CHILDREN RECEIVE MENTAL HEALTH SERVICES from schools more often than from any other service system (Adelman & Taylor, 2010; Burns et al., 1995; Farmer, Burns, Phillips, Angold, & Costello, 2003; Hoagwood et al., 2007). Schools are in a unique position to provide mental health intervention because parents and school staff are often the first to notice youth mental health issues (Loade & Mastroyannopoulos, 2010). School-based mental health interventions increase the accessibility of services to youth and help decrease barriers to mental health care (Owens et al., 2002; Weist, Lever, Bradshaw, & Owens, 2014). School providers also have the advantage of potentially communicating with and observing a student’s interactions with peers, teachers, and parents, as well as their academic functioning more easily than community-based providers, whose services are often limited to outpatient clinics (Mennuti & Christner, 2005). Because youth spend the majority of their days in school, an understanding of school ecology also enables effective mental health treatment regardless of the setting in which youth are treated.

We outline the unique position of school psychologists, at both the master’s and doctoral levels, to provide and influence the use of cognitive behavioral therapy (CBT) in school settings. The use of CBT in schools and school psychology as a discipline are described and applied examples provided.

CBT in Schools

CBT has been shown to be effective in the treatment of numerous childhood disorders (Kazdin & Weisz, 1998; Ollendick & King, 2004; Weisz & Kazdin, 2010, 2018) and has been advocated for use within school settings (Hoagwood & Erwin, 1997; Mennuti & Christner, 2013). CBT fits well with the existing structure and culture of traditional school settings, which may help to increase its acceptance by school staff (Mennuti & Christner, 2005). The structure of CBT is familiar to both students and educators: agenda setting, psychoeducation, in-session practice, and the assigning of practice or homework are already commonplace within education systems (Mennuti & Christner, 2005). CBT protocols are relatively short in duration, adaptable for individual youths’ current needs, and solution-focused (Reinecke, Dattilio, & Freeman, 2003), allowing providers working in schools to utilize CBT on three different levels: prevention, early identification, and direct service to youth (Mennuti & Christner, 2013). CBT also works well within schools because it is often more time-limited than other approaches, and time is often tightly constrained at schools, both within the day and across the academic year (Mennuti & Christner, 2005).

School Psychology

The field of school psychology encompasses the delivery of psychological services and supports to children and adolescents, often (although not solely) in schools, particularly with regards to students’ academic goals and learning. School psychologists can hold either a master’s degree with a specialist license, with which they can practice in schools, or a doctoral degree, with which they can become a licensed psychologist through the same avenues that Ph.D.s in clinical or counseling psychology or doctors in psychology (Psy.D.) become licensed. Practice settings for doctoral-level school psychologists vary immensely, from traditional school settings, to academic positions, community mental health settings, private practices, and pediatric psychology settings, such as hospitals, primary care, and specialty care clinics.

In practice, master’s-level school psychologists typically work in schools, assessing students for learning difficulties and coordinating a variety of services to support students’ academic success and psychological functioning. These services can include direct psychological services, identifying and implementing specialized programs targeting specific academic skills, and coordinating services among general and special education teachers, school counselors and social workers, families, and community-based services. Generally, school psychologists working within schools do not administer interventions themselves and instead provide recommendations for interventions and consultation to specialists or teachers implementing them. In fact, school psychologists are the only professional psychologists specifically trained in indirect service delivery (D’Amato, Zafiris, McConnell, & Dean, 2011). Behavioral consultation with teachers is a core practice of school psychologists that is rooted in learning theory to identify the function of student behaviors in classrooms and design an intervention to resolve the problem (Sheridan & Kratochwill, 2007). School consultation often also incorporates other evidence-based practices, such as motivational interviewing, to address teachers’ ambivalence about change (Holdaway & Owens, 2015; Reinke, Herman, & Sprick, 2011).

Historically, school psychologists in school settings have focused on the population of students served by Section 504 and special education services. More specifically, the school psychologists’ role focused on assessing whether students qualify to receive those services, and coordinating with school personnel to deliver them, primarily in response to an increasing legal demand to serve students with disabilities as mandated by the Individuals with Disabilities Education Act (IDEA) of 1990. Because of increased demand for individual assessments for services, school psychologists spent much more of their time in the 1990s conducting intelligence tests and writing psychological reports detailing students’ eligibility for services than ever before. Subsequent legislation—the No Child Left Behind Act of 2001 and the reauthorization of IDEA in 2004—pushed the field of school psychology towards a Response to Intervention (RTI) model, whereby assessment requirements were reduced so that intervention was targeted towards addressing individual needs before they could be designated as having a learning disability (Ball, Pierson, & McIntosh, 2011). This expanded role means that school psychologists can be an important part of prevention by intervening with youth who are showing some early signs of difficulty but do not yet have a level of impairment necessitating referral for therapy. Thus, school psychologists are well-positioned to use CBT for prevention at the universal, targeted, and indicated levels. Most practitioners of CBT come into con-
tact with youth only once they are already experiencing serious mental health concerns; school psychologists can intervene at an earlier stage and hopefully limit the negative impact experienced by youth (Krautochwill, 2007).

Compared to their master’s-level counterparts, Ph.D.-level school psychologists obtain advanced training in psychoeducational and psychosocial assessment and therapy along with additional coursework and practice in research methods. Training in research methodology qualifies school psychologists to organize and evaluate mental health delivery systems in a variety of contexts with validated tools. Furthermore, the bulk of training for school psychologists focuses on the needs of children and adolescents and the systems of care in which they already operate, such as schools. Even when doctoral-level school psychologists are not practicing in school settings, their foundational experiences in schools help them develop expertise collaborating across disciplines with teachers, administrative personnel, and other educational specialists, and working within delivery systems of care. All of these experiences make school psychology trainees well-poised to work in multidisciplinary spaces, serving as ambassadors for psychology and evidence-based practices such as CBT in mental health.

The school psychology program at the University of Texas at Austin, the first school psychology program to be accredited by the American Psychological Association, is an exemplar training model. The program is interdisciplinary and follows the scientist-practitioner model in its doctoral and master’s-level training, which include the same courses in the first 2 years of the programs. These courses provide key foundations in research methodology, development, learning, family interventions, social/emotional and behavioral assessment, and behavioral and cognitive-behavioral mental health interventions, as well as school psychology-specific coursework on the law, ethics, and history of school psychology, psychoeducational assessment and intervention, and consultation. Courses emphasize a multicultural, evidence-based lens to interventions and research. Master’s and doctoral students all complete a 1-year school-based practicum and gain a diversity of experiences conducting assessments, consultation, and delivering therapy in school settings. Doctoral students take additional courses for specialty emphases, some of which include diversity, pediatric psychology, neuropsychology, academic/research, and child clinical.

After the initial school practicum in their second year, doctoral students obtain various practicum experiences pertaining to individual interests, including in community mental health clinics, school-based therapy clinics, and integrated behavioral health settings, such as a pediatric cancer center, community primary care centers, and hospital consultation-liaison services for youth and families. Since 2009, 98% of doctoral students who have applied to internships obtained them and 96% of these internship sites were APA/CPA accredited. Internship placement sites predominantly include medical centers, integrated behavioral health settings, community mental health clinics, schools, and juvenile justice centers. The perspectives of doctoral students within these settings are enriched by their understanding of the school context because they have multiple experiences coordinating within a child’s mesosystem among diverse personnel from the school, medical clinic, and governmental agencies, such as the juvenile justice system.

School Psychologists as Ambassadors for CBT in Schools

Research suggests that school psychologists working in schools spend more of their time than they would like on writing psychological reports and IQ testing, and less time than they would like on working in primary and secondary screening and prevention, consultation, research and program evaluation, and conducting therapy, even after the historical push toward an RTI model (Filter, Ebsen, & Dibos, 2013). However, technological advances in delivering psychometric tools and the contracting of cheaper psychometricians to conduct psychoeducational evaluations will likely make conducting assessments less of a central focus of master’s-level school psychologists’ jobs, such that existing school psychologists may focus more centrally on indirect services, such as consultation with teachers and systems-level screening and intervention. School psychologists in the future may also spend more time doing therapy than the typical school psychologist in school settings currently does.

Both master’s and Ph.D.-level school psychologists have potentially important and unique qualifications that would allow them to contribute to the dissemination of CBT. Ph.D.-level school psychologists are particularly well trained to integrate practices at the systems level and advocate for policy-level changes to include mental health services with other school services. Ph.D.-level school psychologists can also initiate collaborations between schools and local academic institutions, such as the Act & Adapt project (described below), to work with school personnel in implementing CBT and evidence-based interventions. As those in charge of recommending, and often coordinating, services for students, master’s-level school psychologists are in an excellent position to advocate for more students to receive both effective preventive and targeted mental health care services and to coordinate their delivery with allied providers. Additionally, their training in consultation makes them uniquely qualified to work with school counselors, social workers, and teachers to disseminate elements of CBT effectively within classrooms and other settings. For example, school psychologists are particularly prepared to coordinate with teachers to disseminate evidence-based classroom-level interventions, such as the Good Behavior Game, that have been shown to affect a wide variety of long-term child mental health outcomes, such as drug use and antisocial behavior (Bradshaw et al., 2009; Embry, 2002). Indeed, school psychologists have key access to critical change agents that play important roles in children’s lives, allowing them to increase the ecological validity of the interventions they deliver.

This article describes three examples of school psychologists fostering the use of CBT in school settings from the University of Texas at Austin’s (UT Austin) School Psychology program: (a) Two faculty in the UT Austin School Psychology program have collaborated with three local middle schools to conduct a feasibility study to support school providers’ use of a CBT-based depression prevention program for youth in schools, called Act & Adapt (Bearman & Weisz, 2009; Polo, Bearman, Short, Ho, & Weisz, 2006); (b) A graduate of this school psychology program has opened Vida Clinic, a school co-located mental health organization that specializes in school-based mental health services; (c) Another graduate of UT Austin, along with current graduate students of UT Austin’s school psychology program, has developed a webinar series to train school nurses in CBT-based mental health care. 

Act & Adapt

Act & Adapt is a CBT-based coping skills intervention that has been adapted
for use in the school setting, adjusting for time, financial, and training constraints (Bearman & Weisz, 2009; Polo et al., 2006). It is a manualized, video-guided group depression prevention program that teaches youth to learn how to “act” in response to problems that are in their control and “adapt” to stressors that are outside of their control using coping skills, such as behavioral activation and cognitive restructuring. Groups were co-led by master’s and doctoral students in the school psychology program at UT Austin and school staff, interns, and social workers already embedded in the middle schools. The Act & Adapt program was modified to fit into the typical school context, with shortened sessions (30 minutes of content) and more flexible delivery than in the initial design. In addition to expanding service capacity at the schools, a key goal of this research collaboration was to transfer CBT knowledge to school personnel so that they could independently provide these groups to future students without school psychology student support.

School-based mental health providers (N = 8) completed surveys before and after implementing the depression prevention program. Providers’ knowledge and use of evidence-based practices were measured using the Practice Elements Checklist (PEC; Weist et al., 2009) and their attitudes toward the use of evidence-based practices was measured using the Evidence-Based Practices Attitudes Scale (EBPAS; Aarons, 2004). T-tests were used to examine pre- and postimplementation scores on the PEC and EBPAS. The PEC subscales, PEC total scores, and EBPAS total scores, except for the ADHD subscale score on the PEC, had medium effect sizes (range from d = 0.3–0.64; Cohen, 1988). Provider scores on knowledge and use of evidence-based depression techniques improved by a large effect size (d = 0.81; Cohen, 1988), a finding concordant with the goals of the CBT-based preventive depression intervention. As expected, given the small sample size, t-tests revealed no significant differences between providers’ knowledge, use, and attitudes pre- and postimplementation. It is difficult to interpret and generalize these results because of the small sample size and lack of a control group. Nevertheless, the substantial effect sizes do suggest that academic-practice partnerships among schools and school psychology programs can influence the use, knowledge, and attitudes of CBT by school-based mental health providers.

Vida Clinic

Vida Clinic is a mental health organization that focuses on school-based mental health programs founded by a graduate of UT Austin’s School Psychology doctoral program. The founder’s background in school psychology facilitated a partnership between Vida Clinic and the Austin Independent School District; Vida Clinic currently has 23 co-located elementary school-based clinics, one middle school clinic, and three high-school-based clinics. Despite being physically located on school campuses, Vida Clinic is an embedded clinic that works as a separate entity from the school. By operating directly on school campuses, the clinics can serve a population that has had trouble accessing traditional mental health services, specifically minority and low-income families (Farmer et al., 2003; Levy & Land, 1994). On-campus locations also allow Vida Clinic to provide services to children, their families, and staff, through teacher consultations, trainings, and school-wide workshops in addition to individual, family, and group therapy. Also, clinicians can pull students directly from the classroom for therapy, working with teachers to ensure that students do not miss important instructional time. The clinic follows a multisystemic approach and emphasizes the use of evidence-based assessment, monitoring client progress through frequent interviews and the use of the Behavior Assessment System for Children—third edition (BASC-3; Kamphaus & Reynolds, 2015).

Many of the therapists at the clinics utilize CBT with their clients. Vida Clinic is one of the practicum sites for UT Austin’s School Psychology graduate program through which practicum students engage in CBT with clients. Individual interventions conducted within the school setting have excellent external validity for students. For example, the school setting facilitates working with teachers on classroom management strategies to address disruptive behavior in the classroom. Furthermore, in-school exposure-based CBT for anxiety can be particularly effective if they directly address the situations in which children experience anxiety, such as eating in the cafeteria, using public bathrooms, or talking in class.

Training School Nurses in CBT

Dell Children’s Medical Center’s Educational Advocacy Program (DCEAP) is a program created in fall of 2016 to help families navigate the stresses related to their transition from hospital- to school-based care following an illness. In addition to providing families with an advocate to communicate with the school and facilitate student reentry, DCEAP team members, who are all affiliated with the school psychology program in the educational psychology department at UT Austin, strive to find new ways to educate school personnel in effective behavioral health interventions. Recently, the DCEAP team created an 8-part webinar series for Austin-area school nurses to increase knowledge of mental health issues, reduce barriers to mental health screening and empirically supported intervention, and strengthen the school-hospital connection. Webinar speakers were all experts in the field who have a CBT orientation and backgrounds in school psychology or child psychology. Webinar topics were selected by graduate research assistants in school psychology using feedback from previous trainings and current trends in mental health research with youth. School nurses (n = 79) from one Austin school district have received training via monthly webinars on topics including: (a) motivational interviewing, (b) an overview of cognitive behavioral therapy, (c) CBT coping skills for depression, (d) CBT for anxiety, and (e) CBT for self-injurious behavior. Screening tools and additional information on webinar topics were provided to viewers after each webinar. Preliminary pre- and postwebinar survey results suggest that this method of disseminating of CBT to school nurses is effective in increasing knowledge of CBT foundations and practice.

Conclusion

The majority of youth who receive mental health care are served by schools and, thus, locating mental health services on school campuses and integrating them with other services increases youth accessibility to mental health treatment. CBT fits well in a school context because it coincides with the existing structure in schools and can conform to time and resource restrictions. Schools are also informative microcosms of knowledge for practice-based research on how evidence-based interventions can better fit the needs of schools and their diverse populations.

School psychologists are uniquely qualified to disseminate CBT in schools and to allied professionals that work in schools. As demonstrated by programs like Act & Adapt, school psychologists are highly familiar with school systems and contexts, which allows them to design research stud-
ies that fit with school settings and appropriately adjust interventions to work within schools. Furthermore, knowledge of mental health interventions at the universal, targeted, and individual level make school psychologists well-suited to bring a cognitive-behavioral lens to each of these levels, to adapt CBT interventions to be most useful given children’s ecologies in schools, and to intervene with effective care before problems cause considerable impairment. School psychologists’ expertise in interdisciplinary collaboration also make them excellent candidates for coordinating between service systems, such as with medical professionals and schools.

While there are still substantial barriers to the implementation of CBT-based interventions in school settings, including the high existing workload of school psychologists and lack of policy and resources facilitating school psychologists’ involvement in mental health service delivery, the role of a school psychologist can and should extend far beyond that of assessor for special education services. School psychologists at the master’s and doctoral levels can be particularly valuable coordinators of services and principle disseminators of CBT.

References


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