Cognitive-Behavioral Interventions in Educational Settings
A Handbook for Practice
Second Edition

Edited by
Rosemary B. Mennuti, Ray W. Christner, Arthur Freeman
Cognitive-Behavioral Interventions in Educational Settings
I dedicate this book with love to Jean.  
She provides me the support and encouragement to remember how to fly.

Rosemary B. Mennuti

I dedicate this book to my grandmother, Pauline Poling. Her kindness, encouragement, and fortitude have been my inspiration to go beyond all expectations.

Ray W. Christner

This effort is a gift to my long-time colleagues at Philadelphia College of Osteopathic Medicine from whom I have gained so much over the years.

Art Freeman
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In recent years, significant advances have occurred in the use of cognitive-behavioral interventions for child and adolescent emotional and behavioral difficulties. Specifically, cognitive-behavior therapy (CBT) has been applied to a number of common clinical problems in youth, including anxiety, attention deficit hyperactivity disorder (ADHD), conduct disorder, depression, eating disorders, and oppositional defiant disorder, to name a few. Additionally, over the past several years, a number of excellent references have been developed for child and adolescent clinicians on the practical and empirical support of using CBT with youth (see Christner, Stewart, & Freeman, 2008; Friedberg & McClure, 2002; Kendall, 2006; Reinecke, Dattilio, & Freeman, 2003; Silverman & Hinshaw, 2008).

However, despite the growth of literature on the use of CBT with young clients, there remain only few resources on its use with children in educational or school settings. Given the critical role of schools and school staff in the cognitive, behavioral, emotional, social, and interpersonal development of children and adolescents, it is only fitting that school-based clinicians and school systems begin considering the implementation of CBT intervention services to help children and adolescents in need. With growing evidence supporting the use of cognitive-behavioral interventions with young clients (see Kendall, 2006; Ollendick & King, 2004), CBT or cognitive-behavioral interventions are promising for use within school settings.
THE COGNITIVE-BEHAVIORAL MODEL

Evidence for Using CBT

Education and mental-health professionals have become familiar with the phrase “evidenced-based practice.” The common use of this term illustrates the move toward offering services based on sound theoretical principles and interventions supported through empirically based studies. CBT is one such approach in that a growing body of evidence over the past 20 years supports its efficacy and effectiveness when working with children and adolescents. To date, current studies on the use of CBT with children and adolescents have been generally impressive (Reinecke et al. 2003). However, as noted earlier, despite the positive support of CBT in the literature, most current research on CBT with children and adolescents has involved primarily clinical populations and settings rather than addressing the use of CBT in schools.

Although much of this research has occurred in clinical settings, the promise CBT has as an effective treatment to ameliorate a number of childhood difficulties (e.g., depression, anxiety, and disruptive behaviors) should not be ignored (see reviews in Kazdin & Weisz, 1998; Kendall, 2006; Ollendick & King, 2004; Weisz & Kazdin, 2010). In addition, ongoing research continues to find potential uses for CBT with children and adolescents that have yet to be termed “evidence-based.” Use of CBT with issues such as eating disorders, posttraumatic stress disorder, substance abuse, school-related problems, and health conditions shows potential, yet further investigation is warranted. Although there continues to be a dearth of research on treatment for all problems facing children and adolescents today, through the use of clear case conceptualization and continual progress monitoring clinicians can modify cognitive-behavioral interventions to meet their individual client’s needs.

Specific interventions are known for the common concerns children face but how do practitioners determine what works best? Typically, a structured manualized approach is chosen to be used for effective treatment in that it offers clearly defined procedures to use, step-by-step procedures to follow, and specific activities to implement. Examples of such treatment manuals include Coping Cat (Kendall & Hedtke, 2006), Cognitive-Behavior Group Therapy—Adolescent (CBGT-A; Albano, 2000), Coping Power Program (Lochman, Wells, & Lenhart, 2008), Coping with Depression (Clarke, Lewinsohn, & Hops, 1990), and

http://www.routledgementalhealth.com/9780415807401
An Introduction to Cognitive-Behavioral Therapy with Youth

Aggression Replacement Training (ART; Glick & Gibb, 2010). All of these programs include techniques that have an evidence base for a specific problem. While the manualized programs can be effective and efficient, there are limitations with this method of practice. Often, such approaches lack flexibility or do not meet the individual needs of a child. Further, though they may address the needed skills, they do not always address the barriers and difficulties that affect implementation.

An alternative to a manualized approach to treatment is what Chorpita (2007) coined as modular cognitive therapy. He proposed identifying the common practice elements found in manuals for specific problems and matching these modules with specific identified needs of an individual (Chorpita, Becker, & Daleiden, 2007). Modular cognitive therapy provides structured flexibility and decreases the demands of following a manual-based program by using specific techniques from manual-based programs, allowing the use of outcome research to develop good interventions, and basing intervention on specific client needs, and allowing good clinical judgment to determine what strategies and skills are needed, when and for how long. However, in order for this approach to be valuable, the mental-health provider must have good case conceptualization skills, use progress monitoring efficiently to measure outcomes, and have a good understanding of the literature across various disorders and problems that are often found in school settings. Possible modules might include: social skills, communication skills, activity scheduling, guided imagery, relationship building, etc. Notwithstanding the evidence supporting the use and accurate implementation of CBT strategies and techniques with children and adolescents, it is critical that school-based practitioners have an understanding of the fundamental tenets of CBT and its application to youth in general before applying it within their practice. For those interested in modular-based approaches to CBT, readers are referred to Chorpita (2007) and Friedberg, McClure, and Garcia (2009).

The CBT Model

The CBT model with children, as with adults, suggests that emotions and accompanying behaviors are the result of the connection between a given situation, the child’s belief system (through which he or she interprets given situations), and the child’s thoughts about the event (positive and negative). It is important to view this connection as multidirectional rather than linear, which suggests that there is not a cause-and-effect
relationship but, instead, a dynamic interactional process between situational, cognitive, affective/physiological, and behavioral components (see Figure 1.1). Having awareness of the situational factors (e.g., social aspects, school factors, home) that activate a student’s belief system, being able to link the beliefs with the child’s cognitive process, and translating these concepts into clear and helpful strategies for the child are essential for effective interventions.

CBT focuses on the way in which a child interprets his or her experiences and how these thoughts ultimately influence his or her emotional or behavioral functioning (Friedberg & McClure, 2002; Reinecke et al., 2003). For example, consider Sydney, an 11-year-old girl who presents with significant anxiety when engaging in social activities with peers at school (e.g., group work, lunch, recess). Although it is important to understand the context of her anxiety (when in a social situation), knowledge of her physiological reactions (nausea, sweaty palm, feeling dizzy), automatic thoughts (e.g., “They are not going to like me. I’m going to embarrass myself.”), and her beliefs (e.g., “If I mess up, no one will like me.”) is more important to developing interventions than just “combating her anxiety.”

![Figure 1.1 Multidirectional model of CBT. © 2010 R. W. Christner & R. B. Mennuti.](http://www.routledgementalhealth.com/9780415807401)
CBT represents two interacting perspectives (cognitive and behavioral), which are combined to understand the child or adolescent and to develop interventions to address presenting problems. Behavioral components can be viewed in two ways—environmental influences and/or skill deficits. Clinicians should examine environmental influences and experiences (e.g., teacher or parent interactions, ineffective parenting, past trauma, etc.) to help conceptualize the student’s problems, and, in some cases, changes to the environment will be the necessary intervention (e.g., positive behavioral support, token economies, etc.). Alternatively, many problems experienced by students are the result of behavioral skill deficits (e.g., poor self-regulation, underdeveloped social skills, etc.).

From the cognitive perspective, there are also two factors to consider—cognitive distortions and cognitive deficiencies (Kendall & MacDonald, 1993). Cognitive distortions involve the errors in thinking that lead the individual to misinterpret or misperceive a situation or event (Freeman, Pretzer, Fleming, & Simon, 2004). A number of experts in CBT have offered examples of cognitive distortions experienced by individuals, though most of these examples are of adult thoughts (see J. Beck, 1995; Burns, 1999). Christner and Allen (2004) provided examples of several cognitive distortions commonly seen in school-aged children (see Table 1.1). Students who display cognitive distortions often experience internalized difficulties (e.g., anxiety and depression). The second cognitive factor, called “cognitive deficiency” by Kendall and MacDonald (1993) suggests deficits in a student’s cognitive-processing abilities. Thus, students with cognitive deficiencies may have minimal forethought or problem-solving skills, resulting in impulsive and attention problems. Keeping in mind the role of various cognitive and behavioral factors, school-based professionals using a CBT framework will assist students by initiating the acquisition of new skills (both cognitive and behavioral), while also offering opportunities to facilitate a change in cognitive processes and thinking.

**CBT in Schools**

Although many educators believe that psychological counseling services are difficult to “fit” into the educational culture, the structure and framework of CBT parallel other educational services, making it more easily accepted among educators (Christner & Allen, 2003; Christner, Mennuti, Heim, Gipe, & Rubinstein, 2011; Christner, Mennuti, & Whitaker,
2009; Christner, Stewart-Allen, & Mennuti, 2004; Mennuti & Christner, 2005, 2010). Given CBT’s time-limited, present-oriented, and solution-focused approach (Reinecke et al., 2003), it can be easily adapted to an intervention delivery-model that encompasses services at differing levels that represent greater specificity, complexity, and intensity. In fact, as will be seen throughout this book, school-based clinicians can offer CBT interventions on a continuum—from prevention to early identification to direct individual service.

Table 1.1  Common Cognitive Distortions Encountered in Therapy with Students in Educational Settings

<table>
<thead>
<tr>
<th>Distortion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dichotomous thinking</td>
<td>The student views a situation in only two categories rather than on a continuum. The world is either black or white with no shades of gray. For example, “I’m either a good student or a failure.”</td>
</tr>
<tr>
<td>2. Overgeneralization</td>
<td>The student views a current event as being characteristic of life in general, instead of one situation among many. For example, “Because I failed that science test, I’ll never graduate or make it in college.”</td>
</tr>
<tr>
<td>3. Mind reading</td>
<td>The student believes he or she knows what others are thinking about him or her without any evidence. For example, “I just know that Mr. P. is angry with me.”</td>
</tr>
<tr>
<td>4. Emotional reasoning</td>
<td>The student assumes that his or her feelings or emotional reactions reflect the true situation. For example, “I feel like no one likes me, so no one likes me.”</td>
</tr>
<tr>
<td>5. Disqualifying the positive</td>
<td>The student discounts positive experiences that conflict with his or her negative views. For example, “I only did well on those quizzes because Mrs. Jones helped me and I got lucky.”</td>
</tr>
<tr>
<td>6. Catastrophizing</td>
<td>The student predicts that future situations will be negative and treats them as intolerable catastrophes. For example, “I better not even try the assignment because I might screw it up, and that would be awful.”</td>
</tr>
<tr>
<td>7. Personalization</td>
<td>The student assumes that he or she is the cause of negative circumstances. For example, “My teacher didn’t smile at me this morning. I must have failed that test and made her unhappy.”</td>
</tr>
<tr>
<td>8. Should/Must statements</td>
<td>The student uses should or must to describe how he or she or others are to behave or act. For example, “I must always get A’s, and I should never make mistakes.”</td>
</tr>
<tr>
<td>9. Comparing</td>
<td>The student compares his or her performance to others who are higher performing or older. For example, “Compared to my older brother, my work looks like a kindergartener did it.”</td>
</tr>
<tr>
<td>10. Selective abstraction</td>
<td>The student focuses attention to one detail (usually negative), and ignores other relevant aspects. For example, “My teacher gave me an unsatisfactory on the last assignment, so this means I’m one of his worst students.”</td>
</tr>
<tr>
<td>11. Labeling</td>
<td>The student attaches a global label to describe him or herself rather than looking at behaviors and actions. For example, “I’m a loser” rather than “I played poorly in last night’s game.”</td>
</tr>
</tbody>
</table>

(Material developed and presented by Christner & Stewart-Allen, 2004).
The components and possible service-delivery options of CBT are consistent with the educational environment, where both time and resources are often limited. The present-oriented and solution-focused approach of CBT is also appealing in school settings, as it addresses the student’s issues without overly relying on diagnosing a specific pathology. In addition, the structure of CBT, which focuses on psychoeducation, skill building, between-session work (i.e., homework), agenda setting, and progress monitoring, is congruent with most activities that already exist in today’s school settings. Thus, although these components assist in providing intervention services, they also strengthen the link between psychological counseling and other services provided in schools.

School-based clinicians have access to the combination of teacher interaction, peer influence, and personal-performance efforts and outcomes, all of which offer an insight into a student’s perceptions and thought processes that many outside clinicians do not have access to (Christner, Mennuti, & Whitaker, 2009; Mennuti & Christner, 2005). We view the school setting as a “natural laboratory” for observing interpersonal dynamics and gathering data about the problems facing students, as well as a “safe” and pure setting for students to “experiment” with newly-learned skills from counseling sessions. Often, the problems associated with the generalization of skills learned in counseling or therapy services are that the skills are being taught in a setting far removed from the child’s daily environment. Goldstein and Goldstein (1998) noted that for interventions to have the greatest effect, they must be implemented in close proximity to the target behavior. Therefore, offering services within schools rather than in outside settings (e.g., outpatient clinics, inpatient units, etc.) has great advantages, especially given the opportunity for immediate generalization following sessions.

ISSUES AFFECTING COGNITIVE-BEHAVIORAL PRACTICE

Developmental Issues
Although a number of professionals not trained in CBT have criticized it as a “paint-by-number” or manualized approach, those with experience in the application of CBT realize that this is not the case. In fact, practitioners using CBT rely on data obtained through assessment and case conceptualization
in order to think strategically about the individual and to plan for effective and specific interventions based on the student’s age, developmental level, and presenting problems. Through a clear case conceptualization of the student and his or her problems, the school-based clinician is able to select and utilize precise interventions to address the area most amenable to treatment at the time. In Chapter 4, Murphy and Christner offer a thorough review of case conceptualization, with specific emphasis on understanding school-related cases.

A major component when working with school-aged children is having a comprehensive understanding of the fundamentals of child and adolescent development. Providing psychological counseling or psychotherapy with children and adolescents is more than knowing a list of specific techniques or strategies. Thus, clinicians well grounded in the foundations of development are more likely to implement interventions compatible with the child’s functional level and avoid a trial-and-error approach to finding “what works.” Because a child must have the capacity to attend to information, comprehend language, use working memory, and express him- or herself verbally to benefit from a number of cognitive-based strategies, it is essential for school-based practitioners to assess and focus on these individual factors when designing specific programs for a student. Practitioners must determine the precise mix of cognitive and behavioral techniques based on the student’s need and developmental level. Take, for instance, a student who is limited in both cognitive and language development. This student will require interventions that have a greater percentage of strategies focusing on behavioral components. We are not suggesting that cognitive techniques are inappropriate for use with younger children or those with severe behaviors but, instead, that cognitive interventions will be less directly relied on for those students at a lower developmental level or who display an increased level of behavior problems (Christner, Allen, & Maus, 2004; Mennuti & Christner, 2005). When looking at developmental level, it is important to note that the developmental level is not always consistent with chronological age.

**Risk and Resilience**

Research within the field of developmental psychopathology regarding risk factors, protective factors, and resiliency factors (Doll & Lyon, 1998) provides useful information for practitioners working with youth. The work of Coie and colleagues
(1993) has focused on identifying risk factors associated with the development of psychological problems. Essentially, risk factors are thought to increase the risk that children will be unable as adults to contribute to society, earn a living, and form healthy families. Coie et al. identified seven domains of risk factors including:

- Constitutional handicaps
- Skill-development delays
- Emotional difficulties
- Family circumstances
- Interpersonal problems
- School problems
- Ecological risks

Within each of the seven domains, a number of generic risk factors exist that may be found individually or in combination to affect a specific child. Of particular concern are risk factors such as poverty, minimal parent education, marital discord or family dysfunction, ineffective parenting, child maltreatment, poor physical health of the child or parents, parent mental illness or inadequacy, and large family size (Doll & Lyon, 1998). Although many of these specific factors are out of the clinician’s control, they provide information that may help school-based professionals identify students at risk and offer interventions that may serve protective functions.

In as much as children with risk factors are technically “at-risk,” not all children with risk factors will have poor outcomes. Thus, equally if not more important is understanding factors that serve a protective role for children and adolescents and increase their likelihood of being resilient. Coie et al. (1993) indicated these protective factors serve one of the following purposes:

- To decrease risk directly
- To serve as a buffer through interaction with risk factors
- To disrupt the chain reaction from risk factors to disorder
- To prevent the initial occurrence of the risk factor

As Rutter (1985) identified, there are three broad domains of protective factors that promote the purposes noted above.
These include individual characteristics, interaction with the environment, and broader societal influences (e.g., quality schools).

By using knowledge of risk factors, protective mechanisms, and resiliency, clinicians can design interventions for students that minimize areas of risk while fostering their strengths and developing a sense of competency. Interventions occurring early in the treatment process may concentrate on skill building (e.g., social skills, problem-solving skills, etc.) through psychoeducation. With this approach, clinicians help students correct maladaptive practices that serve as risk factors while at the same time promote protective factors that minimize risk (e.g., strengthening peer relationships, increasing self-monitoring skills, improving parent-child interactions, and increasing school success).

**Motivation to Change**

Final factors that school-based practitioners should consider when providing services to children and adolescents include the student’s motivation and attitude. These factors not only affect the collaborative relationship but also influence subsequent intervention implementation and outcomes. Take, for instance, a student who is referred for being disruptive within his classroom. Using a directive approach discussing reasons why he should not disrupt classroom instruction will likely be met with opposition and resulting failure. Instead, clinicians who have know-how will use the student’s motivation (e.g., “Let’s find ways of getting your teacher off our back.”) to increase intervention adherence and further promote the partnership with the student.

The idea of readiness or motivation for change is not a new concept in general, although it is one that is novel to many practitioners in an educational setting. In school settings, when a student has a problem, no matter if it is academic or behavioral, many automatically assume that the student is ready and motivated to make the necessary change. Consequently, plans that require “action” for success are often developed and implemented and then fail because the student is neither ready nor motivated. To serve children and adolescents better, we advocate for school-based clinicians to begin matching interventions to the child’s “stage of change.” For example, action therapy, experiments, etc., may best serve those children who are in the preparation for action or action stage. The work of Prochaska and DiClemente (Prochaska & DiClemente, 2005).
An Introduction to Cognitive-Behavioral Therapy with Youth (1982; Prochaska, DiClemente, & Norcross, 1992) is among the most frequently cited references in the literature regarding this concept and includes six stages: (1) Precontemplation, (2) Contemplation, (3) Preparation for Action, (4) Action, (5) Maintenance, and (6) Relapse. Based on this model the readiness-to-change stages are indicated in Table 1.2.

A recent revision of this model by Freeman and Dolan (2001) expands the stages of change model to include more specificity, and thus identifies 10 stages through which individuals pass during the change process. These include (1) Noncontemplation, (2) Anticontemplation, (3) Precontemplation, (4) Contemplation, (5) Action Planning, (6) Action, (7) Prelapse, (8) Laspe, (9) Re-lapse, and (10) Maintenance. See Freeman and Dolan (2001) for a thorough review of each of these stages. However, although Prochaska and DiClemente’s model and the revisions by Freeman and Dolan (2001) have been applied to a number of psychological, psychosocial, and medical issues (see Prochaska, Redding, Harlow, Rossi, & Velicer, 1994), no references exist for the use of the readiness to change model with youth in schools. Although stages of change models have not yet been specifically identified for children and youth clients, using the aforementioned models to help “meet the student where he or she is” can have great benefit. School-based clinicians can begin using and monitoring the usefulness of stages of change models in case conceptualization and treatment intervention with regard to school-related problems, but further investigation is needed to establish empirical support.
A Model of CBT with Youth

Our model of practice using CBT is organized around the change process and the constructs of therapy that overlap and blend in the therapeutic process to allow change in a child to occur. In working with children with a range of mental-health issues, we propose a model to describe what we do as therapists with individuals with whom we work. Figure 1.2 illustrates this model. Basically, the client and the therapist come together with common goals of allowing growth and change to occur, thereby promoting well-being and success. The work to be done is held together by the relationship that is formed and nurtured throughout the treatment. This bond is imperative, yet it alone is not sufficient for change to occur. Inside the relationships, there are three main areas that must be considered: case conceptualization, session structure, and components of practice. It is the clinical judgment and expertise of the practitioner that determine the treatment process within the context of the ongoing relationship between client and therapist.

Therapeutic Relationship

A component central to the use of CBT with children and adolescents is the working relationship. Interestingly, those
professionals critical of CBT often claim that it is manualized and that it ignores the relevance of the “therapeutic relationship.” Those who are trained in CBT are aware that this claim is far from traditional practice. In fact, Aaron T. Beck and his colleagues (1979) have emphasized the need for active interaction between therapist and “patient,” and they note that “slighting the therapeutic relationship” (p. 27) is a common error in the therapy process. It is important, and even necessary, for this interaction to be empathetic and empowering in order to allow the client to explore his or her authentic thoughts and feelings in such a way that allows for insight and understanding to foster positive movement and change.

The relationship when working with children and adolescents is one of connection and collaboration. When the connection is a positive, authentic relationship, it can facilitate the therapy process and enhance the overall outcome. Despite the clinical relevance of the therapeutic relationship in providing service to youth, there continues to be limited research regarding this dynamic. One meta-analytic review, Shirk and Karver (2003), found support that the therapeutic relationship has a modest, yet consistent, correlation with therapeutic outcome for youth. Although this finding is important to consider, it is imperative to acknowledge that a factor such as “relationship” is difficult to study quantitatively, and that further investigation in this area is needed. Through the use of qualitative studies, the concept of the therapeutic relationship and its role, as it is conceived and valued by children, could be understood first and then quantified based on what children need and know, rather than on a preexisting framework of what we think it is that children need. By taking an in-depth look at the phenomenon of the therapeutic relationship with children, we will enhance our understanding of this process, which is crucial to developing effective treatment.

A collaborative, working relationship between a professional and client (child, adolescent, or adult) is not merely “getting along,” nor is it a simple interaction or friendship. Instead, a positive healing relationship is a complex dynamic in which a bond exists. This bond promotes a connection and trust between two people, and an emotional availability and presence that facilitate comfort and openness. Once a sense of safety and trust is established, children can risk being open about who they are and what they believe. Thus, the relationship becomes the foundation on which strategies and interventions can develop and thrive.
It is the relationship that is helping and growth fostering, and, in turn, encourages change in treatment and in daily functioning. Although collaboration generally suggests an “equal” or 50/50 involvement between the school-based clinician and child, this is not the case in actual treatment. In fact, a school-based clinician will need to meet a specific student at his or her level (based on age, motivation, etc.), while holding a place for dignity and respect (Mennuti & Christner, 2005). Initially, until the student matures in the therapy process, the ratio of clinician to student work may be 30/70 or 40/60.

A number of basic tasks are available to help clinicians facilitate an authentic relationship. For instance, frequent and brief summations throughout the session will likely assist in keeping focus and demonstrating involvement within the session while further establishing and maintaining the relationship. These summations convey to the student that the clinician is emotionally available and understands what the student is saying and feeling. It is also useful to acquire feedback that will help clarify information or misunderstandings. Creating an atmosphere of empowerment and freedom to question facilitates sharing and learning together. It also provides an opportunity for conflict to occur and to be openly discussed and resolved. Finally, the permission and expectation of students to question, examine, and explore is often uncharacteristic of most school-based interactions, yet lies at the heart of growth and change for children. Although disconnections can and will occur, a discussion of the rupture in the relationship often leads to a better bond and strengthens the existing therapeutic relationship.

Case Conceptualization
Case conceptualization is at the heart of the therapeutic treatment. It is the thinking process and understanding of who we are treating that must occur and be genuinely understood before proceeding with therapy. Case conceptualization is like a tapestry, where the complexity of all of the threads is studied as individual components and then woven together to develop the picture of the child and their issues and concerns. These ideas and understanding serve as the building blocks to treatment planning and intervention selection. Although collecting the data needed can be an easy task, the skill is in knowing what to gather and how to weave it all together.
It must be remembered that new information will constantly come forth and allow us to add the additional blocks to build a comprehensive, fluid, and dynamic intervention plan fitting the individual needs of each unique child and their problems. The role of case conceptualization is to conceptualize the child’s problem, select the problem of focus and the intervention point, collaboratively determine goals, choose interventions and techniques, predict behavior, and help manage noncompliance. Christner and Murphy develop the details of this process in Chapter 4.

Session Structure
This section of the model deals with the procedures for carrying out the actual therapeutic sessions where you will be conducting the specific appropriate strategies. Let us first touch upon the fundamentals of using CBT with children. It is critical that the session length be appropriate for the specific child. This is often influenced by age and/or developmental level. The other basics include expanding the child’s emotional vocabulary, identifying and disputing dysfunctional ideas, teaching self-instructional techniques, teaching problem-solving skills, providing the opportunity to role-play specific skills, providing opportunities to practice skills learned (aka—homework), allowing the opportunity for generalization, and reinforcing positive behavior and skill mastery. The actual session is structured in such a way that it provides a consistent approach to each meeting. The session always begins with a relational check-in followed by these steps:

- setting the agenda
- reviewing the current status of the child and the events of the past week or time since the last meeting
- soliciting feedback regarding the previous session
- reviewing any homework that was given from the previous session
- focusing on the main agenda items that were collaboratively developed during the agenda setting
- developing new homework for between-session continuity and soliciting feedback on the current session
- checking-in on the relationship.

The application of the order of the session is somewhat flexible depending on the needs of the child and the clinical
Components of Practice (Interventions and Techniques)

When using CBT interventions with youth, a number of valuable strategies are available for responding to the various problems of children. In fact, quite a few detailed approaches exist to address specific disorders, many of which we highlight in Section II of this book. To obtain specific cognitive and behavioral techniques beyond what we cover in this volume, we direct the reader to the following books: *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts* by Friedberg and McClure (2002), *Cognitive Therapy Techniques for Children and Adolescents: Tools for Enhancing Practice* by Friedberg, McClure, and Garcia (2009), and *What Works When with Children and Adolescents: A Handbook of Counseling Techniques* by Vernon (2002). We encourage practitioners to use the knowledge gleaned about individual students to help identify which modules and interventions would be most effective to meet the unique needs of the children they treat.

CONCLUSION

Given the need for short-term, flexible mental-health services within school settings, the CBT model is ideal. The structure and framework of CBT parallel the existing organization of school systems, while allowing for interventions that focus on situation, cognitive, behavioral, affective, and social factors inherent in many difficulties seen in youth. CBT has much promise for enhancing and modifying service delivery in
schools, and has the potential to go beyond providing interventions to individual students. School-based clinicians must use their knowledge of CBT, as well as their understanding of youth in general, to develop effective and efficient treatment or intervention planning.

Although considerable advancements have occurred with regard to supporting the use of CBT with children and adolescents, a number of areas continue to require research before full advancements in the use of CBT in schools will occur. Despite the existing evidence base supporting the efficacy and effectiveness of CBT for a variety of child and adolescent problems, further investigation is necessary to obtain a wider knowledge base of problems that can be treated with CBT, as well as to expand the use of CBT to a multilevel framework of interventions (see Chapter 2 for discussion of a multileveled school-based mental-health model).

Furthermore, notwithstanding the need for school-based mental-health programs, there is question whether school-based clinicians are sufficiently trained to provide CBT interventions. This is a challenge facing university training facilities, as well as those organizations providing continuing professional development for school-based practitioners. Finally, using CBT as a means of addressing students' problems will require a paradigm shift for many educators. Most services provided to date in schools, for emotional and behavioral issues, have primarily involved behavioral interventions. However, current trends are now moving in a direction where support for use of cognitive and behavioral intervention is growing, as well as the need to develop service-delivery models to meet the needs of students.

REFLECTION QUESTIONS

1. What is your current theoretical approach to psychotherapy? How might you incorporate CBT into your practice and move toward a CBT orientation?
2. How might you determine a child's readiness to change, and what interventions might you include in your treatment planning as a result of determining that readiness?
3. Think of one of your current cases. How might you approach the case differently using a CBT conceptualization and modular-based interventions?
Professional Resources
Association of Behavioral and Cognitive Therapies (ABCT).
www.abct.org.

REFERENCES


http://www.routledgementalhealth.com/9780415807401


