Cognitive Therapy for Children and Adolescents: Day Two

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June 16, 2017

Agenda

Modular Treatment of Suicidality
Modular Treatment of Anxiety
Application to Families

TREATING SUICIDALITY IN YOUTH
Understanding Suicidal Behavior in Children and Adolescents

Overall SI and SB are conceptualized as an ill-founded problem solving strategy (Linehan and many others)

Marked by Helplessness and Hopelessness

Caught in a miserable present and want to escape

Find out the specifics and parameters surrounding the hopelessness and helplessness

Reasons for Living

Deal directly with client ambivalence

Make use of Developmental Milestones (driving, prom, graduation, etc.) (Daniel & Goldston, 2009)

Items on Reasons for Living Inventory (Osman et al., 1998)

• What do you hope to accomplish?
• What do you want to be?
• What would your family lose?
• How would they cope with losing you?
• Who depends on you?
• What does your religion say?
• How would your friends view your suicide?

Distress Tolerance Skills

(Linehan)

SI and SA may be linked to a general intolerance for distress

Emotional intolerance spurs impulsivity and emotional dysregulation

Distress tolerances DOES NOT EQUAL distraction

DT is the capacity to embrace negative emotional arousal and persist so adaptive problem solving can be achieved
Factors to Consider (Tishler et al.)

**Current presentation**
- Intent to die
- Plan, method and access to means
  - Unsecured methods (guns, meds, etc.)
- Symptoms (depression, psychosis)
- Substance use
- Reasons for living
- Cognitive level of child
- Social isolation
- Bullying

**History**
- History of prior attempts
- History of ideation
- Mental health history
- History of substance use/abuse
- History of Trauma
  - Physical/Emotional/Sexual abuse
- Number of Emergency Department visits for “accidents”
- Chronic medical condition

**Family**
- Marital conflict
- Domestic violence
- Financial issues
- Parental incarceration
- Parental substance abuse/use
- Level of parent involvement/supervision
- Family history of suicide
Suicidality in Adolescents

Bridge, Goldstein, & Brent (2006)

Risk factors
• Intent includes
  • Belief about intent
  • Preparation before the attempt
  • Preventing discovery
  • Communication
• Things that distinguish completers from attempters
  • Planning
  • Timing the attempt to avoid detection
  • Confiding plans ahead of time
  • Expressing wish to die

Suicidality in Adolescents

Disorders

Mood disorders
Substance Use Disorders
Conduct Disorder
Psychotic spectrum
Anxiety
PTSD
Eating Disorders

Suicidality in Adolescents

Individual Psychological Factors

Impulsive aggression: tendency to react to frustration or provocation with hostility. History of assaultive behavior
Impulsivity in general
Neuroticism: experiences prolonged and severe periods of negative affect
Low self-esteem
Hopelessness
Perfectionism
Nuanced SI Assessment
Focused on typical explicit AND implicit cognition
Implicit indicators (Friedberg & McClure, in press)
Level of cognitive narrowing/tunneling (Wenzel & Beck, 2008)
Constricted affect
Foreschorted future/Hopelessness

Three Questions (Friedberg & McClure, 2015)
How in control? (scale of 1-10)
How safe? (1-10)
How honest? (1-10)
ALWAYS follow-up on anything less than 10
ALWAYS Unpack the ratings
What makes them a ___?

Understanding Suicidal Ideation
Undertake a functional analysis
Different motivations call for different interventions (Persons, 1989)
• Trying to get revenge
• Being angry and unskilled in dealing with it
• Trying to restore a relationship
**Functional Analysis**

*Pay attention to the interpersonal conflict*

- Younger children = parents/family
- Adolescents = peers

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**Working with Suicidal Youngsters**

*Increasing motivation and engagement*

Want to integrate safe-guarding procedures with effective interventions (Rudd and Joiner)

- Safety Plan
- Hope Box
- Reasons for Living
- Distress tolerance skills

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**Safety Plan (Wenzel et al., 2008)**

*Much more active than a no-suicide contract*

Core concept of the empirically based practice

Includes

- Warning signs
- Coping strategies
- Removal of means
- Ways to contact
  - Therapist
  - Emergency Rooms
  - Crisis services
Hope Box (Berk et al., 2008)

Items that are associated with positive feelings, coping skills, and reasons to live

Photographs
Favorite CD’s, DVD’s, books
Foods
Scents
Games
Puzzles
Letters
Trip souvenirs

Distress Tolerance Skills

Examples
Crunch raw eggs on self
Hold ice
Immerse hands in cold water
Walk
Play computer games
Cut tomatoes
Cut open ketchup packets
Listen to a nature sound
For more ideas go to
• www.dbtselfhelp.com

Time Projection
Friedberg & McClure (2015)

• Problem solving-like intervention that puts space in between distressing emotion and impulsive action

Sample Time Projection

• Focuses on the notion that suicide is always a permanent solution to an often temporary problem
Questions
How will you feel about this in 6 hours? What would you do differently?
How will you feel in one day? What would you do differently?
In 1 week? In 1 month? 6 months?
1 year? 5 years?

MODULAR APPROACH TO ANXIETY SPECTRUM

Psychoeducation
FREEING YOUR CHILD FROM ANXIETY
Constructing a Hierarchy
Like ladders where each rung represents a step toward higher levels of distress
Key is defining each item very specifically
Makes use of scaling (SUDS)
Bubble Up
File my Fear Away
Up, Up and Away

Fear Thermometer/Fear Ruler
Operationalizes level of distress
Makes distress a “matter of degrees” which in turn reduces all or none thinking

Bubble-up
Use of soap bubbles as units of distress
Each bubble represents one unit
Fun way to teach graduated approach
Decreases all or none thinking
Child Friendly Thought Records

You practice on various forms!!!!!
## Relaxation Training

**Controlled breathing**
- Diaphragmatic breathing
- Ten Candles (Wexler, 1991)
- Straw and Cotton Ball
- Bubbles

**Progressive muscle relaxation**
- Tensing and relaxing different muscle groups
- Dinosaur Script (Geddie, 1992)
- Other developmentally appropriate scripts (Kendall et al., 1992)

## Cognitive Restructuring

## Cognitive Interventions
- Thought crown
- Thought Necklace
- Handprint on your heart
- Hansel and Gretel
- Talking Back to Fear
- Real versus false alarms
Decatastrophizing Procedures

3-D thinking (Friedberg et al., 2009)
Count Dreadula (Friedberg et al., 2009)
Shake it off

Shoshana’s Master of Disaster

Disaster I can master: The girls at my lunch table will continue to pick on me because my hair looks frizzy in my braids and I don’t have a date to the dance.

Master Questions:

How sure I am the disaster will happen (Circle one)

1 2 3 4 5

Not Kind of A lot

When has the disaster happened before? Circle one

Never Sometimes A lot

If the disaster has not happened, what convinces you it will happen now?

1 2 3 4 5

Not well Kind of Really Well

Master of Disaster

What’s your explanation for the disaster happening?

I am ugly and people think I suck as a person.

What is another explanation for your sense it will happen again?

They are just mean and look for someone to pick on and make feel bad.

If your disaster has happened in the past, how did you handle it?

1 2 3 4 5

Not well Kind of Really Well
Master of Disaster

What did you do?
I really blew it. I got depressed, scratched on myself a little with an exacto knife, and stopped eating for a while.

If you did not handle it well, what is different about you now? What could you do now that would be helpful?
I am stronger now. I really can’t punish myself for other people’s bullsh-t just because they treat people like crap doesn’t mean I should treat myself like crap. Their opinions do not shape me. I’m not clay in their hands. I am just going to make myself who I am.

If you have a plan for the disaster, how bad could it be? How in control are you?
Really in control.

Master of Disaster

Conclusion
Although I let the girls control me before with their mean comments, I know not to let them do that again. What I do makes me who I am, not their opinions. I can handle their crap without cutting or stopping eating.
What is Required from the Clinician in an Experiential Procedure?

Psychological presence on the part of the clinician which allows for attention to be direct to the moment to moment actions in therapy

Direct, clear communication with the patient

Collaboration

Accurate & effective data collection

What is Required of the Clinician?

“Good clinical skills” (Friedberg, Gorman & Beidel, in press)

Welcoming the patient’s and therapist’s negative emotional arousal

Harvesting open and flexible attitudes in both the therapist and patient

Tolerating ambiguity in both the patient and therapist

Creativity

Performance Attainment

Need to be mindful of developmental issues (Kingery et al., 2006)

Use of rewards and parent involvement (contingent rewards)

Exposures should be seen as “experiments” (Gosch et al., 2006)

Following the experiment, data is analyzed (levels of distress, degree of mastery)
Performance Attainment

Patient is always the one in control!!!

Exposure should be to all aspects:
- Cognitive
- Behavioral
- Physiological
- Interpersonal
- Emotional

Educating the Patient re: Exposure

Things get worse before they get better
Lean into discomfort
Learning a new language (Huppert & Baker-Morisette, 2003)
Cave metaphor (Hembree et al., 2003)
House of cards metaphor

Therapeutic Alliance and Exposure

No one wants to do exposure
The task is to help them be willing to (Hayes et al., 1999; Hembree & Cahill, 2007)
Align with the patient vs. the distress
Performance Attainment
Focus is on the application of acquired skills
Way for the child to “show that I can” (Kendall et al., 1992)
Face what you fear
May be done gradually or fully (flooding)

Performance Attainment
• May be delivered imaginally or in vivo
• May include escape or distraction component
• Not just for anxiety
• May be a “common factor”
• Many ways to design exposures (Kendall et al., 2005)

Therapeutic Alliance and Exposure
Self-disclosure is helpful with children (Gosch et al., 2006)
Collaboration is key
Exposure

- Interoceptive exposure
- Worry exposure
- Imaginal exposure
- Graduated exposure
  - “lean into discomfort”
- Flooding (full exposure)
  - “dive into discomfort”
- In vivo
- Virtual Reality
- Imaginal

Creative Experiential Procedures (Friedberg et al., 2009)

- Games
- Crafts
- Improv theatre

Augmenting Engagement in Exposure

- “Describe what you see. What do you smell?
  - What emotions are you feeling?
  - What is running through your head?
  - Who is there with you?
  - What is happening inside your body?
  - What is the temperature in the room?”
Augmenting Imaginal Exposure
Dolls
Puppets
Articles of clothing
Video tapes
Audiotapes
Newspaper, books

Checklist for Exposure and Experiments
Checklist for exposures and behavioral experiments
Does the patient and family understand the rationale for exposure?
Is the exposure target properly specified?
Has the patient made predictions and rated their degree of belief?
Have you anticipated possible problems?
Is the experiment a no-lose situation? (“everything is data”)

Checklist for Exposure and Experiments—Con’t
How will the data be collected?
Have any medical issues been addressed?
Is the experiment graduated?
Have doubts and fears been therapeutically processed?
Are patient changes in bodily, behavioral, cognitive, and emotional being monitored?
Are you mindful about forms of avoidance and safety behaviors?
Performance Attainment

Sample exposure exercises

- Taking a test
- Read aloud in front of people
- Wearing a shirt inside out
- Do a silly dance
- Read in a made up language
- Breathe through a straw
- Pop a balloon
- Shred brochures

Performance Attainment

Praise

Tangible rewards

Badge of courage (Friedberg & McClure, 2002).

Cat’s Vomit Hierarchy

Practice “throwing up”  SUDS=10
Drink carbonated beverage quickly  SUDS=9
Hold water in mouth  SUDS=8
Put baby food on cheeks  SUDS=7
Smear baby food on hands  SUDS=6
Touch small bits of baby food on finger tips  SUDS=6
Smell baby food (green peas, ham)  SUDS=6
Listen to vomit sound effects  SUDS=5
Write the vomit book (I hurl, you hurl)  SUDS=5
### Molly’s Toilet Hierarchy

<table>
<thead>
<tr>
<th>Task</th>
<th>SUDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit and eliminate on automatic flush toilet</td>
<td>10</td>
</tr>
<tr>
<td>Sit and eliminate on manual flush toilet</td>
<td>10</td>
</tr>
<tr>
<td>Sit on toilet while flushing on automatic toilet</td>
<td>9</td>
</tr>
<tr>
<td>Sit on toilet while flushing toilet on manual toilet</td>
<td>8</td>
</tr>
<tr>
<td>Flush water down toilet while standing</td>
<td>7</td>
</tr>
</tbody>
</table>

### Molly’s Toilet Hierarchy, Con’t.

<table>
<thead>
<tr>
<th>Task</th>
<th>SUDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ride to glory</td>
<td>6</td>
</tr>
<tr>
<td>Listen to tape</td>
<td>6</td>
</tr>
<tr>
<td>Tape institutional toilets flushing</td>
<td>6</td>
</tr>
<tr>
<td>Listening to increasingly loud flushing sounds occurring unpredictably</td>
<td>5</td>
</tr>
<tr>
<td>Listening to increasingly loud flushing sounds controlled by self</td>
<td>5</td>
</tr>
</tbody>
</table>

### Checklist for Exposure and Experiments

- Does the patient and family understand the rationale for exposure?
- Is the exposure target properly specified?
- Has the patient made predictions and rated their degree of belief?
- Have you anticipated possible problems?
- Is the experiment a no-lose situation? (“everything is data”)
- How will the data be collected?
**Checklist for Exposure and Experiments**

- Have any medical issues been addressed?
- Is the experiment graduated?
- Have doubts and fears been therapeutically processed?
- Are patient changes in bodily, behavioral, cognitive, and emotions being monitored?
- Are you mindful about forms of avoidance and safety behaviors?

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**OBSESSIVE COMPULSIVE DISORDER**

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**Psychoeducation**
Psychoeducation

- Children and Adolescents
  - Oxford Series “It’s the thought that counts”
  - NIMH
  - AACAP
  - Anxiety Disorders of America
  - OCD Foundation
  - ABCT
  - About our kids
  - Dr. Barzvi [www.drbarzvi.com](http://www.drbarzvi.com)

False alarms
- Wave metaphor
- Hill metaphor (Wagner, 2000)

Target-monitoring
Self-monitoring and scaling

MAPPING
SCARED OCD scale
CY-BOCS
SUDS
Ladder
Thermometer
Bubble up
Control pie
Creates a Hierarchy

Cognitive Restructuring

Self-instruction: Separating the child from the OCD
Name the enemy (Fristad et al, 1999)
Name the OCD (March & Mulle, 1998)
It’s me, not OCD (Friedberg, McClure, Hillwig-Garcia, 2009)
Advantages and Disadvantages of the OCD (Purdon & Clark, 2005)
Facilitative Strategies

**Counting obsessions and compulsions**
- Gradually reduce the number of times an action is performed
- Change the way the counting is done
- Substitute something else for the counting (lists colors, months of the year, favorite sports teams) Be sure to vary the substitution!!
- Count to the “wrong” number

Treating Thought and Action Fusion

(Purdon & Clark, 2005, p.79)

“*The link between thoughts and action is INDIRECT. There are numerous factors that determine whether or not you carry out an action.*”

Thought-Action Fusion

*(Try to lose control)*

- Yelling something out loud in the waiting room
- Singing at the bus stop, in line at a restaurant
- Jumping up and down wildly in public
Facilitative Strategies

**Rituals: “Break the OCD rules” (Chansky, 2000)**
- Delay the ritual
- Shorten the ritual
- Do the ritual differently
- Do the ritual more slowly

**Make the rules conditional rather than absolute**
- “Might instead of will”
  - “I might contract AIDS if I sit in a chair with a spot on it instead of I will contract AIDS if I sit in a chair with a spot on it.”
  - “I might yell out a bad word in school if I don’t count 1-2-3 instead of I will yell out a bad if I don’t count 1-2-3.”

**Reducing checking (Chansky, 2000)**
- Identify danger zones
- Have a plan
- Mindfully decide how many times to check
  - Gradually reduce
- Put up signs (NO CHECKING ZONES)
- Make a checking budget
  - Have checking coupons (brightly colored cards)
Reducing Checking

Anti-checking strategies

- Leave a door open
- Leave a schoolbook at home
- Load the bookbag with your eyes closed
- Cover the mirror

Facilitative Strategies

Handling Reassurance Seeking (It's a form of checking) (Chansky, 2000)

- Have blocks of time for reassurance seeking and no checking times
- Have the child write the answer on the card
- Have reassurance seeking coupons
- Give points for not seeking reassurance
- Have the child alter the reassuring questions

Handling Reassurance Seeking - Continued

- Have reassurance seeking coupons
- Give points for not seeking reassurance
- Have the child alter the reassuring questions
  - Ask it incorrectly
  - Backward
  - Sing it
  - Make it nonsensical (are the Martians invading earth today?)
Cognitive Interventions
Cognitive reappraisal
Advantages/Disadvantages
Test of evidence
Reattribution

Cognitive Techniques
Cognitive continua
Metaphors
Decatastrophizing
Probability of harm
Monitoring of rituals
Challenging core beliefs (schema)

Exposure and Experiments
Therapeutic Adventures

Traditional
Musical contaminants
Germ scavenger hunt
Pop-up monkeys
Chinese finger trap (Hayes et al, 1999)
Family craft sets

APPLICATION TO FAMILIES

Ways to include parents/families in treatment

Coach
Contingency manager
Co-patients
CBT Family Therapy

Dattilio
- Emphasizes reciprocal interactions of family members' cognitions, emotions, actions, and relationships
- Appreciates systemic factors
- Remember reinforcement patterns are inherently systemic
- Family members strive to maintain the homeostasis
- Problems arise when member's cognitions and behaviors disrupt the homeostasis

Family schema

Beliefs bounce off each member

Family Schema: “Jointly held about mostly family phenomena such as day-to-day dilemmas and interactions. They may also pertain to non-family phenomena as well as cultural, political, and spiritual arenas” (Dattilio, 2002)

Family Schema

Partners combine their individual schemata to form family schema
- Child assimilates to family schema or family schema accommodates to children
### Modularity remains intact in Family Work

- Psychoeducation
- Target Monitoring
- Basic Behavioral Tasks
- Cognitive Restructuring
- Behavioral enactments

### Follows identical session structure

- Check in
- Agenda setting
- Session structure
- Processing session content
- Homework
- Feedback

### Target monitoring

- Circle of perception (Dattilio, 2000, 2002)
- Behavior logs
- Good/bad feelings
- Thought records
  - Individual thoughts
  - Family rules
Basic Behavioral Tasks
Often includes the classic behavioral parent/family therapy tasks of contingency management
Naturally mapping the Functional Analysis is key

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Basic Behavioral Tasks
Antecedent -> Behavior <- Consequence
Very difficult to implement if the FA is not done correctly
You want to see it for yourself

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Cognitive Restructuring
Traditional
- Test of evidence
- Reattribution
- Decatastrophizing
- Problem solving
Window of acceptability (Friedberg, 2006)
Acceptable and non-acceptable feelings
Shiny car metaphor

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Cognitive Restructuring

Window of acceptability (Friedberg, 2006)
Acceptable and non-acceptable feelings
Shiny car metaphor

Behavioral experiments

Getting to know you
Family crafts
The Blind Car (Boal, 1992)
Games
Homework

Summary
Depressed and anxious youth need an active form of treatment.
Lean into the discomfort associated with addressing more severe cases.
Anxious youth need skills and experience in approach behaviors.
CBT can be seamlessly integrated into family work.
Summary
Many techniques within each module
Lots of choices and flexibility
All modules may not be necessary for every child
Exposure/Experiments is a very powerful module
Active treatment is helpful

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