Essential Counseling Skills for School Psychologists

CASP SPRING INSTITUTE 2022

Anxiety and Depressive Disorders

General Overview

Anxiety Disorders

- Panic Disorders –Repeated panic attacks (brief episodes of intense dread accompanied by a variety of physical and other symptoms) together with worry about having additional attacks.
- Agoraphobia –Fear situations or places where they might have trouble obtaining help if they became anxious.
- Generalized Anxiety Disorder – These individuals feel tense or anxious much of the time and worry about many different issues.

Explaining Anxiety to Parents/Teachers

- A certain amount of anxiety isn't just normal but adaptive.
- Normal fear keeps us out of dangerous situations.
- Yes, we all feel fear, but no he/she can't just get over it.
- The best explanation is fear takes over and forces our bodies to betray us.
- I will tell parents/teachers to think of the thing their most afraid of and then tell them to imagine their brain not letting them stop thinking of it.

Explaining Anxiety to Parents/Teachers

- In the case of panic attacks, imagine running as fast as they can for 30 seconds, and when they stop running their heart and breathing won't stop.
- Another way to explain panic attacks, have the parent/teacher breath through a coffee straw for 2 minutes to simulate breathing during a panic attack.
- Ultimately, I try and explain that anxiety disorders are biological and dis-logical

Panic Disorder

- A common anxiety disorder in which the person experiences unexpected panic attacks and worries about having another.
- Though the panic attacks are usually uncued, situationally predisposed attacks and cued/situationally bound attacks also occur.
- A strong minority will have nocturnal panic attacks in addition to having them when awake.
- Approximately half of individuals with panic disorder will have symptoms of agoraphobia.

Panic Attack Symptoms

- During a panic attack a person typically feels foreboding- a sense of disaster that is usually accompanied by cardiac symptoms and trouble breathing.
- The experience usually last less than 30 minutes.

Other Panic Symptoms

- Trembling or shaking
- Dizziness
- Shortness of breath
- Sweating
- Chest pain
- Typically described as feeling like they are **"Going Crazy"**

Panic Attack Facts

- Previously believed only to occur in adulthood
- Seen more commonly in children starting around 11 yrs.
- Panic disorder is lower among children and adolescents than other anxiety disorders. However, prevalence rate increase in adolescence.
- Rates are twice as high for female adolescents than male adolescents (consistent with adults).

Agoraphobia

- The fear some people have of any situation or place where escape seems difficult or embarrassing, or where help might be unavailable if anxiety should occur.
- Open or public places such as theaters and crowded stores or travel from home.
- Persons with agoraphobia either avoid the feared place or situation entirely.
- If they must confront it, they suffer intense anxiety or require the presence of a companion

Agoraphobia Facts

- Used to be a companion of Panic Disorder in DSM-IV (Panic Disorder with or without Agoraphobia)
- DSM-V now treats it as two separate disorders.
- The excessive anxiety and avoidance lasts for at least six months.
- Occurs in childhood but peaks in late adolescence and early adulthood.

Generalized Anxiety Disorder

- A chronic anxiety disorder, defined by excessive anxiety and worry more days than not over a period of 6 months.
- The individual finds it difficult to control the worry
- "A chain of thoughts and images, negatively affect-laden and relatively uncontrollable…"
- Physiological symptoms

Worries Reported by Kids and Teens

- The future
- Past behavior
- Competence in areas such as sports, academics, and peer relationships.
- Natural disasters
- Being physically attached
- Being bullied

GAD Diagnostic Symptoms

- Children must have only one of these symptoms while adults need 3
- Muscle tension
- Irritability
- Restlessness
- Difficulty with concertation or mind going blank,
- Being really tired
- Difficulty sleeping

Worry or GAD?

- The worry of GAD is not typically situation specific. It starts without a specific cause.
- It is hard to control.
- The student presents with the physiological features.
- GAD on average is diagnosed around the age of 30 years.
- However, onset can be traced back to early teens.
- No difference found between the number or types of symptoms reported by kids vs. teens.

Depressive Disorders

- Major Depressive Disorder – No manic/hypomanic will be either recurrent or single episode
- Persistent Depressive Disorder– No high phases lasts much longer than MDD. Not usually severe enough to be called an episode of major depression.
- Disruptive Mood Dysregulation Disorder – A child's mood is persistently negative between frequent, severe explosions of temper

Explaining Depression to Parents/Teachers

- It's different then just feeling sad or down
- It is a medical disorder that is the result of their brain chemistry. That imbalance impacts their feelings and the way they experience the world around them. It may make them feel like your being dismissive even when you are showing them love.
- There isn't one event that makes a child depressed nor is it because they weren't loved or have bad parents

Major Depressive Disorder

- A person who has one or more major depressive episode without manic or hypomanic symptoms, is said to have major depressive disorder.
- Common condition affecting approximately 7% of the population
- Affects women twice as often as males
- Typical onset is in the mid to late 20s but can occur at anytime time of life from childhood to old age.

Features of MDD

- Characterized by one or more major depressive episodes
- A major depressive episode entails:
  - A period of at least 2 weeks during which a person experiences depressed mood or loss of interest or pleasure in nearly all activities most of the day,
  - Nearly every day,
  - Accompanied by at least four additional symptoms of depression present nearly every day

Symptoms of MDD

- Significant weight loss (not related to dieting), or significant weight gain, or decrease/increase in appetite (leptin/grelin)
- Insomnia or hypersomnia
- Psychomotor agitation or retardation sever enough o be observable by others
- Fatigue or loss of energy
- Feelings of worthlessness, or excessive or inappropriate guilt

Symptoms of MDD Cont.

- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thought of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan to commit suicide
- The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Duration/Population MDD

- Symptoms can last on average from 6 to 9 months
- However, the range can really be from a few weeks to many years.
- Strongly hereditary – first degree relatives have a risk several times higher than the general population
- For many individuals depressive symptoms remain the same from one episode to the next.
- The average age for onset is 14 yrs. for boys and girls

Persistent Depressive Disorder

- These individuals are chronically depressed.
- For years at a time they have many of the same symptoms found in major depression: low mood, fatigue, hopelessness, trouble concentrating, and problems with appetite and fatigue.
- No inappropriate guilt and thoughts of death or suicidal ideation.

PDD

- It can begin at any age however, late onset is uncommon
- Classic cases start quietly and so early in life that some individuals regard their habitual low mood as normal
- They often suffer quietly, they tend to put their energy into work or school and have little left over for the social aspects of their life.
- Because they don't appear severely disabled these individuals may go without treatment until their symptoms worsen into a major depressive episode.

PDD Onset

- Average age of onset for boys and girls is 11 yrs.
- Children's mood may present as more irritable rather than depressed
- It must last for at least 1 year for children/adolescents
- The DSM-V now emphasizes persistence of the symptoms rather than severity

Disruptive Mood Dysregulation Disorder

- New to the DSM-V
- Intended to provide an alternative to an excess of diagnosis of bipolar disorders in children when the presentation is marked by severe and persistent temper outbursts and irritability rather than classic episodic mood changes.
- Defined as pronounced and frequent temper outbursts, with rage, aggression, and persistently angry mood.

Symptoms

- Minor provocations (too much mustard on a hot dog or their favorite shirt is in the wash) can provoke the child into intense anger and aggression.
- Some children may refuse to do chores, homework, or bathe.
- Outbursts occur every couple of days on average.
- The child's mood is persistently negative – depressed, angry, or irritable.

Initial Interview

Getting therapy started

Clinical Interview

- It involves an interpersonal interaction that has a mutually accepted purpose, with formal, clearly defined roles and a set of norms governing the interaction.
- The purpose is to obtain relevant information in order to make an informed decision about the interviewee.
- May cover a specific set of topics or histories; formulate a detailed description of a specific problem, and/or conduct a mental status exam.
- The interviewer uses probing techniques to obtain detailed and accurate information.

Clinical Interview

- Establish an accepting atmosphere in which interviewees/clients feel comfortable talking about themselves.
- Must be respectful, genuine, and empathic.
- Must have a sound knowledge of child development, psychopathology, and effective listening skills
- Must gather information and continuously assess the interviewees' thinking, affect, perceptions, and attributions.

Clinical Interview Snapshot

- Takes about 45 minutes (once experienced)
- 15% determine chief complaint (~ 7 minutes)
- 30% pursue specific diagnosis (~13 minutes)
- 15% medical history, family history (~ 7 minutes)
- 25% personal history, social history, evaluate psychopathology (~11 minutes)
- 10% conduct mental status exam (~4 minutes)
- 5% discuss diagnosis and treatment, plan next meeting (~2 minutes)

Starting The Interview

- Introduce self, offer to shake hands, indicate preferred seating arrangement
- Avoid small talk
- Try to do interview without other informants present
- Take notes, but not obsessively – still need to maintain rapport and observe behavior
- Opening Question: Please tell me what problems made you come for treatment.
- Then allow patient to describe reasons for seeking treatment

Starting The Interview

- Continue to Maintain Rapport
- Assess your own feelings
- Consider how you speak
- Talk the client's language
- Maintain Boundaries – friendly collaboration, addressing a client
- Show your experience – sound authoritative not authoritarian
- Use verbal and nonverbal encouragements
- Offer reassurance as appropriate

During The Interview

- Answer questions clearly and as directly as possible
- Periodically assess how the interview is going and make adjustments as needed
- Don't be afraid of silence.
- Check to see that your understanding of the problem is correct by offering a concise summary of the essential details

Ending The Interview

- Evaluate the information -do you need follow up interviews?
- End the interview in the same friendly manner that it started.
- At the end of the interview give the interviewee an opportunity to ask you any question that they may have.

Being A Good Listener

- Listen creatively and empathically and to probe skillfully beneath the surface of the conversation.
- Be free of preoccupations and give your full attention.
- Attention not only to what the interviewee says but also to how they say it. The tone, expressions, gestures, as well as to the physiological cues, such as pupil dilation, tremors, and blushing.
- Be aware of what is not said, the feelings or facts lurking behind the interviewee's words.

Questions to Avoid

- Yes or No - don't want to create a feeling of being interrogated
- Double Barreled Questions - may confuse or impact ability to answer
- Long Multiple Questions - may confuse or impact ability to answer
- Leading Questions/Coercive Questions - don't telegraph the answer you want/expect

Questions to Avoid

- Random Probing Questions - don't go fishing
- Embarrassing or Accusatory Questions - may lead to defensiveness and impact answers
- Why Questions - may lead to a need to justify the behavior you are exploring

Fundamental Skills for Counseling

Techniques that work regardless of the theoretical orientation

Listening Responses

- Listening can be defined as involving three processes: 1) receiving the message; 2) processing the message; and 3) sending a message.
- In general, these techniques are responses to client behaviors (i.e., statements, body language, etc.).
- They are intended to communicate to the client that: 1) the therapist is listening; and 2) the therapist is accurately receiving/processing the information.

Types of Listening Responses

- **Clarification:** Is it that…?" "I'm confused about…Could you go over that again, please?" and "Sounds to me like you're saying…"
- **Paraphrase:** "I had a lousy day today." In response, a therapist may say, "Things didn't go so well for you today."
- **Reflection:** "You're feeling uncomfortable about seeing him again," "You really resent being treated like a child," and "Sounds as if you're really angry at your mother."

Types of Listening Responses

- **Summarization:** the therapist synthesizes what has been communicated during a session and highlights the major affective and cognitive themes. Thus, a summary is a type of clarification.
- **Minimal Verbal Responses:** These are verbal cues such as "uh-huh," "mm-mm," I see," and "yes," all of which indicate that the therapist is listening and following along.

Action Responses

- Action responses, unlike listening responses, are active rather than passive and involve counselor-directed more than client-driven style of communication.
- These responses are based heavily on the therapist's perceptions and hypotheses and move beyond the client's frame of reference.
- These are the means through which information is gathered and change processes like consciousness raising occur.

Types of Action Responses

Probing: Probes are open and close ended questions which are employed to obtain more information about something.

- **Close-Ended Probes**: useful if the therapist needs a particular fact or seeks specific information. typically begin with words such as "are," "do," "can," "is," "did," can be answered with yes, no, or short response.
- **Open-Ended Probes:** beginning the interview; encouraging the client to express more information; eliciting examples of particular behaviors, thoughts, or feelings; and developing client commitment to communicate.

Types of Action Responses

Confronting: providing the client with honest feedback about what is really going on.

- Genuineness, "I feel you really don't want to talk about this," and "I'm wondering why you feel you always have to take the blame. What do you get out of that?"
- Discrepancy, "You say you're angry, yet you're smiling,"
- Use "I" messages, to "own" your responsibility for the confrontation. by openly sharing your own genuine responses to the client or by focusing on avoidance or resistance.

Types of Action Responses

Interpreting: the therapist adds something to the client's statement or tries to help the client understand their underlying feelings, their relation to the verbal message, and the relation of both to the current situation.

- "I just can't bring myself to write that report. I always put it off and it's hanging me up right now."
- "You seem to resent having to do something you don't want to do."
- If the interpretation is useful, it will add to the client's understanding, and the therapist will receive a reaction reflecting, "Yes, that's it." If it's not useful, the client may say, "No, not that but…"

Types of Action Responses

Information Giving: the therapist shares objective and factual information

- Side effects of medications, reactions to trauma or stress, and the pattern of typical development (in children, adults, or the elderly).
- It is important to make a distinction between *informing* and *advising*, which is subjective and verges on telling the client on what to do. Advice is all right as long as it is tentative, with no strings attached, and as long as it is clearly advice, not a demand.

Types of Action Responses

Checking Out: occurs when the therapist is confused about his or her perceptions of the client's verbal or non-verbal behavior or when the client has a hunch the bears trying out.

- "I feel that you're upset with me. Can we talk about that?" "Does it seem as if…?" or "I have a hunch that this feeling is familiar to you."
- The therapist asks the client to confirm or correct the perception or understanding, in contrast to a clarifying request, which elicits a deeper, clearer understanding.

CBT Strategies for Counseling in Schools

CBT Overview

- Merges behavior therapy with cognitive therapy - short term, problem focused cognitive and behavioral strategies
- Primarily focuses on helping clients identify and change maladaptive attitudes and beliefs
- Changes cognitive processing, emotional experiences, and problem behaviors,
- May also include techniques to change behavior through modifying associated responses and/or antecedents and consequences in the situation.

CBT Overview

- The therapeutic process generally involves teaching and guiding the client toward more adaptive ways to think and behave.
- Historically developed for and is traditionally use to treat adults.
- General consensus that CBT approaches have empirical support for treating psychological disorders of childhood.
- CBT approaches for children must consider developmental issues.

Definition and Guiding Principals

- A class of interventions and techniques based on cognitive and behavioral theories and supported by scientific evidence.
- Behavioral perspectives within CBT consider how behaviors are learned through paired associations & cognitive perspectives
- CBT emphasizes the role of thinking in how we act & feel.

Definition and Guiding Principals Cont.

- Partly based on the notion that thoughts mediate our emotional & behavioral responses not external events (people, situations) that cause our responses but rather our thoughts about those events. If we change our thoughts, we can change our behaviors & feelings.
- All behavioral and emotional responses are learned and therefore can be unlearned by replacing unwanted responses with new ways of reacting.
- An array of therapies that have common principals.

Five Guiding Principals of CBT

- Collaborative effort between client and therapist.
- Promotes self-efficacy to tolerate emotions and change behavior.
- Short term and directive
- Present focused and goal oriented
- Monitors progress toward goals

Collaborative Effort Between Client and Therapist

- CBT involves collaboration between the client and the therapist.
- The client elaborates on goals and the therapist helps the client achieve those goals.
- The therapist has the theoretical and technical expertise and the client is an expert about him/herself who actively participates in the treatment.
- Clients become self-sufficient and do not need to rely on the relationship with the therapist for change to occur.

Promotes Self-Efficacy to Tolerate Emotions and Change Behavior

- CBT encourages clients to use scientific or inductive reasoning
- Clients use logic to evaluate their unwanted or upsetting thoughts, rather than basing their emotional reactions and behaviors on perceptions that may be inaccurate.
- Clients are taught that they can tolerate negative emotions and choose new ways to behave.

Short Term and Directive

- Time limited and based on achieving goals that are initially set by the client and the therapist.
- Structured and directive
- An agenda of skills to be taught by the therapist that focus on helping the client to achieve his or her goals.
- Typically, therapists provide instruction and homework assignments to complement what is taught in the session.

Present-Focused and Goal-Oriented

- The CBT therapist does not focus on developmental origins of behavior.
- Instead, CBT emphasizes things that can be done now to resolve current difficulties and achieve goals in a step by step fashion.

Monitors Progress Toward Goals

- Progress toward goals is tracked and monitored via objective behavior as well as self-report.
- Consistent with the empirical approach, therapy is modified as needed if progress is not being made.

General Strategies Used in CBT

Cognitive Restructuring

- Cognitively based therapies in the cognitive restructuring category assume that maladaptive thoughts lead to negative reactions; therefore, these thought patterns are challenged, and the goal is to replace them with more appropriate and adaptive beliefs.
- Beck's cognitive therapy of depression
- Ellis's rational emotive behavior therapy

Skills and Reinforcement Strategies

- Largely based on behavioral principles
- Teach coping/problem solving skills
- Help clients cope/solve problems that generalize to a wide variety of problems that clients might encounter.
- Not specific to a particular disorder/target a core deficit that is believed to cut across various disorders or distress reactions.

Skills and Reinforcement Strategies Cont.

Systematic Rational Restructuring

- Clients are taught the process of exposing themselves to anxiety-provoking images or situations, monitoring cognitions, developing rational reevaluations, and measuring subsequent changes in anxiety levels.
- Behavioral monitoring clients are taught to observe and record their own feelings, thoughts, and behaviors as they occur, so that they can become aware of the relationships between these variables, then institute cognitive and behavioral changes.

Skills and Reinforcement Strategies Cont.

- Stress inoculation training involves educating clients about the nature of stress, teaching coping skills, and rehearsing these new skills during exposures to stressors.
- Relaxation training (progressive muscle relaxation or diaphragmatic breathing) and behavioral rehearsal (teaching skills through instruction, modeling, role play, and feedback).

Problem Solving Therapy

- Learning the process of problem solving - identifying problems, clarifying goals, generating possible solutions, evaluating the possible outcomes, then implementing and evaluating the solution.
- Equips clients with the tools they need to deal effectively with future stressors or difficulties.

Exposure Based CBT

- Based on principles of extinction of classically conditioned responses and are mostly used to treat anxiety, although they are also sometimes used to treat substance use or eating disorders.
- Clients are exposed to the feared object/situation repeatedly without reinforcement or avoidance, until the object/situation loses its association with the fear or craving.

Modifying CBT for Children and Adolescents

The younger they are the harder we work

Developmental Modifications for CBT

- Children are dependent upon larger systems within which they are embedded and display a wide range of cognitive maturation or ability.
- Include parents or other key caregivers in the treatment process, incorporate concrete and tangible examples, use methods that match the child's cognitive abilities, and/or to incorporate lessons into developmentally appropriate play routines.

Developmental Modifications for CBT

- Motivation to attend therapy is a critical component that needs to be considered in CBT youth.
- Therapists must assess the child's motivation and use methods that make the treatment a generally enjoyable experience.
- It may be important to include parents in the treatment process with children of younger ages or developmental levels. In adolescence, a decision needs to be made about whether it is appropriate to include parents.

Developmental Modifications for CBT

- Parents may consider discussing upcoming events and challenges with their children to help be better prepared for difficult situations. They can anticipate the event and have thought about what coping skills might be helpful.
- Parents are encouraged to focus on the positive aspects of the anticipated event and to remind children to their repertoires of coping skills.

Developmental Modifications for CBT

- Children should be able to generalize acquired skills beyond the therapy setting - home, school, and with friends.
- Incorporate role plays based on typical or challenging social situations in order for children to practice some of the encounters they are likely to face in real life situations.
- Interpersonal relations and greater autonomy from parents can also be woven into therapy.

Motivation

- Children may not see their behavior as problematic, nor view their behaviors as excessive, or their expectations unrealistic.
- They may be more likely to deny their symptoms and less likely to desire help as the potential for self-reflection continues to develop over the elementary school years.
- Psychoeducation may be more critical in the case of a child, than in the case of an adult.

Motivation - Psychoeducation

- Provide information to the child and family about the purpose for engaging in certain exercises
- Have the child summarize frequently during sessions to gauge his/her level of understanding.
- Help children understand why counseling is relevant, or what about it might be motivating from the child's point of view.
- Motivators might include finding it easier to make friends or less nagging from parents or teachers about their behavior in school or at home.

Modifications for Children

- Meet more frequently than once a week.
- May improve the efficacy of CBT because it helps children retain what is discussed in each session and decreases the amount of time between assigning homework and evaluating how the assignment went.
- Greater efficiency because less time is needed to review from one session to the next, rapport and cohesion develop faster and distractions between session can be minimized.
- Make examples more concrete and tangible

Modifications for Children

- Children may benefit from more behavioral interventions (deep breathing) earlier in treatment to demonstrate the effectiveness of coping skills.
- When working with a group of children with depression initiate a fun and energizing activity, meant to create intense positive emotional engagement, to allow children to experience a boost in mood during session.

Modifications for Children Cont.

- Use examples from a child's own life to make learning cognitive constructs more concrete.
- The link between thoughts and emotions can be solidified by using examples that are real to life and therefore easier to understand.
- Stories and videotaped vignettes may help to make abstract ideas more concrete.

Visual Aids

- Children may benefit from labeling a cutout of a child's body with the locations in which they feel the physical sensations of an emotional experience.
- Cartoons with blank thought bubbles can help to promote thinking about what another individual may be experiencing.
- A visual thermometer can be used to label and monitor the child's intensity of emotion.

Metaphors

- In many CBT programs for treating OCD in children and adolescents, it is typical for youth to be asked to give OCD a nasty nickname to which they can talk back.
- When metaphors are used, they should be age appropriate and simple to understand. Metaphors involving popular TV characters, scenes from video games, or sports references.

Relaxation Strategies

- Scripts that use the notion of a metal robot (tensing) and rag doll (relaxed) can be easier for children and adolescents to follow than standard relaxation training language.
- Children and adolescents may also benefit from pictures that demonstrate the specific muscles that are to be tensed and relaxed as the sequence progresses.
- Relaxation for children should also be shorter in duration, with fewer distinctions between different muscle groups than is typical for training relaxation skills in adults.

Play and CBT

- There are many different ways in which lessons can be incorporated into play routines. In some treatment programs, activities can even be tailored to the specific interests of the child or group of children, in order to maximize interest in engagement.
- As a general recommendation, creative expressions such as drawing, writing stories, dancing, and singing can be used to reinforce key concepts.

Play and CBT Cont.

- A game of hot potato in the first half of treatment could require a child to identify an emotional expression, while a similar game in the second half of treatment could require a child to find a way to turn a negative thought into a positive one.
- When selecting techniques, therapist may need to be sensitive to the needs and abilities of older children who may resent games or activities that they view as immature.

Please feel free to reach out

GMKpsychservices@gmail.com