizing this process can at times identify themes in common word choices or phrases that identify thinking patterns. An example of child and adolescent sentence stems for anger management is provided in the Appendix, Exhibit 2.1 and Exhibit 2.2. Another format for discovering thinking errors is using If/Then questionnaires (see sample in Appendix, Exhibit 2.3). If/Then questionnaires can be created by the counselor to target a variety of counseling needs (e.g., depression, withdrawal, anger, anxiety). Both sentence completion technique and If/Then questionnaires can be adapted to the reading and developmental levels of the student.

Cognitive Distortions

In the CBT literature there are dozens of cognitive distortions listed. However, Table 2.2 provides definitions and examples of the more common thinking errors found among school-age children and youth. Although individual students can display quite different clusters of distortions, some cognitive distortions commonly occur in the thinking of individuals with certain forms of mental health needs. For example, blaming, dichotomous thinking, entitlement beliefs, fairness fallacy, jumping to conclusions, labeling, and shoulds/must thinking are often consistent with acting-out, bullying, disruptive, or aggressive behaviors. Those with diagnoses such as conduct disorder and intermittent explosive disorder, in particular, have a propensity toward quick blaming of others, mind reading, feeling justified in harsh judgment of others, and polarized thinking about their perception of right and wrong.

Students with internalizing behavioral problems that may include pessimism, social withdrawal, anxiousness, and helplessness or hopelessness features also are prone to manifest as a cluster of distortions. These include catastrophizing, control fallacies, discounting the positive, ignoring the good, fortune-telling, negative filtering, and unfair comparisons. Individuals with diagnoses such as anxiety, depression, reactive attachment, and phobias typically struggle with feeling victimized, overwhelmed, and lacking control of their own destiny. Both externalizers and internalizers can be prone to personalization, overgeneralizing, and emotional reasoning.

TABLE 2.2 Common Cognitive Distortions and Thinking Errors

Cognitive Distortions (Automatic Thoughts, Thinking Errors, Thinking Traps, Stinkin' Thinkin')	Descriptor and Examples
Blaming (Finger Pointing, Who-Dun-It, Shame Game, Lame Blame)	Shifting responsibility for negative events to others. The opposite of personalization: holding other people solely responsible for events for which the person doing the blaming is at least partially responsible. "I shouldn't get detention, it is all their fault."
Catastrophizing (Disaster Forecaster, Doctor Gloom/Doom) *Note:* Catastrophizing is a subtype of magnification/minimization (Burns, 1980, 1989)	Views the future with disastrous outcomes (e.g., grossly exaggerated and tragic) based on perceptions of minor negative events, portraying a negative event or situation as a major disaster or tragedy (more so than most others would view the event). "I didn't get a date for the prom; my life is over now."
Control fallacy (Poor Me)	Child perceives self as a helpless victim of an external force or circumstance. "I can't help it if I'm no good at schoolwork, I have ADHD." "The teacher is so hard, I can't win."
Dichotomous thinking or polarized thinking (All or Nothing, No Middle Riddle; One-Eyed Ogre)	Putting experiences in one of two extreme categories, do not recognize a continuum of experiences or outcomes, may be expressed in superlatives, perceiving things in black or white terms and absolutes as opposed to gradations or shades of gray. "People are all bad." "I am an absolute failure."
Discounting the positive (Disqualifying the Positive, Count-less Thinking, Ignoring the Good)	Youth has a negative affirmation bias, clinging to a negative self-view despite positive outcomes, discounting positive events or negating their existence. "Getting into that college was pure luck."
Emotional reasoning (Prisoner of Feelings, The Roller Coaster)	Child feels that his/her current feelings are the truth, lacks awareness that feelings are not facts, viewing and describing events through an emotional filter. Essentially, a person's emotional tone inordinately colors his or her experience. "I feel energized around her; therefore, I must be totally in love."
Entitlement beliefs (The Princess, The Prince, The Revenger)	An individual believes he/she is exempt from the requirements others may be held to or have special privilege. "I know this stuff; I don't need to turn in the homework."
Fairness fallacy (Right Knight, The Regulator)	Student believes he/she knows what is truly fair and has rigid expectations that others should share that view and act accordingly. "It's not fair that I got 2 days detention and they only got 1 day."
Fortune-telling (The Crystal Ball). *Note:* Fortune-telling is a subtype of jumping to conclusions (Burns, 1980, 1989)	This distortion involves predicting a negative future event (not necessarily projected out globally or long-term) without evidence or supporting predictive information. "Even though I try, I won't make the team."
Jumping to conclusions (The Jumper, Too Fast Forward). *Note:* Jumping to conclusions has two subtypes; fortune-telling and mind reading	Child responds to situation without all the information needed to make a sound assessment, settling on conclusions that are based on little evidence if any. "The teacher looks tired; she won't check the homework so I don't need to do it."
Labeling (Mislabeling, The Name Game)	The child uses derogatory names to describe him/herself holistically in response to isolated circumstances. "I am a loser."

(*continued*)

TABLE 2.2 Common Cognitive Distortions and Thinking Errors (*continued*)

Cognitive Distortions (Automatic Thoughts, Thinking Errors, Thinking Traps, Stinkin' Thinkin')	Descriptor and Examples
Magnification and minimization (The Amplifier, The Shrinker). *Note:* Catastrophizing is a subtype of magnification/minimization	The child attributes disproportional weight (greater or lesser) to perceived failures or negative events. Magnification is sometimes described as "making a mountain out of a molehill" or making a big deal out of something that is not as significant as it is portrayed. Minimization is portraying a significant event, situation, or personal accomplishment as being marginal or inconsequential. "Winning that trophy was just luck, not really important."
Mind reading (Tragic Magic Thinking). *Note:* Mind reading is a subtype of jumping to conclusions (Burns, 1980, 1989)	Individual thinks she or he knows what others are thinking about her or him without any facts (i.e., no conversation with the person or supporting evidence); making overly presumptuous judgments about other people based on one's own bias or based on their nonverbal communication. "I know from the way she looks at me that she just hates me."
Negative filtering (Wearing Dark Glasses, The Blues News)	Magnifying a negative aspect of an incident while ignoring the rest, focusing exclusively on negative aspects of a situation to the exclusion of positive or neutral aspects. "I stuttered on the very last word of my presentation. It went horribly!"
Overgeneralizing (The Repeat-Repeat)	Perceives a current event to be representative of all events or life overall, predicts same negative outcome repeatedly over time, thinks something will *always* occur because it happened once. Making broad assessments, judgments, or generalizations based on a single or small set of particulars or from insufficient experiences and evidence. "I am never going to be able to give a presentation since I had a panic attack last time."
Personalization (Me-Me, Mini-Me, It's All About Me)	Assumption that he or she is the cause of a negative event, despite a lack of evidence. Attributing personal responsibility for events over which a person has little or no control. "They must have cancelled the show because my audition was miserable."
Should/must thinking (Bossy Thoughts)	Student thinks of own actions and those of others as needing to conform to rigid "should" and "must" rules. Thoughts can be guilt-ridden if directed at themselves or result in anger when directed at others. "They *should* give it up." "I really *should* get better grades and I *must* start dieting."
Unfair comparisons or comparing (Foul Referee)	Student holds him- or herself to an unrealistic and unfair comparison. "My dancing is awful compared to the prima ballerina."
What If (The Guessing Game)	Student approaches situations second-guessing possible but highly improbable negative contingencies. "What if I don't wake up on time for the test?" "What if my brain goes blank?" "What if the teacher quits and I can't get help?"

Note: In the CBT literature, some cognitive distortions are referred to by more than one term (depending on the author). Additionally, theoretical terms may be difficult for children and adolescents to understand; therefore, this table has alternate names for distortions from CBT literature as well as child-friendly versions of terms provided in parentheses.
Source: Boyes (2013), Burns (1980, 1989), Leahy and Holland (2000), Mennuti, Christner, and Freeman (2012).

Cognitive Models

Once initial cognitive distortions are identified, counselors can set a foundation for recognizing those thoughts by first teaching the causal connection to help children attend to their own patterns. Two frameworks for understanding the reciprocal nature of thoughts to behaviors—the Cognitive Model (i.e., thoughts–emotions–behaviors) and the ABC model (i.e., antecedent–beliefs–consequences)—can be used for discussion (see Appendix, Exhibits 2.4, 2.5). The ABC three-step model from the work of Ellis (1991) utilizes the term *antecedent* to document the initial behavior or situation and the automatic thoughts. Then beliefs are noted and reviewed to determine whether they are rational or irrational and finally consequences are indicated to help students understand the relationship of A–B–C. Several Appendix exhibits (2.6, 2.8, 4.14 to 4.16) utilize the ABC model to illustrate how negative events and rational beliefs don't necessarily erase the negative feelings but suggest healthy and unhealthy responses to negative events. For example, a child who has a puppy killed by a car can have irrational beliefs of self-blame and guilt when he or she is not responsible or employ a rational belief that the puppy was loved and, yes, it was sad and it is OK to cry and miss the puppy knowing the sad feelings will subside with time. The cognitive model provides a structure for illustrating that thoughts, feelings, and behaviors influence each other and can directly influence outcomes. For most adolescents, discussion of cognitive models with a schematic of the concepts will be adequate. However, for sessions with young children, it may be helpful to have them participate in activities that illustrate the cognitive concepts in a more concrete manner or to use more iconic representations of the process. Activity examples for teaching concepts to young children are included as follows:

- **Cognitive circles**: Have students draw the three cognitive circles model (i.e., Venn diagram) or use a worksheet with the circles and write in specific thoughts–feelings–behaviors they have experienced (see Appendix, Exhibit 2.4).
- **Hula-hula-hula loop**: Have children arrange three hula-hoops on the floor labeled "thoughts," "feelings," and "actions," then jump in each hoop as they describe a recent sequence in their own thought patterns. If the sequence is negative (e.g., "I am afraid to talk to other kids, I feel shy, I am going to be quiet."), they are coached to reframe the sequence as they move "*through the hoops*" again (e.g., "I think I can say hello to other kids, I feel good, I am going to practice saying hi.").
- **Negative trap/negative fall**: Use child-friendly terminology for negative cycles, such as the negative trap (can use visual or demonstration of a mousetrap) or the negative fall (can use downward cascading shapes or pictures of persons falling).
- **Magic thought circles/thought bubbles**: Use child-friendly terms for positive cycles, such as thought bubbles (also called magic thought circles; Stallard, 2002) or positive launch (e.g., of a rocket), while helping the child recall positive circumstances and the thoughts and feelings associated with those events. In some cases, children may need coaching to recall positive cycles in their life and reassurance that they are capable of influencing their own thought–feeling–behavior sequences. An example of a worksheet for negative fall–positive launch can be found in the Appendix, Exhibit 2.7.

- **Face reader:** For children who negatively misinterpret others' behaviors, utilizing photos of expressions and actions (e.g., sad face, child skating off a ramp, child surprised) to first discuss what the student thinks the person in the photo is thinking and feeling and then reexamining other alternative thoughts/feelings that could go with the expression may be helpful. Negative misinterpretation of others' expressions/actions is a hallmark of externalizers and also a propensity of children with social phobia and a fear of negative appraisal by others. In the examples just noted, alternative interpretations of a sad face could be tiredness, a child skating off a ramp could be interpreted as fun or scary, a child surprised could be interpreted as fearful or excited. The point is to illustrate that the conclusion does not have to be negative and understanding others have a range of feelings and that we often do not know what they are thinking without asking them; there is no need to jump to a negative conclusion.
- **Good fortune:** The concept of positive thoughts creating positive feelings can be illustrated by opening a whole box of fortune cookies and discussing how it feels to get a positive note inside the cookie. Students can rank their notes from most favorite to good and may wish to retain some of the statements for their own positive affirmations.
- **My pie:** This exercise is meant to teach the concept that what we put into our mind effects what we get out. It involves making a pie (either physically or with pictures) and selecting contrasting ingredients (e.g., sugar/salt, cherries/pebbles, premade pie crust/aluminum foil, and so forth) and then discussing what the outcomes or consequences of each recipe will be. The same example can apply to making a sandwich or soup, and so on.
- **Detective effective**: Detective effective is a game of looking for facts or evidence. Children can use a magnifying glass to collect samples in plastic bags while gathering physical evidence if a statement is true (e.g., "There is ice in the refrigerator and under the desk." "There are bugs under rocks and in the sink."). Following the evidence-gathering stage, all the facts the students collected are discussed and the children decide whether the original statements were true. This game moves from a concrete exercise, to a social exercise (e.g., Does your teacher like tomato juice? How will you find out the facts? What did you learn from your teacher interview?), then to sharing challenges to their own automatic negative thoughts.

The number of games available to illustrate reciprocal thought–feeling–behavior relationships to students is unlimited and offers school personnel the opportunity to be creative. When the activities align with a child's natural interest (e.g., sports, art), their level of engagement also is likely to increase.

Socratic Questioning

After students have an understanding of the cognitive model and automatic negative or irrational thoughts have been identified, the goal of counseling is to help the student recognize and change these thoughts. The Socratic method is a technique for providing a dialogue with individuals that guides them to discover new understanding through carefully scaffolded sequences of questions (J. S. Beck, 2011; Kendall, 2006). There are several approaches for inquiry, including clarification questions, probing

TABLE 2.3 Socratic Questioning Examples

Clarification Questions	Probing Assumptions
What would an example be.....?	What evidence/facts are there for .....?
What is another way to say that.....?	What evidence/facts are there against .....?
Tell me more about that.....?	What are other explanations for.....?
Do you mean..... or .....?	Would a jury think this was evidence.....?
Tell me another way to understand.....?	Why is that the case.....?
Examining Viewpoints	**Questions About Questions**
How is this different from.....?	What would the answer to that question mean to you.....?
How is this like.....?	Why did you choose to ask that question.....?
What is another way to look at this.....?	How will it help to know the answer to .....?
What opinion might others have about.....?	What would be a better question.....?
Is it possible that.....?	What are the causes/benefits of asking.....?

assumptions, examining viewpoints or perspectives, and questions about questions. Examples of each type are provided in Table 2.3.

Thought Journaling

Thought journaling (sometimes also called thought records or daily mood logs) is another option for helping individuals discover and better understand their own thinking patterns. Generally, students are provided an explanation of the cognitive behavioral model or ABC model and a thought record form is provided for documentation in-between counseling sessions. Students are instructed to use the thought record to note their thoughts, feelings, and actions following any stressful or negative event. One benefit of the thought record is that it can be reviewed by the adolescent later, after she or he is past the emotional state of having a negative circumstance and over time can foster insight into his or her own thinking patterns. For children, the counselor may wish to review thought records with the child during intervention to assist him or her in understanding negative patterns. The thought record also can help demonstrate progress over time as thoughts become more positive and thus change behaviors and outcomes.

Multiple examples of thought records are provided in the Appendix, Exhibits 2.8 to 2.10 and 4.14 to 4.16, and there are several versions of the ABC framework. The first exhibit (2.8) displays a simple three-column ABC model. This can be presented in a four-column format (see Appendix, Exhibit 2.9), which breaks consequences down into both short and long term to help children understand the sustaining effect of behaviors and thoughts. An alternating four-column form also can provide prompts to assist the student in practicing how to self-challenge irrational beliefs (see Appendix, ABCD sample, Exhibit 2.10). This last form may be more helpful after a student has mastered the three-step form or has begun successfully challenging distortions in the counseling intervention sessions. Another approach to thought records is to create forms specifically targeting symptoms (e.g., depression, perfectionism, posttraumatic stress disorder). The Cognitive Behavioral Self-Help Resources website offers freely available download forms for dozens of customized thought records, activity diaries, and thought-challenging forms (www.get.gg/gallery.htm).

RELAXATION TRAINING

There are a number of relaxation techniques available, including diaphragmatic breathing, guided imagery (also called creative visualization), and progressive muscle relaxation, which can be helpful in reducing anxious and angry behaviors (see Appendix, Exhibits, 4.23 to 4.26). In the diaphragmatic-breathing (also called belly breathing or calm breathing) techniques, students are first taught to sit or lie down with good spinal alignment, then to breath slowly (1 to 3 seconds) and deeply through the nose, ensuring they breathe into the stomach as noted by stomach-area expansion (in–out); the breath is held 2 to 3 seconds and then air is exhaled slowly through the mouth (1 to 3 seconds). The purpose of belly breathing is to counteract the shallow, fast breathing that persons prone to explosive anger or anxiousness exhibit. Fast breathing can cause hyperventilating, dizziness, and fainting. Belly breathing is intended to be a relatively short activity intended to reduce the initial heightened arousal state. It is not mean to be sustained, thereby permitting avoidance, withdrawal, or used as a substitute for better long-term strategies of problem solving.

The guided imagery technique most applicable to school intervention is a form of meditation or "safe place" visualization. It involves temporarily alleviating emotional distress by replacing intrusive thoughts with a mental picture of a place or event that is calming to the child. Students are asked to identify favorite places (e.g., the beach, the forest) and a script is utilized initially by the counselor and later self-administered by the student as needed. Children are asked to sit in a comfortable place, close their eyes and either listen to a recording of the script or imagine the location. Recorded guided imagery will typically have background sounds consistent with the described location. Some newer applications include visual images as well (see section on low-intensity CBT applications). The script usually describes a location emphasizing multiple senses (e.g., "You are standing on a pristine beach, hearing the waves gently caress the shore, smelling the fresh salt air and feeling the warm sand beneath you."). It is important not to confuse two other CBT imagery techniques: imagery exposure and imagery rescripting. Imagery exposure involves recalling a particularly emotional event in detail and examining the feelings/thought of those moments with the help of the counselor in an effort to identify feelings and better understand behaviors exhibited (e.g., the fight-or-flight response). Imagery rescripting can be utilized with more significant mental health needs, including intrusive images, contamination, bulimia, and suicidality (Holmes, Arntz, & Smucker, 2007). These two particular imagery methods require additional training and are beyond the scope of this text.

The progressive muscle relaxation technique involves teaching students to tense and then relax muscle groups to release tension. Over time, the students will be able to identify the places in which they hold tension (e.g., pulling shoulders up too high) and use those indicators for self-awareness of their own emerging anxiousness. Initially, the counselor will read or use a tape-recorded script with instructions for relaxing sequential muscle groups (e.g., close eyes and tense forehead, release; repeat with shoulder, torso, abdomen, legs, feet).

Children also can use simple strategies that allow time between a negative event and their first behavior reaction with the potential to lower the initial stress response. Examples might include teaching a child to count to 10 (forward or backward), touch all fingers sequentially to the palm, hold tongue on roof of mouth for a few seconds, and push two hands solidly (but gently) against each other or place the feet

firmly on the floor for a few seconds. Ready access to favored activities may also be helpful (e.g., MP3 player with favorite music). Each of these techniques will give the child time to think before reacting and may be especially helpful with explosive outbursts.

To monitor progress and help the student learn which relaxation methods work best for him or her, counselors can ask children to keep a relaxation journal (also called a relaxation diary or relaxation log) and review the outcomes during counseling sessions. A sample relaxation log is provided in the Appendix, Exhibit 2.11. One caution in applying relaxation is that for children with avoidance issues (e.g., social withdrawal, giving up easily on school tasks) the opportunity to self-implement a relaxation strategy can aid continued avoidance. Applying relaxation strategies also may be counterproductive for youth with ruminating or obsessive thoughts as it affords more time to engage in those processes. Thus, monitoring and judgment on the use of relaxation training are important considerations.

CONTINGENT REINFORCEMENT

A number of experts in child and adolescent intervention literature acknowledge the positive impact of CBT strategies but also argue that CBT can be enhanced by adding contingency reinforcement. Contingency management is based on positive reinforcement strategies that offer a reward or incentives for a targeted behavior (e.g., increasing social interactions). Including teachers and parents in the contingency management is important to counseling intervention as it promotes generalization of newly learned strategies but also may change teachers' and parents' behaviors that have inadvertently sustained problem behaviors (e.g., excessive reassurance). Studies indicated that behavioral incentives increase voluntary attendance at counseling sessions, completion of therapy homework assignments, lower substance abuse, and can promote generalization of skills to other settings (Carroll, 2006; Cavollo et al., 2007; Kamon, Budney, & Stanger, 2005).

INCORPORATING TECHNOLOGY: LOW-INTENSITY CBT INTERVENTIONS

The 21st century has experienced an explosion of fascinating and innovative technological advances that have resulted in enhancing the data management and communication capabilities in business. During the last two decades these capabilities have also extended from business applications to include a plethora of personal devices that enhance individuals' access to important information and wide communication options, 24 hours a day. The use of technology to provide brief CBT is one of several applications known as low-intensity CBT intervention. Low-intensity therapy methods are not labor intensive for the counselor and may include programmed phone reminders or mood checks, e-mailed or texted positive messages, electronic bulletin boards, chat rooms, self-help books or websites, instant text messaging, phone apps, or computer-guided CBT programs.

Most low-intensity interventions are self-administered, flexible enough to fit into the student's schedule outside of the school day and free or of minimal cost. However, computer software CBT programs may be expensive, thus school systems

may wish to purchase these tools for counselor and student use, especially for common issues such as depression, anxiety, and anger management. It also may be necessary to provide dedicated computer space and monitoring for their utilization. It is important to note also that bulletin boards and chat rooms require special safety consideration, as those two methods may not be designed and monitored by a mental health professional. Some sites have trained mental health professionals who review comments, can edit or block inappropriate materials, and also require membership that entails identification of users, whereas nonmembers cannot access the content. However, other sites do not monitor posted messages, open access allows the general public to view and respond to comments, and these sites may not edit/remove inappropriate, even harmful content. Self-disclosure should also be a precaution as with the use of any Internet media. It will be important for the therapist to be informed regarding the credibility and professional monitoring of any recommended sites as well as the maturity of the user. Bulletin boards involve the asynchronous posting of information, whereas chat rooms have real-time responses by participants (Griffiths & Reynolds, 2010). Peers utilizing the site also will have varying levels of insight and symptomology; thus, the wherewithal of a student to exercise prudent judgment in accepting suggestions from others is very important. Additionally, the research support for these forums is mixed (Griffiths, Calear, & Banfield, 2009; Griffiths, Calear, Banfield, & Tam, 2009). Examples of more credible chat rooms/bulletin boards include those sponsored by government and/or mental health agencies (e.g., National Alliance on Mental Health; see www.namiccns.org/index.php/support/online-support). Overall, low-intensity methods are a valuable method to empower students to access affirmations, coping-skills reminders, and to self-monitor their own feelings and mood states.

From the original landline phone, to the home computer, and now wireless smartphones and portable laptops, the current generation of students are more tech savvy than any group before them. Many professionals argue this technology also can be utilized as a potent method of bringing CBT applications on a moment's notice at any time, to any location, to serve those with mental health and behavioral needs (Bennett-Levy et al., 2010). Some authors describe low-intensity CBT methods as an opportunity to provide graduated or "stepped care," which is self-paced and can improve cost-effectiveness and thus increase access to therapy (Bennett-Levy et al., 2010; Bower & Gilbody, 2005). Additional benefits include the self-correcting nature of low-intensity methods, the ability to generalize to a variety of contexts throughout the child's day, including the home and community environments as well as providing school intervention service in the spirit of least restrictive settings as noted in the Individuals with Disabilities Education Improvement Act (2004) guidelines. In fact, whether the goal is to extend practice opportunities and reinforce concepts learned within CBT sessions or to reach those individuals who are less willing to participate in counselor-led sessions, there is research to support positive effects for low-intensity CBT approaches. For example, studies have indicated lowering negative effects of panic attacks, phobias, and increased predictability for suicide risk assessment utilizing technology applications such as computer interview, self-exposure, and self-help guided therapy texts (Greist et al., 1973; Kenwright et al., 2005; Marks, 2001; Swinson et al., 1992). Additionally, there is empirical support for the utilization of self-directed computer-aided programs (Barak, Hen, Boniel-Nissim, & Shapira, 2008; Spek et al., 2007).

The CBT applications noted in Table 2.4 have been found to be specifically effective in reducing negative symptomology for depression, panic attacks, and phobias (National Institute for Health and Clinical Excellence [NICE], 2006).

Regardless of the type of low-intensity CBT technique selected for a student, there are several strategies that can make the supplemental supports more effective:

- Explain the limits of confidentiality in utilizing Internet-accessed media and/or communicating by phone.
- Introduce and model the technique in session with corrective feedback to ensure the student knows how to apply the strategies. For example, downloading a phone app for diaphragmatic breathing and practicing with the adolescent to ensure he or she can easily use the prompts and pull-down menus or tabs.
- Monitor and adjust the frequency of strategies, which may include initially setting a higher frequency of positive affirmation messages on an app and then change both the message and frequency over time as the child responds to the technique or needs to focus on additional areas. Some apps offer built-in data graphs that the therapist and child can review that may inform frequency needs and indicate patterns for the time of day or situations that are most stressful for the student.
- It may be helpful to review the utilization and progress of low-intensity CBT methods at the beginning of each new session and answer any questions regarding the materials. For example, if a student is using thought records to challenge worry thoughts during the week, it would be important to review those record sheets for patterns, session discussion points, and/or to monitor correct understanding of the process.
- Additionally, offer students a variety of low-intensity methods and personal choices, which may increase utilization, especially if the range of methods changes over time to enhance novelty and maintain interest.

Although not a conclusive list, Table 2.4 highlights some low-intensity applications and their corresponding targeted therapy objectives. Many of the apps are available free of charge and can be easily accessed by youth. These resources include coached breathing, guided imagery, progressive muscle relaxation, and journaling thought records. Each strategy can be taught during counseling sessions with modeling and corrective feedback, then self-reinforced throughout the week by utilizing low-intensity CBT methods.

CASE CONCEPTUALIZATION

Case conceptualization (also called case formation) involves a process of understanding the student's needs from all the data gathered about the student (e.g., referral concern, interviews, classroom observations) and then formulating hypotheses regarding the mechanisms maintaining his or her emotional and behavioral challenges. Mechanisms may include a range of triggers, life circumstances, thinking errors, or even neurological anomalies. The hypotheses are based on sound theoretical frameworks as a guide to understand the child's functioning (e.g., helpless/hopelessness common to depression). Once hypotheses are created, intervention

TABLE 2.4 Low-Intensity CBT Applications

Low-Intensity CBT Application	Skills
Breathe to Relax—iOS and Android Phone/Tablets Application iOS: https://itunes.apple.com/ca/app/breathe2relax/id425720246 Android: https:/play.google.com/store/apps/details?id=org.t2health.breathe2relax&hl=en (This app offers soothing music and scenic backgrounds with verbally coached inhale/exhale instructions and also creates a graphic report of self-rated stress levels for monitoring.)	Diaphragmatic breathing FREE APP
CBT-I Coach—iOS and Android Phone/Tablets Application iOS: https://itunes.apple.com/us/app/cbt-i-coach/id655918660?mt=8 Android: https://play.google.com/store/apps/details?id=com.t2.cbt_i&hl=en (This app offers verbally coached breathing exercises, guided muscle relaxation with graphic visual of adult human body, and guided imagery with a choice of visual backgrounds for three locations [i.e., forest, country road, beach].)	Diaphragmatic breathing, muscle relaxation, guided imagery FREE APP
CBT Tools for Kids—iOS Phone/Tablet Application iOS: https://itunes.apple.com/us/app/cbt-tools-for-kids/id596804744?mt=8 (The graphics of this app are child friendly with an iconic feeling monitor, a place to note the precipitating event to a feeling [e.g., school grade, family, friends], child body graphic to identify physiological response [increase heart rate, jaw tension], and produces a running history record, a thinking skills with advice guide, and suggested positive actions to reduce stress.)	Self-monitoring, relaxation, thinking tools
Positive Affirmation Lite—iOS and Android Phones/Tablets https://play.google.com/store/apps/details?id=net.mindfsck.PosAffLite&hl=en (This app permits menu selection of affirmations or entering individualized affirmation texts, selecting a visualization background and programming the number of times per day that the message is sent.)	Positive affirmations
Unique Daily Affirmations Lite—iOS Phones/Tablets https://play.google.com/store/apps/details?id=com.gopherapps.affirmations (This app offers a cheerful graphic background and a large-button icon that can be pushed to reveal a positive message.)	Positive affirmations
Negative to Positive: Erase Negative Thought Patterns—iOS phone/tablet https://itunes.apple.com/us/app/negative-to-positive-free./id525454263? mt=8 (This app offers several scenic background options and verbal coaching for relaxation.)	Relaxation technique
Cognitive Behavioral Therapy Self-Help Resources www.stopp.gg (This website offers a variety of thought record download files specifically tailored to anger, obsessions and compulsions, perfectionism, body dysmorphia, depression, social anxiety, posttraumatic stress disorder, panic attack, worry, general thought challenges, and an ABC worksheet. Additionally, the STOPP method worksheet is included [i.e., Stop, Take a breath, Observe, Pull back for perspective, and Practice what works].)	Journaling, thought records/ diary
Additional iPhone, iTouch, iPad, and Android Applications http://www.getselfhelp.co.uk/links2.htm#Apps%20for%20Smart%20Phones (This site offers a thought diary, mood & anxiety diary, eCBT, iCBT, CBT referee, iStress, gratitude journal, journal diary, Live Happy, My Thoughts, Smart Goals, LifeTick [values & goals], Beat Panic, CBT Self-Help, MoodKit, Affirmations, Music for Refreshment, MoodPanda, MoodJournal, Emotional Freedom Technique (EFT) Clinic, and Panic Aid)	Journaling, thought-stopping worksheets, diaries, affirmations
Beating the Blues www.beatingtheblues.co.nz/what-is-it-practitioners.html (This computer-aided software program offers empirically supported strategies for reducing depression symptoms [NICE, 2006].)	Computerized CBT program
FearFighter www.fearfighter.com/about-fearfighter (This self-guided computer-aided program offers empirically supported strategies for reducing panic/phobia symptoms [NICE, 2006].)	Computerized program

methods used to address those factors can be applied to test the hypotheses. It is not unusual for new hypotheses to emerge throughout the counseling sequence, as there is more time for observing the student and the child also begins to reveal more about him- or herself. There are a number of prescriptive case conceptualization processes in the literature that counselors may wish to utilize. J. S. Beck (2011, pp. 29–30) offers a case formulation model that suggests the counselor ask her- or himself a series of questions (e.g., What are the student's problems? What distortions are associated with those problems?) to help provide clarity on the counseling goals and methods. Her method includes investigating the child's core beliefs, assumptions, rules, compensatory strategies, and situation, as well as the automatic thoughts and subsequent affect and behavior.

During case conceptualization, considerations should be given also to parent/caregiver collaboration and child diversity factors. The American Counseling Association recommends that counselors maintain an awareness of their own attitudes, beliefs, and potential biases as well as the worldview and beliefs of the child and family when making intervention decisions and assessing student needs (Arredondo et al., 1996).

CONTRAINDICATIONS FOR COUNSELING THERAPY

The application of CBT is dependent on a student's ability to understand causal connections among thoughts–feelings–behaviors, insightful self-awareness, and a motivation to participate in a meaningful way. Therefore, cognitive ability and maturity are essential considerations in selecting CBT as a counseling method. For students with significant intellectual disabilities, CBT may not be the most effective intervention methods. A second consideration is the child's developmental stage. Early Piagetian developmental theory noted that preoperational children (i.e., ages 2 to 7 years old) tend to function primarily from an egocentric view. Thus, it is unlikely they will have great insight into their own thinking patterns or insight into others' perspectives during social interactions. Concrete operational age children (i.e., 7 to 11) can reason better than younger children, especially if concepts are demonstrated or put into concrete examples. Thus, CBT counseling that incorporates concrete activities and examples is likely to be somewhat effective. In comparison, children in the formal operational stage (i.e., ages 12 and older) can reason deeply, even about abstract concepts; therefore, the CBT framework is a good match for their metacognitive skills. In fact, research by Durlak, Fuhrman, and Lampman (1991) found CBT outcomes consistent with early Piagetian developmental theory in that children in the formal operations stage (ages 11 and older) have twice the positive effects utilizing CBT as children ages 2 to 10.

Additional contraindications for the use of CBT include suicidality, abuse, and psychosis. Suicidal thoughts and ideation require mood stabilization, a safety plan, and sometimes psychopharmacological intervention first before the underlying core belief system of the individual can be addressed. In circumstances of abuse, protective measures for safety and reporting the incident are the first considerations. Often, abused children are quickly separated from caregivers or other significant persons in

their lives, which can also introduce complex guilt and abandonment feelings. For these children and adolescents, a more specialized counseling approach, trauma-focused cognitive behavioral therapy (TFBT) may be more appropriate. TFBT combines components of traditional CBT with family therapy elements and behavioral modification (Silverman et al., 2008; United States Department of Health and Human Services, 2012). Youth who are receiving treatment for psychosis typically require a combined treatment plan that includes antipsychotic medications and social support systems, and may include CBT. However, if the child or adolescent is having a psychotic episode or quickly cycling between episodes, he or she will not have the reasoning and insight required for effective CBT.

GETTING STARTED

Counseling children and youth requires the ability to adapt theoretical terms and concepts to their personal developmental level, as well as the ability to build rapport and trust. In essence, these are communication skills. Goals for the initial session should include ample opportunities for the student to introduce himself or herself, ask questions, and get to know the counselor. Rapport can be established by maintaining good eye contact, having a warm demeanor, and using vocabulary that is consistent with the child's level. The first session will also need to include a discussion of the limits of confidentiality, signing any required consent forms, and a review of session boundaries and expectations. For group counseling, it may be helpful to have the students generate the session guidelines (e.g., take turns talking). It also is important to share the goals of the counseling intervention and to elicit student input. Progress-monitoring measures (see Chapter 1) and therapy homework assignments that reinforce concepts from the session will be key elements throughout the intervention, thus a discussion of these at the first meeting may be helpful in setting expectations. When the counselor and/or school intervention team decide that counseling goals are met, it is helpful to give the student advance notice of the termination of therapy. This is especially important for counseling interventions because there is a supportive relationship with the student and she or he may feel nervous about the withdrawing of services, or in some cases, may even feel abandoned. Informing the student of the impending last session, offering a way to contact counseling services if needed, and celebrating new skills acquired are strategies to ease the transition. Lastly, there is support in the literature for the use of follow-up booster sessions several weeks or months following intervention. These sessions offer a review of strategies as well as a method to document the stability of counseling effects.

In summary, CBT offers many effective strategies that can be successfully implemented within school systems, especially for students who present mild- to moderate-level mental health needs. Whether the child has a *DSM* diagnosis or just presents behavioral challenges, there are elements of CBT that can enhance his or her personal functioning. For intensive student needs, a combination of CBT with other therapies, behavioral management techniques, and perhaps psychopharmacological interventions may be required.

REFERENCES

Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). *Operationalization of the multicultural counseling competencies*. Alexandria, VA: American Counseling Association.

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, *26*, 109–160.

Beck, A. T. (1991). *Cognitive therapy and the emotional disorders*. New York, NY: Penguin.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York, NY: Guilford Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Bennett-Levy, J., Richards, D. A., Farrand, P., Christensen, H., Griffiths, K. M., Kavanagh, D. J., . . . Williams, C. (Eds.). (2010). *Oxford guide to low intensity CBT interventions*. New York, NY: Oxford University Press.

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: Access, effectiveness and efficiency. *British Journal of Psychiatry*, *186*, 11–17.

Boyes, A. (2013). 50 common cognitive distortions. *Psychology Today*. Retrieved from http://www.psychologytoday.com/blog/in-practice/201301/50-common-cognitive-distortions

Burns, D. D. (1980). *Feeling good: The new mood therapy*. New York, NY: Morrow.

Burns, D. D. (1989). *The feeling good handbook: Using the new mood therapy in everyday life*. New York, NY: Morrow.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, *26*, 17–31.

Carroll, K. (2006). *Maximizing the efficacy of cognitive behavior therapy and contingency management*. Retrieved from http://clinicaltrials.gov/show/NCT00350649

Cavollo, D. A., Cooney, J. L., Duhig, A. M., Smith, A. E., Liss, T. B., McFetridge, A. K., & Krishnan-Sarin, S. D. (2007). Combining cognitive behavioral therapy with contingency management for smoking cessation in adolescent smokers: A preliminary comparison of two different CBT formats. *American Journal on Addictions*, *6*, 468–474.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Durlak, J., Fuhrman, T., & Lampman, C. (1991). Effectiveness of cognitive-behaviour therapy for maladaptive children: A meta-analysis. *Psychological Bulletin*, *110*, 204–214.

Ellis, A. (1991). The revised ABC's of rational-emotive therapy. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, *9*, 139–172.

Greist, J. H., Gustafson, D. H., Stauss, F. F., Rowse, F. L., Laughren, T. P., & Chiles, J. A. (1973). Computer interview for suicide-risk prediction. *American Journal of Psychiatry*, *130*, 1327–1332.

Griffiths, K. M., Calear, A., & Banfield, M. (2009). Internet support groups (ISGs) and depression (2): Do ISGs reduce depressive symptoms? *Journal of Medical Internet Research*, *11*, e40.

Griffiths, K. M., Calear, A., Banfield, M., & Tam, A. (2009). Internet support groups (ISGs) and depression (2): What is known about depression ISGs? *Journal of Medical Internet Research*, *11*, e40.

Griffiths, K. M., & Reynolds, J. (2010). Online mutual support bulletin boards. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, . . . & C. Williams (Eds.), *Oxford guide to low intensity CBT interventions* (pp. 295–301). New York, NY: Oxford University Press.

Holmes, E. A., Arntz, A., & Smucker, M. R. (2007). Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes. *Journal of Behavior Therapy and Experimental Psychiatry, 38*, 297–305.

Individuals with Disabilities Education Improvement Act, 20 U.S.C. § 1400 *et seq*. (2004).

Kamon, J., Budney, A., & Stanger, C. (2005). A contingency management intervention for adolescent marijuana abuse and conduct problems. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*, 513–521.

Kendall, P. C. (2006). *Child and adolescent therapy: Cognitive-behavioral procedures*. New York, NY: Guilford Press.

Kenwright, M., Marks, I., Graham, C., Franses, A., & Mataix-Cols, D. (2005). Brief scheduled phone support from a clinician to enhance computer-aided self-help for obsessive-compulsive disorder: Randomized controlled trial. *Journal of Clinical Psychology*, *61*, 1499–1508.

Leahy, R. L., & Holland, S. J. (2000). *Treatment plans and interventions for depression and anxiety disorders*. New York, NY: Guildford Press.

Marks, I. M. (2001). *Living with fear* (2nd ed.). New York, NY: McGraw-Hill.

Mennuti, R. B., Christner, R. W., & Freeman, A. (2012). *Cognitive behavioral interventions in educational settings: A handbook for practice* (2nd ed.). New York, NY: Routledge.

National Institute for Health and Clinical Excellence. (2006). *Computerized cognitive behavior therapy for depression and anxiety*. London, UK: Author.

Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology*, *37*, 156–183.

Spek, V., Cuipers, P., Nyklicek, I., Riper, H., Keyzer, J., & Pop, V. (2007). Internet-based cognitive behavior therapy for symptoms of depression and anxiety: A meta-analysis. *Psychological Medicine*, *37*, 319–328.

Stallard, P. (2002). *Think good–feel good: A cognitive-behavioral therapy workbook for children and young people*. Hoboken, NJ: John Wiley.

Swinson, R. P., Soulios, C., Cox, B. J., & Kuch, K. (1992). Brief treatment of emergency room patients with panic attacks. *American Journal of Psychiatry*, *149*, 944–946.

United States Department of Health and Human Services, Administration for Children and Families. (2012). *Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma*. Retrieved from https://www.childwelfare.gov/pubs/trauma/trauma.pdf

PART II

Counseling Structure for Internalizers

THREE

Understanding Internalizing Problems

Chapter 3 provides a brief overview of most of the internalizing disorders and problems experienced by school-age students. Although perhaps not as much or to the same degree as students with externalizing problems that disrupt the school environment, many students with these challenges also are referred to school practitioners to receive cognitive behavioral therapy (CBT; Kutash, Duchnowski, & Lynn, 2006). In this chapter, diagnostic criteria and information are based on the current *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.; American Psychiatric Association [APA], 2013) to provide practitioners with up-to-date information on the clinical presentation of these disorders as well as how these disorders impact the students they serve. In considering student needs, it is important to remember that individuals may share a diagnosis but can vary significantly in their behavioral expressions of symptoms. In other words, students with the same psychiatric disorder may behave quite differently at school and elsewhere and display considerably different academic, behavioral, and emotional needs. Therefore, simply knowing a student's diagnosis is insufficient for being able to make adequate intervention plans for the student. However, knowledge of a student's psychiatric diagnosis and symptoms can be an important starting place with regard to the former because specific forms of CBT have been tailored to specific internalizing disorders and have been found to be effective for treating these disorders.

This chapter provides information on internalizing disorders and problems by reviewing common symptoms, their impairment, and how these manifest in student populations. In addition, because this chapter can only provide a brief overview on these topics, links and resources are included for practitioners who are interested in learning more about any particular disorder. Essentially, this chapter provides an overview of internalizing psychopathology that will then help practitioners to tailor specific CBT interventions to address these disorders and problems, which will be further elaborated in Chapter 4.

ANXIETY AND RELATED DISORDERS

Generalized Anxiety Disorder

The diagnostic criteria for generalized anxiety disorder (GAD) require persistent, excessive anxiety and worry that is difficult to regulate (APA, 2013, pp. 222–226). The worry must not be better accounted for by another mental disorder and should not be attributed to substance use. Additionally, significant impairment in social, occupational, or other aspects of functioning must be present. Out of the six possible symptoms, three or more must be present, which can include but are not limited to the following: irritability, muscle tension, and being easily fatigued (APA, 2013, p. 222). Only one of the six possible symptoms needs to be present in children to warrant diagnosis.

Prevalence rates are lower among adolescents (0.9%) than adults (2.9%) in the United States. In other countries, prevalence rates range from 4% to 3.6%. In regard to gender, GAD occurs twice as often in females than in males. Comorbidities include other anxiety and unipolar depressive disorders (i.e., obsessive-compulsive disorder, social disorder, substance/medication-induced, and posttraumatic stress disorder [PTSD]). Risk factors include a temperament that is neurotic, behaviorally inhibited, and harm avoidant. Like major depressive disorder, genetics account for one third of the risk of developing GAD (APA, 2013, pp. 223–226). Based on the symptomology of GAD, the following components of CBT may be important to consider during school-based counseling with CBT (Bandelow et al., 2013):

- Cognitive distortions: GAD stems from constant perceptions that the world is a dangerous place and, as a result, impedes daily functioning. Maladaptive thoughts include excessive worrying and avoidance of anxiety-provoking events or situations. CBT replaces maladaptive thoughts and cognitive distortions by promoting coping responses, such as thought stopping. Other interventions within CBT include relaxation training (i.e., progressive muscle relaxation to decrease physiological symptomology, self-control desensitization [provides frequent relaxation techniques to reduce worrying], and cognitive restructuring [identifying core beliefs and eliminating catastrophizing]. Homework assignments are encouraged to practice anxiety-reducing coping mechanisms when situations arise in the natural environment (http://www.apa.org/divisions/div12/rev_est/cbt_gad.html).
- Other factors: The Anxiety and Depression Association of America (ADAA) provides resources and suggestions for parents and caregivers of children with GAD (http://www.adaa.org/living-with-anxiety/children/tips-parents-and-caregivers).

Selective Mutism Disorder

The diagnostic criterion for selective mutism disorder is a consistent failure to speak when the expectation is to speak and the failure is not attributed to a communication disorder or inability to use spoken language (APA, 2013, pp. 195–197). It is important to note that selective mutism disorder should only be diagnosed alongside schizophrenia, autism spectrum disorder, or another psychotic disorder if the child is able to produce speech in some social situations (APA, 2013, p. 197). The prevalence rate for selective mutism disorder is extremely rare, ranging between 0.03% and 1% with no variation between race and gender. Comorbidities include separation anxiety disorder (SAD),

social anxiety disorder, and specific phobia. Risk factors include receptive language difficulties, shyness, social isolation/anxiety, and overprotective parents. There is evidence to suggest a genetic component in selective mutism disorder that is similar to social anxiety disorder (APA, 2013, pp. 196–197). Given the aforementioned characteristics associated with selective mutism disorder, the following CBT strategies are warranted:

- Cognitive distortions: Individuals with selective mutism disorder experience maladaptive thoughts when speaking in particular settings. Such maladaptive thoughts include excessive worrying and fear. CBT should be incorporated to alter the negative thoughts into positive thinking and decrease overall anxiety and worrying. The Selective Mutism Anxiety Research & Treatment Center provides parent- and clinician-friendly resources for selective mutism symptomology and interventions (http://www.selectivemutismcenter.org/aboutus/WhatisSelectiveMutism).
- Behavioral activation: The child should gradually be introduced to social environments to help the child feel more comfortable in that setting by decreasing the anxiety through desensitization techniques. Interactions should be encouraged with only one or two students before incorporating the child into a larger group setting. Talking can be encouraged by providing frequent positive reinforcement.

Separation Anxiety Disorder

The *DSM-5* criteria for SAD require a persistent and distressing fear of separating from an attached individual, which results in significant impairment across multiple domains (i.e., social, academic, occupational). There are eight possible symptoms (e.g., repeated nightmares, repeated complaints of physical symptoms, recurrent or excessive distress when facing separation from home or attachment figures), of which three must be present (APA, 2013, pp. 190–197). For children, the disturbance or fear must persist for at least 4 weeks and in adults, 6 months.

Prevalence rates in the United States are highest in children (4%), followed by adolescents (1.6%), and then adults (0.9% to 1.9%). It should be noted that separation anxiety is the most common disorder among children and is equally common in males and females (APA, 2013, p. 192). Comorbidities include GAD, specific phobia, PTSD, panic disorder, social anxiety disorder, agoraphobia, obsessive-compulsive disorder (OCD), and personality disorders. Risk factors include parent overprotection/intrusion and life stressors, such as loss or illness of a loved one, or parental divorce. Other notable risk factors, typically seen in young adults, are leaving the parental home, entering a committed relationship, and becoming a parent. Females are more frequently seen with SAD than males and 73% of a community sample indicated genetic correlates. Suicidality may be associated with separation anxiety disorder in the presence of comorbid mood disorders, anxiety disorders, or substance use (APA, 2013, pp. 192–195). The following suggestions may be helpful in planning school-based supports for children with a variety of anxiety-related disorders, including SAD (Huberty, 2012, 2013):

- CBT strategies: If the onset of SAD is related to death, bereavement counseling strategies will be a consideration. Counseling may also need to address misguided guilt children suffer when parents divorce. Additionally, thinking errors are a consideration.

- Other factors: At times, caregivers may inadvertently exacerbate separation issues by offering excessive reassurance; therefore, a parent discussion regarding appropriate departure from the school may be important. Additionally, children with SAD often have stopped attending school. Therefore, a comprehensive reintegration plan from the school may be important. Plans might include partial day attendance with gradually increasing time until the child is attending full days (Bagnell, 2011). Attendance monitoring will be a crucial progress-monitoring measure. Child and parent resources are available through the AnxietyBC website (http://www.anxietybc.com).

Specific Phobia

Specific phobias are marked by an intense, persistent fear of a specific object or situation that causes clinical distress and is out of proportion to the actual danger posed by the stimulus (APA, 2013, pp. 197–202). The phobia-inducing or phobic object or event provokes immediate fear or anxiety when it is actively avoided or endured. Specifiers should be distinguished for each specific phobia as evidenced by the majority of individuals (75%) experiencing more than one specific phobia (i.e., animal, situational, natural environment).

Prevalence rates are approximately 7% to 9% with similar percentages across the United States and European countries, with lower percentages noted in Asian, African, and Latin American countries (2% to 4%). Prevalence rates are highest among adolescents aged 13 to 17 years of age (16%), followed by children (5%), and the elderly (3% to 5%). Females are twice as likely as males to possess a specific phobia. All of the specifiers, except blood-injection injury, are experienced more frequently in females. Comorbidities include depression, personality disorder, bipolar disorder, eating disorders, obsessive-compulsive disorder, schizophrenia, panic disorder, social disorder, and SAD. Risk factors include living in an environment that has experienced parental loss, separation, or overprotectiveness, abuse (physical or sexual), or a traumatic event with the feared object or situation. Genetic correlates include an increase in the likelihood of having a specific phobia if a close relative has a specific phobia (APA, 2013, pp. 200–202). The following strategies are often effective in treating specific phobias:

- Exposure/response prevention (E/RP): Children with specific phobias have often developed significant behavioral patterns of avoiding the object or situation they are fearful of. Therefore E/RP methods are often utilized.
- Cognitive restructuring: A core symptom of specific phobia is an unrealistic or irrational fear. Therefore, it will be important to explore thinking errors and assist students in acquiring more adaptive thought patterns.
- Other factors: The National Institute of Mental Health (NIMH) offers a wide range of parent- and student-friendly resources addressing specific phobia self-help methods (http://www.nimh.nih.gov/health/publications/anxiety-disorders/index.shtml?ct=39988).

Social Anxiety Disorder (Social Phobia)

The criteria for social phobia require a fear or anxiety of being scrutinized by individuals in a social setting (APA, 2013, pp. 202–208). Similar to specific phobia,

the actual social situation typically produces fear that is out of proportion with the actual situation and is generally avoided or endured with great effort. Behavior examples in children include crying, tantrums, clinging, or inability to speak in social situations. Specifiers include performance only if the fear is restricted to public speaking or performances (i.e., typically seen in musicians, dancers, athletes) but does not include avoidance of the social situation. Additionally, performance fears may impair school, work, or social settings where public speaking is often required (APA, 2013, p. 203).

Prevalence rates are much higher in the United States (7%) than in other countries (0.5% to 2.0%). Females have a rate of social phobia that ranges from 1.5 to 2 times higher than that of males. American Indians and non-Hispanic Whites have the highest social phobia rates in the United States. Comorbidities include major depressive disorder, substance use disorders, social anxiety disorder, delusional disorders, and body dysmorphic disorder. In social anxiety disorder, performance only is comorbid with avoidant personality disorder. More specifically, children with high-functioning autism and selective mutism present with comorbidities to social phobia. Risk factors include fear of negative evaluations and child abuse. Behavioral inhibition is strongly regarded as a genetic component of social phobia and is exhibited through socially anxious parents. Like specific phobia, people are two to six times more likely to develop social phobia if their first-degree relatives have social anxiety (APA, 2013, pp. 204–208). As noted in the text that follows, considerations similar to those noted for specific phobia symptomology are helpful in interventions for social phobia.

- Exposure/response prevention: Exposures for students with social anxiety disorder can be constructed around gradual introductions to feared social situations (e.g., crowded cafeteria spaces or libraries) and/or public performance situations (e.g., class presentation, sports events). These types of exposures will require collaboration with other school personnel (e.g., coach, teachers) to set up appropriately graduated experiences for the child.
- Cognitive restructuring: A core symptom of social anxiety is the expectation of poor performance or negative evaluation and critique by others. Perspective-taking exercises as well as discussions of negative automatic thoughts will be important.
- Other factors: Self-help information is available through the National Social Anxiety Association (http://socialphobia.org).

Somatic Symptom Disorder

Somatic symptom disorder requires excessive thoughts, feelings, or behaviors that are distressing and impair daily functioning as they are related to health concerns (APA, 2013, pp. 311–315). Behavioral examples include the following: pervasive thoughts about the seriousness of symptoms, persistent levels of high anxiety in regard to personal health, and excessive time and energy devoted to health concerns (APA, 2013, p. 311). Severity is categorized using mild, moderate, and severe terminology and can be specified across two categories (i.e., predominant pain and persistent). Prevalence rates are unknown but it is estimated to be around 5% to 7% of the population in the United States and presents more in females than in males. Comorbidities include medical, anxiety, and depressive disorders. Degree of impairment is heightened when

comorbid with a medical illness. Risk factors include a temperament that aligns with neuroticism, an environment that is consistent with low socioeconomic status and limited education, and stressful life events, such as sexual abuse, and concurrent physical illness or psychiatric disorder (APA, 2013, pp. 312–315). The text that follows offers considerations for counseling intervention design:

- Cognitive restructuring: A hallmark of somatic symptom disorder is irrational beliefs regarding health and these thoughts will be a primary focus of thinking errors.
- Other factors: To rule out legitimate physical ailments, it may be important to consider a physician's well-check visit before beginning intervention for persistent somatic complaints. Given the nature of somatic complaints, students in school with this disorder will often visit the school nurse and request to leave school. Therefore, collaboration with the school nurse to monitor clinic visits can be an important source of progress-monitoring data. If permitted to leave school frequently due to somatic complaints and the home activities they return to are enjoyable (e.g., watching TV, playing), it is possible that this school policy can be reinforcing the behaviors. Therefore, an agreement between the parents and school administration on when and if the child is permitted to leave school could be an important consideration. The NIMH offers a wide range of parent- and student-friendly resources addressing multiple anxiety-related disorders (http://www.nimh.nih.gov/health/publications/anxiety-disorders/index.shtml?ct=39988).

Panic Disorder

The criteria for panic disorder are consistent with an unexpected panic attack. There are 13 possible symptoms (e.g., sweating, chills, feeling dizzy), of which four must be present in conjunction with either persistent worry about future panic attacks or a significant shift in behavior as a result of the panic attacks (APA, 2013, pp. 208–214). It should be noted that panic disorder is not to be confused with panic attacks because the disorder occurs when the panic attacks are unexpected and not explained by a mental disorder and panic attacks should be used as a specifier with other mental disorders when explained by such (APA, 2013, p. 214).

Prevalence rates for panic disorder are consistent across the United States and European countries (2% to 3%) but lower in Asian, African, and Latin American countries (0.1% to 0.8%). In terms of race, panic disorder is more evident in non-Latino Whites and American Indians, and in females. Panic disorder increases at the onset of puberty and peaks in adulthood. Comorbidities include anxiety disorders (more specifically, agoraphobia), major depression, bipolar disorder, and mild alcohol use disorder. Risk factors include neuroticism and increased anxiety sensitivity, as well as childhood sexual and physical abuse, and drug use (e.g., smoking). There is a genetic component of panic disorder and it is evident through the amygdala, children of parents with mental disorders, and respiratory disturbances (e.g., asthma). Comorbidities of panic disorder and child abuse may contribute to higher rates of suicidality (APA, 2013, pp. 210–213). The following intervention components will be important considerations when planning counseling for panic disorder:

- Cognitive restructuring: Replacing distorted thoughts will be a key component of reducing anxiety that precedes panic attacks. A common thinking distortion among persons with this disorder is alarm reactions consistent with catastrophizing.
- Other factors: For some persons whose panic is related to specific events, adding E/RP may be helpful depending on the nature of the specific fear. However, it should be noted that exposures can trigger a panic attack, which may include severe physical reactions (e.g., racing heart) that are detrimental. Therefore, exposure therapy for panic disorder is only recommended under strict supervision and with access to medical support if an emergency occurs. There are adolescent-friendly self-help and parent resources available through the Teen Mental Health Organization (http://teenmentalhealth.org/new/learn/mental-disorders/panic-disorder) in addition to anxiety-related resources at the NIMH (http://www.nimh.nih.gov/health/publications/anxiety-disorders/index.shtml?ct=39988).

TRAUMA AND STRESSOR-RELATED DISORDERS

Adjustment Disorder

Adjustment disorder criteria according to the *DSM-5* are warranted when emotional or behavioral symptoms that are clinically significant are presented within 3 months of a known stressor (APA, 2013, pp. 286–289). To be classified as adjustment disorder, the distress must be out of proportion to the actual severity level of the stressor and/or result in significant impairment in social, occupational, or other areas of functioning. Specifiers include adjustment disorder with depressed mood, anxiety, mixed anxiety and depressed mood, disturbance of conduct, mixed disturbance of emotions and conduct, and unspecified (APA, 2013, p. 287). Prevalence rates are high, ranging from 5% to 20% in those receiving outpatient mental health treatment, and can increase to as high as 50% in a hospital psychiatric consultation setting. Comorbidities include most mental disorders (e.g., PTSD, acute stress disorder, major depressive disorder, personality disorders) and medical disorders because the symptomology may not be explained by the mental or medical disorder alone. Environmentally, individuals from disadvantaged backgrounds may experience many stressors and thus be at increased risk for adjustment disorder (APA, 2013, pp. 287–289). The following intervention considerations are pertinent to adjustment disorders:

- Cognitive behavioral interventions for adjustment disorders will be dependent on the reason for the temporary adjustment issue. If the issues are related to the loss of a loved one, strategies consistent with those for depressive or bereavement needs may be appropriate (see Depressive Disorders section). If the adjustment is related to trauma, strategies utilized for PTSD may be helpful. In general, students experiencing adjustment disorders will need school personnel to provide a warm, nurturing environment with temporary counseling supports. Prolonged symptoms or the emergence of significant distortions may lead to other mental health diagnoses.

Posttraumatic Stress Disorder

Posttraumatic stress disorder, also known as PTSD, requires exposure to death, significant injuries, or violent sexual acts (APA, 2013, pp. 271–274). Exposure is broadly defined as direct experience, witnessing the event, or learning of the event from someone emotionally close to the child. Symptoms are accompanied by intrusion images or thoughts related to the event. Flashbacks, nightmares, recklessness, startle response, insomnia, and difficulty concentrating are some of the frequent symptoms.

- Cognitive behavioral strategies: The *DSM-5* (APA, 2013, p. 273) notes several thinking errors exhibited by children with PTSD, including unwarranted guilt and shame due to personalization of the events. Additionally, social withdrawal and a reduction in pleasurable activities can be characteristics of very young children with PTSD. Therefore, exercises that identify personalization distortions, social exposures, and behavioral activation techniques to increase activity may be helpful. The National Child Traumatic Stress Network offers a manual on CBT for children experiencing trauma as well as support resources (http://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf).

BIPOLAR AND RELATED DISORDERS

Bipolar I Disorder

The hallmark symptom of bipolar I disorder (colloquially referred to as bipolar or manic depressive disorder) is a period of mania lasting at least 1 week. Manic episodes are characterized by an intensely and unduly elevated mood as compared to the individual's baseline mood, which results in functional impairment (APA, 2013, p. 123). Episodes are accompanied by other manic symptoms, including feelings of grandiosity, disorganized thoughts, distractibility, reduced need for sleep, and increased goal-directed behavior (APA, 2013, pp. 123–124). Manic episodes may occur before or after hypomanic episodes (less severe manifestations of manic episodes) or depressive episodes (similar to those observed in major depressive disorder). Bipolar I disorder is classified according to the severity of symptomology, the category of the most recent episode (manic, hypomanic, depressed, and unspecified), and the presence of psychotic features, remission, or other course specifiers (APA, 2013, pp. 126–127).

Bipolar I disorder affects about 0.6% of the U.S. population annually. It more frequently occurs in individuals with family histories of related disorders and in individuals of high socioeconomic status. Females and males appear to have similar prevalence rates but experience different courses (APA, 2013, p. 130). Because bipolar I disorder usually manifests in late adolescence, diagnosis in young children should be based on extreme variation from the child's typical mood. Common comorbidities include disorders related to anxiety, inattention, disruptive behaviors, and substance abuse (APA, 2013, pp. 130, 132).

- CBT skills training: CBT using mood tracking, thought records, and cognitive distortions may help individuals with mood lability and inaccurate thought patterns that are characteristic of bipolar I disorder. Encouraging

individuals to carefully document fluctuations in their mood and thoughts as well as the antecedents and consequences for these changes can help them become aware of what prompts such shifts and help them challenge their maladaptive thought patterns (e.g., dichotomous thinking).

- Psychoeducation: Parents and educators may have misconceptions about the nature of bipolar I disorder. Sufficient evidence-based and practical resources should be provided to promote an accurate and comprehensive understanding of bipolar I disorder.
- Other factors: Bipolar I disorder is very highly correlated with suicide completion, thus consultation with parents, mental health agencies, and physicians is warranted. The NIMH provides information about the occurrence of bipolar I disorder specifically in children and adolescents (http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-adolescents/index.shtml).

Cyclothymic Disorder

Cyclothymic disorder (cyclothymia) is characterized by a pattern of hypomanic and depressive episodes that does not meet full criteria for bipolar I disorder. Such episodes must recur for at least 1 year in children and adolescents (or 2 years in adults) and remain present for at least half of the specified period (APA, 2013, p. 139). Individuals with cyclothymic disorder have a persistently shifting mood that cycles between periods of near mania and depressive symptomology that are not severe enough to be classified as a different disorder (APA, 2013, p. 140). Cyclothymic disorder affects up to 1% of the population and often first appears around adolescence, although children with the disorder report symptomology near age 7. A family history of bipolar and depressive disorders is a significant risk factor, and as many as half of individuals with cyclothymic disorder eventually develop bipolar I disorder or another related condition (APA, 2013, pp. 140–141). Adults with cyclothymic disorder often have comorbid substance abuse or sleep problems, whereas children are more likely to have comorbid attention deficit hyperactivity disorder (APA, 2013, p. 140).

- CBT skills training: As with bipolar I disorder, CBT may be useful in the treatment of cyclothymic disorder. CBT skills can help individuals monitor their mood, identify potential triggers for mood changes, and implement behavior modifications to alter these patterns of events. Identifying cognitive distortions that are present during hypomanic periods (e.g., peak-end rule, minimizing/maximizing) or depressive periods (e.g., labeling, shoulds, and catastrophizing) may help individuals with cyclothymic disorder in regulating and improving their thought patterns. Behavioral activation through potentially pleasurable activities can also be useful for periods featuring depressive symptomology.
- Other factors: Due to the high likelihood of cyclothymic disorder's evolution into a more severe condition, individuals with the disorder should be carefully monitored. The Mayo Clinic provides information about cyclothymic disorder and its treatment (http://www.mayoclinic.org/diseasesconditions/cyclothymia/basics/definition/con-20028763).

DEPRESSIVE DISORDERS

Major Depressive Disorder

Major depressive disorder (MDD; often called depression) is characterized by a very low mood, decreased pleasure or interest in activities, or irritability in children/adolescents that persists in most circumstances for at least 2 weeks (APA, 2013, pp. 160–163). Additional criteria include noticeable differences in weight, appetite, sleep, or movement; chronic fatigue; inability to concentrate; feeling insignificant or experiencing undue guilt; and suicidal ideation or attempts (APA, 2013, pp. 161–163). MDD is always categorized as either a single or recurrent episode, and particular descriptors are used to delineate severity (mild, moderate, severe), psychotic features, partial or full remission, and unspecified manifestations of MDD. The course of MDD is specified through additional labels where applicable (e.g., with anxious distress, with atypical features, with seasonal pattern; APA, 2013, p. 162). Individuals with unremitting symptomology generally have poorer outcomes than those whose symptoms recently appeared or are less severe (APA, 2013, p. 165).

Major depressive disorder affects 7% of the population annually and is notably more common in females (approximately 1.5 to 3 times more likely compared to males) and in adolescents or young adults (approximately 3 times more likely compared to older adults; APA, 2013, p. 165). Several other internalizing disorders may be comorbid with MDD, including eating disorders, obsessive-compulsive disorder, and panic disorder. Co-occurrence with substance abuse or borderline personality is also common (APA, 2013, p. 168). Risk factors include negative affect or temperament, traumatic life events, and immediate family members who have or previously had MDD. A number of school-based CBT strategies have empirical support for remediating symptoms, including:

- Cognitive distortions: Individuals with major depressive disorder (especially those with severe feelings of worthlessness, guilt, or lack of hope) likely experience cognitive distortions that alter their views of themselves and their environments (Stirk, Kaplinski, & Gudmunden, 2009). Common distortions include mind reading, fortune-telling, labeling, overgeneralizing, personalizing, discounting positives, negative filtering, and inability to disconfirm.
- Behavioral activation: One of the defining features of MDD is loss of interest in previously pleasurable activities. Encouraging individuals with MDD to participate in activities they have enjoyed (or that might be enjoyable) can help them recognize the relationship between mood and behavior and create environmental reinforcements.
- Relaxation training: Similar to behavioral activation in intent, relaxation training seeks to change behaviors in order to produce an eventual effect on mood. Teaching students how to relax (e.g., guided imagery and visualization techniques, diaphragmatic breathing, grounding techniques) may help them de-emphasize their most distressful thoughts.
- Other factors: The possibility of suicide is a significant cause for concern in treating MDD. The National Alliance on Mental Illness (NAMI) provides MDD treatment information and resources (http://www.nami.org/Template.cfm?Section=depression).

Persistent Depressive Disorder

Previously known as dysthymia, persistent depressive disorder (PDD) is characterized by a chronically low or irritable mood that persists for an extended period of time (at least 2 years, or 1 year for children or adolescents). This may be accompanied by changes in appetite or sleep, loss of energy, inability to concentrate, low self-worth, or feelings of despair and helplessness (APA, 2013, p. 168). PDD uses similar specifiers to those accompanying MDD. PDD often develops early in life and persists over time but affects approximately 0.5% of the population in a given year (APA, 2013, pp. 169–170). In addition to comorbidities noted for MDD, individuals with PDD are more likely to have anxiety and substance-related disorders as well as personality disorders when PDD occurs early in life. Loss of a parent and having relatives with PDD are both risk factors, and individuals who have PDD with lowered overall functioning generally have poorer outcomes (APA, 2013, p. 170).

- Cognitive distortions: Many of the same techniques that are useful in treating MDD may be efficacious for PDD, including using cognitive restructuring by targeting distortions. Supporting the student in challenging his or her distortions outside of therapy may be particularly helpful for individuals with long-term, pervasive depression, such as PDD, due to the enmeshment of depressive symptomology and daily activities.
- Behavioral activation: Students with PDD may find it difficult to engage in activities that were previously enjoyable. Opportunities for behavioral activation and potentially positive activities can be incorporated into both the school and home settings.
- Relaxation training: Integrating relaxation training into daily life may be beneficial for students who experience PDD. Such training could be used during stressful events as well as during daily life to promote improved mood throughout the day.
- The NIMH website discusses PDD as well as MDD (https://www.nimh.nih.gov/health/topics/depression/index.shtml).

Disruptive Mood Dysregulation Disorder

Disruptive mood dysregulation disorder (DMDD) is a new addition to the *DSM-5* that was created to curtail the overdiagnosis of bipolar disorder in children (APA, 2013, p. 157). The diagnosis must be made between ages 6 and 18, with the first symptoms occurring before age 10. The hallmark symptom of DMDD is a pattern of chronic and intensely agitated mood that has appeared in multiple settings for at least 1 year. This irritability manifests as either tantrums at least three times per week or as a persistent mood with overriding anger easily observed by others. Agitation must be severe and beyond developmental expectations (APA, 2013, p. 156).

DMDD occurs in approximately 2% to 5% of children and adolescents with elevated prevalence noted in males and elementary-age children (APA, 2013, p. 157). Additional psychiatric symptoms frequently occur with DMDD, and comorbidity

with ODD is the most common; however, individuals with DMDD also have elevated health concerns and may be diagnosed with other behavior-related disorders as well (APA, 2013, p. 160).

- CBT skills training: Children with DMDD may benefit from CBT with an emphasis on frustration tolerance and coping skills. Incorporating prevalent distortions (shoulds, blaming, and dichotomous thinking) may help them navigate distressing situations that would otherwise prompt a behavioral outburst or irritable response.
- Behavior modification: Behavior modification programs may be useful in managing the irritable symptomology and temper tantrums associated with DMDD. Such a behavior plan would provide clear expectations for child behavior, structured behavioral monitoring, and appropriate reinforcements for meeting task demands.
- Psychoeducation: Providing parents and teachers with appropriate resources for working with children with DMDD is vital. Because the diagnosis was recently created, individuals outside of mental health professions may not know about DMDD and would likely benefit from education on its symptoms, treatment, and course.
- Other factors: Due to its relatively new classification, resources for DMDD are still emerging. The American Academy of Child and Adolescent Psychiatry provides information about the characteristics and treatment of DMDD on its website (http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Disruptive_Mood_Dysregulation_Disorder_DMDD_110.aspx).

EATING DISORDERS

Anorexia Nervosa

Anorexia nervosa (also called anorexia) is an eating disorder indicated by severely low body weight as measured by body mass index (BMI) percentile, an extreme fear of weight gain, and a distorted body perception (APA, 2013, p. 339). The distorted feature is a hallmark of this diagnosis, as persons with anorexia are noted to actually view themselves as having more weight or body fat than is actually accurate. Individuals with anorexia nervosa may severely inhibit their caloric intake, exercise intensely, or engage in binge-eating/purging behavior. In children with anorexia, they may not experience dramatic weight loss but may instead fail to meet expected weight gains given their height (APA, 2013, p. 339).

Anorexia nervosa is relatively rare (0.4% prevalence in young women) but affects approximately 10 times as many females as males and often originates during youth (APA, 2013, p. 341). Risk factors include participating in activities or cultures that value thinness, stressful or traumatic life events, a family history of eating disorders, and a previous history of anxiety or obsessive behaviors. Brain abnormalities in individuals with anorexia nervosa have been noted using imaging techniques, and numerous starvation-related physiological symptoms (e.g., chronic fatigue, low heart rate, cessation or delay of menstruation for girls, and visible emaciation) accompany the disorder (APA, 2013, p. 342). It is often comorbid with other internalizing

disorders, including forms of depression, anxiety, and OCD. Co-occurrence with bipolar disorder and/or substance abuse is also common (APA, 2013, p. 345).

- Cognitive distortions: Cognitive restructuring could assist individuals with anorexia nervosa in reframing their negative and inaccurate perceptions of themselves and their bodies (Bardick et al., 2004; Lock & Fitzpatrick, 2009). Distortions may include labeling, personalizing, unfair comparisons, regret orientation, emotional reasoning, catastrophizing, and dichotomous thinking.
- Exposure/response prevention: For individuals with severe anxiety about eating food, E/RP can be coupled with CBT to confront anxious thoughts around food and inhibit restricting or binge/purge responses. This should be carefully monitored and may be best administered in a clinic setting with medical supervision.
- Other factors: Anorexia nervosa is a serious medical condition with a very high overall mortality rate and a high suicide rate (APA, 2013, p. 343). Given this, collaboration and consultation with agencies outside the school (i.e., parents, physicians, and inpatient or outpatient treatment programs) is highly recommended. The National Eating Disorders Association (NEDA) offers extensive information on the disorder and its treatment (http://www.anad.org/get-information/about-eating-disorders/anorexia-nervosa).

Bulimia Nervosa

Bulimia nervosa (bulimia) is reflective of a pattern of binge eating, compensation for overeating (i.e., purging, fasting, exercising, or abusing medications), and a fixed relation of self-worth to body shape or weight (APA, 2013, p. 345). It is classified by severity in terms of the number of episodes per week (mild, moderate, severe, extreme) and can also be in either partial or full remission. Unlike anorexia nervosa, individuals with bulimia nervosa are often in a normal range for their height and age (APA, 2013, p. 347).

Bulimia nervosa is more common among young women than anorexia nervosa (1% to 1.5% prevalence) and occurs most frequently in late adolescence/early adulthood (APA, 2013, p. 347). Females also are 10 times more likely than males to have bulimia nervosa. Risk factors encompass stressful life events (including abuse), depression, anxiety, childhood obesity or early puberty, and a preoccupation with weight or the idealization of thinness (APA, 2013, p. 348). Comorbidities are common and may involve depressive, anxious, or other mood disorders; personality disorders; or substance abuse related to weight loss (APA, 2013, pp. 349–350).

- Cognitive distortions: Similar to anorexia nervosa, cognitive restructuring through CBT may help individuals with bulimia nervosa recognize distorted patterns of thinking that affect their perceptions of their bodies and self-worth (Bardick et al., 2004).
- Exposure/response prevention: CBT with E/RP could be used to introduce individuals to distressing situations (i.e., overeating) and inhibit their use of compensatory mechanisms (i.e., purging/exercising/medicating) to challenge their behavioral patterns. It would be important for any E/RP intervention to be accompanied by supervision and medical monitoring.

- Collaboration: Like anorexia nervosa, bulimia nervosa is a serious medical condition that is accompanied by a markedly elevated mortality rate from suicide and other causes (APA, 2013, p. 347). Collaboration and consultation with medical professionals and parent involvement is highly recommended in the treatment of such disorders.
- Other factors: The NEDA provides information related to the disorder (https://www.nationaleatingdisorders.org/bulimia-nervosa) as well as a toolkit for educators working with individuals with eating disorders (https://www.nationaleatingdisorders.org/sites/default/files/Toolkits/educatortoolkit/index.html).

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS

Obsessive-Compulsive Disorder

OCD encompasses a pattern of obsessions (recurring, intrusive, and disturbing thoughts that are actively avoided or suppressed) and/or compulsions (excessive or illogical behaviors or thoughts that the individual believes will alleviate distress) that lead to significant life stress or time spent engaging in such behaviors (APA, 2013, p. 237). OCD can occur with good, poor, or absent insight regarding the inaccuracy of OCD-related beliefs and compulsions. Symptoms are often accompanied by anxiety or repulsion and may occur in multiple domains (e.g., contamination, harm, symmetry or organization, inappropriate or taboo thoughts; APA, 2013, pp. 238–239).

OCD occurs in about 1.2% of Americans, with slightly higher prevalence reported in males during youth. About one quarter of males report symptoms before age 10 (APA, 2013, p. 239). Risk factors for OCD involve traumatic life events (including abuse), a family history of OCD, the presence of other internalizing disorders, negative affect, and a history of restrictive behaviors. Differential brain functioning in areas related to decision making, emotionality, and inhibition has also been observed (APA, 2013, pp. 239–240). Over half of adults with OCD also experience internalizing disorders, including anxiety, depressive, or bipolar disorders. Tic disorders and other OCD-related disorders also regularly co-occur (APA, 2013, p. 242).

- Psychoeducation: Psychoeducation for educators, parents, and individuals with OCD is helpful in providing meaningful information about the nature of OCD and its treatment.
- Exposure/response prevention: CBT with E/RP is an empirically supported treatment for OCD, but it should be implemented only by a trained therapist. In CBT with ERP, the individual challenges the intrusive obsessions by confronting them and engaging in competing behaviors (i.e., not avoiding or accommodating the intrusive thought).
- Other factors: Suicidal ideation is common in individuals with OCD, which occurs in up to 50% of those with OCD; therefore, it will be important to monitor any expressions of suicidal thoughts (APA, 2013, p. 240). The International OCD Foundation gives information about OCD characteristics and treatment (http://www.ocfoundation.org).

Excoriation (Skin-Picking) Disorder and Trichotillomania (Hairpulling Disorder)

Excoriation disorder entails the habitual picking of one's skin (to the point of sores and sometimes bleeding), and trichotillomania entails the habitual pulling out of one's hair (to the point of hair loss). Both are characterized by unsuccessful attempts to modify the behavior and impaired life functioning (APA, 2013, pp. 251, 254). Excoriation behaviors commonly occur on the face and arms and can involve picking healthy or damaged skin (APA, 2013, p. 255). Trichotillomania often involves pulling out hair from the head or eyebrows/eyelids and is regularly accompanied by hairpulling rituals (APA, 2013, p. 252). Symptoms of both disorders may occur in reaction to stress or without active awareness and can result in feelings of satisfaction (APA, 2013, pp. 252, 255). Excoriation disorder and trichotillomania are more common in females than in males in adult populations, but trichotillomania is more common in male children than in female children (APA, 2013, pp. 252, 255). Prevalence rates for both disorders are less than 2% in adults. Both typically originate in adolescence and feature a family history of OCD-related disorders as a risk factor (APA, 2013, pp. 253, 255). Excoriation disorder and trichotillomania are often comorbid with each other as well as MDD and other OCD-related disorders (APA, 2013, pp. 254, 257).

- Psychoeducation: Providing families and educators with information about each disorder may improve general understanding of the conditions and available treatment options.
- Behavior modification: A structured behavior modification program that incorporates active behavior monitoring and ample reinforcements may help the individual increase awareness of his or her behaviors and create an environment in which desirable replacement behaviors (e.g., keeping hands in lap, completing schoolwork) are more likely.
- Other factors: The Trichotillomania Learning Center provides information about treatment options and resources for both disorders (http://www.trich.org/index.html).

Hoarding Disorder

Hoarding disorder is a new addition to the *DSM-5*. It categorizes an intense desire to save objects regardless of value or use and a difficulty separating from such objects. Hoarding disorder can occur with good, poor, or absent insight and/or excessive acquisition of items (APA, 2013, p. 247). It should be distinguished from other possible conditions (e.g., Prader-Willi syndrome, traumatic brain injury, pica, neglect, parental hoarding; APA, 2013, pp. 247–249). Hoarding disorder often manifests in early adolescence and may be more likely in males. Further research on prevalence is needed, but current estimates range from 2% to 6% of the general population (APA, 2013, p. 249). Risk factors include indecision, trauma, and a family history of hoarding. Most people with hoarding disorder also experience other internalizing issues like depressive, anxious, or OCD-related disorders (APA, 2013, pp. 249–251).

- Psychoeducation: Due to the relative newness of the classification, parents and educators may not have extensive knowledge about hoarding disorder's symptoms or treatments. Providing involved individuals with appropriate resources could mitigate this challenge.

- Behavior modification: A behavior modification program that incorporates objective goals, prevention of maladaptive responses, and reinforcement of alternate incompatible behaviors (e.g., cleaning out unneeded items from desk, book bag, or locker) may be helpful.
- Relaxation training: Teaching coping skills for distress may reduce some acquisition behaviors relaxed to anxiousness.
- Cognitive restructuring: For students experiencing irrational thoughts regarding value, scarcity, or need for excessive or unusable items, challenging the distorted perceptions may be useful.
- Behavioral activation: In circumstances in which the child may be inactive or have depressive characteristics, behavioral activation techniques that rekindle positive interests, hobbies, or extracurricular activities may be helpful.
- Other factors: The International OCD Foundation offers a comprehensive guide to hoarding and its treatment (http://www.ocfoundation.org/hoarding/about.aspx).

PERSONALITY DISORDERS

Schizoid Personality Disorder and Schizotypal Personality Disorder

Schizoid and schizotypal personality disorders are similar in that both involve maladaptive and restricted social interactions that occur before early adulthood (APA, 2013, pp. 652, 655). Schizoid personality disorder features extremely limited social interactions, a distinct preference for solitary activity, lack of emotional variance, and indifference or detachment (APA, 2013, pp. 652–653). Schizotypal personality disorder is characterized by an extreme discomfort in social interactions, distortions of behaviors or beliefs, and eccentricities (e.g., magical thinking or speech, paranoia, atypical fantasies, odd behavior; APA, 2013, pp. 655–656). Both disorders are slightly more common in males and have low prevalence in clinical populations. However, some studies report that up to 5% of the general population may be affected with each (APA, 2013, pp. 654–658). Risk factors include having family members with schizophrenia, psychotic, or personality disorders. Both disorders may be preceded by difficult childhood peer interactions and low achievement in school (APA, 2013, pp. 654, 657). Symptomology must be considered in light of cultural determinants that could account for apparent symptoms (e.g., minority cultural backgrounds being interpreted as schizoid personality disorder, or religious thinking translating to schizotypal personality disorder; APA, 2013, pp. 654, 658).

- Cognitive distortions and exposure/response prevention: Due to the avoidance of social interaction, individuals with both disorders could benefit from cognitive restructuring to reframe their negative perceptions about interacting with others. Avoidance of social interactions could be challenged through CBT with E/RP emphasizing social situations.
- Social skills training: Direct instruction in strategies for social interactions may also be used (e.g., introductions, integrating in social settings, creating enjoyable conversations).

- Other factors: The Mayo Clinic offers treatment resources and information on both schizoid personality disorder (http://www.mayoclinic.org/diseases-conditions/schizoid-personality-disorder/basics/definition/CON-20029184?p=1&DSECTION=all) and schizotypal personality disorder (http://www.mayoclinic.org/diseases-conditions/schizotypal-personality-disorder/basics/definition/CON-20027949?p=1).

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bagnell, A. L. (2011). Anxiety and separation disorders. *Pediatrics in Review*, *32*, 440–446.

Bandelow, B., Boerner, R. J., Kasper, S., Linden, M., Wittchen, H., & Möller, H. (2013). The diagnosis and treatment of generalized anxiety disorder. *Continuing Medical Education*, *110*, 300–310.

Bardick, A. D., Bernes, K. B., McCulloch, A. R., Witko, K. D., Spriddle, J. W., & Roest, A. R. (2004). Eating disorder intervention, prevention, and treatment: Recommendations for school counselors. *Professional School Counseling*, *8*, 168–175.

Huberty, T. J. (2012). Interventions for anxiety disorders. *In Anxiety and depression in children and adolescents: Assessment, intervention, and prevention* (pp. 245–281). New York, NY: Springer.

Huberty, T. J. (2013). Anxiety and anxiety disorders in children. *Communiqué*, *41*, 20–21.

Kutash, K., Duchnowski, A., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision-makers*. Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, Tampa, FL.

Lock, J., & Fitzpatrick, K. K. (2009) Advances in psychotherapy for children and adolescents with eating disorders. *American Journal of Psychotherapy*, *63*, 287–303.

Stirk, S. R., Kaplinski, H., & Gudmunden, G. (2009). School-based cognitive behavioral therapy for adolescent depression: A benchmarking study. *Journal of Emotional and Behavioral Disorders*, *17*, 106–117.

FOUR

Cognitive Behavioral Therapy for Internalizing Problems

This chapter reviews several cognitive behavioral interventions that are particularly effective for internalizing disorders and problems. In describing students with internalizing or externalizing problems, some researchers use the terminology *overcontrollers*, *undercontrollers*, and *resilients*. This framework considers the underlying core pathology of internalizing disorders to be a propensity for hypervigilance in self-regulation or overcontrolling (of themselves). Whereas the term *undercontrollers* is used to describe externalizers, the term *resilients* is used to identify children without behavioral difficulties who display a higher level of agreeableness, emotional stability, adaptability, and openness.

Overcontroller is a term from temperament theory that describes persons who have a strong ability to suppress impulsive behaviors (Block & Block, 1980; Caspi, 1998; Joyce, 2010). These individuals also are rigid in their repertoire of responses following self-prescribed narrowing boundaries and are often motivated by unrealistic fear. They can be self-restrictive. In thinking about internalizing disorders (e.g., obsessive-compulsive disorder [OCD], anxiety, phobias, anorexia, depression) they share common characteristics of escaping something deemed fearful (e.g., catastrophe, judgment by others, spiders, weight gain, failure). Studies of pathology and the Big Five model of personality also have found that overcontrollers rate higher on introverted characteristics (Scholte, van Lieshout, de Wit, & van Aken, 2005). The overcontrolling or avoidance behaviors serve to slowly shrink the individual's environment through fewer social interactions and reduced participation in common activities (e.g., heights/flying, food restrictions, joining clubs, and so forth). These overcontrolling characteristics of internalizers are well suited to cognitive behavioral therapy (CBT) strategies that address anxiousness and withdrawal. For internalizers, CBT addresses stress reduction through relaxation, fear reduction through exposures, and unrealistic avoidance thinking patterns through cognitive restructuring.

Specifically, the following therapeutic treatments are highlighted here: exposure/response prevention (E/RP) therapy, behavioral activation, cognitive restructuring, relaxation training, and social skills training. Cognitive restructuring and relaxation training are also reviewed in Chapter 2; however, this section will offer a more

detailed review of these two strategies in lieu of applications and examples for internalizers. The Appendix provides multiple student worksheets illustrating the E/RP, behavioral activation, relaxation training, and social skills concepts delineated in this chapter as well as counselor checklists and handouts for parents/caregivers (see Appendix, Exhibits 4.1 to 4.31).

EXPOSURE/RESPONSE PREVENTION THERAPY

E/RP therapy is a therapeutic technique that is often used to help individuals face and overcome exaggerated fears (see Appendix, Exhibits 4.1 to 4.5 for worksheets/forms). E/RP is grounded in the notion that one must confront his or her fears to learn how to cope with them (J. S. Beck, 2011; Kendall, 2006). Although perhaps counterintuitive, avoiding feared stimuli actually tends to provoke anxiety and ultimately perpetuate fear. The avoidance may initially serve as a protective response for the individual in the short term; however, constant avoidance of feared stimuli or situations can cause the anxiety to become worse as opposed to getting better through repeated exposure. As an individual escapes each encounter (or potential encounter) from the anxiety-provoking stimulus, his or her level of anxiety will increase with each subsequent exposure to the said stimulus. These avoidance behaviors are a hallmark of many internalizing disorders, especially those that are anxiety related (e.g., phobias, generalized anxiety, and separation anxiety disorder).

E/RP works by breaking the problematic pattern that was previously described. Overall, the treatment can help children and adolescents manage their fears and reduce their anxiety associated with specific situations and stimuli. Thus, in order to help children overcome exaggerated fears, counselors should implement the core components of E/RP. Because many internalizing disorders involve the presence of compulsive (i.e., anxiety reducing) behaviors that do not allow an individual to naturally habituate to feelings of anxiety, E/RP works by removing the performance of—and eventual need for performing—compulsive behaviors. Thus, E/RP works by breaking two problematic associations that keep people with anxiety stuck: (a) the association between feeling anxious and needing to perform compulsive behaviors and (b) the association between needing to perform compulsive behaviors and feeling relief.

Through breaking the previous associations, E/RP instead teaches individuals that they need not dread feeling anxious, that they do not need to do anything to prevent or reduce their anxious feelings, and that these feelings will naturally remit at some point without the individual needing to engage in any specific behavior. To exemplify how E/RP works, consider the experience of a person with obsessive worries or concerns that he or she might become contaminated and get sick from being exposed to germs from touching objects around the school (e.g., door knobs, writing utensils, locker combinations). Each time the student touches one of these objects, he or she experiences an increase in anxiety related to his or her intrusive and obsessive thought about being contaminated (e.g., "I'm sure that my hand is now covered in germs from touching that doorknob. I've seen people at this school use the restroom and not wash their hands before touching it."). In response to feeling distress or anxiety that is associated with having contamination-related obsessive thoughts, the student likely will perform some compulsive behavior to mitigate this distress, such as washing his or her hands with soap or applying

hand sanitizer. In addition, the student probably with make concerted efforts to avoid coming into contact with objects that he or she thinks might be contaminated by not touching them, handling them only with an object that he or she perceives will prevent contamination (e.g., a glove, a paper towel), or touching them only with one hand and not the other to preserve at least one uncontaminated hand for other tasks, such as eating or grooming.

The use of E/RP would then involve having the student deliberately touch objects that he or she perceives are contaminated while refraining from engaging in the aforementioned compulsive washing and avoiding behaviors. From doing this, the child likely would experience a state of anxiety that will not decrease as quickly as it would if the child performed a compulsion. Instead, the child likely will feel distressed for a period of time that tends to vary considerably on a person-by-person basis; however, assuming that the counselor has selected an appropriate exposure task, which will be discussed later in this chapter, the child likely will habituate or experience a noticeable decrease in his or her anxiety within 10 to 30 minutes. The crux of E/RP then involves facing one's anxiety or fear directly, resisting the engagement of anxiety-reductive compulsive behaviors that are temporarily useful but ultimately impairing in their use over time, and tolerating distress while waiting for habituation to one's feelings of anxiety and a concomitant reduction in related obsessive thoughts.

To implement E/RP the counselor must first gather information on the various situations and stimuli that incite the student's inflated fear response. Then, with the help of the therapist, the student creates a fear hierarchy by ranking the level of anxiety that he or she experiences or expects to experience with each exposure to the feared stimuli or situations. The ranking system that undergirds this hierarchy-development process involves subjective units of distress (SUDs), which are thumbnail self-report estimates of anxiety or distress. Using SUDs involves having the student rank his or her level of anxiety for each potential exposure on a scale ranging from 0 (totally relaxed) to 10 (full panic; Wolpe, 1969). However, as broached in Chapter 1, some students—especially older students—prefer to use a 0 to 100 scale to calibrate their anxiety or distress more specifically.

Following the development of the E/RP hierarchy, the student is exposed to the anxiety-provoking stimuli or situations and response prevention, then is encouraged in response to being exposed. In general, this process involves having the counselor encourage the student to refrain from avoiding the stimuli or situation though actively distancing him- or herself, engaging in a compulsive or anxiety-reducing behavior or a mental ritual that reduces anxiety. As implied, E/RP should be applied in several specific stages. These stages include providing psychoeducation, developing an E/RP hierarchy, conducting behavioral exposures, and then engaging in treatment termination work to help support relapse prevention. Although the amount of time and the number of sessions spent on each of these stages varies considerably across treated individuals, in general, one or two sessions should be spent on psychoeducation; only one session should be allocated to developing the E/RP hierarchy, the majority of the rest of the sessions should be delegated toward conducting behavioral exposures, and treatment termination and relapse-prevention sessions should be less time limited and more tailored to the specific student's need.

When conducting exposures with students, it is important to begin with lower ranked situations or stimuli first and then gradually confront higher ranked items on the E/RP hierarchy. Thus, counselors may begin with exposures that are

expected to elicit moderate anxiety (about 4 to 5 SUDs) as opposed to exposures that may elicit marked anxiety (about 8+ SUDs) or limited anxiety (greater than 3 SUDs). If the counselor attempts the former, he or she may cause the student to become flooded with anxiety, which is counterproductive for most clients. However, if she or he attempts the latter, the student may not feel enough anxiety to experience feelings of habituation related to the exposure task.

Immediately prior to conducting behavioral exposures, the counselor should express that the student will face his or her fears in therapy in a structured and systematic manner with the help of the therapist. In other words, the counselor will hold the child's hand while they wade into the pool together and learn to swim as opposed to pushing the child into the deep end. The therapist should also emphasize that he or she will not ask the child to do anything that he or she is not willing to model himself or herself. As a general principle, counselors should be willing to do whatever behavioral task that he or she is asking the child to do either before while modeling the task or concomitantly with the child. Implying the former and expressing the latter can help develop rapport with the child as well as alleviate anxiety the child may have about treatment.

Through repeated exposure and having success in tolerating the anxiety-provoking stimuli/situation in the absence of using anxiety-reducing compulsions, the therapeutic approach behind E/RP works to break two symptom-maintaining associations: the belief that the anxiety-provoking stimuli/situation actually should be feared and that anxiety-reductive behaviors need to be performed to mitigate distress associated with confronting the anxiety-provoking stimuli/situations. By breaking these associations during the course of therapy, students learn to habituate to their feelings of anxiety as well as that they can tolerate their anxious feelings better than they initially perceived. Because behavioral exposures purport to cause anxiety or distress, a clear treatment rationale should be provided prior to exposure implementation to ensure that the student understands the purpose of treatment and is engaged in the process. Successful E/RP is an additive and empowering process because students become better able to face feared situations and stimuli in a progressive manner. In other words, while advancing through therapy and completing each successive item on the E/RP hierarchy, children will generally be better prepared to face the next item.

Behavioral exposure exercises, whether conducted with a counselor or independently, are varied in their degree of intensity and these intensity levels vary markedly across individuals, even if they have the same diagnosis. However, in general, imaginal exposures that involve in-session role-playing, script generation, and imaginal activities (e.g., "imagine that you are holding a snake") tend to be less intense or produce lower levels of anxiety than in vivo or "in real life" exposures that involve directly confronting a feared stimulus or situation.

Regardless of the type of exposure task or its intensity, students are encouraged to endure the discomfort, report and keep track of their SUDs ratings, and allow their feelings of anxiety to abate naturally. The time that it will take for the former to happen will be variable across students; however, over treatment, the number of minutes that it takes to experience a significant reduction in SUDs or to habituate generally decreases. As a general thumbnail, the exposure can be discontinued when the student's SUDs are reported to be at a "3/10," which indicates that he or she is experiencing more relaxed and calm feelings. Throughout

E/RP therapy, the counselor should repeat this process until the student habituates and is ready to move on to the next item on the E/RP hierarchy.

Finally, it is important to note that the provision of reassurance with E/RP is controversial and that processes associated with E/RP are counterintuitive on some levels to counselors who are oriented toward always providing students with immediate support and relief. Remember, however, that problematic compulsive behaviors associated with many disorders also provide immediate support and relief. Thus, in this vein, it would be inappropriate to tell a child experiencing an animal-based version of specific phobia that all dogs are good and that they will not harm him or her, because, although unfortunate, unexpected dog attacks do occur. Therefore, as core—yet potentially overlooked principles—honesty and objectivity must be central to the application of E/RP. Although providing reassurance in the process of engaging in E/RP may seem beneficial to the student, if the former principles are neglected, a therapist's best efforts to help a student may amount to little more than reinforcing his or her problematic behavior.

When to Use or Not Use Exposure/Response Prevention Therapy

E/RP can be used to treat a range of anxiety (e.g., social anxiety disorder, specific phobia, and separation anxiety disorder) and obsessive-compulsive and related disorders (e.g., OCD, body dysmorphic disorder [BDD]). Because behavioral exposures can elicit significant discomfort and distress in students, it is critical for a legal guardian to consent to this form of treatment before the initiation of exposures. In addition, the participating students should be notified about the treatment and what it entails in advance of beginning exposures. Then, with parental consent and assent from the student, the counselor and the student can work together to develop a treatment plan that involves developing a hierarchy and engaging in behavioral exposures.

Although E/RP is an effective treatment for many disorders, it should not be used for all students who present with these disorders. For example, it is contraindicated to use E/RP with individuals who display psychotic symptoms, as they may not perceive their fears as being irrational and instead of habituating to their anxiety they may experience even greater distress during the course of exposures. In addition, E/RP therapy should not be used for children who exhibit marked sensitivity to feelings of anxiety because these individuals also may not habituate to their feelings of anxiety and instead leave the session feeling even more anxious than when it began. Finally, E/RP should not be implemented as a treatment option for children who have extreme depression and children who are highly aggressive or display agitation tendencies. Because of the challenge associated with facing fears, E/RP therapy can create acting-out behaviors during the sessions among children who are highly aggressive or display agitation tendencies.

BEHAVIORAL ACTIVATION

Behavioral activation is an intervention strategy that is employed to help individuals cope with social withdrawal and depressed moods (see Appendix, Exhibits 4.6 to 4.11). Behavioral activation is based on the premise that people are less likely to engage in enjoyable activities when they feel depressed and apathetic.

Often people are less active when they are in a depressed mood, and when their activity level declines they may become even more withdrawn, unmotivated, and lethargic (J. S. Beck, 2011; Leahy & Holland, 2000). Hence, there is a high probability that people in this negative emotional state will experience a worsening of their depression because they are not actively engaging in pleasurable activities or social interactions. Thus, to combat this problem, behavioral activation can be implemented to help individuals to be more active and gradually engage in pleasurable activities to improve their current situation and mood. However, engaging in this process alone can be challenging because the task of engaging in pleasurable activities can be daunting for individuals who are depressed and display low motivation. Therefore, engaging in behavioral activation with a therapist can help increase a student's motivation to be more active as well as encourage his or her efforts to stick with activities that may seem more distressing or exhausting at first until his or her mood lifts and these activities become pleasurable.

To apply behavioral activation with students, a counselor should first help students to identify and list a variety of activities that they can pursue that might elicit pleasure or even tepid enjoyment. In order to optimize students' success when engaging in this intervention, activities should be carefully chosen. Thus, in this regard, it would not be reasonable to encourage a student in the midst of an episode of major depression to begin a highly challenging new hobby (e.g., playing guitar) that likely will contribute to feelings of frustration in the short term and will not result in feelings of mastery until months of practice are applied to the hobby. Instead, simpler or facile tasks should be chosen and encouraged, such as spending time with friends on a daily basis, going for walks around the block, or attending a new club or extracurricular activity.

While working with students to assign behavioral activation tasks, counselors may want to encourage students to first engage in activities that are easy to complete and assign increasingly challenging activities throughout the course of treatment after the students display consistent success with the easier activities. In this regard, if a student starts regularly attending intermural sports after school and enjoying participating in this club, he or she could be encouraged to sign up for a sporting team. Moreover, in addition to beginning with easier activities that encourage success and enjoyment, students also may experience more success if they start off by completing a fewer number of activities and then gradually increase their number each subsequent week. Finally, whenever possible, it is beneficial for activities selected as part of the behavioral activation process to be as personally meaningful as possible. Therefore, even if a student does not seem motivated to make any changes for his or her benefit, he or she can be encouraged to "experiment" with helping others or giving back to society. In this vein, a student can be encouraged to volunteer at a humane society if the student reports that he or she loves animals or any nonprofit organization that is consistent with the student's values and beliefs. Further, students can be reinforced for their prosocial efforts by the counselor and instructed to volunteer to see whether they feel any better or experience a lift in their mood while helping others.

After a list of activities is identified for inclusion in behavioral activation therapy, students are then encouraged to plan a weekly schedule that includes these activities in session. To help students understand how engaging in several activities can impact their moods with behavioral activation, the final step of the

process includes encouraging students to monitor their moods before and after activities are attempted and completed. Monitoring their progress can help students recognize their individual accomplishments as well as recognize when they are not feeling depressed, hopeless, or dysthymic. Overall, this process can elevate their mood, increase their motivation for other life activities, and encourage them to keep moving forward in their daily pursuits and with future goals. Furthermore, having a counselor periodically review a log of a student's moods may help the student become more mindful of when he or she is feeling well or at least okay as opposed to depressed or distressed. Moreover, this process can help counselors identify patterns of behavior that may warrant further discussion, therapeutic exploration, and collaborative problem solving. Behavioral activation may be repeated until the student's activity monitoring data illustrates that he or she is consistently experiencing more pleasurable feelings before and after activities are completed.

When to Use or Not Use Behavioral Activation

Behavioral activation can be used to help individuals cope with depression, persistent depressive disorder (PDD), lethargy, and withdrawal. It should not be used if an indication of suicidality and medical problems such as hypothyroidism exist. To protect their immediate well-being, individuals with potential suicidal intent need to be carefully evaluated and provided with inpatient care to ensure their safety. Individuals with medical problems, such as hypothyroidism, need to be seen by a physician. Behavioral activation also should not be implemented as a treatment option for students who have a history of failing active therapy (e.g., CBT, behavior modification) or who demonstrate poor treatment adherence. Unfortunately, these individuals may experience even greater feelings of depression if they are unable to perform even rudimentary functional activities as part of the behavioral activation process. Finally, similar to any counseling intervention that is conducted in K–12 schools, parents should be kept informed throughout the process when behavioral activation is initiated with a student. Furthermore, when possible, counselors should also partner with parents throughout the intervention period so that parents can apply the principles of behavioral activation at home and help students comply with activities that are selected to be completed outside of counseling sessions.

COGNITIVE RESTRUCTURING

As noted in Chapter 2, cognitive restructuring is a therapeutic technique that is commonly used to challenge cognitive distortions and correct negative thinking patterns that contribute to depression, anxiety, or other problems (see Appendix, Exhibits 4.12 to 4.21 for worksheets and forms). It is based on the premise that one's irrational thoughts and beliefs about a specific event can lead to unhealthy emotions and behaviors that maintain depression, anxiety, and related problems (A. T. Beck, 1991; J. S. Beck, 1995, 2011). Thus, cognitive distortions can include any number of ways that individuals think in maladaptive, nonobjective, and irrational ways, and the primary objective of cognitive restructuring is to help individuals challenge and reframe their cognitive distortions or replace them with thoughts that are more adaptive,

objective, and rational or based in reality (Burns, 1980, 1989). Through this process, individuals often experience improvements in their affective state or mood because of the integral link between thoughts and emotions.

To illustrate this link, consider some of the thoughts that often are experienced by a person with depression: "I'm worthless," "I can't do anything well," "Nobody likes me." Now imagine being bombarded by these thoughts dozens of times throughout the day and not being able to do anything to address them. From this example, one can imagine how a person's mood might begin to suffer from being overwhelmed with negative self-thoughts, limiting beliefs, and demotivating cognitions. Moreover, a person may start to internalize and believe these thoughts, which can then negatively impact his or her behavior and throw him or her into a spiral in which he or she is no longer doing activities and tasks that bring him or her pleasure and enjoyment in life, such as socializing with others and engaging in hobbies. This described process has been coined the "depression trap" and it is hard for individuals to liberate themselves from this coercive process when they are being negatively affected by depressing thoughts and ruminations.

Whereas behavioral activation involves increasing the amount of pleasurable experiences a person has on a regular basis, cognitive restructuring aims to target a different point of intervention: the problematic thoughts themselves. By disputing, reframing, and replacing these distortions, maladaptive thoughts, and self-defeating beliefs, individuals can experience relief from thoughts that torment them as well as experience concomitant improvement in their mood or affective state. Thus, as a therapeutic method, counselors can use cognitive restructuring to help students become more aware of their thinking, evaluate the validity of their thoughts, challenge problematic cognitions, and change their beliefs to better suit them and help them succeed in school and life.

The first step of cognitive restructuring involves teaching students about the relationship among their thoughts, emotions, and behaviors. This relationship is often represented by a triad (see Appendix, Exhibit 2.4) in that thoughts impact feelings that then impact emotions, which then impact behaviors and finally subsequent thoughts. To illustrate this process, it will be helpful for the counselor to offer the student examples, such as "consider the impact of a positive thought (e.g., the thought of finding a $100 bill lying on the sidewalk), then think about how you would feel (e.g., excited, joyful) and what you might then do (e.g., buy something desirable, save for a rainy day, pay off a debt, and so forth). Just hearing this might make you feel a little excited as you think of what you could do with $100!" Now, on the other hand, try a different thought experiment that illustrates the same relationship among thoughts, emotions, and behaviors. "Right now, think about a friend having lost a pet. Try to think of how he or she would feel. What emotions would you feel? How do you feel just reading this right now? How might these disquieting feelings impact your behavior? Perhaps you might hug the person you were just thinking about or tell your friend that you understand when you see him or her." Exhibit 2.4 (see Appendix) visually represents the relationships among thoughts, emotions, and behaviors. This exhibit can be used to elucidate these relationships through encouraging a student to think of a cognitive distortion that he or she commonly experiences and then follow how it impacts his or her emotions, behaviors, subsequent thoughts, and so on.

After students comprehend that their thoughts can elicit negative emotions and behaviors, they can be prompted by the counselor to identify some of their problematic thoughts. These thoughts are generally difficult for individuals to identify without help because they tend to seem to occur spontaneously and automatically as opposed to the result of conscious reflection. Additionally, they often are rooted in what individuals perceive to be an emotional truth (e.g., "I think that I am a loser" →"I feel like a loser" →"I must be a loser"), which then tends to inflate their salience and significance, as well as people's willingness to accept them as true.

Because individuals often believe that their automatic thoughts are true in the same way that a goldfish might think that the entire world is covered in water, it can be helpful to encourage students to "get outside of their heads" or envision "thinking with someone else's brain" for a few minutes to evaluate critically their own thoughts. Additionally, they also can be encouraged to view their own thoughts from another person's perspective to help distance themselves from their thoughts, which can be an effective thought experiment for students with depression, who often are much harsher with their self-appraisals than they are when appraising others.

In addition to the previous strategies, counselors can also utilize the Socratic questioning method, as reviewed in Chapter 2 (see Table 2.3), to help the student discover maladaptive thoughts, ways in which they are maladaptive, and identify errors in reasoning. Through using this technique, counselors can descend deeper and past surface responses to uncover meaningful answers to the counselor's questions. For example, the following dialogue illustrates the use of Socratic questioning for a student with an internalizing problem (i.e., test anxiety) to get to a deeper fear that the student harbors:

Counselor: "What are you so anxious about?"
Student: "My math test on Friday!"
Counselor: "What is so scary about the math test?"
Student: "I'm afraid that I will fail the test."
Counselor: "What is so scary about failing the test?"
Student: "If I fail the test, I might fail the class!!!"
Counselor: "What is so disastrous about failing the class?"
Student: "My parents will get really mad and they might not let me go to college."

It is important to note that asking the question "why?" often is not as effective as "what?" or an alternative question because it can cause students to become defensive or say "I don't know" if they are not self-reflective.

Yet another approach to identifying problematic thoughts involves keeping a record of the problematic thoughts using a thought record. When encouraging students with internalizing difficulties to keep a thought record, the counselor should tell the student to pay attention to changes in his or her mood or affective state and then jot down what was happening right before this change was noticed and what the student was thinking about. Thought records can be created easily by folding a regular blank sheet of paper into three or four columns that can be used for a student to record the aforementioned information. Through its use, a thought record will help students begin to see the functional relationship between their thoughts and

moods as well as events that trigger changes in both of these domains. Additional examples of thought records can be found in the Appendix, Exhibits 2.8, 2.9, 2.10, and 4.14 to 4.16.

In addition to helping with the former, thought records can also have therapeutic indications. In this regard, the counselor can encourage students to add an extra column that allows them to dispute or reframe their problematic thoughts (see Appendix, Exhibit 2.9). For example, a child with social anxiety disorder might notice that he is anxious when he is asked to read in front of his peers aloud in class. In response to this situation, he might have the thought that people will think that he is stupid if he mispronounces a word or stutters. Thus, he would write down the following statement on his thought record: "People will think I'm stupid if I make an error reading." Of course, this thought likely will increase the student's anxiety and perhaps even impede his ability to focus on reading aloud. Therefore, to challenge this problematic thought, the student can write down a range of replacement thoughts: "Everyone makes mistakes reading sometimes and this does not mean the student is stupid," "Making a mistake reading really isn't a big deal and I probably won't even remember making a mistake by tomorrow," "It doesn't really matter what other people think about my reading ability" and so forth.

Through reviewing information collected on thought records or through directly focusing on problematic thoughts that the student seems to harbor in session, counselors can help students better identify, understand, and eventually challenge these thoughts through using a list that included common cognitive distortions and thinking errors. Many of these have already been alluded to in other portions of this book; however, common cognitive distortions include all-or-nothing thinking, overgeneralization, disqualifying the positive, personalization, emotional reasoning, catastrophizing, negative filtering, and labeling (see Chapter 2, Table 2.2).

In a counseling session, students can be encouraged to come up with an example of each cognitive distortion that applies to their own life or someone else. They can then describe ways in which the distortion is either irrational, inaccurate, maladaptive, or problematic in another way and list more adaptive ways to think about the event or situation that may be precipitating the cognitive distortion. Because cognitive restructuring is abstract and challenging, many students may lack the metacognitive skills to evaluate their thoughts effectively or understand how their mind works, a counselor may have to provide specific examples for the student to follow or use props, such as cartoons or puppets, that the student can identify with and observe. In this vein, a counselor could cut pictures out of magazines or print them off the Internet that depict people engaged in dramatic situations (e.g., falling off a bike, getting back a test with a failing grade on it) and have the child describe a thought that the person in the picture might be thinking. Then, if the student describes a thought that suggests the presence of a cognitive distortion, the counselor can encourage the student to come up with better or different thoughts that the person could think to make him or her feel better. Finally, it is important to note that because terms like "cognitive distortions" and "maladaptive thoughts" are jargon terms and not likely to be well received by very young students, therapists should avoid using these terms when working with them. Instead, in collaboration with the student, the counselor could come up with clever substitute words for these terms such as "stinkin' thinkin'." Examples of additional child-friendly terms can be found in Chapter 2, Table 2.2.

When to Use or Not Use Cognitive Restructuring

Cognitive restructuring can be used with students who display a range of internalizing forms of psychopathology. In addition, it can be used with students who have low self-esteem, biases, limiting beliefs, negative attributions (e.g., global and stable), or maladaptive thoughts in general. However, counselors should refrain from using cognitive restructuring as a therapeutic approach for children who display obsessive or ruminating symptomology, especially if these obsessions are highly ritualized as is the case with individuals who have OCD. Cognitive skills required for cognitive restructuring include the ability to engage in self-reflection and reasoning, consider the perspective of others, and understand cause–effect relationships. Therefore, as noted in Chapter 2, this method of treatment should not be used with students who have low cognitive functioning, very young children (i.e., preschool and first- and second-grade students), and any other students who display poor insight and a very limited metacognitive ability. Counselors may have to determine the student's level of insight and metacognitive skills through interviewing the child, teachers, parents, and so forth.

RELAXATION TRAINING

Relaxation training, as reviewed in Chapter 2, is a therapeutic technique that can be utilized to help individuals reduce high levels of anxiety and stress (see Appendix, Exhibits 4.22 to 4.26). Relaxation training is based on the idea that although most people encounter stressful and anxiety-producing events, people respond to stress and anxiety in different ways (Otto, Simon, Olatunji, Sung, & Pollack, 2011). Because stressful and anxiety-producing events can cause individuals to feel overwhelmed and have a heightened sense of anxiety, relaxation training is generally implemented to help individuals learn how to cope with stress and anxiety in a healthy manner by learning how to remain calm and slow their bodies or physiological responses down (e.g., manage a racing heartbeat, slow rapid breathing).

The first step in teaching relaxation training involves explaining to students the purpose of relaxation training and what they can expect from employing these strategies. This explanation can include a description of different reactions that people often have when faced with stressful and anxiety-provoking events (e.g., unhealthy vs. healthy responses). With internalizers, the counselor may also want to discuss how relaxation training can be a viable and beneficial coping strategy for anxiety reduction. The techniques described in Chapter 2, including *diaphragmatic breathing*, *progressive muscle relaxation,* and *visual and guided imagery*, are all known to be effective in addressing internalizing difficulties.

When to Use or Not Use Relaxation Training

Relaxation training is generally used to reduce anxiety and stress in students with internalizing problems. More specifically, relaxation training is typically implemented for youth who express somatic complaints, including those who may frequently visit the school nurse for nonjustified headaches and stomachaches.

This form of treatment can also be used with individuals who exhibit problems with emotional regulation, such as being overly dramatic or demonstrating disproportional anxious responses to everyday demands. Relaxation training should not be used for individuals who display significant compulsive symptomology, as they may use this method to ruminate over their problems more. Further, relaxation training should not be used for children/adolescents who display extreme avoidant behaviors, as they may utilize the relaxation to enhance their avoidant tendencies.

SOCIAL SKILLS TRAINING

Social skills training is a method of treatment that can be used to foster more effective interpersonal interactions for students who experience internalizing problems that negatively impact their performance of these skills (See Appendix, Exhibits 4.27 to 4.31). More specifically, social skills training can be implemented to help students enhance their functional communication skills, problem-solving abilities, and conflict-resolution skills. Social skills training is grounded in the assumption that interpersonal relationships are critical to one's healthy functioning in society. Students who have trouble communicating their needs to others, interpreting various social cues, resolving conflict, and solving problems are likely to experience negative outcomes, such as peer rejection, anxiety, and depression. For example, assertiveness training is a common targeted skill for students with internalizing problems, as they often struggle with appropriately articulating and conveying their feelings and needs to others. Therefore, counselors can implement social skills training to help students to improve their behaviors, daily functioning, and social interactions.

Social skills training includes several steps. The first step involves identifying students' specific skill deficits. This can be accomplished through multiple assessment methods, such as direct observations and parent, child, and teacher interviews. Norm-referenced standardized rating scales are beneficial as well. After counselors determine a student's specific skill deficit(s), several educational techniques can be employed. Role-playing and modeling are two approaches to teaching students effective social skills. With respect to role-playing, the student can review and act out various scenarios that serve to increase his or her ability to exhibit the targeted skill(s). Some students may find it difficult to perform certain behaviors through role-playing. Thus, counselors can also utilize modeling during social skills training. Modeling, often referred to as observational learning, involves the child/adolescent learning a specific skill by observing and imitating others. Through modeling, the counselor can demonstrate various behaviors that the student is expected to learn. Peer modeling is a viable option as well, as it involves the student observing and imitating exemplars from his or her age group.

Students also can review and rehearse various social interaction scripts. Social interaction scripts provide students with more direct instruction regarding appropriate language to use and specific behaviors to exhibit during their interpersonal interactions (e.g., maintain eye contact, speak clearly, and so forth). Although social scripts can be used during in-session role-play activities, students can also store shortened scripts in their pockets, wallets, backpacks, and so forth to help them engage in successful interactions in their natural environments. Counselors should utilize corrective feedback throughout social skills training sessions, which entails providing students

with constructive criticism about their demonstration of a specific skill and helping them discover how to more accurately perform the skill. Counselors also should provide consistent positive reinforcement and foster many opportunities for the student to practice the acquired skills for generalization.

When to Use or Not Use Social Skills Training

Social skills training is best used for children/adolescents who experience behavior and skills deficits. This includes students who have no knowledge about the specific social skill and students who are aware of when it is appropriate to use a specific social skill. Accordingly, social skills training is not recommended for students who have a performance deficit. If a child knows a skill and elects not to use it or generalizes the skill to multiple settings, then a behavioral modification plan may be more appropriate.

In conclusion, there are several cognitive behavioral interventions that can be implemented in school settings to address the needs of students who experience internalizing disorders and problems. The following therapeutic treatments were highlighted in this chapter: E/RP therapy, behavioral activation, cognitive restructuring, relaxation training, and social skills training. Each method of support may not be appropriate for every child/adolescent. Therefore, it is important for counselors to understand when and when not to use the various approaches. Furthermore, parents and students should be informed about the purpose and process of each method of treatment (see Appendix, Exhibits 4.2, 4.7, 4.13, and 4.23 for parent handouts). Several activities were illustrated throughout this chapter. Such activities can be reproduced and utilized throughout the course of treatment. Some adaptations may be required depending on the student's age and development.

REFERENCES

Beck, A. T. (1991). *Cognitive therapy and the emotional disorders*. New York, NY: Penguin.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York, NY: Guilford Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.

Block, J. H., & Block, J. (1980). The role of ego-control and ego-resiliency in the organization of behavior. In W. A. Collins (Ed.), *Minnesota Symposium on Child Psychology* (Vol. 13, pp. 39–101). Hillsdale, NJ: Erlbaum.

Burns, D. (1980). *Feeling good: The new mood therapy*. New York, NY: Morrow.

Burns, D. (1989). *The feeling good handbook: Using the new mood therapy in everyday life*. New York, NY: Morrow.

Caspi, A. (1998). Personality development across the life course. In W. Damon (Series Ed.) & N. Eisenberg (Vol. Ed.), *Handbook of child psychology* (Vol. 3, pp. 135–160). New York, NY: John Wiley.

Joyce, D. (2010). *Essentials of temperament assessment*. Hoboken, NJ: John Wiley.

Kendall, P. C. (2006). *Child and adolescent therapy: Cognitive-behavioral procedures*. New York, NY: Guilford Press.

Leahy, R. L., & Holland, S. J. (2000). *Treatment plans and interventions for depression and anxiety disorders*. New York, NY: Guildford Press.

Otto, M. W., Simon, N. M., Olatunji, B. O., Sung, S. C., & Pollack, M. H. (2011). *10-Minute CBT: Integrating cognitive-behavioral strategies into your practice*. New York, NY: Oxford Press.

Scholte, R. H. J., van Lieshout, C. F. M., de Wit, C. A. M., & van Aken, M. A. G. (2005). Adolescent personality types and subtypes and their psychosocial adjustment. *Merrill-Palmer Quarterly*, *51*, 258–287.

Wolpe, J. (1969). *The practice of behavior therapy*. New York, NY: Pergamon Press.

PART III

Counseling Structure for Externalizers

FIVE

Understanding Externalizing Problems

The *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.; American Psychiatric Association [APA], 2013) criteria for the externalizing disorders described in this chapter are divided into two categories consistent with the *DSM-5* manual: disruptive and neurodevelopmental disorders. Disruptive disorders are often first diagnosed in elementary or middle school as they tend to have onset in early childhood or adolescence, whereas neurodevelopmental disorders have onset during the preschool developmental period. It should be noted that although *DSM-5* criteria are reviewed, this text does not provide a comprehensive listing of all qualifiers and the *DSM-5* should be consulted for greater diagnostic detail prior to identifying or confirming any diagnosis. The chapter also describes definitions and characteristics of aggression and bullying behaviors. Although aggression and bullying may not be diagnoses, they do represent a constellation of inappropriate actions that are all too frequent in schools and can be harmful and disruptive in educational settings. Information from a national website along with family and clinician resources that are empirically supported are also provided for each disorder. The sites may provide helpful parent education materials and self-help materials; some also sponsor blogs and chat rooms as a source of support. A more extensive list of Internet resources can be found in Chapter 2, Table 2.1.

DISRUPTIVE, IMPULSE-CONTROL, AND CONDUCT DISORDERS

Unlike internalizing disorders that can be overlooked because they do not often interfere with the learning of classmates, disruptive disorders have long been a source of concern in school systems as they often disturb the entire classroom. The three *DSM-5* disruptive disorders covered in this section, conduct disorder (CD), intermittent explosive disorder (IED), and oppositional defiant disorder (ODD), are more often diagnosed in males.

Conduct Disorder

The criteria for CD require a persistent and reoccurring pattern of actions that violate the rights of others and/or societal norms. There are 15 possible symptoms across four categories (e.g., aggression to animals or people, destroying property, theft or deceit, and violating serious rules), of which three must be present (APA, 2013). Behavior examples include bullying, fighting, cruelty to animals or people, mugging, setting fires, burglary, conning others, and stealing. Specifiers include childhood-onset type (poorest prognosis), adolescent-onset type, and unspecified-onset type with severity ratings of mild, moderate, or severe. Additionally, significant impairment in school, work, or interpersonal functioning must be present (APA, 2013).

Prevalence rates range from 2% to 10% and appear to be consistent across race, ethnicity, and countries. Comorbidities include ODD, attention deficit hyperactivity disorder (ADHD), specific learning disorders, anxiety, and depressive/bipolar disorders. Risk factors include a temperament that is undercontrolled, lower intelligence (especially verbal skills), harsh parenting, family substance abuse, deviant peers, and parental mental health diagnoses (e.g., CD, depression, ADHD). Physiological correlates include less automatic fear response than typical and abnormalities in the prefrontal lobe and amygdala interfering with how affect is processed. It also is noted that CD is associated with a slower resting heart rate and lower physiological reactivity in response to a threat or danger (APA, 2013). Given the aforementioned characteristics and risk factors associated with CD, the following components of cognitive behavioral therapy (CBT) may be important to explore during case conceptualization:

- Communication patterns: Explore feeling vocabulary given the propensity for lower verbal IQ, consider escalating verbal conflict and potential coercive cycle or harsh parenting, which may require both parent training and explicit instruction on articulating needs in nonconfrontational language (e.g., "I" statements).
- Cognitive distortions: CBT has been found to have significant positive effects in teaching anger management to students with disruptive disorders as fighting and victimization of others may be related to a propensity to misinterpret social cues as having hostile meaning (Beck & Fernandez, 1998; Crick & Dodge, 1996; Dodge & Frame, 1982; Frick, 1998). At times bullying and victimization may be related to revenge or entitlement beliefs. Therefore, it may be important to consider possible mind reading, labeling, negative filtering, dichotomous thinking, shoulds, blaming, and judgment-focus distortions. CBT has been noted as an efficacious method for addressing CD (Chambless & Ollendick, 2001).
- Cognitive behavioral skills training: Insight is noted to be limited for many students with CD; thus, coupling CBT with behavioral modification strategies, significant opportunity for practicing skills, and generalization to multiple settings will be important (Frick, 1998). Supplemental CBT techniques may need to include training in how to recognize physiological precursors to anger, impulse inhibition, positive social skills (e.g., turn taking, reciprocity in conversations, active listening, perspective taking), problem-solving skills, and exercises in generating alternative solutions for conflict resolution (Frick, 1998).

- Other factors: Additional interventions for CD with empirical support include parent training, anger coping therapy, delinquency prevention programs, problem-solving skills, and rational–emotive therapy. Some individuals with CD have a pattern that is considered callous with little empathy for others (e.g., difficulty processing affect), manipulative, prone to violent behaviors (e.g., rape, violence), have substance abuse factors, and have a lower resting heart rate that is not distressed by these actions (APA, 2013; August, Bloomquist, Hektner, Klimes-Dougan, & Lee, 2013; Frick, 1998). Following this pattern, individuals can purposefully engage in calculating behaviors for personal gain and will require a multifaceted intervention plan beyond foundational CBT. The National Academy of Child and Adolescent Psychiatry offers resources for parents and clinicians related to the CD (www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Conduct_Disorder_Resource_Center/FAQ.aspx#cdfaq3).

It should be noted that youth with CD have a wide range of impairment from mild to severe and those with the most significant level may need multiyear supports. Some states serve students with CD under the emotional disturbance classification of the Individuals with Disabilities Education Improvement Act (IDEIA, 2004, Part 300 A, Section 300.34 [c][2]) through either pull-out or self-contained programs with ongoing counseling supports.

Intermittent Explosive Disorder

The diagnostic criterion for IED requires a repeated pattern of impulsive (not premeditated) aggressive outbursts (APA, 2013). Outbursts can manifest verbally (e.g., tantrums) or physically (property damage, harm to animals or people). The prevalence rate for IED is estimated at 2.7% in the general U.S. population, it occurs more often among persons under age 40, and the occurrence is lower in some other countries (e.g., Asia). Comorbidities include depression, anxiety, and substance abuse, CD, ODD, and ADHD. Risk factors include early childhood trauma experiences and first-degree relatives with IED. Brain abnormalities related to the limbic system and amygdala (especially related to anger) are known physiological correlates (APA, 2013). Based on the symptomology of IED, the following considerations may be important to designing counseling components:

- Cognitive distortions: A hallmark of IED is outbursts that are impulsive, thus counseling will need to address identifying precursors to anger in order to apply relaxation strategies quickly as well as problem-solving skills in generating more prosocial approaches to meeting needs. As students with IED are prone to quick anger, exploring the possibility of misinterpreted social cues as a causal factor in angry outbursts and teaching anger management skills can be helpful (Beck & Fernandez, 1998; Dodge & Frame, 1982). Mind reading, labeling, negative filtering, dichotomous thinking, shoulds, blaming, and judgment-focus distortions can be related to viewing others in a hostile manner; therefore, these may be important to consider.
- Other factors: As trauma before age 20 is a risk factor, it may also be important to review history and consider any needs for additional counseling methods known to be effective for trauma victims. The National Child Traumatic Stress Network maintains a list of resources on their website (www.nctsnet.org/resources/topics/treatments-that-work/promising-practices).

Students with IED may qualify for long-term and intensive services under the emotional disturbance classification of the IDEIA if they have not responded positively to earlier tiered intervention supports.

Oppositional Defiant Disorder

The *DSM-5* requires a pattern of angry, argumentative, vindictive, defiant behaviors over a 6-month time frame for a diagnosis of ODD (APA, 2013). There are possibly eight symptoms, including being angry or resentful, arguing with authority, and blaming or annoying others. The severity of symptoms can range from mild to moderate. Additionally, the behaviors should have a negative impact on the student's school, work, or interpersonal functioning and cause distress to those closest to the child (APA, 2013). Prevalence rates range from 1% to 11% and are consistent across race, ethnicity, and countries. Risk factors include emotional reactivity, low frustration tolerance, and a history of poor parenting. ODD has several physiological correlates, including brain anomalies in the amygdala and prefrontal cortex, as well as lower basal cortisol reactivity and lower overall heart rate (APA, 2013). The following considerations may align well with ODD symptomology and be important during case conceptualization (see Fisher ODD case example in Chapter 8).

- Cognitive distortions: The angry, defiant, and vindictive components of ODD may benefit from relaxation strategies that dissipate irritable moods, as well as investigation of possible cognitive distortions in thinking, particularly blaming and a judgment focus on others. The propensity to be argumentative also may benefit from discussions of the ODD student's communication style (both nonverbal and verbal) and fostering new methods of expressing needs in a nonhostile manner. In a temperament study of youth with ODD, a strong preference for making decisions based on their own sense of justice and logic as well as a propensity toward abrupt opinions and less sensitivity to the feelings of others was indicated. Students with ODD also noted a preference for concrete thinking patterns that may oversimplify issues and perceive yes/no solutions (Joyce, 2010; Joyce & Oakland, 2005; Oakland & Joyce, 2006). Given these expressed preferences, judgment focus, shoulds, and dichotomous thinking may be important to consider when addressing distortions. Emotional reactivity and low frustration tolerance characteristics may benefit from some controlled applications of exposure if carefully monitored.
- Other factors: As ODD has a strong correlation with neglectful, harsh, and inconsistent parenting, coupling counseling intervention with parent training should also be considered. A national review of efficacious and well-established treatments for ODD indicates parent training, functional family therapy, multisystemic therapy, anger management, problem-solving skills, rational–emotive therapy, and videotape modeling are empirically supported interventions in addition to CBT (Chambless & Ollendick, 2001). The National Dissemination Center for Children with Disabilities offers some parent and clinician resources for ODD interventions (nichcy.org/how-oppositional-defiant-disorder-works).

NEURODEVELOPMENTAL DISORDERS

As stated earlier, neurodevelopmental disorders have an early onset with symptoms often observable prior to school age. These disorders can be comorbid with each other and result in impairments that affect an individual's daily life functioning (APA, 2013, p. 31). The *DSM-5* lists several disorders under the neurodevelopmental category (e.g., intellectual disability, communication disorders, specific learning disorders, and motor disorders). However, the three chosen for review in this text are noted to have some positive effects when select components of CBT are applied. The three disorders—ADHD, autism spectrum disorder (ASD), and Tourette's—also share a higher frequency among males.

Attention Deficit Hyperactivity Disorder

The diagnosis of ADHD is based on reoccurring inattentive and hyper or impulsive behaviors (APA, 2013). Inattentive symptoms may include not attending to details, resulting in making mistakes, difficulty listening or following directions, as well as struggles with organization skills and forgetfulness. Hyperactive/impulsive symptoms present as fidgeting, restlessness, excessive nonproductive motor movement (e.g., running), as well as a propensity to blurt answers and interrupt conversations (APA, 2013). Additionally, the child has impairment in school, work, or interpersonal functioning (APA, 2013).

Prevalence rates are estimated at 5% and the diagnosis is more often applied to White children in the United States. High comorbidity rates are reported for ODD, CD, and disruptive mood dysregulation. Specific learning disabilities and anxiety can be comorbid as well, although the rate is lower. Risk factors include lower behavior inhibition, higher risk taking, low birth weight, and maternal use of alcohol during pregnancy. A strong heritability factor is indicated, especially in first-degree relatives with ADHD (APA, 2013). The following components of CBT may be helpful during case conceptualization (also see the case example of Carlos in Chapter 7 and the case example of Jim in Chapter 8):

- Psychoeducation: Helping students understand their ADHD and learn that they can build strategies to minimize impact may be helpful. Also educating parents regarding the neurological basis of ADHD may help alleviate some negative attitudes toward the child's behaviors. In a study by Shaw et al. (2007), delays of brain maturation and cortex thickness were noted in the frontal and temporal lobes of patients with ADHD. Delays were significant (i.e., 2 to 5 years), affecting areas of the brain responsible for attention, planning, and self-regulation of behaviors. The National Institute of Mental Health (2007) offers a brief video illustrating the brain development lag on their website and this may be a useful tool to share with parents in understanding the impact of ADHD (www.nimh.nih.gov/news/science-news/2007/brain-matures-a-few-years-late-in-adhd-but-follows-normal-pattern.shtml). Additional parent and clinician resources are available from the National Resource Center on ADHD (help4adhd.org/aboutus.cfm).
- Cognitive strategies: Although ADHD is not characterized by significant thinking distortions, there are some students who perceive that they do not

have any control over their symptoms and therefore cannot change outcomes. Research has found that cognitive therapy can be beneficial to students with ADHD who have distorted thought patterns (Chambless & Ollendick, 2001).

- Other considerations: For students with ADHD, considering possible distortions related to fortune-telling and overgeneralizing may be helpful in reframing defeating self-talk (Pelham & Fabiano, 2008). Although not all students with ADHD receive special education services, some states may serve them under "other health-impaired status" in IDEIA or Section 504 provisions.

Autism Spectrum Disorder

The *DSM-5* criteria for diagnosis of ASD reflect significant impairing symptoms across two areas: social communication and interaction, as well as a repetitive/restrictive pattern of activities, interests, or behaviors (APA, 2013). Communication may include deficits in social interactions characterized by a lack of conversational reciprocity or initiating friendships, as well as a lack of eye contact, facial expressions, and interest in others. The repetitive and restricted behaviors may include unusual sensitivity to sounds or fabrics, fixated interests, rigid routines, or lining up objects. Additionally, these characteristics must impair important life functions (e.g., social, work). Severity is specified on three levels.

The prevalence of ASD in the general population is 1% and about 70% of individuals with ASD have a comorbidity with other mental health disorders, such as ADHD, anxiety, intellectual disability, and depressive disorders. Although not conclusive, various nonspecific risk factors, such as the advanced age of parents, low birth weight, and fetal exposure to teratogens such as valproate, are thought to contribute to ASD (APA, 2013). Emerging research has documented heritability rates of 37% to 90%, as well as identified gene mutations (APA, 2013).

There is research to support positive effects for CBT in interventions for children with ASD, particularly those in the average range or who exhibit higher intellectual functioning (Reaven, Blakeley-Smith, Culhane-Shelburne, & Hepburn, 2012; Rotheram Fuller & MacMullen, 2011). However, it also should be noted that there are a number of well-established behavioral-focused treatment options that will benefit children with ASD (e.g., behavioral modification, video modeling for social skills, pivotal response training, picture exchange communication system) and perhaps should be considered as primary interventions (Koegel, 2006; Shukla-Mehta, Miller, & Callahan, 2010; Steiner, Gengoux, Klin, & Chawarska, 2013). Children identified with ASD are entitled to special education services under the IDEIA (2004). The following components within CBT may be helpful.

- Cognitive behavioral strategies: Research has indicated that CBT can have positive results for some symptoms of ASD, specifically reducing anxiety among children while improving their social communication and awareness of others in the environment (Rotheram-Fuller & MacMullen, 2011). Additionally, there is support for the contingency management aspects of counseling (Chambless & Ollendick, 2001).

- Controversies and evidence: In applying any CBT strategy for children with ASD, it is important to consider modifications that accommodate the child's cognitive and communication skills.
- Social skills training: Social scripts, modeling, and corrective feedback are also noted as successful strategies in helping children with ASD acquire vital interaction skills (Reichow & Volkmar, 2010).
- Other resources: Several national autism support organizations are available online and offer a plethora of resources to families and clinicians on effective interventions. The following websites also include empirically supported intervention references:
  - Autism Speaks, www.autismspeaks.org
  - The Center for Autism and Related Disorders, www.centerforautism.com
  - The National Autism Center, www.nationalautismcenter.org/learning/guides.php).

Tourette's Disorder

In the *DSM-5*, Tourette's is listed as a neurodevelopmental motor disorder (APA, 2013, pp. 81–84). Diagnosis requires that both a movement and at least one vocal tic be evident, although children can present with multiple tics simultaneously. The symptoms also must have occurred for over 1 year. The prevalence rate is 3% to 8% among children and is consistent across ethnicity and race. Comorbidities include ADHD, OCD, depressive/bipolar disorders, and some substance use. The manifestation of Tourette's symptoms appears to worsen when children and adolescents are anxious, overly tired, or highly excited (APA, 2013, p. 83). CBT has been found to be effective as an intervention for Tourette's by reducing stress and thereby reducing the anxiety that exacerbates Tourette's symptoms (Piacentini et al., 2010). The *DSM-5* (2013, p. 83) notes that later parental age at birth and low birth weight correlate with Tourette's. Additionally, there is research indicating some genetic variants related to alleles. The following specific strategies will be important considerations in planning counseling interventions:

- Psychoeducation: Providing accurate information regarding the disorder for students with Tourette's may empower them to better manage symptoms. For example, knowing that being overtired, overexcited, or anxious can cause tics to increase, students have the opportunity to take control of their sleep hygiene to reduce fatigue and manage their schedules to reduce stressful events.
- Cognitive strategies: The cognitive relaxation techniques of CBT can assist students with Tourette's in reducing their stress responses; exposure to situations they avoid because they are stress inducing may help students understand that anxiety will naturally abate over time.

Tourette's is not a mental health disability that is directly identified in IDEIA; however, schools have a wide range of tiered intervention support options, including behavioral modification, that may be helpful. Two national Tourette's support websites include the National Tourette Syndrome Association, www.tsa-usa.org, and the Centers for Disease Control and Prevention (www.cdc.gov/ncbddd/tourette/research.html).

BULLYING IN SCHOOLS

Bullying includes multiple forms of aggression from persons who perceive a power imbalance and willfully subject others to intentional, unwanted, and unprovoked verbal or physical actions that are hurtful and result in the victim feeling oppressed, stressed, or uncomfortable. The aggressive acts can be physical (e.g., punching, hitting, shoving, poking, choking, hairpulling, biting, excessive tickling) or verbal such as name-calling, teasing, or gossip. Bullying also can take the form of emotional manipulation through rejecting, terrorizing, extorting, humiliating, blackmailing, isolating, ostracizing, or rating persons. Sexual bullying may include acts of exhibitionism, voyeurism, propositioning, harassment, or inappropriate contact. Cyberbullying includes many of the aforementioned characteristics facilitated through social media. Bullying is not a diagnosis and youth without any mental health challenges can display these behaviors, although many of the behaviors do overlap with CD and perhaps ODD or IED.

The research literature on CBT and bullying indicates that CBT strategies can be highly effective in assisting victims, as they often experience subclinical depression or anxiety type effects. However, the research is mixed on the effects of CBT on perpetrators, with greatest support for teaching aggression replacement behaviors and prosocial competencies, as well as a systemic approach that includes schoolwide positive behavioral supports (Camodeca & Goossens, 2004; Espelage & Swearer, 2003). The National Education Association provides bully prevention and intervention strategies and toolkits for schools (www.nea.org/home/neabullyfree.html). Additional resources can be located through the Association for Cognitive and Behavioral Therapies website, which offers a range of resources to school counselors in addressing bullying, including the use of CBT strategies (www.abct.org/Information/?m=mInformation&fa=fs_BULLYING).

In conclusion, externalizing disorders, although each is unique, share a number of common behaviors, including impulsive actions, poor self-regulation, low frustration tolerance, emotional reactivity, difficulty following rules, and sometimes aggression. In many cases these characteristics can benefit from psychoeducation, relaxation training, cognitive restructuring/reframing, and the problem-solving aspects of CBT. Chapter 6 reviews strategies for applying these CBT components to youth with externalizing disorders.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

August, G. J., Bloomquist, M. L., Hektner, J. M., Klimes-Dougan, B., & Lee, S. (2013). A 10-year randomized controlled trial of the Early Risers conduct problems preventive intervention: Effects on externalizing and internalizing in late high school. *Journal of Consulting and Clinical Psychology*, *82*, 355–360.

Beck, R., & Fernandez, E. (1998). Cognitive-behavioral therapy in the treatment of anger: A meta-analysis. *Cognitive Therapy and Research*, *22*, 63–74.

Camodeca, M., & Goossens, F. A. (2004). Aggression, social cognitions, anger and sadness in bullies and victims. *Journal of Child Psychology and Psychiatry*, *46*, 186–197.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Crick, N. R., & Dodge, K. A. (1996). Social information processing mechanisms in reactive and proactive aggression. *Child Development*, *67*, 993–1002.

Dodge, K. A., & Frame, C. L. (1982). Social cognitive biases and deficits in aggressive boys. *Child Development*, *53*, 620–635.

Espelage, D. L., & Swearer, S. (2003). Research on school bullying and victimization: What we have learned and where do we go from here? *School Psychology Review*, *23*, 365–383.

Frick, P. J. (1998). *Conduct disorders and severe antisocial behavior*. New York, NY: Plenum Press.

Individuals with Disabilities Education Improvement Act, 20 U.S.C. § 1400 *et seq.* (2004).

Joyce, D. (2010). *Essentials of temperament assessment*. Hoboken, NJ: Wiley & Sons.

Joyce, D., & Oakland T. (2005). Temperament differences among children with conduct disorder and oppositional defiant disorder. *California School Psychologist*, *10*, 125–136.

Koegel, R. L. (2006). *Pivotal response treatments for autism: Communication, social, and academic development*. Baltimore, MD: Paul H. Brookes.

National Institute of Mental Health. (2007). *Brain matures a few years late in ADHD, but follows normal pattern* [MP4]. Retrieved from http://www.nimh.nih.gov/news/science-news/2007/brain-matures-a-few-years-late-in-adhd-but-follows-normal-pattern.shtml

Oakland, T., & Joyce, D. (2006). Temperament-based learning styles and school-based applications. *Canadian Journal of School Psychology*, *19*(1/2), 59–74.

Pelham, W. E., & Fabiano, G. A. (2008). Evidence-based psychosocial treatment for attention deficit/hyperactivity disorder: An update. *Journal of Clinical Child and Adolescent Psychology*, *37*, 185–214.

Piacentini, J., Woods, D. W., Scahill, L., Wilhelm, S., Peterson, A. L., Chang, S., … Walkup, J. T. (2010). Behavior therapy for children with Tourette disorder: A randomized controlled trial. *Journal of the American Medical Association*, *303*, 1929–1937.

Reaven, J., Blakeley-Smith, A., Culhane-Shelburne, K., & Hepburn, S. (2012). Group cognitive behavior therapy for children with high-functioning autism spectrum disorders and anxiety: A randomized trial. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *53*, 410–419.

Reichow, B. I., & Volkmar, F. R. (2010). Social skills interventions for individuals with autism: Evaluation for evidence-based practices within a best evidence synthesis framework. *Journal of Autism and Developmental Disorders*, *40*, 149–166. doi:10.1007/s10803-009-0842-0

Rotheram-Fuller, E., & MacMullen, L. (2011). Cognitive-behavioral therapy for children with autism spectrum disorders. *Psychology in the Schools*, *48*, 263–271. doi:10.1002/pits.20552

Shaw, P., Eckstrand, K., Sharp, W., Blumenthal, J., Lerch, J. P., Greenstein, D., … Clasen, L. (2007). Attention deficit hyperactivity disorder is characterized by a delay in cortical maturation. *Proceedings of the National Academy of Sciences of the United States of America*, *104*, 19649–19654.

Shukla-Mehta, S., Miller, T., & Callahan, K. J. (2010). Evaluating the effectiveness of video instruction on social and communication skills training for children with autism spectrum disorders: A review of the literature. *Focus on Autism and Other Developmental Disabilities*, *25*, 23–36.

Steiner, A. M., Gengoux, G. W., Klin, A., & Chawarska, K. (2013). Pivotal response treatment for infants at-risk for autism spectrum disorders: A pilot study. *Journal of Autism and Developmental Disorders*, *43*, 91–102.

SIX

Cognitive Behavioral Therapy for Externalizing Problems

This chapter reviews several additional cognitive behavioral interventions that are often well suited for addressing externalizing behaviors, such as angry outbursts, poor emotional vocabulary, and stress-related feelings of agitation. Counseling for externalizers can also benefit from the strategies discussed in Chapters 2 and 4 and, with some modifications, internalizers may benefit from the strategies noted in this chapter.

The term *undercontroller* is often helpful in conceptualizing the behavioral difficulties of externalizers (Block & Block, 1980; Caspi, 1998; Joyce, 2010). A hallmark of undercontrollers is exhibiting self-regulation behaviors that are less inhibited than typical with a propensity to breach the boundaries of others. They often have difficulty with self-control and act on impulses without consideration for consequences or a need to be agreeable, they lack appropriate fear, and can exhibit purposeful manipulation of others (Scholte, van Lieshout, de Wit, & van Aken, 2005). In addressing the needs of undercontrollers or externalizer problems, cognitive behavioral therapy (CBT) relaxation strategies coupled with the ability to identify physiological precursors to aggression may best target reducing anger or creating time to think before acting impulsively. Cognitive restructuring may challenge thinking distortions related to entitlement, misperceptions of injustice, or blaming others. For disruptive disorders, a multifaceted blend of behavior modification strategies, CBT, and sometimes psychopharmacology may be required. The following therapeutic methods will be highlighted in this chapter: physiological precursors/triggers, feeling vocabulary, common cognitive distortions, and supplemental parent training services.

IDENTIFYING PHYSIOLOGICAL PRECURSORS/TRIGGERS

Many externalizing behaviors (e.g., conduct disorder [CD], oppositional defiant disorder [ODD], intermittent explosive disorder [IED]) are closely linked to a highly reactive and sometimes impulsive temper. The goal of teaching students awareness of their own physiological precursors to inappropriate behaviors is to provide an advance warning system they can use to control their feelings. The technique

also offers an individual time to stop and think of alternative actions. Most individuals understand that a racing heartbeat, sweaty palms, pacing, or a flushed face indicate building stress. However, children with disruptive disorders often do not have this insight. They typically will describe their anger as instantaneous ("I go straight to red-hot mad.") and beyond their control ("I was born with a temper, I can't stop it."). The process of identifying physiological precursors is designed to dispel these myths.

Step One: The first step in the process, often called normalizing, involves understanding that feelings and emotions are real and everyone has them. The counselor also acknowledges that emotions can be very powerful but we are still in control of how they are used. Additionally, the initial sessions should emphasize that even negative emotions can be put to good use. Generally, examples of common innocuous incidents that may spark anger are discussed (e.g., lost money due to a hole in a coat pocket, being splashed with mud by a passing car). Then examples of multiple response options are provided and the counselor encourages the child to generate ideas as well (e.g., could try to find the lost money, could wash off the mud and laugh about it). The counselor also discusses how even a negative feeling could result in a good consequence if the individual chooses to learn from it (e.g., sew up the hole in the pocket, walk further away from the street).

Step Two: The next step in this process is identifying the individual's particular physiological stress responses. This can be accomplished by having children recall a time when they were upset and talking about what physiological changes they noticed. For students with limited insight, the counselor may need to suggest common ways people first feel stress and ask the child or adolescent to identify which ones are applicable to them personally. For younger children it may be necessary to provide a body map drawing to explain the location of specific physiological reactions (e.g., stomachaches). An example of a physiological stress reaction list and a body map are provided in the Appendix, Exhibits 6.1 and 6.2.

Step Three: In addition to physiological precursors, if students can identify the *triggers* that immediately precede stressful reactions, they have an opportunity to interrupt the stress-building process and perhaps change any habitual negative reacting patterns. Counselors will need to ensure understanding of the cognitive model first (see Appendix, Exhibits 2.4 to 2.10, 4.14 to 4.16) and assist students in keeping thought records to identity circumstances or actions that tend to elicit maladaptive thought and behavior responses. Information from teacher referrals and observational data may also help the clinician identify triggers for the child (e.g., teacher report that child becomes angry when called on to answer questions).

Step Four: Once students are able to identify *triggers and physiological precursors* that suggest impending stress, they have the opportunity to implement a relaxation technique in order to manage feelings. Chapter 2 offers detailed descriptions of several relaxation methods (e.g., diaphragmatic breathing, progressive muscle relaxation, and guided imagery; see Appendix, Exhibits 4.23 to 4.26).

Step Five: The next step in this process includes teaching the student problem-solving skills with the goal of establishing the ability to self-generate alternative and adaptive behavior choices. Sometimes students with externalizing difficulties have found maladaptive ways to solve their problems that may include acting out with verbal or physical aggression, defiant compliance refusal, or manipulative and covert actions (e.g., revenge, pitting parents against each other, sabotage). It would

be hard to argue that those methods are not effective as they do often accomplish a temporary goal for the student, although the long-term consequences are negative. Instead of debating the effectiveness of maladaptive behaviors, the counselor strives to reframe student thoughts by creating "win–win" scenarios and long-term positive outcomes. It may take some time and a number of sessions to accomplish this. The ABCD form in the Appendix (Exhibit 2.10) may be helpful in encouraging students to differentiate between immediate and long-term consequences.

Another strategy for teaching problem solving is brainstorming alternative solutions and examining the pros and cons of the items identified in the brainstorming exercise (See Appendix, Exhibit 6.3), then using the best option. It is important to note that for some children with externalizing problems, there may be a propensity to debate or negatively judge ideas too quickly. Therefore, the instructions for brainstorming should include an emphasis on quickly jotting down possible positive solutions without evaluation. After the list is made, the second step is to evaluate the pros and cons of each idea. Finally, the student is guided to select a *best* solution from the brainstorming list based on which item has the most pros and no critical downside. As these are new behaviors for the student, it also may be important to practice the new behavior in session through role-play scenarios before asking the student to try the strategies in a real-life situation. Counselors may wish to make the brainstorming exercise a homework assignment to be completed when the student encounters a stressful situation outside of intervention sessions and then review the choices and outcomes in session. In particular, a review of the student's thoughts following efforts to try a new solution will help guide future counseling sessions, which may need to address obvious skill deficits or thinking errors.

When to Use or Not Use Identification of Physiological Precursors/Triggers

As with other counseling interventions, identification of physiological precursors and triggers will require the cognitive skills and maturity to understand and accurately assess one's own thoughts, feelings, and behaviors. Therefore, cognitive abilities will be an important consideration for this technique. Additionally, the authenticity of reported feelings and efforts at brainstorming require self-disclosure, motivation, and honesty. For students with significant malingering, manipulative, or covert behavior tendencies, this method may be less effective. In regard to homework assignments for externalizers, often coupling assignments with a positive reinforcement plan (e.g., small incentives/rewards for returning completed worksheets) will increase meaningful participation. It may also be helpful to elicit parent participation in prompting, encouraging, and assisting with therapy homework exercises.

BUILDING FEELING VOCABULARY

Exercises for building feeling vocabulary may be helpful for children exhibiting verbal aggression and students with lower verbal IQs who demonstrate a propensity toward instrumental aggression. The underlying premises for using strategies to increase feeling vocabulary are that (a) students may lack needed communication skills to articulate their needs appropriately and that (b) some children have

a restricted emotional vocabulary limited to dichotomous or superlative terms (e.g., excellent–awful; mad–happy). For example, there is evidence in the literature that a lower verbal IQ is associated with some externalizing disorders, such as CD (American Psychiatric Association [APA], 2013). Additionally, a number of cognitive distortions (e.g., dichotomous thinking, catastrophizing) are characterized by superlatives and a very limited range of expression for nuanced differences in emotions. Finally, the counselor may also wish to discuss how others perceive or interpret emotional vocabulary that is expressed to them. Often, children with externalizing disorders do not realize that their use of a very narrow range of often superlative emotional vocabulary can be offensive or stressful to others. Sometimes asking the student questions regarding how others might feel when they hear the student's vocabulary can be helpful. Additionally, teaching students to express needs using "I" statements (e.g., "I feel afraid when you call on me in class.") and nonblaming language may be helpful (e.g., "How do you think ___ feels when he hears that you think he makes you furious?" "How could you express you are upset with kinder words?" "What if you used different words and told ____ you were feeling very *concerned* about the event?") The following activities may be helpful in explaining vocabulary repertoire for words that more accurately communicate feelings.

- Name game: Using games that require students to quickly name pictures of expressed emotions (without using the same word twice) can be a fun way to build vocabulary to express a range of feelings. Adding a timer and beat-the-clock feature may also make the activity more engaging.
- Order that feeling: This game provides the student with a list of words that can be used to express a positive or negative feeling and then asks the child to move the words along a ruler from least to most. For example, given the words *calm, unsettled, upset, agitated, frustrated, mad, angry*, and *furious*, the student would be expected to order them from the least (i.e., calm) to the most significant (i.e., furious) expression.
- Emotional vocabulary cards: For children who initially have difficulty remembering and utilizing new feeling vocabulary words, it may be helpful to have them select a few new words that can be laminated on a card and kept with them throughout the week as a reference for practice. Additionally, writing the new words inside of a rubber or plastic bracelet provides a very discreet way for students to always have an accessible reminder of their new words.

When to Use or Not Use Strategies for Building Feeling Vocabulary

Special sensitivity is warranted for teaching feeling vocabulary in group settings when children have speech difficulties and may find the exercises embarrassing. For those children, individual practice may be more appropriate. It also is important to consider the reading and developmental level of children when setting up expectations for expanding feeling vocabulary. Even for children of younger ages there is a wide range of simple feeling words they can use to express emotions. Additionally, for students prone to using expletives, setting boundaries and expectations for nonconfrontational word choices will be important.

COGNITIVE RESTRUCTURING

Cognitive restructuring is the heart of cognitive behavioral therapy and also key to addressing the needs of children and adolescents with externalizing disorders. Chapter 2 discusses the methods of cognitive restructuring and common distortions, all of which are applicable to externalizers. However, for those with disruptive and aggressive manifestations (e.g., CD, ODD, IED), the most likely distortions include issues related to misinterpreting others' intentions, jumping to conclusions, negative filtering, blaming, entitlement beliefs, fairness fallacy, and labeling. Therefore, it will be important during case conceptualization to give consideration to hypotheses related to these distortions. For children with neurodevelopmental disorders who have problematic externalized behaviors (e.g., attention deficit hyperactivity disorder [ADHD], autism spectrum disorder [ASD], Tourette's), cognitive restructuring will be less prominent given they do not share the distortions common to disruptive disorders. However, the relaxation techniques are applicable to anxiety-induced symptomology (e.g., task frustration in ADHD, tics in Tourette's) as well as social skills training for students with ADHD and ASD (APA, 2013; Chambless & Ollendick, 2001).

When to Use or Not Use Cognitive Restructuring

Cognitive restructuring is contraindicated for externalizing disorders that exhibit assaultive or extreme hostile behaviors. The prerequisites inherent in the change process for CBT require student amenability to counseling, an alliance between the clinician and the student, as well as forthright self-disclosure. In circumstances in which students are uncooperative, behavioral strategies may be a better option.

PARENT TRAINING

A number of research studies have indicated the effectiveness of parent training for increasing positive outcomes in students with externalizing behaviors (Anatopoulos, Shelton, DuPaul, & Guevremont, 1993; Chambless & Ollendick, 2001; Webster-Stratton, Hollingsworth, & Kolpacoff, 1989). Strategies often address communication skills, attending to positive behaviors, setting boundaries and expectations, behavioral modification strategies (e.g., use of a home token economy for reinforcement of positive behaviors), as well as increased supervision (Barkley, 1997). Although most schools do not offer extensive parent training workshops, there are opportunities to provide psychoeducational materials to parents that will help them better understand their children's behaviors and any mental health diagnoses. Providing handouts that explain CBT strategies applied at school also offers the opportunity for parents to reinforce concepts and extend the child's application and generalization of new skills learned during session. Guiding parents to support groups and empirically supported resources may also be helpful (see Chapter 2, Table 2.1 for national resource websites). Additionally, parent involvement can be provided through updated interviews regarding their child's needs throughout the

intervention sequence as well as frequent communication regarding changes in family stressors, medication changes, or outside services.

When to Use or Not Use Parent Training

Parent training is most effective when guided by empirically supported curricula with a trained professional. Depending on the chosen curricula, authors of parent training materials may caution against use with extremely hostile or aggressive youth (Barkley, 1997, p. 13). There are programs that offer in vivo parent coaching that is supervised and may be appropriate for assisting parents dealing with exceptionally challenging child behavior (e.g., parent–child interaction therapy).

In conclusion, there are many cognitive behavioral interventions that can be effective in addressing externalizing behaviors and it is feasible to apply most of these within the school setting. The following therapeutic treatments were highlighted in this chapter: physiological precursors and triggers, building feeling vocabulary, cognitive restructuring, and parent training. Although each method is empirically supported, the outcomes will vary by individual and severity of the behavioral needs. For children with the most significant needs, school personnel will need to design multifaceted intervention plans, special education programs may be warranted, and collaboration with outside medical or mental health providers will be essential.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Anatopoulos, A. D., Shelton, T. L., DuPaul, G. J., & Guevremont, D. C. (1993). Parent training for attention-deficit hyperactivity disorder: Its impact on parent functioning. *Journal of Abnormal Child Psychology*, *21*, 581–596.

Barkley, R. A. (1997). *Defiant children: A clinician's manual for assessment and parent training* (2nd ed.). New York, NY: Guilford Press.

Block, J. H., & Block, J. (1980). The role of ego-control and ego-resiliency in the organization of behavior. In W. A. Collins (Ed.), *Minnesota Symposium on Child Psychology* (Vol. 13, pp. 39–101). Hillsdale, NJ: Erlbaum.

Caspi, A. (1998). Personality development across the life course. In W. Damon (Series Ed.) & N. Eisenberg (Vol. Ed.), *Handbook of child psychology; Social, emotional, and personality development* (Vol. 3, pp. 135–160). New York, NY: John Wiley.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Joyce, D. (2010). *Essentials of temperament assessment*. Hoboken, NJ: John Wiley.

Scholte, R. H. J., van Lieshout, C. F. M., de Wit, C. A. M., & van Aken, M. A. G. (2005). Adolescent personality types and subtypes and their psychosocial adjustment. *Merrill-Palmer Quarterly*, *51*, 258–287.

Webster-Stratton, C., Hollingsworth, T., & Kolpacoff, M. (1989). The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct-problem children. *Journal of Consulting and Clinical Psychology*, *57*, 550–553.

PART IV

Counseling Report Case Samples for Children and Adolescents

SEVEN

Elementary School Counseling Sample Reports

This chapter provides sample reports for three elementary school-age students' cases. Each case has a very short report format that can be used for the purpose of reporting progress-monitoring data and a second longer and more formal version consistent with traditional counseling reports. The first report addresses cognitive behavioral therapy (CBT) counseling for Amia, a third-grade, 8-year-old student. Counseling goals include CBT and behavioral activation techniques to challenging negative filtering distortion and to increase physical movement and involvement in pleasant activities. Progress-monitoring measures include daily behavioral report card (DBRC) and observational data examples.

The second report offers an example of CBT and exposure strategies for Brittany, an 11-year-old, sixth-grade child with separation anxiety disorder (SAD) and school refusal. Intervention goals targeted increasing school attendance utilizing behavior modification and exposure strategies, lowering anxiety related to parental separation utilizing CBT, and monitoring psychopharmacological treatment compliance and medication side effects. The intervention delivery employs a multifaceted design with responsibilities for components of intervention designated for multiple school personnel. Progress-monitoring measures include the *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.; American Psychiatric Association [APA], 2013) level 2 somatic symptom parent rating, the *DSM-5* disorder-specific severity measure for SAD and naturally occurring school data (i.e., absences, tardies, grades).

The final report provides an overview of seven counseling sessions addressing the needs of Carlos, a fourth-grade student with attention deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD). The CBT components utilized included a psychoeducational component teaching Carlos about his diagnoses and also includes instruction on the cognitive triad relationship among thoughts, emotions, and behaviors. Exposure with response-prevention technique was applied for three issues: compulsive touching, cloth picking, and low frustration tolerance resulting in avoiding tasks. Subjective units of distress (SUDs) data were collected for all three targeted behaviors.

ELEMENTARY SAMPLE REPORT FOR COUNSELING INTERVENTION: DEPRESSIVE SYMPTOMS—AMIA

Individual Counseling Summary

Summary contains privileged/confidential information—may only be released with written parental consent except as provided by law.

Student: Amia Beaumont **Age**: 8 years, 1 month **Grade:** 3rd
Date: 10-16-15 **School Psychologist**: Hua Zhang, EdS, NCSP

Counseling Goals and Target Skills: Intervention plan includes a DBRC plan that reinforces interacting with others (i.e., recess and small-group projects). Short-term counseling with a CBT and behavioral activation focus will be provided. The counseling will address challenging Amia's negative filtering thinking pattern and (e.g., no dance class, longer bus ride, no orange popsicles in the cafeteria, and no one she knows), and increasing her movement level and involvement in pleasant activities.

Summary and Recommendations: Six weeks of intervention indicate significant improvement in Amia's self-initiated interactions with others as documented in both DBRC points and observations in recess and classroom group work (see Amia's progress-monitoring data charts in Figures 7.1 and 7.2).

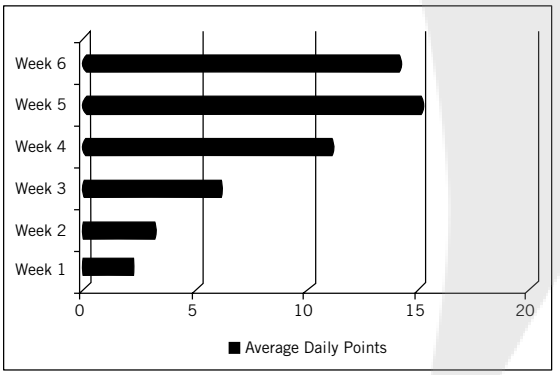


Figure 7.1 Daily behavioral report card progress-monitoring data—Amia.

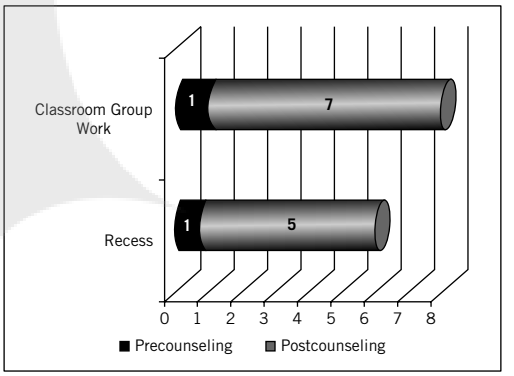


Figure 7.2 Number of self-initiated interactions with others across settings; observation data—Amia.

Counseling Intervention Report: Armistead Elementary

This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

Name: Amia Beaumont
Date of Report: 10-12-15
Date of Birth: 9-12-07
School Psychologist: Hua Zhang, EdS, NCSP
Age: 8 years, 1 month
Grade: 3rd

Referral Notes

Amia was initially referred to the school progress-monitoring team due to concerns regarding her recent transition to Armistead Elementary. Her teachers noted she has had difficulty making friends due to some withdrawn behaviors, she becomes tearful and won't talk when expected to work in groups, and she appears somewhat lethargic (e.g., sitting by the teacher bench at recess with her head down, walking slowly in line, sitting by herself in the cafeteria). Her parents indicate the changes occurred when they moved over the summer and a recent pediatrician visit noted good health. Although the physician noted some subclinical depressive symptoms, a diagnosis was not deemed warranted at this time. Her mother mentioned that Amia is an only child with a sweet demeanor, has a consistent history of high achievement, and enjoys pleasing adults. However, recently Amia is focused on missing her old friends, ruminating about her old neighborhood, and complaining about her new school (e.g., no dance class, longer bus ride, no orange popsicles in the cafeteria, and no one she knows). Additionally, her activity and sleep patterns have not been consistent (e.g., she is more often lying on the couch watching TV than playing, sometimes she is so slow getting ready in the mornings that she is late for the bus, and she often appears tired). Her parents think this may be due to the change in their work schedules and the city noises Amia hears at night, as they used to live in the countryside. They have asked the school for counseling assistance and also expressed a desire for suggestions on how to best track Amia's progress on benchmark tests and class assignments with teachers.

Intervention Plan

In collaboration with parents, the following short-term intervention plan was established with components:

- The school social worker would collaborate with Amia's parents on good sleep hygiene (e.g., setting an established bedtime, presleep routine, strategies to reduce light in the room, use of soundtrack that masks city noises and perhaps recreates sounds of the countryside), provide contact information for local after-school programs (perhaps including dance classes) that will transport Amia from the school to help her make social connections, discuss ways to help Amia find friends in the neighborhood, and assist the parents with navigating the school's online student assignment and academic progress-tracking system. Additionally, strategies to help Amia notice positive aspects of the neighborhood and school would be discussed (e.g., trips to the local theater and market, visiting the neighborhood park, riding the subway).
- The school counselor would add Amia to her weekly friendship group for new students to the school. The group participates in social skills–building exercises (e.g., how to introduce one's self to new people, how to enter a

conversation by finding common interests, reciprocity in conversations, and so forth).

- The school psychologist would consult with the teachers on a DBRC in-class behavior plan that reinforces interacting with others (i.e., recess and small-group projects). Short-term counseling with a CBT and behavioral activation focus would be provided. The counseling will address challenging Amia's negative filtering (e.g., no dance class, longer bus ride, no orange popsicles in the cafeteria, and no one she knows), and increasing her involvement in pleasant activities.

Session 1: Rapport Building

The first session with Amia covered discussion of confidentiality and the purposes of counseling. Rapport-building exercises included having her share stories of her family, past school, friends, and preferred activities. Additionally, she was provided with a tour of the school to answer some questions she had regarding use of the library and the gym. During the tour she was introduced to school personnel and obtained her library card. A reinforcer inventory was completed and identified Amia's preferred reinforcers (i.e., art supplies, princess pencils, animal stickers, and teacher praise). At the end of the session her new DBRC was discussed, noting that she could earn points toward her preferred rewards for participating in recess and small-group projects (participation was defined as talking to others, sharing work with others, and playing in recess games). Her homework was to discuss her DBRC plan with her teacher and to review her plan and what she learned in session with her parents.

Session 2: Increasing Pleasant Activities

Amia was provided two exercises in this session; a beat-the-clock game naming positive activities and a values tower game. The beat-the-clock game involved naming at least three fun things she enjoyed across five life arenas (e.g., on weekends, school, at grandparents' house, and at church) before the timer range. At first she had difficulty thinking of anything she liked to do now and noted what she used to do (e.g., play with dogs at neighbors, have a picnic with old friend, dress up for her old church service). The discussion evolved around her ability to still participate in most of these activities in her new home. The second activity involved labeling bricks with her values ("What do you love the most?"), which she reported as her family, her grandparents, her cat, her red sequin slippers, her old friend Casey, and her good grades. She then arranged the blocks into a tower with the most important ones (i.e., her family and grandparents) on top. The subsequent discussion involved noting how many really important good things were still in her life and then comparing those to her complaints (e.g., no popsicles or dance class at new school). Before leaving she completed a "Fun Stuff Calendar" for the next week with five fun activities she could do (e.g., play with her cat every night, have an orange popsicle at home on the weekend instead of at school, wear her sequin shoes to her new church mass on Sunday, and so forth) and was instructed to share her calendar with her parents.

Sessions 3, 4, 5: Identifying Stinkin' Thinkin' (Negative Filtering)

At the beginning of each session, Amia's "Fun Stuff Calendar" was reviewed to track how well she was increasing pleasant activities and how that affected her mood.

During sessions 3 to 5, the relationship among thoughts, feelings, and behaviors was discussed in detail. Amia's additional homework for each session was to keep a journal, briefly (2 to 4 words) noting any negative or positive thoughts about the school. During sessions, her lists of negatives were reviewed and her pattern toward negative filtering was discussed. Negative filtering was described as "wearing dark-colored glasses," "stinkin' thinkin'," and "thought traps" that create anxious self-talk. Viewpoint questioning techniques were utilized to challenge negative thoughts and she was provided a laminated card with three questions that she could keep with her during the day (e.g., "What is a different way to look at this?" "How could I think about this another way?" "What is good about this?") Upon review of her journals, for each negative, an alternative positive aspect list was made and the new positive statements were rehearsed. Role-reversal strategies also were applied (e.g., "What would you tell me if I said that and you wanted to change my stinkin' thinkin'?"). Any positive notes she generated in homework were celebrated and discussed as they related to her new experiences in trying to participate in school more and her efforts to meet new children. Progress on her DBRC points was also applauded.

Session 6: Review and Closure

The final session included review of CBT concepts and a brief lunch celebration for with new friends that she invited.

Progress-Monitoring Evaluation

Four observations (20 minutes each, two in recess, two in group classroom projects) indicate Amia has significantly increased the number of interactions with others (e.g., spoke to another child, joined a game or activity). DBRC data also indicated positive progress toward increasing her interactions with others and contributions to class projects. Additionally, she has completed the 6-week friendship group and reports indicate she has made two new girlfriends. Amia's parents report she is sleeping better, makes fewer negative comments toward her transition, and shows interest in joining an after-school girls' club. At this time, further individualized CBT is no longer deemed necessary. See Figures 7.1 and 7.2 for Amia's progress-monitoring data.

Hua Zhang, EdS, NCSP
School Psychologist, State Certification # 444555

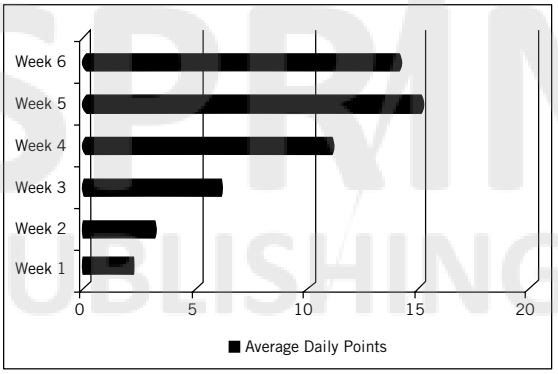


Figure 7.1 Daily behavioral report card progress-monitoring data—Amia.

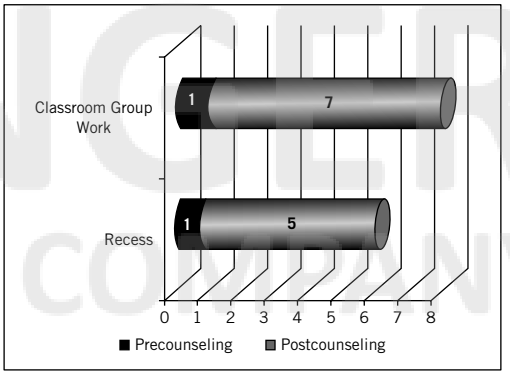


Figure 7.2 Number of self-initiated interactions with others across settings; observation data—Amia.

ELEMENTARY SAMPLE REPORT FOR COUNSELING INTERVENTION: SEPARATION ANXIETY WITH SCHOOL REFUSAL—BRITTANY

Individual Counseling Summary

Summary contains privileged/confidential information—may only be released with written parental consent except as provided by law.

Student: Brittany Watson **Age:** 11 years, 0 months **Grade:** 6th
Date: 11-23-15 **Nurse Practitioner:** Cayla Jackson, PhD

Counseling Goals and Target Skills: Increase school attendance utilizing behavior modification and CBT exposure strategies, lower Brittany's anxiety-related self-talk by challenging and reframing her catastrophizing distortions, and monitor psychopharmacological treatment compliance and side effects.

Summary and Recommendations: Following 12 weeks of intervention, Brittany has demonstrated progress in her ability to successfully separate from her mother and attend school for the full day. She reports lower somatic symptoms and weekday administration of fluvoxamine has been consistent with no significant side effects. Additionally, her separation anxiety severity level has dropped from extreme to mild. Closing counseling intervention with two scheduled booster sessions following winter break when she returns for the spring semester and keeping her behavior modification plan intact are recommended (see Brittany's progress-monitoring data charts in Figures 7.3 and 7.4).

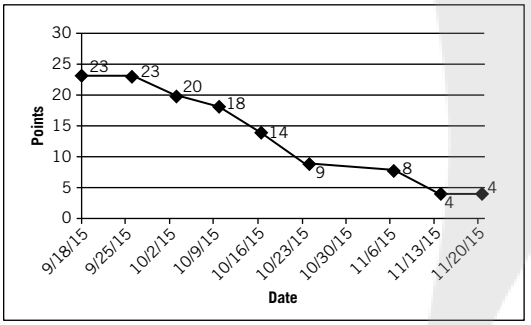


Figure 7.3 *DSM*-5 level 2 somatic symptoms rating (range 1–30)—Brittany.

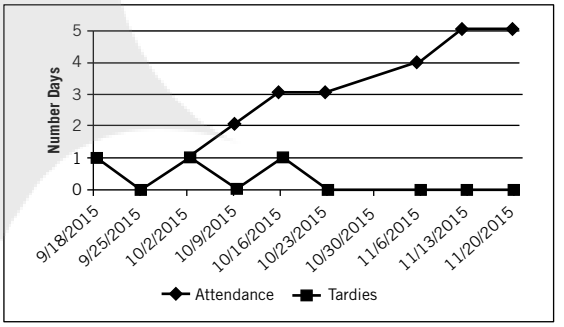


Figure 7.4 Progress-monitoring weekly attendance data—Brittany.

Consultation Intervention Report: Mountain View Elementary School

This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

Name: Brittany Watson **Grade:** 6th **Date of Report:** 11-23-15
Date of Birth: 11-14-04 **Age:** 11 years, 0 months
Nurse Practitioner: Cayla Jackson, PhD

Reason for Referral

Brittany was referred to the school student success team (SST) for intervention following 8 days of absences during her first 2 weeks of middle school.

Problem Identification

Brittany was diagnosed with separation anxiety disorder (SAD) by her pediatrician over the summer following a series of doctor visits for somatic complaints and her refusal to leave the house without her mother. Brittany's mother spent 2 months in the hospital during the spring semester last school year recovering from injuries due to a car accident. Although Ms. Watson is now fully recovered, Brittany reports being fearful her mother will again be injured while she is away at school. Pediatrician reports indicate an *extreme* severity level of SAD symptoms, including terror, fear, worry, nervousness, intrusive thoughts of harm coming to her mother, muscle tension, and refusal to separate from her mother. Brittany is closely monitored with monthly exams by her pediatrician and records note good physical health with a propensity for multiple somatic complaints (e.g., headache, stomachache).

Records from her prior school indicate good grades but expressed anxiousness over moving to middle school this academic year even prior to her mother's accident. Although Brittany did first attend the third day of classes, she left following several hours in the school clinic with complaints of stomach pain, headache, and chest pain. On several other occasions, her mother drove her to school but Brittany refused to leave the car despite attempts by school personnel to console her. It was also noted that Brittany's mother feels she cannot persuade Brittany to take her new medication responsibly and the pediatrician thinks the perscription could alleviate some of her anxiety in making this transition to middle school. In conference with the SST, her mother (i.e., Ms. Watson), her pediatrician (i.e., Dr. Jamila Q. Brown, via phone consult), and her new teachers the following intervention plan was established.

- Dr. Cayla Jackson, the school nurse practitioner, would provide Brittany with eduational information on separation anxiety disorder, including a self-help book that she could read as counseling progressed; administer Brittany's medication (fluvoxamine) at school and monitor for side effects; provide counseling to Brittany during her daily medication check-ins addressing relaxation strategies (e.g., counting backward, slow deep-breathing); structure positive replacement thoughts for Brittany's "catastrophizing" statements; and collect a weekly self-report *DSM-5* severity measure for SAD data.
- Mr. Roger Cooper, the school psychologist, would consult with teachers on classroom behavioral modification strategies, including a token economy

plan to reinforce school attendance (e.g., identify high-value reinforcers for Brittany, praise for attendance, reinforce relaxation strategies and dissuade unnecessary nurse visits for somatic complaints, ignoring innocuous clinging and excessive reassurance-seeking behaviors).

- The school guidance counselor, Dr. Alicia Montgomery, would coordinate a graduated attendance schedule (i.e., ¼ day, ½ day, whole day) with teachers; meet with Ms. Watson during Brittany's initial morning check-ins to provide educational materials for SAD; discuss home strategies (e.g., planning for adequate rest prior to school; avoiding reassurance behaviors, such as frequent hugging at the school, long good-byes, warnings "to be careful"; not permitting high-value activites, such as watching TV or phoning friends, when Brittany is home from school during school hours; and a reward system for attendance); and acquire weekly parent *DSM-5* somatic symptom ratings.

Counseling Intervention Summary

Brittany received 10- to 15-minute counseling sessions daily (September 18th to November 20th). Initially, disscussions involved learning relaxation strategies (e.g., diaphramatic breathing, counting slowly backward from 20) and medication compliance. In the beginning, Brittany attended school on a modified schedule 1 to 2 hours per day, which was increased quickly to half days and ultimately full days. Subsequent counseling focused on helping Brittany understand the relationship between her catastrophizing thoughts ("Something bad will happen if I am not with my mom." "I can't stand it here without my mom.") and her feelings and her actions. Strategies included: (a) looking for the evidence of those statements, (b) generating evidence-based positive replacement statements ("My mom is healthy now." "My mom will be proud of me for going to school."), and (c) cost–benefit analysis of that type of thinking. Intervention results indicate improved attendance, no recent tardies, and compliance with medication (without side effects). *DSM-5* somatic symptoms ratings have lowered from 23 (high range) to 4 points (minimal range). Additionally, the *DSM-5* severity measure for SAD lowered from 4 (extreme) to 1 (moderate). Recommendations include continuing her classroom behavioral modification strategies and closing daily counseling intervention. However, a few booster sessions following winter break as spring semester starts in January may be helpful. See Figures 7.3 to 7.5 for Brittany's progress-monitoring data.

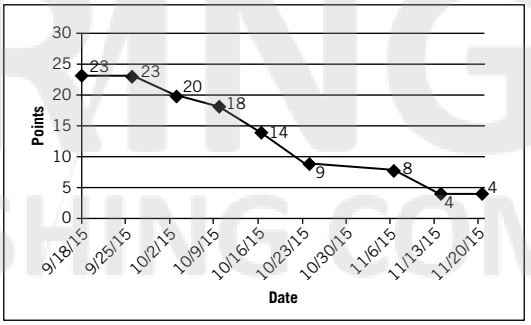


Figure 7.3 *DSM*-5 level 2 somatic symptoms rating (range 1–30)—Brittany.

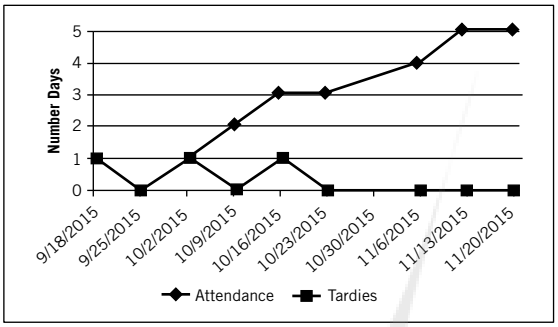


Figure 7.4 Progress-monitoring weekly attendance data—Brittany.

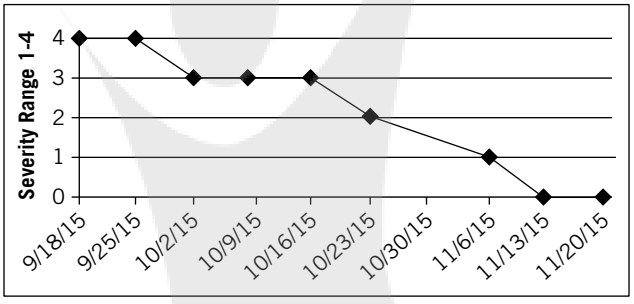


Figure 7.5 *DSM-5* parent rating severity of separation anxiety disorder symptoms—Brittany.

ELEMENTARY SAMPLE REPORT FOR COUNSELING INTERVENTION: ADHD AND OCD—CARLOS

Individual Counseling Summary

Summary contains privileged/confidential information—may only be released with written parental consent except as provided by law.

Student: Carlos Hernandez **Age:** 10 years, 3 months **Grade:** 4th
Date: 4-21-14 **Counselor:** Maria Sutton, LSW

Counseling Goals and Target Skills: Understanding of cognitive triad needed; learn two relaxation strategies; lower anxiety related to touching and eliminate cloth-picking compulsions; build frustration tolerance in completing nonpreferred tasks, including homework.

Summary and Recommendations: Carlos has demonstrated progress regarding his ability to understand the cognitive triad as it relates to his own thinking processes, to resist cloth-picking behaviors, and to avoid touching compulsions. He may continue to benefit from booster sessions to remind him of strategies over time and teacher cuing and prompting for ADHD propensity to be inattentive (see Carlos's progress-monitoring data charts in Figures 7.6 and 7.7).

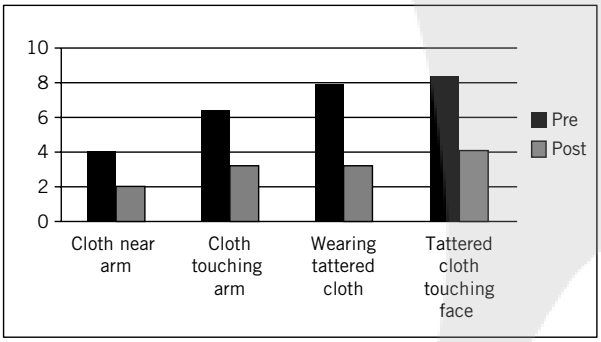


Figure 7.6 Cloth-picking exposure data; pre- and postcounseling self-reported subjective units of distress—Carlos.

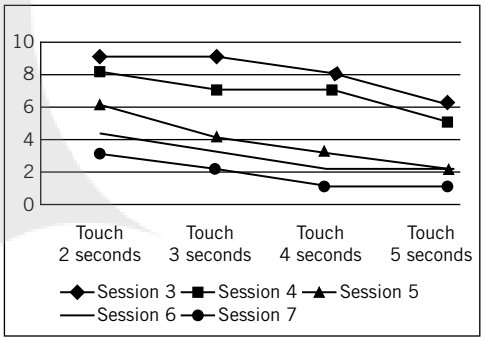


Figure 7.7 Touching exposures data; self-reported subjective units of distress (range 1–10)—Carlos.

Psychoeducational Intervention Report: Westin Elementary School

This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

Name: Carlos Hernandez
Date of Birth: 1-12-04
Age: 10 years, 3 months
Grade: 4th
Date of First Meeting: 2-14-14
Date of Final Meeting: 4-10-14
Counselor: Maria Sutton, LSW
Date of Report: 4-13-14

Reason for Referral

Carlos is a 10-year-old male with previous diagnoses of attention deficit hyperactivity disorder (ADHD) and obsessive-compulsive disorder (OCD). He was referred by Dr. Jose Mars for school-based counseling to supplement his outpatient family therapy and address his manifestation of compulsive behaviors, impulsivity, and work frustration at school. His symptoms are reportedly negatively affecting his functioning at school and home.

Background Information and History of Presenting Concerns

Mrs. Hernandez indicated that she had an unremarkable pregnancy culminating in a natural delivery with no significant complications. No significant developmental delays, injuries, or illnesses were noted. Paternal family history is positive for ADHD. She described Carlos as a beautiful and engaging baby, but noted he always had problems transitioning, being held for any length of time, as he wanted to be active, and sustaining attention to her voice. Carlos lives with both of his parents and two younger sisters (ages 3 and 5). He enjoys playing with his sisters and is described as a protective big brother. In terms of his psychiatric history, she reported that Carlos was diagnosed with ADHD by a psychologist when he was 5 years of age due to significant problems with both hyperactivity/impulsivity and inattention in kindergarten. She also reported that a neurologist withheld a diagnosis of autism spectrum disorder based on referral for sensory difficulties when he was 3. Reportedly, his eye contact, communication, and interpersonal skills *did not* reflect significant impairment. His current psychiatrist, Dr. Mars, diagnosed him with OCD 2 years ago as some obsessions about order of his clothing and routine, as well as compulsions to straighten items in his room, became evident. Mrs. Hernandez also mentioned that Carlos has benefited from ADHD medication (i.e., Focalin), which he began 3 years ago, as he seems more focused, less hyper, and calmer during the day. Mrs. Hernandez also indicated that Carlos likes school, has a few select good friends, and enjoys soccer. She is most concerned that, over the last year, Carlos has started to become more "obsessed" about destroying his clothing if it has marks of wear and will compulsively pull the threads out of various fabrics. He also has a need to touch people back if they brush against him and he cannot be the last one being touched. His mother also noted that many of his behaviors are impulsive and that he has difficulty listening to her directions. He can become quickly frustrated if he considers homework hard and seems to give up easily on chores he does not want to finish.

Carlos is currently in fourth grade. He reportedly repeated third grade due to academic difficulties in reading and writing (e.g., failed state benchmark exams) that emerged last year. It is unclear whether he became anxious about the testing, as prior grades were all Cs and Bs. He currently receives supplemental Tier II intervention services for reading and writing. The interventionist reported that his

curriculum-based measures indicate excellent progress toward improving his reading and writing skills and intervention may not be required next semester. She did note that initially Carlos would give up easily on hard items but with lots of praise and encouragement he can persist. Other than incidents related to his obsessive and compulsive behaviors, his teachers indicate that he has never had discipline referrals at school. Socially, his primary teacher, Mrs. Morales, reported that he has a few close friends who share his interest in comic books and soccer. She also noted that Carlos sometimes has difficulty sharing with others but has never had any difficulty maintaining eye contact, showing affection, or having emotional reciprocity. Additional interviews with two of Carlos's other teachers indicated he is a kind and dutiful student who appears to enjoy school. They noted he generally tries to follow directions, although at times it is necessary to cue, prompt, and remind him to focus on tasks. He is described as having a couple of good friends he regularly engages with; although he does occasionally offend students who don't know him well with his touching and cloth-picking compulsions. They described a recent crowded cafeteria incident during which Carlos was accidently bumped by both the student in front of and behind him in line. He responded by repeatedly tapping them on the back and appeared agitated. The other children laughed at first but then became angry with him as he persisted in tapping them, which resulted in brief scuffling until the teacher intervened. Additionally, he is noted to pick at clothing, sometimes tearing the hems out of his own shirts and sometimes reaching for strings on others' clothing or cloth items in the classroom. Teachers are most concerned about the potential for Carlos's touching and picking compulsions to result in isolating him from others or creating confrontations with students who do not understand him. They also have noticed that he pouts increasingly if he becomes upset when expected to share books or work cooperatively on projects with shared objects.

Counseling Summary

During the initial session, Carlos interacted and followed directions appropriately, although he was noted to have significant hyperactivity and impulsivity. He also could not restrain himself from picking at a loose book binder that was on the table. He appeared motivated to improve his daily social and emotional functioning, noting he wants "kids to like him."

Following consent for counseling and parent agreement to the session goals, intervention was implemented. The counselor utilized a CBT approach to target Carlos's OCD and ADHD symptoms. A psychoeducational component was provided during the first session to assist Carlos in understanding his ADHD and OCD as well as his power to manage these symptoms. The relationship among thoughts, emotions, and behaviors was also taught and reviewed periodically. The primary modality for therapy included exposure and response-prevention techniques along with behavior modification training. Sessions were provided on a weekly basis for a total of seven sessions. Exposure hierarchies were collaboratively created during the first two sessions to guide therapy goals and Carlos's mother agreed to the process. See Figures 7.6 to 7.8 for Carlos's progress-monitoring data. Counseling was structured into three main domains:

1. Touching issues: Over the course of the seven-session treatment period, numerous exposures were used both during the therapy session and as homework in collaboration with Carlos's parents to target his compulsions involving touching and retouching others. In vivo exposures were used with

increasing duration (e.g., touching his shoulder or arm from 2 to 5 seconds) of touching without Carlos engaging in compulsive retouching. He reported an initial SUDS level on his first exposure hierarchy of 9. The SUDS range was 1 to 10. The first few exposures were challenging for Carlos and required multiple trials for habituation. By the end of the last week of intervention, he was able to calmly respond to 5 seconds of touching his shoulder and arm without much apparent distress. He also reported that he was no longer distressed if others accidently touched him in crowded lines or the classroom.

2. Cloth-picking issues: In order to target Carlos's compulsive cloth-picking behaviors, several exposures were performed during counseling. The OCD hierarchy in this area was progressively used to decrease his anxiety while touching or being close to frayed cloth and clothing. At first, a small frayed piece of cloth was placed near him while the counselor directed him to refrain from touching or picking at the object. This was followed by increasingly difficult and anxiety-producing exposures in this area (i.e., frayed cloth touching his arm, wearing a shirt with loose threads/tear, tattered cloth touching his face). Carlos reported initial SUDS levels on his hierarchy of up to approximately 8 involving consistent touching by frayed clothing. Similar to his other touching exposures, the beginning exposures were challenging and included some tearfulness but he was able to quickly progress up through his hierarchy to the most challenging exposures and within several sessions he was able to wear a very tattered and uncomfortable T-shirt his mother had loaned to the counselor without significant distress or engaging in compulsive picking.
3. Frustration issues: Due to the teachers' and family's concerns with Carlos's low frustration tolerance, the therapist used various CBT exposures and psychoeducational techniques to assist with these behaviors. First, Carlos was taught to recognize the precursors to his anxiousness (e.g., faster breathing, rocking, feeling defeated). The therapist also presented him with two specific relaxation coping skills for frustration (i.e., diaphragmatic breathing, and visualizing successfully completing the goal) and role-played their use. Next, a number of progressive exposures were enacted that targeted his response to several challenges (e.g., a difficult puzzle, hard word game based on his vocabulary list, and completing a school writing homework assignment during the session). The first exposures remained challenging for Carlos with the engagement of compulsive, anxiety-reducing behaviors, such as repeated touching and tearing at his paper. During these challenges the therapist then guided him through identifying his emotional state, normalizing the event, and using coping skills. As with previous exposures, he quickly progressed through his hierarchy and was able to participate in high-intensity exposures with no apparent distress by the end of the seventh session.

Counseling Plan Evaluation and Summary

Carlos is a 10-year-old male in the fourth grade at Westin Elementary who was referred to receive counseling intervention related to OCD and ADHD symptomology. He participated in a total of seven counseling sessions, which lasted between 45 and 60 minutes. Based on collected SUDS data as well as parent reports, Carlos appeared to make significant progress in the targeted areas described previously. His family is currently continuing outside family therapy to provide home supports. Facilitating

factors for Carlos's success include his positive regard for school, his network of supportive family and friends, as well as his desire to control his compulsions and build positive interactions with others. Closure of counseling intervention is recommended at this time with scheduled booster sessions at 1 and 2 months post intervention. The purpose of booster sessions is to review CBT concepts and strategies with Carlos as well as to monitor his continued positive progress.

Maria Sutton 4-13-14
Licensed Social Worker Date

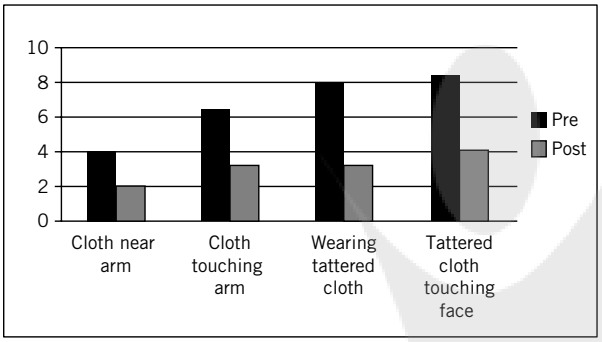


Figure 7.6 Cloth-picking exposure data; pre- and postcounseling self-reported subjective units of distress—Carlos.

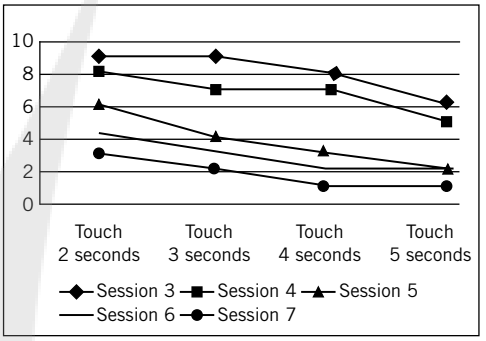


Figure 7.7 Touching exposures data; self-reported subjective units of distress (range 1–10)—Carlos.

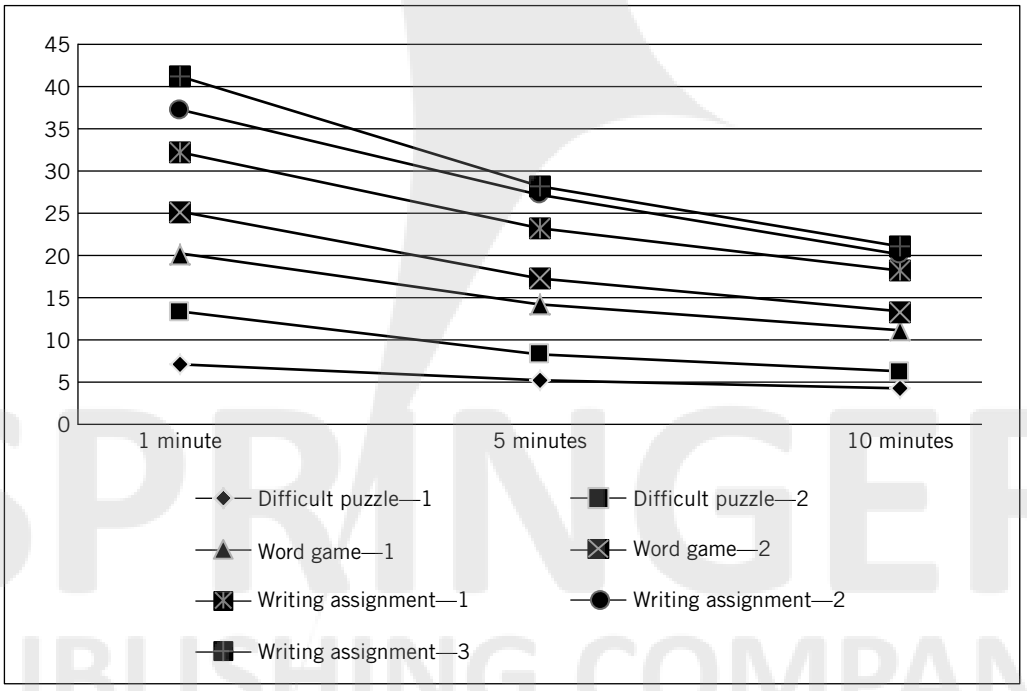


Figure 7.8 Frustration exposures data; subjective units of distress—Carlos.

REFERENCE

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

EIGHT

Secondary/Postsecondary Counseling Reports

The first sample report in this chapter reviews counseling intervention for Jim, a 13-year-old, seventh-grade student identified with attention deficit hyperactivity disorder (ADHD) and anxiety-related characteristics. Counseling goals included identifying triggers or physiological precursors to his anxious behaviors, learning relaxation strategies for self-calming, identifying and reframing cognitive distortions (fortune-telling, discounting positives, overgeneralizing), and use of "I" statements to express needs and organization skills. Progress-monitoring techniques included utilizing Subjective Units of Distress Scale (SUDS), Behavioral Assessment System for Children, 2nd Edition (BASC-2) Internalizing Progress Monitor ratings, the Revised Children's Manifest Anxiety Scale (RCMAS), and pre-/post counseling knowledge questions.

The second report example addresses Tier III, individualized and intensive counseling intervention results for Fisher, a 16-year-old 10th grader. He had a history of multiple involuntary commitments for psychiatric treatment and diagnoses of oppositional defiant disorder, anxiety, and depression. Counseling goals included identifying physiological precursors to his anger outbursts, building his expressive vocabulary for feeling words, learning relaxation strategies that include tablet applications, and identifying and reframing cognitive distortions (mind reading, blaming, shoulds, dichotomous thinking). Progress-monitoring measures included a skills knowledge questionnaire, emotion vocabulary assessment, and the BASC-2 Progress Monitor rating scale for Externalizing Problems and ADHD.

The final sample report involves a 12th-grade, dual-enrolled high school/postsecondary student, Amitola, and counseling intervention included exposures with response prevention therapy addressing obsessive-compulsive disorder (OCD) symptoms (i.e., excessive need for object symmetry, distress over disposing of waste, and fear of harm to self or others). The Children's Yale–Brown Obsessive Compulsive Scale (CY-BOCS) ratings were utilized for counseling outcome data.

SECONDARY SAMPLE REPORT FOR COUNSELING INTERVENTION: ANXIETY AND ADHD—JIM

Individual Counseling Summary

Summary contains privileged/confidential information—may only be released with written parental consent except as provided by law.

Student: Jim Patten **Age:** 13 years, 1 month
Grade: 7th **Date:** 4-15-15
Counselor/Supervisor(s): Tanisha Harris/Dr. James Roy

Counseling Goals and Target Skills: Identify triggers, recognize physiological precursors to anxiety, learn strategies to manage anxiety (self-calming techniques), identify and reframe cognitive distortions (fortune-telling, discounting positives, overgeneralizing), appropriately convey feelings/needs—rephrased as "I" statements—and learn organization skills.

Summary and Recommendations: Jim has demonstrated progress regarding his ability to cope with stress and manage his work. Tier III counseling support does not appear to be needed at this time. However, Jim may benefit from monthly booster sessions as needed to support his continued progress and reinforce his utilization of helpful skills that he has acquired during counseling (see Jim's progress-monitoring data charts in Figures 8.1 and 8.2).

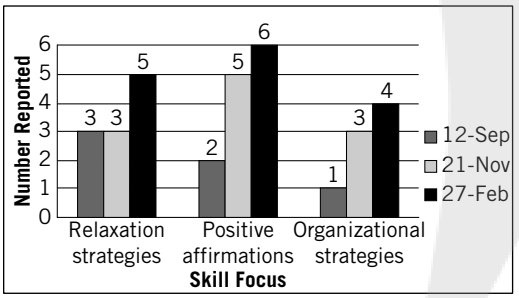


Figure 8.1 Knowledge acquisition progress-monitoring data; psychoeducation skills assessment—Jim.

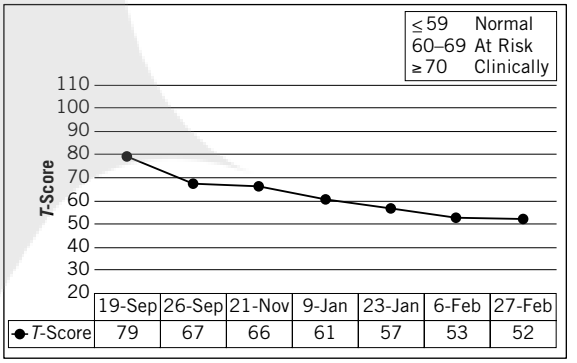


Figure 8.2 BASC-2 progress monitoring: internalizing problems—Jim.

Individual Counseling Report: Whattemit School

This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

Student's Name: Jim Patten
Date of Birth: 3-8-2002
Age: 13 years, 1 month
Grade: 7th
Counselor: Tanisha Harris, MEd
Supervisor: Dr. James Roy, CCMHC
Date of Report: 4-15-15

Referral Concern

Jim was referred for Tier III individual counseling based on teacher and parent concerns regarding difficulties with managing stress and anxiety, self-regulation, and organizing his schoolwork. Parent consent for counseling was obtained.

Counseling Goals and Target Skills

Jim participated in individual counseling guided by psychoeducation and cognitive behavioral techniques. The goal of counseling was to help Jim identify triggers to his anxiety and learn effective strategies that he can utilize to manage his stress. Based on the parent referral, student interview, and precounseling social–emotional and behavioral ratings, specific goals for counseling support were established. These goals included: learning how to stay organized in school, identifying and utilizing relaxation techniques, conveying his feelings appropriately through "I" statements, and identifying and reframing cognitive distortions.

Assessment Measures

An interview was conducted with Jim on September 3, 2014, to gain his perspective regarding his needs and goals for counseling. Jim reported that he enjoys building things, reading, and fixing computers. He explained that he admires his ability to persist and not give up, as well as his knowledge about science-related concepts. When he grows up he wants to be an engineer. Regarding his areas of difficulties, Jim noted that his stress and anxiety are triggered by keeping up with the amount of schoolwork his teachers assign and worrying about the accuracy of completed assignments. He described automatic thoughts that he has when being called on in class by his teachers (e.g., "Everyone is going to think I am dumb." "My teachers just want to embarrass me." "I'm usually wrong.") and focusing on negative interactions between him and his parents regarding his school performance (e.g., "arguing back and forth," "They say I'm good in science but that is easy." "They are always harping and really think I can't keep up with schoolwork.") in which he discounts positive feedback. Additionally, Jim indicated that he believed that he could not regulate his behaviors and manage his workload due to his diagnosis of ADHD. As a result, Jim noted that he wants to learn how to cope with his stress and anxiety and manage his schoolwork. He agreed to limits of confidentiality and assented to counseling.

Jim was also asked to complete several social–emotional and behavioral rating scales to further assess his needs. The Revised Children's Manifest Anxiety Scale, 2nd Edition (RCMAS-2; Table 8.1) and the BASC-2 (Table 8.2) were administered to Jim. The BASC-2 is an omnibus behavior rating scale designed to broadly assess children and adolescents' emotional and behavioral functioning, and the RCMAS-2

TABLE 8.1 Revised Children's Manifest Anxiety Scale, 2nd Edition

Subscale	*T*-Score	Percentile
Total Anxiety	**68***	**96**
Physiological anxiety	68*	96
Worry	63*	90
Social anxiety	65*	93

*Score in the at-risk range.

TABLE 8.2 Behavioral Assessment System for Children, 2nd Edition: Self-Report Adolescent

Subscale	*T*-Score	Percentile
School problems	**52**	**61**
Attitude toward school	50	56
Attitude toward teachers	60*	84
Sensation seeking	45	32
Internalizing problems	**79****	**99**
Atypicality	77**	98
Locus of control	65*	90
Social stress	72**	97
Anxiety	82**	99
Depression	65*	90
Sense of inadequacy	71**	96
Somatization	82**	99
Inattention/hyperactivity	**73****	**98**
Attention problems	71**	91
Hyperactivity	70**	96
Emotional symptoms index	**77****	**98**
Personal adjustment	**36***	**10**
Relations with parents	46	33
Interpersonal relations	49	33
Self-esteem	34*	8
Self-reliance	30*	3

*Score in the at-risk range. **Score in the clinically significant range.

is designed to help measure a child or adolescent's overall level of anxiety. Jim's self-report ratings on the BASC-2 indicated risk of clinically significant concerns in multiple areas: attitude toward teachers, atypicality, social stress, anxiety, depression, somatization, attention and hyperactivity, self-esteem, and self-reliance. With respect to Jim's attitude toward his teachers, Jim noted that he sometimes feels misunderstood and when teachers provide him feedback in front of the entire class he feels like he is not smart. His views regarding his capabilities relate to his at-risk ratings with respect to self-esteem and self-reliance. Although he endorsed clinically

significant ratings for atypical behaviors (e.g., hearing voices in his head), he clarified that he frequently repeats verbal phrases and words to help him with memorization. Furthermore, at-risk ratings on the depression scale showed that Jim often felt sad, depressed, and like his life was not getting better. Clinically significant concerns for attention and hyperactivity are consistent with his diagnosis of ADHD inattentive type as he reported that he struggles with sitting still and maintaining attention. An additional measure of anxiety, the RCMAS-2, indicated at-risk ratings on the Total Anxiety Scale, and the Physiological Anxiety, Social Anxiety, and Worry subscales.

Outcome of the Intervention

In addition to the aforementioned measures, the BASC-2 Progress Monitor Student Form for Internalizing Problems was administered during the beginning, middle, and end of the counseling intervention (see Figure 8.2). Jim's ratings indicated that he reported clinically significant concerns at the beginning of counseling. However, his self-report ratings now reflect normal-range functioning for internalizing concerns. This suggests that Jim perceives fewer difficulties related to his original anxiousness and depression characteristics. A skills questionnaire also was administered during the beginning, middle, and following the end of the counseling intervention period (see Figure 8.1). Overall, Jim's knowledge of relaxation techniques, positive affirmations, and organizational skills has increased. He was able to articulate five relaxation strategies that he had learned in counseling and felt were helpful to him (i.e., diaphragmatic breathing, visualization/imagery, progressive muscle relaxation, listening to soothing music, and counting to 20 backwards). Jim had created six positive affirmations to use when automatic negative thoughts emerged or he felt discouraged (e.g., "I am in charge of my ADHD." "I am the stress master." "My teachers know I'm good at science and art."). He also was able to readily identify four out of the six organization skills taught (e.g., color-coded files for class homework and notes, keeping assignment deadlines in his calendar, looking at next week's assignments to plan ahead, and starting homework after school instead of late at night.). Additionally, he reports that he is utilizing these strategies more to help him improve in school and cope with his identified stressors.

Jim also was asked to complete the SUDS during each session. His anxiousness in response to his self-identified stress triggers was assessed during each counseling session: organizing schoolwork, completing schoolwork, teachers calling on him in class, and parent–child interaction regarding his school performance. Jim's SUDS data indicated an overall decrease in self-reported anxiety from the beginning to end of the counseling intervention period (see Figure 8.3). Furthermore, clinical observations recorded during counseling sessions indicate that Jim is demonstrating more automaticity with respect to generating alternative adaptive thoughts to replace his cognitive distortions.

Jim's teachers provided additional insight regarding his progress in their classrooms. Overall, his teachers report that Jim is utilizing better organization skills and has turned in most homework assignments. They think this is still an area for continued improvement. They noted that he does well when he is focused and attentive, works in groups, and receives positive feedback, but he struggles more with individual-based assignments. His teachers also mentioned they have observed him

utilizing "I" statements to request assistance when he does not understand concepts or is expressing apprehension.

Recommendations

Overall, Jim has demonstrated progress regarding his ability to cope with stress and anxious behaviors as well as manage his schoolwork. In lieu of his progress, Tier III counseling support does not appear to be needed at this time. However, Jim may benefit from positive teacher and parent acknowledgment when he utilizes his strategies to continue reinforcing these behaviors.

Tanisha Harris, MEd
Practica Student – Guidance Program

James Roy, PhD
Certified Clinical Mental Health Counselor (CCMHC)

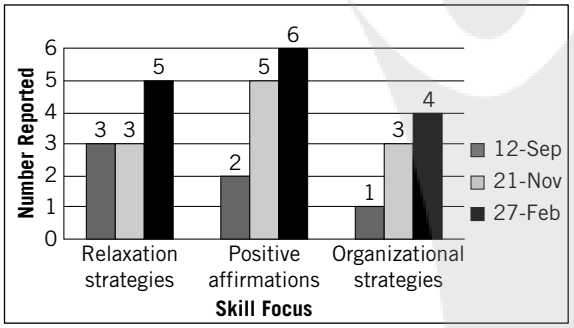


Figure 8.1 Knowledge acquisition progress-monitoring data; psychoeducation skills assessment—Jim.

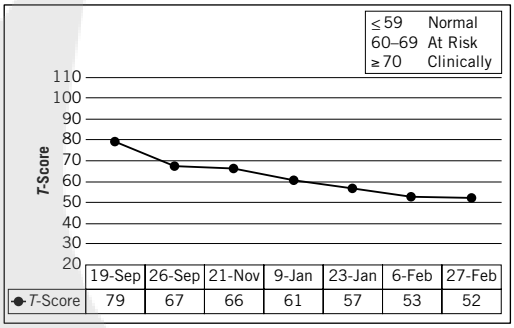


Figure 8.2 BASC-2 progress monitoring: internalizing problems—Jim.

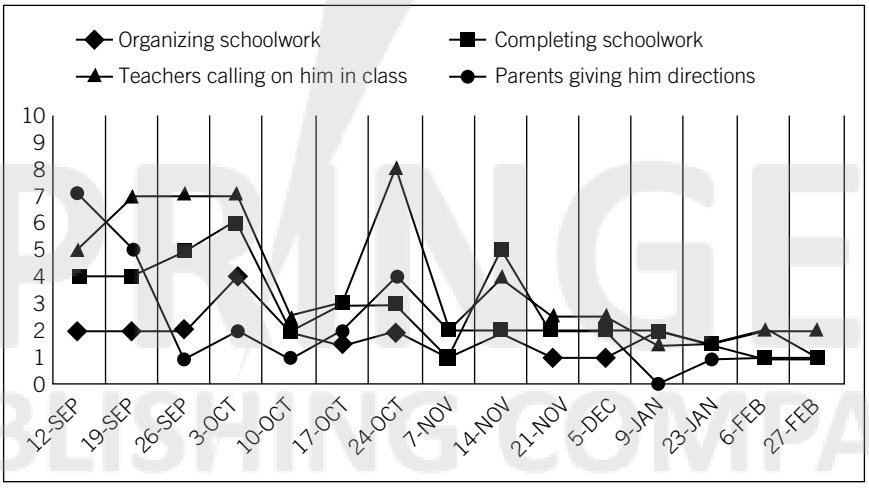


Figure 8.3 Subjective units of distress (scale 1–10) progress-monitoring data—Jim.

Summary of Sessions

Session 1

The first half of the interview session was devoted to building rapport with Jim. During this session the counselor introduced himself, explained his role as a supportive adult, and described the purpose of weekly meetings. The limits of confidentiality were also explained to Jim and he assented to counseling. During the second half of the session Jim was asked to complete the BASC-2 and RCMAS-2 and respond to interview questions posed by the counselor. The purpose of the interview was to garner Jim's perspective and identify his self-determined goals for counseling. Jim noted that his goals for counseling were to learn how to cope with stress and manage his schoolwork.

Session 2

During this session the counselor administered the BASC-2 Progress Monitor Student Form for Internalizing Problems and asked questions regarding his knowledge of relaxation techniques, positive affirmations, and organization skills to further assess his needs. Additionally, Jim identified triggers to his stress and anxiety and reflected on his reactive thoughts when the identified triggers occurred. The counselor also introduced controlled breathing/taking a few slow deep breaths and counting down as two relaxation techniques that he could utilize. Jim added that listening to music helps him stay calm and he has some songs saved on his phone that he can listen to with ear buds when needed. His homework was to practice his relaxation techniques daily and keep a thought journal.

Session 3

At the beginning of the session, homework was reviewed. Jim discussed his maladaptive self-talk related to having ADHD (e.g., "I can't do it because I have ADHD."). This was coupled with a review of several celebrities who are identified as having ADHD and their statements regarding their choice to cope with the common symptoms. During this session the counselor also had Jim bring his book bag, folders, and calendar. He noted that Jim's folders were not organized and Jim reported that he seldom used his planner. Thus, given that the purpose of this session was to help Jim learn that he could manage his ADHD and cope with the symptoms, two organizational strategies were introduced: organizing his school class folders by using differentiating colors and writing in his planner to keep up with his work. Additionally, two more relaxation strategies were taught (i.e., progressive muscle relaxation and guided imagery utilizing apps on his phone so he could access the strategies throughout the day). At the end of the session, Jim was coached on creating a list of six positive affirmations that he identified to help him challenge his negative thoughts about his abilities and others' perceptions of him. His homework was to organize his book bag and planner, try the two phone apps during the week, and practice positive affirmations daily.

Session 4

At the beginning of the session, homework was reviewed and concepts were reinforced. While brainstorming additional organization supports, Jim indicated that attending after-school help sessions, advance checking of next week's assignments,

monitoring the status of his assignments using the online school database, and starting homework as soon as he arrived home would also help him. Additionally, the relationship among thoughts (self-talk), emotions, and behaviors that may be self-defeating was discussed. The counselor utilized the Socratic questioning method to begin challenging Jim's distortions (e.g., fortune-telling, discounting the positive, overgeneralizing). His counseling homework was to continue journaling and to utilize his positive affirmations and challenge distortions as he identified them by "asking what is the evidence for this" and "what is the evidence against this."

Session 5

At the beginning of the session, Jim's journaling homework was reviewed in lieu of helping him identify distortions, challenging those distortions, and envisioning more positive outcomes. His positive affirmations and relaxation strategies also were reviewed. During this session, Jim also explained that his interactions with his mom about his poor school performance were stressful because they often include Jim and his mom yelling back and forth and Jim walking away. During the second half of the session, the counselor utilized the Parent Child Coercive Cycle concept (www.pendletonpsych.com/therapy-helpers/parent-child-coercive-cycle-handout) as a framework to help Jim understand the potentially escalating patterns of hostile discussion mechanisms (e.g., raising tone, blaming, name-calling, threats, ultimatums) and alternate replacement strategies (e.g., "I" statements, needs expression, calm tones, active listening) to better cope with his parental interactions regarding his academic performance. Jim identified physiological symptoms that he feels when he becomes stressed during these interactions and specific actions and nonverbal cues that he could take to stay calm (e.g., maintain a low voice tone, refrain from frowning, and keeping his arms down at his sides in a relaxed manner). Additionally, discussion of thought-stopping and -challenging techniques was continued. His homework was to continue utilizing his thought journal and to track how often he utilized "I" statements, a calm voice, and active listening in responding to his parents.

Session 6

At the beginning of the session, counseling homework was reviewed. The first half of this session was dedicated to addressing Jim's self-reported tendency to put his head down during class when he is stressed and overwhelmed. Thus, Jim and the counselor reaffirmed adaptive alternative behaviors that he could engage in (e.g., utilize positive affirmations/relaxation techniques, continue to complete his work, and seek help after school during help sessions). The counselor continued to address cognitive distortions of fortune-telling and overgeneralizing based on review of his thought journal by questioning his viewpoints and perspectives (e.g., "What alternative ways of looking at this are there?" "What does it do for you to continue to think this way?" "Who benefits from this?"). His homework was to begin applying viewpoint questions to himself when distortions emerged.

Session 7

During the beginning of the session, the counselor engaged in a check-in with Jim regarding his use of organizational skills, relaxation techniques, and challenging

thoughts. The counselor role-played several stressful scenarios with Jim (e.g., teacher calling on him, parent making a request), coaching him on utilizing his new communication and replacement-thought skills. His homework was to continue practicing his organization, relaxation, and thought-challenging techniques.

Sessions 8 and 9

Homework was reviewed at the beginning of the sessions and Jim's progress in reaching several of his therapy goals was praised. He noted continued struggles with being called on in class (e.g., teachers want to humiliate him and students think he is not smart). Thus, challenges to these thoughts were again practiced. Furthermore, the counselor took the role of student and had Jim take the role of counselor in coaching how to address evidence to support and challenge thoughts. His homework was to reflect on his counseling progress and write down which strategies he was finding helpful as well as areas for continued growth. The counselor mentioned to Jim that formal counseling would close at the next session.

Session 10

During this session, Jim presented his thoughts regarding acquired skills and areas of improvement. He also identified areas for continued work (e.g., challenging his automatic thoughts and relaxing before responding to parent and teacher requests so he could better represent his nonverbal signals and thoughts to others). The skills questionnaire was administered and final progress-monitoring data collected. The counselor thanked Jim for his participation and earnest efforts, complimented him on his progress, and encouraged him to continue developing his strategies. Additionally, Jim was encouraged to stop by the counselor's office periodically to check in on his progress as he felt the need.

SECONDARY SAMPLE REPORT FOR COUNSELING INTERVENTION: OPPOSITIONAL DEFIANT DISORDER—FISHER

Individual Counseling Summary

Summary contains privileged/confidential information and may only be released with written parental consent except as provided by law.

Student: Fisher Meyer **Age:** 16 years, 1 month
Grade: 10th **Date:** 4-28-15 **School Psychologist:** Dr. Martha Collins

Counseling Goals and Target Skills: Improve emotional expressiveness and coping skills, build feeling vocabulary, recognize physiological precursors to range of feelings, interpret nonverbal external cues from others more appropriately and positively, articulate feelings/needs through "I" statements, identify and utilize self-calming techniques, identify and reframe cognitive distortions (i.e., blaming, shoulds, mind reading, dichotomous thinking).

Summary and Recommendations: Data and counseling observations indicate that Fisher has demonstrated behavioral improvements and increased knowledge of emotional feeling vocabulary and self-calming strategies. Given that his mother reports that he will be attending a yearlong inpatient program beginning this summer (in 3 weeks), Fisher may benefit from continued counseling sessions during the final couple of weeks of the term to help him identify coping strategies that he can utilize during the upcoming transition from his home to the treatment facility. Continued intensive therapy will be provided by the treatment center until Fisher returns (see Fisher's progress-monitoring data charts in Figures 8.4 and 8.5).

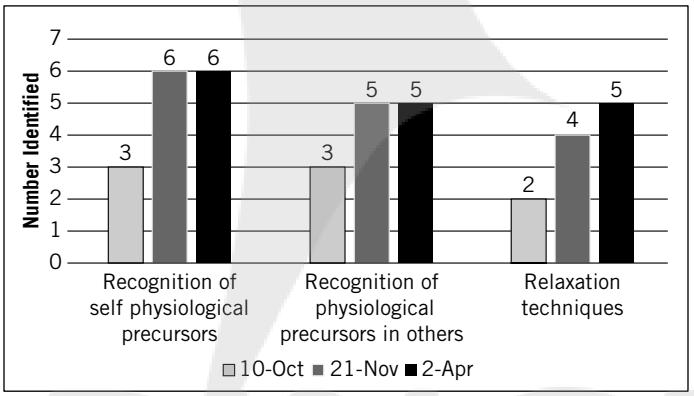


Figure 8.4 Knowledge acquisition progress-monitoring; skills questionnaire—Fisher.

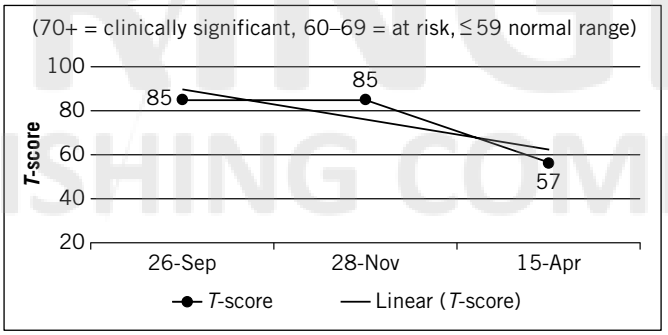


Figure 8.5 BASC-2 progress monitor externalizing and attention deficit hyperactivity disorder—Fisher.

Individual Counseling Report

This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

Student's Name: Fisher Meyer
Date of Birth: 3-27-99
Age: 16 years, 1 month
Grade: 10th
Date of Report: 4-28-15
School Psychologist: Dr. Martha Collins, NCSP

Referral Concerns

Fisher was referred for Tier III individual counseling by his parents and the high school guidance counselor, due to concerns regarding coping skills, including difficulties expressing his emotions, initiating frequent arguments, and making vague threats of self-harm.

Background Information

Due to the severity of Fisher's behaviors as reported by his parents, an interview was conducted with his mother, Mrs. Klein, on September 11, 2014, to gain more information about Fisher's behavioral and intervention history. She indicated a full-term healthy pregnancy and delivery with Fisher. No significant illnesses or injury was reported. There is no family history of psychiatric disorders. Fisher resides in New York City with his mother, stepfather, and two younger brothers. His biological father lives in New York City as well, and Fisher regularly visits with his father, as Mrs. Klein and Mr. Meyer have 50/50 custody of Fisher and his siblings. Mrs. Klein noted that Fisher enjoys geography and history and he can remember everything he reads. He has always made passing grades, enjoys computer games, and is skilled at skateboarding.

She noted that although most of his behavioral problems occur in the home environment, he struggles with refusing to go to school at times by displaying tantrums and often feels isolated around school peers. As such, Mrs. Klein explained that Fisher does not think that other kids are nice to him and frequently alleges they are "out to get him" or "think he is stupid." He also blames others for his anger and is quick to tell everyone else what he thinks they should be doing. Fisher's mother also reported that he threatens to harm himself frequently. However, she indicated that he does not have a plan and she did not think he had intent but was rather seeking a response from her. In the past, she has reported his threats three times to medical professionals. He was hospitalized once but quickly released. The other two times, he was not kept following intake as it was noted he says those things to upset his family and indicated no suicidal ideation. A diagnosis of oppositional defiant disorder (ODD) was provided last year. Ms. Klein also described Fisher's relationship with his family members as problematic, as he frequently initiates arguments and threatens to harm his siblings, mother, and stepfather. Mrs. Klein explained that after Fisher vocalizes threats, he is very apologetic and he appears sad and empathetic. He also has difficulties eating and sleeping, and frequently complains about being nauseated and having trouble breathing when upset. She thinks he may get an upset stomach and be hyperventilating from his anger and reports his physician has indicated Fisher is in good physical health.

According to Mrs. Klein, Fisher began to exhibit aggressive behaviors when he was 4 years old. During this time, Fisher's mother and father obtained a divorce and his father moved to the northern part of the country. Mr. Klein, Fisher's father,

returned to Fisher's life when Fisher was in the seventh grade. Although his behaviors started when he was younger and may have been influenced by his parents' divorce, Mrs. Klein now attributes his problematic behaviors to limited peer interactions and being jealous of others' popularity among peers. He received several evaluations, pharmaceutical interventions, and therapeutic treatments. These include:

- May 2006: Evaluated by Copper Pediatrics for behavioral concerns, prescribed Tenex
- April 2007: School evaluation and functional behavioral assessment due to anxiety regarding changes in routines, resulting in 1-year behavior plan with good results
- May 2007: Evaluated by Dr. Adil Bitar and diagnosed with adjustment disorder due to poor coping skills
- January 2008: Evaluated by Claremont Hospital and diagnosed with adjustment disorder, released in 24 hours
- June 2009: Prescribed clonidine to help him sleep, family therapy with Dr. Bitar began, continued intermittent services until 2014
- March 2012: Involuntary psychiatric commitment and diagnosed with adjustment disorder, released in 5 hours
- February 2014: Involuntary psychiatric intake, diagnosed with ODD, released in 4 hours
- March 2014: Juvenile Justice Department evaluation due to sibling assault charges, ODD diagnosis confirmed, will place in treatment program starting in May 2015

A review of school records indicated passing grades, although absences were high and Fisher had acquired four office discipline referrals (ODRs) for yelling at others while blaming them for annoying him. Teacher concerns included manifesting a quick temper with others when he thinks they have said something inappropriate or bumped him on purpose. They described several incidents during which Fisher had verbal tirades telling others they were all wrong and should behave in a specific manner. They also noted positive qualities for Fisher's ability to easily grasp new material and his interest in science.

A meeting with school personnel, Mrs. Klein, and Fisher's recent therapist, Dr. Bitar, was held to discuss Fisher's needs and the type of supplemental services the school could offer as well as collaborative strategies to bridge family and school counseling services. Continued family and individual private therapy were recommended and the limitations of school-based counseling intervention were noted. It was agreed that Fisher would be provided school counseling services in addition to outside family supports. Mrs. Klein reported that Fisher was no longer taking medications at the time of the interview. Because Fisher experienced difficulties expressing his emotions when feeling overwhelmed, frustrated, or angry, Mrs. Klein explained that her goals for counseling provided at the school included helping Fisher appropriately articulate and convey his feelings to others.

Counseling Goals and Target Skills

Fisher participated in individual counseling guided by psychoeducation and cognitive behavioral techniques. The goal of counseling was to help Fisher build

his feelings vocabulary so he could express needs more appropriately; recognize physiological precursors to a range of feelings so he could identify emerging anger before reacting; generate alternative interpretations of external cues that others may display when they are experiencing various emotions; articulate his feelings appropriately through the use of "I" statements; identify and utilize calming or relaxation techniques; and reframe his thoughts related to "mind reading," "should," "blaming," and dichotomous (i.e., all-or-nothing) thinking distortions.

Assessment Measures

An interview was conducted with Fisher on September 1, 2014, to gain his perspective regarding his needs and goals for counseling. He noted that he enjoys swimming and playing video games, and he likes it when he is good at schoolwork. He generally provided vague answers in response to the emotional functioning interview questions. However, he noted that he is stressed and sad sometimes but tries not to tell others about his feelings until he "explodes and then I just get in trouble for cursing." Based on the interview, as well as parent/teacher reports, Fisher's awareness and repertoire of feeling words to express his needs were targeted for intervention and assessed at the beginning and middle of the counseling sequence. The counselor also noted that Fisher had difficulties identifying physiological precursors to his own anger outbursts and interpreting external indicators of various emotions from others; thus, his knowledge of these areas was also assessed throughout the counseling intervention period (see Figure 8.4). In addition, the BASC-2 Progress Monitor Parent Form for Externalizing and ADHD Problems was administered to Fisher's mother during the beginning, middle, and end of the counseling intervention to gauge progress given that she reported that his maladaptive behaviors were more often exhibited in the home environment (see Figure 8.5). Her precounseling ratings indicated that Fisher experienced clinically significant concerns. As noted during her interview, she reported that he frequently displays oppositional behaviors, changes his mood, loses his temper, and acts without thinking. As a result of her ratings, Fisher's knowledge of self-calming strategies also was targeted for development and assessed throughout counseling as well.

Outcome of the Intervention

Mrs. Klein's ratings show that she reported clinically significant concerns at the beginning and middle of counseling. However, her ratings on April 15, 2015, indicate that Fisher exhibited normal-range functioning for externalizing concerns at the end of the counseling intervention period. This suggests that Fisher may be experiencing fewer difficulties at home related to displaying oppositional behaviors, changing his mood, losing his temper, and acting without thinking. His mother did note fewer disagreements were occurring with his siblings since counseling began.

With respect to counseling observations, Fisher has demonstrated an increased awareness of a variety of feeling words that he can utilize to describe his feelings rather than cursing or participating in "all good" or "all bad" superlatives. He also has shown improvement regarding his ability to identify physiological precursors to his feelings, external indicators of various emotions displayed by others (e.g., facial expressions), and self-calming techniques. Additionally, Fisher and Mrs. Klein reported that he is using the relaxation techniques that he has learned

in counseling more frequently when he becomes frustrated, overwhelmed, and angry. Finally, through role-playing and explicit feedback provided, Fisher has displayed the ability to reframe maladaptive thoughts that may contribute to his exhibition of problematic behavior and utilize "I" statements to express his needs.

It is important to note that during the latter portion of the counseling intervention period, Fisher was removed from his home twice under the New York Mental Hygiene law due to threatening the physical safety of his siblings. As a result, Fisher received a dual diagnosis of anxiety/depression. During this time he also acquired 21 school absences and was temporarily removed from his home to an adjudicated youth group home. Additionally, he is now prescribed Celexa, Risperdal, and Intuniv, and he is receiving mandated intensive cognitive behavioral therapy (CBT) as an outpatient through the New York Youth Clinic to address issues related to depression and anxiety. At this time, Fisher is receiving outside therapy and he will be placed in a full-time yearlong residential program through the adjudicated youth initiative starting in May 2015.

Recommendations

Overall, progress-monitoring data and counseling observations indicate that Fisher has demonstrated behavioral improvements and increased knowledge of emotional feeling vocabulary and self-calming strategies throughout the school year. However, significant gains in attendance and family functioning were not realized. His mother reports that he will be attending a yearlong residential program beginning this summer where he will continue to receive therapy. On his return to school, it will be important to assess his needs and consider continued intensive social–emotional supports.

Martha Collins, PhD, NCSP
School Psychologist

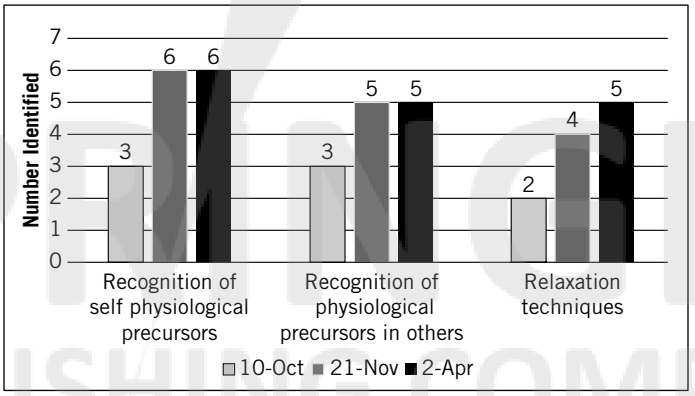


Figure 8.4 Knowledge acquisition progress-monitoring data; skills questionnaire—Fisher.

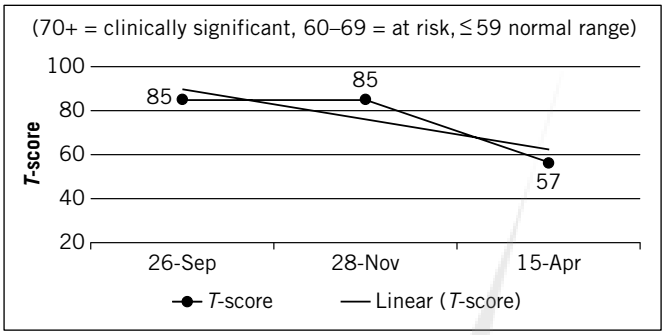


Figure 8.5 BASC-2 progress monitor externalizing and attention deficit hyperactivity disorder—Fisher.

Summary of Sessions

Session 1

The first half of the session was devoted to rapport building with Fisher. During this session the counselor introduced herself, explained her role as a supportive adult, and described the purpose of weekly meetings. The limits of confidentiality were also explained to Fisher and he assented to counseling. During the second half of the session Fisher was interviewed to develop case conceptualization and better understand his perspectives and the initial goals of counseling were reviewed. He was taught two relaxation strategies (i.e., progressive muscle relaxation and slow diaphragmatic breathing) and a skills questionnaire was completed. As Fisher has a history of hyperventilating, the differences between fast breathing and slow, controlled breathing were practiced several times in session. His homework was to practice the relaxation techniques.

Session 2

Relaxation strategies from the prior week were reviewed. The counselor asked Fisher to complete a "Name the Feelings" activity. During this activity Fisher was asked to label a variety of facial expressions with corresponding feeling words. He had great difficulty completing this task, as he primarily used three words—"sad," "angry," and "happy"—to describe the facial expressions. The counselor discussed Fisher's diagnoses with him as well as coping mechanisms that are often helpful for persons with ODD, anxiety, and depression. The initial goals of acquiring a broader feeling vocabulary, learning relaxation techniques, and recognition of physiological precursors were delineated. An additional relaxation technique—guided imagery—was taught and an app for coaching him in this skill was downloaded to his personal tablet. His homework assignment was to begin a thought journal and to note any time he felt he was becoming angry as well as to practice his relaxation strategies, including using the guided imagery application on his tablet. The tablet program would prompt him to note the precipitating events and Fisher was informed that these would be reviewed to identify patterns at the following sessions.

Sessions 4 to 6

Homework was reviewed at the beginning of each session, including Fisher's tablet data on how often he accessed his relaxation application and any precipitating event patterns that prompted his stress. The purpose of these sessions was to increase his awareness of his own physiological precursors to anger and to build Fisher's feeling vocabulary and the use of "I" statements as a way to facilitate better communication with others. Physiological precursors were identified through review of his journal entries regarding what he feels before becoming angry (e.g., "I feel red-hot face," "I start breathing fast," "My heart is pounding"). The triad among thoughts, feelings, and behaviors was reviewed and Fisher was encouraged to start using his relaxation techniques immediately when he feels any of his physiological precursors for anger. Vocabulary-building activities included Fisher downloading a variety of action pictures of his favorite skateboarding athletes and providing at least two emotion words to express each of their facial expressions without repeating the same word. Additionally, he reviewed video clips of a variety of emotions to identify the individual's feelings, and was taught to role-play scenarios with the counselor in which he addressed students and his family regarding his feelings. Corrective feedback and coaching were provided. He also was prompted to think about how he knows other individuals are experiencing specific emotions by observing and reflecting on their behaviors, facial expressions, and social interactions. Furthermore, Fisher and the counselor discussed that individuals' expressions can have more than one possible interpretation; therefore, it is important not to assume the worst interpretation; one can experience multiple feelings at once and feelings range along a continuum. Fisher was taught two additional relaxation strategies (i.e., exercise and affirmations). Homework included continuing his thought journals, using a calm tone/expression with others and in "I" statements when expressing his needs as a replacement for confrontational approaches, as well as utilizing relaxation strategies.

Sessions 7 to 18

Homework was reviewed at the beginning of each session. A midpoint skills questionnaire was administered to Fisher to assess his awareness of physiological precursors to a range of feelings that he may experience, external cues and physiological precursors that others may display when they are experiencing various emotions, and calming down/relaxation techniques. The core purpose of sessions 7 to 18 was cognitive restructuring. Based on parent/teacher/self-report and journal entries, four cognitive distortions were identified: mind reading, should, blaming, and dichotomous thinking. Each area was challenged using Socratic questioning and assumption-probing techniques. Additionally, Fisher was highly responsive to a "revising the schema" approach wherein he could identify new and positive ways to view himself and others for a balanced perspective. Homework included identifying and challenging distortions for himself. As Fisher did not like the written journaling process, he agreed to keep thoughts in his tablet and those were reviewed electronically during sessions. It

should be noted that during this time several holidays occurred and Fisher also was out of school for an involuntary psychiatric intake due to a family altercation, thus the focus of counseling often included debriefing regarding recent incidents.

Sessions 19 and 20

During the final sessions, transition plans and supports were discussed as Fisher was being moved out of the school to a mandated residential adjudicated youth program. His identification of anger precursors, emotion-naming vocabulary, use of "I" statements, relaxation techniques, and cognitive restructuring skills were reviewed. Special attention was given to inoculation techniques (i.e., how he might adapt these strategies to his new environment to assist his transition and address stressors that may occur). He also requested information on the residential program, which was provided, and a family preparation visit was facilitated through his caseworker.

DUAL-ENROLLED HIGH SCHOOL/ POSTSECONDARY COUNSELING INTERVENTION: OCD—AMITOLA

Counseling Summary

Summary contains privileged/confidential information and may only be released with written parental consent except as provided by law.

Name: Amitola Benally **Date:** 12-4-15
Clinician/Psychologist: Alo Nez, MEd, Intern/Achak Yazzie, PhD
Age/Enrollment Status: 18 years, 1 month / dual-enrolled 12th-grade, Willow High School & Associates of Arts degree, High Point College

Counseling Goals and Target Skills: Provide 10 CBT sessions with exposure therapy to ameliorate OCD symptoms, including excessive need for object symmetry, distress over disposing of waste, and fear of harm to self or others.

Summary and Recommendations: At the end of 10 sessions, Amitola reported no longer experiencing distress over discarding waste, object symmetry, or fears that she might harm others. She still has fears that she might harm herself and presents a need to seek reassurance that she is a good person. The severity of CY-BOCS obsessions, compulsions, and total symptoms ratings decreased. She has made arrangements to complete fall semester makeup work and return to classes for the spring. Continued symptom monitoring with her psychiatrist and counseling services at the High Point College Student Health Center are recommended (Figure 8.6).

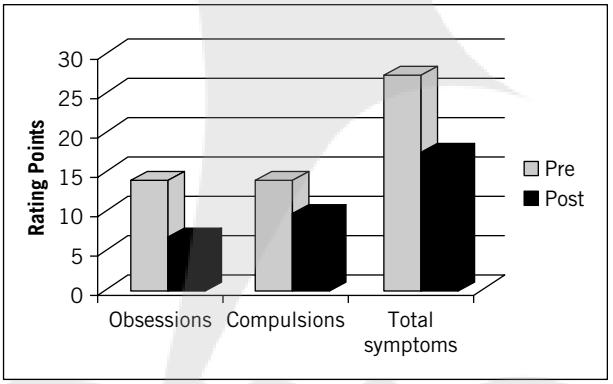


Figure 8.6 Children's Yale–Brown Obsessive Compulsive Scale (CY-BOCS) pre-/postcounseling symptom data—Amitola.

Behavioral Intervention Case Report

This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

Dual Enrolled: 12th grade, Willow High School & Associates of Arts degree, High Point College

Student Name: Amitola Benally
Age: 18 years, 1 month
Date of Report: 12-4-15
Clinician: Alo Nez, MEd
Supervisor: Achak Yazzie, PhD

Reason for Referral

Amitola self-referred to the High Point College Student Health Center due to her impairing symptoms of OCD. She consented to share information with her mother, Mrs. Benally, and high school counseling personnel. Amitola also consented to a clinician interview at the clinic with her mother. Her mother reports that Amitola's OCD symptoms have increased in severity over the past 12 months. They now interfere with her social, academic, and family functioning. Mrs. Benally also reports that Amitola's mood has worsened as a result of her OCD symptom impairment.

Developmental, Medical, and Family History

Amitola lives with her biological mother (Mrs. Allison Benally) in Kodiak, Alaska. Amitola's father (Mr. Abey Benally) passed away shortly after Amitola's birth. Her mother reports that Amitola has always been a fast learner and that she acquires new skills quickly. Amitola has received services through the gifted education program since third grade and has maintained A–B grades throughout her academic years. She has participated in the dual-enrollment program between Willow High School and High Point College for the past 2 years and is two semesters away from completing her AA degree course requirements.

Based on Ms. Benally's interview, Amitola's developmental history is unremarkable for any specific medical conditions or developmental delays. However, Amitola began attending a new school when she was about 14 years old. At that time, she began to engage in compulsive behaviors (e.g., touching and tapping objects), which eventually resulted in other students singling her out and teasing or avoiding her. At the age of 16 she began dual enrollment and her mother thought the change of environments and friends might be helpful. At this time, Amitola also reported strong urges to order objects in her environment (e.g., first shoes, clothing, and her bedroom furniture; then her car, class notes, and household objects) so they were symmetrical and linear (i.e., she would only place or lift objects on or off surfaces at specific angles that she thought were appropriate). She also began counting objects compulsively (e.g., cars, signs, lamp fixtures). Amitola's OCD symptoms waxed and waned in severity over the past few years but became increasingly life disruptive over the past 12 months. During midterms this fall semester, Amitola stopped attending classes regularly and her grades will reflect failing scores if her work is not made up. She currently has a medical extension. Mrs. Benally reports that Amitola wants to "get over her OCD" so that she can finish her AA degree and continue college to pursue a bachelor's degree.

Amitola takes several medications to help manage her symptoms of OCD and some depression symptoms. She currently takes Xanax (1 mg), Abilify (5 mg), Luvox (150 mg), and Seroquel (300 mg). Amitola reports experiencing the following side effects of these medications: dehydration, dry mouth, chronic fatigue, low energy levels in general, weight gain, and decreased concentration. She notes the weight gain is discouraging and depressing for her.

Instruments Administered and Interviews

- BASC-2: Parent form
- CY-BOCS: Parent Interview

Symptom Identification and Analysis

Data were collected using the BASC-2 Parent Rating Scale (Table 8.3), a clinician-administered assessment, and during an intake interview with a licensed psychologist who specializes in the assessment and treatment of obsessive-compulsive spectrum disorders.

TABLE 8.3 Behavior Assessment System for Children, 2nd Edition: Parent Rating Scale

Subscale	*T*-Score	Percentile
Hyperactivity	46	41
Aggression	48	48
Conduct	45	34
Externalizing composite	46	41
Anxiety	75	99
Depression	70	96
Somatization	59	83
Internalizing composite	70	96
Attention problems	71	96
Atypicality	57	83
Withdrawal	70	96
Behavioral symptoms index	69	94
Adaptability	52	52
Social skills	46	41
Leadership	45	34
Activities of daily living	34	7
Functional communication	52	52
Adaptive skills composite	42	30
Validity Scales		
F	Acceptable	
Response pattern	Acceptable	
Consistency	Acceptable	

Note: A score of 50 is average and scores of 40 to 60 are in the average range.

Mrs. Benally's responses on the BASC-2 Parent Rating Scale indicate that Amitola has severe internalizing problems. Amitola's symptoms of anxiety and depression were in the clinically significant range. Additionally, Mrs. Benally reported that Amitola also has clinically significant attention difficulties and is at risk for social withdrawal.

Obsessive-Compulsive Symptoms

Amitola's symptoms of depression, inattention, and social withdrawal appear to be secondary to her OCD symptoms. Since the exacerbation of her OCD symptoms approximately 12 months ago, Amitola has had fewer social contacts, she stopped attending school, spent less time doing pleasurable activities (e.g., attending movies with friends, jogging) and more time engaging in anxiety-reducing rituals (e.g., ordering objects in her room), and she now has difficulty concentrating due to intrusive thoughts (e.g., thoughts of losing things, her mother dying).

Amitola was interviewed using the CY-BOCS to determine her current OCD symptoms and the severity of these symptoms (see Figure 8.6). Her overall score was 28 (moderate to severely impaired), her current obsessions rating is 14, and her compulsions rating is 14. Obsessions include:

- Aggressive obsessions: Amitola fears that she might be compelled to harm herself or others. For example, she is afraid that she might cut herself or stab her mother with sharp objects (e.g., knifes, scissors).
- Hoarding obsessions: Amitola has difficulty discarding and throwing away useless objects or things of limited value (e.g., old school papers, candy wrappers). She reports that she often personalizes objects, becomes attached to them, and then feels a sensation of loss when she throws them away.
- Symmetry obsessions: Amitola is concerned about objects being symmetrical or aligned in linear patterns in space. For example, she feels that objects (e.g., shoes, books) should be ordered at specific angles and she will become distressed if they are not organized accordingly.

Amitola engages in the following compulsions to mitigate her anxiety:

- Hiding and avoiding: Amitola hides, avoids, or buries sharp objects that she is afraid she may use to harm herself or others.
- Hoarding: Amitola will collect useless objects that she has difficulty throwing away, such as old school papers, empty candy wrappers, and used water bottles.
- Ordering: Amitola will order and rearrange objects that she thinks are out of place. If an object is at the "wrong" angle or placed on the table at the wrong angle, she will replace the object until it is placed "correctly" (e.g., moving the living room furniture).
- Confessing: Amitola will confess her distressing thoughts to her mother and seek reassurance that she is a good person and does not intend to harm others.

Intervention Design

Limitations of confidentiality were discussed prior to beginning counseling. Two weeks of intensive therapy were scheduled (10 sessions total) at the High Point

College Student Health Center. Sessions were determined to range from about 50 to 60 minutes in length.

Intervention Implementation

Session 1. The CBT model for treating OCD was discussed with Amitola; specifically, how exposure-based therapy is a well-established treatment for OCD. Amitola's motivation for therapy was assessed and she expressed some doubts about the possibility of her symptoms improving. However, she reported that she desperately wanted her OCD symptoms to decrease and to not have to take so much medication, as it makes her "feel like a zombie." Amitola's insight into her OCD symptoms seemed low as she believed that she needed to perform specific rituals (e.g., confessing) to prevent bad things from happening (e.g., harming her mother).

Session 2. Amitola worked with the therapist to construct an exposure and response prevention (E/RP) hierarchy that would guide therapy through subsequent sessions. The point of this activity was to develop a list of about 10 things or situations that increase Amitola's anxiety and cause her to engage in compulsions or avoidant behavior. Some of the items that were added to Amitola's E/RP hierarchy include throwing away useless objects (e.g., old papers, candy wrappers), arranging objects imperfectly (e.g., leaving her desk materials set at an awkward angle), messing up the order of books on her bookshelf, wasting supplies (e.g., pens, markers), having a sharp object in her environment (e.g., keeping scissors on her desk), and holding a sharp object in her hand until her anxiety decreases. The previous items were rank ordered so that items could be mastered sequentially, from easy to hard over the course of therapy.

Session 3. Amitola was encouraged to leave a pen uncapped for 10 minutes, leave a desk drawer open and stare at it for 10 minutes, and leave her papers face down for 10 minutes. Amitola estimated that the first two exposures would cause mild anxiety in her and be relatively easy to accomplish. However, she thought that the third exposure would be more challenging and cause moderate anxiety in her. Amitola was able to accomplish all exposures in session and on the third exposure, she was encouraged to throw away multiple objects from her book bag (e.g., wrappers, old paper, plastic bottle). Amitola reported that this caused her to experience about an 8 out of 10 on the Subjective Units of Distress Scale (SUDs; 0 = no distress; 10 = extreme distress). Amitola was encouraged to wait until her anxiety decreased to at least 4 SUDs before terminating the exposure so that she could experience her anxiety decreasing naturally without engaging in any anxiety-mitigating rituals. For homework, Amitola was instructed to repeat the same exposures at home that evening with the assistance of her mother.

Session 4. Amitola reported that she left a desk drawer open (about 3 inches) and a marker uncapped overnight. This caused her to experience mild anxiety (about 4–5 SUDs) but she still was able to fall asleep. She did not attempt to throw away items as she thought that it would cause her to feel too much anxiety. Therefore, therapy began by repeating the discarding exposure. This time, however, Amitola experienced less anxiety (about 7 SUDs) than in the previous session and her anxiety abated more quickly than it did previously. Amitola then was encouraged to sit at a desk and touch a pair of scissors. Initially, at this suggestion, Amitola said that this exposure was too extreme. However, she was able to put her arm on the edge of

the desk that had a pair of scissors lying on it. In total, Amitola's anxiety increased to about 8 SUDs and decreased to about 4 SUDs during exposures. Amitola was encouraged to practice the exposures at home in the presence of her mother.

Session 5. Amitola reported that she had successfully completed her discarding homework assignment from the previous week. Amitola stated that she experienced considerable anxiety touching the scissors, but that her anxiety was not as high as it was in the previous session. In session, the scissors exposure was repeated. Amitola also was encouraged to write a story about her own safety and prevent herself from confessing her anxiety associated with thinking about self-harm. Amitola was able to write the story but she had great difficulty preventing herself from talking aloud and seeking reassurance. Therefore, Amitola was encouraged to delay reassurance seeking (initially for 1 minute, then for 3 minutes, 5 minutes, and 10 minutes). Eventually, Amitola was able to prevent herself from seeking reassurance about 15 times. For homework, she was encouraged to prevent herself from seeking reassurance for at least 1 hour. Additionally, she was encouraged to throw away at least 15 pieces of paper from her old schoolwork and sort out clothing from her closet that was old and no longer fit.

Session 6. Amitola reported that she was able to throw away 33 pieces of paper from her middle school work and to leave scissors out overnight but had little success in not seeking reassurance from her mother. In session, Amitola was encouraged to hold a sharp object in her hand while the therapist was in the room. Initially she held a staple remover and reported that this caused about 7 SUDs of anxiety. Amitola then was encouraged to complete the same series of exposures using a closed pair of scissors. She experienced a maximum of about 6 SUDs. For homework, Amitola was encouraged to avoid confessions for reassurance seeking for 4 hours.

Session 7. Amitola reported that she was able to touch scissors several times with only moderate anxiety. She also reported forgetting about the scissors being out on her desk overnight. Amitola reported that completing the previous exposure was a personal success for her. Amitola was encouraged to hold an open pair of scissors in session. Amitola reported that this exposure caused her about 9 SUDs. She requested to discontinue the exposure but was encouraged to stick with the task for an additional 3 minutes to see whether her anxiety decreased. After 3 minutes passed, Amitola reported that her SUDs were decreasing and that she could continue with the task. In total, it took about 35 minutes for Amitola's SUDs to decrease from 9 to 4. After Amitola's anxiety habituated to a manageable level, she was encouraged to hold the scissors and a sharp protractor. It took about 25 minutes for Amitola's anxiety to habituate during the second exposure. For homework, Amitola was encouraged to withhold reassurance-seeking confession for the entire evening and to begin her makeup assignments for her classes.

Session 8. Amitola reported that she made it until 9:30 p.m. without confessing her anxiety to her mother or seeking reassurance that she is a good daughter and good person. She reported that this was a "great accomplishment." Amitola stated that her compulsive confession functioned less to gain reassurance from her mother and more to obtain attention and empathy. She also noted that she had pulled out her planner and organized her makeup work for classes, although she had not attempted any assignments yet. In session, Amitola repeated the exposures completed in session the previous day. Amitola's SUDs increased to about 7 during these exposures. However, her anxiety habituated more quickly than it did in the

previous session. At the conclusion of the session, Amitola reported that she felt like she was much more in control of her obsessive thoughts. She stated that even if she had the thought that she might harm herself or someone else if she had sharp objects, she no longer believes that she will do so. Amitola was encouraged to begin her makeup class readings and at least one assignment.

Session 9. Amitola came to session with a partially completed makeup essay and showed several e-mails to the therapist regarding scheduling makeup tests over the break. Amitola was able to accomplish this homework with relative ease. She stated that she was surprised how easy it was for her to accomplish these tasks and how she spontaneously threw away the first draft of her essay (something she would have kept in the past) and how little distress she felt in the process of doing so. For homework, Amitola was encouraged to continue her closet sorting and set appointments for her makeup exams.

Session 10. Amitola seemed proud of being able to complete her homework from the previous session. She reported that she had set three exam makeup dates and completed the first essay. She felt she did not have time to sort the closet but indicated she had an agreement with her mother to complete the closet sort during the holidays and to go shopping for a few new items. She noted the scissors are still on her desk at home. Relapse-prevention strategies were covered in session, including being attentive to the resurgence of OCD symptoms, being neglectful of one's schoolwork or family commitments, and not taking sufficient time to engage in pleasurable activities. Amitola identified that her anxiety might increase when she begins attending school again in the spring semester. She was encouraged to use the knowledge she learned in therapy and to call the High Point College Student Health Center if her anxiety symptoms become unmanageable. Consent was obtained to share her counseling intervention results with her physician.

Counseling Intervention Evaluation

Amitola received 10 sessions of CBT to treat her symptoms of OCD. The CY-BOCS was used to assess her OCD symptoms and symptom severity levels at posttest to determine her response to intervention.

OCD Symptoms

At posttest, Amitola no longer reported experiencing excessive concerns about discarding waste, lining things up symmetrically, having the need to rearrange and align furniture, experiencing fears that she might harm others, and confessing to her mother seeking reassurance that she was a good person and would not harm others. However, she still has fears that she might harm herself or experience calamity. She still feels the need to seek parental reassurance that she is a good person who would not harm herself. Amitola's pretest, posttest, and past OCD symptoms are listed in the text that follows.

OCD Symptom Severity. The overall severity of Amitola's OCD symptoms decreased between pre- and posttest assessments. Specifically, she reported spending less time doing compulsions or being bothered by obsessions, experiencing less interference in her daily functioning due to her symptoms, experiencing less distress from her symptoms, and feeling greater control over her symptoms. Amitola's

overall levels of OCD symptom severity decreased from a total score of 28 (moderate to severely impaired) on the CY-BOCS to a score of 17 (mildly impaired). Amitola also experienced consistent decreases in the severity of her obsessions and compulsions on the CY-BOCS (Figure 8.6).

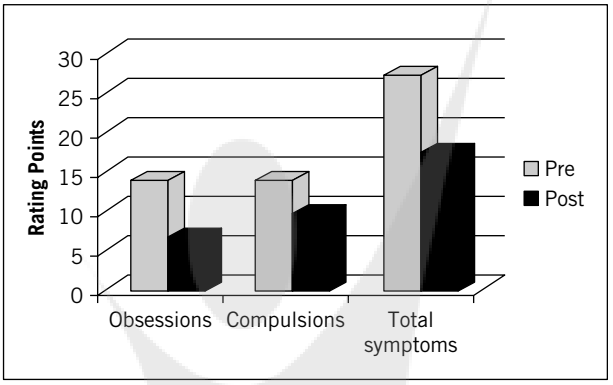


Figure 8.6 Children's Yale–Brown Obsessive Compulsive Scale (CY-BOCS) pre-/postcounseling symptom data—Amitola.

Summary

Amitola is an 18-year-old, dual-enrolled student who self-referred to the High Point College Student Health Center due to her life-disruptive OCD symptoms. She participated in 10 sessions of CBT conducted over a 2-week period. Amitola's response to intervention was assessed on the CY-BOCS. Amitola no longer reported experiencing distress over discarding waste, having an excessive need for object symmetry, or fearing that she might harm others. However, she still has fears that she might harm herself and has a need to seek reassurance that she is a good person. The severity of Amitola's obsessions, compulsions, and total OCD symptoms also decreased during the intervention period as evidenced by reduced symptom levels at posttreatment.

Recommendations

1. Amitola should self-monitor for OCD symptom relapses and new symptoms. She may wish to call the High Point College Student Health Center if she notices any of the following: new obsessions and/or compulsions; new avoidance of stimuli or situations; rationalizing, minimizing, or denying her OCD symptoms; increased school or social problems due to inflexibility; irritability or symptom flare-ups; lack of motivation or social support.
2. Amitola should continue checkups with her psychiatrist to monitor medications and symptoms.
3. Amitola should spend more time doing pleasurable activities, including being with friends, being physically active, and being creative.

4. The Obsessive-Compulsive Foundation offers a website with psychoeducational information for its members, a network of service providers, community activities, and local support group connections that may be helpful, http://www.ocfoundation.org/find_a_support_group.aspx.

It was a pleasure having the opportunity to work with Amitola. Please do not hesitate to call us in case you have questions or comments.

Clinician: *Alo Nez, MEd*	Supervisor: *Achak Yazzie, PhD*
Clinical Psychology Intern	Psychologist, License PQ123

REFERENCE

Reynolds, C. R., & Richmond, B. O. (2008). *Revised Children's Manifest Anxiety Scale: Second Edition* (RCMAS-2). Los Angeles, CA: WPS.

Appendix

EXHIBIT 1.1

Subjective Units of Distress Scale: Feeling Thermometer

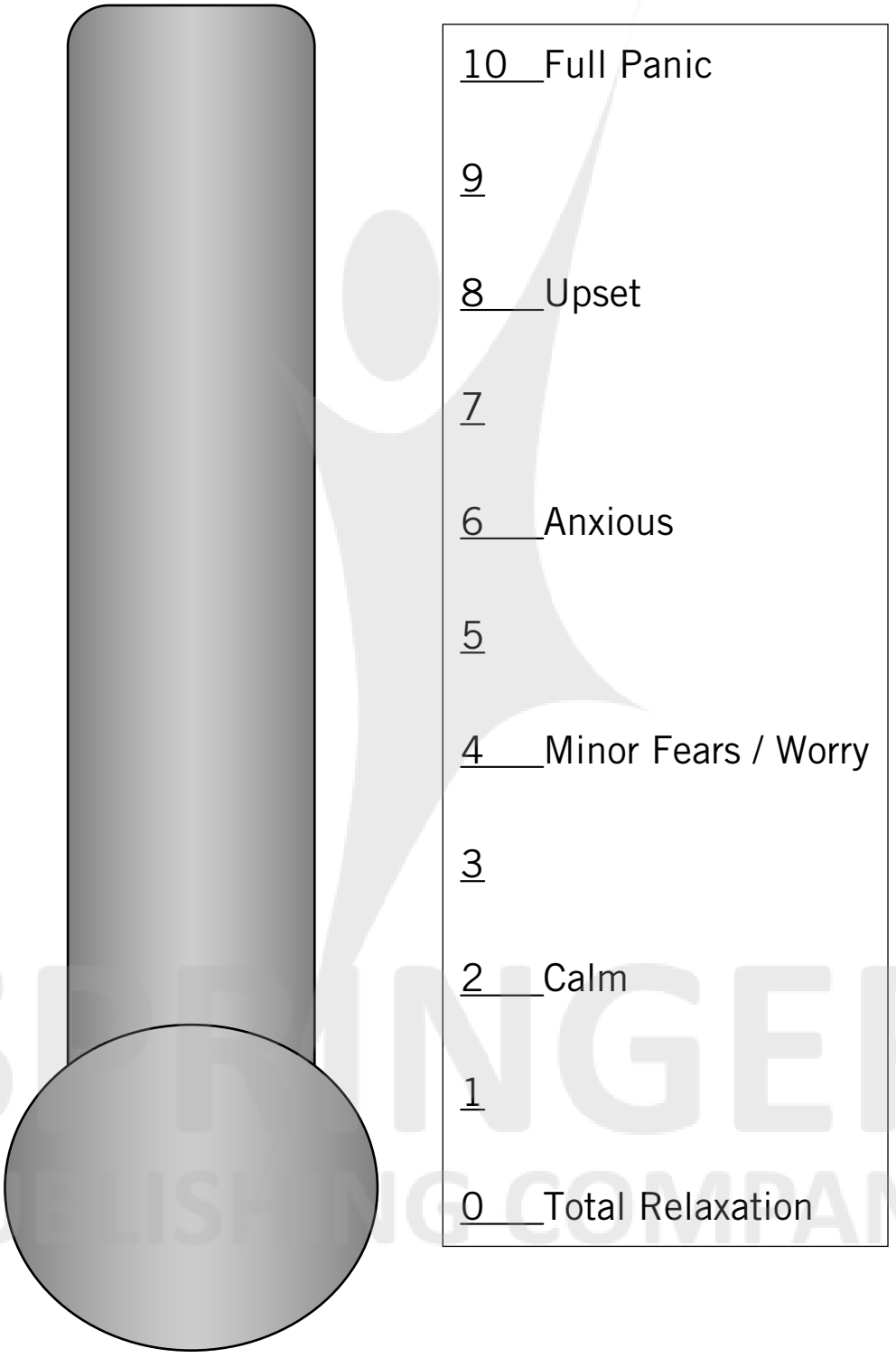


EXHIBIT 1.2

Subjective Units of Distress Scale: What I Feel Inside

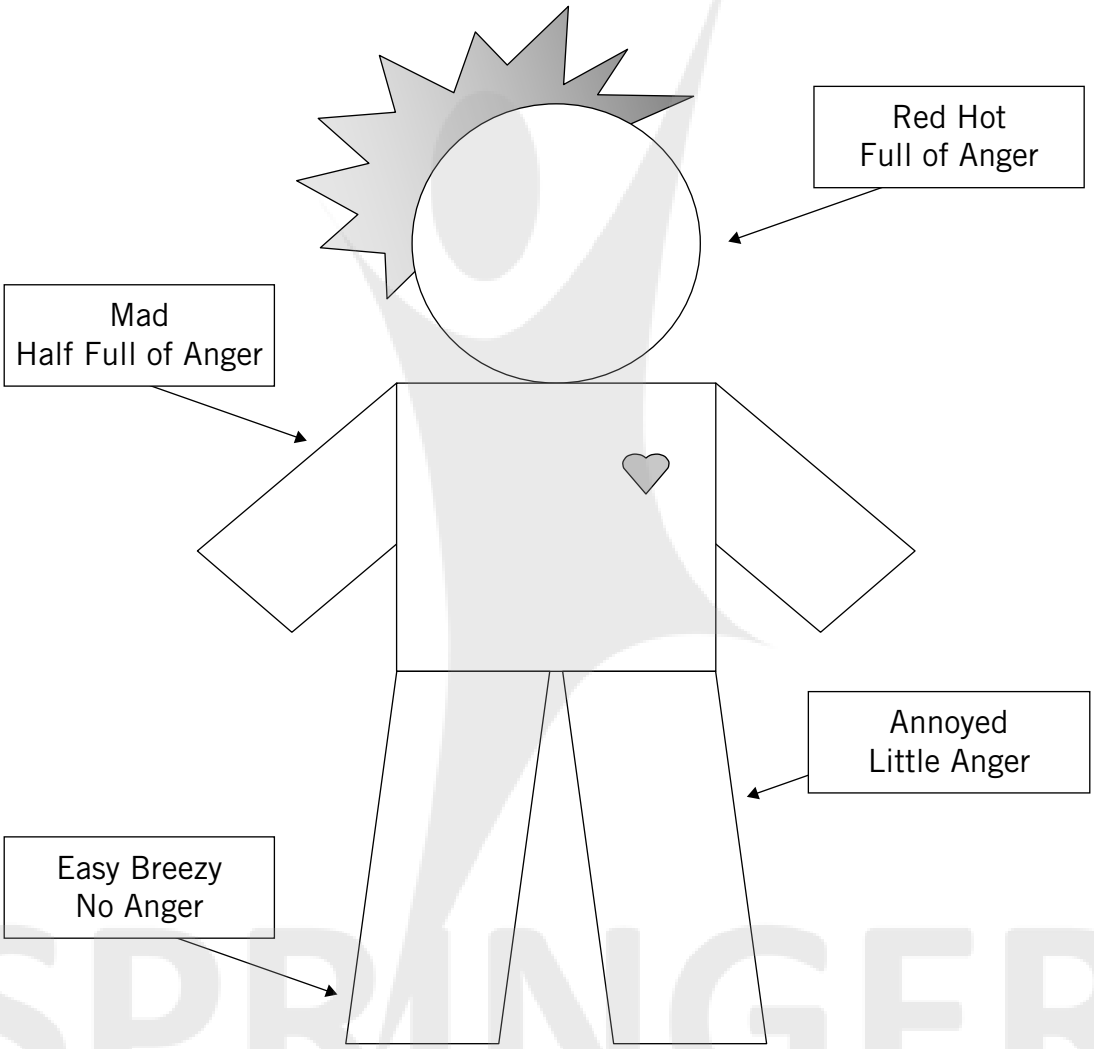


EXHIBIT 2.1

Student Sentence Completion Exercise

1. My best class is _____
2. I am good at _____
3. When I grow up, I want to be _____
4. Other kids _____
5. My family is _____
6. The worst thing is _____
7. At home _____
8. What upsets me is _____
9. People think _____
10. The best _____
11. My mind _____
12. Most girls _____
13. At school _____
14. I feel _____
15. Boys are _____

EXHIBIT 2.2

Adolescent Sentence Completion Exercise

1. My favorite class subject is _____
2. The best thing I do is _____
3. My career goal is _____
4. My friends are best at _____
5. The best thing my family could do is _____
6. If I could change something, I would _____
7. My parents' ideas are _____
8. The most perturbing thing is _____
9. People don't know I think _____
10. In my personal life _____
11. My thoughts often _____
12. Most females consider _____
13. My teachers think I am _____
14. My purpose in life is _____
15. Men are usually _____

EXHIBIT 2.3

If/Then Questionnaire

IF I ace the test, **THEN** _____

IF I make a mistake, **THEN** _____

IF Others are nice to me, **THEN** _____

IF I feel hurt, **THEN** _____

IF I join the group, **THEN** _____

IF I am mad, **THEN** _____

IF My parents are happy, **THEN** _____

IF I let people down, **THEN** _____

EXHIBIT 2.4

CBT Cognitive Model

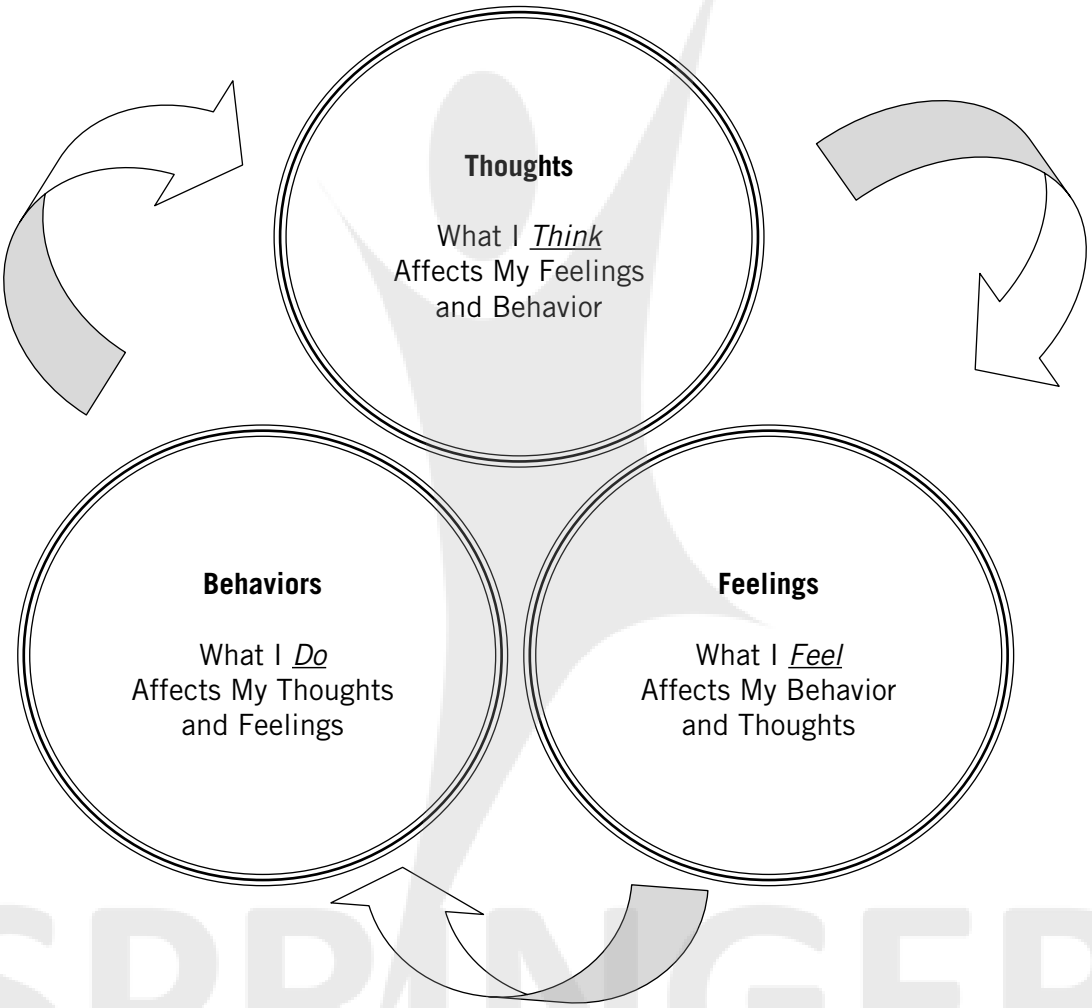


EXHIBIT 2.5

Three-Step ABC Model

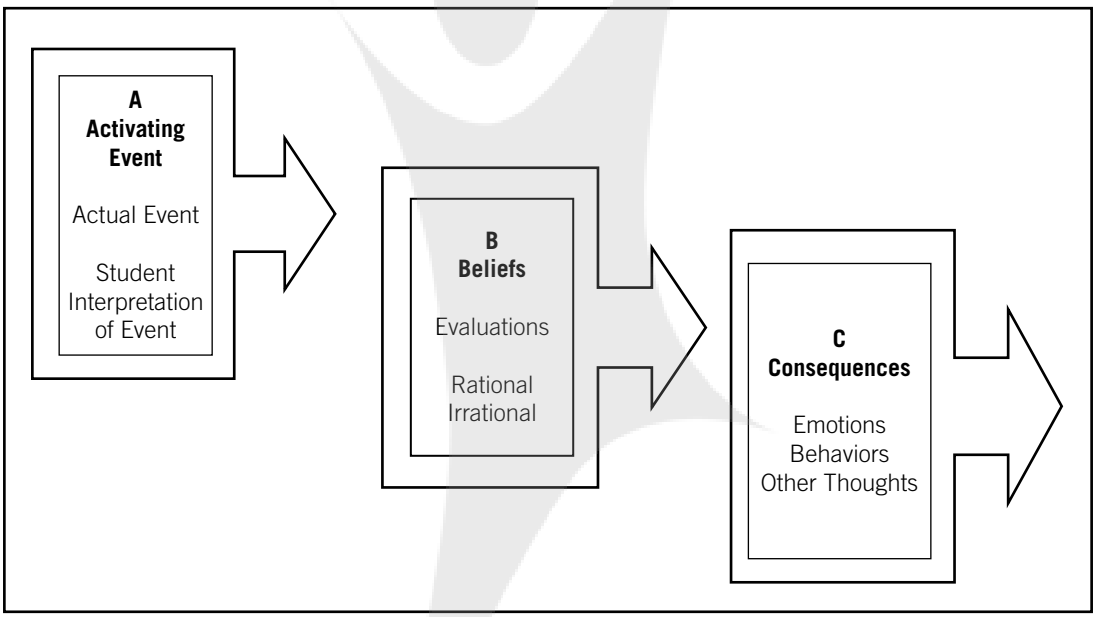


EXHIBIT 2.6

ABC Model: Alternate Consequences

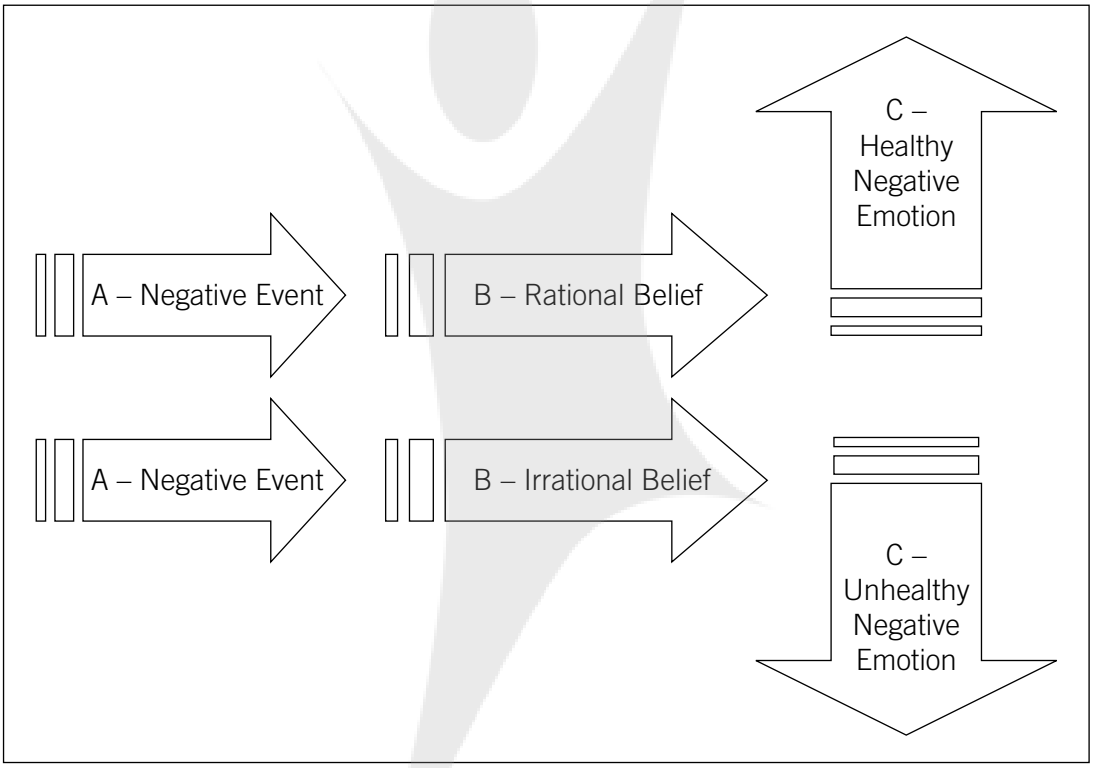


EXHIBIT 2.7

Comparing the Negative Fall and the Positive Launch

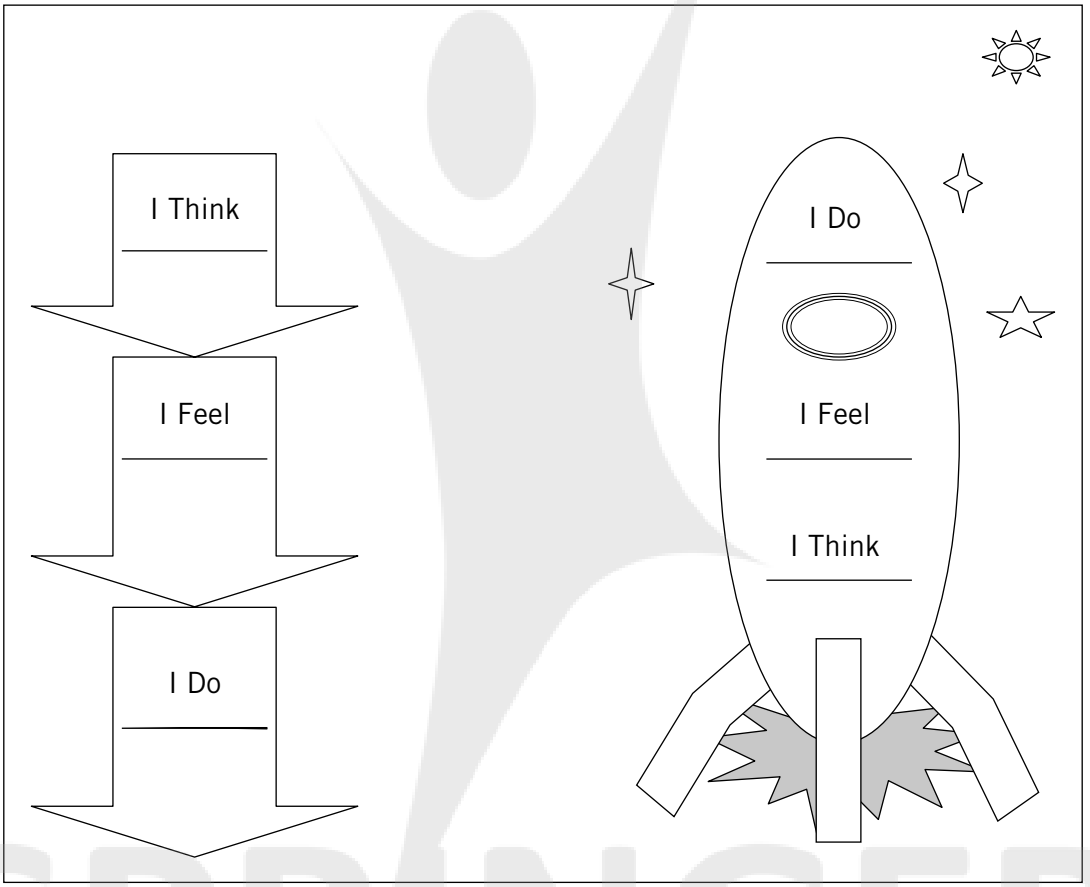


EXHIBIT 2.8

ABC Record Form

A—Activating Event	B—Beliefs	C—Consequences
(What happened? What action did you take? What was your first thought?)	(What automatic thought did you have?)	(What are the possible consequences?)
What type of thought was it?	Rational **OR** irrational? What is something different that you could tell yourself?	What could you do differently next time?

Review notes:

EXHIBIT 2.9

Four-Column Functional Assessment of ABCs

A—Activating Event	B—Behavior	C—Consequences Short Term	C—Consequences Long Term
What happened immediately before?	What action did you take?	What was the immediate result? (What happened in 5 seconds, 1 hour, 2 hours?)	What are the long-term outcomes or results?

Review notes:

EXHIBIT 2.10

Four-Column Functional Assessment of ABCD

A—Activating Event	B—Behavior	C—Consequences	D—Disputing
What happened immediately before?	What action did you take?	What was the outcome?	Challenge your belief—Is it true or false? What is an alternative rational belief? What FACTS support this? What FACTS do not support this?

Review notes:

EXHIBIT 2.11

Relaxation Log

Date/Time: _____

Relaxation Strategy Used: _____

Experience: _____ (What Happened)

Circle Rating *Before* Relaxation:

Low 1 2 3 4 5 6 7 8 9 10 High

Circle Rating *After* Relaxation:

Low 1 2 3 4 5 6 7 8 9 10 High

EXHIBIT 4.1

Counselor's Checklist for Exposure/Response Prevention Therapy

Explain the exposure/response prevention therapeutic process to the parent/caregiver and student.

Gather the parent/caregiver's consent and student's assent to participate in E/RP therapy.

Identify the student's fear-provoking triggers with the student.

Create a fear hierarchy with the student using the Subjective Units of Distress Scale (SUDS).

Expose the student to the fear-provoking stimuli.

Start with lower ranked fears and gradually move to higher ranked fears.

Encourage the student to endure the discomfort and utilize relaxation techniques to overcome his or her distress.

Assess the student's level of anxiety during the exposure exercises using the SUDS.

Repeat the process until the student's SUDS data indicate that the student consistently experiences low levels of anxiety (e.g., minor worry, calmness, and relaxation) when exposed to the stimuli.

EXHIBIT 4.2

Exposure/Response Prevention Therapy: Information for Parents/Caregivers

Exposure/Response Prevention Therapy

Exposure/response prevention (E/RP) therapy is a therapeutic technique that is often utilized to help individuals face and overcome exaggerated fears. E/RP is grounded in the idea that a person must confront his or her fears to learn how to cope with them. When people avoid those situations that provoke anxiety and distress, their heightened fear is more likely to remain. Although the avoidance may serve as a protective response for the individual, constant avoidance can cause the anxiety to become worse as opposed to getting better. E/RP can help children and adolescents manage their fears and reduce their anxiety.

The E/RP Process

First, the counselor collaborates with the child to identify situations and circumstances that produce the child's fear. The child then creates a fear hierarchy with the counselor by ranking the level of anxiety that is experienced with each situation. Next, the child is exposed to the fear-producing situations under the supervision of his or her counselor. During this exposure, response prevention will occur in which the counselor encourages the child to refrain from avoiding the fear-producing situation(s). Instead, the child is encouraged to endure any discomfort and utilize coping strategies (e.g., relaxation techniques) to learn how to reduce feelings of anxiety and distress. Students are first exposed to situations that provoke lower levels of anxiety and gradually are exposed to situations that provoke higher levels of anxiety. The child's anxiety level is assessed throughout the process to monitor his or her progress. The exposure discontinues when he or she is experiencing more relaxed and calm feelings in response to the fear-producing situation(s).

What Does the Exposure Entail?

Exposure exercises can be executed through several methods, ranging from less intense to highly intense. In the order of intensity levels, such methods include:

1. ***Imaginal exposure:*** The student imagines himself or herself in the fear-producing situation.
2. ***In-session exposure/role-playing:*** The student acts out a scenario in which he or she is exposed to the fear-producing situation.
3. ***Viewing visual images of the fear-eliciting situation:*** The student views visual representations of the fear-producing situation (e.g., pictures and videos).
4. ***In vivo exposure:*** The student directly confronts the situation.

EXHIBIT 4.3

Exposure Hierarchy Worksheet Example

Purpose: Help students rank their level of anxiety in response to situations of exaggerated fear.

Developmental Considerations: May need to present visual illustrations to younger children (e.g., smiley faces) to help them identify the level of anxiety they experience with each situation.

Situation	SUDS Ranking
Preparing for a class presentation at home (e.g., putting a PowerPoint presentation together)	2
Rehearsing my presentation in the mirror	5
Rehearsing my presentation in front of my parents/caregivers	6
Presenting in front of the entire class	10

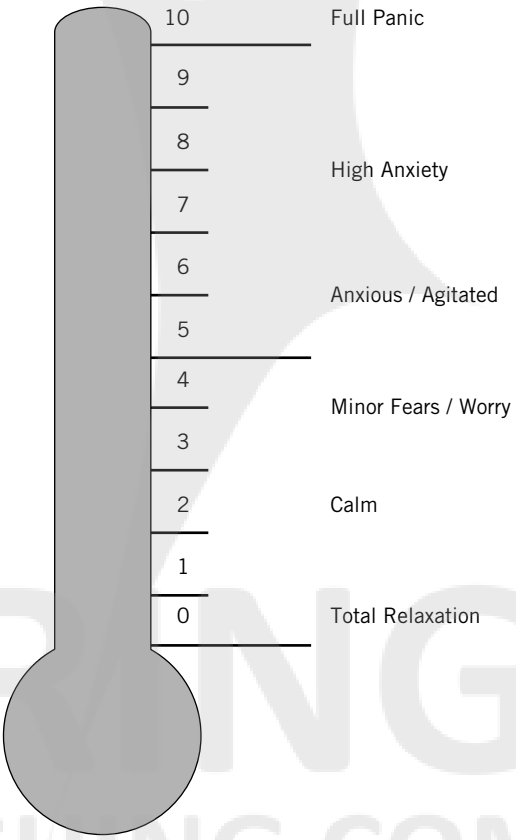


EXHIBIT 4.4

Exposure Hierarchy Worksheet

Directions: Write down the situations that cause you to feel anxious and afraid, and then add them to the first column, ranking them in order of how distressing they are. In the second column, write how anxious each one makes you, from 0 (totally relaxed) to 10 (full panic).

Situation	SUDS Ranking

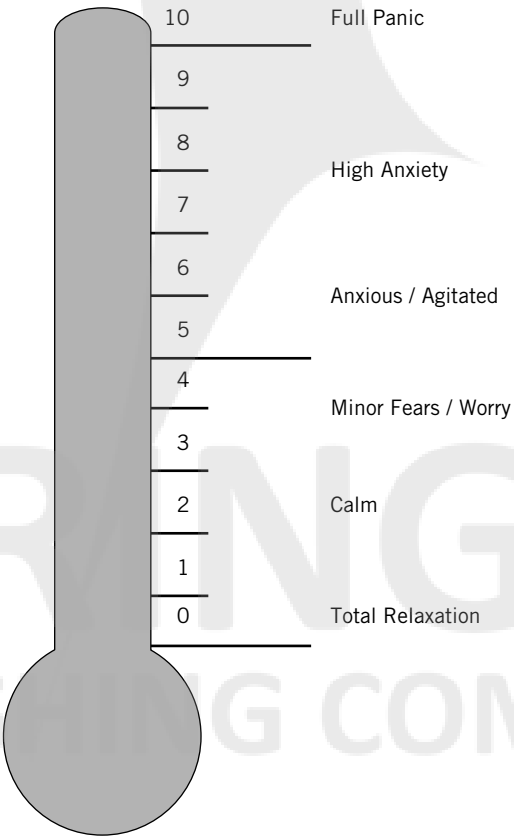


EXHIBIT 4.5

Subjective Units of Distress Scale

EXHIBIT 4.6

Counselor's Checklist for Behavioral Activation

Explain the behavioral activation process to the parent/caregiver and student.

Help the student list a variety of activities that he or she can pursue.

Help the student to generate a weekly schedule and include the activities on the schedule.

Teach the student how to monitor his or her mood before and after various activities are completed.

Encourage the student to monitor his or her moods throughout the week so that you all can discuss his or her progress in later sessions.

In subsequent sessions, review the student's mood-level ratings, identify critical patterns with the student (e.g., activities that may not result in a significant mood change), and engage in collaborative problem solving regarding how to optimize the student's success.

Repeat the process until the student's activity-monitoring data show that he or she is consistently experiencing more pleasurable feelings before and after various activities are completed.

EXHIBIT 4.7

Behavioral Activation: Information for Parents/Caregivers

Behavioral Activation

Behavioral activation is an intervention strategy that is implemented to help individuals cope with social withdrawal and depressed moods. Behavioral activation is based on the premise that people are less likely to engage in enjoyable activities when they feel depressed. When their activity level declines, they may become even more withdrawn, unmotivated, and lethargic. Hence, there is a high probability that their depressed moods will continue to worsen. This may also cause these individuals to feel even more isolated and detached from others. Behavioral activation can help individuals gradually engage in pleasurable activities to decrease their avoidance and isolation, and improve their mood. Engaging in pleasurable activities can be challenging for individuals who are not motivated and are depressed. Thus, your child's counselor will support him or her throughout the process to help your child succeed.

Behavioral Activation Process

First, the child is encouraged to identify and list a variety of activities that she or he can pursue. The counselor then encourages the child to engage first in activities that are easy to complete and then assigns increasingly challenging activities throughout the course of treatment. Students are also encouraged to start off by completing a few activities and gradually increase the number of activities that they are expected to pursue each week. After a list of activities is identified, the child is encouraged to plan his or her weekly schedule to include the chosen activities. To help students understand how engaging in several activities can impact their moods using behavioral activation, the final step of the process includes encouraging students to monitor their moods before and after the activity is completed. Monitoring their progress can help students recognize their individual accomplishments. This can elevate mood, increase motivation, and encourage them to keep moving forward. Behavioral activation may be repeated until the child's activity-monitoring data show that he or she is consistently experiencing more pleasurable feelings before and after various activities are completed.

What Kind of Activities Are Children Encouraged to Pursue?

Students are encouraged to engage in a variety of activities. Here are some guidelines that the counselor will follow when helping students identify activities to complete:

1. ***Safe***: Activities should be safe.
2. ***Achievable***: Activities should promote a sense of accomplishment.
3. ***Reasonable***: Activities should be reasonable to complete.
4. ***Meaningful***: Activities should be meaningful to the student.

EXHIBIT 4.8

Activity Identification and Monitoring Worksheet Example

Purpose: To help students identify a range of activities that they can pursue and to monitor how each activity impacts their mood.

Developmental Considerations: Counselors may want to present visual illustrations to younger children (e.g., smiley faces) to help them identify their mood level in response to each activity.

List of Positively Rewarding Activities

1. Reading fictional material
2. Singing in my choir
3. Going to the mall with friends
4. Local sightseeing
5. Fishing
6. Bowling
7. Walking and jogging
8. Going to lunch dates with my sister
9. Attending family dinners
10. Camping

0	1	2	3	4	5	6	7	8	9	10
None	Low				OK				High	Extreme

	Depression Feelings	Pleasurable Feelings
Activity: Reading fiction, Date: 5/1/14		
Before	8	2
After	4	6
Activity: Going to the mall with friends, Date 5/3/14		
Before	6	1
After	2	8

EXHIBIT 4.9

Positively Rewarding Activities

Directions: List activities that might be fun and pleasurable for you. If you can't think of any, work with a partner to help you identify a variety of activities. Let's see how many activities you can list. Ready, Set, Go!

EXHIBIT 4.10

Weekly Activity Schedule Worksheet Example

Purpose: To help students plan their weekly activities in advance.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00–9:00 a.m.	Walking	Walking	Walking	Walking	Walking	Walking	Walking
9:00–10:00 a.m.		Class	Class	Class	Class	Class	
10:00–11:00 a.m.		Class	Class	Class	Class	Class	Cleaning my house
11:00–12:00 p.m.	Singing in my choir						Cleaning my house
12:00–1:00 p.m.	Singing in my choir	Lunch date			Baking a cake		
1:00–2:00 p.m.							Fishing
2:00–3:00 p.m.	Family dinner	Mentoring	Sight-seeing	Mentoring		Mentoring	Fishing
3:00–4:00 p.m.	Family dinner	Mentoring	Sight-seeing	Mentoring		Mentoring	Fishing

EXHIBIT 4.11

Weekly Activity Schedule

Directions: List the activities that you will complete during each time block daily throughout the upcoming week.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00–9:00							
9:00–10:00							
10:00–11:00							
11:00–12:00							
12:00–1:00							
1:00–2:00							
2:00–3:00							
3:00–4:00							
4:00–5:00							
5:00–6:00							
6:00–7:00							
7:00–8:00							

EXHIBIT 4.12

Counselor's Checklist for Cognitive Restructuring

Explain the cognitive restructuring process to the parent/caregiver and student.

Introduce the relationship between activating events and one's thoughts, emotions, and behaviors (e.g., utilize the ABC figure).

Prompt the student to identify irrational and distorted thoughts.

Challenge the student's distorted thinking through perspective-taking exercises, using the Socratic questioning method, and/or through reflective thought recording.

Prompt the student to identify the specific cognitive distortions that exist.

Help the student reframe his or her distorted and irrational thoughts and/or replace such thoughts with coping statements/positive affirmations.

Repeat the process until the student's thoughts reflect a more balanced and rational manner of thinking.

EXHIBIT 4.13

Cognitive Restructuring: Information for Parents/Caregivers

Cognitive Restructuring

Cognitive restructuring is a therapeutic technique that is commonly used to challenge and correct negative thinking patterns that elicit depression and anxiety-related problems. It is based on the premise that one's irrational thoughts and beliefs about a specific event can lead to unhealthy emotions and behaviors that maintain depression and anxiety-related problems. Irrational thoughts are often referred to as cognitive distortions. Thus, the primary objective of cognitive restructuring is to help individuals challenge and reframe the cognitive distortions that are associated with their maladaptive emotions and behaviors. By disputing, reframing, and replacing unfavorable thoughts and beliefs, individuals are better prepared to manage and cope with their difficulties. Cognitive restructuring is a method that counselors can utilize to help students become more aware of their thinking, and to change their distortions to more positive and rational patterns of thinking.

Cognitive Restructuring Process

The first step in the process entails teaching children about the relationship among their thoughts, emotions, and behaviors. After a child understands that his or her thoughts can produce negative emotions and behaviors, he or she can then be prompted to identify his or her problematic thoughts. These thoughts are generally brief, spontaneous, and not based on reflection. In order for the student to interpret such thoughts as problematic, several strategies can be employed. First, students can be encouraged to view their thoughts from another person's perspective. Counselors can also utilize a semi-structured questioning method to help the student discover his or her problematic thoughts, understand why such thoughts are problematic, and identify errors in his or her reasoning. Another approach includes encouraging the student to maintain a journal or record of events that occur and his or her succeeding thoughts, behaviors, and consequences. These activities can help the student challenge and become more aware of his or her thinking.

After the student identifies his or her thought(s) as irrational and problematic, the counselor then prompts the student to identify the specific type of cognitive distortion(s) that exist. This can further help the student understand the nature of his or her thinking. After the student identifies his or her irrational thought, why the thought is problematic, and errors in his or her reasoning, the counselor assists the student with generating a more rational thought to replace the distorted thought. This process can be repeated until the student's thoughts reflect a more balanced and rational manner of thinking.

EXHIBIT 4.14

Three-Step ABC Figure Worksheet Example

Purpose: To help children/adolescents understand the relationship among experienced events, their beliefs about the events, and various consequences that they may endure.

Developmental Considerations: Counselors may want to present visual illustrations to younger children (e.g., clip art or magazine cutouts) to help them understand the relationship among antecedent events, beliefs, and consequences.

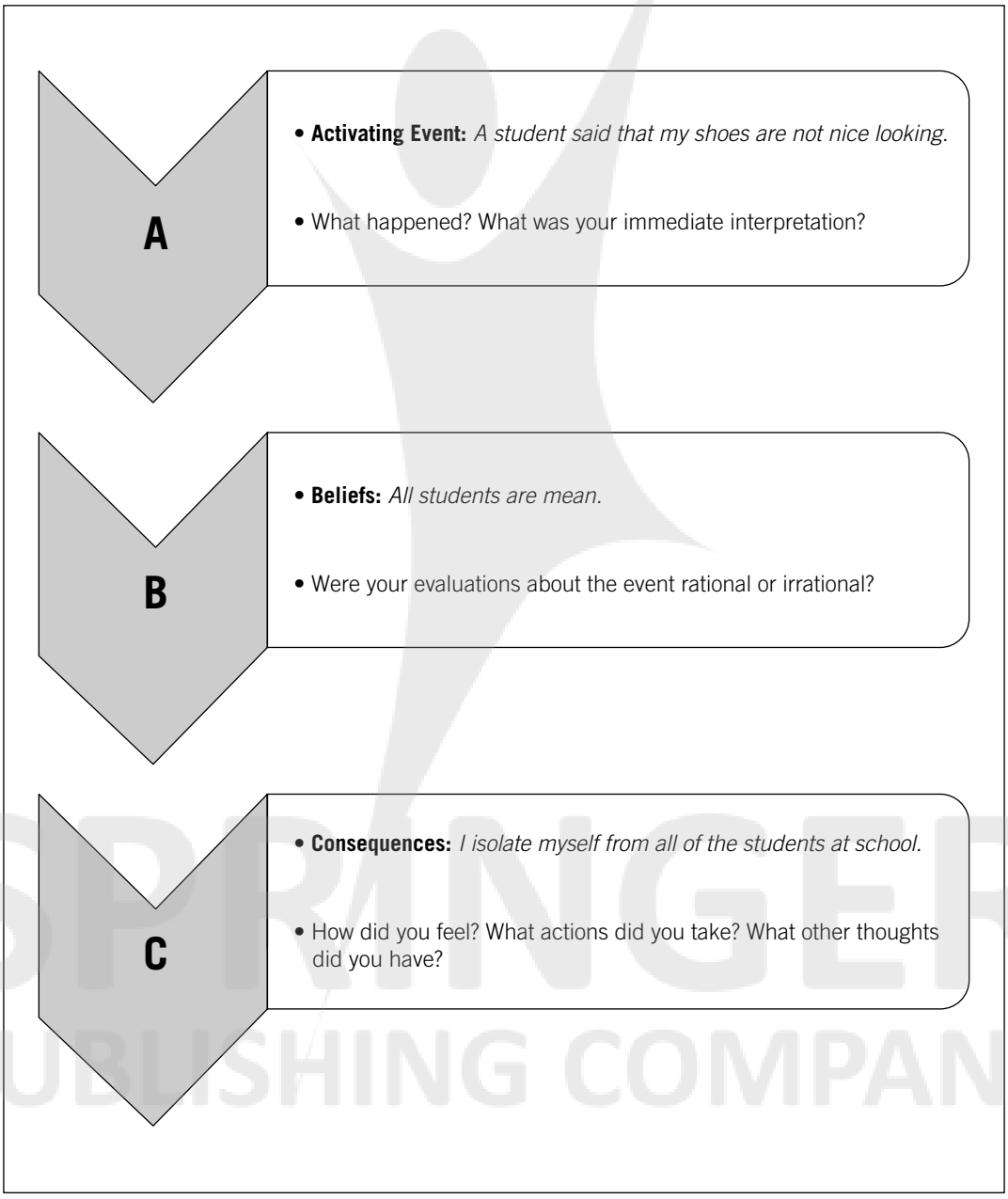


EXHIBIT 4.15

Three-Step ABC Worksheet

Directions: In the following boxes describe a situation/event, your belief(s) about the event, and the consequences/outcomes of your belief(s).

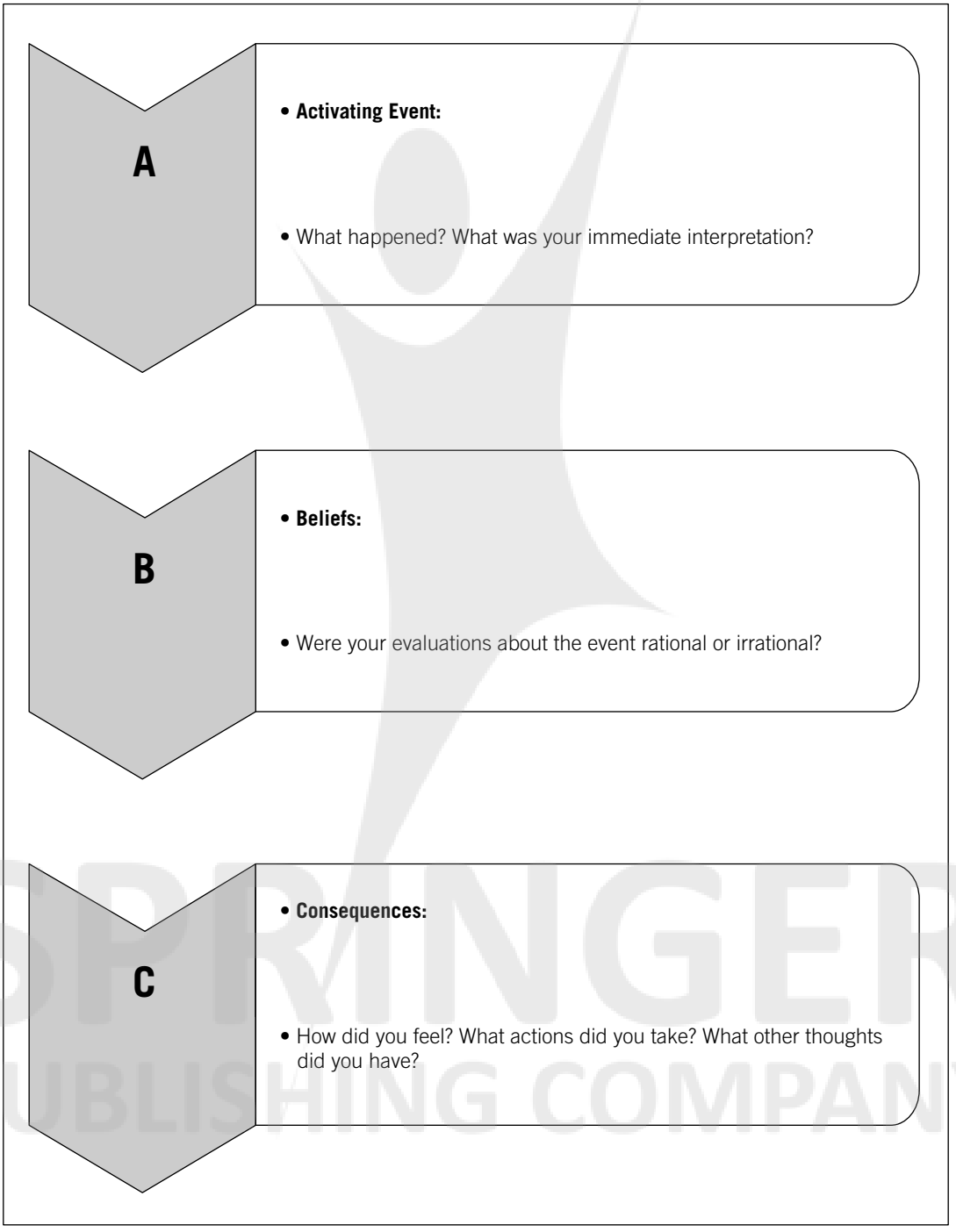


EXHIBIT 4.16

ABC Worksheet

Directions: In the following boxes describe a situation/event, your belief(s) about the event, and the consequences/outcomes of your belief(s).

A (Activating Event)	NEGATIVE EVENT	NEGATIVE EVENT
B (Belief)	RATIONAL BELIEF	IRRATIONAL BELIEF
C (Consequence)	HEALTHY EMOTION	UNHEALTHY EMOTION

EXHIBIT 4.17

Perspective-Taking Scenarios

Directions: Review and discuss each scenario with the student. Emphasize to students that people may have different perspectives/points of view in response to various situations.

Scenario 1: The Case of the Missing Cards

Last week, John's favorite collection of baseball cards went missing. No one could solve the case, so John called a detective to investigate the incident.

- What does a detective look for in an incident?
- Why might the detective ask multiple people about what they saw?

Scenario 2: A Ride in the Sky

You were recently in a hot-air balloon that flew over a playground. You saw many things below during your ride.

- Tell me what you saw happen. Be sure to talk about all of the children who were there.
- What do you think each one was thinking?
- How would each child see it differently?

Scenario 3: A Lunchtime Brawl

During lunch, 10 students were joking and throwing food at each other and at other students.

- What if you were **in the group/another student/a teacher/a parent**, what do you think you'll see, hear, and feel?

EXHIBIT 4.18

Perspective-Taking Worksheet Example

Purpose: To help children/adolescents understand that others may have different backgrounds, beliefs, and experiences, and interpret things differently.

Developmental Considerations: Young children may need concrete activities to further illustrate the concept of perspective taking. Adolescents may benefit from examples using art or optical illusions.

The Perspective Detective

Activating Event	What Are Your Thoughts and Feelings About the Event?	What Are Some Possible Thoughts and Feelings That _____ Has About the Event?
My friends went to a party without me.	*Thoughts: They probably don't like me anymore.* *Feelings: I feel somber.*	*Person: Friend* *Thought 1: I don't like Jane anymore, so I'm not going to invite her to the party.* *Feelings 1: I feel excited.* *Thought 2: Oh no, I forgot to invite Jane!* *Feelings 2: I feel gloomy.*

EXHIBIT 4.19

Perspective-Taking Worksheet

The Perspective Detective

Activating Event	What Are Your Thoughts and Feelings About the Event?	What Are Some Possible Thoughts and Feelings That _____ Has About the Event?

EXHIBIT 4.20

Coping Statements/Positive Affirmation Worksheet Example

Purpose: To help students generate positive affirmations/statements to replace negative thoughts.

Developmental Considerations: For students who have trouble generating positive affirmations/statements, the counselor may need to provide a list of positive affirmations for the student.

Negative Thought	Positive Affirmation
"I won't succeed at this task."	"I've done this before, so I am confident that I can do this."
"I hate myself."	"I am a good and likeable person."
"There's no way I can pass my test."	"I studied hard and I can give this my best effort."
"I'm a total failure."	"I have many gifts and talents."

EXHIBIT 4.21

My Coping Statements: Positive Affirmations

Directions: List positive affirmations/statements that you might use to replace negative thoughts that you have. If you can't think of any, work with a partner to help you identify multiple affirmations. Let's see how many affirmations you can list. Ready, Set, Go!

Negative Thought	Positive Affirmation

EXHIBIT 4.22

Counselor's Checklist for Relaxation Training

Explain the relaxation training process to the parent/caregiver and student.

Introduce the various relaxation techniques to the students
- Diaphragmatic breathing
- Progressive muscle relaxation
- Guided/visual imagery

Rehearse the appropriate application of the various techniques during the counseling session (e.g., using relaxation scripts).

Prompt the student to maintain a relaxation journal to help him or her monitor the effectiveness of relaxation techniques.

In subsequent sessions, review the student's relaxation journal to identify critical patterns and engage in collaborative problem solving regarding how to optimize the student's success.

Continue to practice the application of the relaxation techniques and help the student identify when they can be used.

Repeat the process until the student demonstrates a clear understanding of the correct application of the techniques.

EXHIBIT 4.23

Relaxation Training: Information for Parents/Caregivers

Relaxation Training

Relaxation training is a therapeutic technique that can be utilized to help individuals reduce high levels of anxiety and stress. Relaxation training is based on the idea that although most people encounter stressful and anxiety-producing events, people respond to stress and anxiety in different ways. Given that stressful and anxiety-producing events can cause individuals to feel overwhelmed and result in a heightened sense of anxiety, relaxation training is generally implemented to help individuals learn how to cope with stress and anxiety in a healthy manner by learning how to remain calm and slow their bodies down (e.g., manage a racing heartbeat). Counselors can teach children/adolescents a variety of relaxation techniques throughout their sessions.

The Relaxation-Training Process

The first step in the process entails explaining to the student the idea behind and the value of relaxation training. After the counselor provides a general overview of relaxation training, the counselor then teaches the child/adolescent about various relaxation techniques. Finally, the counselor engages in various exercises and activities during the sessions to help the student learn how to correctly apply each technique (e.g., using relaxation scripts). Students are also encouraged to maintain a relaxation journal to learn how to monitor and evaluate the effectiveness of the techniques as a personal coping strategy. The relaxation journal can also be used to help the counselor identify critical patterns with the student and engage in collaborative problem solving regarding how to optimize the student's success.

What Are Relaxation Techniques?

There are several relaxation techniques that children/adolescents can learn to help them remain calm and cope with stress and anxiety. These include:

1. ***Diaphragmatic breathing***: Students learn how to engage in deep and relaxed abdominal breathing.
2. ***Progressive muscle relaxation***: Students learn how to intentionally tense and relax various muscle groups in the body.
3. ***Visual and guided imagery***: Students learn the method of actively imagining a pleasant and peaceful scene.

EXHIBIT 4.24

Relaxation Journal Worksheet Example

Purpose: Help children/adolescents understand the relationship among experienced events, their stress and anxiety level, and use of relaxation techniques (use SUDS to rate stress/anxiety).

Developmental Considerations: Present visual illustrations to younger children (e.g., smiley faces) to help them identify the level of stress/anxiety they experience with each situation.

Stressful Event	Anxiety or Stress Level	What Physical and Emotional Symptoms Did You Feel?	Relaxation Technique	Anxiety or Stress Level
My teacher notified the class about an upcoming test.	7	*My heart was racing; my muscles were tensed; my palms started sweating; I felt scared and nervous.*	*Deep breathing*	3

EXHIBIT 4.25

Relaxation Journal Worksheet

Directions: Reflect on an incident that happened within the last month. List your stress level and describe how you felt before you utilized a specific relaxation technique and list your stress level after you utilized the relaxation technique.

Stressful Event	Anxiety or Stress Level	What Physical and Emotional Symptoms Did You Feel?	Relaxation Technique	Anxiety or Stress Level

EXHIBIT 4.26

Relaxation Script Examples

We are going to do some exercises that will help you learn how to stay calm and relaxed. But to proceed, there are some rules you must follow. First, avoid any movements that cause pain. This will keep you safe. Second, you must do everything I say, unless you feel some discomfort. Third, you must practice. The more you practice, the calmer you can be. Okay, first sit as comfortable as you can in your chair or on the floor. Remember to pay close attention to your body, follow my instructions very carefully, and work hard. You can do it! Let's go!

Progressive Muscle Relaxation

Select a muscle in your body. Squeeze and tighten this muscle for 5 seconds. After 5 seconds, quickly release it. Feel the difference between relaxation and tension? Squeeze and tighten your muscle again. Continue to hold this tension. Squeeze the muscle harder and tighter. Now release. Squeeze and tighten your muscle again. Now relax!

MUSCLE GROUPS

Right and left hand/forearm	Forehead	Upper back
Right and left upper arm	Eyes and cheeks	Lower back
Right and left upper leg	Mouth and jaw	Hips and legs
Right and left lower leg	Torso	Shoulders
Right and left foot	Stomach	Shoulder blades

Diaphragmatic Breathing

Touch your abdominal (or belly) muscles. Inhale slowly. Take a deep and powerful breath. Hold this breath for 3 to 5 seconds. Exhale slowly. Take another slow and deep breath. Hold this breath again. Now exhale slowly. Feel your hand moving slowly. Take another slow and deep breath. Exhale slowly. Release all of the tension. Now relax!

Guided Safe-Place Imagery

Close your eyes. Imagine yourself in a peaceful and soothing place. Imagine that you are on a beach. Picture details about this peaceful place. Are you at the beach alone? See the waves washing onto the shoreline. Listen to the sound of the waves. What else do you hear? Listen to the calls of the seagulls. Imagine the wind blowing. Can you feel the cool breeze? How does it feel to be in this peaceful place?

Note: Additional relaxation scripts can be retrieved from www.therapysites.com/userfiles/2139734/file/Grounding%20Exercises.pdf

EXHIBIT 4.27

Counselor's Checklist for Social Skills Training

- ✓ Explain the social skills training process to the parent/caregiver and student.
- ✓ Identify the student's specific skill deficits.
- ✓ Determine which teaching method you will employ.
  * Multiple teaching methods can be implemented throughout the intervention.
- ✓ Observe the student's demonstration of the targeted skills and discuss the student's performance of the targeted skills in other settings.
- ✓ Provide corrective feedback to the student regarding how to improve his or her performance of the targeted skills.
- ✓ In subsequent sessions, continue to prompt the student to practice performing the skills and provide positive reinforcement to encourage generalization.
- ✓ Repeat the process until the student demonstrates a clear understanding of how to perform the targeted skills.

EXHIBIT 4.28

Social Skills Training: Information for Parents/Caregivers

Social Skills Training

Social skills training is a method of treatment that can be used to foster more effective interpersonal interactions for children/adolescents who experience internalizing-related difficulties. More specifically, social skills training can be implemented to help children/adolescents execute enriched communication, problem solving, and conflict-resolution skills throughout their day-to-day interactions. Social skills training is grounded in the assumption that interpersonal relationships are critical to one's healthy functioning. Students who have trouble communicating their needs to others, interpreting various social cues, resolving conflict, and solving problems are likely to experience negative outcomes, such as peer rejection, anxiety, and depression. Therefore, counselors can implement social skills training as a treatment option to help children/adolescents improve their behaviors and functioning during their everyday social interactions. Social skills training includes several steps.

The Social Skills Training Process

The first step in social skills training entails identifying students' specific skill deficits. After counselors determine a student's specific skill deficit(s), several educational techniques can be employed. Role-playing and modeling are two approaches to teaching students effective social skills. With respect to role-playing, the student can review and act out various scenarios that serve to increase his or her ability to exhibit the targeted skill(s). Some students may find it difficult to perform certain behaviors through role-playing. Thus, counselors can also utilize modeling during social skills training. Modeling involves the child/adolescent learning a specific skill by observing and imitating others. Through modeling, the counselor can demonstrate various behaviors that the student is expected to learn. Peer modeling is a viable option as well, as it involves the student observing and imitating exemplars from his or her age group.

Students can also review and rehearse various social interaction scripts. Social interaction scripts provide students with more direct instruction regarding appropriate language to use and specific behaviors to exhibit during their interpersonal interactions (e.g., maintain eye contact, speak clearly, and so forth). While social scripts can be used during in-session role-play activities, students can also store shortened scripts in their pockets, wallets, backpacks, and so on to help them engage in successful interactions in their natural environments. Counselors typically utilize corrective feedback and positive reinforcement throughout social skills training sessions, which entail providing students with praise and constructive criticism regarding their demonstration of a specific skill. Counselors also help students discover how to more accurately perform the skill.

EXHIBIT 4.29

Social Interaction Script Examples

Purpose: To help students practice engaging in prosocial and healthy interactions.

Developmental Considerations: Counselors may want to present visual illustrations to younger children (e.g., pictures) to help them understand the behavioral expectations.

Asking for Help in Class

You are struggling with an assignment and you don't understand what to do. Because you are struggling, you begin to feel overwhelmed and anxious.

1. Raise your hand.
2. Wait until the teacher gives you permission to speak.
3. Ask for help in a polite way: Use a calm tone of voice, speak clearly, speak slowly, make eye contact.
4. After you receive help, say "Thank you."
5. If your teacher and peers can't help you, still say "Thank you."

Making New Friends

You are feeling sad and lonely because you don't have many friends at school. You see a new student sitting alone at lunch, and you really want to get to know him or her.

1. Introduce yourself: State your name, use a friendly tone of voice, maintain eye contact, speak clearly, speak slowly.
2. Ask him or her to share his or her name with you.
3. Tell him or her about your hobbies, interests, and likes (don't take over the conversation).
4. Ask him or her to share his or her hobbies, interests, and likes.
5. Try to find a common interest and hobby.
6. When you all are finished chatting, tell the student that you enjoyed talking to and meeting him or her.

Resolving a Conflict With Your Friend

You and your friend are hanging out today. Your friend wants to go to the movies but you want to go to the mall. You want to share your concerns, but you don't want to ruin your friendship.

1. Tell your friend how you feel about the problem (e.g., "I feel frustrated because we want to do different things.").
2. Ask you friend how he or she feels about the problem.
3. Listen to his or her answer: Do not speak while he or she is speaking, maintain eye contact.
4. Nod your head to let him or her know that you are listening and you care about her or his feelings too.
5. Ask your friend whether you can compromise and find another solution.
6. Ask him or her to provide some ideas.
7. You provide ideas.
8. Decide on a solution.

EXHIBIT 4.30

Assertiveness Training Example

Purpose: To help students learn how to assert their feelings and rights.

Developmental Considerations: Counselors may want to present visual illustrations to younger children (e.g., pictures) to help them understand the behavioral expectations.

A. Identify the problem:
- **a.** What happened?
- **b.** Why is it a problem?

Another student told me that I'm not smart. It made me feel sad and depressed.

B. Describe your feelings using "I" statements:
- **a.** I feel _____ because _____.
- **b.** "I feel" should be followed by an emotion word; try to refrain from using "that you" or "like you."

"I feel hurt because you told me that I'm not smart."

C. Describe the changes you want to see happen:
- **a.** Changes should be reasonable.
- **b.** Changes should consider the needs and feelings of the other person.

"I would like for you and I to use kind words to each other."

D. Describe the potential consequences of being assertive:
- **a.** How would you feel?
- **b.** What might happen?

"I may feel calm and happy."
"My classmate may agree to say more kind words to me."

EXHIBIT 4.31

Assertiveness Training

Directions: Reflect on an incident that happened within the last month. Describe the problem. Practice being assertive using the following prompts. Consider what might happen if you were more assertive.

A. Identify the problem:

- **a.** What happened?
- **b.** Why is it a problem?

B. Describe your feelings using "I" statements:

- **a.** I feel _____ because _____.
- **b.** "I feel" should be followed by an emotion word; try to refrain from using "that you" or "like you."

C. Describe the changes you want to see happen:

- **a.** Changes should be reasonable.
- **b.** Changes should consider the needs and feelings of the other person.

D. Describe the potential consequences of being assertive:

- **a.** How would you feel?
- **b.** What might happen?

EXHIBIT 6.1

Physiological Stress Reaction List

Directions: Mark each item that applies to you.

Head

- ☐ Forehead wrinkling
- ☐ Eyes squinting
- ☐ Eyes rolling
- ☐ Frowning
- ☐ Scowling
- ☐ Staring
- ☐ Lip pursing
- ☐ Lip smacking
- ☐ Dry mouth
- ☐ Swallowing
- ☐ Jaw clenching
- ☐ Teeth grinding
- ☐ Neck rolling
- ☐ Dizziness
- ☐ Feeling faint
- ☐ Feeling flushed/turning red

Shoulders/Back/Torso

- ☐ Shoulders pulling up
- ☐ Shoulders rolling forward
- ☐ Shoulder ache
- ☐ Backache
- ☐ Back tightening
- ☐ Indigestion
- ☐ Stomach growling
- ☐ Stomachache
- ☐ Rocking
- ☐ Heart racing

Arms/Hands

- ☐ Fist clenching
- ☐ Finger tapping
- ☐ Folded arms
- ☐ Sweaty palms

Legs/Feet

- ☐ Foot tapping
- ☐ Shaking

EXHIBIT 6.2

My Feelings Map

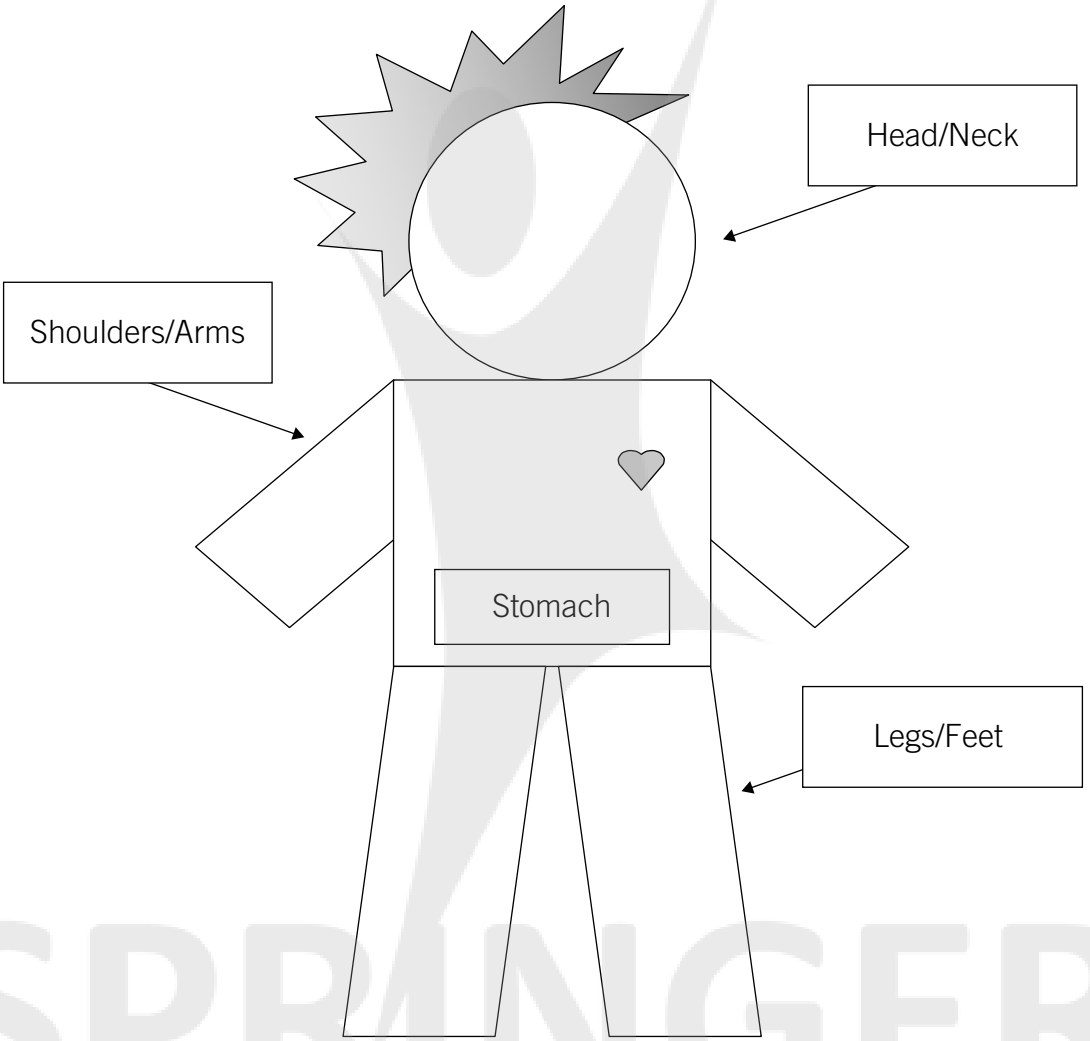


EXHIBIT 6.3

Problem Solving

A. What is the problem? _____

B. Brainstorm ideas for solutions to the problem and note the pros and cons.

My Idea	Pros/Cons
1.	
2.	
3.	
4.	
5.	

C. Which idea is best? _____

D. What is my action plan to try the solution? _____

E. How did I feel *after* I tried it? _____

Index