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INTRODUCTION

After family, schools function as the center of children's lives. Family and community identities and activities emanate from local elementary and secondary schools. These educational institutions are the center of service delivery to children and adolescents not only for academic instruction but also for extracurricular activities and a large range of community services. Community organizations and special events often convene within the school setting. Public schools remain one of the few mandated service providers for youth. Within the context of special education requirements, schools provide mental health services to children and adolescents even when other agencies or private practitioners may deflect or limit services.

As a focal point in the lives of children, adolescents, and their families, schools can be the optimal setting for the provision of psychotherapy for youth. School psychologists, social workers, and counselors observe, assess, interact, and intervene with students within their natural work and social

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environments where issues and problems commonly emerge. They may follow students and work with families periodically over the course of many years. Mental health service providers in community supported clinics and private service delivery settings must work closely with schools to understand the character and manifestation of the child or adolescent's psychological symptoms. Then, they must collaborate closely with school staff for problem solving and intervention planning, integrating aspects of treatment into the school context.

A central assumption of this text is that school-centered therapy is the most effective format for addressing social, emotional, and behavioral issues for children and adolescents. Therapeutic interventions are more likely to benefit students when strategies are integrated across individual, family, and school contexts.

But there are challenges to integrating such programs in schools. Although there is a growing recognition of the link between academic success and mental health, schools struggle to develop effective strategies to integrate services. There has been limited guidance provided for the adaptation of empirically supported clinical strategies to the school context. Too often, therapy is conceived as an isolated task with minimal attention paid to educational interventions or influencing the social contexts in which problems occur. Insufficient frameworks exist for therapists outside the school setting to collaborate with educators and implement interventions to address functioning at school. This text will provide strategies to address these issues.

As a former director of a zero-reject public therapeutic day school in a large metropolitan area, I have been privileged to work with diverse students who have experienced the most severe impairments from psychological disorders. Our staff collaborated with multiple partners working both within and outside of the school setting—chief among them teachers, other educators, parents, and youth—to design and implement therapeutic interventions for children experiencing internalizing and externalizing disorders. The same integrated approach proved effective in work in standard school settings.

Drawing on this extensive personal experience designing and providing therapeutic services within elementary and secondary schools, I present in this book a practical framework for delivering evidence-based interventions (EBIs) in schools. I suggest how to both select interventions and make appropriate adaptations for the school context. The text covers interventions in both standard and special education programs, and it advocates for a comprehensive multitiered approach.

In this book, I cover the major symptom patterns affecting youth, provide practical examples of intervention strategies, and point the reader to specific empirically supported protocols. It is beyond the scope of this text to describe each intervention component in complete detail; rather, I provide

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broad descriptions, focusing on how these interventions interface with the school context and what this means for implementation. My overall goal is to help bridge the gap between research and applied settings. This book is appropriate for school psychologists, social workers, and counselors and for clinical psychologists and other community mental health practitioners who work closely with schools to treat the psychological issues faced by the children and families they serve. Classroom teachers will benefit from each section's description of instructional supports.

I use case examples to illustrate case conceptualization and intervention protocols, drawn from my own direct clinical experience as well as that of my colleagues. To protect client confidentiality, cases have been blended or modified.

I address interventions for both children and adolescents. When there are developmental differences that must be addressed regarding assessment and intervention, I have made distinctions between the two groups. When a concept applies across developmental levels, I refer to *children and adolescents*. At times, however, for economy of expression, I use the terms *children* and *youth* to refer to students at all age levels.

The remainder of this chapter provides essential background conceptual information about evidence-based interventions in schools, followed by an explanation of the book's organization.

MOVEMENT TOWARD THE DELINEATION OF EVIDENCE-BASED PSYCHOTHERAPY

Psychological treatment research is focused on defining reliably effective treatment protocols for addressing the full range of child and adolescent psychological disorders (Weisz & Kazdin, 2010). The search for EBI strategies has emerged as the central research mission in child and adolescent psychology (Silverman & Hinshaw, 2008). Significant progress has been made in defining what intervention strategies work to address specific psychological disorders and symptom patterns. The goal is to define and implement empirically supported treatment protocols that can effectively treat children across all settings in which children are served.

The "efficacy" of treatment strategies is generally determined on the basis of randomized controlled studies using standardized intervention protocols that clearly attribute client change to treatment applications. Many of these findings have been noted in controlled research settings, and the subsequent challenge is to demonstrate the "effectiveness" of the intervention protocol in inherently more complex and less controlled clinical practice settings. The research community is concerned that EBIs are not finding their

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way into community and school settings. On the other hand, field practitioners note that research subjects are often dissimilar to community and school clients in terms of complexity of symptom manifestation, number of comorbidities, initiation and sustenance of treatment, and expressed motivation for change. The challenge for clinicians is to persist with the application of EBIs but to refine and modify protocols to establish effectiveness in field settings. The challenge for child intervention researchers is to measure the transportability of treatments, assessing their effectiveness beyond research settings to deployment in a range of clinical settings (Ollendick & King, 2012). A related effort is the study of implementation practice, which examines the strategies and supports required to successfully transport methods to field settings (Forman et al., 2013). Recognizing the promise and the limitations of current treatment research, school-centered therapists apply EBIs in practice, modify strategies as necessary for client and setting, and continue to monitor the effectiveness of their interventions.

BRIDGING THE GAP: APPLYING EBIs IN SCHOOLS

Mental health practitioners have a responsibility to apply empirically supported assessment and intervention strategies to benefit their clients. School-centered therapy efforts hold promise for bridging the practice gap that is often perceived to exist between controlled studies conducted in university settings and the complexity of field practice. The introduction of the response to intervention (RtI) paradigm to academic curriculums in schools presents an interesting parallel to the needs for mental health services delivery (Sugai & Horner, 2009). Regarding academic instruction, RtI emphasizes the need for using both core and remedial instruction based on scientifically supported practices while continually evaluating curriculum effectiveness through routine progress monitoring. Outcome measurement informs the need to modify intervention strategies. Education's emphasis on data-based decision making is a natural fit for the implementation of EBIs in mental health services.

Assessment

Research sets the foundation for understanding the variables that contribute to the etiology, manifestation, and sustenance of social, emotional, or behavioral symptoms. EBI research clearly defines its target population and uses evidence-based assessment strategies to accurately define treatment subjects' symptoms and needs. Care is taken to isolate which intervention protocols work for which populations. This approach recognizes that one size

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does not fit all. The empirical literature delineates specific strategies for children exhibiting different diagnostic patterns. This assessment-to-treatment link is critically important. Assessment leads to selective application of EBIs to youth displaying different symptom patterns. Analogous to differentiated academic instruction, individualized approaches to psychological intervention are used based on what is known from EBI research.

School systems are reasonably reluctant to attach diagnostic labels to students. The identification of an emotional disability qualifying for special education services requires substantial interference with academic progress. However, the designation of an Emotional Disability remains a broad description covering a wide diversity of psychological orders. Attention-deficit/hyperactivity disorder (ADHD), a relatively high-incidence disorder with clear educational impact, may fall under the Other Health Impaired eligibility category, whereas other psychological disorders with clear neurological or biological characteristics may not. What this means for the application of EBIs to school-centered therapy is that practitioners must be careful to also use specific symptom profile assessment strategies to ensure appropriate selection and application of EBIs. At times, there are subtle differences in presentation that can prompt selection of substantially different intervention strategies. For example, for their empirically supported school-centered anger management programs, J. Larson and Lochman (2010) differentiated the intervention paths required for students displaying proactive versus reactive aggression.

The establishment and transmission of EBIs rely on data collection. Schools routinely collect and track a large amount of data. Therapists associated with schools have access to significant quantitative and qualitative data beyond formal psychological assessments. School psychologists, social workers, and counselors are involved in the same setting as the child and his or her peers for up to 7 hours per day, permitting multiple opportunities for observational data and helpful access to environmental conditions.

Applying EBI Protocols

To ascertain which intervention strategies are effective, research programs often initially limit the number of treatment variables or factors that are targeted. The challenge for school-centered practice is to define, account for, and target interventions to address a wider range of contributing factors. However, the very complexity of the field context also presents some advantages as well. Therapists working within and closely with schools possess superior knowledge of contextual variables such as family, school culture, peer networks, and community influences. Their expert understanding of the local context, systemic variables, and setting demands provides a distinct advantage for effective modification of EBI protocols. Their awareness of

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key systemic and environmental factors improves their capacity for tailoring interventions to the student's context and selecting treatment modules that are best fits for this student in this setting. Association with schools provides enhanced access to key contextual participants. Parents, teachers, and representatives of community resources can readily convene for problem solving.

Because they work within the school, these practitioners also may have long-term opportunities for access, support, and treatment booster sessions. Interventions do not have to be completed in one continuous series, and these therapists can track progress and initiate follow-up contacts on their own. Community mental health service providers who integrate their intervention work with schools can create many of these same advantages.

Intervention Manuals

EBIs are typically developed with detailed procedural manuals outlining the therapeutic elements that were validated in efficacy studies. Fidelity to implementation of the core features of the intervention manual are required to ensure that empirically supported strategies are actually used. Some have objected that this approach is mechanistic and attempts to merely turn therapy into a technical exercise while undervaluing unique therapist variables and individual creativity. However, the alternative of reliance on instinctual "seat of the pants" strategies to guide interventions risks limiting the reliability and validity of treatments and negates the potential for development of core strategies that can consistently address similar issues across children. See Ollendick and King (2012) for a more extended review of this controversy.

Effective therapists recognize the need for conducting therapy within the framework of empirically supported practices. Experienced therapists are aware of the self-correcting elements of therapeutic interactions where clients either communicate the limitations of our case conceptualization or demonstrate the need for intervention modifications through inadequate or stalled progress on treatment goals. Expert therapists responsively and responsibly adapt core methods to individual circumstances while continuing to operate within the general framework of defined EBI strategies, assessing progress through repeated collection of outcome data. When faced with the most difficult cases within school settings, it is important to avoid premature abandonment of EBI protocols. These challenging cases tend to present with more severe symptoms, complicating contextual factors, and additional barriers to treatment. Persisting in the application of EBIs and patiently "staying the course" are essential in these treatment-resistant cases. These clients typically face both extraordinary stressors and more frequent damaging environmental events. Although flexibility and adaptation are necessary, the child, parents, and teachers all require enhanced support and focus from the therapist on sticking to the plan and proven methods to achieve goals. Progress may be

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slower and more incremental, but past attempts at solutions have generally been fleeting and prematurely terminated.

Flexibility Within Fidelity

Kendall and Beidas (2007) coined the catchphrase "flexibility within fidelity" to frame the application of manualized treatments in a balanced and practical manner. Kendall is the lead author of the widely applied manualized EBIs for child anxiety management, *The Coping Cat* (Kendall & Hedtke, 2006). He argued that manual-based treatments cannot be applied as inflexible cookbooks. Instead, manuals are designed to provide a structure, focus, and outline for intervention strategies. Manuals outline the essential elements of a protocol, the sequence of intervention application, and operationalized strategies for therapeutic activities. When firmly grounded in an understanding of an empirically derived protocol, practitioners can then flexibly adapt techniques to the needs and challenges of working with an individual client within a specific family and school context.

In a similar fashion, Ollendick and King (2012) asserted that manuals should be perceived as providing guidelines and structures that specify the principles and strategies that were supported in efficacy studies. Information in manuals goes beyond a reference to a broad approach or school of psychotherapy such as cognitive behavioral therapy (CBT) or psychodynamic by specifying the elements of the umbrella approach that require implementation for success with this client in these circumstances. For example, family therapy strategies have proven efficacy to address a variety of issues, but different procedures and strategies are used to address different clinical problems and divergent family systems. Even though they possess many common underlying features, a family therapy manual for treating eating disorders differs in essential elements from one targeting juvenile addictions. Chorpita, Daleiden, and Weisz (2005) suggested that manuals emphasize the principles rather than the procedures of change. However, therapists need to be careful that the scope of their modifications of manual strategies does not render their efforts as merely random and devoid of any empirical foundation.

School-centered therapists are typically generalists required to respond to the full range of presenting child and adolescent psychological disorders. Intervention manuals provide them with the necessary structure and guidelines to address diverse treatment targets with proven methods. Their broad experience qualifies them to thoughtfully and flexibly adapt protocols to address the needs of children in their school and community settings. School-centered therapists frequently face cases with multiple comorbidities. In most cases, they need to target the most life-interfering problem first. Fortunately, a reduction in primary symptoms can reduce general stress and contribute to either a corollary lessening of other symptoms or an improved readiness to

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respond to interventions specific to a secondary condition. Because within CBT approaches, coping and problem-solving skills treatments contain many common elements, acquisition of adaptive skills to address one disorder can contribute toward improvement in other areas.

Modular Approaches

Chorpita (2007) proposed an additional strategy for implementing EBI strategies. He suggested dividing empirically validated treatment protocols into modules containing clinical strategies for targeting specific subgoals. The therapist assesses the needs of an individual client and selectively chooses the strategies necessary for this symptom presentation. Although the sequence of application of techniques might make a difference in some circumstances, it is likely that affected children with the same diagnosis will still demonstrate variable skills deficits. For example, some children with social anxiety may have sufficient foundational social skills but be constrained by cognitive distortions that block social involvements, whereas others may require treatment modules that focus strongly on both elements. Whether a certain treatment module is used and how much time is devoted to its implementation will depend on the profile and responsiveness to intervention of the particular client. This approach remains rooted in the EBI movement but provides a rational alternative to the rigid application of manualized programs.

DEFINITIONS AND SELECTION OF EBIs

The term *evidence based* is used across many different disciplines. Many attempts have been made to categorize levels of empirical support within psychology; however, an attempt to specifically define EBI remains challenging (Ollendick & King, 2012). Kazdin and Weisz (2010) suggested that *evidence based* should be viewed as a spectrum rather than a clear definitive categorization. They noted that there is no single cutoff criteria yet established. Interventions that are labeled as *evidence based* require controlled efficacy research that clearly specifies characteristics of the target population, uses operationally defined intervention procedures, and reports multiple outcome measures. Replicated random control designs provide clearest data. Programs that are also supported by effectiveness research in field-based settings stake the strongest claim for empirical support. Chorpita et al. (2005) suggested that when several variations of treatments demonstrate evidential support, it is possible to identify common elements across protocols that may be defined as central contributors to positive treatment outcomes. For example, exposure strategies have been found to be a core element of various empirically supported protocols for anxiety management.

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It is beyond the scope of this text to provide a full discussion of issues surrounding the definition of evidence-based research. For the purposes of this text, I integrate EBIs from the spectrum of evidence-based findings as described by Kazdin and Weisz (2010). I will particularly present protocols represented in respected major compendiums of EBI clinical practice for children and adolescents (see Kendall, 2012b; Mash & Barkley, 2006; Reinecke, Dattilio, & Freeman, 2003; Silverman & Hinshaw, 2008; Weisz & Kazdin, 2010). Preferences are given to interventions that have empirical support for their effectiveness in clinical settings or contain elements that can be readily used in practical school-centered applications. There is an emerging body of EBI research involving protocols designed for and validated within schools (J. Larson, 2005; J. Larson & Lochman, 2010; Stark et al., 2007). These works are of particular relevance to this effort and justify extended treatment.

MULTITIERED SYSTEMS OF SUPPORT

Contemporary educational practice organizes assessment and intervention practices within multitiered systems of support (MTSS; Stoiber, 2014). This framework is designed to serve the needs of all students. It emphasizes prevention, early intervention, universal screening, social-emotional learning for all students, routine progress monitoring, the application of evidence-based assessment and intervention strategies to address problems, and matching the intensity of intervention to level of need. Usually conceptualized within three tiers, the first tier addresses the needs of the general student population. The second tier provides early intervention services to those identified at-risk for problems or demonstrating early or moderate symptoms. The third tier provides intense services for students exhibiting significant difficulties.

School-centered therapy contributes substantially to MTSS. Its multiple evidence-based methods and formats respond to students at all levels but are particularly responsive to the challenges experienced in second and third tiers. The text's concluding chapter presents a comprehensive model for psychological service delivery within MTSS that incorporates school-centered therapy.

ORGANIZATION OF THIS BOOK

This book consists of three parts. Part I addresses central foundation issues in the provision of mental health services in schools. Chapter 1 explores the advantages of mental health work in schools, highlighting the critical needs for therapeutic services for children and adolescents and the potential

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for schools to provide increased access to these essential services. It delineates the substantial benefits of intervening with youth in the natural environment where they are required to exhibit adaptive social, coping, and problem-solving skills on a daily basis. Chapter 2 provides an overview of the current state-of-the-art psychological interventions for children and adolescents. It summarizes how these strategies are extended to universal psychological education, prevention, and early intervention programs. Chapter 3 presents a comprehensive case conceptualization model that provides an overarching framework for intervention planning across all symptom profiles. Built on a foundation of cognitive behavioral and systemic approaches, it sets the stage for the selection and implementation of EBI protocols. Its goal is to link assessment to intervention to outcome.

Part II presents therapeutic interventions for specific child and adolescent psychological disorders and considers how these interventions relate to the school context. The chapters in Part II cover ADHD (Chapter 4), disruptive behavior disorders (Chapter 5), pediatric bipolar disorder (Chapter 6), depression (Chapter 7), anxiety and trauma (Chapter 8), and autism spectrum disorder (Chapter 9). Each of these chapters examines and integrates the following six domains:

- diagnostic characteristics and assessment frameworks;
- developmental considerations for assessment and intervention;
- child- and adolescent-specific therapeutic intervention strategies;
- instructional supports, educational accommodations, and coordination with school-centered intervention protocols;
- crisis intervention protocols; and
- family and systemic supports and interventions.

Finally, the book's Afterword places school-centered therapy in the context of comprehensive multitiered service delivery in the schools. Psychological education is being recognized as an essential educational task. Schools recognize that learning adaptive social, coping, and problem-solving skills is core curriculum alongside reading, mathematics, science, and history. With the introduction of response to intervention strategies, mental health prevention and intervention efforts are being organized into multitiered intervention models that not only strive for early intervention but also recognize that some students require therapeutic interventions to succeed academically and socially in school. Therapists working closely with schools must understand the possibilities and supports within this multitier schema; therapists in schools must ensure that EBIs are practiced to benefit students at every level of service need.

School-centered therapy provides an opportunity for integrating therapeutic services into the center of the daily lives of children and adolescents. The critical need for increasing access to mental health services and

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integrating multidimensional service delivery has emerged as a theme not only within the psychological and educational communities but also within policy-making centers. Although the call for full-service schools is not new, national funding for school health centers, which include mental health services may provide unprecedented opportunities for helping children. Both challenges and opportunities abound. Program development will require vision and creative resource management. Innovative practices must continue to be informed by the growing empirical understanding of what best serves the needs of children and families.