ORIGINAL ARTICLE

Predictors of Trauma Symptoms Among Children Referred for Behavioral School-based Mental Health Counseling

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Abstract

Child mental health researchers often focus on interventions that improve externalizing problems (i.e., disruptive, aggressive, and impulsive behaviors), due to the relationship between children's externalizing behaviors and social, emotional, and academic disparities. School-based mental health counselors work to reduce externalizing problems due to the relationship between these behaviors and school-based problems, such as bullying victimization, school adjustment difficulties, and suspension. Children with complex trauma histories often exhibit externalizing problems. Unfortunately, limited research examines school trauma screening and guidelines for schools to effectively distinguish behavioral and trauma-related symptoms. As a result, we examined whether children's trauma symptoms predicted their externalizing problems that prompted referrals for school-based mental health counseling interventions at three Title-I elementary schools.

Keywords School-based mental health counseling · Trauma · Externalizing behaviors

Externalizing behavioral problems (i.e., disruptive, aggressive, and impulsive behaviors) are among the most common reasons for child mental health referrals in the United States (Randall et al., 2020; Sukhodolsky et al., 2016). Externalizing problems during childhood are associated with significant academic and social consequences, such as: (a) suspension in early elementary years (kindergarten through first grade; Yang et al., 2018); (b) cyber bullying victimization (Holfeld & Mishna, 2019; Schütz et al., 2022); and (c) poor teacher-student relationships and school adjustment struggles (Demirtaş-Zorbaz & Ergene, 2019; Roorda & Koomen, 2021). School-based mental health professions (e.g., school counselors, mental health counselors) can provide early interventions to decrease externalizing behavioral problems and prevent these future academic and social consequences (Dillman Taylor et al., 2021). Children from low socioeconomic households are at higher risk for worsening externalizing behaviors because mental health services are often financially burdensome for caregivers (Dillman Taylor et al., 2021). For many children, school-based interventions may be the only mental healthcare services received during their elementary and middle school years (Lambie et al., 2019).

Mental health counselors are trained to provide interventions to prevent, treat, and support clients who present with various psychological, emotional, and behavioral disorders (American Mental Health Counselors Association [AMHCA], 2021). However, mental health counselors adopt more holistic approaches to understand their clients' concerns and wellbeing, rather than viewing their clients as sums of their symptoms (AMHCA, 2021; Hansen, 2012; Pistole & Roberts, 2002). Therefore, school-based mental health counselors (SBMHC) should not view children as sums of their disruptive, impulsive, defiant, and externalizing behaviors. Crenshaw and Swan (2019) encouraged counselors to understand that children often exhibit externalizing behaviors to communicate emotional, social, and relational wounds or struggles that are difficult to verbally articulate during childhood. Perry and Winfrey (2021) noted that child mental health professionals need to stop asking "what's wrong with you," or "why are you behaving that way," and start asking the essential question—"what happened to you" (p. 17). As a result, we examined whether children's trauma symptoms predicted their problem behaviors scores that prompted referrals for school-based mental health counseling interventions (SBMHCI) at three Title I elementary schools.

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Externalizing Problems

Clinicians and researchers use the term *externalizing problems* to cluster social, emotional, and behavioral problems with prominent disruptive, aggressive, and impulsive symptoms (Achenbach et al., 2016; American Psychiatric Association, 2013). Allen and colleagues (Allen et al., 2021) described externalizing behaviors as "non-compliance with caregiver directives, rule-breaking, aggression towards others, and delinquency" (p. 2). Multifaceted risk factors, including family dynamics, peer interactions, school setting, and community engagement, contribute to the presence of externalizing behaviors in adolescents (Zajac et al., 2015). When caregivers exhibit coercive and punitive behaviors toward children, there is an increased risk for child externalizing behaviors (Akcinar & Baydar, 2016). Children are observant and internalize messages throughout their environments. Observed interactions between family members also influence externalizing behaviors, even when children are not directly involved in the interactions (Bronfenbrenner, 1992).

Often, clinicians focus on mental health interventions that reduce externalizing behavioral problems, due to the intertwined relationship between children's externalizing behaviors and academic disparities. Researchers have confirmed that externalizing problems are related to various educational consequences, such as: lower academic self-concepts (Passiatore et al., 2017), lower math and reading achievement (Wu et al., 2014), and decreased school engagement (Olivier et al., 2020). In addition, higher levels of externalizing behaviors correlate with increased school absenteeism (Gubbels et al., 2019).

Okano and colleagues (Okano et al., 2020) conducted a longitudinal study with a developmental cohort ($N = 1048$) to examine the intertwined relationship between child externalizing problems and academic achievement problems. Okano and colleagues identified that externalized behavioral problems during elementary grades were associated with decreased academic success during early high school years, highlighting the negative developmental cascades of these behaviors. In addition, Yang and colleagues (Yang et al., 2018) found that children's externalizing problems were the most common predictors of the school suspension. Specifically, children rated as aggressive, disruptive, and defiant by their teachers were most likely to be suspended during early elementary years.

Childhood Trauma

Nearly 70% of children endure at least one traumatic experience by age 16 (SAMHSA, 2022) and as many as 15% of youth trauma survivors develop PTSD during childhood (U.S. Department of Veteran Affairs, 2022). The American Psychiatric Association (2013) defined a traumatic experience as "any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual" (p. 830). The National Child Traumatic Stress Network (NCTSN, n.d.b) described childhood traumatic events as upsetting, violent, and frightening experiences that threaten children's lives and/or physical wellbeing, or witnessing a loved one (i.e., attachment figure) experience a traumatic event. Childhood traumatic events can include physical, emotional, and sexual abuse, serious neglect, natural disasters, sudden loss of a caregiver, medical trauma, war experiences, and community violence (NCTSN, n.d.b). Other sources of childhood trauma are known as Adverse Childhood Experiences (ACE). Felitti et al. (1998) were the first researchers to examine the life-threatening impacts of childhood adversities through their groundbreaking CDC-Kaiser Permanente study. ACE exposures included early household experiences related to (a) abuse (physical, psychological, and sexual), (b) neglect (physical and emotional), and (c) parental/household member characteristics (substance abuse, separation, death/loss, mental illness, and domestic violence). Felitti and colleagues found a dose–response relationship between individuals' number of ACE exposures and mental and physical health disparities later in life, such as heart disease, diabetes, substance abuse, depression, and suicide attempts. Individuals with six or more ACEs are at-risk for premature death, and their average life expectancies are 20 years shorter than individuals with zero ACEs (Brown et al., 2009).

Children's exposure to trauma is associated with negative behavioral outcomes (Kerig, 2019). During school-age years, children exposed to traumatic events often experience developmental disruptions, sleep disturbances, nightmares, difficulties concentrating, and unsafe and aggressive behaviors (NCTSN, n.d.a). Children exposed to chronic and prolonged interpersonal trauma (e.g., complex trauma and ACEs) exhibit *attentional and behavioral dysregulation* because these intense traumas negatively impact neurological development. For example, Luby et al. (2019) discovered decreased hippocampus and amygdala volumes among children who experienced high levels of ACEs during preschool-age years. When children experience damage or compromised development within the amygdala and hippocampus regions, they struggle with processing environmental cues and differentiating threatening and safe situations. When children are pre-occupied with misread environmental threats, they are more likely to exhibit behavioral problems and maladaptive self-soothing strategies (e.g., substance use; van der Kolk et al., 2009). Children with complex trauma histories also experience *relational dysregulation,* leading to impulsive (rather than instrumental or coercive) aggression toward others because they feel unsafe within relationships (van der Kolk et al., 2009). Thus, it seems unreasonable to expect youth who have experienced

trauma to behave in "typical" manners (Parker et al., 2021) as difficulties can impact broad areas of functioning, such as relationships, cognition, and social development (Davis & Siegel, 2000; Pine & Cohen, 2002). As a result, adolescents with a history of traumatic events face many academic obstacles and struggle in their school setting (Parker et al., 2020).

Trauma and Academic Disparities

Like children who exhibit externalizing and disruptive behaviors, children with trauma exposures also experience academic difficulties and school suspensions (Loomis, 2020; Orr et al., 2022; Pierce et al., 2022). Orr and colleagues (Orr et al., 2022) examined the impacts of children's ($N = 26,743$; grades 1 through 10; 55.9% Aboriginal [e.g., indigenous]) domestic violence (DV) exposures on school suspension patterns and revealed that children with DV exposures were significantly more likely to experience school suspensions. Additionally, children with DV exposures were more likely to receive suspensions during earlier school years, compared to non-DV exposed children who received suspensions at older ages (e.g., high school; Orr et al., 2022). Similarly, Loomis (2020) found that children exposed to family violence were more likely to receive suspensions, and identified that externalizing and disruptive behaviors significantly mediated the relationship between family violence exposures and school suspensions. These findings are not limited to children with exposure to DV, but also apply to children who have experienced incidents identified as adverse childhood experiences (ACEs).

Pierce and colleagues (Pierce et al., 2022) examined the relationship between adolescents' exposures to cumulative ACEs and school suspensions/expulsions. Specifically, Pierce et al. (2022) were the first researchers to consider the role of ACEs on school suspensions using Felitti's et al. (1998) original 10-item ACE questionnaire. The original 10-item ACE questionnaire screens for the following trauma exposures: (a) abuse (physical, psychological, and sexual); (b) neglect (physical and emotional); and (c) caregiver factors (caregiver disappearance, intimate partner violence, substance abuse, incarceration, and mental illness). The researchers found that adolescents' cumulative ACEs (prior to 5-years-old) predicted school suspensions during adolescence, and youth exposed to four or more ACEs were four times more likely to experience suspension and expulsion (Pierce et al., 2022). Therefore, mental health services in the school setting play an important role in supporting children who have trauma exposures.

School-based Mental Health Counseling

The Education Advisory Board (EAB, 2021) found that superintendents in each state-identified "adolescents in crisis" as a top concern. Factors such as barriers to access to mental health care, the persistent stigma associated with mental health, and inconsistent care contribute to the ongoing mental health crisis observed in schools (EAB, 2021). Thus, mental health services delivered at schools are optimal as schools serve as a convenient location point for accessing mental health services (Lambie et al., 2019; Pullmann et al., 2014). Additionally, SBMHCI remove barriers such as transportation and health insurance requirements, deliver services in a safe and familiar environment, and promote growth through relationships with teachers and staff (Whitaker et al., 2018).

School-based mental health services are described as specific interventions or strategies applied in the school setting which are intended to address emotional, behavioral, or social functioning (Rones & Hoagwood, 2000). According to Dryfoos (1994), school-based mental health services include mental health services delivered by school-personnel or professionals employed by community agencies. The inclusion of school-based mental health services bridges the common disconnection between school-based and community-based services with a common goal of promoting the wellbeing of children (Doll et al., 2017).

Schools with at least 40 percent of students identified as living in low-income households receive Title 1 status (US Department of Education, 2018). The US Department of Education (2018) reported that in 2015—2016, the Title 1 program served more than 28 million students by providing extra funding to schools. Due to the unique academic and personal/social needs of students living in poverty, often additional funds from the Title 1 program are used to hire additional instructional staff and support staff, including school counselors and mental health counselors (US Department of Education 2018). SBMHCI are found to promote mental health access to historically underserved groups, including youth from lower income backgrounds (Whitaker et al., 2018). Therefore, SBMHCI addresses the unique needs of students enrolled at Title 1 elementary schools (Kelchner et al., 2019; Lambie et al., 2019).

Current Study

Considering the gaps in current literature, the purpose of our study was to examine the predictive relationship between children's levels of PTSD symptoms and their externalizing behavioral problem scores associated with SBMHCI referrals. Therefore, the following research questions (RQ) guided our investigation:

RQ 1. Do children's hyperarousal and reexperiencing PTSD symptoms (*Child PTSD Symptom Scale* [CPSS]; Foa et al., 2001) predict their externalizing behavior scores (*Child Behavior Checklist* [CBCL]; Achenbach & Rescorla, 2001)?

RQ 2. Do children's demographic qualities (e.g., age, race, gender) correlate with their hyperarousal PTSD symptoms scores and/or externalizing behavior scores?

Methods

Participants

Prior to data collection, we obtained institutional review board approval to ensure adherence to ethical research practices. The participants ($N = 39$) in the current study received the SBMHCI through a university-elementary school partnership. Participants were recruited from three Title-I elementary schools in the Southeast United States during the 2018–2019 academic year. Children were referred for the SBMHCI by school counselors and administrators, and all services were provided in Title-I elementary schools. Upon receiving referrals, the partnership staff contacted students' families for initial screening and intake processes. After receiving informed consent from students' caregivers/guardians, participants were assigned a counselor and a date to begin the 50-min weekly SBMHCI sessions.

Our participants included 16 females (41%) and 23 males (59%). Demographic data (See Table 1) indicated that the largest proportion of participants identified as Black and/or African American ($n = 17$; 43.6%), followed by White ($n = 12$; 30.8%), Hispanic and/or Latinx ($n = 6$; 15.4%), and Multiracial ($n = 4$; 10.3%). Participants were children in kindergarten through sixth grade, and their ages ranged from 5 – 11 years-old ($M = 7.9$ years; $SD = 1.80$). Children received between two and thirty-eight SBMHCI sessions ($M = 15.74$; $SD = 9.17$). The variation in number of sessions attended is primarily based on when the partnership received the referral to begin services. Additionally, some children missed SBMHCI sessions due to illness or family obligations.

Instrumentation

Child Behavior Checklist (CBCL)

We measured children's externalizing behavior problems using the *Child Behavior Checklist* (CBCL) School-age form for ages 6–18 (Achenbach & Rescorla, 2001). For this study, we utilized baseline (e.g., pre-SBMHCI) CBCL *Externalizing* sub-scores to examine the behavioral profiles of children who were referred for the SBMHCI. The CBCL

Table 1 Participant characteristics

Characteristic	N	%
Gender		
Females	16	41%
Males	23	59%
Race and/or Ethnicity		
White	12	30.8%
Latinx or Hispanic	6	15.4%
Black or African American	17	43.6%
Multiracial	4	10.3%
Age		
5-years-old	2	5.1%
6-years-old	11	28.2%
7-years-old	4	10.3%
8-years-old	6	15.4%
9-years-old	7	17.9%
10-years-old	6	15.4%
11-years-old	3	7.7%

is completed by parents/caregivers, and consists of 120 items worded in statements, such as: "*Doesn't feel guilty after misbehaving*" (Achenbach & Rescorla, 2001). Parents report whether the statements correspond with their child's behaviors on a three-point Likert-type scale (from 0 ["Not True"] to 2 ["Very True or Often True"]; Achenbach & Rescorla, 2001). The CBCL generate raw scores; yet, for interpretation, professionals using the CBCL should convert scores to *T* scores using Achenbach and Rescorla's (2001) normative sample. For the eight CBCL subscales, scores of 70 or greater indicate a clinical range, scores between 65 and 69 are in the borderline range, and scores less than 65 are in the normal range. The scale developers demonstrated that the CBCL had strong internal consistency ($a = 0.80$) and test–retest reliability ($r = 0.85$).

Child PTSD Symptom Scale (CPSS)

The CPSS measures the prevalence of post-traumatic stress disorder (PTSD) symptoms experienced by youth in the past month. Assessment versions include a self-report completed by the children, and an amended parent/guardian assessment. Both directly follow the criteria for PTSD as outlined in the DSM-4. The self-report can be conducted in roughly 15 min and is intended for use with participants aged 8–18. Seventeen questions relate to PTSD diagnostic criteria, while 7 items assess the impact of the symptoms. The CPSS yields a score of total severity, as well as three sub-scores: (a) reexperiencing, (b) avoidant, (c) hyperarousal. Total severity scores range from 0 to 51, with impairment scores ranging from 0 to 7. Individuals with more severe symptomology

and/or impairments score higher of the CPSS. The internal consistency reliability of the CPSS scores is reported as strong-to-excellent for total (0.89), reexperiencing subscale (0.80), avoidant subscale (0.73), hyperarousal subscale (0.70), and impairment score (0.89).

Data Analysis

We created a Statistical Package for the Social Sciences (SPSS Version 28) dataset for analysis, and entered participants' baseline CBCL scores, CPSS scores, and demographic data. First, we screened for missing data and conducted analyses for assumptions testing. Eight cases were removed prior to data analyses due to full CBCL and/or CSS scales missing. We conducted preliminary analyses to examine whether statistical assumptions for multiple linear regression (MLR) were met, including: (a) linearity, (b) independence of errors, (c) normality, (d) homoscedasticity of residuals, and (e) non-multicollinearity (Tabachnick & Fidell, 2013). We determined that the independence of errors and linearity assumptions were met through visual inspections of the scatterplot of standardized residuals versus standardized predicted values (i.e., the points were randomly displayed in scatterplot). Additionally, the spread of points in the scatterplot of residuals appeared constant, which provided evidence of homoscedasticity. The assumption of non-multicollinearity was met, as evidenced by the variance inflation factors ($VIF = 1.269$) and tolerance values (0.788). Next, we examined the unstandardized residuals and confirmed that the assumption of normality was met, evidenced by the Shapiro–Wilk test ($SW = 0.956$, $df = 39$, $p = 0.133$), as well as skewness (-0.074) and kurtosis (-0.871) values. Additionally, we screened casewise diagnostics and confirmed that no individual cases contributed extreme influence on the model, including Cook's distance (0.000—0.320), Dfbeta values (ranging from -1.37 to 1.62), and centered leverage values (0.001—0.20). We conducted an MLR to examine whether children's hyperarousal and reexperiencing trauma symptoms (as measured by CPSS subscale scores) predicted CBCL *External* scores.

Results

We computed a MLR model to examine whether children's hyperarousal and reexperiencing PTSD symptoms predicted their baseline CBCL External scores. CBCL *External* score was the dependent variable, and CPSS *Hyperarousal* and *Reexperiencing* scores were the independent variables. Results from the MLR model identified a statistically significant effect, ($F_{(1, 35)} = 7.194$, $p = 0.002$; See Table 2), demonstrating that children's

Table 2 Regression coefficients of CPSS hyperarousal and reexperiencing on CBCL external scores

Variable	B	Beta	Std. Error	T	p
Constant	50.050		2.961	16.902	≤.001
Reexperiencing	.086	.039	.359	.240	.811
Hyperarousal	1.197	.521	.368	3.250	.003

Dependent variable = CBCL *External* score

CPSS *Hyperarousal and Reexperiencing* scores accounted for 29.1% of the variance in their CBCL *External* scores ($R^2 = 0.291$). However, only participants' *Hyperarousal* scores significantly predicted CBCL *External* scores. The unstandardized *B* coefficient indicated that for every one-point increase in children's CPSS *Hyperarousal* scores, there was a 1.197-point increase in CBCL *External* scores ($p = 0.003$). For *Reexperiencing* scores, the unstandardized *B* coefficient indicated that for every one-point increase, participants' CBCL External scores increased by 0.086 points; however, contributions of *Reexperiencing* to the MLR were not statistically significant ($p = 0.811$).

After observing that *Reexperiencing* scores did not contribute to the MLR, we recomputed a secondary linear regression model excluding this variable. In the final model, we included one independent variable (*Hyperarousal* CPSS scores). The final regression model identified a statistically significant effect, ($F_{(1, 36)} = 14.715$, $p < 0.001$; See Table 3). Independently, participants' *Hyperarousal* scores accounted for 29% of the variance in CBCL External scores ($R^2 = 0.290$).

We computed a post-hoc Pearson correlation analysis to examine whether there were correlations between participants' demographic variables, CBCL *Externalizing scores*, and CPSS hyperarousal scores. There were no statistically significant correlations between the CPSS and CBCL scores and participants racial identity, gender, age, or grade. The only statistically significant correlation within the model was between CBCL *Externalizing* scores and CPSS *Hyperarousal* scores ($r = 0.538$, $p < 0.001$; 28.94% of the variance explained).

Table 3 Regression coefficients of CPSS hyperarousal on CBCL external scores

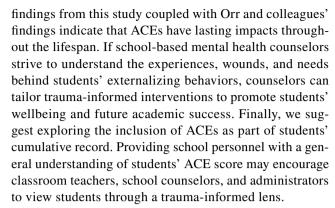| Variable	B	Beta	Std. Error	T	p
Constant	50.276		2.771	18.142	<.001
Hyperarousal	1.237**	.539	.323	18.142	≤.001

Dependent variable = CBCL External score

** $p < .001$

Discussion

In this study, we explored whether trauma-specific symptoms predicted elementary students' problem behaviors that promoted SBMHCI referrals. Specifically, we examined the extent to which children's reexperiencing and hyperarousal symptom levels predicted their externalizing behavior scores. We hypothesized that reexperiencing and hyperarousal symptoms would predict parent-rated externalizing behaviors. Our findings identified that hyperarousal symptoms (CPSS *Hyperarousal* subscale scores) independently predicted approximately 30% of the variance in children's externalizing behavior scores (CBCL *Externalizing* scores). Our model indicated that as children's CPSS *Hyperarousal* scores increased, their CBCL Externalizing scores (as reported by caregivers) also increased. Diagnostic indicators for PTSD trauma arousal symptoms include characteristics likely misidentified as "acting out behaviors," such as difficulties concentrating, hypervigilance, unsafe behaviors, irritability, and anger (APA, 2013).

Implications

We found that a large proportion of children referred for SBMHC services due to externalizing problems presented with serious trauma-related symptomatology. First, these findings present implications for child counselors and counselors working within school settings. While the behavioral assessments, such as the CBCL, are often utilized to assess mental health needs and therapeutic outcomes for SBMHCIs and other child mental health interventions, clinicians should consider adding trauma screeners, such as the CPSS (Foa et al., 2001), or the *Pediatric ACEs and Related Life Events Screener* (PEARLS; Koita et al., 2018). When clinicians administer behavioral assessments without understanding the child's potential trauma exposures and symptoms, they may miss vital information for treatment planning. Teachers who receive training have a more positive attitude towards trauma-informed care (McIntyre et al., 2019). Therefore, we suggest that the impact of trauma on children's behaviors be integrated into professional development trainings for classroom teachers as well as integrate trauma-informed care campus wide and at the systems level (Cowen et al., 2013; McIntyre et al., 2019), increase awareness of all school personnel. As evidenced by Orr and colleagues' (2022) findings, children exposed to family and domestic violence are more likely to have poor school attendance, are more likely to move during the school year, and receive school suspensions than their non-exposed peers. Thus, the

findings from this study coupled with Orr and colleagues' findings indicate that ACEs have lasting impacts throughout the lifespan. If school-based mental health counselors strive to understand the experiences, wounds, and needs behind students' externalizing behaviors, counselors can tailor trauma-informed interventions to promote students' wellbeing and future academic success. Finally, we suggest exploring the inclusion of ACEs as part of students' cumulative record. Providing school personnel with a general understanding of students' ACE score may encourage classroom teachers, school counselors, and administrators to view students through a trauma-informed lens.

The findings from our study also pose implications for counselor educators and supervisors. Children who are referred for SBMHCI based because of externalizing behavioral problems presented with higher levels of hyperarousal PTSD symptoms. We encourage counselor educators and supervisors to place a higher emphasis on trauma-informed care while working with children in Title-I elementary schools. According to the Council for the Accreditation of Counseling and Related Programs (CACREP) *Standards* (2016), counseling curriculum should include preparation and education about the impacts of "crisis, disasters, and trauma on diverse individuals across the lifespan" (Sect. 2, standard 3.g., p. 11). Prior to working with children in Title-I elementary settings in practicum or internship, mental health counseling trainees will benefit from training related to identifying trauma symptoms based on developmental levels, and how children's presenting problems may relate to traumatic experiences. Moreover, counselor education programs are encouraged to provide trainees with preparation related to delivering trauma-sensitive and developmentally appropriate child mental health interventions, such as Play Therapy (Parker et al., 2021; Ray et al., 2022) or Trauma-Focused Cognitive Behavior Therapy (TF-CBT; Peters et al., 2021).

Limitations

While this study provided insight and evidence that behavioral checklists fail to capture the influence of traumatic experiences and arousal symptoms on children's presenting problems in the school-based mental health setting, there were limitations in the present study. First, the researchers did not collect data related to children's trauma histories or ACE exposures. Future researchers should examine whether specific and/or cumulative traumatic experiences contribute to children's CBCL Externalizing scores. For example, researchers may examine whether children who endure specific ACEs (e.g., sexual abuse or physical abuse) exhibit higher levels of externalizing problems at home and school. In addition, researchers should examine the predictive relationship between arousal symptoms and CBCL scores

among a larger sample size to determine whether the CBCL scores are consistently predicted by trauma symptoms. These studies may shed light on important considerations for the child mental health field. For example, if child clients are scoring in the "clinical range" on the CBCL Externalizing subscale, counselors may need to assess for trauma and maltreatment.

Conclusion

Children often exhibit disruptive, aggressive, and externalizing behaviors when they are trying to communicate difficult experiences that are too painful to verbally articulate or directly disclose to others (Crenshaw & Swan, 2019). Child mental health researchers often focus on behavioral problem outcomes because of the social impacts of these behaviors at home, school, and within the community, and because adults struggle to manage children who are disruptive. Landreth (2012) asserted "when you focus on the problem, you lose sight of the child" as a rule of thumb for child counselors (p. 80). When counselors hyperfocus their change efforts on "fixing" behaviors seen as disruptive, counselors may fail to understand the child's internal world and what the child is truly attempting to communicate through these behaviors.

Declarations

Conflict of Interest We have no known conflicts to disclose.

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