The Future of School Psychology: Selected Topics

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Presentation Outline

► The Model Licensure Act (MLA)
► Addressing autism spectrum disorders
► Addressing PTSD and the School Crisis Intervention Response
► Addressing bipolar disorders
► Response to Intervention (RtI)

Why is this topic important?

► APA is currently considering changes to their model act for licensure of psychologists that has the potential to change the title of “school psychologist” and potentially the practice of school psychology.
► The effect of the change will be determined at the state level.
► Thus, CASP will play a crucial role in how each state responds to these changes.

School Psychology and the APA Model Act for the State Licensure of Psychologists Revisions

Understanding the impact of possible change, and planning for state action.

Adapted, modified, and referenced from the NASP Public Policy Institute

The Title School Psychologist

► ... has been widely recognized for both specialist level and doctoral level degrees since the 1950’s.
► ... has been specifically acknowledged by APA governance through the exemption language since 1977.

Some background on school psychology title and credentialing

► School psychologists have been credentialed by state boards of education long before licensure standards were set for psychologists.
► The title “school psychologist” is an accurate reflection of the training and supervised field-based experiences in psychology and education required for credentialing in the states.
Current MLA Language (1987)

3. It is recognized that school psychologists who are certified by the state education agency are permitted to use the term school psychologist or certified school psychologist as long as they are practicing in the public schools. Individuals who have been certified as school psychologists by the (cite relevant state education authority or statutory provisions) shall be permitted to use the term "school psychologist" or "certified school psychologist." Such persons shall be restricted in their practice to employment within those settings under the purview of the state board of education.

Proposed MLA Language (2007)

4. In jurisdictions in which individuals have been previously exempted or excluded from psychology licensure (in some instances this has included I/O and consulting psychologists and/or school psychologists), but are now expected to become licensed under the new regulations, a provision for extending licensure to those psychologists should be enacted. Such a provision would not be needed in jurisdictions that have had generic licensure laws that did not include exemptions for some psychologists.

Credentialing Key Facts

In CA who gives school psychologists their right to practice?

- In Public Schools...
  - School Psychology Credential
  - California Commission on Teacher Credentialing (CCTC)
    - [http://www.ctc.ca.gov/](http://www.ctc.ca.gov/)
- In Private Practice...
  - Licensed Educational Psychologist
  - California Board of Behavioral Sciences (BBS)
    - [http://www.bbs.ca.gov/](http://www.bbs.ca.gov/)

Guidelines for Credentialing

- NASP Credentialing Standards (2000)
  - [www.nasponline.org/standards/index.aspx](http://www.nasponline.org/standards/index.aspx)
- APA Model Act for State Licensure (1987)
- Association of State and Provincial Psychology Boards Model Act of Licensure (2001)

Credentialing Distinctions

- NASP standards are:
  - Specialist Level
    - Equivalent to 60 graduate hours
    - Ed.S.
    - Masters Degree + Certificate of Advanced Study
  - Doctoral Level
    - Ph.D.
    - Ed.D.
    - Psy.D.
Credentialing Key Ideas

- In CA, as with virtually all other states in the Union, the credential, title, and regulation of school-based school psychology practice is conducted by CCTC (not by BBS or the California Board of Psychology).
  - Exception: Texas Board of Psychological Examiners credentials “licensed specialists in school psychology”

Credentialing Facts

- 49 + DC
  - Number of States wherein Education Agencies credential school psychologists
- 29
  - Number of States wherein Education Agencies use Nationally Certified School Psychologist (NCSP) standards
- 43 + DC
  - Number of State Education Agencies that credential School Psychologists at both the specialist and doctoral levels
- 45 + DC
  - Number of State Education Agencies that credential school psychologists using the title “School Psychologist”

Credentialing Facts

- Highest degree for Practitioners
  - 75.6% Specialist level
  - 24.4% Doctoral level
- Among Practitioners
  - 91% are credentialed by State Education Agencies
  - 30.6% are also licensed

Credentialing Key Facts

- In addition to CA, 9 other states credential school psychologists for independent practice through various means:
  1. CA - Board of Behavioral Sciences Licensure
     - Licensed Educational Psychologist
  2. FL Department of Health
     - Licensed School Psychology
  3. IN - Department of Education: Division of Professional Standards
     - Independent Practice Endorsement
  4. MA Allied Board of Mental Health

Credentialing Key Facts

- American Psychological Association’s Model Act for State Licensure of Psychologists (Model Act) is its prototype recommended language to be used by states to draft legislation and regulation for licensing psychologists.

What is the APA Model Act?
Basic Tenets of the Model Act

► APA recommends restricting the use of the term "psychologist" to those persons who
  a) have an earned doctorate in psychology
  b) are licensed by state psychology licensing boards.
► APA also recommends that psychological practice be restricted to those who hold doctoral degrees and are licensed psychologists.

School Psychology Exemption

► Since 1977, APA's Model Act included an exemption for school psychologists to use the title "school psychologist" provided they are:
  • Appropriately credentialed by their state board of education
  • Practice in school settings

Current Model Act

► The current Model Act was adopted in 1987.
► APA is considering changes to this policy statement that contains several issues of concern and relevance to school psychologists.

What are the major changes?

► Industrial/organization and consulting psychology licensure requirement
► Sequence of training change to allow two years of documented supervised training experiences to now be pre-doctoral or postdoctoral.
► Removal the title exemption language for school psychologists that recognizes the right of specialist level school psychologists credentialed by their state education agency and practicing in public schools to use the term "psychologist" in their title.

What are the major changes?

► Addition of the requirement that a person be "licensed" to use the title "psychologist"
► Changes in the description of psychological services to include more specific descriptions of services typically offered in schools by school psychologists (e.g., "evaluating," "assessing," "cognition," "skills," etc.)

School Psychologist Exemption

► The proposed model act removes the exemption language that reflects recognition of the right of specialist and doctoral level school psychologists credentialed by their state education agency and practicing in public schools to use the term "psychologist" in their title.
How does removing the exemption affect school psychology?

► The exemption itself represents a formal recognition of the agreement between APA and school psychologists that the title school psychologist and school based practice are well established and well protected by state education agencies.

How does removing the exemption affect school psychology?

► Removing the exemption presents a message to state legislatures and state regulation agencies that only doctoral level practitioners are eligible for the “title” of psychologist and potentially to practice psychology independently in any setting.

NASP/CASP Oppose this Change

► NASP has responded to these proposed changes by formally notifying APA through a variety of formats that it opposes removing the exemption.
► NASP’s response is posted on the NASP website.
  • www.nasponline.org/standards/apama.aspx
► CASP’s response is posted on the CASP website.
  • http://www.casponline.org/

NASP/CASP Oppose this Change

► NASP/CASP are committed to supporting school psychologists’ rights to retain their title and protect school psychology practice.
► NASP standards for credentialing of school psychologists have been influential in CA.
► Credential for school psychologists is determined state by state, so it is the responsibility of CASP leadership to monitor and advocate for school psychology title and practice in our state.

The Good News and Bad News

► The good news is that the title “school psychologist” and independent school based practice are well established across the country. There is no automatic threat to either of these by changes in the Model Act itself.

More Good News

► Keep in mind APA’s Model Act is a recommended prototype for state legislation and not an official law or regulation. It requires action by state legislatures to affect substantive change.
Still More Good News

  ▪ Nothing in this Act shall be construed to prevent persons who are credentialed as school psychologists by the (name of regulatory body for public education) from using the title “school psychologist” and practicing psychology as defined in this Act as long as such practice is restricted to regular employment within a setting under the purview of the (name of regulatory body for public education). Such individuals must be employees of the educational setting and not independent contractors providing psychological services to educational settings.

The Bad News

► APA is influential, especially with state psychological licensing boards. It has the potential to push for changes in well established laws and regulations on the basis of the change in the Model Act.
  ▪ APA is a large well funded organization with its own political agenda to protect and expand market share for doctoral level psychologists and shrinking resources from insurance and private funding sources.
  ▪ Schools are a logical target for expansion that have relatively recently become of interest to APA over the last decade.

What NASP has done

► NASP has mounted a major effort to gather its members, leaders and national partners and stakeholder groups to respond.
  ▪ NASP is providing CASP with resources to do the same at the state level.

What NASP has done and is doing

► NASP communicated via email to all members and stakeholder groups about responding to APA during the public comment period (ended on Nov. 1, 2007).
  ▪ NASP created sets of model letters and a mechanism to respond online.
  ▪ NASP is monitoring the public response to the APA Model Act.
  ▪ NASP is pursuing a legal opinion regarding restraint of trade.
  ▪ NASP is providing training, support, and materials (like these) to assist states in launching a grassroots advocacy response.

Now that you know...
What do you do?

► We all need to proactively advocate for APA to reinstate the school psychology exemption in the model act.
  ▪ We all need to gather support from other stakeholder groups to do the same.

Introduction to Key Messages

► The exemption within APA’s 1987 Model Licensure Act is a recognition of school psychologists’ long history of contributing to schools and the field of education, and as a specialty area within psychology.
  ▪ Many recognizable benefits have resulted from the 1977 and current 1987 title exemption for school psychologists who are credentialed by their state education agency and practice in public school settings.
The Future of School Psychology: Selected Topics

Key Message #1
► Specialist-level school psychologists provide critical services that support the mental health and academic achievement of all children.
  - School psychologists are trained to implement prevention activities and to provide interventions for mental health and learning issues at the individual, group, and school-wide levels.
  - Today there is significant recognition within the education and health communities of the importance of having school-employed professionals like school psychologists to provide these services in order to meet the growing needs of students.

Key Message #2
► Removing the exemption would undermine services to children and families at a time of growing need and current shortages especially in schools in rural and urban areas.
  - There is no benefit to the public, to students and families, schools, or to the profession of psychology to change this exemption for school psychologists credentialed by state education agencies, particularly at a time when there are shortages of school psychologists nationally.
  - Shortages are severe in some under-resourced urban and rural school settings.
  - The shortages are even more critical for individuals of minority and culturally and linguistically diverse backgrounds to serve in school settings.

Key Message #3
► The credentialing and regulation of school psychologists by CCTC protects the public and ensures services to children and families.
  - CCTC has stringent standards for the graduate education and credentialing of school psychologists that protect the public.
  - The proposed changes could cause unnecessary confusion and conflict with well-established state laws and CCTC regulations.

Rationale to support state boards of education’s role in regulating school psychology title and practice:
► Maintaining the current exemption would prevent potential conflicts between State Education Agencies and Psychology Licensing Boards for school-based practice.
► Laws and regulations for school psychology are well established in most states and have been under the purview of state boards of education for many years.
► The school psychologist title and credential are recognized for school-based practice in nearly all of the 50 states and the District of Columbia.

More ideas to support CCTC regulating school psychology title and practice
► Credentialing by CCTC helps ensure alignment of standards with other highly-trained school personnel.
► CCTC has a vested interest in the quality of school personnel and is empowered by the state to set these standards.
► Currently existing credentialing practices by CCTC ensures that highly qualified school psychologists are employed by CA schools and provide needed services to children.

“School Psychologist” title
► The title “school psychologist” has been associated with school psychological services for more than 50 years.
► The “title goes with the services.”
► Doctoral level and specialist level school psychologists do not have differentiated responsibilities in schools.
**Links to Relevant APA Policy Documents**

  - Year by year history of resolutions related to professional affairs
- [www.apa.org/about/division/cpmprofessional.html](http://www.apa.org/about/division/cpmprofessional.html)
  - APA Council Policy Manual: L. Professional Affairs
- [www.apa.org/apags/licensureaction.html](http://www.apa.org/apags/licensureaction.html)
  - "5 Easy Steps to Implement the APA Policy on Licensure"

**What else do you need to do?**

- All school psychologists need to be constantly vigilant at the state level about state credentialing and advocate for school psychology title and practice (regardless of the outcome of changes in the model act).
- All school psychologists need to consistently and proactively communicate your distinct expertise and contribution to outcomes for children, families and schools.

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- Response to Intervention (RtI)

**Acknowledgement**

Adapted from...

Introduction:
Reasons for Increased Vigilance

► Autistic spectrum disorders are much more common than previously suggested.
  • 60 (vs. 4 to 6) per 10,000 in the general population (Chakrabarti & Fombonne, 2001).
  • 600% increase in the numbers served under the autism IDEA eligibility classification (U.S. Department of Education, 2003).
  • 95% of school psychologists report an increase in the number of students with ASD being referred for assessment (Kohrt, 2004).

Explanations for Changing ASD Rates in the General Population

► Changes in diagnostic criteria.
► Heightened public awareness of autism.
► Increased willingness and ability to diagnose autism.
► Availability of resources for children with autism.
► Yet to be identified environmental factors.

Increased Prevalence in Special Education (U.S. Department of Education, 2005)

Student Classified as Autistic Under IDEA as a Percentage of all Students with Disabilities: 1991 to 2004

Explanations for Changing ASD Rates in Special Education

► Classification substitution
  • IEP teams have become better able to identify students with autism.
  • Autism is more acceptable in today’s schools than is the diagnosis of mental retardation.
  • The intensive early intervention services often made available to students with autism are not always offered to the child whose primary eligibility classification is mental retardation.

Classification Substitution? (U.S. Department of Education, 2005)

Percentage of Students Classified as Autistic or Mentally Retarded Under IDEA as a Percentage of all Students with Disabilities: 1991 to 2004

Classification Substitution? (U.S. Department of Education, 2005)

School Population Rates of Mental Retardation and Autism Special Education Eligibility Classifications: 1991 to 2004

Classification Substitution? (U.S. Department of Education, 2005)

Changes in Special Education Classification Rates (1991 to 2004; for Children Ages 6 to 11)

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<th>Category</th>
<th>1991 Rate</th>
<th>2004 Rate</th>
<th>Rate Change</th>
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<td>4.04</td>
<td>+3.91</td>
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<td>Deaf-Blindness</td>
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<td>Visual Impairments</td>
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<td>Multiple Disabilities</td>
<td>2.26</td>
<td>2.14</td>
<td>-0.12</td>
</tr>
</tbody>
</table>

Reasons for Increased Vigilance

► Autism can be identified early in development, and...
► Early intervention is an important determinant of the course of autism.

Source: Howlin & Asgharian (1999)

Reasons for Increased Vigilance

► Not all cases of autism will be identified before school entry.
  • Average Age of Autistic Disorder identification is 5 1/2 years of age.
  • Average Age of Asperger's Disorder identification is 11 years of age.

Educator Roles, Responsibilities, and Limitations

► Educators need to be more vigilant for symptoms of autism among the students that they serve, and better prepared to assist in the process of identifying these disorders.

Source: Yeargin-Allsopp et al. (2003)

Educator Roles, Responsibilities, and Limitations

► Case Finding
  • All educators should be expected to participate in case finding (i.e., routine developmental surveillance of children in the general population to recognize risk factors and identify warning signs of autism).
  • This would include special educators training general educators to identify the risk factors and warning signs of autism.
Educator Roles, Responsibilities, and Limitations

► Screening
  ▪ All school psychologists should be prepared to participate in the behavioral screening of the student who has risk factors and/or displays warning signs of autism (i.e., able to conduct screenings to determine the need for diagnostic assessments).
  ▪ All school psychologists should be able to distinguish between screening and diagnosis.

► Special Education Eligibility
  ▪ All educators should be expected to conduct the special education eligibility evaluation, which determines educational needs.
  ▪ The ability to conduct such assessments will require educators (especially school psychologists) to be knowledgeable of the accommodations necessary to obtain valid test results when working with the child who has an ASD.

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Educator Roles, Responsibilities, and Limitations

► Only those school psychologists with appropriate training and supervision should diagnose a specific autism spectrum disorder.


Acknowledgements

► Adapted from...
PTSD

- PTSD necessarily involves exposure to a traumatic stressor.
- A traumatic stressor can generate initial stress reactions in just about anyone.
- However, not everyone exposed to these events develops PTSD.
  - Typically, the majority of exposed individuals recover and only a minority develop PTSD.
- Among those who develop PTSD, significant impairments in daily functioning (including interpersonal and academic functioning) are observed.
- Developmentally younger individuals are more vulnerable to PTSD.

PTSD

- Prevalence among children and adolescents
  - General Population
    - Trauma Exposure: approximately 25%
    - PTSD: 6 to 10%
  - Urban Populations
    - Trauma Exposure: as high as 80%
    - PTSD: as high as 30%

Buka et al., 2001; Costello et al., 2002; Dynegory & Yule, 2006; Seedat et al., 2004

Range of Possible Traumatic Stress Reactions

- Not Psychopathological (Common)
  - Initial Crisis Reactions
  - Acute Stress Disorder
  - Acute Post-Traumatic Stress Disorder
  - Chronic Post-Traumatic Stress Disorder

- Psychopathological (Uncommon)

PTSD

- The role of the school-based mental health professional is to be...
  - able to recognize and screen for PTSD symptoms.
  - aware of the fact PTSD may generate significant school functioning challenges.
  - knowledgeable of effective treatments for PTSD and appropriate local referrals.
  - cognizant of the limits of their training.
- It is not necessarily to...
  - diagnose PTSD.
  - treat PTSD.

DSM-IV-TR Diagnostic Criteria

- An anxiety disorder that develops secondary to exposure (experiencing, witnessing, or learning about) to an "extreme traumatic stressor."
  - An event that involves actual or threatened death or serious injury, or threat to one's physical integrity.
- "The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior)."

(APA, 2000, p. 463)
DSM-IV-TR Diagnostic Criteria

► Core Symptoms
   1. Persistent reexperiencing of the trauma.
   2. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.
   3. Persistent symptoms of increased arousal.
► Duration of the disturbance is more than one month.
► The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APA, 2000

DSM-IV-TR Diagnostic Criteria

► Reexperiencing Symptoms
   1. Recurrent/intrusive distressing recollections.
   2. Recurrent distressing dreams.
   3. Acting/feeling as if the event were recurring.
   4. Psychological distress at exposure to cues that symbolize/resemble the traumatic event.
   5. Physiological reactivity on exposure to cues that symbolize/resemble the traumatic event.

APA, 2000

DSM-IV-TR Diagnostic Criteria

► Avoidance & Numbing Symptoms
   1. Avoids thoughts, feelings, or conversations.
   2. Avoids activities, places, or people.
   3. Inability to recall important aspects of the trauma.
   4. Diminished interest/participation in significant activities.
   6. Restricted range of affect.
   7. Sense of a foreshortened future.

APA, 2000

DSM-IV-TR Diagnostic Criteria

► Increased Arousal Symptoms
   1. Difficulty falling or staying asleep.
   2. Irritability or outbursts of anger.
   3. Difficulty concentrating.
   4. Hypervigilance.
   5. Exaggerated startle response.

APA, 2000

DSM-IV-TR Diagnostic Criteria

► PTSD may be specified as
   • Acute
   • Chronic
   • Delayed onset

APA, 2000

DSM-IV-TR Diagnostic Criteria

► Associated Features
   • Survivor guilt
   • Impaired social/interpersonal functioning
   • Auditory hallucinations & paranoid ideation
   • Impaired affect modulations
   • Self-destructive and impulsive behavior
   • Somatic complaints
   • Shame, despair, or hopelessness
   • Hostility
   • Social withdrawal

APA, 2000
DSM-IV-TR Diagnostic Criteria

► Associated Mental Disorders
  • Major Depressive Disorder
  • Substance-Related Disorders
  • Panic Disorder
  • Agoraphobia
  • Obsessive-Compulsive Disorder
  • Generalized Anxiety Disorder
  • Social Phobia
  • Specific Phobia
  • Bipolar Disorder

APA, 2000

Causes of PTSD

► Traumatic Event Variables
  • Type
    ► Predictability
    ► Assaultive Interpersonal Violence
    ► Fatalities
  • Severity
    ► Duration
    ► Intensity
  • Exposure
    ► Physical Proximity
    ► Emotional Proximity

Nickerson et al., (in press)

Causes of PTSD

► Environmental Factors
  • Parental Reactions
  • Social Supports
  • History of Environmental Adversity/Traumatic Stress
  • Family Atmosphere
  • Family Mental Health History
  • Poverty

Nickerson et al., (in press)

Causes of PTSD

► Internal Personal Vulnerabilities
  • Psychological Factors
    ► Crisis Perceptions and Reactions
    ► Mental Illness
    ► Developmental Level
    ► Coping Strategies
    ► Locus of Control
    ► Self-esteem

Nickerson et al., (in press)

Causes of PTSD

► Internal Personal Vulnerabilities (cont.)
  • Genetic Factors
    ► Family Studies
    ► Twin Studies
    ► Candidate Gene Studies

Nickerson et al., (in press)
Causes of PTSD

- Internal Personal Vulnerabilities (cont.)
  - Neurobiological Factors

Consequences of PTSD

- Affects on cognitive functioning
  1. Motivation and persistence in academic tasks
  2. Development of short- and long-term goals
  3. Sequential memory
  4. Ordinal positioning
  5. Procedural memory
  6. Attention

Consequences of PTSD

- Emotional and behavioral consequences occurring across age groups:
  1. Regression to childish/dependent behavior
  2. Fears/anxieties
  3. Changes in eating patterns
  4. Changes in sleeping patterns
  5. Gender differences
  6. School problems
  7. Disciplinary Referrals
  8. Freezing
  9. Dissociation

Consequences of PTSD

- Conditions Co-morbid with Child PTSD
  - AD/HD
  - Depression
  - Obsessive/Compulsive Disorder
  - Oppositional/Defiant Disorder
  - Anxiety Disorder
  - Conduct Disorder

Consequences of PTSD

- Academic
  1. Cognitive
  2. Academic achievement
  3. Academic performance
  4. Grade retention
  5. Adult outcome
  6. School behavior

Consequences of PTSD

- Developmental considerations:
  - Preschoolers
    - Reactions not as clearly connected to the crisis event as observed among older students.
    - Reactions tend to be expressed nonverbally.
    - Given equal levels of distress and impairment, may not display as many PTSD symptoms as older children.
    - Temporary loss of recently achieved developmental milestones.
    - Trauma related play.

Sources: American Psychiatric Association, 2000; Barkowitz, 2003; Cook-Cottone, 2004; Dulmus, 2003; Joshi & Lewin, 2004; National Institute of Mental Health, 2001; Yorbi et al., 2004)
### Consequences of PTSD

**Developmental considerations: School-age children**
- Reactions tend to be more directly connected to crisis event.
- Event specific fears may be displayed.
- Reactions are often expressed behaviorally.
- Feelings associated with the traumatic stress are often expressed via physical symptoms.
- Trauma related play (becomes more complex and elaborate).
- Repetitive verbal descriptions of the event.
- Problems paying attention.


### Consequences of PTSD

**Developmental considerations: Preadolescents and adolescents**
- More adult like reactions
- Sense of foreshortened future
- Oppositional/aggressive behaviors to regain a sense of control
- School avoidance
- Self-injurious behavior and thinking
- Revenge fantasies
- Substance abuse
- Learning problems


### Initial Assessment of PTSD

**Variable 1: Crisis Event Type**
- **a)** Human Caused (vs. Natural)
- **b)** Intentional (vs. Accidental)
- **c)** Fatalities

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Source: Brock (2006)

**Variable 2: Crisis Exposure**
- **a)** Physical proximity
  - Intensity of crisis experience
- **b)** Emotional proximity

*Risk factors that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Source: Brock (2006)

**Variable 3: Threat Perceptions**
- Subjective impressions can be more important that actual crisis exposure.
- Adult reactions are important influences on student threat perceptions.

* Risk factor that increase the probability of psychological trauma and, as such, should result in increased vigilance for psychological trauma warning signs.

Source: Brock (2006)

**Variable 4: Crisis Reactions**

Severe acute stress reactions predict PTSD. Reactions suggesting the need for an immediate mental health referral
- Dissociation
- Hyperarousal
- Persistent re-experiencing of the crisis event
- Persistent avoidance of crisis reminders
- Significant depression
- Psychotic symptoms

*Warning signs that provide concrete indication of psychological trauma

Source: Brock (2006)
Initial Assessment of PTSD

Variable 4: Crisis Reactions
- Cultural considerations
  - Other important determinants of crisis reactions in general, and grief in particular, are family, cultural and religious beliefs.
  - Providers of crisis intervention assistance should inform themselves about cultural norms with the assistance of community cultural leaders who best understand local customs.

Assumptions

► The skill sets of school mental health professionals are best utilized when they are embedded within a multidisciplinary team that engages in crisis prevention, preparedness, response, and recovery.
► By virtue of their professional training they are best prepared to address the psychological issues associated with school crises.
► School crisis management is relatively unique and as such requires its own conceptual model.

Crisis Intervention and Recovery

The Roles of School-Based Mental Health Professions

► This two day workshop provides a specific examination of the school-based mental health professionals’ role and responsibilities, with a special emphasis on crisis intervention and recovery.

Crisis Intervention & Recovery: Workshop Overview

► Introduction
  ► Crisis events
  ► Crisis reactions
  ► Crisis intervention
  ► The Incident Command Structure

► PREPARE Model
  ► Prevent and prepare for psychological trauma
  ► Reaffirm physical health, and ensure perceptions of security and safety
  ► Evaluate psychological trauma
  ► Provide interventions and respond to student psychological needs
  ► Examine effectiveness of crisis prevention and intervention

► Conclusion
  ► Evaluating and concluding the school crisis intervention
  ► Care for the caregiver

Crisis Intervention & Recovery: Workshop Objectives

Following the workshop, participants will:

► Report improved attitudes toward, and readiness to provide, school crisis intervention.
► Be able to:
  ► Identify the variables that determine the traumatizing potential of a crisis event.
  ► Identify the range of school crisis interventions specified by the PREPARE acronym.

Crisis Intervention & Recovery: Workshop Objectives

Following the workshop, participants will (continued):

► Be able to:
  ► Indicate how school crisis interventions fit into the larger school crisis response.
  ► Specify the factors that critical to evaluating psychological trauma risk subsequent to a crisis event.
  ► Match psychological trauma risk to a range of appropriate school crisis interventions.
Prevent & Prepare for Psychological Trauma

Crisis Prevention
- Prevention is the primary responsibility of school crisis teams.
  - Must include activities that ensure both physical and psychological safety.
    - Physical safety includes activities that are focused on the physical structures of the school environment.
    - Psychological safety includes activities that are focused on the emotional and behavioral well-being of students and staff.

Source: Reeves & Nickerson (2004)

Foster Internal Resiliency
- Promote active (or approach oriented) coping styles.
- Promote student mental health.
- Teach students how to better regulate their emotions.
- Develop problem-solving skills.
- Promote self-confidence and self-esteem.
- Promote internal locus of control.
- Validate the importance of faith and belief systems.

Source: Brock (2002d)

Foster External Resiliency
- Support families (i.e., provide parent education and appropriate social services).
- Facilitate peer relationships.
- Provide access to positive adult role models.
- Ensure connections with pro-social institutions.
- Others?

Source: Brock (2002d)

Keep Students Safe
- Remove students from dangerous or harmful situations.
- Implement disaster/crisis response procedures (e.g., evacuations, lockdowns, etc.).
- “The immediate response following a crisis is to ensure safety by removing children and families from continued threat of danger” (Joshi & Lewin, 2004, p. 715).
- “To begin the healing process, discontinuation of existing stressors is of immediate importance” (Barenbaum et al., 2004, p. 48).

Avoid Crisis Scenes and Images
- Direct ambulatory students away from the crisis site.
- Do not allow students to view medical triage.
- Restrict and/or monitor television viewing.

Source: Brock (2002d)

Reaffirm Physical Health
- Provide
  - Shelter
  - Food and water
  - Clothing
  - Other issues?
Ensure Perceptions of Security & Safety

► Adult behavior in response to the crisis is key.
► Security and safety measures may need to be concrete and visible.

Reaffirm Physical Health and Ensure Perceptions of Security & Safety

“Once traumatic events have stopped or been eliminated, the process of restoration begins. Non-psychiatric interventions, such as provision of basic needs, food, shelter and clothing, help provide the stability required to ascertain the numbers of youth needing specialized psychiatric care”
(Barenbaum et al., 2004, p. 49).

Evaluating Psychological Trauma

Psychological Triage Defined

“The process of evaluating and sorting victims by immediacy of treatment needed and directing them to immediate or delayed treatment. The goal of triage is to do the greatest good for the greatest number of victims”
(NIMH, 2001, p. 27).

Evaluating Psychological Trauma

Rationale

1) Not all individuals will be equally affected by a crisis.
   ▪ One size does not fit all.
   ▪ Some will need intensive intervention.
   ▪ Others will need very little, if any intervention.

Evaluating Psychological Trauma

Rationale

2) Recovery from crisis exposure is the norm.
   ▪ Crisis intervention should be offered in response to demonstrated need.
   ▪ “Not everyone exposed to trauma either needs or wants professional help”
   (McIntyre et al., 2001, p. 73).

 EXCEPTION: Students with pre-existing psychopathology.

Evaluating Psychological Trauma

Rationale

3) There is a need to identify those who will recover relatively independently.
   ▪ Crisis intervention may cause harm if not truly needed.
     i. It may increase crisis exposure.
     ii. It may reduce perceptions of independent problem solving.
     iii. It may generate self-fulfilling prophecies.

Berkowitz (2003), Everly (1999)
The Future of School Psychology: Selected Topics

LACOE
June 16, 2008

Stephen E. Brock, Ph.D., NCSP 22

A Crisis Event Occurs
Reaffirm Physical Health
Ensure Perceptions of Safety & Security
Evaluate Psychological Trauma

Low Risk for Psychological Trauma
Re-establish Social Support
Psycho-Education (Caregiver Training)

Moderate Risk for Psychological Trauma
Re-establish Social Support
Psycho-Education (Caregiver Training & Psycho-Educational Groups)
Immediate Psychological First Aid

High Risk for Psychological Trauma
Re-establish Social Support
Psycho-Education (Caregiver Training & Psycho-Educational Groups)
Immediate Psychological First Aid
Longer Term Psychotherapy

Levels of School Crisis Interventions

Indicated Psychotherapy
Selected Psycho-educational Groups
Psychological First Aid

Universal Prevention Psychological Trauma
Reaffirm Physical Health
Ensure Perceptions of Safety & Security
Evaluate Psychological Trauma
Re-establish Social Support Systems
Caregiver Trainings

PROVIDE INTERVENTIONS and RESPOND TO PSYCHOLOGICAL NEEDS

► Recognize signs of students in need of more direct crisis intervention.
► Be aware of populations predisposed to risk for psychological trauma.
► Maintain a calm presence when providing any crisis intervention.
► Be sensitive to culture and diversity.

Linking the Evaluation to School Crisis Interventions

Challenges
• Extremely violent and life-threatening crisis events (e.g., mass violence).
• Chronic crisis exposure.
• Caregivers significantly affected by the crisis.
• The presence of psychopathology.

Re-establish Social Support Systems

Specific Techniques
• Reunite students with their caregivers
• Reunite students with their close friends, teachers, and classmates
• Return to familiar school environments and routines
• Facilitate community connections
• Empower with caregiving/recovery knowledge

The Primary School Crisis Intervention

• Being with and sharing crisis experiences with positive social supports facilitates recovery from trauma.
• Lower levels of such support is a strong predictor of PTSD.
• This support is especially important to the recovery of children.


Re-establish Social Support Systems

Challenges
• Extremely violent and life-threatening crisis events (e.g., mass violence).
• Chronic crisis exposure.
• Caregivers significantly affected by the crisis.
• The presence of psychopathology.
### Psychological Education

#### Empowering Crisis Survivors and Caregivers
- Psycho-education is designed to provide students, staff, and caregivers with knowledge that will assist in understanding, preparing for, and responding to the crisis event, and the problems and reactions it generates (both in oneself and among others).

#### Psychological Education

#### Rationale
- Children often have incorrect beliefs about the crisis event.
- Children are more likely than adults to use avoidance coping.
- Facilitates a sense of control over the recovery process.
- Capitalizes on strengths and promotes self-confidence.
- Provides connections to mental health resources (without stigma).

#### Psychological Education

#### Limitations
- Not sufficient for the more severely traumatized.
- Must be paired with other psychological interventions and professional mental health treatment.
- Limited research.

#### Psychological Education

#### Specific Techniques
- Psycho-Educational Groups
- Caregiver Trainings
- Informational Bulletins, Flyers, and/or Handouts

#### Psychological Education

#### Psychological Interventions

a) Immediate Psychological First Aid Interventions.
   i. Group
   ii. Individual
b) Long Term Psychotherapeutic Treatment Interventions.
### Psychological Interventions

#### Group Psychological First Aid

- **Goals**
  
  a) The crisis event is understood.
  
  b) Crisis experiences and reactions are understood and normalized.
  
  c) Adaptive coping with the crisis and crisis problems is facilitated.
  
  d) Crisis survivors begin to look forward.

*In 2-day workshop, you learn how to conduct a group psychological first aid session.*

#### Psychotherapeutic Treatment Interventions

- Empirically Supported Treatment Options (Feeny et al., 2004).
- Cognitive-Behavioral Approaches.
  
  a) Imaginal and In Vivo Exposure.
  
  b) Eye-Movement Desensitization and Reprocessing (EMDR).
  
  c) Anxiety-Management Training.
  
  d) Group-Delivered Cognitive-Behavioral Interventions.

### Concluding the School Crisis Intervention

The school crisis response can be concluded when all individuals have obtained the knowledge and/or support they need to cope with crisis generated problems.

### Evaluating and Concluding the School Crisis Intervention

**Outcomes reflecting effectiveness**

...Continued...

4. Students attend school at or above pre-crisis attendance rates.
5. School behavior problems (i.e., aggressive, delinquent, and criminal behavior) occur at or below pre-crisis levels.
6. Student academic functioning is at or above pre-crisis level.

### Caring for the Caregiver

**We often forget to take care of ourselves!**

**Recommendations**

- Debriefing with other crisis responders.
- Ongoing professional development.
- Mentor/Mentee relationships.
- Maintain normal routines and comfortable rituals.
- Exercise.
- Rest/Sleep.
- Avoid excessive use of alcohol and drugs.

The Future of School Psychology: Selected Topics

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June 16, 2008

Training and Resources

► To schedule 1 & 2 day workshop trainings on PREPARE curriculum
  • contact Melissa Reeves, mereev@aol.com or Ted Feinberg, tfeinberg@naspweb.org

► Online Crisis Intervention Resources
  • http://www.nasponline.org/NEAT/crisismain.html

Presentation Outline

► The Model Licensure Act (MLA)
► Addressing autism spectrum disorders
► Addressing PTSD and the School Crisis Intervention Response
► Addressing bipolar disorders
► Response to Intervention (RtI)

Acknowledgements


DSM-IV-TR Diagnosis

1. Importance of early diagnosis
2. Pediatric bipolar disorder is especially challenging to identify.
   • Characterized by severe affect dysregulation, high levels of agitation, aggression.
   • Relative to adults, children have a mixed presentation, a chronic course, poor response to mood stabilizers, high comorbidity with ADHD
3. Symptoms similar to other disorders.
   • For example, ADHD, depression, Oppositional Defiant Disorder, Obsessive Compulsive Disorder, and Separation Anxiety Disorder.
4. Treatments differ significantly.
5. The school psychologist may be the first mental health professional to see bipolar.

Fenton et al. (2003)

DSM-IV-TR Diagnosis

Diagnostic Classifications

► Bipolar I Disorder
  • One or more Manic Episode or Mixed Manic Episode
  • Minor or Major Depressive Episodes often present
  • May have psychotic symptoms
► Bipolar II Disorder
  • One or more Major Depressive Episode
  • One or more Hypomanic Episode
  • No full Manic or Mixed Manic Episodes

APA (2000)
### DSM-IV-TR Diagnosis

**Diagnostic Classifications**

- Cyclothymia
  - Numerous periods with hypomanic and depressive symptoms
  - No full Manic, Major Depressive, or Mixed Episodes

- Bipolar Disorder Not Otherwise Specified
  - Bipolar features that do not meet criteria for any specific bipolar disorder.

### DSM-IV-TR Diagnosis

**Manic Episode Criteria**

- A distinct period of abnormally and persistently elevated, expansive, or irritable mood.
- Lasting at least 1 week.
- Three or more (four if the mood is only irritible) of the following symptoms:
  1. Inflated self-esteem or grandiosity
  2. Decreased need for sleep
  3. Pressured speech or more talkative than usual
  4. Flight of ideas or racing thoughts
  5. Distractibility
  6. Psychomotor agitation or increase in goal-directed activity
  7. Hedonistic interests

### DSM-IV-TR Diagnosis

**Manic Episode Criteria (cont.)**

- Causes marked impairment in occupational functioning in usual social activities or relationships, or
- Necessitates hospitalization to prevent harm to self or others, or
- Has psychotic features
- Not due to substance use or abuse (e.g., drug abuse, medication, other treatment), or a general medical condition (e.g., hyperthyroidism).

### Manic Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased Need for Sleep: Unable to fall or stay asleep or waking up too early because of increased energy, leading to a significant reduction in sleep yet feeling well rested.</td>
<td>Despite only sleeping 3 hours the night before, a child is still energized throughout the day</td>
</tr>
<tr>
<td>Increased Speech: Dramatically amplified volume, uninterruptible rate, or pressure to keep talking.</td>
<td>A child suddenly begins to talk extremely loudly, more rapidly, and cannot be interrupted by the teacher</td>
</tr>
<tr>
<td>Flight of Ideas or Racing Thoughts: Report or observation (via speech/writing) of speeded-up, tangential or circumstantial thoughts.</td>
<td>A teacher cannot follow a child's rambling speech that is out of character for the child (i.e., not related to any cognitive or language impairment the child might have)</td>
</tr>
</tbody>
</table>

### Manic Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
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<tbody>
<tr>
<td>Euphoria: Elevated (too happy, silly, giddy) and expansive (about everything) mood, “out of the blue” or as an inappropriate reaction to external events for an extended period of time.</td>
<td>A child laughs hysterically for 30 minutes after a mildly funny comment by a peer and despite other students staring at him.</td>
</tr>
<tr>
<td>Irritability: Energized, angry, raging, or intensely irritable mood, “out of the blue” or as an inappropriate reaction to external events for an extended period of time.</td>
<td>In reaction to meeting a substitute teacher, a child flies into a violent 20-minute rage.</td>
</tr>
<tr>
<td>Inflated Self-Esteem or Grandiosity: Believing, talking or acting as if he is considerably better at something or has special powers or abilities despite clear evidence to the contrary.</td>
<td>A child believes and tells others she is able to fly from the top of the school building.</td>
</tr>
</tbody>
</table>

### Manic Symptoms at School

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<tr>
<td>Distractibility: Increased inattentiveness beyond child's baseline attentional capacity.</td>
<td>A child is distracted by sounds in the hallway, which would typically not bother her.</td>
</tr>
<tr>
<td>Increase in Goal-Directed Activity or Psychomotor Activity: Hyper-focused on making friends, engaging in multiple school projects or hobbies or in sexual encounters, or a striking increase in and duration of energy.</td>
<td>A child starts to rearrange the school library or clean everyone's desks, or plan to build an elaborate fort in the playground, but never finishes any of these projects.</td>
</tr>
<tr>
<td>Excessive Involvement in Pleasurable or Dangerous Activities: Sudden unrestrained participation in an action that is likely to lead to painful or very negative consequences.</td>
<td>A previously mild-mannered child may write dirty notes to the children in class or attempt to jump out of a moving school bus.</td>
</tr>
</tbody>
</table>

**DSM-IV-TR Diagnosis**

**Hypomanic Criteria**
- Similarities with Manic Episode
  - Same symptoms
- Differences from Manic Episode
  - Length of time
  - Impairment not as severe
  - May not be viewed by the individual as pathological
  - However, others may be troubled by erratic behavior

APA (2000)

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**DSM-IV-TR Diagnosis**

**Major Depressive Episode Criteria**
- A period of depressed mood or loss of interest or pleasure in nearly all activities
  - In children and adolescents, the mood may be irritable rather than sad.
- Lasting consistently for at least 2 weeks.
- Represents a significant change from previous functioning.

APA (2000)

---

**DSM-IV-TR Diagnosis**

**Major Depressive Episode Criteria (cont.)**
- Five or more of the following symptoms (at least one of which is either 1) or 2):
  1) Depressed mood
  2) Diminished interest in activities
  3) Significant weight loss or gain
  4) Insomnia or hypersomnia
  5) Psychomotor agitation or retardation
  6) Fatigue/loss of energy
  7) Feelings of worthlessness/inappropriate guilt
  8) Diminished ability to think or concentrate/indecisiveness
  9) Suicidal ideation or suicide attempt

APA (2000)

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**Major Depressive Symptoms at School**

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed Mood</td>
<td>A child appears down or flat or is cranky or grouchy in class and on the playground.</td>
</tr>
<tr>
<td>Markedly Diminished Interest or Pleasure in All Activities</td>
<td>A child reports feeling empty or bored and shows no interest in previously enjoyable school or peer activities.</td>
</tr>
<tr>
<td>Significant Weight Loss/Gain or Appetite Increase/Decrease</td>
<td>A child looks much thinner and drawn or a great deal heavier, or has no appetite or an excessive appetite at lunch time.</td>
</tr>
<tr>
<td>Fatigue/Loss of Energy</td>
<td>A child looks run down, often groggy or tired, or reports sleeping through alarm despite getting 12 hours of sleep.</td>
</tr>
<tr>
<td>Psychomotor Agitation/Retardation</td>
<td>A child is extremely fidgety or can’t stay seated. His speech or movement is sluggish or he avoids physical activities.</td>
</tr>
<tr>
<td>Insomnia or Hypersomnia</td>
<td>A child looks worn out, is often groggy or tardy, or reports sleeping through alarm despite getting 12 hours of sleep.</td>
</tr>
<tr>
<td>Markedly Diminished Interest or Pleasure in All Activities</td>
<td>A child is extremely fidgety or can’t stay seated. His speech or movement is sluggish or he avoids physical activities.</td>
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<tr>
<td>Significant Weight Loss/Gain or Appetite Increase/Decrease</td>
<td>A child looks run down, often groggy or tired, or reports sleeping through alarm despite getting 12 hours of sleep.</td>
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From Lofthouse & Fristad (2006, p. 216)
## Major Depressive Symptoms at School

<table>
<thead>
<tr>
<th>Symptom/Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Self-Esteem, Feelings of Worthlessness or Excessive Guilt</td>
<td>A child frequently tells herself or others “I’m no good, I hate myself, no one likes me, I can’t do anything.” She feels bad about and dwells on accidentally bumping into someone in the corridor or having not said hello to a friend.</td>
</tr>
<tr>
<td>Diminished Ability to Think or Concentrate, or Indecisiveness</td>
<td>A child can’t seem to focus in class, complete work, or choose unstructured class activities.</td>
</tr>
</tbody>
</table>

From Lofthouse & Fristad (2006, p. 216)

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## DSM-IV-TR Diagnosis

### Mixed Episode Criteria
- Both Manic and Major Depressive Episode criteria are met nearly every day for a least a 1 week period.
- Rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a Manic and Depressive episode.
- Causes marked impairment in occupational functioning or in usual social activities or relationships, or
- Necessitates hospitalization to prevent harm to self or others, or
- Has psychotic features
- Not due to substance use or abuse, or a general medical condition

APA (2000)

---

## Juvenile Bipolar Disorder

### Terms used to define juvenile bipolar disorder.
- Ultrarapid cycling = 5 to 364 episodes/year
  - Brief frequent manic episodes lasting hours to days, but less than the 4-days required under Hypomania criteria (10%).
- Ultradian cycling = >365 episodes/year
  - Repeated brief cycles lasting minutes to hours (77%).
  - Chronic baseline mania (Wozniak et al., 1995).
  - Ultradian is Latin for “many times per day.”

AACAP (2007); Geller et al. (2000)

---

## Recurrent Thoughts of Death or Suicidality

- Obsession with morbid thoughts or events, or suicidal ideation, planning, or attempts to kill self
- A child frequently tells herself or others “I’m so sad, I hate myself, no one likes me, I can’t do anything.” She feels bad about and dwells on accidentally bumping into someone in the corridor or having not said hello to a friend.

From Lofthouse & Fristad (2006, p. 216)

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## DSM-IV-TR Diagnosis

### Rapid-Cycling Specifier
- Can be applied to Bipolar I or II
- Four or more mood episodes (i.e., Major Depressive, Manic, Mixed, or Hypomanic) per 12 months
- May occur in any order or combination
- Must be demarcated by ...
  - a period of full remission, or
  - a switch to an episode of the opposite polarity
    - Manic, Hypomanic, and Mixed are on the same pole
- NOTE: This definition is different from that used in some literature, where in cycling refers to mood changes within an episode (Geller et al., 2004).

APA (2000)

---

## Juveniles

- Longer duration of episodes
- Higher rates or rapid cycling.
- Lower rates of inter-episode recovery.
  - Chronic and continuous.

AACAP (2007); NIMH (2001)
Juvenile Bipolar Disorder

► Adults
  • Mania includes marked euphoria, grandiosity, and irritability
  • Racing thoughts, increased psychomotor activity, and mood lability.
► Adolescents
  • Mania is frequently associated with psychosis, mood lability, and depression.
  • Tends to be more chronic and difficult to treat than adult BPD.
  • Prognosis similar to worse than adult BPD
► Prepubertal Children
  • Mania involves markedly labile/erratic changes in mood, energy levels, and behavior.
  • Predominant mood is VERY severe irritability (often associated with violence) rather than euphoria.
  • Irritability, anger, belligerence, depression, and mixed features are more common.
  • Mania is commonly mixed with depression.

AACAP (2007); NIMH (2001); Wozniak et al. (1995)

Juvenile Bipolar Disorder

► Unique Features of Pediatric Bipolar Disorder
  • Chronic with long episodes
  • Predominantly mixed episodes (20% to 84%) and/or rapid cycling (46% to 87%)
  • Prominent irritability (77% to 98%)
  • High rate of comorbid ADHD (75% to 98%) and anxiety disorders (5% to 50%)

Pavuluri et al. (2005)

Juvenile Bipolar Disorder

► Bipolar Disorder in childhood and adolescence appear to be the same clinical entity.
► However, there are significant developmental variations in illness expression.

<table>
<thead>
<tr>
<th></th>
<th>Childhood</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Gender</td>
<td>67.5%</td>
<td>48.2%</td>
</tr>
<tr>
<td>Chronic Course</td>
<td>57.5%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Episodic Course</td>
<td>42.5%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Attention-deficit/Hyperactivity Disorder</td>
<td>38.7%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>35.9%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

Masi et al. (2006)

Juvenile Bipolar Disorder

► NIMH Roundtable
  • Bipolar disorder exists among prepubertal children.
    ► Narrow Phenotype
      • Meet full DSM-IV criteria
      • More common in adolescent-onset BPD
    ► Broad Phenotype
      • Don't meet full DSM-IV criteria, but have BPD symptoms that are severely impairing.
      • More common in childhood-onset BPD
      • Suggested use of the BPD NOS category to children who did not fit the narrow definition of the disorder.

NIMH (2001)

Juvenile Bipolar Disorder

1. Sleep/Wake Cycle Disturbances
2. ADHD-like symptoms
3. Aggression/Poor Frustration Tolerance
4. Intense Affective Rages
5. Bossy and overbearing, extremely oppositional
6. Fear of Harm or social phobia
7. Hypersexuality
8. Laughing hysterically/acting infectiously happy
9. Deep depression
10. Sensory Sensitivities
11. Carbohydrate Cravings
12. Somatic Complaints

Danielyan et al. (2007)
Course: Pediatric Bipolar Disorder

► Remission
  • 2 to 7 weeks without meeting DSM criteria
► Recovery
  • 8 weeks without meeting DSM criteria
  • 40% to 100% will recovery in a period of 1 to 2 years
► Relapse
  • 2 weeks meeting DSM criteria
  • 60% to 70% of those that recover relapse on average between 10 to 12 months
► Chronic
  • Failure to recover for a period of at least 2 years

Pavuluri et al. (2005)

Co-existing Disabilities

► Attention-deficit/Hyperactivity Disorder (AD/HD)
  • Rates range between 11% and 75%
► Oppositional Defiant Disorder
  • Rates range between 46.4% and 75%
► Conduct Disorder
  • Rates range between 5.6 and 37%
► Anxiety Disorders
  • Rates range between 12.5% and 56%
► Substance Abuse Disorders
  • 0 to 40%

Pavuluri et al. (2005)

Co-existing Disabilities

AD/HD Criteria Comparison

Bipolar Disorder (mania)  AD/HD

1. More talkative than usual, or pressure to keep talking
2. Distractibility
3. Increase in goal-directed activity or psychomotor agitation

1. Often talks excessively
2. Is often easily distracted by extraneous stimuli
3. Is often “on the go” or often acts as if “driven by a motor”

Differentiation = irritable and/or elated mood, grandiosity, decreased need for sleep, hypersexuality, and age of symptom onset (Geller et al., 1998).

Pavuluri et al. (2005)

Co-existing Disabilities

► Developmental Differences
  • Children have higher rates of ADHD than do adolescents
  • Adolescents have higher rates of substance abuse
    ▶ Risk of substance abuse 8.8 times higher in adolescent-onset bipolar disorder than childhood-onset bipolar disorder
  • Children have higher rates of pervasive developmental disorder (particularly Asperger’s Disorder, 11%)
► Unipolar Depression?
► Schizophrenia?

Pavuluri et al. (2005)

Associated Impairments

Suicidal Behaviors
► Prevalence of suicide attempts
  • 40-45%
► Age of first attempt
► Multiple attempts
► Severity of attempts
► Suicidal ideation

Cognitive Deficits
► Executive Functions
► Attention
► Memory
► Sensory-Motor Integration
► Nonverbal Problem-Solving
► Academic Deficits
  • Mathematics
The Future of School Psychology:
Selected Topics

Stephen E. Brock, Ph.D., NCSP 31

LACOE
June 16, 2008

**Associated Impairments**

Psychosocial Deficits
- Relationships
  - Peers
  - Family members
- Recognition and Regulation of Emotion
- Social Problem-Solving
- Self-Esteem
- Impulse Control

**Prognosis**

*With respect to prognosis,... [early onset bipolar spectrum disorder] may include a prolonged and highly relapsing course; significant impairments in home, school, and peer functioning; legal difficulties; multiple hospitalizations and increased rates of substance abuse and suicide.*

*In short, children with [early onset bipolar spectrum disorder] have a chronic brain disorder that is biopsychosocial in nature and, at this current time, cannot be cured or grown out of.*


**Recognize Educational Implications**

Outcome by subtype (research with adults)
- Bipolar Disorder I
  - More severe; tend to experience more cycling & mixed episodes; experience more substance abuse; tend to recover to premorbid level of functioning between episodes.
- Bipolar Disorder II
  - More chronic; more episodes with shorter inter-episode intervals; more major depressive episodes; typically present with less intense and often unrecognized manic phases; tend to experience more anxiety.
- Cyclothymia
  - Can be impairing; often unrecognized; many develop more severe form of Bipolar illness.
- Bipolar Disorder Not Otherwise Specified (NOS)
  - Largest group of individuals

**Special Education Assessment**

*Grade retention*
*Learning disabilities*
*Special Education*
*Required tutoring*
*Adolescent onset = significant disruptions*
  - Before onset
    - 71% good to excellent work effort
    - 58% specific academic strengths
  - After onset
    - 67% significant difficulties in math
    - 38% graduated from high school

Lofthouse & Fristad (2006)
The Future of School Psychology:
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June 16, 2008

Special Education Assessment

► Special Education Eligibility Categories
  • Emotionally Disturbed (ED)
  •Other Health Impaired (OHI)

Special Education Assessment

ED

► Likely more opportunity to access special programs.
► Can be an accurate representation.
► Draws attention to mood issues.
► Represents the presentation of the disorder.

OHI

► Label less stigmatizing.
► Also an accurate representation.
► Implies a medical condition that is outside of the student’s control.
► Represents the origin of the disorder.

Special Education Assessment

► Socio-Emotional Functioning
  Rating Scales
  ► General
    • Child Behavior Checklist (CBCL)
    • Behavior Assessment System for Children (BASC-II)
    • Devereux Scales of Mental Disorders (DSMD)
  ► Mania
    • Washington University in St. Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U KSADS)
    • Young Mania Rating Scale
    • Young Mania Rating Scale - Parent Version
    • General Behavior Inventory (GBI)
  ► Depression
    • Beck Depression Inventory (BDI)
    • Hamilton Rating Scale for Depression
    • Reynolds Adolescent Depression Scale (RADS-2)
  ► Mania

Special Education Assessment

► Socio-Emotional Functioning, cont.
  Rating Scales
  ► Comorbid conditions
    • Attention
      • Conners’ Rating Scales
      • Brown Attention-Deficit Disorder Scales for Children and Adolescents
    • Conduct
      • Scale for Assessing Emotional Disturbance (SAED)
    • Anxiety
      • Revised Children’s Manifest Anxiety Scale (RCMAS)
  ► Informal Measures
    • Sentence Completions
    • Guess Why Game?

School-Based Interventions

► Specific Recommendations
  1. Build, maintain, and educate the school-based team.
  2. Address medication side-effects
  3. Account for sleep disorders; and impaired concentration, focus, & memory
  4. Address mood swings.
  5. Adjust the environment.
  6. School counseling.
  7. Consider alternatives to regular classroom.

Lofthouse & Fristad (2006)

School-Based Interventions

► Build, maintain, and educate the school-based team.
  • Professionals and paraprofessionals must understand bipolar disorder.
  • School staff must understand, have compassion for, and know how to work successfully with the student.
  • Communication between home and school (and ideally community mental health professionals) is important.
The Future of School Psychology:
Selected Topics

LACOE
June 16, 2008

School-Based Interventions
► Address Medication Side Effects
  ▪ Excessive thirst
    ➢ Ensure access to water at all times
  ▪ Diarrhea and frequent urination
    ➢ Ensure access to the restroom
  ▪ Cognitive dulling and visual blurring
    ➢ Provide books on tape and/or reading partners
    ➢ Reduce reading requirements
  ▪ Fatigue or sleepiness
    ➢ Don’t punish or single out for sleepiness

School-Based Interventions
► Account for Sleep Disorders
  ▪ Allow late school arrival.
  ▪ Shorten school day.
  ▪ Provide assistance for missed assignments

School-Based Interventions
► Account for Impaired Concentration, Focus, and Memory
  ▪ Provide lesson outlines
  ▪ Break assignments down to small parts
  ▪ Preferential seating (front of class)
  ▪ Task organizers include breaks

School-Based Interventions
► Account for Mood Swings: Mania
  1. Allow students to work in calm environments
  2. Reduce work load, increase breaks
  3. Don’t allow student to be the focus of attention
  4. Provide “escape” opportunities
  5. Consider sending the student home.

School-Based Interventions
► Adjust the Physical Environment
  ▪ Lighting
  ▪ Noise
  ▪ Temperature

Massachusetts General Hospital

Stephen E. Brock, Ph.D., NCSP
School-Based Interventions

► Counseling
  ▪ Individual or group?
    ► Will it be part of the IEP as a Designated Instructional Service (DIS)?
    ▪ Goal(s)...
  ▪ Crisis Intervention
    ► Will it be written into the BSP?

► Possible elements of a counseling program
  ▪ Education
  ▪ Coping skills
  ▪ Social skills
  ▪ Suicidal ideation/behaviors
  ▪ Substance use

Presentation Outline

► The Model Licensure Act (MLA)
► Addressing autism spectrum disorders
► Addressing PTSD and the School Crisis Intervention Response
► Addressing bipolar disorders
► Response to Intervention (RtI)

Introduction to Response to Intervention and the Three Tiered Model

► RtI models have three critical components:
  1. A focus on high quality, research based instruction
  2. monitoring student progress in response to that instruction and
  3. determining the need for more intensive services based upon two separate criteria:
    ▪ the student’s standing in comparison to benchmarks and
    ▪ rate of growth in response to instruction/intervention.
  ▪ RtI models require collaboration between regular and special education in the provision of services.
    ▪ This collaboration may involve activities such as consultation regarding assessment of progress or direct service to students.

► According to IDEA 2004, LEAs “shall not be required to take into consideration whether a child has a severe discrepancy between achievement and intellectual ability” when determining if a child has a specific learning disability.
► IDEA 2004 also includes language that allows for the use of “a process that determines if the child responds to scientific, research-based interventions as a part of the evaluation procedures.”

Introduction to Response to Intervention and the Three Tiered Model

► Using response to intervention represents an approach to assessment that is based in a problem solving approach rather than the traditional model emphasizing differential diagnosis.
► A problem solving approach, in its simplest form, involves four steps:
  1. defining the problem,
  2. implementing an intervention,
  3. evaluating the effectiveness of the intervention, and
  4. making a decision as to the need for further intervention (either a different intervention or more intense intervention).
Introduction to Response to Intervention and the Three Tiered Model

► In and RtI process the focus of assessment shifts from diagnosing student problems that prevent him or her from learning to determining what strategies are most effective in promote student learning.
► When the resources needed to establish learning become too intensive for general education to manage, eligibility for special supports and services is considered.

Introduction to Response to Intervention and the Three Tiered Model

► Essential to understanding and implementing RtI models are
  1. using data measuring a student's response to an intervention as a key part of an evaluation,
  2. the requirement that all assessments be instructionally relevant, and
  3. new standards for technical adequacy associated with intervention
     - delivery (e.g., intervention integrity),
     - measurement of child behaviors (e.g., adequate modeling of trend or growth over time), and
     - systems of decision-making (e.g., cut-scores).

Introduction to Response to Intervention and the Three Tiered Model

► Maximizing the potential of an RtI model requires systems level change addressing such issues as:
  ▪ the provision of intervention services,
  ▪ monitoring and analyzing data on student progress and
  ▪ the use of that data in determining eligibility for services.
► School psychologists have the training and background to be active consultants in the development and implementation of RtI models in their schools.

Introduction to Response to Intervention and the Three Tiered Model

► Although the use of an RtI model has been legislated as part of the eligibility process for SLD it is also applicable to behavioral concerns.
► Referred to as FAA, it has been used for years in CA.

Introduction to Response to Intervention and the Three Tiered Model

► In addition, the assessment process is ongoing and occurs prior to and over the life of the intervention process.
► This approach represents a significant conceptual shift for many school psychologists and will require considerable discussion among school practitioners.

Introduction to Response to Intervention and the Three Tiered Model

► Response to intervention is often presented as a three tier model in which each tier provides an increasingly intensive level of intervention.
► The model rests upon the use of empirically supported instruction for all students.
► Students not making sufficient progress in response to this instruction are first provided with interventions within the classroom.
Introduction to Response to Intervention and the Three Tiered Model

- Children not showing adequate progress in response to these classroom interventions would be referred for further analysis of the academic problem and more intense interventions.
- Intensity can be increased through such characteristics as duration, size of group or nature of instruction.
- Children who do not respond to these first and second tier interventions are then referred to the third tier, which provides a level of service similar to current special education practice.

Introduction to Response to Intervention and the Three Tiered Model

- Students referred to tier three are provided a comprehensive assessment to identify instructional need and determine special education eligibility.
- Along with progress monitoring and other data gathered at tiers one and two, additional data sources that provide reliable, valid, and instructionally relevant information are selected as necessary.

Knowledge/Skills Important for the School psychologist

- General Understanding of Effective Instructional Practices
- Designing and Implementing Effective Interventions
- Monitoring Progress and Response to Intervention

General Understanding of Effective Instructional Practices

- School psychologists need to have the knowledge and skills that will promote sound educational practice (i.e., the use of effective behavioral/instructional strategies and interventions that facilitate student attainment of academic standards).
  - Across all tiers, school psychologists need general knowledge of the California standards and expectations and how the school curricula and general education assessments relate to these standards.
- At tier one, school psychologists should be able to assist school staff in determining if the general education curriculum and classroom-based interventions have the requisite empirical support to help students reach state standards.

Designing and Implementing Effective Interventions

- Across all tiers, school psychologists need...
  - to have access to resources related to interventions with proven efficacy and the skills to determine whether an intervention is likely to be effective in a given situation.
  - to know strategies designed to increase the likely effectiveness of an intervention such as intervention training and monitoring of implementation
  - know how ecological (both home and school) and student-related variables influence intervention design and implementation
  - the knowledge and skills required to utilize single subject experimental design strategies to determine effective interventions for identified students.
Designing and Implementing Effective Interventions

► At tier one, school psychologists need to
  • have knowledge of effective classroom based instruction and methods for differentiating instructional strategies according to student need.
► At tier two, school psychologists need to
  • know how to identify key student and intervention characteristics and consider these characteristics in determining which interventions are most likely to result in positive outcomes. have the ability to identify specific skill or performance deficits in order to
  • assist in the process of selecting specific interventions.

Designing and Implementing Effective Interventions

► At tier three, school psychologists need
  • knowledge of assessments that will provide information useful in designing and implementing interventions.
  • to have the knowledge and skills needed to facilitate the development of, and participate in, comprehensive assessments that identify areas of academic and behavioral need and areas in which a student may require instructional accommodations and modifications.

Designing and Implementing Effective Interventions

► The comprehensive assessment...
  • These data are also used to determine if the student is eligible for special education.
  • The comprehensive evaluation considers all variables that potentially affect the individual student’s learning.
  • Comprehensive assessment data sources are selected because they
    • are judged to have the potential to provide information about a student’s specific learning needs and
    • have been supported by the empirical literature to provide data useful in the selection of instructional accommodations and modifications.

Monitoring Progress and Response to Intervention

► Across all tiers, school psychologists need
  • to have the knowledge and skills to monitor student progress over time and use these data to inform decisions about instructional effectiveness.
► At tier one, progress monitoring involves
  • collecting data for all students through universal screening,
  • the development of benchmarks and
  • the monitoring of individual students.

Monitoring Progress and Response to Intervention

► At tier two, school psychologists need to have
  • the knowledge and skills necessary to facilitate the development of systems for
    • monitoring the progress of individual students in response to interventions,
    • helping teachers use that information to adjust instruction and
    • compare a student’s growth and the level of performance to his or her peers.

Monitoring Progress and Response to Intervention

► At tier three school psychologists also must have the knowledge and skills needed to conduct a comprehensive evaluation.
  • These evaluations use data from multiple sources to address educational need and eligibility for special education services.
  • School psychologists have the knowledge and skills to identify data sources and assessment tools that
    • are judged to have the potential to provide information about a specific student’s specific learning needs and
    • are supported by the empirical literature to provide data useful in the selection of instructional accommodations and modifications.
  • Such data sources may include instructionally relevant information collected at tiers one and two, for example, data identifying specific performance or skill deficits.
The Future of School Psychology:
Selected Topics

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Resources

INTERVENTIONS
► Institute of Child Health and Human Development
  2000. Report of the National Reading Panel: Teaching
  Children to Read. www.nichd.nih.gov/publications/nrp
► www.nasponline.org
► Florida Center for Reading Research www.fcrr.org
► www.ed.gov/about/offices/list/ies/index.html
► University of Oregon reading tests reviews www.idea.uoregon.edu

Resources

PROGRESS MONITORING AND CBM
► Training materials/probes www.interventioncentral.org
► Read Naturally www.readnaturally.com
► CBM Website List - http://www.luc.edu/schools/education/c487/lap/velde.htm
► Progress monitoring www.studentprogress.org
► www.aimsweb.com
► University of Oregon - Dibels http://dibels.uoregon.edu and www.idea.uoregon.edu
► Florida Project - http://sss.usf.edu/cbm/cbm.htm

Resources

IDEA 2004
► http://www.nasponline.org/advocacy/2004LDRoun
dtableRecsTransmittal.pdf
► http://www.idea.practices.org/
► http://www.cde.ca.gov/sp/se/lr/ideareathztn.asp
► http://www.wrightslaw.com/idea/news/05.0613.re
gs.reformat.htm

Resources

RTI
► National Association of State Directors of
  Special Education has publication on RtI
  www.nasdse.org
► www.wested.org/nercc/rti.htm
► www.nrcl.org/symposium2003/index.html