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TEACHING Social Skills to Youth with Mental Health DISORDERS

Incorporating Social Skills into Treatment Planning *for* 109 Disorders

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Introduction

"Hyper" Harry

Harry, an eleven-year-old boy, is described by his parents and teachers as a child whose "motor is always running." It's been that way since Harry entered kindergarten at age five. In the classroom, it is difficult for Harry to pay or sustain attention; he doesn't concentrate on details and, as a result, makes careless mistakes in his schoolwork. Harry's teachers frequently reprimand him for interrupting others, not waiting his turn, and constantly talking to other classmates during study time, even when the students are given time to quietly do something they like. He regularly loses his homework and textbooks or forgets to bring them home, and when he does remember, his parents report "it's like pulling teeth" to get him to sit down for any length of time to complete his studies. As a result, his grades are failing, even though his teachers say he's capable of doing the work.

At home, it is more of the same. Harry forgets to do chores and has trouble sitting through dinner and other family activities. Harry's father thinks Harry is "lazy" and

"irresponsible" and that he would do better in school and at home if he just "applied himself and tried harder." Lately, Harry and his father have had heated arguments over Harry's failing schoolwork and his forgetfulness regarding his chores. Harry's relationships with his parents, brother and sisters, teachers, and friends are becoming strained, causing Harry further frustration and resulting in more frequent temper outbursts.

Recently, Harry was referred by his teacher for a full psychoeducational evaluation. Because Harry's symptoms are seriously affecting his academic and social functioning at school, it was determined that he qualified for special education services under the category "Other Health Impairment (OHI)." Harry's parents agreed that his symptoms also are causing significant problems at home. The school psychologist provided Harry's parents with phone numbers of several local counselors. Harry's parents took him to counseling, and, after several sessions, it became clear to Harry's therapist that the family needed extra support in managing Harry's behavior. Harry's therapist recommended that they contact family preservation services.

"Unmanageable" Dwayne

Over the past year, Dwayne's temper has gotten worse. He frequently "loses his cool" when his mother asks him to help out at home or do his chores. At these times, Dwayne argues and often gets into shouting matches with his mother; he curses, openly tests her authority, and is verbally aggressive. Dwayne's mother describes her twelve-year-old son as stubborn and unwilling to compromise or negotiate with her. She says, "He wants it his way or no way." Many times, Dwayne refuses his mother's requests by simply ignoring her and purposely breaks the rules she makes. Dwayne's mother tries to discipline her son by grounding him or not letting him watch TV or talk on the phone, but he doesn't accept the consequences. He won't take responsibility for his behavior and constantly makes up stories and lies or blames others for his misdeeds.

These same behaviors are becoming more and more prevalent at school. His teachers are frustrated by

his constant challenges to their authority, rules, and consequences. Dwayne is spending more time in the office for his defiance, and his schoolwork is suffering. When Dwayne is in class, his teachers report that he deliberately annoys other students and is spiteful and vindictive toward classmates and teachers whom he believes "have done him wrong."

Recently, Dwayne was kicked out of the local mall by a security officer after the officer questioned him and a friend about a shoplifting incident that neither boy was involved in. During the questioning, Dwayne got mad and threatened the security guard. Dwayne doesn't have many friends anymore, and his mother considers the friends that he does have to be "troublemakers." Dwayne and his mother have been attending outpatient therapy for the past six months with no real results. During therapy sessions, Dwayne is defensive and, at times, refuses to talk to his therapist. During the most recent session, Dwayne's therapist suggested that a higher level of care may be necessary. Dwayne's mother, at the end her rope, made the decision to place him in a residential group home program.

"Down in the Dumps" Jamie

Twice during the past year, thirteen-year-old Jamie tried to commit suicide. On both occasions, she was briefly hospitalized in an inpatient care facility. The first attempt was ten months ago when Jamie overdosed on aspirin; recently, she cut her wrists. She says she tried to hurt herself because she is "no good" and "doesn't care more."

During the last year and a half, Jamie has been "down in the dumps" several times. During these stretches, which often last a few weeks, her parents report that Jamie has no energy and constantly seems tired and fatigued; they often find her tearful and crying. It is almost impossible to get her to go to school, where she previously had been a good student and active in school activities and sports. Once an "A" and "B" student, her grades have dropped dramatically, and she is currently failing most of her classes. Jamie's teachers are concerned; they report she has difficulty concentrating,

is easily distracted, and is unable to make simple decisions like what topic to select for an English paper. Most surprisingly, Jamie doesn't have any interest in going to drama practice. She usually loves this activity and has been in many plays since she was very young. Three months ago, when she wasn't in one of her "down cycles," she earned a major role in the school play; now she wants to quit. Jamie says she is no good and would only "screw it up."

At meals, Jamie just picks at her favorite foods. She is a slim girl, so her weight loss is noticeable. Jamie says that it is difficult for her to get to sleep. She also reports she wakes up in the middle of the night and can't get back to sleep. During the day, she is irritable and spends most of her time alone in her room. Her friends call and ask her to go out but she says she is too tired. Her parents are afraid she might succeed in hurting herself; they "want the old Jamie back."

Since Jamie's first suicide attempt, she has been attending both outpatient therapy and psychiatric visits regularly. During the most recent session with her psychologist, Jamie reported active suicidal ideation. She had a plan and meant to carry it out. Jamie also admitted to cutting her inner thighs with a razor blade several times a week to "punish herself." Jamie's psychologist provided Jamie's psychiatrist with this information, and the psychiatrist recommended placement in an intensive residential psychiatric program for youth.

Mental Health Disorder Diagnoses

Each of the youths described in these three examples is suffering from a mental health disorder. Harry's behaviors and related symptoms point to Attention-Deficit/Hyperactivity Disorder. The temper outbursts and aggression displayed by Dwayne could be signs of Oppositional Defiant Disorder. Finally, Jamie's attempts to harm herself indicate Major Depressive Disorder.

These types of diagnoses are defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR), one of the world's standard tools for evaluating and diagnosing mental health disorders in children, adolescents, and adults. Progress in clas-

sifying and identifying mental health disorders has led to improved instruction and training for treatment providers that is more intensely focused on how to effectively treat youth with specific mental health disorders. This, in turn, has led to more appropriate and accurate treatment for youth.

Helping caregivers and treatment providers further improve the care they provide is the goal of this book. Through years of experience working with thousands of children and adolescents with behavioral and mental disorders, Boys Town's research has proven that social skill instruction – teaching youth alternative positive behaviors they can use to replace current inappropriate behavior – is extremely effective in helping youth overcome their problems. In many situations, a lack of certain social skills can contribute to, and often exacerbate, an existing mental health disorder. For example, if Harry were to learn skills such as "Following Instructions" or "Staying on Task," and these were reinforced both at school and at home, some of his problem behaviors would improve, alleviating many of the frustrations related to Harry's behaviors.

By showing how this social skill instruction approach can be applied to the treatment of DSM-IV-TR disorders, this book can serve as a valuable guide in helping treatment providers effectively and successfully treat youth in their care. (Treatment providers can include youth-care workers, group home caregivers, consultants, foster parents, shelter workers and administrators, family interventionists, staff working in psychiatric settings, teachers, school counselors, therapists, social workers, psychiatrists, physicians, psychologists, clinicians, and other health and mental health professionals.)

What's in This Book

There are five parts to this book. A history of the DSM-IV-TR is outlined in the first chapter, along with an introduction to the importance of other mental health disorder assessment and evaluation tools. There also is an explanation of the multiaxial assessment system – detailed in the DSM-IV-TR – that can help mental health professionals during the evaluation process. A discussion

of individualized treatment planning regarding DSM-IV-TR mental health disorder diagnoses and social skill instruction follows in the second chapter.

The third chapter discusses the Boys Town Teaching Model, the Boys Town Social Skill Curriculum, the concept of social skill instruction, and the importance and effectiveness of such teaching in the treatment of mental health disorders.

Chapter 4 offers a series of charts containing DSM-IV-TR diagnoses that are common for children and adolescents, and the various social skills that caregivers and treatment providers might target as part of a treatment plan for each disorder. These charts don't include all DSM-IV-TR disorders, but those that are likely to have associated social skills deficits that might be targeted in treatment. The various disorders and charts are listed in the order they appear in the DSM-IV-TR.

Examples of treatment plans for the three youth described at the beginning of this book are included in Chapter 5. These examples demonstrate how social skills can be integrated into a youth's overall treatment plan for particular DSM-IV-TR diagnoses across different settings – home and school, residential group home, and psychiatric facility – and levels of care.

Of course, only qualified professionals who have had the proper schooling, clinical training, and experience should use the DSM-IV-TR to evaluate and diagnose youth who may have a mental health disorder. This book is intended only as a guide for how to integrate social skill training into treatment planning and should not be used to make diagnoses. (Youth will see a therapist, psychologist, or psychiatrist for assessment and diagnostic purposes. An accurate DSM-IV-TR diagnosis of a troubled youth enables treatment providers across the entire spectrum of treatment settings – home, schools, shelters, foster care, residential treatment programs, psychiatric treatment settings, and so on – to develop better, more effective treatment plans.)

We hope you find this book useful in your work with children and adolescents. All youth must learn social skills in order to find success in their lives. Teaching these social skills as part of treatment for a mental health

disorder truly can enhance a youth's progress and help him or her to overcome problems.

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Chapter 1

Psychological Assessment and the DSM-IV-TR

The initial impetus for developing a classification of mental health disorders was the collection of statistical information for the U.S. Census back in 1840. At that time, there was one crude category for such disorders – "idiocy/insanity." By the 1880 census, there were seven categories of mental illnesses. This gathering of statistical information on mental health disorders continued until 1952. That's when the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (or DSM-I) was published by the American Psychiatric Association. This manual contained a glossary of descriptions of the diagnostic categories and was the first official manual of mental health disorders designed for clinical use. Shortly thereafter, the DSM-II, which contained a new round of diagnostic revisions, was published. The DSM-III followed in 1980. It introduced a number of important methodological innovations and a descriptive approach that attempted to be neutral with respect to the theories of etiology. In 1987, the American Psychiatric Association published the DSM-III-R, which contained revisions and corrections for inconsistencies and instances where crite-

ria were not entirely clear in the DSM-III (American Psychiatric Association, 1994).

The DSM-IV, published in 1994, came about due to the substantial increase in research that was generated by the DSM-III and DSM-III-R. By that time, research regarding diagnoses was available in the empirical literature or other data sets. The DSM-IV content was based on "…historical tradition (as embodied in the DSM-III and DSM-III-R)…, evidence from reviews of the literature, analyses of unpublished data sets, results of field trials, and consensus of the field" (American Psychiatric Association, 2000, p. xxvii). The DSM-IV includes 340 mental health disorders, nearly 120 more than the DSM-III-R. In 2000, the DSM-IV-TR was released in order to address necessary text revisions. There were no major changes to diagnostic criteria, and no diagnoses were added or removed; the revisions were mainly to correct errors and provide updates.

The Use of Multiaxial Assessment

In order to arrive at an accurate DSM-IV-TR diagnosis, and ultimately provide successful treatment, an effective evaluation process is necessary. One widely recognized procedure for evaluating an individual with a mental health disorder is the multiaxial assessment system detailed in the DSM-IV-TR. In this process, mental health professionals obtain comprehensive information about different domains in a person's life and then examine this information during the evaluation process to help them achieve the most precise DSM-IV-TR disorder diagnosis possible.

The DSM-IV multiaxial assessment system includes:

Axis I	Clinical Disorders Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

Axis I and Axis II are two separate classifications that contain all the various mental health disorders in the DSM-IV-TR. The items grouped and reported under Axis I are classified by the DSM-IV-TR as "Clinical Disorders" or "Other Conditions That May Be a Focus of Clinical Attention," while the disorders grouped and reported under Axis II are classified by the DSM-IV-TR as "Personality Disorders" or "Mental Retardation." The reason for separating these two less common categories of disorders into different axes is to ensure that they will be given adequate consideration by mental health professionals and not be overlooked due to a focus on the more common clinical disorders listed in Axis I.

The focus of Axis III is any current general medical conditions that might be relevant to the understanding or management of an individual's mental health disorder. An example of this, according to the DSM-IV-TR, would be when "…hypothyroidism is a direct cause of depressive symptoms…" (American Psychiatric Association, 2000, p. 29). The DSM-IV-TR says that "Axis IV is for reporting psychosocial and environmental problems that may affect diagnosis, treatment, and prognosis…" (American Psychiatric Association, 2000, p. 31) of a DSM-IV-TR disorder. Examples of this include divorce, death of a family member, job loss, being a crime victim, and so on. Mental health professionals also are asked to report the severity (mild, moderate, or severe) of the present stressors.

Finally, Axis V summarizes a mental health professional's judgment of an individual's overall level of functioning on the Global Assessment of Functioning (GAF) scale. The GAF scale can be used at admission, at various times during treatment, and at discharge. Using this scale can be extremely beneficial in treatment planning and in measuring the success of treatment over time.

According to the DSM-IV-TR, "a multiaxial system provides a convenient format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis. In addition, the multiaxial system promotes the application of the biopsychosocial approach model in clinical, educational, and research settings" (American Psychiatric Association, 2000, p. 27). Such a comprehen-

sive and systematic evaluation system allows a mental health professional to take into account all aspects of a person's life that might be contributing to the problem instead of focusing only on a single presenting problem. In the end, this extensive evaluation process greatly enhances a mental health professional's diagnostic capabilities.

DSM-IV-TR and Diagnostic Assessment

The DSM-IV-TR is generally one of the first evaluation tools utilized by trained and knowledgeable mental health professionals to accurately diagnose mental health disorders. Other information can come from youth interviews, parent/guardian interviews, teacher interviews, medical records, educational records, educational assessments, psychological assessments, behavioral observations, and other measures. The use of these methods allows mental health professionals to gather more detailed information about a youth's problem, thus helping to strengthen the accuracy of the evaluation and diagnostic process.

Another important evaluation tool widely used by mental health professionals – in concert with the DSM-IV-TR – is the National Institute of Mental Health Diagnostic Interview Schedule for Children (DISC) (Shaffer, Fisher, & Lucas, 1997). This is a structured interview for children and adolescents that allows mental health professionals to obtain diagnostic criteria information for common psychiatric disorders. Friman (1997) says that DISC data "…provides information on the kinds of psychological problems exhibited by youth…" entering various treatment environments and that "the value of this information is most apparent in treatment planning" (p. 192).

Psychological assessments are often used by mental health professionals when considering diagnosis. Behavior rating report forms are simple psychological assessment tools designed to produce valid diagnostic information. Several assessment systems utilize multi-informant report rating scales. Some of these include:

- Achenbach System for Empirically Based Assessment (ASEBA) – Child Behavior Checklist Parent Form (CBCL), Achenbach Teacher Report Form (TRF), and Achenbach Youth Self-Report Form (YSRF) (Achenbach & Rescorla, 2001)
- Behavior Assessment System for Children, Second Edition (BASC-2) – Parent Rating Scales (PRS), Teacher Rating Scales (TRS), and Self-Report of Personality (SRP) (Reynolds & Kamphaus, 2004)
- Conners' Comprehensive Behavior Rating Scales (CBRS) – Parent Response Booklet (P), Teacher Response Booklet (T), and Self-Report Response Booklet (SR) (Conners, 2008)

These assessment tools produce a variety of information about a youth's perceived behavioral, emotional, and social functioning. The system utilized will depend on a youth's age, available informants, and the specific information that is desired. Scores on these assessments can help to indicate whether or not a youth is experiencing more symptoms than most youth his or her age and gender. This information also can be helpful when planning and evaluating treatment plans for particular youth.

Educational assessments also are used by mental health professionals and school personnel to provide information about a youth's cognitive ability or achievement. These scores are important to consider when developing treatment plans. For example, if a youth's verbal ability is significantly below average, a treatment strategy that relies heavily on language would not be appropriate for that youth.

Cognitive ability provides information about an individual's capabilities in a variety of areas (verbal comprehension, perceptual reasoning, processing speed, working memory, etc.) and is often termed an individual's intelligence quotient or "IQ." There are numerous tests that measure IQ; each differs in the appropriate age range for testing and the specific domains of intelligence that are considered. Some common examples include:

- Weschler Preschool and Primary Scale of Intelligence, Third Edition (WPPSI-III) (Weschler, 2002a)
- Weschler Intelligence Scale for Children, Fourth Edition (WISC-IV) (Weschler, 2003)
- Weschler Adult Intelligence Scale, Third Edition (WAIS-III) (Weschler, 1997)
- Weschler Abbreviated Scale of Intelligence (WASI) (Weschler, 1999)
- Stanford-Binet Intelligence Scale, Fifth Edition (SB5) (Roid, 2003)
- Woodcock-Johnson III Tests of Cognitive Abilities (WJ-III) (Woodcock, McGrew, & Mather, 2001a).

Achievement is the level at which an individual is currently performing in a given academic area (reading, mathematics, written language, oral language, etc.). Achievement scores are used to determine whether or not an individual meets criteria for a learning disability. Generally, a large discrepancy between one's ability and one's achievement indicates that a learning disability may be present, since the individual is not achieving at the level that would be expected.

Like ability measures, there are many available achievement measures that test a variety of academic areas. Examples include:

- Weschler Individual Achievement Test, Second Edition (WIAT-II) (Weschler, 2002b)
- Woodcock Johnson III Tests of Achievement (WJ-III) (Woodcock, McGrew, & Mather, 2001b)
- Wide Range Achievement Test, Fourth Edition (WRAT-4) (Wilkinson & Robertson, 2005)

Many types of assessment methods can be used to help mental health professionals arrive at an appropriate diagnosis. These methods also can be helpful when developing treatment plans and evaluating the effectiveness of interventions. Only a handful of assessment measures were selected for this discussion; numerous others are frequently used.

Summary

The DSM-IV-TR evolved from a mere collection of statistical information for the U.S. Census in 1840 to being the world's standard tool for evaluating and diagnosing mental health disorders in children, adolescents, and adults. Numerous assessment tools have been devised to help in diagnosis determination. A few of these measures include the DISC, behavior rating report forms, cognitive tests, and achievement tests. Besides providing mental health professionals with more comprehensive information during the evaluation process, these tools also help produce thorough evaluations that lead to more accurate diagnoses. This information enables treatment providers to create and develop therapeutic, successful treatment plans for youth who require mental health services.