COUNSELING INTERVENTIONS FOR SCHOOL PSYCHOLOGISTS

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OBJECTIVES
- Discuss how counseling fits in the practice of school psychology
- Explore the importance of an effective therapeutic relationship
- Discuss how to select and use specific techniques to address referral problems and individual student and system characteristics
- Explore techniques that take into account cognitive abilities, verbal abilities, motivation, and other sources of support
- Address the measurement of intervention outcomes

COUNSELING IN CONTEXT

Bronfenbrenner’s Ecological/Systems Model
Roles of school psychologist
Nature and process of counseling
Working within special education model
Linking assessment to intervention
Family and systems issues
Case study approach

Constraints in Counseling Role
- Educational need must be present
- IEP team consensus needed
- Measurable outcomes required
- Specific time frame adhered to
- Multiple relationships considered
- Available time and support for role

Advantages for Counseling
- Naturalistic environment for observation and generalization
- Parents not charged a fee
- Teacher consultation available
- Can be supported by parent, teacher, administrator consultation
- Students are already there

Preparation/Competence
- Graduate training
- Experiences in school practice
- Theoretical/Empirical Grounding
- Limitations/Concerns

Ethical Considerations
- Multiple Relationships
- Consent/Assent
- Confidentiality
- Competence
Purpose of Counseling as a Related Service?

- Ultimately, the purpose of counseling is dismissal from counseling.
- General goals, along with short-term goals and objectives will move us in the direction of dismissal.
- Counseling is not the only change option.

Related Service Counseling

See Federal Register, V. 71, No. 156, Monday, August 14, 2006

Related services means...services as are required to assist a child with a disability to benefit from special education and includes... psychological services... counseling services...

Related Service Counseling

Related services also include... parent counseling and training.

Counseling services means services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.

More Psychological Services

Planning and managing a program of psychological services, including psychological counseling for children and parents

Assisting in developing positive behavioral intervention strategies

California Guidance Documents for Related Services

Parent Counseling/Training

Assisting parents in understanding the special needs of their child

Providing parents with information about child development

Helping parents to acquire the necessary skills that will allow them to support the implementation of their child’s IEP
Referral

- Referral should ideally be an extension of the RTI process
- Are there good Tier I practices in place?
- Referral for counseling as a related service should ask specific questions.
  - Does X need counseling to be successful in school?
  - Does X have competencies to make counseling beneficial?
  - If counseling is indicated, what are the goals?

What is Counseling as a Related Service?

Recall that IDEIA is vague on the subject.

Essentially, it a service (or set of services) provided to address social, emotional, and behavioral functioning in an effort to assist a child to benefit from special education.*

IDEIA 2004 Requirements

Annual goals must include:
Description of how and when progress will be measured;
A statement of the related service, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modification or supports for school personnel that will be provided to enable the child to…

Overview of Steps

- Referral
- Assessment
- IEP Development
- Intervention
- Progress monitoring
- Dismissal
- Follow-up

Evidence-Based Practices (EBPs)

Evidence-Based Practices: What Are They?

The American Psychological Association (APA) has defined EBP as:

…the synthesis of empirical evidence, clinical expertise, and patient values in implementing treatments.
Evidence-Based Practices: What Does it Mean?

- Strong Evidence: randomized controlled studies, well-designed and implemented, show effectiveness in at least 2 settings
- Possible Evidence: do not meet above criteria, but studies support positive change via meta-analysis and/or pre-post design
- No Evidence


More Sites for EBPs

- Intensive Interventions
- Effective Child Therapies
- Evidence-Based Behavioral Practice
- California Evidence-Based Clearinghouse for Child Welfare

Counseling Process

School Climate

Referral

Parental Support

Technique

Relationship

Outcome

Example: Eclectic Counseling Model

Person-Centered
Active Listening
Empathy
Unconditional Positive Regard

Relationship as Foundation

Play, Sand Tray, Open-Ended
Art Therapy, Drawings, Movement
Gestalt Therapy, Relaxation, Mindfulness
CBT, Reality Therapy, DBT Solution-Oriented

Less Directive
More Directive

Child Oriented Counseling: General Goals

- Provide a place of trust and safety in school
- Reinforce and support other school missions
- Build capacity for self-help, self-direction, and self-regulation, bolster social capital (EF)
- Develop empathy through experiences of active listening and positive regard
Psychotherapy (counseling) works. Much research shows about 75-80% of people who enter psychotherapy benefit, across a wide range of disorders and treatment formats. Like all complex human endeavors, many factors account for the success (or failure) of counseling. The client, the counselor, their relationship, the technique, and the context all play a role—an optimal fit of these factors promotes effective treatment.

--Norcross & Lambert, 2010

"In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?" - Carl Rogers, Ph.D.

Research-supported conclusions from 20+ meta-analyses:

- The relationship makes substantial contributions to patient success
- It accounts for why clients succeed (or not) as much as the therapy method
- Efforts to promote evidence-based treatments (EBPs) without considering the relationship are incomplete and potentially misleading

--Norcross & Lambert, 2010

Alliance with both youth and their parents is predictive of positive outcome
- Treatment plan should incorporate both youth and parent perspectives, which requires attention to multiple perspectives
- Alliance formation is a recurrent task that must be monitored over time for successful outcomes
- Nonsignificant but stronger outcomes for behavioral counseling strategies with youth

--Shirk & Carver, 2010

Therapist: So, what’s it like when you’re feeling really down?
Client: I get like I don’t want to talk to anyone. I’m like get away, leave me alone. My dad asks me how I’m doing and I just say nothing or walk away.
Therapist: You just want some space. You don’t want to be pushed.
Client: Exactly.
Therapist: In here. I’m going to ask you a lot about how you are feeling. If you feel like I’m pushing you, is it possible you won’t want to talk with me?
Client: I don’t think that’ll happen because you’re not in my face. Talking gets my stress out. When I’m in a bad mood on the day of our meetings, I look forward to our talking.

Example provided in Shirk & Carver, 2010 (SAMHSA)

Effective Counseling Relationship Characteristics

- Alliance
- Empathy
- Goal Consensus and Collaboration
- Positive Regard and Affirmation
- Congruence/Genuineness

-Norcross & Lambert, 2010
How to Establish Effective Counseling Relationships

- Reliability
- Communication
- Maintaining Trust & Boundaries
- Humor/Fun
- Uniqueness of Interaction
  - Distinct from other adult/child relationships
  - Personalized

Client Concerns about Counseling in School

- “They say it’s private, but it doesn’t really feel like that.”
- “Why do they always just dive in? Makes kids back off. Each kid’s got to be able to adjust, let him open up to you.”
- “Kids hate tactics. Not just talking, find something the kid enjoys.”
- “It makes me really angry when they want to talk the whole time.”

Counseling Activities: Questions to Guide Choices

- What is the child’s developmental level, especially verbally and cognitively?
- What is the trust level?
- Is there a specific presenting problem? Motivation for change?
- Are supportive resources (parents, teachers) available to implement strategies?
- Is immediate change necessary for the child’s safety or well-being? May require crisis intervention, systems intervention first.

Low Cognitive/Low Verbal

Behavioral Techniques to foster consistent environmental structure, behavioral expectations, and consequences (consider behavioral consultation, parent training)

Behavior contracts/charts/visual aids to document and reinforce progress. Tangible rewards effective.

*above most effective if match home/school efforts for specific behavior change

- Low verbal demand art/play activities to build sense of safety and alternatives to verbal communication
- Focus on relationship: reliability, acceptance, respect and fun

*last 2 more pertinent to ongoing counseling relationship

Examples of Technique

- Drawing
- Clay
- Visual Aids
  - voice volume control
  - do2learn.com
Nondirective Approaches with low verbal demand

Social modeling (e.g., movie clips, counselor modeling via role play)

Bibliotherapy (e.g., fables, commercial therapy materials)

Unconditional positive regard

Nondirective mode (warmth, genuineness, tracking, reflection, tolerance of low structure, theme and metaphor recognition)

Person-Centered counseling (congruence of ideal and real selves, relationship of primary importance)

Can be effective when motivation and trust need to be developed

Presume client capacity for growth and health

Gary Landreth: Nondirective Play Therapy

Person-Centered Play Therapy has broad research support across ages, problems, and type of play approach (Prout & Fedewa, 2015), although there is a lot of variation in studies (setting, length & number of sessions, etc.)

Tray dimensions (30 x 20 x 3 inches)

Array of miniatures in the categories of people, animals, vegetation, buildings, vehicles, fences and signs, natural items (shells, rocks, nests, etc), fantasy (monsters, dragons, aliens, fairies, etc.), spiritual/mystical, landscaping (bridge, treasure), household (tools, furniture)

Dry high-quality sand

Water as an option
Use of sandtray developed concurrently with play therapy (Freud, Klein), which was conceptualized as a technique for forming solid therapeutic relationships *substituting play for verbalization* in work with children. Kalff, a Swiss Jungian analyst, further expanded and popularized the technique, calling it “Sandplay” (Homeyer & Sweeney, 2002).

Clients have the capacity for self-healing given supportive, healthy context. Verbalization by client and interpretation by therapist are not required.

- Empty Worlds (<50 elements)
- Unpeopled Worlds
- Aggression
- Closed Worlds (fenced in)
- Worlds with Rows (over-exaggerated uniformity)
- Disorganized worlds

Clients have the capacity for self-healing given supportive, healthy context. Verbalization by client and interpretation by therapist are not required.

**Possible Indicators of Emotional Disturbance**

- Empty Worlds (<50 elements)
- Unpeopled Worlds
- Aggression
- Closed Worlds (fenced in)
- Worlds with Rows (over-exaggerated uniformity)
- Disorganized worlds

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**Positive Content/Transformation**

- Journey along a path, around a center
- Bridging—linking of elements
- Vitality—organic growth, machines work on task
- Deepening—treasure unearthed, well dug
- Birthing—baby born, flower opens
- Reconstructing—creative use of elements
- Centering/Balance of elements
- Integrating—congruent use of entire tray

Clients have the capacity for self-healing given supportive, healthy context. Verbalization by client and interpretation by therapist are not required.

**Rationale for Sandtray with TBI**

- Trauma and loss have occurred
- Verbal abilities may be impaired
- No rules to remember and follow
- Client controls action and outcomes of their scenes. May be directive or nondirective, depending on client skills and needs

Clients have the capacity for self-healing given supportive, healthy context. Verbalization by client and interpretation by therapist are not required.

**Nondirective Sandtray Technique**

- General Prompt—Make a scene in the sand that tells about you
- Observe production, with no need to question or track
- Prompt—Tell me about your scene
- Photograph

Clients have the capacity for self-healing given supportive, healthy context. Verbalization by client and interpretation by therapist are not required.

**Directive Sandtray Technique Example**

- Specific Prompt—Create a scene that describes your life before the accident (TBI)
- Specific Prompt—Create a scene that describes your life after the accident (TBI)
- Specific Prompt—Create a scene that describes your future
- Therapeutic Prompt—Add something to this scene that makes the (boy, girl, animal) feel safer

Clients have the capacity for self-healing given supportive, healthy context. Verbalization by client and interpretation by therapist are not required.
Case Study 4: MS

- 18 year old male admitted to residential program for 6 months for anger control issues, drug and alcohol abuse
- TBI at age 10 when hit by car while walking; reports suggest temporal and frontal injuries (not specified)
- Poor judgment and impulse control, word retrieval and comprehension difficulties
- Truancy, suspensions, expulsions, and problems with law and emotional regulation emerged over next several years
- Borderline IQ (premorbid average), with low average VIQ/PIQ, but very low processing speed.
- Motor planning and coordination problems and bilateral sensory deficits.

Art activities with prompts (KFD, Collage, Timeline, Scribble Art)
- Clay activities (e.g., make something that tells about you)
- Therapeutic use of games

**These techniques can be incorporated into CBT, Reality Therapy, Solution-Oriented**
Cognitive-Behavioral Therapy

"Men are disturbed not by things, but by the view which they take of them." - Epictetus (1st century AD)

**These require verbalization, metacognition, ability to remember and to think/plan ahead

Basic Principles

Client is understood in terms of his/her current thinking and its impact on feelings and behaviors.

What's the relationship between thoughts, feelings, and behaviors?

Basic Principles

• Foundation: strong therapeutic alliance

• Relationship Characteristics: warmth, caring, empathy, trust

Basic Principles

• The technique requires collaboration and active participation.

• Teamwork, partnership, working together involves gradual transition to increasingly active client.

• Requires some degree of metacognition, self-awareness, and motivation.
Basic Principles

- Sessions are goal oriented and problem focused.
- What are your problems, goals, and obstacles?

- Initial emphasis is on the present.
- Discussion involves the here and now. Counselor examines past experiences selectively when indicated.

- CBT is a psychoeducational model.
- The counselor teaches the client to be his/her own therapist, teaches the method to prevent relapse.

- CBT is a time-limited therapy.
- It typically requires 4-20 sessions to provide symptom relief and avoid relapse.

Structured sessions:
- Mood check
- Brief review of the week
- Collaboratively set agenda
- Feedback from previous session/HW review
- Discuss agenda items
- Assign homework
- Summarize/feedback

Sample Sequence

- Tell me about one thing that happened this week that you handled in a way you feel good about.
- Tell me about one thing that you wish you’d done differently.
- Was there a time when you were empathetic or helped someone else?
- What is something you enjoyed this week? What are you looking forward to?
Basic Principles
Teach clients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.
- Socratic questioning (guided questions)
- Collaborative empiricism (examining data together)

Cognitive Conceptualization
A situation triggers:
- Automatic thought (from core belief)
- Habits/Patterns become established

GOAL: Breaking Habits of Thought and Behavior

Cognitive Conceptualization
Ex: Thinking about father’s verbal abuse leads to automatic thought: “Not even my family loves me.”
(derived from core belief: I’m worthless)
Leads to feeling sad and little to no hope for change

Thinking Errors
- All or nothing
  “If I’m not a total success, I’m a failure”
- Catastrophizing
  “I’ll be so upset, I won’t be able to function at all”
- Discounting the positive
  “I did that project well, but only because I got lucky”

Thinking Errors
- Personalization
  “The waiter was curt to me because I did something wrong”
- Imperatives
  “I shouldn’t make mistakes” or “I must always be successful”
- Mind reading
  “He thinks I don’t do anything right”

<table>
<thead>
<tr>
<th>Situation</th>
<th>AT and % belief</th>
<th>Emotion</th>
<th>Adaptive response</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fight with father with verbal abuse and name calling</td>
<td>No one loves me. I’m worthless. 90%</td>
<td>Sad Hopeless</td>
<td>What’s the evidence that the AT is true? Is there another explanation? What’s the worst that could happen? What’s the effect of believing the AT?</td>
<td>New belief % in AT. New emotion or change in intensity. What will you do?</td>
</tr>
</tbody>
</table>
Mood Disorders
- Anxiety Disorders
- OCD
- Eating Disorders
- Substance Abuse
- Autism Spectrum Disorders
- Externalizing Disorders
- Psychotic Disorders

Choice Theory (Reality Therapy)
William Glasser

Choice Theory: 5 Basic Needs
1. Survival (the only physiological need): food, water, shelter, sleep, elimination, sexuality
2. Love & Belonging: be with & relate to others; share, join, & have relationships with others
3. Power: gain importance, recognition, & achieve competence
4. Freedom: move, choose, act, & think without restriction
5. Fun: learn, laugh, play, experience pleasure

The need that is satisfied least drives our behavior the most

Empirical Support for CBT

Choice Theory & Reality Therapy
Glasser was a board-certified psychiatrist
- Famous (or infamous) for never prescribing meds for clients
- Started teaching Reality Therapy in 1965
- Passed away August, 2013
- Techniques popular and appealing but lacks strong empirical base; can be incorporated into other techniques

Love & Belongingness
- It is the most important need because we need people to satisfy the other needs
- Based on choice theory, clients are choosing their behavior in an attempt to deal with the frustration caused by unsatisfying relationships
- The therapeutic relationship is so critical because when a client comes to you, it is most likely that they are in distress because the belongingness/love need is not being satisfied
The Quality World

- Shortly after birth throughout the rest of our lives, we begin storing information about what feels very good to us.
- They become specific pictures in our heads of the things that meet our basic needs.
- Encourage clients to take inventory of personal quality world.

Mental Illness According to Dr. Glasser

- Mental illness, for the most part, represents a choice (sometimes a very creative choice) to deal with the frustrated needs that are in our quality world.
- Very few mental illnesses can be attributed to brain anomalies (Alzheimer's).

Total Behavior

- All behavior is made up of 4 inseparable but distinct components:
  1. Acting
  2. Thinking
  3. Feeling
  4. Physiology
- Focus of RT is acting & thinking because we can control those.
- Main difference between CBT & RT: It is easier to act your way into a different way of thinking than to think your way into a different way of acting.

Role of Feelings

- Feelings are like a barometer of how well we are satisfying our needs within our quality world.
- When we feel, sad, angry, frustrated, etc., the root will be a need within our quality world that is being unmet.

The WDEP System

- Wants – What do you want? What do you want to have happen? How do you want this to turn out?
- Doing – What are you doing? (Actions, thinking, feeling). Don’t ask why...ask what.
- Plan – What’s your plan? What are you going to do?
**Other CBT-Related Models**

- Rational-Emotive Behavior Therapy (ABCDE model, focuses on intense feelings and their consequences)
- Behavior Therapy (requires less cognitive sophistication, more systemic intervention)
- Positive Psychology (not problem focused)
- Mindfulness Cognitive-Behavior Therapy (incorporates acceptance/awareness)
- Acceptance and Commitment Therapy (mindfulness + activation therapy)
- Dialectical Behavior Therapy

**Evidence-Based Manualized Approaches**

- Depression:
  - IPT
  - ACTION (Stark).
  - CWDA (ages 12-18) *Coping With Depression-Adolescents Manual and Workbook*
- Anxiety: Coping CAT (ages 7-13 plus adolescent version) *CAT* (Kendall, Furr, Podell, 2010)

**Brief Counseling Techniques**

- Solution-Oriented Brief Therapy
- Motivational Interviewing

**Solution-Focused Brief Therapy**

- Origins in family therapy
- Emphasizes what client wants to achieve in therapy rather than problems or failings
- Individuals best at generating own solutions
- Builds on client’s resources and motivation
- Adaptations for younger children

**Solution-Oriented Techniques**

- Take collaborative stance (resistance normal)
- Explore previous solutions
- Solution-oriented questions
- Miracle questions
- Scaling questions

**Solution Oriented Session**
Motivational Interviewing
- Establishing rapport, listening reflectively
- Asking open-ended questions to explore motivations for change
- Affirming the client's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals
- Asking permission before providing information or advice
- Responding to resistance without direct confrontation
- Resistance is used as a feedback signal to the therapist to adjust the approach. Encouraging the client's self-efficacy for change
- Developing an action plan to which the client is willing to commit

Explore Evidence Base by Disorder
- Effective Child Therapy
  - What class of techniques do you believe gets the most empirical support? Why?
  - Inclusion of family, multisystemic elements increases effectiveness of interventions
  - Remember that for EBI (EBP), the specific participants must be well-defined and may not represent your client(s). Settings where outcome is measured may be different. Techniques and training may be less flexible.

Considering Individual vs. Group Intervention
- Severity of emotional/behavioral interference
- Interpersonal relating/capacity to listen & share
- Ability to adhere to group ground rules
- Specific situational issues (e.g., divorce, grief) that lend themselves to group intervention.

Group Counseling
- Advance preparation (needs assessment, member selection, # sessions, curriculum, evaluation)
- Leadership skills (and getting coleader if possible)
- Multicultural considerations (ethnicity, homogeneous/heterogeneous, self-disclosure, social behaviors, etc.)

Major Advantage: UNIVERSALITY— I am not alone.

Family Considerations
- Take advantage of the opportunities we have to form alliances with families: interviews, IEP meetings, PTA talks
- Recognize that all behavior occurs in the context of dynamic and interdependent systems
- Use active listening and group management techniques to facilitate effective family-school collaboration

Counseling with Drug-Abusing Youth*
- Develop a strong yet caring relationship
- Help him or her to break the functional value of the drug use
- Abstinence is ideal but may need behavioral shaping towards that goal
- Motivational Interviewing (person-centered, not confrontational)
- Most effective with use/abuse rather than addiction

*adapted from NASP webinar presented by Ken Winters, Ph.D. on Nov. 6, 2013
Crisis Counseling
- People react differently to crises: meet them where they are
- Respect cultural differences in involving outsiders, grieving process, rituals
- Consider developmental levels in understanding of death and loss
- Recognize that teachers/staff grieve too
- Be prepared to follow up at a later date

Is Counseling Working?
- Providers have an obligation to collect data so that efficacy can be assessed, revisions made if needed, and dismissal planned when goals are attained.
- This is consistent with data-based decision making.

Progress Monitoring
- We’re required to monitor and report on counseling progress.
- Emphasis should be placed on data.
- Several tools can be used:
  - Counselor-made measures
  - Published Norm-Referenced Tests (pre-post)
  - Criterion-referenced measures (SEL curriculum, GAS, IEP)

Counselor-Made Measures
- Can be individualized to match IEP goals and objectives
- Completed by teachers, parents, students, etc.
- Can be informed by other sources of data (e.g., observations, behavior frequency counts, etc.)

HFD in Early Counseling Session
- “Me biting myself because that’s the way I’ve been. Feeling confused.”
Me looking Chinese, feeling happy, in a good mood. Lost a lot of weight.

PNRTs
- Provide a normative basis
- Typically not sensitive to small changes
- May have better reliability
- Easy to duplicate
- Ex: CDI-2, MASC-2, BRIEF, BASC

Progress Monitoring
- Behavioral Progress Monitoring

Criterion-Referenced Measures
- What if a school developed criteria for social, behavioral, and emotional success? Scope and sequence for social-emotional learning
- Skills and subskills enumerated
- Clear criteria and cut scores
- Could be used as an indicator of counseling progress, similar to IEP

Example of IEP Progress Report

Goal: Alex will make measurable progress in the area of behavioral functioning.
Objective: Demonstrate productive behavior in academic situations by increasing task completion (85%).

Progress report: Alex was seen for six counseling sessions this reporting period. Consultation with teachers and his mother played an instrumental role in monitoring and modifying his behavior. He has demonstrated greatly improved coping strategies and significant gains in assignment completion (85%).

Goal Attainment Scaling
- Criterion-reference progress monitoring tool
- Gaining popularity in education, mental health, and medicine
- Specific behaviors and criteria must be measurable
- Nonoverlapping data points

**Data-based decision**

**IEP committee decision if special education related service**

**Ultimately the goal**

**Continued support for generalization**

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**Table: Goal Attainment Scaling**

<table>
<thead>
<tr>
<th>Level of Expected Outcome</th>
<th>Rating</th>
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<tbody>
<tr>
<td>MUCH MORE Than EXPECTED</td>
<td>+2</td>
</tr>
<tr>
<td>MORE than EXPECTED</td>
<td>+1</td>
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<tr>
<td>EXPECTED Outcome</td>
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</tbody>
</table>

**Behavioral Statement of Expected Outcome: Goal 1**

**Behavioral Statement of Expected Outcome: Goal 2**

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**References**


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**Thank You!**

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**Always link progress to IEP**

- Regardless of the method(s) used, progress should always be framed in terms of the IEP goals and objectives, if related services counseling.
- Progress reporting should be data driven as well as narrative.

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**To Get CEUs**

- W12DJ