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Conjoint Behavioral Consultation: Application to the School-Based Treatment of Anxiety Disorders

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Abstract

In the current paper we discuss the treatment of childhood anxiety disorders using a problem-solving consultation framework. The role of consultation as a service delivery model in a school setting is elaborated on, as well as the contribution that consultation has in the movement towards evidence-based practices in school psychology. Additionally, a description of the role of consultation specifically in the treatment of childhood anxiety is provided. The role of parents and teachers in treatment is further elucidated, and the separate influence each may have on traditional treatment outcomes is presented. Finally, we discuss the benefits of using a conjoint behavioral consultation model (CBC) of treatment, whereby a mental health professional consults with a child's parents and teachers, who collaborate to assess, monitor, and treat the child's problems. We conclude with a discussion of the benefits of this collaborative approach to treatment of childhood anxiety and illustrate the application of CBC with a case example of selective mutism.

Anxiety disorders are among the most common forms of psychopathology in children and adolescents (Costello, Egger, & Angold, 2004). Epidemiological studies since 1986 have reported that anxiety disorders as a group were present in approximately 6%-18% of the population of children ages 6-17 (Costello et al., 2004). Numerous studies have also suggested that levels of anxiety tend to worsen over time and persist into adulthood (Strauss, Lease, Last, & Francis, 1988), and therefore, stress the importance of addressing these problems early in childhood. Given the high prevalence and the negative outcomes associated with anxiety disorders in children, there is a growing need for the development of effective treatments as well as methods for making treatments accessible to affected youth. Consultation, in particular conjoint behavioral consultation, can be

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used to promote the incorporation of evidence-based mental health practice into schools.

Within the past decade, researchers have begun to examine school-based consultation that incorporates both parents and teachers, currently referred to as conjoint behavioral consultation (CBC; Sheridan & Kratochwill, 1992). Consultation, when applied in a conjoint fashion can facilitate the communication between home and school, increase treatment strength, and promote generalization of treatment effects over time (Sheridan, Kratochwill, & Bergan, 1996). Successful outcomes have been reported when clinicians use a collaborative and complimentary treatment approach involving both teachers and parents (Gortmaker, Warnes, & Sheridan, 2004).

The purpose of the current paper is to describe: (a) the advantages of conjoint behavioral consultation (CBC) in evidence-based practice over traditional treatment models and (b) the application of CBC to the treatment of childhood anxiety in the school setting. We will also discuss the role of parents and teachers in the treatment of anxiety disorders and conclude with the application of CBC through a case example of Selective Mutism.

Consultation as a Model for Service Delivery

Interventions used to treat childhood problems are implemented using a number of different models of service delivery. A service delivery model denotes how a specific intervention will be implemented, including who the clinician will work with directly, as well as who will implement the techniques in a given treatment. Consultation is one example of a service delivery model in which a clinician, serving as a consultant, uses problem-solving strategies to address the needs of a consultee and a client (Kratochwill & Bergan, 1990). Moreover, rather than delivering services directly to clients (e.g., children) as in traditional models of treatment, consultants (e.g., mental health practitioners) work with the consultees (teachers, parents, or peers), who implement the treatment plans derived via the consultation process (Gutkin, 1996). Therefore, consultation is an indirect model of service delivery because treatment is not administered by a mental health practitioner, but by parents or teachers who serve as consultees.

There are a number of benefits to consultation that extend beyond traditional models of treatment. First, as opposed to traditional therapy, consultation involves a problem-solving approach in which consultants and consultees each contribute their own expertise to facilitate solutions for client problems (Kratochwill & Bergan, 1990). In addition, consultation allows for a broader impact of services, as consultees, serving as treatment agents, gain valuable skills that can

be generalized to other children in the future. The indirect nature of consultation makes it feasible for school-based treatment, given that the need for mental health treatment is often greater than the availability of such services (Kratochwill & Bergan, 1990). For many children, the school setting is the sole provider for mental health services (Burns, Phillips, Wagner, Barth, Kolko, Campbell, & Landsverk, 2004; Egger & Burns, 2004). Finally, consultation is more cost-effective than traditional forms of treatment because consultant resources are distributed among consultees who can deliver services to a greater number of children than would be possible by the consultant alone.

Evidence-Based Practice: The Role of Consultation

Hoagwood, Burns, Kiser, Ringeisen, and Schoenwald (2001) define evidence-based practice (EBP) as a "body of scientific knowledge about service practices (i.e., referral, assessment, and case management) or about the impact of clinical treatments or services on the mental health problems of children and adolescents" (p.1179). Central to the use of evidence-based practice is the selection and implementation of treatments supported by research evidence. According to the Surgeon General's 1999 report on mental health, the use of evidence-based treatments in child mental health systems, including schools, is clearly becoming a national priority (U.S. Department of Health and Human Services, 1999). Current research has helped to establish a strong need for evidence-based prevention and intervention programs in schools; however, there has been limited application of these types of programs for a wide range of childhood problems (Kratochwill, Albers, & Shernoff, 2004). One reason why schools traditionally have not been effective providers of evidenced-based practices is that many of these programs require collaboration to be implemented effectively (Kratochwill et al., 2004). Consultation is a model of service delivery that's hallmark is collaboration, which varies in form by consultee-client roles.

Benefits of Consultation to Evidence-Based Practice. The indirect nature of consultation lends itself well to the implementation of evidence-based interventions (EBIs) in schools. Currently, there is a research to practice gap, whereby researchers create EBIs that may have limited transportability to the school setting. Therefore, the availability of EBIs in practice is somewhat restricted. By using consultation as a model for delivering treatment(s) in a school setting, researchers can increase accessibility to EBIs by providing them to school-based professionals. Consultation can also reduce barriers to EBI implementation, such as intervention complexity, because consultants can provide professional development training and ongoing guidance and

supervision to increase the likelihood that the interventions will be implemented with integrity. These benefits of the consultation model for EBI implementation may increase the probability of positive outcomes for students.

Models of Consultation. There are a variety of consultation models presented within the literature (see Kratochwill & Pittman, 2002). Each model varies based on the individual(s) who serves as the consultee. Consultees may include a child, the child's teacher(s), the child's parent(s), or both the parent(s) and teacher(s). In teacher-based consultation, a teacher serves as the mediator for client treatment (Kratochwill & Pittman, 2002). This is the most common and well-researched form of school-based consultation because teacher availability in a school setting traditionally has made teacher service as a consultee both feasible and appropriate. A second model of school-based consultation is parent-based consultation. Although less research exists on the use of parent-based consultation, it is increasingly recognized as a practical option in the field of school psychology (Sheridan & Kratochwill, 1992). A third consultation model that has appeared in recent literature is peer-mediated consultation. This format involves the target child's peer(s) serving as mediators for changing the child's behavior (Kratochwill & Pittman, 2002). Generally peers serve in the consultee role by acting as peer tutors, reinforcing agents, or facilitators of generalization (Kalfus, 1984).

Conjoint Behavioral Consultation

One of the more recently conceptualized models of consultation is conjoint behavioral consultation (CBC). Sheridan and Kratochwill (1992) defined conjoint behavioral consultation (CBC) as "a systematic, indirect form of service-delivery, in which parents and teachers are joined to work together to address the academic, social, or behavioral needs of an individual for whom both parties bear some responsibility" (p.122). CBC is unique in that it involves both parents and teachers in child treatment, a necessary component to the success of treatment for some child and adolescent disorders, in particular anxiety disorders. Its focus is on the relationship between home and school environments and their reciprocal influence on one another, making both parents and teachers necessary components of effective child treatment. In its original conception, CBC was used to address problems that occurred in both home and school settings. However, it is now recognized as a model that can be effective even when a problem occurs in only one of the two settings (Sheridan & Colton, 1994). Whether the problem occurs at home or at school is not the issue because both settings interact to influence a child's functioning, making intervention agents from both settings necessary.

There are four main goals for CBC, which include: (a) sharing the responsibility for the problem solution, (b) improving communication and interactions among the child, family, and school personnel, (c) obtaining comprehensive and functional information related to the identified problem, and (d) improving the skills of all parties (Sheridan & Colton, 1994). CBC is typically initiated following a referral made by a child's teacher. A school mental health professional, serving as the consultant, initiates the collaboration between the child's teacher and parent(s) beginning with one of four structured meetings. At each meeting, the consultant follows a series of interview questions that guide and focus the assessment and intervention processes.

The four structured meetings, or stages, of CBC are parallel to those outlined in traditional behavioral consultation (Kratochwill & Bergan, 1990). Sheridan and Colton (1994) and Gortmaker et al. (2004) describe the four stages of CBC. In the first stage, *conjoint problem identification*, the consultant, and the child's parent(s) and teacher (a) identify and prioritize their concerns for the child, (b) determine contextual factors that contribute to the child's problem behavior, and (c) define a treatment goal, including procedures for progress monitoring prior to intervention implementation. The second stage, *conjoint problem analysis*, takes place several weeks after the initial meeting, and involves an evaluation of baseline data and if necessary the implementation of a functional behavioral analysis of the child's behavior. Additionally, the consultant and the consultees reevaluate the original treatment goal making adjustments as needed. An intervention plan is laid out including specific guidelines for implementation. Finally, the consultant and the consultees agree upon a procedure for collecting data throughout the intervention. The third stage of CBC is *conjoint treatment implementation*, where consultees implement and monitor the intervention and the consultant provides intervention training if necessary. Modifications are made to the intervention throughout implementation based on the collaborative evaluation of the intervention process. In the final stage of CBC, *conjoint treatment evaluation*, consultants and consultees evaluate intervention effectiveness and whether treatment goals have been met according to intervention data, as well as address issues of maintenance and generalization of treatment effects.

Research has demonstrated the effectiveness of CBC with behavioral, academic, and affective difficulties (Sheridan, Eagle, Cowan, & Mickelson, 2001). In a study by Colton and Sheridan (1998), the CBC model was used to implement an intervention to improve the cooperative peer interactions of boys diagnosed with attention deficit hyperactivity disorder (ADHD). The authors reported an increase in student positive peer interactions as a result of the CBC mediated

intervention (Sheridan et al., 2001). Use of the CBC model for service delivery has yielded positive results for working with clients with academic difficulties as well. For example, Weiner, Sheridan, and Jenson (1998) implemented the CBC model with parents and teachers of students at risk for failing mathematics. The students demonstrated increases in homework completion and accuracy following the implementation of an intervention using the CBC model (Weiner et al., 1998). Finally, conjoint behavioral consultation has also demonstrated effectiveness for children with various internalizing problems. In a study by Kratochwill and Sheridan (1990), the CBC model was used to deliver a behavioral intervention for withdrawn children. Results indicated that CBC was an effective method of service-delivery for helping children to initiate social interactions in both the home and school settings (Kratochwill & Sheridan, 1990). In summary, multiple research studies demonstrate that CBC is an effective model of service delivery for addressing a variety of problems in both home and school settings.

The Role of CBC in the Treatment of Anxiety

There is limited research on the use of CBC in the treatment of anxiety. The CBC model; however, may be important for several reasons. First, unlike traditional anxiety treatment, teachers and parents are not just participants in treatment; they receive more extensive guidance, professional development, and ongoing training so that they become intervention agents themselves. This is an important aspect given the high prevalence of anxiety disorders in youth (Costello et al., 2004). The process allows consultees to: (a) learn how to recognize symptoms of anxiety, (b) learn how to refer children with such symptoms for treatment, and (c) develop skills that can be used to intervene with other children who have anxiety problems in the future. This is particularly important since children with anxiety disorders are often not identified and referred for treatment (Albano, Chorpita, & Barlow, 1996). Finally, exposure to the collaborative problem solving process in CBC provides consultees with a framework to address future child anxiety problems.

Parental involvement in traditional anxiety treatment. Research has shown that parents play a role in the development and/or maintenance of their child's anxiety, and thus, may have a significant impact on treatment outcomes (Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004). A number of researchers have examined the role of parent involvement in treatment studies of childhood anxiety. For example, Barrett, Dadds, and Rapee (1996) compared the effects of two treatment groups on child anxiety: cognitive behavior therapy

(CBT) vs. cognitive behavior therapy plus family management (CBT + FAM). The authors found that children in the CBT + FAM condition demonstrated significant improvements in anxiety symptoms when compared to children who received CBT alone (95.6% vs. 70.3% respectively). The significant improvements were maintained at both 6- and 12-month follow-ups. Additionally, in a recent review of family-based treatments for various childhood anxiety disorders, Ginsburg and Schlossberg (2002) reported that family-based cognitive-behavior therapy is superior to or as equally effective as individual cognitive-behavior therapy. In fact, they stated that 60-90% of children that received CBT + FAM no longer met criteria for anxiety disorders following treatment. Finally, in a study by Mendlowitz, Manassis, Bradley, Scapillato, Mieziitis, and Shaw (1999), findings suggested that parents played a positive role in anxiety treatment by providing feedback and monitoring their child's coping strategies, which the researchers suggested made the parents "co-therapists" for the child when they were not in the therapy sessions. Therefore, based on the research conducted, it is evident that parents can play an important role in the treatment of their child's anxiety.

Research on the use of parents as "co-therapists" for the treatment of anxiety is not new. Silverman and Kurtines (1996, 2005) proposed a transfer of control model of treatment whereby a therapist gradually transfers knowledge and skills to parents, who transfer the same information to children. The process of transferring control from therapist to parent to child, leads to the eventual development of independent coping skills in children (Silverman & Kurtines, 2005). Therapists can also transfer control to teachers, although there is less research available on the effectiveness of this procedure.

Teacher involvement in traditional anxiety treatment. Past research on anxiety disorders does not include much information on the role that teachers play in treatment. However, a child's anxious behaviors are often targeted at school. For example, a common childhood problem is school phobia, which involves anxiety about attending school and often avoidance of school altogether (Last, Hansen, & Franco, 1998). School phobia may stem from a number of anxiety diagnoses, but is frequently, associated with separation anxiety disorder (SAD) and social phobic disorder (Last et al., 1998). Symptoms associated with school phobia, such as declining school performance and poor school attendance, are often reported by the child's teacher, who can play a key role in the intervention process. For example, in the Skills for Social and Academic Success program (SASS), a school-based intervention for social anxiety disorders in youth, teachers identify student areas of social difficulty and provide opportunities for classroom-

based exposures, as well as feedback about student progress (Fisher, Masia-Warner, & Klein, 2004; Masia-Warner, Klein, Dent, Fisher, Alvir, Albano, & Guardino, 2005). In fact, Masia-Warner et al., in press, state that teacher collaboration is an important component to the success of the SASS program in the school setting, which is exhibited by the program's qualitative and quantitative outcome data.

Conclusion. In summary, traditional treatment studies have demonstrated the effectiveness of both parent and teacher involvement in child anxiety disorder treatment. Within the CBC model, parents and teachers are not only involved in treatment, but are the treatment agents. Unlike the transfer of control process described by Silverman and Kurtines (1996, 2005), the CBC model uses parents and teachers as the primary treatment agents from the conception of treatment. Consultants serve as guides who teach the skills necessary for treatment validity. Of course, parents and teachers are not expected to implement a thorough cognitive behavioral therapy program that would require extensive education and training. Rather, in the CBC model, they are taught anxiety treatment strategies, including components of cognitive behavioral therapy, such as cognitive restructuring and relaxation training.

Given the aforementioned discussion about the role of parents in the development and maintenance of child anxiety, parents that serve as treatment agents can not only treat the target child, but they can also generalize treatment to siblings, reducing the likelihood of sibling anxiety development. Specifically, parents could implement the skills acquired through the CBC process with their other children who may have the propensity for anxiety. Teachers can prevent the further development of anxiety in students through the application of their intervention skills in the classroom. Additionally, the setting specific nature of some anxiety symptoms creates difficulties for a traditional model of treatment, where mental health professionals do not always have the luxury of providing in vivo treatment. Parents and teachers may be more feasible treatment agents because they can provide treatment in settings that are not always accessible to practitioners adhering to traditional treatment models (e.g., child's, relative's, and friend's homes; classrooms; recess; cafeteria; extracurricular activities). Furthermore, when the CBC process concludes, parents and teachers are equipped to maintain treatment effects without the continued involvement of a mental health professional.

Application of Conjoint Behavioral Consultation to a Case Example

Selective Mutism (SM) is an anxiety-based disorder marked by a reluctance to speak in specific situations, such as the classroom, despite speaking normally in other situations (refer to *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., 2000, for the diagnostic criteria of SM). The ultimate treatment goal for students with SM is to generalize speech to situations where students do not already speak, such as the classroom. The collaborative nature of CBC provides an arena for parents and teachers to work toward this common goal (Christenson & Sheridan, 2001).

Research using traditional models of treatment has demonstrated that both parents and teachers play an important role in the treatment of SM (Pionek-Stone, Kratochwill, Sladeczek, & Serlin, 2002). Few studies, however, have utilized parents and teachers together, in aspects of assessment, treatment planning, treatment implementation, and treatment evaluation, although current literature supports this conjoint approach to treating SM (Joseph, 1999). Parent involvement in the treatment of selective mutism is essential because they may be the only persons with whom the child will speak (Schill, Kratochwill, & Gardner, 1996). In addition, parents can identify possible reinforcers, and implement behavior management techniques (Gortmaker et al., 2004). Teacher's involvement is also seen as crucial, because children with SM commonly refuse to speak in school. Studies using traditional treatment models have reported the effectiveness of teacher assistance with various intervention techniques, including, but not limited to, delivering reinforcement, participating in stimulus fading, and modeling behavior for the child (Gortmaker et al., 2004). In a recent study by Gortmaker et al. (2004), researchers implemented a treatment for SM with a five-year old boy (Robert) using conjoint behavioral consultation. The CBC process consisted of the four stages previously discussed, all of which involved both the parents and the teacher.

Conjoint problem identification, the first of the four stages, was based on a structured interview conducted with both the teacher and the parents together. The purpose of the interview was to determine the frequency and nature of Robert's speaking in school, and the method for collecting baseline data regarding Robert's speech. The second meeting, *conjoint problem analysis*, was also based on a structured interview, in which the team (consultant, teacher, and parents) discussed the baseline data that were collected, determined goals for Robert, discussed factors that might influence his reluctance to speak during school, and developed an intervention plan to increase the

frequency of Robert's speech in school. The third consultation stage, *conjoint treatment implementation*, involved two components: programming common stimuli (i.e., stimulus fading) and reinforcement (i.e., contingency management).

During the intervention process, Robert's parents interacted with Robert and his teacher in an alternative setting using stimulus fading procedures. They provided Robert with reinforcers for speaking behavior (e.g., stickers, verbal praise). Once Robert was comfortable speaking in front of his teacher, their interactions were transferred into the classroom setting and Robert's teacher gradually became a stimulus for speech. At this point in the intervention, Robert was able to speak to his teacher without the presence of his parents. Although Gortmaker et al. (2004) began the intervention in an alternative setting such as a restaurant or the teacher's home, we recommend beginning the intervention in settings within the school building, such as Robert's empty classroom or the school psychologist's office. To promote further speech in the classroom, Robert's teacher and parents used stickers, verbal praise, daily rewards, and adult attention as reinforcers at home and at school for speaking behavior at school. The final stage in the consultation procedure was *conjoint treatment evaluation*, during which the consultation team reviewed the data collected, evaluated the treatment goals, and made modifications to the intervention if necessary. Robert increased from a baseline score of zero vocalizations to 7.7 per day; the vocalizations were generalized to multiple individuals (Gortmaker et al., 2004).

The results of Robert's case provide important implications for individuals using conjoint behavioral consultation as a model for service delivery. In particular, Robert's case illustrates the use of intervention agents that compliment each other (i.e., parents and teacher), yielding positive child outcomes. For example, Robert was only comfortable speaking to his parents, whose involvement in initial intervention sessions was imperative so that Robert's teacher could also become a stimulus for speech. As Robert became more comfortable speaking to his teacher without the presence of his parents, his teacher took primary responsibility for intervention implementation. Robert's parents remained involved by providing him with encouragement and reinforcers to support his speaking behavior at school. In summary, use of the CBC model promoted the development of a comprehensive plan that allowed for Robert's parents and teacher to develop skills that enabled them to serve as complimentary intervention agents to help Robert reach his target goals (Gortmaker et al., 2004). The current case study is one of few examinations of the use of CBC for an anxiety-based disorder; therefore, it is evident that future research is needed in this area.

Conclusion

The CBC model of service delivery is an effective approach for implementing treatment for childhood anxiety disorders. Research supports the involvement of both parents and teachers in traditional treatment models for a variety of childhood problems, including anxiety. CBC extends beyond a traditional model of treatment, working to build a bridge between home and school, giving parents and teachers the knowledge, skills, and training necessary to serve as effective intervention agents. Moreover, CBC promotes a positive working alliance between the child's teacher and parents, which in turn, fosters successful treatment outcomes for the child as well as future maintenance of treatment effects.

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Matching In-Health Needs: Pilot School-Ba

St. Luke

Jewish Board

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The primary goal was to cific intervention program Center attacks on Septer program, and its research gram was evaluated in a measures of posttrauma pression, and externalizii classroom intervention. I re-assessed and those wh an individualized interv individualized interventi individual interventions : group of symptoms. Stud proposed.

Multicultural, inne traumatic events, (Brown, Jannes, Braur Center attack on Sept

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