Cognitive Behavioral Play Therapy

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Why Learn More About CBT?

- Most Researched Method
- Powerful Results for Many Disorders
- Increasingly Popular
- Can Be Integrated Easily With Play Therapy Methods
Typical Points of Skepticism

- “How Would Anyone Else Know What A Useful Thought Would Be For Me?”
- “How Can Children Engage in Therapies with Such Sophisticated Cognitive Demands”
- “CBT Takes the Art Out of Therapy”
- “The Relationship Doesn’t Matter In CBT”
Group Experiential Activity
Here

Is the Point Where
You
Become Convinced
That This Might Be Useful
Course Outline

- What CBT Is
- Prior Cognitive Behavioral Play Therapies
- Cognitive Model and CBT Theory
- Session Structure for Older Youth
- Typical Child/Adolescent CBT Interventions
- Play Therapy CBT Interventions
- Behavioral Therapies Involving Play
- Interventions Specifically for Depression and Suicidality
- Play Therapy Interventions for Depression and Suicidality
Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT):

- CBT is not a single therapy, but multiple models following a common theoretical basis
- Multiple treatment manuals/models exist to treat a variety of disorders/diagnoses
- Empirically-based
CBTs (cont.)

- Techniques draw from cognitive and behavioral theories
- Focus on symptom resolution in the here and now
- Sessions are structured and goal-oriented
- Sessions focus on teaching cognitive and behavioral skills to manage symptoms
- Model originally developed with adults, downward extension to children/teens
CBT Play Therapies Are Not New

- Susan Knell

- Drewes
  - Blending Play Therapy with CBT (2009)

- Play Therapists
  - Goodyear-Brown, Kinney-Noziska, Shelby
Origins of CBT

- Theory: Beck’s cognitive model:
  - Situation → Thought → Feeling/Behavior

- The situation itself doesn’t directly determine how one feels, emotions/behaviors are determined by the interpretation of the situation.

- Scenario: You are walking down the street and see a friend of yours. You say “Hi!” He/she does not respond and walks right by you. What is going through your mind?

- Behavioral models/behaviorism also part of CBT (e.g., classical and operant conditioning, teaching behavioral skills, etc.)
Aaron T. Beck is widely considered to be the founding father of CBT

- Started as an analyst
- Found focusing on conscious thoughts more productive and practical
- Major contribution is conducting research on psychotherapy outcome
Initial Assessment: Is CBT an appropriate treatment for your client?

- **Diagnosis**
  - Is CBT the right treatment for the disorder?
  - CBT models tend to be diagnosis-specific
    - Use of Standardized Measures
    - Establish Diagnosis Clearly Before Developing a Treatment plan
Is CBT Appropriate for Your Patient?

- Ability to do “talk therapy”
  - More of an issue for the “C” vs. the “B”
  - For young children, need to incorporate play methods, but can still follow same theory
  - Environmental intervention is critical with young children
Initial Sessions

- Introduction to CBT model and structure
- Defining problems and setting measurable goals for treatment
- Build rapport/therapeutic relationship
  - This is central to CBT
CBT is Goal-Oriented!

- Choose a personal goal to discuss during presentation
- How Will This Goal Be Accomplished?
CBT Has Shown Powerful Results for Youth

- Trauma
- Depression
- Other Anxiety Disorders and Selective Mutism
  - Panic
  - OCD
  - GAD
  - SAD
- Suicidality
BTs Have Shown Strong Results for:

- Developmental Delay Level of Functioning
- ADHD symptoms
- Disruptive Behavior Disorders
- Reduction in Child Abuse Frequency
Resources

- Friedberg and McClure (2002)
  - Clinical Practice of Cognitive Therapy with Children and Adolescents
- www.abct.org
- www.copingcat.com
- www.tfcbt.musc.edu
- www.pcit.org
- www.incredibleyears.com
CBT Session Structure
General Session Structure

- Brief update and mood check
  - (How was your week? What has your mood been like?)

- Bridge from previous session
  - (Do you remember what we talked about in the last session?)

- Review of homework

- Setting the agenda

- Discussion of agenda items

- Assignment of new homework

- Final summary and feedback
Check-In and Mood Check
Brief Check-In

- Patient needs to be adequately socialized to expectations/procedures of CBT
- May Need Assistance Prioritizing
  - Q-Sort Tasks with “Most-Important,” “Can Wait,” and “Not Necessary Categories”
  - Q-Sort with “My Problem” and “Adult Problem”
Problems with Brief Update for Adolescents

- Patient gives rambling, too detailed, or unfocused account of week
- Therapist should jump in and encourage synthesis
- Point is to get a quick overview of the week to decide what to put on the agenda
- Too brief/no description of week
- Ask multiple choice questions
Mood Check with Children and Adolescents

- **Mood check**
  - Teach Affective Expression
  - Use faces, pictures, movies to help identify mood states

- Introduce Cognitive Model in simplified way
  - faces and thought bubbles
  - baseball diamond
  - playful activities

- Need to ask a lot of questions when identifying problems
Feeling Thermometer

Feel the Worst

Feel the Best

10
9
8
7
6
5
4
3
2
1
0
Play-Based Mood Check Techniques
Problems with Mood Check

- Patient has difficulty reporting her mood/uses vague terms (“I feel ok”)
- May need to coach patient on how to identify and label emotions first
- Patient doesn’t want to fill out BDI, etc.
- Socialize patient to usefulness of these forms
Bridge

- Links sessions and session content
- If patient doesn’t remember last session
  - Use memory jogs
  - Teach patient importance of connecting the sessions
CBT Homework
Increasing Homework Compliance

- Practice homework in session
- Explain and have patient explain rationale for homework
- Assign specific behaviors – specify what behavior should occur, how frequently, when, and so forth
- Review how homework will be monitored
- Get feedback about thoughts/beliefs and practical obstacles that might pose barriers
- Get an 80% commitment to completing homework
- Titrate homework (i.e., small increments that ensure success)
- Use rewards
- Work with parents to support and not interfere with homework
- Patients who do homework are most likely to get better!
Homework

- Typical types of homework assigned in CBT include:
  - Altering cognitions
  - Trying behaviors (e.g., exposure, behavioral activation, coping skills)
  - Self-monitoring (e.g., Panic Record, Mood Monitor, DTR)

- Homework should be connected to treatment goals and theoretical rationale/approach
Sample
Homework for Young Children

- Usually involves caregivers
- Should be a game or play-based activity
- Can be playing about a targeted situation
- Should be an experiential activity
  - Behavioral experiment
  - Exposure
Make sure to review homework

If you don’t, it gives the message that it is unimportant

and the patient won’t do it
Common Difficulties with Homework Completion

- Doing homework at the last minute
- Forgetting the rationale for the homework
- Disorganization (help patient schedule and prioritize)
- Homework is too hard/difficult for the patient
- Interfering cognitions
  - “This won’t help me” “I shouldn’t have to do homework”
- Therapist cognitions
  - “I’ll offend the patient if I assign homework,” “the exposure will be too upsetting for her,” “I’m not sure I really believe in CBT”
- Lack of motivation/commitment to the treatment
General Session Structure

- Brief update and mood check (How was your week? What has your mood been like?)
- Bridge from previous session (Do you remember what we talked about in the last session?)
- Review of homework
- Setting the agenda
- Discussion of agenda items
- Assignment of new homework
- Final summary and feedback
Agenda Setting
Agenda-Setting Is Important

- Makes therapy efficient/Decreases unproductive discourse
- Lets patient know how therapy works
- Highlights take-home points
- Keeps treatment goal-oriented
- Allows therapist/patient to prioritize topics and use time wisely
  - therapist knows what topics need to be covered
  - therapist can flexibly configure session topics to integrate patient needs
- Agenda is combination of therapist and patient-initiated topics
Agenda Setting

- 2-3 items at the most on the agenda
- Beginning of session discussion is very brief (mood check, brief update, bridge) and items that need to be discussed further are put on the agenda
- In the first session, socialize patient to the practice of agenda setting
Problems with Agenda

- Patient doesn’t contribute to agenda
- Patient wants to put too many things on agenda
- Rambling/Difficulty defining a prob. for agenda
- Teach patient how this is done
- Help patient transform thoughts (or lack thereof) into agenda items
- Assess for cognitions that may be in the way, (e.g., “You are the doctor, you know best what we should talk about”, “I don’t want to be here anyway”)
- Assess commitment to therapy
Agenda Items

- Never more than 2-3 items on agenda
- Use capsule summaries
Agenda Setting Practice

- Divide into pairs
- Ask your partner to give you a “brief update” of his/her past week at work
- Set an agenda with 2-3 items to discuss
Agenda Content

- The actual work/interventions
- (Will follow with Cognitions later in this presentation)
Final Summary and Feedback

- Patient may be reluctant to share feedback or may be critical
Interventions with Children, Adolescents and Families
CBT with Younger Children and Adolescents

- Same theory guides treatment
- Interventions may look different
- Can use same session structure
- Can also integrate key concepts with less distinct components
- Children usually do not seek their own treatment
- Children usually do not find talking to a therapist or about feelings/thoughts enjoyable
- Need to make therapy fun and engaging
- Learn by doing
- Work with the family and the school
Working with Families in CBT

- Family/collateral work
  - Generally supports individually-based interventions in CBT
  - In BTs, improves quality of parent-child interactions
- Less focus on systems-based interventions
- Parents are taught skills taught to youth, so parents can serve as coaches
- Psychoeducation
- Helping parents facilitate interventions v. interfere with them
- Decreasing family conflict
- Providing youth with support for difficult interventions (e.g., exposure)
- As in all therapy with children/teens, parents are an important source of information, assist in measuring progress
Cognition-Based Interventions
Types of Cognitions

- **Beliefs**
  - Global
  - Developed in childhood
  - “I am helpless” “I am unlovable”

- **Intermediate Beliefs**
  - Attitudes: judgments, “being weak is bad”
  - Rules: “Shoulds,” (e.g., “I should be able to handle everything”)
  - Assumptions: “If/then” statements, (e.g., “If I hurt them before they hurt me, then I’ll be ok”)

- **Automatic Thoughts**
  - Situation-specific
  - Stream of consciousness, “surface” thoughts
  - “I can’t handle this” or “I’m going to fail out of school”
Identifying Automatic Thoughts

- What was going through your mind?
- Ask in response to negative emotions/problematic behaviors
- Can use imagery if patient if having difficulty identifying thoughts
- With kids – may need to give multiple choice
- Want the exact thoughts the patient had, not interpretations
  - (e.g., NOT Thx: “What was going through your mind when you saw your best friend leaving for a play date with the new girl?” Pt: “I think I was in denial about my feelings”)
- Encourage patient to put thoughts into statement form (this form is easier to work with)
- Underlying purpose: How do these thoughts impact mood and behavior?
- When thoughts impact mood and behavior negatively, we are going to try to change them.
Common Cognitive Distortions

- All or none thinking
- Catastrophizing
- Futurizing
Cognitive Restructuring

- Can look at both the **validity** and **usefulness** of an automatic thought.

- Automatic thoughts are often true and should not be assumed to be “distorted”.

- CT has moved away from idea of thoughts being “rational” v. “irrational”.

- If the automatic thought about is true (e.g., “I am going to fail math,”) then help the youth cope with the situation and think about it in the most helpful way possible (e.g., “I can get through this” vs. “my life is over.”)
Cognitive Restructuring: Automatic Thoughts

- Test the evidence for the thought (validity)
- Is there another way to look at the situation that might make me feel better? (usefulness)
- Is this a helpful thought? (usefulness)
- What are the pros/cons of having this thought? (usefulness)
- If the situation is true, what is the most useful way for me to think about it? (usefulness)
Cognition Test

<table>
<thead>
<tr>
<th>Is It True?</th>
<th>Is It Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>True and Helpful</td>
<td>True and Unhelpful</td>
</tr>
<tr>
<td>Untrue but Nice To Think About</td>
<td>Untrue and Unhelpful</td>
</tr>
</tbody>
</table>
Play Therapy Techniques for

- Validity of Cognitions
  - Donkey Story
  - Solomon Role Plays

- Helpfulness of Cognitions
  - Scared Samantha
- Testing cognitive distortions (validity)
- Behavioral experiments (validity)
- Engaging in previously avoided situations/behaviors (validity)
- Distraction
- If youth is unable to engage in cognitive restructuring, focus on behavioral techniques and/or experiential techniques
Dysfunctional Thought Record

- Typically assigned as homework

- Way to track automatic thoughts and cognitive restructuring
Cognitive Restructuring

- Therapist uses Socratic Method
- Do not directly challenge the patient
- Beginner’s mistake is to try to “argue” the patient out of a thought
- Restructuring works best when patient comes to conclusion that thought should be changed on his/her own, not by therapist lecturing him/her
Creating Alternative Responses

- This is a PROCESS. Often need to test several alternative responses before the patient finds one that “fits”

- Always ask patients to what degree, out of 100%, that they believe the new thoughts

- If they don’t believe at the 80% level or higher, it won’t work!
Cognitive Restructuring with Younger Children

- With younger children, keep “restructuring” simple
  - (e.g., Thx: When I am scared I tell myself things that make me feel better, like “it will be ok.”
  - What can you say to yourself to make yourself feel better when you are scared?)

- Can give multiple choice, use handouts, puppet shows, and play-based activities
Sample Play Therapy Techniques
EMT
for Preschoolers
(Experiential Mastery Technique; Shelby, 1994)

- Child draws what he or she fears
  (refrain from drawing past or present perpetrators who are currently involved in child’s life)
- Child can say anything to drawing, though he/she could not do so at the time
- Child instructed that he/she is in charge of this drawing and he/she can do anything he/she wants to the drawing.
Lose the Bruise
(Goodyear-Brown, 2004)

- Name Unhelpful Thought

- Represent it with tossed ball

- Hit or Shield ball while responding with contradictory, more helpful thought
Shelby, Bond, Felix, Hsu, 2004; National Center for Child Traumatic Stress
• Describe Trial Process
• Select Thought to Be Tried
• Pt. Role-Plays Attorney #1: Argues Veracity of the Thought
• Pt. Role-Plays Attorney #2: Disputes Evidence Presented By First Attorney
• Therapist Serves as Judge: Must Be a Fair Trial
• Pt. Is Asked How Jurors Would Vote Based on Evidence
BLAMEBERRY PIE

- In this pie go all the reasons why it happened
- Th. writes & adds to pie
- Review each to determine fit
- Separate Misattributions
Coping Card Example

Negative Belief:
I can’t tolerate the pain

Feeling:
Depression, hopelessness

Positive Beliefs:
1) I can handle it. I have always handled it in the past.
2) I am capable of feeling good.
3) There are things to look forward to.
4) I’ve gotten through it before.
Core Beliefs
Core Beliefs

- Typically fall into two categories:
  - helpless
  - unlovable
- Are derived in childhood
- Operate as “schemas” which selectively attend to consistent information and discount contrary information.
- Tend to be global and cross-situational
Identifying Core Beliefs

- Downward arrow technique
  - (“what would that mean about you?”)

- Recognizing a common theme in ATs
Additional techniques for modifying core beliefs

- Psychoeducation
- Reviewing historical origins

Amongst Children:
  - Caregiver and Teacher Training/Support
  - Target The Opposite of the Core Belief
    - Increase Frequency, Quality, or Intensity
Case Example:

- CBT Play Therapy Session with a Preschooler Whose Mother Accidentally Ran Over Him With Her Car
SITUATION

THOUGHTS

BEHAVIORS

FEELINGS
Mood?

Experiential Activity
Behavioral Intervention Techniques

- Behavioral assessment – define behavior, baseline rate of behavior, antecedents and consequences
- Activity monitoring and scheduling
- Contingency management
- Coping: Distraction, Relaxation, Mindfulness
- Exposure
- Role plays/Social skills/Assertiveness/Problem-Solving
- Behavioral experiments
Behaviorism

- Functional/chain analysis (determine empirically what is causing and maintaining the behavior)
- Operant conditioning/reinforcement – what is maintaining the behavior?
- Classical conditioning – pairing of stimulus and response
- Teaching new behaviors (skills training)
REINFORCEMENT

Consequence following a behavior that increases the likelihood of a behavior occurring again.
POSITIVE REINFORCEMENT

Increase frequency of a behavior by providing a consequence that the person finds positive/rewarding

- If teen gets money for emptying the dishwasher, he/she is more likely to do it again
- If a suicide attempt leads to a boyfriend coming back, patient is likely to do it again
NEGATIVE REINFORCEMENT

Increases frequency of a behavior by removing or stopping a consequence that the person finds aversive

- Baby stops crying if mom gives a pacifier, mom is likely to give pacifier again when baby cries
- Suicide attempt leads mom to stop yelling at teen, youth is likely to attempt suicide again when mom yells
- Patient yells at therapist every time he/she asks about diary card, therapist stops asking about diary card
Decreasing the Likelihood of a Behavior

- Extinction – stopping reinforcement of a behavior that was previously reinforced

- Punishment – application of aversive consequences
Contingency Management

- “Contingency” means that a reward is contingent on performing a desired act.
- “Management” is the art, science, or practice of arranging these rewards to shape behavior.
- Rewards=reinforcement
Reinforcement

- Contingency Management Opportunities
  - Reinforcement within Interaction
    - Differential Reinforcement Procedures
  - Situational Reinforcement
    - Premack Principle
  - Systematic Reinforcement of Behavior
    - Behavior Modification Systems
Behavioral Therapies

- For the Treatment of Disruptive Behavior Disorders
  - Parent Child Interaction Therapy (PCIT) (www.pcit.org)
  - Incredible Years (IY) (www.incredibleyears.com)
Play Is Included

- Both Methods Appreciate the Importance of Enhancing Caregiver-child relationships through Caregiver-Child Play
PCIT

- Child-Directed Phase:
  - Relationship Enhancement

- Parent-Directed Phase:
  - Compliance
PCIT PRIDE Skills

- Praise
- Reflection
- Imitation
- Description of Child’s Behaviors
- Enthusiastic/Engaged
PCIT Case Examples
Behavioral Theory and Principles

For Your Resource
Premack Principle

- As a rule, preferred behaviors can be used to reinforce non-preferred behaviors. A formal statement of the Premack principle is as follows: high-probability behaviors (those performed frequently under conditions of free choice) can be used to reinforce low-probability behaviors.
- “First this, then this”
- “First eat your vegetables, then you can have dessert.”
Behavior Modification Systems

- “Sticker charts don’t work with my child.”
- Establishing clear, specific behaviors
  - Identifying “positive” behaviors
  - Measurable
- Get a baseline
- Rates of observation/data collection
  - Who is responsible for recording? Generating new charts?
- Reinforcer scheduling
  - Daily, Weekly, Monthly
Behavior Modification Systems for School

- Linking school behavior to home contingencies
- Use of a Daily Report Card
- Working with teachers
Behavior Modification Systems

Points to emphasize to parents

- Kids can help design it
- Explain contingencies clearly
- Use of a Rewards menu
- Start low, go slow
- Reward immediately
- Reinforce AFTER the desired behavior
- Consistency
- Extinction burst
Extinction Burst
Depression
Treatment of Adolescent Depression

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DSM IV DIAGNOSIS: MDD

- Depressed/irritable mood
- Loss of interest or pleasure
- Change in weight or appetite
- Insomnia or hypersomnia
- Lack of energy
- Psychomotor agitation or retardation
- Feelings of worthlessness or guilt
- Inability to concentrate or make decisions
- Thoughts of suicide

- 5/9 symptoms are present most of the day, nearly every day, for at least 2 weeks, one of symptoms must be #1 or 2.
- Substantial impairments in school functioning, social relationships, and family relationships
- Need to consider symptoms in terms of adolescent-specific impairments
Child/Adolescent-Specific Symptoms of Depression

- Increased irritability, anger, or hostility
- Lack of interest in playing with friends, sports, games
- Persistent boredom
- Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness
- Frequent absences from school or poor performance in school
- Talk of or efforts to run away from home
- Excessive late night television, refusal to wake for school in the morning
- Alcohol or substance abuse
- Social isolation
Treatment for Depression in Children and Adolescents

- Pharmacotherapy
- Psychotherapy
- Combination psychotherapy and pharmacotherapy
SSRIs have mixed support, with positive RCTs for several (fluoxetine, paroxetine, citalopram, sertraline), but majority are negative studies.

Prozac and Lexapro only FDA-approved medications for depression in children and teens (Lexapro recently approved).

Prior TCA studies negative.
SSRIs and Suicidality in Teens

- 2004 – FDA issues black box warning
- Findings based on adverse event reports – 2% v. 4% experienced suicidal thoughts or behavior (as compared to placebo)
- No differences using standardized measures
- No completed suicides
- Depression is a risk factor for suicide
- Research has shown higher rates of SSRI prescriptions are associated with lower suicide rates
- Recent increase in teen suicide rates may be related to decrease in SSRI prescriptions
- Follow-up studies have found mixed results
- Need to weigh relative risk of untreated depression v. small SSRI-related risk
- Youth on SSRIs must be carefully monitored
439 randomized to:
- Fluoxetine (up to 40 mg)
- Cognitive behavior therapy (CBT)
- Fluoxetine plus CBT
- Placebo

Primary outcome measure is change in CDRS-R scores across 12 weeks
36-Week TADS Findings

Main outcome measures: CDRS scores, CGI scores, Reynolds adolescent self-report scores (Archives of General Psychiatry, 2007)

- Subjects received maintenance treatment until week 36
- Improvement occurred in all 3 treatment groups by 36 weeks.
- Response rates: 86% combined treatment, 81% meds alone, 81% CBT alone.
- Treatment with Prozac led to quicker improvement (both alone and combined with CBT).
- CBT alone catches up to Prozac at midpoint of treatment and to combination treatment at the end of treatment.
- Patients treated with Prozac alone 2x more likely to have a suicidal event
- CBT may be protective against suicidality
- Overall, combined treatment appears to be the best course of action
6 site, 5-year NIMH study
334 outpatient adolescents, ages 12-17 years, with diagnosis of major depression
Depression persists despite at least 6 weeks of SSRI treatment
Acute phase 12-week trial

JAMA Feb 27, 2008
Randomized to:
- Different SSRI
- Different SSRI plus CBT
- Different class of agent (venlafaxine)
- Different class of agent (venlafaxine) plus CBT
Response Rates by Group in TORDIA

CBT vs none, 54.8% vs 40.5%, p<0.009, no difference between Effexor and SSRIs

JAMA Feb 27, 2008
Basic Elements of CBT Used in Major Adolescent Depression Trials

- Psychoeducation
  - Connection between thoughts, feelings, behaviors
  - Positive/Negative Spirals
- Activity Scheduling/Behavioral Activation
  - Mood and Activity Monitoring
- Cognitive Restructuring
  - Cognitive Distortions and Positive Counter-thoughts
- Family Intervention
  - Communication
  - Education
  - Reinforcement
- Social Skills
- Problem Solving
- Emotion Regulation
Feel unhappy → Crabby → Withdraw to room → Feel worse → Fight with family members and friends → Feel even worse → Feel unhappy
UPWARD SPIRAL

Feel great

Have fun with friends

Feel good

Do well in school or work
Activity Scheduling/Behavioral Activation
Mood and Activity Monitoring

- Review importance of pleasant activities in decreasing depression
- Have youth select pleasant activities they would like to do from list
- Assign homework to monitor mood and activities
- Look at graph of mood and activities
- Set mood and activity goals (e.g., “how many activities do you need to do to reach your mood goal?”)
- Pleasure and mastery activities (fun and success)
- Problem-solving impediments to doing pleasant activities
- Review plan with parents!
Barriers to Activity Scheduling

- “Nothing is fun for me”
  - Encourage acting “as if”
- Use reinforcements/contingency management
- Activities are impractical
- Look past pleasant activities
- Need to work on social skills for social activities
1. Did you notice patterns/changes in your mood and activity levels?
2. How many activities does teen have to do to reach a certain mood goal?
3. What are some of the things that seem to be related to doing pleasant activities? What got in the way of you doing fun activities?
4. High impact activities
5. Process of trial and error
Thoughts Module
Cognitive Restructuring

Beck’s cognitive model:

- Situation → Thought → Feeling/Behavior

The situation itself doesn’t directly determine how one feels, emotions/behaviors are determined by the INTERPRETATION of the situation.

Therefore, you need to change thoughts to change mood.

Scenario: You are walking down the street and see a friend of yours. You say “hi!” He/she does not respond and walks right by you. What is going through your mind?
Identifying Automatic Thoughts

- What was going through your mind?
- Ask in response to negative emotions and problematic situations
- Can use imagery if youth is having difficulty identifying thoughts
- May need to give multiple choice options

**Underlying purpose:** How do these thoughts impact mood and behavior?

- When thoughts impact mood and behavior negatively, we are going to try to change them
Cognitive Restructuring: Automatic Thoughts

- Test the evidence for the thought
- Is there another way to look at the situation that might make me feel better?
- Is this a helpful thought?
- If the situation is true, what is the most useful way for me to think about it?
- Testing cognitive distortions
- Behavioral experiments
- Engaging in previously avoided situations/behaviors
- Distraction
Cognitive Restructuring

- One of most challenging interventions
- Difficult to do when youth is still severely depressed
- Do not argue with patients if they are not ready for this yet
- For younger children use affirmations or positive self-statements
Thought Record

- Typically assigned as homework
- Way to track automatic thoughts and cognitive restructuring
Cognitive Restructuring Example

Negative Belief:
I shouldn’t be depressed.

Feeling:
Depression, hopelessness

Positive Beliefs:
1) I’ve been through a lot. I have every right to feel however I want.
2) I have a chemical imbalance which lots of people have. I’m sad because of that.
3) There are reasons why I am depressed. Reasons can be from the past or current issues.
4) It’s ok to be depressed.
5) One advantage to being depressed is that I’ve met some real good friends because of it.
6) Being depressed has made me be able to be a very feeling person and I can be very understanding of others due to all that I’ve been through.
Changing Negative Thoughts

“Hot seat” exercise
- Have group choose an activating event
- Have group say negative thoughts that might occur
- Have youth in the “hot seat” say positive counter-thoughts

“Walk Toward the Light”
Family Interventions
Psychoeducation

- Depression is an illness
- Depression is not under the teen’s control and he/she cannot overcome it using “willpower”
- Parents often come down hard on teens who are functioning poorly and worsen the depression by being critical or having unrealistic expectations
- Remind them they are seeing symptoms not a bad kid
Family Communication

- Teach communication skills
  - Speaker/listener technique
  - “I” statements.
- Identify negative communication strategies, such as interrupting others, lecturing, blaming, name-calling, and putting others down.
- Review nonverbal indicators of negative communication
  - Not looking directly at the person who is talking
  - Negative expressions
- Listening does not mean agreeing
- Role plays
- Start with neutral topics before moving on to “hot” topics.
Family High Expectations and Positive Reinforcement

- Help family members develop reasonable expectations for their depressed teen
- Tell parents to “pick their battles”
- Education families about depression
- Provide positive feedback/reinforcement
- Tokens
- Catch a positive
RELAPSE PREVENTION

- Maintaining gains
- Emergency planning
  - Identify potential stresses
  - Develop coping plans
- Recognize signs of depression early
- Depression prevention plan
Suicidality


**Adolescent Suicide Statistics**

- Suicide was the 3rd leading cause of death among 10-14 year-olds (behind accidents and malignant neoplasms) and among 14-19 year olds (behind accidents and homicide).

- Prior suicide attempts are one of the strongest predictors of completed suicide and subsequent suicide attempts in youth (e.g., Lewinsohn et al., 1993)
Despite the seriousness of the problem, relatively little empirical research exists.

Two randomized treatment trials showing an impact on suicidal behavior:

- Multi-systemic therapy was shown to be more effective than hospitalization at decreasing rates of youth-reported suicide attempts (Huey et al., 2004)
- Developmental group therapy (including CBT strategies) was shown to be more effective than routine care at decreasing deliberate self-harm (Wood et al., 2001)
Definitions

- **Suicidal Ideation**: thoughts about wanting to be dead or killing oneself
- **Suicide attempt**: A potentially self-injurious behavior, associated with some evidence of intent to die
- **Completed suicide**: A fatal self-injurious behavior that was associated with some intent to die
- **Non-suicidal self-injury behavior**: Self-injurious behavior not associated with intent to die (intent may be to relieve distress or communicate with another person), often called self mutilation
Common Risk Factors

- Past suicide attempt
- Access to weapons/lethal means
- Psychopathology: Depression, substance abuse, conduct disorder (males)
- Sadness, anger, or other very painful negative emotions (emotion dysregulation)
- The tendency to be aggressive and violent, and to engage in dangerous, illegal, or risky activities
- Impulsivity or acting without thinking
- Alcohol and drug use/abuse
- Family conflict
- Stressful life events: Problems with school, peers, and relationships
- Hopelessness
- The perception that problems cannot be solved, poor problem solving ability
- Family history of suicide
- Male gender
Assessment of Suicidal Behavior

- Ideation
- Plan
- Intent
- Ability to contract for safety/agree to a safety plan
- Distal factors
- Proximal triggers (suicide attempts are generally the result of distal risk factors combined with a proximal trigger)
- Safety of home environment/ability of parents to monitor safety
- Access to lethal means
What to do if client is at risk for suicide/self-harm behaviors

- Remove lethal means
- Create a safety plan
- Establish parental monitoring
- Increase frequency of visits
- Consider hospitalization
Hope Box Intervention (Beck & Colleagues)

- Client is asked to select a box to be filled with reminders of coping skills and reasons to live
- Can be done in session or as homework
- Instructions to client: “Sometimes when a person is really upset and overwhelmed by their emotions, it is hard to think straight and remember to do something positive and safe. The purpose of the hope box is to have it all ready to go in advance so you can jump start yourself into positive thinking and acting.”
Sample Hope Box Items

- Photographs of family, friends, favorite places, pets, etc.
- CDs, tapes, MP3s of favorite songs
- Videos, DVDs, of favorite television shows or movies.
- Favorite books, magazines, comic books
- Favorite foods (e.g., chocolate, tea bags – should be non-perishable!)
- Favorite scents (e.g., perfume, scented candles, incense)
- Videogames
- Crossword puzzles, word search puzzles
- Coping Cards
- Letters
- Favorite gifts (e.g., a bracelet from a friend)
- Paper, pencils, paints, etc. (if youth likes to draw or paint)
- Sheet music, guitar strings, etc. (if the youth plays a musical instrument)
Summary: Tips for Working with Suicidal Clients

- Work with patient and family on removal of lethal means
- Create a detailed safety plan. Review with youth and parents.
- Have family monitor youth at risk
- Increase frequency of visits/level of care if needed
- Assess and document suicide risk in every session
- Keep the family updated/confidentiality
- Create a hope kit as a companion to the safety plan
- Conduct a chain analysis/retelling of the suicide attempt to conceptualize what triggers youth suicidality
- Intervene to decrease triggers of suicide attempts
- Work with family to decrease conflict
- Teach youth skills for regulating emotions
- Work with youth on hopeless thoughts/negative cognitions
- Consult with other clinicians
Child/Adolescent Anxiety Disorders

- Panic Disorder
- GAD
- OCD
- Social Phobia
- Specific Phobia
- Separation Anxiety
- Selective Mutism
- PTSD
Coping Cat

- 16 sessions
- 8 – 13 years old, adolescent version 14-17 years old
- FEAR Plan
- Feeling Frightened (awareness of physical symptoms of anxiety)
- Expecting bad things to happen (recognition of anxious self-talk)
- Attitudes and Actions that will help (behavior and coping talk to use when anxious)
- Results and Rewards (self-evaluation and rewards for effort)
Exposure

- Based on the principle of habituation (until anxiety decreases by 50%)
- Create a graded exposure hierarchy
- Get SUDS ratings before, during, after exposure
- Imaginal and in vivo (imaginal useful to start out and for fears that are more abstract or unlikely to happen [e.g., death of a parent in SA])
- Try not to have the client use distraction or safety behaviors
- Assign for homework, in-session practice is not enough
- Practice, practice, practice
- Also leads to cognitive shift over time
Working with Parents

- Assess parental factors that may interfere with treatment

  - “Rescuing” the child
  - Belief that child is unable to handle anxiety
  - Belief that the child should be able to handle anxiety on his/her own