School-Based Cognitive-Behavioral Interventions

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A little about me…

- PhD in clinical psychology from LSU
- Clinical internship at Kennedy Krieger Institute at Johns Hopkins Medical Center
- Currently a postdoctoral fellow at Cognitive Behavioral Therapy Center of New Orleans (CBT NOLA)

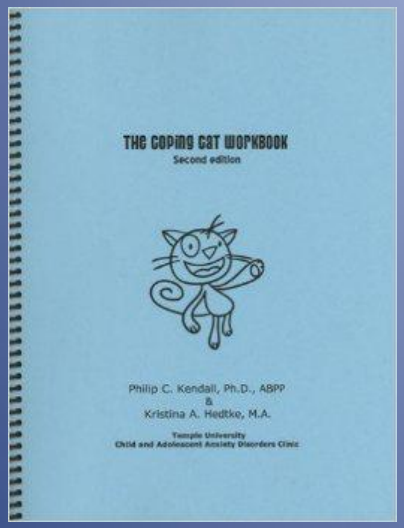
Overview

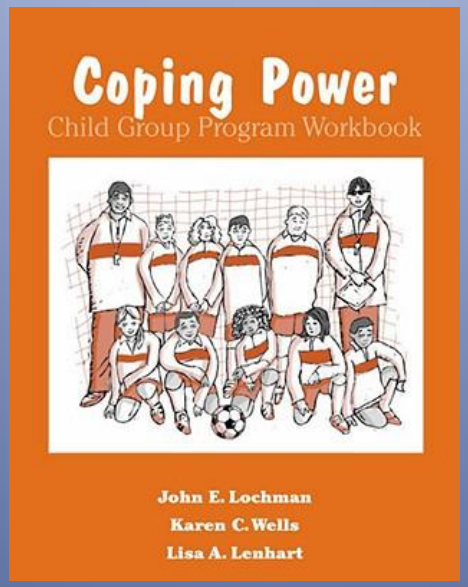
- Cognitive-Behavioral Therapy for Children and Adolescents
- Modular Approach to Treatment
- Frequently Used CBT Techniques
- CBT Techniques for Specific Problems

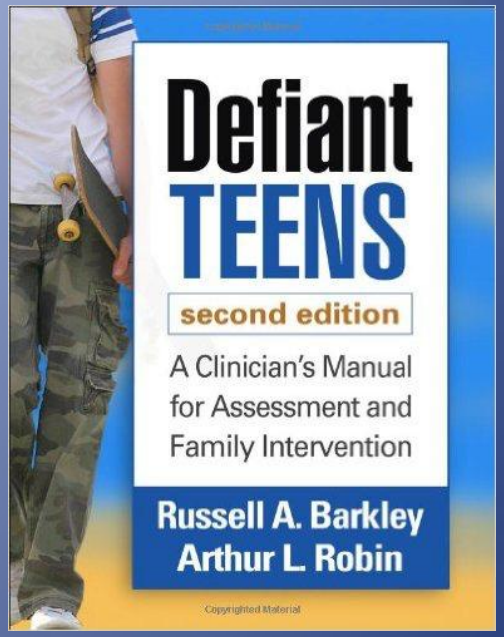
Why CBT?

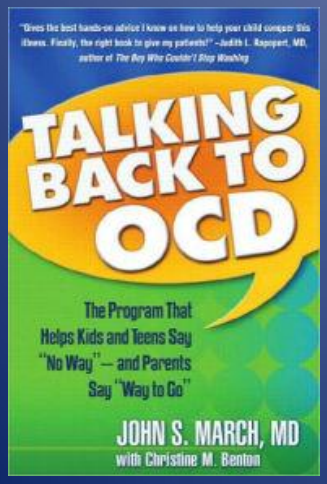
- Ever growing evidence base supporting the use of cognitive-behavioral interventions with children and adolescents (Ollendick & King, 2004; Kendall, 2006)
  - Anxiety (Chorpita, 2007)
  - Aggression (Glick & Gibbs, 2010)
  - ADHD (Goldstein & Goldstein, 1998)
  - Stress (Clarke, Lewinsohn, & Hops, 1990)
  - Depression (Curry & Reinecke, 2003)
  - Social Skills Training (Laugeson & Park, 2014)
  - Eating Disorders (Fischer, Doyle, & le Grange, 2009)

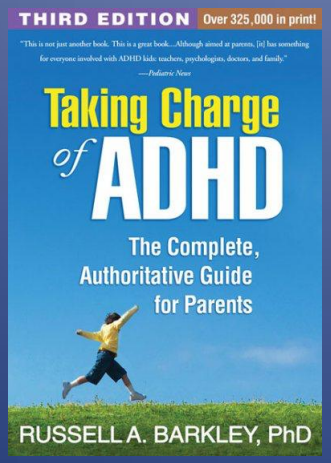
Treatment Manuals

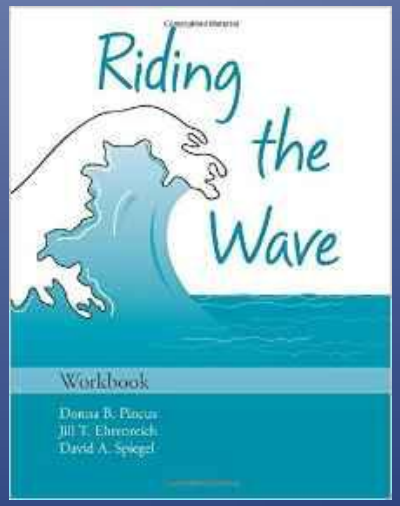


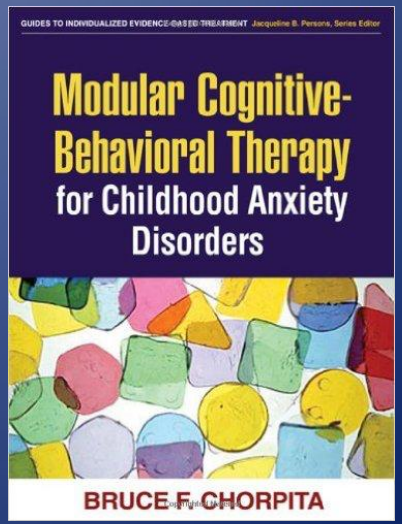












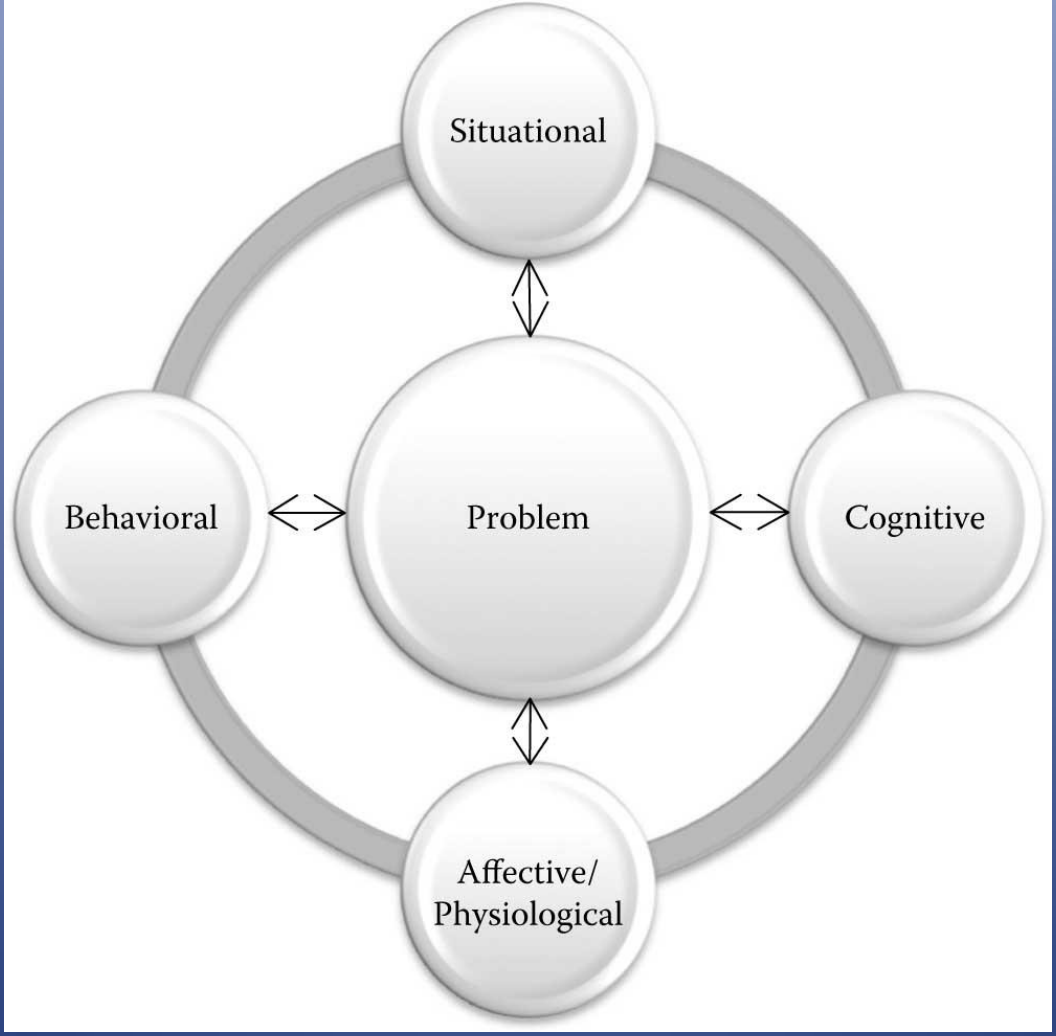
Problems with Manualized Treatments

- Lack flexibility
- Do not meet the individual needs of the child
- Barriers are rarely addressed
  - Time
  - Comorbidities

Modular Approach to Treatment

- Identify common practice elements found in manuals for specific problems and matching these modules with specific identified needs of an individual (Chorpita, Becker, & Daleiden, 2007)
- Structured flexibility
- No need to follow manual-based program session by session
- Allows for use of clinical judgment

CBT Model


Situational
Behavioral
Problem
Cognitive
Affective/
Physiological

CBT in Schools

- CBT's present-oriented, time-limited, and solution focused approach make it easily adaptable for educational environments
- Components of CBT Session
  - Agenda setting – goals for the time allotted
  - Psychoeducation
  - Skill building
  - Homework
- Emphasis on teaching skills
- Can offer interventions on a continuum
  - Prevention
  - Early identification
  - Individual therapy

CBT in Schools

- School SW provide a unique perspective
  - Access to teachers, peers, and performance outcomes
  - Natural laboratory
    - For gathering data on commonly faced problems
    - Provides a safe setting for social experiments
- Interventions have greatest effect when implemented close to natural setting (Goldstein & Goldstein, 1998)

Case Conceptualization

- Provisional description of an individual's presenting problems and a set of inferences about the maintaining factors
- Process follows a problem-solving approach that promotes individual and specific intervention planning
  - Avoids one-size-fits-all services
- Accounts for child's cognitive, affective, and behavioral functioning
  - Also multicultural issues, symptoms, history, relationships

Case Conceptualization

- Goes beyond “putting out fires”
- Based on hypotheses that are meant to be tested
- Should be a working document
  - Changes are made when evidence to do so is presented

Case Conceptualization

Cognitive-Behavioral Case Conceptualization Worksheet for Children and Adolescents

Client's Name: _____ Date of Birth: _____

Ethnicity: _____ Gender: _____ Age: _____

School/District: _____

Problem List

1. _____
2. _____
3. _____
4. _____
5. _____

Assessment Data (e.g., cognitive functioning, self-report, parent/teacher ratings)

Developmental Considerations

Working Hypothesis *(cognitive and/or behavioral)*

Origins of Working Hypothesis

Antecedents/Precipitating Factors

Maintaining Factors/Impediments to Change

Individual: _____

Teacher/Classroom: _____

Family: _____

Systemic: _____

Protective and Resiliency Factors

Diagnostic Impressions/Educational Classification

Intervention Plan

Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Modality: _____ Frequency: _____

Level of Intervention: _____

Level of Family Involvement: _____

Supplemental Interventions: _____

Barriers to Treatment: _____

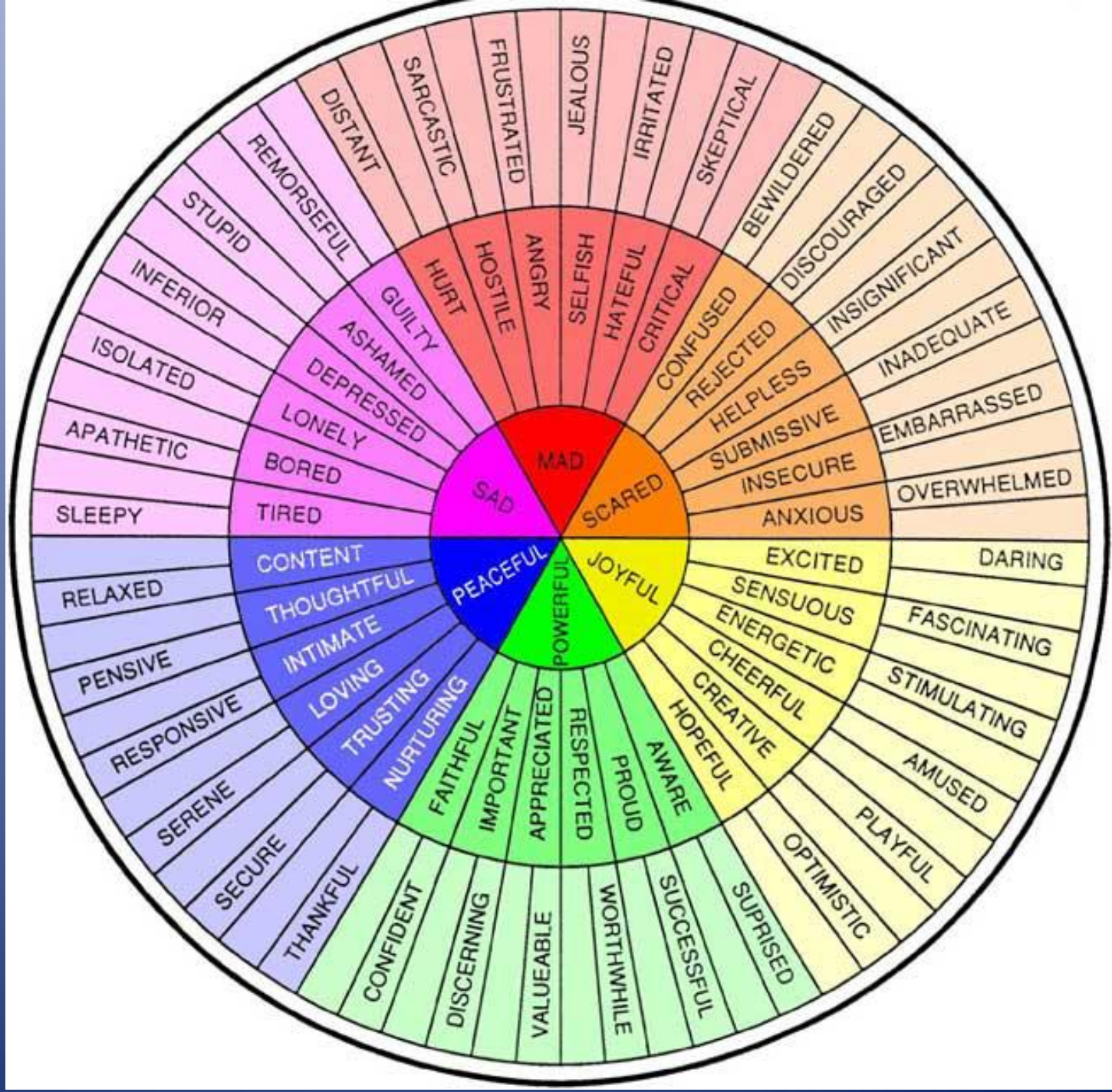
Commonly Used CBT Interventions

- Identifying Emotions
- Behavioral Activation
- Identifying Dysfunctional Thoughts
- Thought Testing
- Subjective Units of Distress (SUDs)
- Fear Hierarchy
- Exposure
- Problem Solving

Identifying Emotions

- Negative emotions are painful
  - Can interfere with a student's capacity to think clearly, solve problems, act effectively, and gain satisfaction
- Gives clinicians an opportunity to validate how students feel
  - Leads to discussion of dysfunctional thoughts and reactions to environmental stimuli
- Important to differential between thoughts and feelings

Identifying Emotions



Behavioral Activation

- Choose activities that child enjoys
- Better to go with active tasks rather than passive ones
- Make sure activities are reasonable
  - Not too expensive, will not get you into trouble, will not harm anyone
- Try to encourage activities that are goal-directed or social in nature
- Schedule events to ensure their completion
- Monitor mood

Daily Mood Scale

Name: _____ Date Started: _____

Day	____	____	____	____	____	____	____
Best	9	9	9	9	9	9	9
	8	8	8	8	8	8	8
	7	7	7	7	7	7	7
	6	6	6	6	6	6	6
Average	5	5	5	5	5	5	5
	4	4	4	4	4	4	4
	3	3	3	3	3	3	3
	2	2	2	2	2	2	2
Worst	1	1	1	1	1	1	1

Day	What happened?
____	_____
____	_____
____	_____
____	_____
____	_____
____	_____
____	_____

Identifying Dysfunctional Thoughts

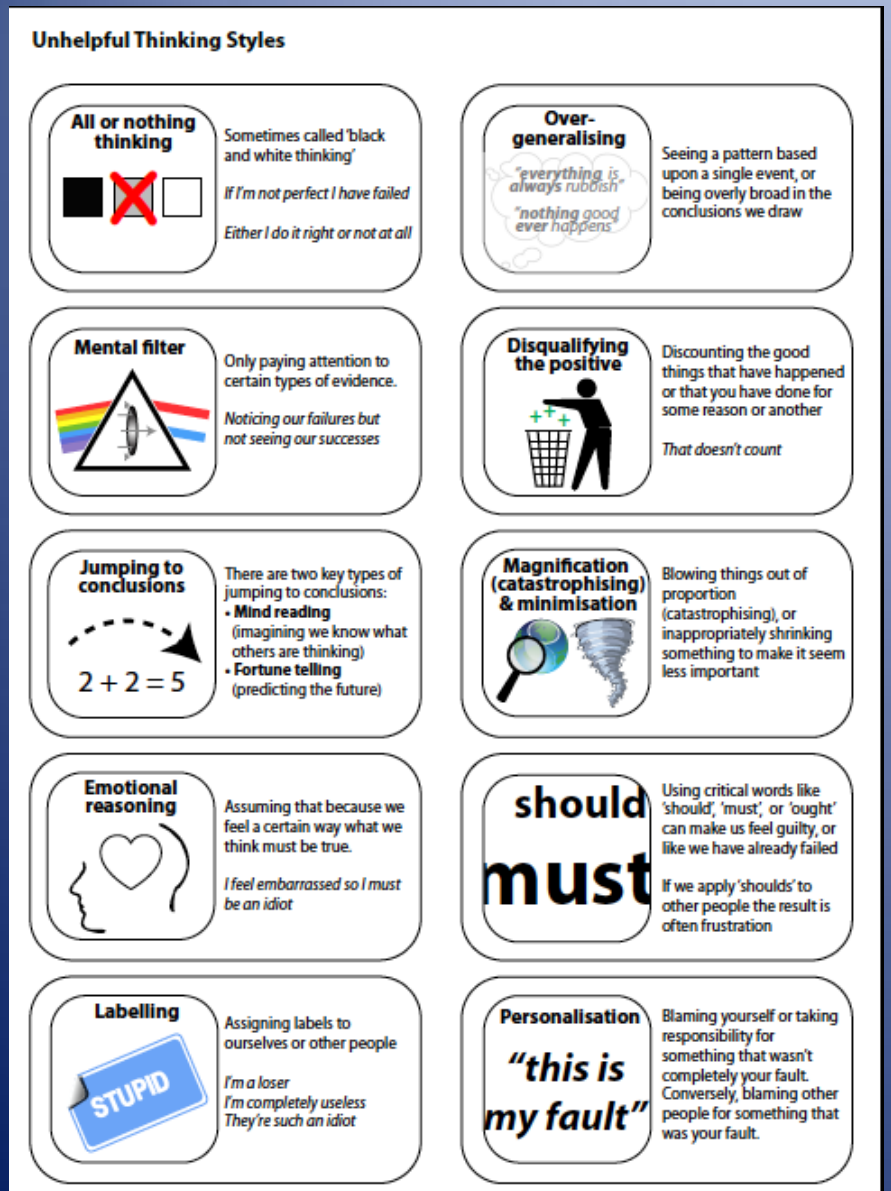
- Interpretation of a situation, rather than situation itself, influences one's subsequent emotion, behavior, and physiological response

- People in negative emotional states often misconstrue neutral or even positive situations
- By critically examining these interpretations (i.e., automatic thoughts) and correcting them, students can experience more positive emotions

Identifying Dysfunctional Thoughts

- We are barely aware of our thoughts
  - With practice, we can learn to bring our thoughts into our consciousness
- We often accept out initial reaction (i.e., automatic thought) as reality
  - "I don't understand (any of) this CBT stuff" → "I'll never understand it" → I'll never be a good clinician" → "I'll probably get fired"
- Dysfunctional thoughts seem to pop up randomly, but they become more predictable once a student's underlying beliefs are identified

Identifying Dysfunctional Thoughts



FORM B.2. Categories of Distorted Automatic Thoughts: A Guide for Patients

1. **Mind reading:** You assume that you know what people think without having sufficient evidence of their thoughts. "He thinks I'm a loser."
2. **Fortunetelling:** You predict the future negatively: Things will get worse, or there is danger ahead. "I'll fail that exam," or "I won't get the job."
3. **Catastrophizing:** You believe that what has happened or will happen will be so awful and unbearable that you won't be able to stand it. "It would be terrible if I failed."
4. **Labeling:** You assign global negative traits to yourself and others. "I'm undesirable," or "He's a rotten person."
5. **Discounting positives:** You claim that the positive things you or others do are trivial. "That's what wives are supposed to do—so it doesn't count when she's nice to me," or "Those successes were easy, so they don't matter."
6. **Negative filtering:** You focus almost exclusively on the negatives and seldom notice the positives. "Look at all of the people who don't like me."
7. **Overgeneralizing:** You perceive a global pattern of negatives on the basis of a single incident. "This generally happens to me. I seem to fail at a lot of things."
8. **Dichotomous thinking:** You view events or people in all-or-nothing terms. "I get rejected by everyone," or "It was a complete waste of time."
9. **Shoulds:** You interpret events in terms of how things should be, rather than simply focusing on what is. "I should do well. If I don't, then I'm a failure."
10. **Personalizing:** You attribute a disproportionate amount of the blame to yourself for negative events, and you fail to see that certain events are also caused by others. "The marriage ended because I failed."
11. **Blaming:** You focus on the other person as the *source of* your negative feelings, and you refuse to take responsibility for changing yourself. "She's to blame for the way I feel now," or "My parents caused all my problems."
12. **Unfair comparisons:** You interpret events in terms of standards that are unrealistic—for example, you focus primarily on others who do better than you and find yourself inferior in the comparison. "She's more successful than I am," or "Others did better than I did on the test."
13. **Regret orientation:** You focus on the idea that you could have done better in the past, rather on what you can do better now. "I could have had a better job if I had tried," or "I shouldn't have said that."
14. **What if?:** You keep asking a series of questions about "what if" something happens, and you fail to be satisfied with any of the answers. "Yeah, but what if I get anxious?" or "What if I can't catch my breath?"
15. **Emotional reasoning:** You let your feelings guide your interpretation of reality. "I feel depressed; therefore, my marriage is not working out."
16. **Inability to disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought "I'm unlovable," you reject as *irrelevant* any evidence that people like you. Consequently, your thought cannot be refuted. "That's not the real issue. There are deeper problems. There are other factors."
17. **Judgment focus:** You view yourself, others, and events in terms of evaluations as good–bad or superior–inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, and finding that you and others fall short. You are focused on the judgments of others as well as your own judgments of yourself. "I didn't perform well in college," or "If I take up tennis, I won't do well," or "Look how successful she is. I'm not successful."

Thought Testing

- Examine the validity of the automatic thought
- Explore the possibility of other interpretations
- Decatastrophize the problematic situation
- Recognize the impact of believing the automatic thought
- Gain distance from the thought
- Typically use Socratic dialogue

Thought Testing for Children

Thought Detective

Thought the challenge:

What's the evidence?

For your thought?

Against your thought?

Weigh the evidence. Which side wins?

What's the worst thing that could happen? How would you cope?

What's the best thing that could happen?

What will probably happen?

What would I tell a friend who was having the same thought?

What's my alternative thought?

Thought Testing for Adolescents

Testing Your Thoughts

Describe the situation: _____

What am I thinking or imagining? (Automatic Thought) _____

_____

How much do I believe the thought? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How does that thought make me feel? Afraid Angry Anxious Confused Depressed Embarrassed Frustrated Guilty Hurt Overwhelmed Sad Other _____

How strong is this feeling? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What makes me think the thought is true? _____

_____

What makes me think the thought is not true? _____

_____

What's the worst that could happen? What would I then do to cope? _____

_____

What's the best that could happen? _____

_____

What will probably happen? _____

_____

What would happen if I kept telling myself the original thought? _____

_____

What would I tell my friend if this happened to him or her? _____

_____

Any thinking errors showing up in this thought? All or Nothing Thinking Catastrophizing Labeling Mind Reading Magnification/Minimization Other _____

What's my balanced or alternative thought? _____

_____

How much do I believe the first thought now? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How strong is my negative feeling now? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Exposure

- Used to treat anxiety and irrational fears
- Step by Step Procedures
  1. Assessment of the avoidance behavior to determine what exactly the student fears
     - Assess for safety signals or other subtle avoidance behaviors
  2. Provide brief rationale for exposures
  3. Generate fear hierarchy
     - Assess SUDs for each feared situation

Exposure

- Step by Step Procedures
  4. Begin repeated, systematic exposure to feared items
     - Typically start on items with low fear ratings and work up
     - Done with therapist (model)
     - Monitor SUDs throughout exposure
     - Sit with anxiety; no avoiding
  5. Once a feared item elicits only mild fear, move to next item on fear hierarchy
  6. Assign exposures for homework
  7. Review progress; give feedback

Assessing Distress Level

Subjective Units of Distress Scale (SUDS)

100 = Feels unbearably bad, beside yourself, out of control as in a nervous breakdown. You probably need to be admitted to a psychiatric emergency room.

90 = Feeling desperate. What most people call a 100 is actually a 90. Extremely freaked out. It almost feels unbearable and you are getting scared of what you might do. Feeling very, very bad. Starting to lose control of your emotions.

80 = Freaking out. Some definitely bad feelings.

70 = Starting to freak out, on the edge. You can maintain control with difficulty.

60 = Feeling bad. You begin to think something ought to be done about the way you feel.

50 = Moderately upset, uncomfortable. Unpleasant feelings still manageable with some effort.

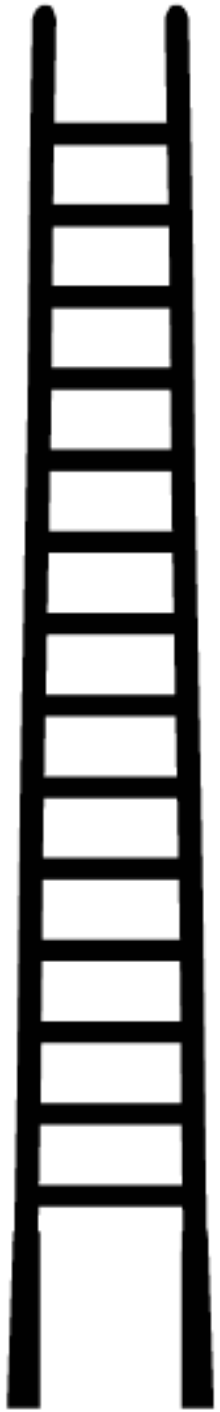
40 = Somewhat upset and you cannot easily ignore the unpleasant thought. Can handle it OK but don't feel good.

30 = Mildly upset. Bothered to the point that you notice it.

20 = A little bit upset but not noticeable unless you took care to pay attention to your feelings and then realize, "yes" there is something bothering me.

10 = No acute distress and feeling basically good. Perhaps deep down, if you looked hard, you might notice something a slightly unpleasant but not much.

0 = Peace, serenity, total relief. No more anxiety of any kind about any particular issue.



Situation	Anxiety (0-100%)

Fear Hierarchy

Exposure

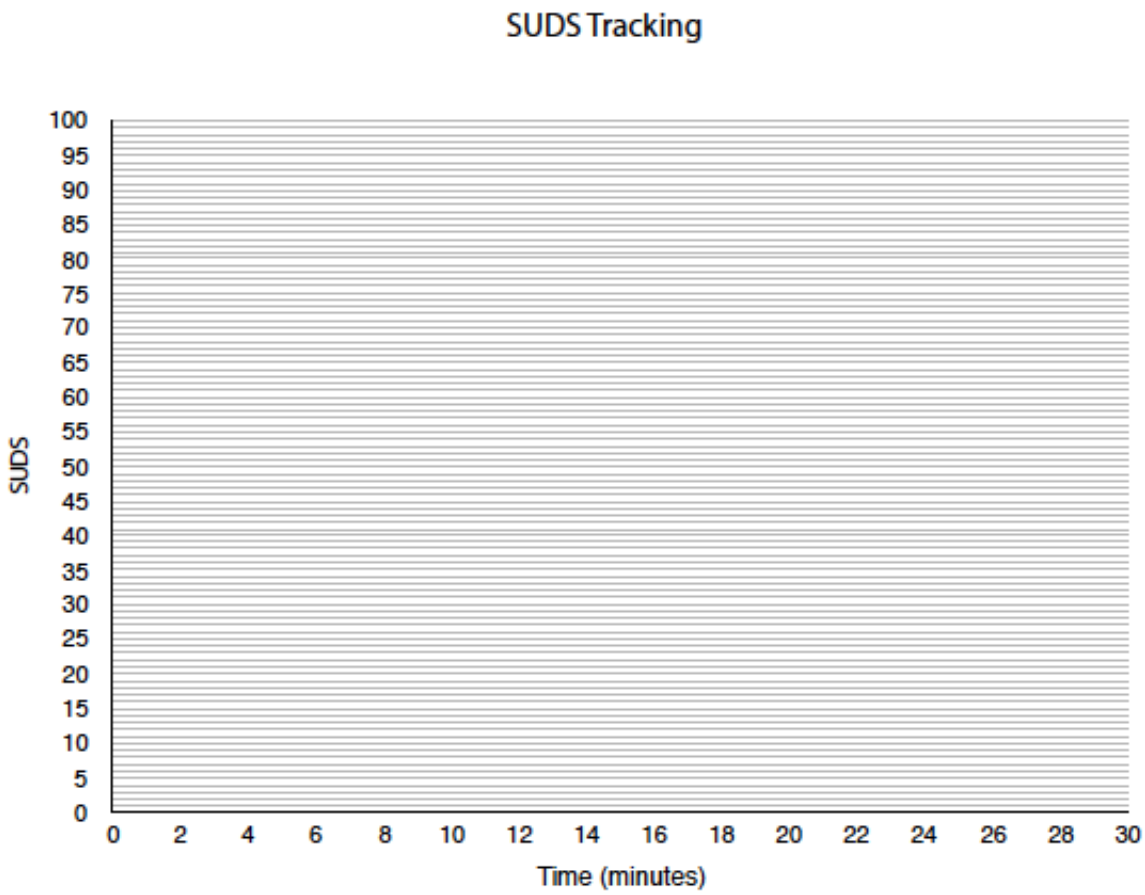
- How does it work?
  - Extinction – CS is repeatedly presented in the absence of the aversive US
  - Cognitive restructuring – patients learn to that the feared stimuli are harmless
- Habituation - diminishing of a physiological or emotional response to a frequently repeated stimulus
- Testing hypotheses
  - What are your expectations of this event?
  - What is the feared outcome?

Exposure Record

What are you going to do:

Expected SUDS (0-100):

Hypothesis to test:



Exposure

Problem Solving

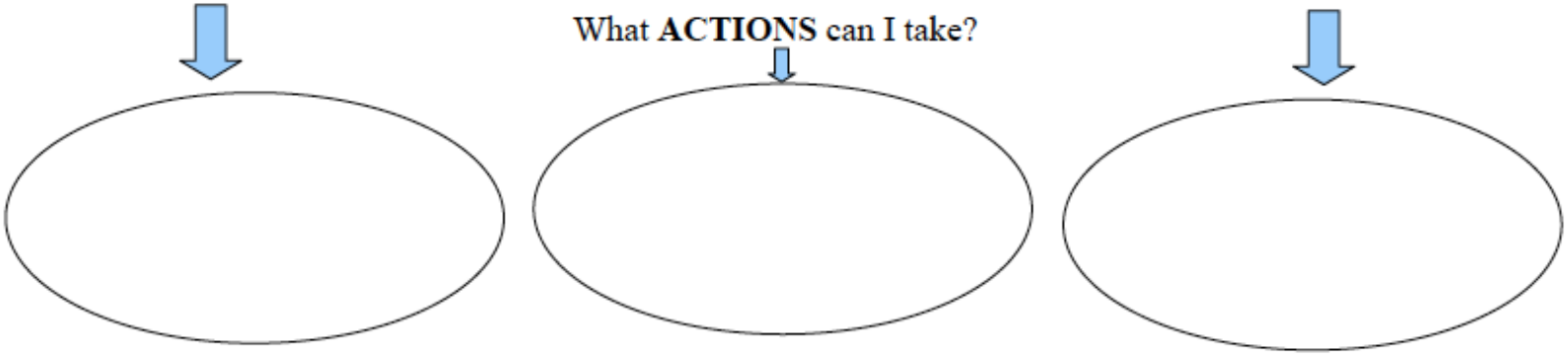
- Problems are an ubiquitous part of life
- Inadequate problem solving is associated with a host of psychological problems
- Three broad steps
  - Generate a variety of potentially effective solutions to a problem
  - Judiciously chooses the best of these solutions
  - Implements and evaluates the chosen solution
- Used to treat a variety of disorders
- Because it's a broadly applicable coping skill, it often serves a dual purpose
  - Treats the immediate problems
  - Prepares patients to deal with future problems on their own; may prevent new symptoms from developing

Problem Solving

Problem Solving Activity

What is the **PROBLEM**?

What **ACTIONS** can I take?



What are the good and bad **CONSEQUENCES** of those actions?

Good	Bad
1.	1.
2.	2.
3.	3.

Good	Bad
1.	1.
2.	2.
3.	3.

Good	Bad
1.	1.
2.	2.
3.	3.

EVALUATE 1-5:

1 2 3 4 5

1 2 3 4 5

1 2 3 4 5

DO the best action!!

Helpful Books