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.

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A PRACTITIONER’S TOOLKIT

Diana Joyce-Beaulieu, PhD, NCSP
Michael L. Sulkowski, PhD, NCSP

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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 xi
Foreword by Thomas Oakland, PhD, ABPP, ABPN xiii
Preface xv
Acknowledgments xvii

PART I: INTRODUCTION TO COGNITIVE BEHAVIORAL THERAPY

1. Effectively Integrating CBT Counseling Into School Services 3
   DSM-5 Child and Adolescent Diagnoses and Age of Onset 5
   Counseling Within Multitiered Systems of Support in Schools 9
   Progress Monitoring 12
   CBT Efficacy in School-Based Applications 23

2. What Is Cognitive Behavioral Therapy? 27
   Psychoeducation 29
   Cognitive Restructuring 29
   Sentence Completion and If/Then Questionnaires 31
   Relaxation Training 37
   Contingent Reinforcement 38
   Incorporating Technology: Low-Intensity CBT Interventions 38
   Case Conceptualization 40
   Contraindications for Counseling Therapy 42
   Getting Started 43

PART II: COUNSELING STRUCTURE FOR INTERNALIZERS

3. Understanding Internalizing Problems 49
   (Olivia Soutullo and Lee Purvis, coauthors)
   Anxiety and Related Disorders 50
   Generalized Anxiety Disorder 50
   Selective Mutism Disorder 50
   Separation Anxiety Disorder 51
   Specific Phobia 52
   Social Anxiety Disorder (Social Phobia) 52
Contents

Somatic Symptom Disorder 53
Panic Disorder 54
Trauma and Stressor-Related Disorders 55
Adjustment Disorder 55
Posttraumatic Stress Disorder 56
Bipolar and Related Disorders 56
Bipolar I Disorder 56
Cyclothymic Disorder 57
Depressive Disorders 58
Major Depressive Disorder 58
Persistent Depressive Disorder 59
Disruptive Mood Dysregulation Disorder 59
Eating Disorders 60
Anorexia Nervosa 60
Bulimia Nervosa 61
Obsessive-Compulsive and Related Disorders 62
Obsessive-Compulsive Disorder 62
Excoriation (Skin-Picking) Disorder and Trichotillomania
(Hairpulling Disorder) 63
Hoarding Disorder 63
Personality Disorders 64
Schizoid Personality Disorder and Schizotypal Personality Disorder 64

4. Cognitive Behavioral Therapy for Internalizing Problems
(Janise Parker, coauthor) 67
Exposure/Response Prevention Therapy 68
When to Use or Not Use Exposure/Response Prevention Therapy 71
Behavioral Activation 71
When to Use or Not Use Behavioral Activation 73
Cognitive Restructuring 73
When to Use or Not Use Cognitive Restructuring 77
Relaxation Training 77
When to Use or Not Use Relaxation Training 77
Social Skills Training 78
When to Use or Not Use Social Skills Training 79

PART III: COUNSELING STRUCTURE FOR EXTERNALIZERS

5. Understanding Externalizing Problems 83
Disruptive, Impulse-Control, and Conduct Disorders 83
Conduct Disorder 84
Intermittent Explosive Disorder 85
Oppositional Defiant Disorder 86
Neurodevelopmental Disorders 87
Attention Deficit Hyperactivity Disorder 87
Autism Spectrum Disorder 88
Tourette's Disorder 89
Bullying in Schools 90

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6. Cognitive Behavioral Therapy for Externalizing Problems 93
   Identifying Physiological Precursors/Triggers 93
   When to Use or Not Use Identification of Physiological Precursors/Triggers 95
   Building Feeling Vocabulary 95
   When to Use or Not Use Strategies for Building Feeling Vocabulary 96
   Cognitive Restructuring 97
   When to Use or Not Use Cognitive Restructuring 97
   Parent Training 97
   When to Use or Not Use Parent Training 98

PART IV: COUNSELING REPORT CASE SAMPLES FOR CHILDREN AND ADOLESCENTS

7. Elementary School Counseling Sample Reports 101

8. Secondary/Postsecondary Counseling Reports 115

Appendix 141
Index 191
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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!
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

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

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.
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence</th>
<th>Age of Onset Range</th>
<th>Gender</th>
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</thead>
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<tr>
<td>ADHD</td>
<td>5.0</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>5.0–20</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>0.4</td>
<td>&gt; F</td>
<td></td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>0.2–3.3</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Autism Spectrum</td>
<td>1.0</td>
<td>&gt; M</td>
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<td>Bipolar I</td>
<td>0.6</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Bipolar II</td>
<td>0.3</td>
<td>M = F</td>
<td></td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>1.6–5.9</td>
<td>&gt; F</td>
<td></td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>1.0–1.5</td>
<td>&gt; F</td>
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</tr>
<tr>
<td>Conduct Disorder</td>
<td>2.0–10</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Cyclothymia</td>
<td>0.4–1.0</td>
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</tr>
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<td>Disruptive Mood Dysregulation</td>
<td>2.0–5.0</td>
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<tr>
<td>Excoriation (skin picking)</td>
<td>1.4</td>
<td>&gt; F</td>
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<tr>
<td>Histrionic Personality</td>
<td>1.8</td>
<td>&gt; F</td>
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</tr>
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<td>Generalized Anxiety</td>
<td>0.9</td>
<td>&gt; F</td>
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</tr>
<tr>
<td>Hoarding</td>
<td>2.0–6.0</td>
<td>&gt; M</td>
<td></td>
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<tr>
<td>Intermittent Explosive Disorder</td>
<td>2.7</td>
<td>&gt; M</td>
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<tr>
<td>Major Depressive</td>
<td>7.0</td>
<td>&gt; F</td>
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<tr>
<td>Narcissistic Personality</td>
<td>≤6.2</td>
<td>&gt; M</td>
<td></td>
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<tr>
<td>Obsessive-Compulsive Personality</td>
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<td>&gt; M</td>
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<tr>
<td>Obsessive-Compulsive Personality</td>
<td>2.1–7.9</td>
<td>&gt; M</td>
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<tr>
<td>Oppositional Defiant</td>
<td>1.0–11.0</td>
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<td>Panic</td>
<td>2.0–3.0</td>
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<td>&gt; M</td>
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<td>2.3–4.4</td>
<td>&gt; M</td>
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<td>Persistent Depressive</td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>8.7</td>
<td></td>
<td>&gt; F</td>
</tr>
<tr>
<td>Reactive Attachment</td>
<td>?</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>Schizoid Personality</td>
<td>3.1–4.9</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.3–0.7</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Schizotypal Personality</td>
<td>4.6</td>
<td>&gt; M</td>
<td></td>
</tr>
<tr>
<td>Selective Mutism</td>
<td>0.03–1.0</td>
<td>M = F</td>
<td></td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>1.6–4.0</td>
<td>M = F</td>
<td></td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>7.0</td>
<td></td>
<td>&gt; F</td>
</tr>
<tr>
<td>Somatic Symptom</td>
<td>5.0–7.0</td>
<td></td>
<td>&gt; F</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>5.0–16</td>
<td></td>
<td>&gt; F</td>
</tr>
<tr>
<td>Tourette’s</td>
<td>3.0–8.0</td>
<td></td>
<td>&gt; M</td>
</tr>
<tr>
<td>Trichotillomania (hairpulling)</td>
<td>1.0–2.0</td>
<td></td>
<td>&gt; F</td>
</tr>
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</table>

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>
<thead>
<tr>
<th>TABLE 1.2 Behavior Modification Strategies</th>
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<tbody>
<tr>
<td>Technique</td>
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| 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)

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description and Goals</th>
<th>Key Points for Implementation</th>
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</table>
| 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     | 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)
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:

### TABLE 1.2 Behavior Modification Strategies (continued)

<table>
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<tr>
<th>Technique</th>
<th>Description and Goals</th>
<th>Key Points for Implementation</th>
</tr>
</thead>
</table>
| 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. |

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
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.
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.
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
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.](image-url)
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

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

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 psychotism).
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, post-traumatic 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**


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Chapter One  Effectively Integrating CBT Counseling Into School Services


