COGNITIVE BEHAVIORAL THERAPY IN K-12 SCHOOL SETTINGS

A Practitioner's Workbook

Diana Joyce-Beaulieu
Michael L. Sulkowski
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 counseling. She is a licensed psychologist and nationally certified school psychologist with supervision responsibilities for graduate-student practical experiences across several school districts and outpatient clinics. Her research interests include mental health services for children and adolescents, including diagnosis and counseling. Her publications include four books and numerous peer-reviewed chapters and articles. She also has served as coprincipal investigator for two professional development grants to research training models for multiti ered 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 has a conjoint appointment in the Department of Psychiatry, where he trains psychology interns and psychiatric fellows in the use of evidence-based forms of psychotherapy. He also maintains a private practice in Tucson, Arizona, in which he treats children, adolescents, and adults using variants of 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 three books and over 50 journal articles. His research has been highlighted by the receipt of awards from the American Psychological Association and the National Association of School Psychologists.
This is a sample from COGNITIVE BEHAVIORAL THERAPY IN K-12 SCHOOL SETTINGS

Cognitive Behavioral Therapy in K–12 School Settings

A PRACTITIONER’S WORKBOOK

Second Edition

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

SPRINGER PUBLISHING COMPANY
Contact us to receive discount rates on bulk purchases.
We can also customize our books to meet your needs.
For more information please contact: sales@springerpub.com
This book is dedicated to my husband, David Edmund Beaulieu. I am immensely grateful to him, for his keen sense of humor, encouragement, and inspiration during this endeavor. His intelligent conversation, effervescent demeanor, and nurturing spirit provide a sanctuary in my life each and every day.

—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 the hundreds of clients I have worked with over the years who have had the hope and courage for growth and change.

—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
Contributors
Foreword by Thomas L. Good, PhD
Preface
Acknowledgments

PART I: SCHOOL-BASED COGNITIVE BEHAVIORAL THERAPY

1. Effective Cognitive Behavioral Therapy in Schools
   (Alexa R. Dixon and Joseph W. Graham, coauthors)
   
   Introduction
   Overview of Mental Health Needs of Children in the United States
   DSM-5 Child and Adolescent Diagnoses and Age of Onset
   Counseling Within MTSS in Schools
   Progress Monitoring
   CBT Efficacy in School-Based Applications
   Contraindications for Counseling Therapy

2. Cognitive Theoretical Foundations
   
   Introduction
   An Overview of the CBT Theoretical Model
   The Medical Model of Psychopathology
   Internalizing Psychopathology
   Externalizing Psychopathology
   Culturally Responsive CBT

3. Cognitive Behavioral Therapy Essential Components
   
   Introduction
   Case Conceptualization
   Case Conceptualization Models
   Home–School Collaboration
   Adapting for Developmental Factors
   Emergency Indicators
   Therapy Session Planning
   Psychoeducation
   Getting Started
   Terminating Therapy
PART II: COUNSELING TECHNIQUES

4. Emotional and Behavioral Regulation Strategies
   Introduction
   Recognizing Emotions and Physiological Triggers
     Recognizing Feelings
     Identifying Physiological Precursors/Triggers
   Relaxation Training
     Diaphragmatic Breathing
     Progressive Muscle Relaxation
     Guided Imagery
     When to Use/Not Use Relaxation Training
   Mindfulness Training
     Cultivation of Attitude of Openness, Curiosity, and Acceptance
     When to Use/Not Use Mindfulness Training
   Additional Behavioral Regulation Strategies
     Behavioral Activation
     Habit Reversal Training

5. Exposure and Response Prevention and Cognitive Behavioral Therapy
   (Brian A. Zaboski, coauthor)
   Introduction
   Exposure and Response Prevention Therapy
     Starting Exposure Therapy
     Functional Assessment
     Types of Exposures
     The Fear Hierarchy
     Implementing Exposures
     Maximizing Exposure Effectiveness
     When to Use or Not Use Exposure Therapy
   Cognitive Restructuring
     The CBT Triad
     Specific Cognitive Distortions
     Thought Journaling and Records
     Socratic Questioning
     Downward Arrow
     When to Use and Not to Use Cognitive Restructuring

6. Applied Cognitive Behavioral Therapy Session Activities
   (Janise S. Parker, coauthor)
   Introduction
   Counseling Activities for Children Ages 7 to 11
     Teaching the Relationship Between Thoughts, Feelings, and Behaviors
     Building Feeling Vocabulary
     Cognitive Restructuring
   Counseling Activities for Ages 12 and Older
     Sentence Completion and If/Then Questionnaires
7. Case Studies
(Kendra Saunders, Theresa LaPuma, Christopher Poitevien, and Greg M. Muller, coauthors)

Introduction
Child Counseling Case Study: Self-Regulation
  Reason for Referral
  Background Information
  Intervention Plan
  Counseling Sessions
  Intervention Results

Child Counseling Case Study: Unspecified Anxiety
  Reason for Referral
  Background Information
  Intervention Plan
  Counseling Sessions
  Intervention Results

Adolescent Counseling Case Study: Social Anxiety
  Reason for Referral
  Background Information
  Intervention Plan
  Counseling Sessions
  Intervention Results

Adolescent Counseling Case Study: OCD
  Reason for Referral
  Background Information
  Intervention Plan
  Counseling Sessions
  Intervention Results

Appendix: Counseling Worksheets and Handouts
Index
Contributors

Alexa R. Dixon, MEd  Doctoral student, School of Special Education, School Psychology and Early Childhood Studies, University of Florida, Gainesville, Florida

Joseph W. Graham, BA  Doctoral student, School of Special Education, School Psychology and Early Childhood Studies, University of Florida, Gainesville, Florida

Theresa LaPuma, PhD  Postdoctoral Fellow, Commonwealth Psychology Associates, Boston, Massachusetts

Greg M. Muller, MEd  BS Psychology Intern, Cornerstone Consortium, Bradenton, Florida

Janise S. Parker, PhD  Assistant Professor, School Psychology and Counselor Education, College of William & Mary, Williamsburg, Virginia

Christopher Poitevien, MEd  Postdoc, University of Florida, Gainesville, Florida

Kendra Saunders, PhD  School Psychologist, PK Yonge Developmental Laboratory School, Gainesville, Florida

Brian A. Zaboski, PhD  Postdoctoral Fellow, Yale OCD Research Clinic, Yale University, New Haven, Connecticut
Joyce-Beaulieu and Sulkowski's first edition provided an invaluable book for school-based mental health specialists. There are millions of students who cope with complex personal issues (e.g., externalizing or internalizing). These problems are often difficult to resolve and conflicting information about how to address them abounds. In helping with these dilemmas of practice, the authors elucidated rich concepts, research findings, and valuable strategies to use in providing cognitive behavioral therapy (CBT) and other psychological treatments in school settings. To achieve this, the authors combined their professional experience as licensed psychologists and nationally certified school psychologists with the rich knowledge base contained in the extant literature. First, they analyzed a massive, complex, and often conflicting research literature. Second, they synthesized this research to provide concrete, accessible, and applicable strategies for use in school settings. Given this blending of rich practical experience and research knowledge, it is no surprise that the first edition was widely read and highly valued by the professional community. This is a valuable book, and I recommend that it should be in the library of all school psychologists and mental health specialists.

The second edition expands upon the successful first edition in many useful ways. For example, an additional chapter discusses practical and applied CBT in-session interventions. Further, two case studies illustrating how to use and document CBT in school settings have been added, as well as over 50 pages of worksheets. In addition to these dimensions that add to the practicality of the book, there is also a thorough and systematic updating of research and theory. Among this new content is a more detailed approach to conceptualizing CBT cases, planning therapy sessions, and transitioning therapy to ensure continued treatment success. More content is provided on CBT-related concepts that are now more commonly used in school settings, such as mindfulness interventions, acceptance and commitment therapy (ACT), habit reversal training (HRT), and behavioral activation. The second edition (like the first edition) is well written and based upon up-to-date research. It provides a comprehensive description of best practice and is a must-read/must-have book for mental health experts who
work with students in school settings. I recommend this book with considerable enthusiasm.

Thomas L. Good, PhD
Professor Emeritus
Department of Educational Psychology, University of Arizona
American Educational Research Association Fellow
American Psychological Association Fellow
National Academy of Education Member
In *Cognitive Behavioral Therapy in K–12 School Settings: A Practitioner’s Workbook*, Second Edition, we have kept all the essential components of the first edition as recommended by practitioners but also provided a number of additional features. Content is now provided on mindfulness interventions, acceptance and commitment therapy (ACT), habit reversal training (HRT), and behavioral activation. More detailed descriptions of step-by-step cognitive behavioral therapy (CBT) applications also are included (e.g., planning sessions, targeted session activity examples, therapy closure, exposure therapy), as well as two additional case studies. Essentially, the second edition goes more in-depth into translating current clinical practices for the school-based practitioner audience. Additionally, the book has enhanced coverage of culturally responsive CBT research, scholarship, and applied practice tips.

Consistent with the first edition, this book provides practitioners with an easily accessible and practical guide for implementing basic CBT counseling strategies in applied 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, this 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 over 50 forms to use when planning, structuring, and conducting therapy.

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 commonly adopted and implemented in K–12 schools. In the first chapter, this workbook 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 a theoretical foundation for CBT, including understanding the nature of internalizing compared to externalizing behaviors that may interfere with student success. Additionally, the chapter discusses cultural
formation considerations and introduces the CBT triad. Chapter 3 offers a discussion of the essentials of CBT counseling from initial case conceptualization to session planning. Practical strategies for using CBT are reviewed in detail in Chapters 4 and 5. Additionally, Chapter 4 includes content on emotional and behavioral regulation strategies, including recognizing emotions and physiological triggers, relaxation training, mindfulness training, and additional behavioral regulation strategies such as behavioral activation and habit reversal training. Chapter 5 also provides a practical nuts-and-bolts approach to implementing exposure therapy and cognitive restructuring to address a range of internalizing and externalizing disorders. The content in Chapter 6 offers applied session activities that teach CBT concepts as well as a review of technology applications that may help reinforce session content. Finally, sample case studies are included in Chapter 7. 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-2e.

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 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; 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 have great utility in our own practice, and we trust that you will as well.
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 Alexa Dixon and Joseph Graham, who coauthored Chapter 1; Dr. Brian Zaboski, who coauthored Chapter 5; Dr. Janise Parker, who coauthored Chapter 6; and Dr. Kendra Saunders, Dr. Theresa LaPuma, Chris Poitevien, and Greg Muller, who coauthored Chapter 7. It also has been a pleasure to work with Rhonda Dearborn, the senior acquisitions editor for behavioral sciences, and Mehak Massand, assistant editor, at Springer Publishing Company. Their professional support, from guiding the proposal to facilitating the final publication, has brought this project to fruition. Lastly, we wish to express our appreciation to Dr. Thomas L. Good for providing his endorsement of this book and writing the foreword. Thank you!
PART I

School-Based Cognitive Behavioral Therapy
INTRODUCTION

At its essence, counseling is the art of facilitating a trusted and guided conversation that fosters healthy thoughts and behaviors as well as inspires personal insight. Much like the supportive conversations that evolve around social interactions with family and friends, first understanding an individual's needs while establishing rapport is the foundation for counseling. In its most sophisticated form, counseling is the applied science of astutely recognizing thought patterns and then matching evidence-based strategies to needs in order to optimize positive change. Within the plethora of research studies on counseling techniques, cognitive behavioral therapy (CBT) is highly regarded as a first-line treatment for many mental health and personal stressor needs (Silverman et al., 2008). This text focuses on the provision of effective CBT from the initial techniques of rapport building and microskills, facilitating counseling session discussions, to the components that are most efficacious for specific mental health needs. Understanding these precision targeted components allows counselors to streamline intervention, conserving valuable time and resources, so clients are well served and institutions can effectively meet the needs of individuals.

OVERVIEW OF MENTAL HEALTH NEEDS OF CHILDREN IN THE UNITED STATES

The provision of school-based mental health support services has been a longstanding priority for best practice service delivery models in school counseling, school psychology, and school social work associations (American School Counselor Association, 2014; National Association of School Psychologists, 2010; School Social Work Association of America, 2013a). In fact, multiple educational reform efforts have called for further enhancing the integration of mental health services into schools (Atkins, Hoagwood, Kutash, & Seidman, 2010; Schelar, Lofink Love, Taylor, Schlitt, & Even, 2016).

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, 2015; Center for Mental Health in Schools at UCLA, 2014; Joyce-Beaulieu & Rossen, 2014; National Association of School Psychologists, 2010; School Social Work Association of America, 2013b).

In their graduate training, psychologists, school psychologists, counselors, and social workers all receive knowledge of and experience in delivering counseling services to youth and thus are well positioned to provide these services. However, studies also indicate that regardless of their initial training, practitioners also benefit from ongoing training in best practices methods, such as CBT. This continued training serves to help practitioners maintain and enhance skills as well as remain diligent in bridging the gap between practice and emerging research (Beidas & Kendall, 2010). In surveys of therapists and school psychologists, school-based practitioners cite insufficient training and knowledge as barriers to providing these mental health supports (Beidas & Kendall, 2010; Castillo, Arroyo-Plaza, Tan, Sabnis, & Mattison, 2017; Suldo, Friedrich, & Michalowski, 2010). As an example, in a nationally representative sample survey, Hanchon and Fernald (2013) discovered over 90% of school psychology practitioners indicated that they had knowledge and training in counseling techniques but nearly 40% indicated that they felt less than sufficiently prepared in providing individual counseling services in schools, whereas over 40% indicated they felt less than sufficiently prepared to provide group counseling. Other studies note general practitioner criticism of formal treatment manuals and difficulty navigating counseling services within the institutional context of schools (Beidas & Kendall, 2010). In response to these needs, this book endeavors to provide school-based practitioners, whether they are new to the field or seasoned veterans, easily accessible tools to utilize when providing effective CBT for students and offers numerous examples of practical school-based applications. This chapter provides an overview of the use of CBT within schools and the multitiered systems of support (MTSS) model, whereas Chapter 2, Cognitive Theoretical Foundations, and Chapter 3, Cognitive Behavioral Therapy Essential Components, discuss CBT theoretical foundations and essential components. The second section of the text (i.e., Chapter 4, Emotional and Behavioral Regulation Strategies, through Chapter 6, Applied Cognitive Behavioral Therapy Session Activities) offers specific counseling techniques, utilizing a number of session activities and worksheet resources (found in the Appendix). Lastly, Chapter 7, Case Studies, provides case studies that integrate CBT intervention as applied within a school setting. These case studies give a “real-world” context for many of the techniques described in the book.

The delivery of school-based counseling is important 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 youth are available multiple days per week to receive these services. Counseling plans 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. Of those students who will experience significant mental health needs, nearly 10% to 15% will suffer significant impairment in their ability to learn, be successful at school, make and keep friends, and maintain positive relationships with their caregivers (Merikangas et al., 2010; U.S. Department of Health & Human Services [USDHHS], 2000). Another indicator of student adjustment risk is school dropout. Unfortunately, within the general population, only about 82% (i.e., 4 out of every 5) of students in the United States successfully graduate from high school with a regular diploma within 4 years of entering ninth grade. This results in thousands of students dropping out of school each day in the United States (McFarland, Stark, & Cui, 2018). Regular diploma graduation rates vary significantly by state with the District of Columbia lowest at 61% and Iowa highest at 91%. Thirty-five states maintain averages at 80% or higher. Differential graduation rates also exist across gender, income, recency of immigration, race/ethnicity, and disability status. Males and students with low-income circumstances are overrepresented as dropouts across all race/ethnicities, and low-income students have a higher dropout rate than middle- or high-income students (9.4%, 5.4%, and 2.6%, respectively). Among those students with low income, students who also experience homelessness are especially vulnerable for both dropout and mental health distress (Sulkowski & Michael, 2014). Hispanic students born outside the United States have a 21% dropout rate (3.9% for non-Hispanic students) with first-generation students' dropout rates decreasing to 7.1% for Hispanic and 2.2% for non-Hispanic students (McFarland et al., 2018).

In 2013–2014, the regular diploma graduation rate within 4 years of entering ninth grade was 87% for White students, 76% for Hispanic students, and 73% for Black students (McFarland et al., 2018). For students of Hispanic heritage, the dropout rates also differed significantly by subgroups, as those of Cuban, Spaniard, Costa Rican, Panamanian, Colombian, Peruvian, and Venezuelan descent have lower than national mean dropout rates. In contrast, dropout rates for students from Guatemalan and Honduran descent are quite high: 28.7% and 19.5%, respectively (McFarland et al., 2018). Likewise, students of Asian descent generally have lower than mean dropout rates with the exception of Nepalese and Burmese descent: 19.6% and 27.5%, respectively. When data include high school completed by alternative means (e.g., general education diploma [GED]), graduation rates increase for most groups (i.e., White 94%, Black 92%, Hispanic 87%, Asian 99%, Pacific Islander 94%, American Indian/Alaska Native 79%, two or more races 97%; male 92% and female 93%). These data are lower for students with disabilities even when including alternative graduation status (with disability 84%, without disability 93%). For students receiving services for emotional disturbance (ED) under IDEIA, the dropout rate (i.e., no less than 35% from 2005 to 2015) is higher than in any other disability category, including those with intellectual disabilities (U.S. Department
of Education [USDOE], Office of Special Education and Rehabilitative Services, & Office of Special Education Programs, 2018). Across the data, individuals with disabilities, especially ED, males, low income, native-born, American Indian/Alaska Native, and some subgroups within broad race/ethnicity groups appear to be most vulnerable. Therefore, they are likely to need and benefit from social–emotional and counseling supports. Given the unique life circumstances of these individuals, cultural considerations also are warranted in delivering services. Chapter 3, Cognitive Behavioral Therapy Essential Components, to Chapter 5, Exposure and Response Prevention and Cognitive Behavioral Therapy, offer additional information of cultural awareness and competencies for delivering counseling.

Lastly, mental health issues among youth are a global problem that extends well beyond the boundaries of the United States. 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). Of those in need of mental health services worldwide, less than half receive services (Patton et al., 2012), illustrating the significant need. The provision of high-quality and targeted counseling interventions can assist students experiencing these difficulties 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 on addressing the unmet emotional, behavioral, and adjustment needs of youth. Research indicates that the majority of youth (i.e., 70%–80%) who do receive mental health services access these services through their local school districts (Bains & Diallo, 2016; Dowdy et al., 2015). Based on these data, the American Academy of Pediatrics (n.d.) has advocated for the provision of more school-based mental health services, noting the benefits of better access to assessment/evaluation or intervention compliance. As part of their initiatives, they endorsed the Mental Health in Schools Act of 2015 (H.R. 1211), which calls for increased funding and health student programs in schools to promote student well-being. 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 may demonstrate vulnerabilities that warrant considerations for early school-based intervention services (Bains & Diallo, 2016; Dowdy et al., 2015).

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. Examples may include 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 the
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 students with these symptoms are most likely to require more intensive or therapeutic counseling interventions. However, it is important to note that the CBT techniques expressed throughout this book also can be applied to a wide range of adjustment, behavioral, and social–emotional needs for youth even if a formal diagnosis is not indicated. A wealth of research over the past few decades indicates that very specific components of CBT are well suited and effective for treating many specific disorders and thinking distortions; however, the same CBT components are not equally effective for each type of diagnosis. For example, exposure and response prevention (E/RP, see Chapter 5, Exposure and Response Prevention and Cognitive Behavioral Therapy), 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 (OCD) 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. Being aware of specific symptoms of these disorders can assist in planning CBT sessions to focus on the correct targeted skills and avoiding wasted time and counterproductive methods (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 Figure 1.1, which provides a review of the DSM-5 (APA, 2013). Therefore, it is important for school-based counselors to consult the DSM-5 when they are seeking to better understand the students they work with who have mental health diagnoses. The DSM-5 also can offer insight for conceptualization of intervention plans, alert practitioners to common co-occurring symptoms, and offer insights on gender, race/ethnicity, socioeconomic status (SES), and cultural considerations (Joyce-Beaulieu & Sulkowski, 2016).

Elementary behavior specialists, social workers, counselors, and school psychologists are likely to receive the initial teacher referrals for disorders. Depending on the developmental course of specific syndromes, the age of onset varies and thus may be initiated at different points in a child’s educational experience. Therefore,
<table>
<thead>
<tr>
<th>DSM-5 Disorders—Prevalence Rate and Typical Age of Onset</th>
<th>Percentage</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD (Attention Deficit Hyperactivity Disorder)</td>
<td>5.0-20</td>
<td>2</td>
<td>M, F</td>
</tr>
<tr>
<td>Anorexia Nervosa</td>
<td>0.4</td>
<td>3</td>
<td>F</td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>0.2-3.1</td>
<td>4</td>
<td>M, F</td>
</tr>
<tr>
<td>Autism Spectrum</td>
<td>1.0</td>
<td>5</td>
<td>M, F</td>
</tr>
<tr>
<td>Avoidant Personality</td>
<td>2.4</td>
<td>6</td>
<td>M, F</td>
</tr>
<tr>
<td>Bipolar I</td>
<td>0.6</td>
<td>7</td>
<td>M, F</td>
</tr>
<tr>
<td>Bipolar II</td>
<td>0.3</td>
<td>8</td>
<td>M, F</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>1.6-5.5</td>
<td>9</td>
<td>M, F</td>
</tr>
<tr>
<td>Bulimia Nervosa</td>
<td>1.0-1.5</td>
<td>10</td>
<td>M, F</td>
</tr>
<tr>
<td>Conduct</td>
<td>2.0-10</td>
<td>11</td>
<td>M, F</td>
</tr>
<tr>
<td>Cyclothymic</td>
<td>0.4-1.0</td>
<td>12</td>
<td>M, F</td>
</tr>
<tr>
<td>Disruptive Mood Dysregulation</td>
<td>2.0-5.0</td>
<td>13</td>
<td>M, F</td>
</tr>
<tr>
<td>Excoriation (skin picking)</td>
<td>1.4</td>
<td>14</td>
<td>M, F</td>
</tr>
<tr>
<td>Histrionic Personality</td>
<td>0.9</td>
<td>15</td>
<td>M, F</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>0.9</td>
<td>16</td>
<td>M, F</td>
</tr>
<tr>
<td>Hoarding</td>
<td>2.0</td>
<td>17</td>
<td>M, F</td>
</tr>
<tr>
<td>Intermittent Explosive</td>
<td>2.7</td>
<td>18</td>
<td>M, F</td>
</tr>
<tr>
<td>Major Depressive Personality</td>
<td>7.0</td>
<td>19</td>
<td>M, F</td>
</tr>
<tr>
<td>Narcissistic Personality</td>
<td>≤6.2</td>
<td>20</td>
<td>M, F</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Prevalence Rate</th>
<th>Typical Age of Initial Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive-Compulsive Personality</td>
<td>1.2</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Obsessive-Compulsive Personality</td>
<td>2.1–7.9</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Oppositional Defiant</td>
<td>1.0–11.0</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Panic</td>
<td>2.0–3.0</td>
<td>&gt; F</td>
</tr>
<tr>
<td>Paranoid Personality</td>
<td>2.3–4.4</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Persistent Depressive</td>
<td>0.5</td>
<td>?</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>8.7</td>
<td>?</td>
</tr>
<tr>
<td>Reactive Attachment</td>
<td>?</td>
<td>?</td>
</tr>
<tr>
<td>Schizoid Personality</td>
<td>3.1–4.9</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0.3–0.7</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Schizotypal Personality</td>
<td>4.6</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Selective Mutism</td>
<td>0.03–1.0</td>
<td>M = F</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>1.6–4.0</td>
<td>M = F</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>7.0</td>
<td>&gt; F</td>
</tr>
<tr>
<td>Somatic Symptom</td>
<td>5.0–7.0</td>
<td>&gt; F</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>5.0–16</td>
<td>&gt; F</td>
</tr>
<tr>
<td>Tourette's</td>
<td>3.0–8.0</td>
<td>&gt; M</td>
</tr>
<tr>
<td>Trichotillomania (hairpulling)</td>
<td>1.0–2.0</td>
<td>&gt; F</td>
</tr>
</tbody>
</table>

**Figure 1.1** Common DSM-5 psychiatric disorders with prevalence rate and typical age of initial diagnosis.

*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 shading indicates pre-K to 12th grade; dark shading denotes college age. ADHD, attention deficit hyperactivity disorder; DSM-5, Diagnostic and Statistical Manual of Mental Disorders, 5th edition; F, female; M, male; ?, unknown based on DSM-5.
practitioners who are in elementary schools may encounter significantly different child needs from those who are primarily serving students in secondary education settings (see Table 1.1). With appropriate intervention, some emotional stressors and diagnoses seem to resolve within a prescribed time frame (e.g., reactive attachment disorder, typical school adjustment), whereas others are more episodic based on stressors and temporal factors (e.g., adjustment disorders, major depressive disorder) that can recur 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, and schizophrenia). They may require more sustained school and even community services throughout the youth's 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 and high school: excoriation (skin-picking) disorder, social anxiety disorder, and trichotillomania (compulsive hair-pulling disorder)
- 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, as noted in Table 1.1, 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, OCD, oppositional defiant disorder (ODD), panic disorder, persistent depressive mood disorder, posttraumatic stress disorder (PTSD), schizoid personality disorder, schizophrenia, schizotypal personality disorder, and somatic symptom disorder. As the onset of these disorders spans across different academic years, practitioners serving children of all ages will likely need counseling skills to help students who are affected by these disorders.

Specific mental health supports and transition services are often needed to help students with disorders that present during adolescence and young adulthood. 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
### TABLE 1.1 Behavior Modification Strategies

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description and Goals</th>
<th>Key Points for Implementation</th>
</tr>
</thead>
</table>
| 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, and so on, 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 the number of persons in counseling activities, until she or he is more comfortable with others, and then move to a 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.  
■ 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 or him; if she or he forgets, walk back to cafeteria and rehearse. |
| Contingency contract | 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. |

(continued)
<table>
<thead>
<tr>
<th>Technique</th>
<th>Description and Goals</th>
<th>Key Points for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Token reinforcement</strong></td>
<td>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.</td>
<td>■ Identify and define problematic behaviors as well as appropriate replacement behaviors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Identify tokens, feasible reinforcers, and a schedule of reinforcement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Provide reinforcers when desired behavior occurs. Implement a response cost when inappropriate behaviors are exhibited.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ For example, a child earns tokens toward a reinforcer for work completed; not turning in assignments could result in token reduction.</td>
</tr>
<tr>
<td><strong>Replacement behavior training</strong></td>
<td>Replacement behavior training is used to teach new behaviors and skills that can be used in place of problematic behaviors.</td>
<td>■ Identify and define the problematic behavior.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Identify and teach the individual replacement behaviors. This may require modeling and opportunities for student practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Implement schedule of reinforcement for replacement behaviors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ For example, each time a student prone to impulsive anger says “excuse me” or uses an “I” statement, offer points toward earning a reinforcer.</td>
</tr>
<tr>
<td><strong>Interdependent group-oriented contingency management</strong></td>
<td>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.</td>
<td>■ Divide the class into groups or teams.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Model appropriate behaviors and instruct students to role-play behavior.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Identify a group reinforcer (e.g., points, reward).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Post a visual representation of points earned or lost.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Reinforce the winning team at predetermined intervals.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ For example, groups caught displaying good social skills earn points (e.g., helping others, quiet group projects, saying “thank you”).</td>
</tr>
<tr>
<td><strong>Precorrection and prompting</strong></td>
<td>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.</td>
<td>■ Identify the context in which problem behaviors typically occur and clarify behavioral expectations for that setting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Define/model expected behaviors, have student role-play behavior.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Provide reinforcement for appropriate behaviors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Provide cuing and prompting as needed for appropriate behaviors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ For example, prompting a withdrawn student to join a group or cuing the student on introductory comments (e.g., “Say hello to Juan”).</td>
</tr>
<tr>
<td><strong>Differential reinforcement of alternative or incompatible behavior</strong></td>
<td>The purpose of this technique is to weaken maladaptive behaviors by simultaneously strengthening an incompatible or competing response.</td>
<td>■ Identify and define the problematic behavior.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Identify a competing behavior (i.e., one that will be incompatible with the problem behavior).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Reinforce occurrences of the competing behavior while ignoring or redirecting the student when the problematic behavior occurs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ For example, when targeting classroom running, reward in-seat behavior or walking behaviors.</td>
</tr>
</tbody>
</table>
and college, as 82% of high schools offer dual enrollment, according to the National Center of Education Statistics (NCES) report (Marken, Gray, & Lewis, 2013). The number of students in adolescence receiving instruction in college settings for at least part of the day is on the rise (National Research Center for Career and Technical Education, 2010; USDOE, 2011). Students utilizing dual enrollment are typically in ninth grade or higher (although some states, such as Arizona, have no age limit). Therefore, counseling for high-school students may occur within the postsecondary institution in which they are dual enrolled.

### COUNSELING WITHIN MTSS IN SCHOOLS

Although a wide range of mental health high-quality services are available through community agencies and private practitioners, a review of the status of national mental healthcare for youth indicates that those services are most often accessed in a fragmented and noncomprehensive manner. This has often resulted in low service effectiveness, especially for more chronic or severe mental health problems (USDHHS, 2000). Response to intervention (RtI) and MTSS are models of school-based service delivery that have evolved over the past few 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 (Cook et al., 2015; Sulkowski & Michael, 2014; Sulkowski, Wingfield, Jones, & Coulter, 2011). When mental health services are well integrated into a systematic model, academic outcomes improve, behavioral referrals

#### TABLE 1.1 Behavior Modification Strategies (continued)

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description and Goals</th>
<th>Key Points for Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-monitoring</td>
<td>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.</td>
<td>■ Identify target behavior to be monitored.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Set intervention goals as well as time frame for goal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Provide child with a cuing graphic, list, or behavior chart.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Define and describe steps for self-monitoring the behavior and model them for the student.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ 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.</td>
</tr>
<tr>
<td>Self-reinforcement</td>
<td>This technique is used to encourage students to reinforce their own appropriate behaviors with either tangible or intangible rewards.</td>
<td>■ Identify an appropriate reinforcer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Determine contingencies for earning the reinforcer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Describe and model steps for earning and accessing the reinforcer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ For example, student can self-initiate a 2-minute Internet surfing break after 30 minutes of work completion in the library.</td>
</tr>
</tbody>
</table>

decrease (Hussey & Guo, 2003), and there are reduced disparities for students who receive services (Cummings et al., 2010).

The overarching RtI/MTSS frameworks incorporate a multitiered approach to service delivery to help students at varied levels of need (Elliott & Morrison, 2008; Kurns & Tilly, 2008). 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. Examples may include prosocial social–emotional learning curricula embedded within the classroom instruction and positive behavioral intervention and supports (PBIS) framework for structuring school environments for all students. Tier I services 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. They often are provided once or twice a week for 6- to 12-week periods and can be delivered in group settings. Tier II interventions tend to address more common student needs and may include elements of CBT as needed (e.g., relaxation training, identifying negative emotional states, understanding cognitive triad), although other methods may be employed as well. Examples of tier II counseling interventions might include friendship groups, social skills training groups, self-esteem building exercises, problem-solving skills, test anxiety, or conflict resolution strategies. Within a typical school setting, there is generally a continued and revolving need for tier II counseling groups, especially around key student transitions (e.g., adapting to a new school, bereavement or loss, coping with teen relationship stressors). When students respond well to the intervention, a problem-solving team may decide to discontinue. 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 (tier III) often supports 1% to 5% of the student population. Examples might include a semester or more of CBT therapy sessions, meeting 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 also may include other behavioral interventions in addition to counseling (e.g., mentoring, daily behavior report cards, positive reinforcement plans to increase generalization of new behaviors taught in counseling sessions). For students with needs that require sustained intervention, special education eligibility may be considered with a classification of ED. Once identified, individuals receiving ED services may continue to require a structured counseling regimen for multiple years as well as 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 counseling or enhance multifaceted interventions is noted in Table 1.1.

**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: naturally occurring school performance data, observational data, knowledge/skills testing, daily behavioral report cards, behavior rating scales, subjective units of distress (SUDs) data, and the DSM-5 cross-cutting symptomology measures.

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 Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 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 pre- and postintervention 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 the counseling sessions. These data provide 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, measuring a child’s feelings of sadness across several sessions and establishing a period of time that their mood improves and stabilizes can indicate effectiveness and perhaps a good rationale for closing the intervention, whereas a couple of session of not feeling sad 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 counseling 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 also 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 an adolescent’s knowledge of new relaxation techniques and problem-solving strategies as well as obtaining his or her self-rated feelings of anger.

Additionally, interviewing the student directly can provide qualitative information on state-of-mood, attitudes, and perceptions, which will be important to informing therapy sessions. For students who are reticent to share their thoughts verbally, therapists may find sentence completion exercises or if/then questionnaires helpful (see Appendix Exhibits 1.1–1.3 for examples). These data coupled with observations of her or his use of the relaxation techniques in a natural setting (e.g., in class when frustrated, during competitive physical education activities)
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.

Naturally Occurring School Data

A number of readily available sources of behavioral data can be easily accessed by school-based mental health practitioners. These sources do not require extra data collection effort or time for counselors and thus are highly efficient. Often, these data are directly related to the counseling referral concerns and the preferred outcomes that are desired after intervention. As an example, for students with externalizing or acting-out behavioral problems, important and relevant school data to track include office discipline referrals (ODRs), in-school suspensions (ISSs), and incidents of out-of-school suspensions (OSSs). 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, do not participate in class, have low work completion, and have difficulty meeting deadlines for projects, monitoring work completion and grades related to assignments can provide a direct measure of whether counseling to address academic motivation is being effective.

For students with social anxiety who may avoid performance assignments (e.g., oral presentation, group projects) and also may exhibit high rates of absenteeism, attendance data, number of days tardy, and completion of key assignments requiring public evaluation are easily accessible data sources that can help with measuring the efficacy of intervention. As another example, for anxious students with high numbers of unjustified nurse visits and unnecessary requests to go home for somatic complaints (e.g., headaches, stomach pains), their nurse visit data can be tracked across the counseling intervention sessions to show improvements. Nurse visits are logged daily and thus are easy-to-access and naturally occurring data within school systems.

Figure 1.2 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. Weeks 1 to 3 are baseline data, and weeks 4 to 12 represent data during counseling. The counseling sessions aimed to address impulse control difficulties in
a student that resulted in numerous altercations with classmate, 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 was taught to help the student communicate his needs better in a nonconfrontational 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 delivered two times a week (30 minutes per session) for 9 weeks, totaling 18 sessions. Additionally, avoidance issues related to school attendance were addressed. Data indicate the student’s ODR and ISS incidents steadily diminished to zero incidents and stabilized there for several weeks, so counseling appears to have had a positive effect, at least on part of the goals for better self-regulation. However, absences were only modestly improved during the intervention time frame; thus, additional interventions to address attendance were warranted.

Observational Data

School-based mental health professionals are highly familiar with observational data, as these data are 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 post-intervention 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, and establishing peer comparisons.

An example of observational data is noted in Figure 1.3 for an anxious student with a history of maladaptive test behaviors that included significant nail biting, loud finger tapping, and episodes of staring off. These behaviors were interfering with her test performance specifically in math, a class she struggled in academically as she was preoccupied with worry and not finishing quizzes in the allotted time. Therefore, a goal of counseling was to challenge her 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 her more appropriate replacement strategies that she could employ when she was anxious (e.g., four-square breathing relaxation technique, positive self-affirmations). Observations were taken each Friday using time sampling method for 20 minutes with 30-second intervals during the weekly math quiz. The first 2 weeks’ baseline data were collected. Weeks 3 to 8 counseling intervention was implemented twice weekly with 20-minute sessions (total of 12 counseling sessions). Results of this case study indicate that the student improved because she displayed fewer maladaptive behaviors related to her test anxiety. Additionally, teacher data on number of test items completed also indicated improvement. By the 9th week, she was completing all quiz items. Although, not all items were always correct, the interference from math test anxiety behaviors was important to her success. The discrete math skill components continued to be addressed in tier II math intervention. A technique for measuring how well she is applying replacement strategies taught in counseling (e.g., breathing technique) could also be acquired through observing her use of the new strategies during quizzes.

Figure 1.3  Observational data progress-monitoring sample; frequency of maladaptive behaviors during math quizzes.

Maria’s Math Test Anxious Behaviors

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Week 5</th>
<th>Week 6</th>
<th>Week 7</th>
<th>Week 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Weeks 1–2</td>
<td>Counseling Intervention Weeks 3–8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Staring**
- **Nail Biting**
- **Tapping**

---

This is a sample from **COGNITIVE BEHAVIORAL THERAPY IN K-12 SCHOOL SETTINGS**
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 needs 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 her or him 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 1.4 illustrates pre- and posttest progress-monitoring data for a small-group application of CBT addressing social skills. In general, the goal of the CBT sessions was to provide support for four third-grade students from different classrooms who had similar needs. Teacher referrals indicated that the students were socially withdrawn and awkward in interacting with others, and they had been observed to voice maladaptive and self-deprecating statements when they were encouraged to contribute to group projects. These negative statements sometimes also caused others to avoid playing or working with them. Examples of statements were as follows: “Nobody ever likes me” (overgeneralizing), “They won’t like my drawing on the group poster” (fortune-telling), and “I’m just stupid” (labeling). Counseling sessions addressed several of the cognitive distortions displayed by the students.

![Social Skills Positive Affirmation Skill Acquisition Graph]

**Figure 1.4** Knowledge acquisition progress-monitoring sample.
students by teaching the students to identify and employ more adaptive positive self-affirmations as replacement thoughts and also building prosocial skills in interacting with others (e.g., joining a group, reciprocity in sharing ideas).

One 20-minute group counseling session was provided per week for 6 weeks. Over the 6 weeks, each student had to create five positive replacement thoughts he or she could use in difficult situations and memorize the affirmations. These were acquired one per week, and they were given practice scenarios in sessions to build fluency. The affirmations they came up with and began to apply to replace their cognitive distortions included “Some people like me,” “The group poster might be hard but I can try my best,” “I am good at ____, so maybe I’ll be good at this too,” and “Sometimes I may feel stupid but everyone does. I actually do good at school sometimes.” As one can see, all of the replacement self-affirmations are more adaptive, objective, and rational than the cognitive distortions were. Additionally, these statements are not overly Pollyannaish or unreasonably or illogically optimistic. One of the goals in CBT is to be realistic and adaptive but not to be dismissive of real stressors students may encounter. Instead, the positive replacement statements provide relief by reducing students’ use of negative thoughts as opposed to artificially inflating their use of positive ones.

In the example provided in Figure 1.4, Tamika, Brittany, and Aarav memorized and demonstrated fluency in applying five different positive replacement affirmations when presented a variety of social scenarios, by the 6th week. Although their progress was different, they each reached the goal. Verification by the teachers that the children also were hearing using healthier responses in the classroom and were improving both the number and quality of interactions with others also supported invention effectiveness. Adding classroom observations would also strengthen confirmation that the skills were being applied. As noted in the graph, Nathan made little progress and stagnated at week 4. Thus, a rationale could be made for continuing and individualizing intervention for him.

Daily Behavioral Report Cards

Daily behavioral report cards are often utilized as a behavioral modification strategy, and they involve identifying 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. Rewards should be 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, as goal lines are often moved up over time. 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 given 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 throwing away a paper if he felt he made a mistake. Counseling targeted challenging an all-or-nothing (e.g., “I can’t turn it in if it is not just right”) 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 completion of class assignments. As reflected in the daily behavior report card data, the goal was graduated over time. It was first set at completing four tasks per day (e.g., worksheets, assignments, art activity) and then moved up one point each week after the 2nd week of the plan. The teacher also initially provided prompting, cueing, and positive praise for attempts at work, even if the answer was incorrect during the 1st week of intervention. Counseling was provided twice weekly for 4 weeks, and results showed notable improvement by the 3rd week.

**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 5, Exposure and Response Prevention and Cognitive Behavioral Therapy; 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., 1–100, 1–10). For
younger children, it may be helpful to use a smaller number of points and to pro-
vide 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 descrip-
tors. 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 Exhibits 1.4 and 1.5).

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 (particu-
larly when E/RP is occurring). Figure 1.6 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 measure-
ment 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
(e.g., in crowded hallways). This fear resulted in her 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 her 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, her initial level of anxiety was

![Sutton's SUDs Rating](image)

Figure 1.6 Subjective units of distress (SUDs) data progress-monitoring sample;
exposures to crowded situations at school.
a 90/100 SUDs during the first exposure trial. However, this decreased throughout the 30-minute exposure. In subsequent trials, her anxiety started to drop lower than the previous trial start point. 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 experiencing anxiety problems. During trials 4 and 5, the student reported below-50 initial distress via her SUDs ratings. Overall, these data indicate the student was 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.

**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:

- Omnibus measures sample psychopathology across a number of internalizing and externalizing domains and allows comparison to a nationally representative sample of children. The Behavior Assessment System for Children, Third Edition (BASC-3) is one example of an omnibus measure that has multiple mental health scales (e.g., anxiety, depression, withdrawal, somatization, social skills, aggression, attention; Reynolds & Kamphaus, 2015). 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 over time for 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 also has emerged to provide quick options for tier I screening in RtI/MTSS models. These measures typically contain 10 to 30 items and offer a single T-score that can be compared to national norms for identifying emotionally at-risk students. The BASC-3 Behavioral and Emotional Screening System (BASC-3 BESS) and the Conners 3 Global Index (Conners 3 GI) are examples of rating screener measures (Kamphaus & Reynolds, 2015; 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 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 programs that create intervention progress-monitoring graphs. Examples include the BASC-3 Flex Monitor forms. The instrument also offers the option of selecting items from a pool of 600 questions to customize the ratings (Reynolds & Kamphaus, 2016). Additional examples include the Conners 3 ADHD Index (Conners 3 AI), the Children's Depression Inventory–Second Edition, Short Form
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 these scales must be made with caution, as they lack norm-referenced comparison information. Figure 1.7 provides an example of a therapist-created Likert survey with specific questions based on targeted counseling goals and teacher-reported referral needs.

### DSM-5 Cross-Cutting Symptomology Measures

For the first time, the DSM-5 manual offered 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/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 11–17) 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 6–17), and child self-report (i.e., ages 11–17) symptom domain-specific measures (e.g., depression, anger, mania, anxiety).

Disorder-specific severity 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 are based on the World Health Organization Disability Assessment Schedule 2.0 (Üstün, Kostanjsek, Chatterji, & Rehm, 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 are provided for adult (i.e., age 18 and older), child (i.e., ages 11–17), and parent report (i.e., ages 6–17). 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 in Chapter 7, Case Studies.

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 (Silverman et al., 2008). CBT has a long history of empirical support among clinical service providers for helping students with a wide range of needs, including ADHD, autism spectrum disorder, anxiety, bullying, OCD, depression, PTSD, panic attacks, and phobias (Abdulkader, 2017; Albano & Kendall, 2002; Bella-Awusah, Ani, Ajuwon, & Omigbodun, 2016; Kendall, 2006; Luxford, Hadwin, & Kovshoff, 2017; Rones & Hoagwood, 2000; Salloum, Sulkowski, Sirrine, & Storch, 2009). In fact, some researchers have found that CBT has more enduring results than medication for moderate and mild needs, and coupling CBT with medication can extend positive effects over medication alone for anxiety and depression (Carpenter et al., 2018; Cuijpers et al., 2014).

CBT also has been successfully adapted to provision of services within school settings for a wide range of disorders, including depression, anxiety, ODD, PTSD, and OCD (Creed, Reisweber, & Beck, 2012; Masia-Warner, Fisher, Shrout, Rathor, & Klein, 2007; Ruocco, Gordon, & McLean, 2016). 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). Studies support both individual and small-group counseling delivery; however,
results may vary by specific counseling needs (Eiraldi et al., 2016; Zaboski et al., 2019). 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, and personal engagement and commitment to school success (Foster et al., 2005).

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 2–7 years old) tend to function primarily from an egocentric view. Thus, it is unlikely that they will have great insight into their own thinking patterns or insight into others’ perspectives during social interactions. Concrete operational age children (i.e., ages 7–11) 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 (Child Welfare Information Gateway, 2018; Silverman et al., 2008). 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.

REFERENCES


INTRODUCTION

Cognitive behavioral theory (CBT) proposes that thoughts, feelings, and behaviors are interconnected, which allows for different points of intervention. One common evidence-based behavioral intervention approach is called behavioral exposure, exposure therapy, exposure with response prevention (ERP), or exposure with ritual prevention. Collectively, these terms often are used synonymously in the CBT literature. Over a century of clinical trials supports the efficacy of this behavioral approach with a range of psychiatric and behavioral conditions (American Psychological Association, 2016; Anxiety and Depression Association of America, 2015; International OCD Foundation, n.d.). However, ERP is the first-line treatment for obsessive-compulsive disorder (OCD) and other obsessive-compulsive–related disorders (OCRDs) that have compulsive features such as rituals and avoidance (Jordan, Reid, Mariaskin, Augusto, & Sulkowski, 2012). For convenience, exposure therapy is used as an encompassing term unless noted otherwise in this chapter.

EXPOSURE AND RESPONSE PREVENTION THERAPY

Exposure therapy involves repeatedly exposing a person to a feared stimulus, situation, thought, image, or emotional experience that he or she typically would avoid, tolerate with significant or impairing distress, or engage in ritualistic behaviors to neutralize the distress experienced. Next, the person is encouraged not to engage in any avoidant or distress-reducing rituals in order to get used to his or her feelings. This process is called habituation, and it is not unique to humans. Squirrels in the wild are afraid of humans (a perceived threat), yet squirrels in a city park may even approach humans to beg for food—they have habituated to the presence of humans and no longer fear them (see Appendix Exhibits 5.1 and 5.2 for counselor checklist and parent information handouts).

As an example of conducting a behavioral exposure with a student, a student with contamination-related OCD might be encouraged to touch a dirty doorknob and then refrain from washing his or her hands, applying hand sanitizer, or using an
avoidance-related safety object (opening the door with a paper towel). After touching the doorknob, the student should be encouraged to simply wait for his or her distress to decrease naturally or for the person to habituate to the contamination feeling.

The process of habituation breaks two associations that result in individuals engaging in compulsive rituals or avoidant behavior. First, the individuals learn that they do not need to fear or avoid a distressing stimulus or situation. Second, they learn that they can tolerate the stimulus or situation without engaging in compulsive or avoidant behaviors to make themselves feel better. Thus, the ultimate goal for exposure therapy is to teach the student to habituate to a range of stimuli and situations in a gradual and systematic manner and then generalize therapy to real-world situations as they occur outside the context of therapy. The student should learn to face his or her fears in a safe therapeutic environment with gradual success as a goal. Moreover, these students should feel like they stepped out of their comfort zone a little bit, experienced distress from doing so, habituated to whatever was causing the distress, and walked away feeling like they pushed their comfort zone edge and experienced success.

Although the exact processes behind the efficacy exposure therapy continue to be researched, through repeated exposures, adaptive learning and cognitive restructuring are thought to occur as clients extinguish their avoidance behaviors and challenge their cognitive distortions about their fears. Furthermore, this process is thought to have neurodevelopmental effects on the brain, leading to new neural connections that inhibit the old fear pathways contributing to anxiety (Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014). For instance, individuals with social anxiety disorder fear social situations (the feared stimulus), avoid social interactions (the avoidance behavior), and frequently worry about judgment or negative evaluation from others (a cognitive distortion). To address these functional limitations, clients would be exposed to situations in which they interact with others to reduce their avoidant behavior, thinking errors, and anxiety (Zaboski et al., 2019). Over time, they learn that their distorted thoughts about social interactions were not valid and that avoiding people and social situations was not necessary.

It is important to highlight how exposure therapy should be conducted in a gradual and systematic manner that elicits a moderate amount of distress. Pushing these students to do tasks that are too daunting or intense too soon could cause them to feel “flooded” with anxiety or distress, and they may fail to habituate. Instead, they may learn that the stimulus or situation should indeed be avoided or not tolerated. Conversely, however, not encouraging them to step out of their comfort zone also might not lead to habituation because the stimuli or situations they are being exposed to do not elicit enough distress. In other words, they can already tolerate these stimuli or situations, so therapy will have a null effect. With the previous points in mind as a guiding principle, the core components of exposure therapy are discussed next.

Starting Exposure Therapy

When starting exposure therapy, therapists should provide developmentally appropriate psychoeducation for clients about how this therapeutic approach can help. Because exposure therapy can be somewhat abstract and counterintuitive for children and adolescents, drawing a graph (Figure 5.1; see Appendix Exhibits 5.20 and 5.21) can help with elucidating this process. Figure 5.1 places anxiety severity on the...
y-axis and time on the x-axis, and it visually displays the habituation process through repeated exposures. It also lists the interaction of how reducing anxiety results in an increase in desired behavior, which, in this case, is public speaking (see Appendix Exhibits 5.3 and 5.4 for exposure therapy graph teaching sample and worksheet).

With exposure therapy, it can be hard to know if change is happening if it is not being assessed. Therefore, some type of scale should be used to get an approximation of how much anxiety or distress the student is experiencing during exposures. Typically, during the psychoeducational process, a 10-point scale of “subjective units of distress” (SUDs; Wolpe, 1969) is introduced and discussed. On this scale, 1 could be described as feeling perfectly peaceful or relaxed, and 10 could be described as panicking or even fearing for one’s life. The SUD scale will be used in therapy to help guide the therapeutic process and ensure habituation (see Appendix Exhibits 1.4 and 1.5 for examples for young children and Exhibits 5.5–5.7 for examples for adolescents).

Following the introduction of the SUD scale, students can be taught how their compulsive or avoidant behaviors are causing their problems to actually get worse over time and, essentially, how they have been a crutch that provides short-term help but if not cast away become a hindrance and result in long-term problems. This can be illustrated by describing how their avoidant behaviors only temporarily reduce distress by actually drawing this out on paper or a whiteboard. For example, a student could be asked how he or she would feel if he or she stuck his or her hand under the desk and touched a wad of gum. The student might say, “Ew, gross—that would be about 7 SUDs,” and then the therapist could draw the student’s anxiety raising to a 7 on a graph. The therapist could then say, “Well, what if you could go to the sink and wash your hands?” which might prompt the student to say, “I’d feel a lot better; my SUDs would drop to about a 3.” The therapist could then ask, “How would you feel if a student next to you sneezed on your book?” which might prompt the student to say, “Oh, that would be even worse! That would cause 9 SUDs!” Following this, the therapist could ask, “What if you had sanitizer at your
desk and cleaned the book,” to which the student might say, “It would still be kind of gross, but my SUDs probably would drop to about a 5.”

The main point of going through such a discussion with the student during psychoeducation is to illustrate the temporary relief that engaging in compulsive or avoidant behaviors provides and how such behaviors are incapable of providing lasting relief. Second, this process illustrates how performing such behaviors produces a roller-coaster type of function in that anxiety or distress spikes up when exposed to certain stimuli or situations but then drops precipitously through performing compulsive or avoidant behaviors, which prevents the student from habituating to the former. Therefore, instead of “riding the anxiety roller coaster,” the student can be encouraged to “surf the habituation wave.” Doing the latter involves smoothing out the peaks and valleys and instead experiencing habituation through being exposed to moderately distressful stimuli or situations and then “riding them out” by not engaging in compulsive or avoidant behaviors.

There are some other points to cover during psychoeducation that are particularly related to engaging in exposure therapy. The first is that exposure therapy is relatively simple to understand conceptually, but engaging in actual therapy will not always be easy. Therapy fundamentally involves facing one’s fears; however, this can and should be challenging sometimes. For optimal treatment outcomes, it is important to go all the way through the anxiety/fear hierarchy and do the most intense exposures (this is discussed in the following text).

Second, the therapist should reinforce the completion of homework or “between-session practice.” Just meeting with a therapist once a week is better than nothing—yet this is far from best practice. With the guidance of the therapist and the recruitment of others (e.g., parents, teachers, other adults at school, occasionally older siblings), the student should be encouraged to practice exposures at home, school, and in the community to help replicate what was done in therapy and help these gains generalize more broadly.

Third, the therapist should reinforce the point that the overall goal is for the student to experience success with facing fears and to feel like he or she stands a little taller from engaging in exposures. Additionally, the therapist should establish that the student would never be required to do anything that the therapist would be unwilling to do personally and that he or she is willing to go first to model the exposure. Of course, this can be anxiety provoking for the therapist, so it is important to model calmness when asked “to go first.”

Fourth, the therapist should emphasize that treatment is not completely linear. There will be ups and downs and good days and hard ones—but the overall trend is what is most important. This is why it is important to keep in-session logs and homework-related SUD rankings to illustrate tangible progress on a rough day. Fifth, it is important for the therapist to probe the student’s understanding of the information provided during psychoeducation. This can be done by having the student describe what treatment involves, how he or she could benefit from it, what SUDs are, or any of the other exposure therapy components in his or her own words. Lastly, students should have the opportunity to ask any questions that they have about exposure therapy or anything else related to treatment.

**Functional Assessment**

Following psychoeducation, therapists using exposure therapy should conduct a thorough evaluation to understand the nature of the student’s distress. This
functional assessment (Abramowitz, Deacon, & Whiteside, 2012) considers external antecedents/triggers (e.g., teachers, classrooms, academic subject, specific peers) and triggering thoughts (e.g., “This presentation in front of my class is going to be horrible!”, “If I touch this doorknob, I’ll get sick and die.”). Next, consider the consequences of the anxious thought coming true (If I mess up, I’ll be humiliated forever) and other cognitive effects of the anxiety (such as intolerance of uncertainty, fear of panic attacks, thought distortions, and overestimates of feared events coming true). Lastly, functional assessment involves understanding the behaviors used to decrease the anxiety that these thoughts cause; for instance, avoidance (skipping class, refusing to complete assignments, school refusal), overt compulsive behavior (perfectionism, repeatedly asking for reassurance from others, excessive studying/practicing, nail biting), and mental rituals (e.g., repeatedly telling oneself that “it will be okay,” avoiding thoughts about anxiety-provoking situations).

During this process, therapists should also assess for behavioral accommodation. Accommodation refers to efforts from other people (family, teachers, friends) to decrease a person’s distress or anxiety (Storch et al., 2015). Note that accommodation in this sense does not refer to reasonable academic or behavioral accommodations given to students for disabilities. Rather, accommodation in the context of anxiety disorders relates to positive or negative reinforcement of anxiety-related symptoms. This may include a parent who allows a child to skip a day of school to avoid a public speaking assignment, a friend who supplies hand sanitizer to a person with contamination fears, or a teacher who allows a socially anxious student to sit outside the classroom during instruction. As in these examples, inappropriate accommodations may inadvertently serve to enable or maintain maladaptive behaviors. When teachers or parents engage in accommodation of maladaptive behaviors with children, it can be important to also provide consultation to the teachers and psychoeducation for the parents to simultaneously change these enabling influences. Keep in mind that accommodations are not typically malicious; in fact, they tend to reflect a genuine concern and motivation to improve a situation for someone with anxiety. Nevertheless, accommodations often need to be removed or modified throughout treatment, requiring ample consultation and psychoeducation for clients, parents, guardians, and school-based personnel about the mechanisms that maintain anxiety. Essentially, accommodations work like compulsive rituals or avoidant behaviors in that they prevent habituation from occurring.

**Types of Exposures**

There are many ways to structure exposure therapy sessions. As briefly mentioned above, flooding involves prolonged exposure to the most anxiety-provoking stimuli first (Abramowitz, 1996), while a systematic approach utilizes a gradual introduction to feared stimuli (Abramowitz et al., 2012). Although flooding techniques are effective in the hands of veteran exposure therapists, particularly for specific phobias (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008), a more gradual approach to exposure therapy is generally warranted. Because compulsions and avoidance behaviors strengthen anxiety, starting with easier exposures helps clients fully learn to resist compulsive/avoidance urges when faced with an anxiety-provoking situation. Relatedly, beginning with challenging exposures may interfere with habituation to anxiety or distress if clients have not yet developed the skill to resist their compulsive or avoidant behaviors (Blakey & Abramowitz, 2016).
In addition to systematic/flooding techniques, therapists can also choose from imaginal and in vivo (taking place in person) exposures. Clinicians conduct in vivo exposures in natural settings and imaginal exposures in a client’s mind. One popular type of imaginal exposure is the Worry Script. Worry Scripts are short (usually two to three paragraphs), hypothetical stories that involve a worst-case scenario related to one’s fear coming true (Robichaud, 2013). To identify a client’s core fear, the downward arrow technique may help (see Appendix Exhibit 5.8 for the Downward Arrow Technique worksheet; additional exposure therapy worksheets may be accessed at cbt4panic.org/imaginal-exposure-example-script). With this technique, a therapist repeatedly asks what would happen next until a client cannot respond any further. For example, a conversation might progress like this:

**Therapist:** What would happen if you entered the lunchroom?
**Client:** I would get anxious.
**Therapist:** So you walk into the lunchroom and get anxious. Then what?
**Client:** No one would let me sit with them.
**Therapist:** I can see why that would cause you anxiety. What would happen next?
**Client:** Other kids would stare at me.
**Therapist:** Then what?
**Client:** Everyone would get super quiet.
**Therapist:** Wow, how would you handle that awkwardness?
**Client:** I’d just run out of there!
**Therapist:** Yeah, I can’t blame you for wanting to escape an uncomfortable situation. What would happen after that?
**Client:** I guess I would never have any friends.
**Therapist:** Then?
**Client:** I’d be alone.
**Therapist:** What would happen if you were alone?
**Client:** I . . . don’t really know. I’d be miserable I guess.

After using the downward arrow technique, the therapist might help the client write a script about entering the lunchroom, having nowhere to sit, receiving stares from her peers, experiencing an uncomfortable silence, running out of the lunchroom in tears, losing her friends, and being alone. Scripts should include as much detail as possible while conforming to the two to three paragraph rule. Worry scripts and other imaginal exposures are typically appropriate starting points for most hierarchies, serving as stepping stones for the in vivo or real-life challenges later in treatment (see Appendix Exhibit 5.9 for Worry Script Worksheet). Thus, under most circumstances, therapists are encouraged to progress from imaginal exposures to in vivo exposures as early as possible, as these tend to engender the biggest treatment changes (Craske et al., 2014).

**The Fear Hierarchy**

The fear hierarchy is a list of increasingly challenging exposures (imaginal and in vivo) that the client completes through treatment (see Appendix Exhibits 5.5–5.7 for fear hierarchy worksheets). The hierarchy is a living document to which items
will be added or modified as needed and involves continuous consultation with the client. Indeed, when creating the hierarchy, it should be emphasized that the students will not be required to complete any particularly daunting exposure tasks in the immediate future and they will not be requested to do any tasks before they are ready and have had success with easier ones. This approach provides modeling opportunities and strengthens rapport. Table 5.1 is a sample hierarchy for a socially anxious client who is afraid to enter the lunchroom and eat in front of others.

Several features of the hierarchy are worth discussing. First, hierarchy items should always be ethical, legal, and aligned with school codes of conduct (see Olatunji, Deacon, & Abramowitz, 2009). In addition, fear hierarchies should generally contain items that are commonly encountered in our lives and that do not lead to adverse consequences. Walking into a lunchroom, eating in front of others, and eating with peers all satisfy these requirements. Second, unless a client is prohibitively anxious about doing exposures that elicit SUDs ratings from 3 to 5, it is preferable not to start with exposures that are 1s and 2s because doing so increases the number of treatment sessions required with little benefit (remember that 1 is rated as a “totally peaceful” experience). Like other applications of CBT, exposure therapy should be time-limited, goal-directed, and efficient. This premise is especially true in school settings where counseling time duration may be limited to 30 minutes a session as compared to a typical 1-hour session in outpatient or clinic settings.

Third, many hierarchy items are similar yet have minor variations (e.g., run in and out of the lunchroom versus casually walk into the lunchroom). When designing a hierarchy, think about the knobs that can be turned on each exposure: duration, setting, number of people present, the activity completed (e.g., video games versus eating), or the intensity of the experience (e.g., confusedly wandering around to find a seat vs. sitting down immediately). Including small modifications to exposures allows the therapist to develop challenges that represent a variety of SUDs ratings, increasing the ease of gradually transitioning from one exposure to the next.

Fourth, all of the included hierarchy items contain two parts: the exposure stimulus (e.g., walking into the lunchroom, reading the worry script) and the response prevention (no avoidance/reassurance). In this case example, the student frequently engaged in safety behaviors, such as reassurance seeking, in which she would ask, “Am I going to be okay?” as well as avoidance, in which she would avoid the lunchroom altogether. Although the response prevention components in the sample hierarchy may seem redundant, we include them for each case we treat. While monitoring safety behaviors, clinicians already in the habit of documenting them will be accustomed to updating the hierarchy when new ones appear. Moreover, this practice allows for more effective communication between staff members and family assisting with exposures (e.g., teachers, parents), as they will understand which safety behaviors to look for. Hierarchies should be provided to clients during and at the conclusion of treatment, and it can be helpful for them to have a reminder of which safety behaviors they need to resist. Having complete documentation on the hierarchy also provides for smoother referrals to new service or intervention providers, who will not need to complete a fear hierarchy from scratch or guess at the anxiety-avoidance relationships.

Fifth, the hierarchy includes items that were rated past the 10-point SUDs scale (10+). These items are overlearning items and serve as exceptions to the rule that
<table>
<thead>
<tr>
<th>SUDs</th>
<th>Hierarchy Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Write a worry script about going into the lunchroom; no avoidance/reassurance</td>
</tr>
<tr>
<td>4</td>
<td>Read the worry script out loud to the therapist; no avoidance/reassurance</td>
</tr>
<tr>
<td>4</td>
<td>Read the worry script out loud to a family member; no avoidance/reassurance</td>
</tr>
<tr>
<td>4</td>
<td>Draw pictures of the lunchroom in color; no avoidance/reassurance</td>
</tr>
<tr>
<td>3</td>
<td>Draw pictures of the lunchroom with pencil (black and white); no avoidance/reassurance</td>
</tr>
<tr>
<td>4</td>
<td>Play video games outside the lunchroom; no avoidance/reassurance</td>
</tr>
<tr>
<td>7</td>
<td>Play video games inside the lunchroom for 5 min; no reassurance/avoidance</td>
</tr>
<tr>
<td>8</td>
<td>Play video games inside the lunchroom for 10 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>9</td>
<td>Play video games inside the lunchroom for 15 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>9</td>
<td>Complete schoolwork inside the lunchroom for 15 min; no reassurance/avoidance</td>
</tr>
<tr>
<td>5</td>
<td>Run in and out of the lunchroom when no one else is in there; no avoidance/reassurance</td>
</tr>
<tr>
<td>5</td>
<td>Walk casually into the lunchroom when no one else is in there; no avoidance/reassurance</td>
</tr>
<tr>
<td>6</td>
<td>Walk slowly into the lunchroom when no one else is in there; no avoidance/reassurance</td>
</tr>
<tr>
<td>8</td>
<td>Complete a relay race against the therapist in the lunchroom when no one else is there; no avoidance/reassurance</td>
</tr>
<tr>
<td>8</td>
<td>Play video games in the lunchroom when a few peers are present for 10 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>9</td>
<td>Play video games in the lunchroom when a few peers are present for 20 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>4</td>
<td>Eat a small snack outside the lunchroom; no avoidance/reassurance</td>
</tr>
<tr>
<td>4</td>
<td>Eat a larger snack outside the lunchroom; no avoidance/reassurance</td>
</tr>
<tr>
<td>7</td>
<td>Eat a small snack inside the lunchroom; no avoidance/reassurance</td>
</tr>
<tr>
<td>9</td>
<td>Eat a small lunch with preferred peers in the lunchroom; no avoidance/reassurance</td>
</tr>
<tr>
<td>7</td>
<td>Eat all your lunch in the lunchroom during lunchtime for 5 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>8</td>
<td>Eat all your lunch in the lunchroom during lunchtime for 10 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>8</td>
<td>Eat all your lunch in the lunchroom during lunchtime for 15 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>9</td>
<td>Eat all your lunch in the lunchroom during lunchtime for 20 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>9</td>
<td>Eat all your lunch in the lunchroom during lunchtime for 25 min; no avoidance/reassurance</td>
</tr>
<tr>
<td>10</td>
<td>Eat all your lunch in the lunchroom for all of lunchtime; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Walk into the lunchroom confidently, sit down with peers, and eat lunch; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Walk into the lunchroom and pause as you try to find a seat; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Walk into the lunchroom and start eating a snack while you try to find a seat; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Walk into the lunchroom and drop a pencil on the floor in front of others; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Walk into the lunchroom and loudly say “hi” to a peer who is sitting farther away; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Walk into the lunchroom and wave to peers who are sitting on the other side of the room; no avoidance/reassurance</td>
</tr>
<tr>
<td>10+</td>
<td>Sit in the lunchroom while eating your food and reading your worry script; no avoidance/reassurance</td>
</tr>
</tbody>
</table>

SUDs, subjective units of distress.
challenges should be experienced by most people in everyday life. The process of overlearning, or pushing the norm, is akin to studying a little more than needed. Just as on a test you may not know what a teacher might ask, you never know what might trigger anxiety. Keep in mind that although some of these 10+ items may seem extreme, they still represent real, albeit less common, experiences that people encounter. Without preparing clients for such experiences (e.g., going into a lunchroom and not being able to find a seat or tripping in front of others), the risk of relapse increases (Abramowitz et al., 2012).

Regarding the previous point, some guidelines on overlearning may be helpful. Because some items can seem so daunting to some children and adolescents, occasionally it may be beneficial to leave them out of the initial hierarchy building and propose them later after a stronger therapeutic alliance has been built and the client has succeeded with some easier exposures. As is the case with all hierarchy items, overlearning items should always be ethical and legal. For example, although having a student steal something from the school lunchroom would trigger his or her social anxiety, this is highly unethical, against school codes of conduct, and is therefore not an appropriate exposure. At the same time, some items can seem extreme, while being highly ethical and highly beneficial (e.g., rubbing a public entrance doorknob repeatedly and then touching one’s face for a child with contamination obsessions or an irrational fear of germs). When in doubt about an exposure, it is best to consult with a colleague, particularly other professionals trained in delivering exposure therapy. Moreover, as a general principle, it does not hurt to “start low and go slow” when working with new clients or students until it becomes clearer how they habituate. Lastly, the primary goal of exposure therapy is to challenge core fears and elicit anxiety and have the client habituate—not to embarrass or belittle him or her. In the aforementioned hierarchy example, the client was willing to challenge her anxiety by fake tripping in front of others, and her willingness to complete this exposure was a testament to her treatment progress. However, if she were unwilling to complete this challenge out of a reasonable fear of embarrassing herself in front of classmates, working with the client to modify this exposure would be possible so that the same therapeutic effect could be achieved without the immediate social consequences such as maybe fake tripping while walking down a street or in a grocery store. This would mitigate risks associated with having the client’s anxiety increase without habituation occurring or other unintended problems occurring such as being teased or harassed by peers.

Implementing Exposures

With consent and assent obtained from the child and parent(s), initial psychoeducation complete, and a draft of the hierarchy finished, behavioral exposures can commence. Throughout this process, recognize that facing one’s fears is challenging, and like other therapies, exposure therapy requires a strong therapeutic alliance, particularly in the beginning of treatment (Kendall et al., 2009). Using the fear hierarchy, the therapist and the student should collaborate on where to start, favoring a gradual and systematic approach. When a starting place is agreed on, three general elements constitute an effective approach to conducting exposure: It should be (a) gradual, (b) prolonged, and (c) repeated.

To illustrate these elements, it is helpful to return to the fear hierarchy that was previously discussed. One exposure task was playing video games outside the
lunchroom without avoidance/reassurance. Assuming that the fear hierarchy is followed, this exposure would satisfy (a), as it would follow the completion of several easier challenges. To complete a prolonged exposure (b), we might encourage our client to do this exposure for 10, 15, or 20 minutes without any reassurance/avoidance behaviors. To satisfy element (c), a therapist might assign 10 trials of 2-minute exposures in which the child plays video games outside the lunchroom. Additionally, repeatability also refers to repeated exposures between therapy sessions, in other words, electing to complete the exposure again during the next session or for homework.

Importantly, when clients are engaged in exposures, practitioners should look carefully for subtle safety behaviors and mental rituals. Safety behaviors could include subtle forms of avoidance such as being around a “safe person,” carrying a safety object (e.g., cell phone, toy, picture), or wearing special clothes. Mental rituals could be a special mantra that a client performs, a nonreligious/excessive prayer, or some other mental event that is compulsively performed to reduce distress or anxiety. During exposure-based therapy, the therapist should be attentive to the former and actively ask clients if they are doing anything to reduce their distress or anxiety when exposures are being attempted. Safety behaviors and mental rituals, like compulsive and avoidant behavior, effectively interfere with habituation and are counterproductive to therapy.

Additionally, while conducting behavioral exposures, therapists should never reassure anxious behaviors. Thus, when working with an anxious student, it would be contraindicated to tell a client that “Everything will be okay,” “Nothing bad will happen,” or “There is nothing to worry about.” This is not to say that therapists shouldn't be warm, empathetic, and genuine. However, the reality is that nobody knows what the future holds and providing false reassurance tends to just magnify doubts that the client may be having (e.g., “My therapist is just being nice like my teacher—how can he know that my parents will never get in a bad car accident?”). However, in contrast to providing reassurance, therapists should praise a client's effort: “You are doing a great job with this challenge,” “Your progress is excellent,” “I have a lot of respect for your courage right now.” Lastly, therapists should not accommodate anxious behaviors. If a child is part-way through an exposure and wants to quit, the therapist should encourage finishing the exposure trial or engaging in at least one more trial before taking a break or moving to something else temporarily. At the very least, to avoid reinforcing avoidant behavior, the exposure should be reintroduced during the course of treatment (preferably as soon as possible).

The pace of exposure therapy should be matched with the client's progress, measured by how quickly anxiety is decreasing, how quickly the client is moving through the fear hierarchy, and how effectively the client is learning that her or his distorted thoughts are illogical. Exposures may take time. One arbitrary determination of how long an exposure should last is when the SUD decreases by half. Another benchmark we discuss with children/adolescents is to do an exposure until it is extremely boring. Once the exposure has “become boring,” it is an indicator that the activity is no longer evoking fear or distress and the client has acclimated to the task. In any case, the fear hierarchy is not a checklist. Therapists should incorporate old exposures throughout treatment and blend items on the hierarchy.
Maximizing Exposure Effectiveness

In the early implementation of exposure-based treatments, habituation was emphasized. Again, habituation refers to a reduction of anxiety over time (either within a session or between sessions). The astute reader may have noticed that this chapter introduces a habituation-type explanation of how exposure works during psychoeducation (see Figure 5.1). Although this explanation is appealing to clients, and exposure therapists often use habituation as a guideline for treatment (e.g., SUDs decreasing), neither within- nor between-session habituation strongly predicts treatment outcomes (Baker et al., 2010). And though anxiety often decreases during exposures, the magnitude of that decrease is not predictive of overall improvement (Craske et al., 2008). At present, exposure is thought to operate through inhibitory learning (see Craske et al., 2014), in which exposures create new connections that inhibit the old fear connections. These connections are created through doing prolonged exposures that violate one's expectations. Thus, in this paradigm, expectancy violation is emphasized over decreases in anxiety.

Although habituation is a more concrete way of providing psychoeducation to clients, inhibitory learning theory should be applied in clinical practice to maximize therapy outcomes. This can be done in several ways. First, therapists can create expectancy violations by asking clients before they complete an exposure questions such as “What will happen if we do this exposure?” and “How likely from 0% to 100% is [the feared outcome] to occur?” Next, do the exposure until either (a) those expectations are violated or (b) a specific goal is achieved (e.g., I’ve introduced myself to 10 people). Following the exposure, assess whether the feared outcome happened and what was learned (e.g., “You introduced yourself to 10 people. What happened? Did anyone actually yell at you?”).

Another way to utilize inhibitory learning is through deep extinction trials, in which exposures are combined. For instance, in our sample hierarchy above, a deep extinction trial would involve reading a worry script while eating a full meal in the crowded lunchroom. Even though these exposures are more anxiety provoking, they are highly effective, combining multiple challenges to ensure that clients generalize their skills across stimuli and settings. One of the significant benefits of school-based counseling is the opportunity for generalization by applying these techniques across classrooms with multiple teachers and peer groups, in varied environments such as physical education or lunchtime, and across differing times of day. Therapists can also vary the stimulus intensity. For example, it can be empowering to clients to repeat easy exposures they did 10 sessions ago, and it can reinforce prior learning to remember that their fear still has not come true. Consider that a client with an intense contamination fear may benefit from the reminder that, despite his prediction on session 2, the doorknob he touched did not give him an incurable disease. Lastly, exposures should be done in multiple settings to ensure that learning is not just taking place in the therapist’s office.

When to Use or Not Use Exposure Therapy

Exposure therapy 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), but it should not
be used for all students or for all situations. The first consideration in using exposure therapy is time. In less than 30 minutes, it can be difficult to violate anxiety-driven expectations. Following an initial assessment, therapists should consider the severity of a case and whether enough time is allotted to provide adequate treatment. Therapists should also consider whether they themselves can engage in the exposures required to treat specific cases. For a case of OCD with contamination fears, therapists should feel comfortable engaging in exposures with clients, such as eating food that has been placed on a tabletop or touching doorknobs without handwashing.

Exposure therapy does not work with all of the OCD spectrum disorders, specifically skin picking, hair pulling, and hoarding, although emerging research and scholarship suggest that it can be used as an adjunctive treatment approach (Sulkowski, Jacob, & Storch, 2013). Exposure therapy should not be used for psychosis associated with schizophrenia spectrum or other psychotic disorders. In school settings, exposure should be used cautiously for children who exhibit marked emotional reactions to anxiety (e.g., aggression, panic, emotional agitation). Although exposure therapy can be effective for this population, school personnel may lack the resources needed to manage these behaviors safely. Exposure therapy is effective for children and adolescents with depression; however, therapists should assess the nature and severity of these symptoms carefully. Exposure therapy is often helpful for co-occurring mild depression, particularly if those symptoms are secondary to the anxiety. In school settings, more severe depression, particularly with suicidality or self-injurious behaviors, should first be addressed through safety planning, evidence-based treatments for depression (e.g., dialectical behavior therapy, behavioral activation), or outside mental health referrals if needed prior to considering exposure therapy.

**COGNITIVE RESTRUCTURING**

Cognitive restructuring is a therapeutic technique that is commonly used to challenge cognitive distortions and correct negative thinking patterns that contribute to depression, anxiety, anger, or other problems (see Appendix Exhibits 5.10 and 5.11 for a counselor's checklist and parent/guardian information 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 (Beck, 1991; 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, rational, or based in reality (Friedberg, McClure, & Garcia, 2009). Through this process, individuals often experience improvements in their affective state or mood because of the integral link between thoughts and emotions. Additionally, they often experience improvements in their functional behavior because they may not be held back by self-defeating, personally invalidating, fear-based, or irrational thoughts.

To illustrate the previous 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,” and “I’ll never feel any better.” Now imagine being bombarded
by these thoughts dozens of times throughout the day and not being able to do any-
thing about them. From this example, one can imagine how a person’s mood might
begin to suffer from feeling overwhelmed by negative thoughts that they might feel
powerless to manage. 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 engag-
ing in hobbies. Additionally, this may lead to further life problems as students may
stop completing school work; withdraw from friends, family members, and teach-
ers; and generally shut down. This process can be described as a “depression down-
ward withdrawal spiral.” Without therapy, it can be hard for individuals to liberate
themselves from this cascading process when they are being affected by multiple
negative cognitive, mood, and physical factors, possibly leading to life-threatening
critical factors (see Figure 5.2 and Appendix Exhibit 5.12 for a visual description).

Whereas behavioral activation targets physical factors (see Chapter 4, Emotional
and Behavioral Regulation Strategies) and involves increasing the amount of pleas-
urable experiences a person has on a regular basis, cognitive restructuring aims to
target a different point of intervention: the cognitive factors domain. 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
concomitant improvements in their mood or affective state. Thus, as a therapeutic
method, therapists can use cognitive restructuring to help students become more
aware of their thinking, evaluate the validity of their thoughts, challenge problem-
atic cognitions, and change their beliefs to better suit them and help them succeed
in school and life (Sułkowski, Joyce, & Storch, 2012).

Consistent with this model, a triggering or anxiety-provoking event occurs,
which then leads to experiencing anxiety-related thoughts (Beck, 1995). For exam-
ple, a child might stutter while giving a speech in front of his or her peers and
experience cognitive distortions such as “I’m so dumb,” “Everyone noticed—this is
so embarrassing,” or “Now I’m going to get a bad grade.” This might then cause the
child to experience physical symptoms such as becoming flushed, having sweaty
palms, feeling his or her heart race, feeling a little shaky, or even experiencing
somatic symptoms such as having “butterflies in one’s stomach,” having a stomach-
ache, or feeling like he or she could pass out. In such a state, the student might want
to avoid similar situations (being absent for the next time he or she has to speak
in front of peers) or tolerate them with significant distress or through performing
compulsive behaviors (e.g., having safety objects present).

Although less commonly discussed in the CBT literature, the relationship
between anger-inducing or -sustaining thoughts (e.g., personalizing something
negative, blaming others) also influences the presentation of angry feelings and
anger-related problematic behaviors (e.g., being physically aggressive, acting hos-
tile toward others, destroying property; Beck & Fernandez, 1998). Similar to the
depression downward withdrawal spiral’s four domains, Figure 5.3 depicts an anger
upward escalation spiral (also see Appendix Exhibit 5.13). When negative factors
across the domains coalesce, becoming more intense and sustained, individuals can
experience highly maladaptive behaviors. Without therapy, it can be difficult for
them to free themselves from this cascading process, as compounding negative cog-
nitive, mood, and physical factors possibly lead to more negative outcomes for both
themselves and others.
As the anger upward escalation spiral builds, an anger escalation sequence begins (see Figure 5.4 and Appendix Exhibit 5.14). This sequence follows a pattern of reciprocal negative cognitive interpretations and physiological arousal in response to life events that results in negative behavior responses. For example, some type of situation or event triggers a negative cognitive appraisal (“He did it on purpose,” “She’s looking at me funny,” “They’re all out to get me”), which is then related to an increase in arousal/anger. Following this, there could be a negative behavioral response that could further escalate the situation (e.g., getting into a fight, saying something provocative or hurtful), which could then lead to additional negative cognitive appraisals, feelings of anger, and problematic behavioral responses.
The first step of cognitive restructuring involves teaching students about the relationship between their thoughts, emotions, and behaviors. This relationship is often represented by a triad (see Figure 5.5 and Appendix Exhibit 2.1) in that thoughts impact feelings that then impact emotions, which then impact behaviors and finally subsequent thoughts (Beck, 1995, 2011). It should come as little surprise that this triadic model resembles the depression trap, the anxiety escalation, and the anger escalation models that were previously discussed. This is because, similar to how cognitive distortions can negatively impact one's feelings and behaviors, more adaptive thoughts can improve the former. This is the core of cognitive restructuring: to teach clients more adaptive ways to think by challenging their cognitive distortions.

Figure 5.3   The anger upward escalation spiral.

The CBT Triad
To help establish the link between thoughts, feelings, and behaviors, it is helpful for a therapist 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), and 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). 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 between thoughts, emotions, and behaviors. “Right now, think about a friend having lost her pet. Try to think of how she would feel. What emotions would you feel? How do you feel just reading this right now? How might these uncomfortable feelings impact your behavior? Perhaps you might hug the person you were just thinking of or tell her how you understand when you see her.”

After students comprehend that their thoughts can elicit negative emotions and behaviors, they can be prompted by the therapist 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 because 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 the salience and significance of these thoughts, 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, as a thought experiment, it can be helpful to encourage students to “get outside their head” or envision “thinking with someone else’s brain” for a few minutes to critically evaluate 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. Collectively, these strategies are discussed at greater length next with content related to Socratic questioning.

Specific Cognitive Distortions

In the CBT literature, there are dozens of identified cognitive distortions. However, Table 5.2 provides definitions and examples of the more common thinking errors found among children and adolescents experiencing a range of internalizing and externalizing forms of psychopathology (Friedberg et al., 2009; Leahy & Holland, 2000; Mennuti, Christner, & Freeman, 2012). Although individual students can display quite different clusters of cognitive distortions, there are some that are
<table>
<thead>
<tr>
<th>Cognitive Distortions (Automatic Thoughts, Thinking Errors, Thinking Traps, Stinkin' Thinkin')</th>
<th>Descriptor and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blaming (Finger Pointing, Who-Dun-It, Shame Game, Lame Blame)</strong></td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Catastrophizing (Disaster Forecaster, Doctor Gloom/Doom)</strong> <em>Note:</em> Catastrophizing is a subtype of magnification/minimization (Burns, 1980, 1989)</td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Control fallacy (Poor Me)</strong></td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Dichotomous thinking or polarized thinking (All or Nothing, No Middle Riddle; One-Eyed Ogre)</strong></td>
<td>Putting experiences in one of two extreme categories does 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.”</td>
</tr>
<tr>
<td><strong>Discounting the positive (Disqualifying the Positive, Countless Thinking, Ignoring the Good)</strong></td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Emotional reasoning (Prisoner of Feelings, The Roller Coaster)</strong></td>
<td>Child feels that his or her current feelings are the truth and 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.”</td>
</tr>
<tr>
<td><strong>Entitlement beliefs (The Princess, The Prince, The Revenger)</strong></td>
<td>An individual believes he or 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.”</td>
</tr>
<tr>
<td><strong>Fairness fallacy (Right Knight, The Regulator)</strong></td>
<td>Student believes he or 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.”</td>
</tr>
<tr>
<td><strong>Fortune telling (The Crystal Ball). <em>Note:</em> Fortune telling is a subtype of jumping to conclusions (Burns, 1980, 1989)</strong></td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Jumping to conclusions (The Jumper, Too Fast Forward). <em>Note:</em> Jumping to conclusions has two subtypes: fortune telling and mind reading</strong></td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Labeling (Mislabeling, The Name Game)</strong></td>
<td>The child uses derogatory names to describe himself or herself holistically in response to isolated circumstances. “I am a loser.”</td>
</tr>
<tr>
<td>Cognitive Distortions (Automatic Thoughts, Thinking Errors, Thinking Traps, Stinkin’ Thinkin’)</td>
<td>Descriptor and Examples</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Magnification and minimization (The Amplifier, The Shrinker). Note: Catastrophizing is a subtype of magnification/minimization</td>
<td>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.”</td>
</tr>
<tr>
<td>Mind reading (Tragic Magic Thinking). Note: Mind reading is a subtype of jumping to conclusions (Burns, 1980, 1989)</td>
<td>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.”</td>
</tr>
<tr>
<td>Negative filtering (Wearing Dark Glasses, The Blues News)</td>
<td>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!”</td>
</tr>
<tr>
<td>Overgeneralizing (The Repeat-Repeat)</td>
<td>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.”</td>
</tr>
<tr>
<td>Personalization (Me-Me, Mini-Me, It’s All About Me)</td>
<td>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 canceled the show because my audition was miserable.”</td>
</tr>
<tr>
<td>Should/must thinking (Bossy Thoughts)</td>
<td>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.”</td>
</tr>
<tr>
<td>Unfair comparisons or comparing (Foul Referee)</td>
<td>Student holds him- or herself to an unrealistic and unfair comparison. “My dancing is awful compared to the prima ballerina.”</td>
</tr>
<tr>
<td>What If (The Guessing Game)</td>
<td>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?”</td>
</tr>
</tbody>
</table>

Note: In the cognitive behavioral therapy (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.

ADHD, attention deficit hyperactivity disorder.

typical of particular mental health symptoms. For example, blaming, dichotomous thinking, entitlement beliefs, fairness fallacy, jumping to conclusions, labeling, and should/must thinking are often consistent with acting-out, bullying, disruptive acts, or aggressive behaviors. Diagnoses such as conduct disorder and intermittent explosive disorder 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.

On the other hand, diagnoses 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. Those 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.

In a counseling session, a student can be encouraged to come up with an example of each cognitive distortion that applies to his or her own life or someone else. The student can then describe ways that the distortion is irrational, inaccurate, maladaptive, or problematic in another way and list more adaptive ways to think about the event or situation that is related to experiencing the cognitive distortion. However, cognitive restructuring is abstract, and it is challenging for many students to understand how to effectively evaluate their thoughts or understand how their mind works, especially for young students or students who have limited metacognitive skills. Therefore, a therapist 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 therapist 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 therapist can encourage replacing it with better or different thoughts that are likely to make the person feel better. Lastly, it is important to note that because terms such as cognitive distortions and maladaptive thoughts are jargon terms and not likely to be well received by students, therapists should avoid using these terms when working with them. Instead, in collaboration with the student, the therapist could come up with clever substitute words for these terms such as stinkin’ thinkin’.

Once a student can begin identifying cognitive distortions, the therapist can enhance this process and help the client start challenging such distortions or coming up with different ways to think and behave in hypothetical situations that are grounded in real-world experience. In this regard, the ABC model (i.e., antecedent–beliefs–consequences; see Appendix Exhibits 2.2, 2.3, 2.5–2.9) can be used to help understand the functional relationship between triggers or activating events and related feelings and behaviors. The three-step ABC model originates from the work of Ellis (1991), and it utilizes the term antecedent to describe the initial behavior or situation and the automatic thoughts related to it. Then, beliefs are noted and reviewed to determine if they are rational or irrational, and finally, consequences are identified to help students understand the complete functional relationship between
the antecedents (As), behaviors (Bs), and consequences (Cs). In the ABC model, negative events and rational beliefs do not necessarily erase the negative feelings, but there are healthy and unhealthy responses to negative events. For example, a child who loses a favorite pet can have irrational beliefs of self-blame and guilt, even if he or she did nothing but love the pet and could do nothing to prevent its natural death. Moreover, through identifying specific cognitive distortions, he or she could realize that more adaptive and maladaptive ways exist to think about the death of the pet. For example, instead of personalizing the death and feeling guilt or shame, the child could reflect on loving the pet, growing together, and appreciating the role the pet had in the family. Essentially, the cognitive model provides a structure for illustrating that thoughts, feelings, and behaviors influence each other and can directly influence outcomes. Deconstructing and teaching the relationship between the As, Bs, and Cs can be challenging, however. Therefore, therapists should use strategies such as thought records to elucidate the often abstract functional relationships between thoughts, feelings, and behaviors.

**Thought Journaling and Records**

Thought records are commonly used to identify and challenge cognitive distortions, and they extend cognitive interventions downward to have greater utility for student populations. They are also directed toward the three-step ABC model and even can be crafted to extend the model to also include “D,” disputing cognitive distortions by coming up with alternative thoughts/ways of thinking, and/or “E,” evaluating the perceived efficacy of the alternative thoughts as they compare to the initial distortion.

Simply stated, this intervention involves keeping a record of cognitive distortions or maladaptive thoughts and related experiences that can be used to challenge them therapeutically. When encouraging students to keep a thought record, the therapist should tell them to pay attention to changes in their mood or affective state and then jot down what was happening right before this change was noticed (the antecedent, or “A”) and what they were thinking about immediately after (the consequence, or “C”). Thought records can easily be created 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 using them, thought records help students directly see the functional relationship between their own thoughts and feelings as well as events that trigger changes in both domains. Examples of thought records can be found in the Appendix Exhibits 2.6 and 2.7. Additionally, when these thoughts include misperceptions about what others are thinking (e.g., mind reading), perspective-taking scenarios and exercises may help expand thinking options. Asking students to generate alternative and positive interpretations of events also may be helpful (see Appendix Exhibits 5.15–5.21).

As briefly illustrated previously, the logical extension of thought records involves using them therapeutically. In this regard, the therapist can work with the student to identify specific cognitive distortions, label them, and dispute (D) or challenge them (see Appendix Exhibit 2.7). For example, a child with generalized anxiety disorder might notice that he becomes anxious whenever he hears news stories about terrorist attacks. When exposed to such information, he may compulsively call his parents to make sure they are safe, refuse to leave the house, or ask for reassurance that nothing bad will happen to him or them. Because the student
has never been exposed to any serious threats or acts of violence, such concerns are disproportionally related to his reality, especially because his risk for personal harm from a terrorist attack is exceedingly small.

Using a thought record, the student could monitor all of the antecedent events that cause him to experience anxiety (e.g., watching scary and developmentally inappropriate videos online, watching the nightly news with his parents, asking peers about scary things) and his related thoughts. With this example, the student might identify watching a scary video about a terrorist attack (the antecedent “A”) with the thought: “What if a terrorist attack occurs where my mom works?” or “What if the terrorists target my school?” The student should also list the consequences associated with ruminating about such remote possibilities (“I felt sick to my stomach,” “I called my mom immediately to see if she's okay,” “I avoided the school bus and made my parents pick me up”).

Through working with the therapist, the student might identify that he is catastrophizing (viewing the future with unrealistic disastrous outcomes), overgeneralizing (looking at a small number of isolated events and thinking that they represent a much broader and immediate threat), personalizing (taking negative events that happened on the other side of the world or decades ago and applying them to a perceived personal risk), and engaging in emotional reasoning (letting one's own emotional state disproportionately color one's perceptions of reality). This then opens up an opportunity to dispute (D) the identified cognitive distortions. For example, the student might say, “Well, my thought that terrorists were going to attack my school is unlikely. I watched a scary video, which made me afraid and not think clearly and overreact.” After disputing cognitive distortions, the student and the therapist can evaluate (E) the related process: “This is a better way to think about the situation. I feel less worried and more calm now after thinking about things differently.”

Through reviewing information collected on thought journals or records (or through directly focusing on problematic thoughts that the student seems to harbor in session), therapists 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. Table 5.2 presents a more comprehensive list of cognitive distortions, their description, and various examples.

Each year, an increasing number of apps emerge that can be used to monitor one's cognitive processes, identify cognitive distortions, consider different ways of thinking, and monitor one's progress. This is ideal, because students can download such apps on personal devices and literally have them at their fingertips. Every CBT therapist deals with frustrations associated with thought records or journals getting lost or between-session homework not getting completed. Using high-quality CBT apps can help minimize the former, as well as engage students in a familiar setting (i.e., in cyberspace). For information on apps as they emerge, the Anxiety and Depression Association of America (ADAA) rates apps based on their expected age level, ease of use, effectiveness, degree to which they can be personalized, the amount of feedback they provide, and level of research support (adaa.org/finding-help/mobile-apps).
Socratic Questioning

In addition to using thought records to identify and dispute cognitive distortions, therapists can also utilize the Socratic questioning. This intervention approach aims to help individuals discover maladaptive thoughts, determine ways in which they are maladaptive, and identify errors in their reasoning. Furthermore, it can be used independently or with thought records, which likely will have the greatest benefit. Through using this technique, therapists can descend deeper and past surface responses to uncover meaningful answers to the therapist’s questions.

By no means is Socratic questioning a way to control a client’s thoughts or challenge her or his autonomy. It also is not used to challenge deep-seated personal beliefs and values. Instead, it is a tool that the therapist shares with the client so that he or she can reduce the negative impact of cognitive distortions on his or her life. Additionally, while engaged in cognitive restructuring, asking the question why? often is not as effective as what? or an alternative question because it can cause individuals to become defensive or say “I don’t know” if they feel judged. As applied, Socratic questions should be mixed in with the typical therapeutic dialogue or discussion. Being peppered with questions causes people to become defensive or shut down, and it can feel invalidating. Therefore, the traditional counseling skills should be utilized while doing cognitive restructuring. It always is still important to develop and maintain rapport, provide positive regard, show genuine interest in what the client is saying, and use nonverbal attends to prevent therapy from feeling stale, inauthentic, stilted, or even ingenuous.

Often, new CBT practitioners (or individuals who want to begin practicing CBT in school settings) report feeling that they are at a loss on how to do cognitive restructuring. By no means is this their fault. Cognitive restructuring scripts can seem artificial in real-world settings. In contrast to a short script or vignette, does a therapist have the seemingly perfect response to a client or does a real student have the advanced awareness of a scripted client? While reading the examples in this chapter, you might have thought: “I wouldn’t have known to say that” or “The students I’m working with wouldn’t say that or talk that way.” This is probably true, but it is not a problem, and totally okay. The use of cognitive restructuring—and CBT for that matter—should evolve organically. Although it is a short-term form of therapy, clients and therapists move at different rates, and there are no rigid rules on the duration of treatment.

Furthermore, as a school psychologist, school counselor, or social worker, you likely already do things with students that fall under the CBT umbrella (you might just not think of them this way or apply them as systematically). Attentive and thoughtful counselors, educators, and therapists ask questions that encourage students to reflect on their thoughts, change their behaviors, and regulate their emotions more effectively. In fact, cognitive restructuring, in particular, can be reduced to a handful of questions that can be used to dispute cognitive distortions that have many different variations. These questions are as follows:

- What is the evidence for _____?
- What is a better way to think about _____?
- What are the advantages and disadvantages of _____?
- What might other people think about _____?
The following dialogue illustrates the application of these questions to encourage a student to think about his or her thinking as well as some related cognitive distortions. However, it should be noted that prior to engaging in such a dialogue, it is important to have adequate rapport and to validate the way a client is feeling:

Therapist: How are you today?
Student: Terrible. My life is completely over.
Therapist: Oh no. Would you tell me more about what happened?
Student: “Yeah, my boyfriend just broke up with me. He's perfect. I'll never find someone like him, and I'll probably be alone forever!”
Therapist: I'm so sorry that you feel that way. I can tell that you care a lot about him and that you're very upset today.
Student: Thank you. I do care a lot about him.
Therapist: Can I ask you something?
Student: Sure.
Therapist: What evidence is there that he's perfect?
Student: Well, I just think he's special even though he can be mean, and my friends don't like him.
Therapist: I get it, and you have some friends who really have your back. What does your best friend think?
Student: She thinks he's rude and that I can do way better.
Therapist: Instead of thinking that your life is over and that you'll be alone, can you think of a different way to view your current situation?
Student: Yeah, well, I guess I can. We've only been dating for a couple of months, and he's already getting kind of demanding. I just don't want to go to the upcoming dance alone. I'll get over it though. A lot of people just go to hang out in groups anyway.
Therapist: I like how you can see the pluses and minuses of your relationship situation. Can you think of others?
Student: Yeah. This will give me more time for soccer, and I won't feel guilty about dancing with other people at the dance.

Notice that the dialogue includes a range of different variations of the previously listed questions. As much as possible, it is important not to sound robotic or mechanical when challenging cognitive distortions.

Downward Arrow

The “downward arrow” technique (see Appendix Exhibit 5.8) is similar to using Socratic questioning; however, it is typically used to identify core beliefs as opposed to being used as an independent therapeutic technique (Burns, 1980). Additionally, it should be used with caution because it can expose clients to core beliefs about themselves that they are not yet ready to process. As an analogy, it is used to
simultaneously peel back many layers of the onion and expose what is toward the core. The following dialogue illustrates the use of the downward arrow technique with a student with test anxiety to get to a deeper fear that the student harbors:

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

Notice how what stated as a surface-level concern (i.e., the upcoming math test) quickly gave way to a deeper concern through questioning (parental rejection worries). Beck (1995) has identified two deep core fears that are the root of most other fears, worries, and concerns:

1. A fear of being inadequate or helpless
2. A fear of being unlovable

Considering how deeply ingrained such fears may be and how overlaid they may be with other fears, avoidant behaviors, and even self-rejecting or hurtful behaviors, extreme caution is needed when exploring core fears. If attempted, such a process should be client led and include other cognitive, behavioral, and emotion-regulation strategies; and the therapist should pace the process to ensure the well-being of the client.

**When to Use and Not to 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, therapists should refrain from using cognitive restructuring as a therapeutic approach for children who display obsessive or ruminating symptomatology, especially if these obsessions are highly ritualized, as is the case with those 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, Cognitive Theoretical Foundations, this method of treatment should not be used with students who have a low cognitive functioning, very young children (i.e., preschool and first- to second-grade students), and any other students who display poor insight and a very limited metacognitive ability. Therapists may have to determine the student’s level of insight and metacognitive skills through interviewing the child, teachers, parents, or others who know the student well.

As a final caveat, it is not clear exactly why individuals benefit from cognitive restructuring or various cognitive interventions. Surely changing thoughts
can influence emotions and behaviors consistent with the standard CBT model. However, the mere understanding that thoughts are malleable and not rigid also can have a therapeutic benefit. When stuck in rigid thinking, individuals tend to believe that their current thoughts are real, accurate, and irrefutable. However, through the process of engaging in cognitive restructuring, or other therapeutic approaches (e.g., mindfulness), it becomes clear that one’s own thoughts often are inaccurate and disproportionally influenced by one’s feelings, having incomplete information, previous experiences, or myriad of other factors. Therefore, part of the efficacy of cognitive interventions may lie less in the specific therapeutic activities and more in the client’s enhanced understanding that thoughts often are distorted and amenable to change. With this in mind, accuracy in identifying the exact cognitive distortion is less important than understanding that a distortion is present and that there are different ways to think about reality.

REFERENCES


