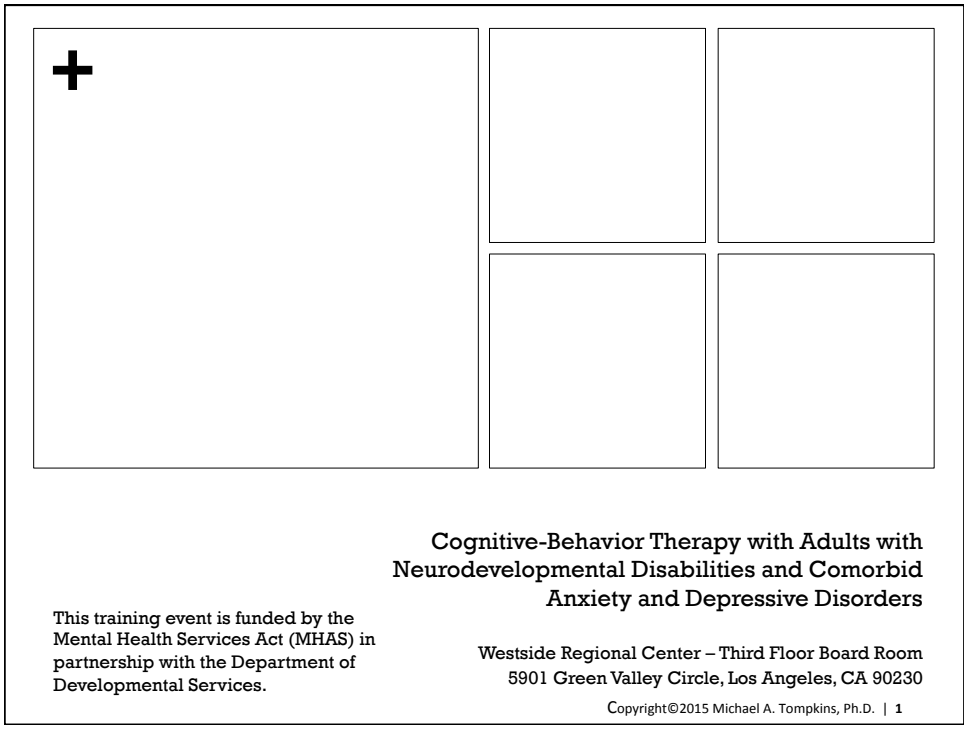
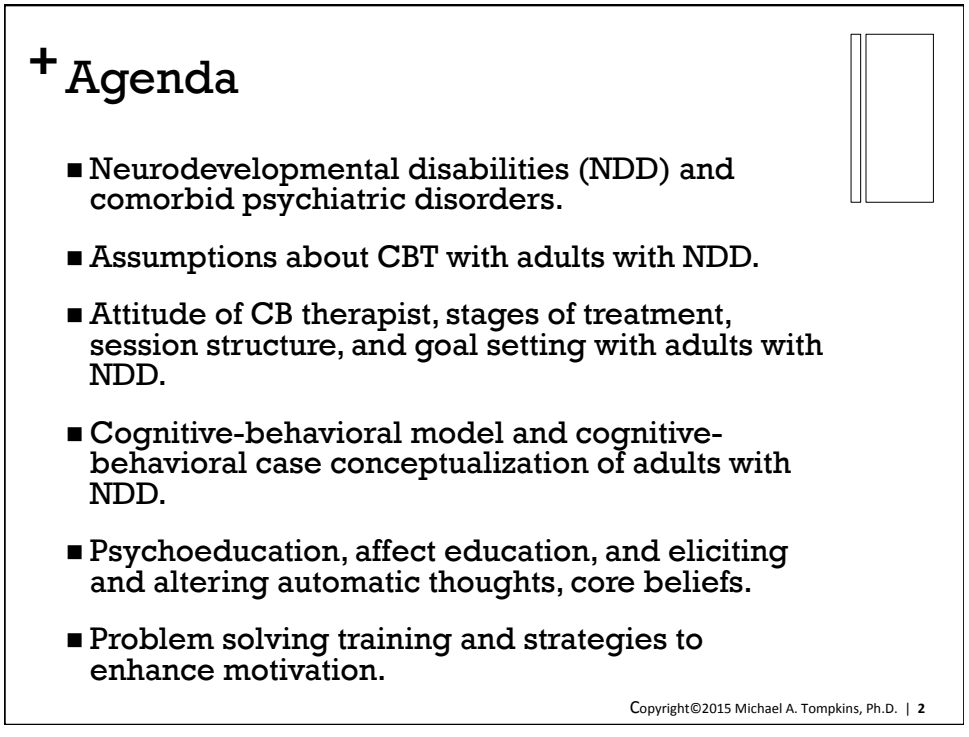


Cognitive-Behavior Therapy with Adults with Neurodevelopmental Disabilities and Comorbid Anxiety and Depressive Disorders

This training event is funded by the Mental Health Services Act (MHAS) in partnership with the Department of Developmental Services.

Westside Regional Center – Third Floor Board Room
5901 Green Valley Circle, Los Angeles, CA 90230



Agenda

- Neurodevelopmental disabilities (NDD) and comorbid psychiatric disorders.
- Assumptions about CBT with adults with NDD.
- Attitude of CB therapist, stages of treatment, session structure, and goal setting with adults with NDD.
- Cognitive-behavioral model and cognitive-behavioral case conceptualization of adults with NDD.
- Psychoeducation, affect education, and eliciting and altering automatic thoughts, core beliefs.
- Problem solving training and strategies to enhance motivation.

This training event is funded by the Mental Health Services Act (MHSA) in partnership with the Department of Developmental Services.

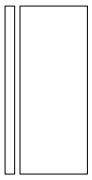
Five Minute Reflection

- What two things (specific or general) would you like to learn from this workshop?
- Why is it important to you and to your clinical practice to learn these things?

Neurodevelopmental Disabilities and Comorbid Psychiatric Disorders

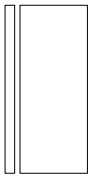
This training event is funded by the Mental Health Services Act (MHSA) in partnership with the Department of Developmental Services.

+ Types of Neurodevelopmental Disabilities (DSM-5)



- Intellectual disability (Intellectual Developmental Disorder).
- Communication disorders.
- Autism spectrum disorder.
- Attention deficit-hyperactivity disorder.
- Specific learning disorders.
- Motor disorders.

+ Comorbid Mental Disorders in NDD Adults



- Difficult to accurately diagnose comorbid mental disorders; symptoms of NDD can mimic symptoms of other disorders (e.g., compulsions vs. fixed interest, anxiety in social situations, tics vs. stereotypic behaviors).
- Comorbid mental disorders often missed because the clinician may recognize only the developmental delay and attribute any odd behaviors to that condition (Silka & Hauser, 1997).
- Case conceptualizations are complex with multiple maintaining variables making treatment of comorbid conditions difficult.

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Clients with NDD May Seek Treatment

- When the client regresses in function secondary to a life event that the client does not have the skills to cope with effectively.
- When the client experiences an unexpected change, small or large, situational or environmental, or developmental.
- When the client becomes aware of the growing disparity between what he can or is doing and what he could or isn't doing.

Common Comorbid Mental Disorders in Adults with Neurodevelopmental Disorders

This training event is funded by the Mental Health Services Act (MHSA) in partnership with the Department of Developmental Services.

Anxiety and Anxiety Disorders in Adults with NDD

- Adults with NDD may meet criteria for an anxiety or mood disorder apart from the anxiety and depression that typically accompanies these disabilities.
- Difficult to accurately diagnose anxiety disorders because adults with NDD may have poor self-awareness of the cognitions linked to their anxious response.
- Perhaps 15-20% of adults with NDD have a comorbid anxiety disorder (Levy et al., 2010).
- Social anxiety disorder, specific phobias (Leyfer et al., 2006), and obsessive-compulsive disorder (Ruscio et al., 2010) most common.

Depression and Depressive Disorders in Adults with NDD

- Depression is frequently undiagnosed and more likely to be overlooked in adults with NDD, perhaps as many as 30% of adults with NDD have comorbid depressive disorder.
- Depression is one of the most frequent psychiatric disorders in adults with intellectual disability (Richards et al., 2001).
- Is client doing what s/he normally doe during the day? Does client complain that s/he doesn't feel like doing things anymore? Is it harder for the staff to encourage client to participate?

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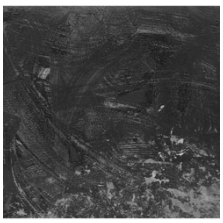
Cognitive-Behavior Therapy



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Definition of Cognitive-Behavior Therapy

- Cognitive-behavior therapy is a focused form of psychotherapy based on a model stipulating that psychological disorders involve dysfunctional thinking.
- Modifying dysfunctional thinking provides improvement in symptoms; modifying dysfunctional beliefs which underlie dysfunctional thinking leads to more durable improvement.
- Cognitive therapy treatment involves a cognitive conceptualization of the disorder and of the particular patient and uses a variety of techniques.

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+ Cognitive-Behavior Therapy with NDD Adults

- Focused on remediating core deficits of the particular NDD.
- Focused on treating common comorbidities in adults with NDD.

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+ General Principles of Cognitive-Behavior Therapy

- Semi-structured (but flexible and creative), efficient, active, guided by case conceptualization and a hypothesis-testing approach.
- Collaborative, respectful, and founded on a strong therapeutic alliance.
- Focused on developing skills and self-efficacy that these skills can be applied effectively to problems.
- Interventions focused on cognitive change (flexibility), in the service of behavioral and emotional change.

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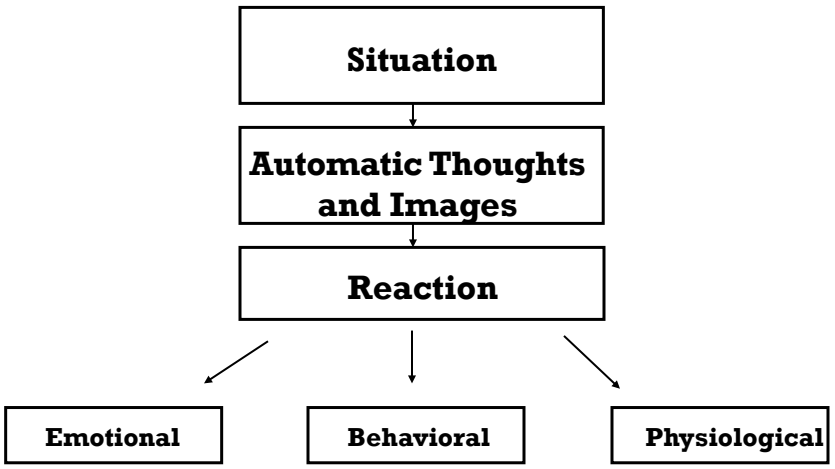
+ Cognitive-Behavioral Model



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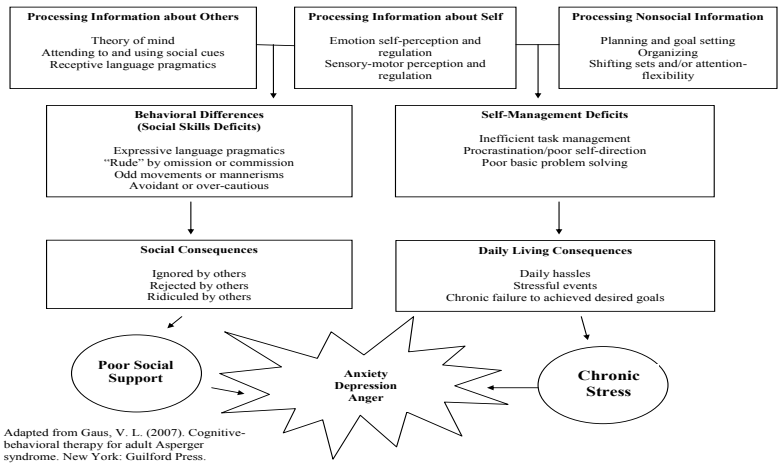
+ Neurocognitive Processes and Conceptualization



Adapted from Gaus, V. L. (2007). Cognitive-behavioral therapy for adult Asperger syndrome. New York: Guilford Press.

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Essential Components of Cognitive-Behavior Therapy?

- Cognitive-behavioral conceptualization.
- Problem-solving orientation.
- Structured session.
- Action plans (out-of-session homework).
- Evaluation of thoughts and core beliefs.
- Behavioral change.
- Relapse prevention.

Assumptions and Goals of CBT with Adults with Neurodevelopmental Disorders

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+ Principle Assumptions Regarding CBT for Adults with NDD

- Individuals with NDD can have normal intelligence and verbal abilities, can learn and can have the same mental health problems as non-NDD individuals.
- Individuals with NDD can benefit from CBT when the treatment considers their inherent neurocognitive weaknesses and is strength-based with a developmental perspective.
- Typically, when treating comorbid anxiety disorders and depressive disorders, the CB therapist must address both the deficits and the comorbid conditions.
- Individuals with NDD and other mental health disorders benefit from multifaceted, individualized treatment plans.
- Comorbid mental health problems as well as the suffering and distress experienced by adults with NDD are influenced by their idiosyncratic and atypical information processing system.

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+ Goals of CBT with Adults with NDD and Co-occurring Problems

- Teach compensatory strategies for deficits that cannot be changed.
- Teach new cognitive and behavioral strategies that were never learned to decrease or manage symptoms of comorbid mental health problems.

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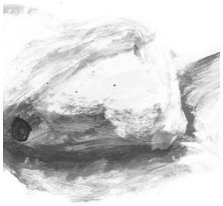
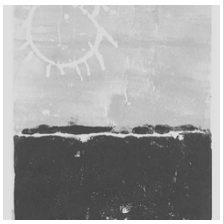
Adjustments to CBT with Adults with Neurodevelopmental Disorders and Comorbid Conditions





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Adjustments to CBT Sessions

- Develop conceptualizations and adjust and stage interventions for anxiety and mood disorders that consider the neurocognitive strengths and weakness of adults with NDD.
- Slow down speech and use language that client understands; present information one item at a time – chunk.
- Solicit feedback frequently to check that client understood correctly; make specific suggestions.
- Build in time to practice, practice, practice skills; do not assume that client will generalize information or skills to new situations, devise ways to do this.
- Client may benefit from shorter sessions; set aside time at end of session to do something fun with the client to allow the person to re-center before leaving therapy session.

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+ Adjustments to Skills Development

- Build a basic feeling vocabulary; and restrict number of feelings taught.
- Emphasize behavioral over cognitive interventions.
- Use multisensory teaching tools and include extensive in-session and out-of-session practice.
- Use repetition in creative ways; use examples from client's situation and life; present information in different ways and keep at it.
- Be patient – client may repeatedly return to inaccurate or unhelpful cognitions or solutions. They can get it but it takes longer.

+ Increase Emphasis on Affect Education

- Adults with NDD can have trouble recognizing and interpreting their own emotions, which can make it difficult for them to know when they are feeling anxious or depressed.
- Affective education includes training in what emotions are, why they are important, and to recognize an emotion.
- Practical and concrete affective education strategies are best (e.g., notebook of feelings, photos or drawings of feelings, visual games).

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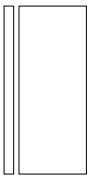
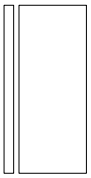
+ Increase Use of Visual Strategies



- Adults with NDD often benefit from more visual and concrete learning aides.
- Use multisensory input (visual, aural, tactile).
- Worksheets, multiple-choice lists, drawings (e.g., where they feel emotions in their bodies, colors corresponding to emotions, blended feelings).
- Thought bubbles, watching movies with volume off and writing scripts of thoughts-feelings-actions.
- Comic books that describe the situations that elicit their particular emotion and how they respond.

+ Incorporate Special Interests in the Rationale and Use of Interventions



- Adults with NDD can have difficulty with social engagement (for a variety of reasons) and fixed interests that limit cognitive and behavioral flexibility.
- Use these special interests to motivate adults with NDD to engage in treatment in and out of session.
- Integrate special interests in choice of metaphors to teach a skill; to provide a rationale for an intervention.

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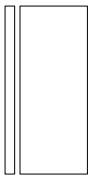
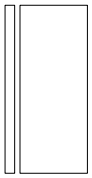
+ Increase Use of Prompting



- Adults with NDD struggle with executive function deficits that influence encoding and follow through; include multiple caregivers in various environments to prompt and reinforce use of skills and behaviors.
- Technological strategies can assist prompting for new behaviors, to practice of skills out-of-session, and to assist generalization.
- Erosion in self-awareness can be rapid for adults with NDD. Include affect education and awareness training throughout treatment and as part of ongoing follow-up meetings.

+ Target Social Skills and Communication Deficits



- Adults with NDD are often anxious and depressed as a result of repeated consequences (social and academic) related to social skills and communication deficits and more broadly, cognitive and behavioral inflexibility.
- Include modules on social skills training or other skills training (e.g., problem-solving, decision-making) conceptualized to influence anxiety and mood.

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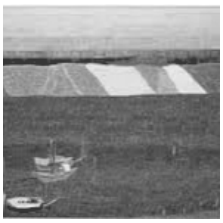
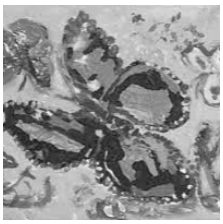
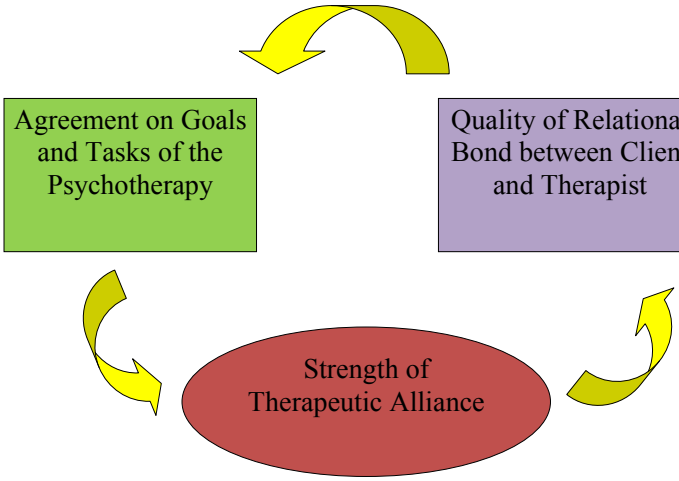
Attitude and Stance of Cognitive-Behavioral Therapist





Model of Therapeutic Alliance



Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research, and Practice, 16, 252-260.

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+ Attitude and Stance

- Compassionate
- Curious
- Collaborative.
- Pragmatic
- Active
- Firm but flexible

+ Guided Discovery

- Listen.
- Ask informational questions.
- Use summaries.
- Ask synthesizing and reflective questions.

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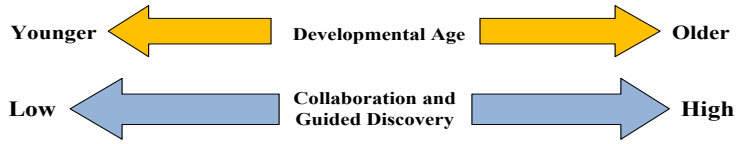
Collaboration & Guided Discovery



Early in treatment	Late in treatment
High acuity	Low acuity
Low motivation	High motivation
Passive, dependent	Active, autonomous
Less reactant to control	Highly reactant to control
Low tolerance for ambiguity (concrete)	High tolerance for ambiguity
Low frustration tolerance	High frustration tolerance
High impulsivity	Low impulsivity
High cultural prescriptions regarding obedience to authority	Low cultural prescriptions regarding obedience to authority
High cultural prescriptions regarding questioning rather than directing	Low cultural prescriptions regarding questioning rather than directing

Adapted from: Friedberg, R. D., & McClure, J. M. (2002). *Clinical practice of cognitive therapy with children and adolescents: The nuts and bolts*. New York: Guilford Press.

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Guided Discovery and Socratic Dialog

- Try this first -- "What helped you feel less anxious when you were anxious like this before?" then offer suggestions – "In the past taking a calming breath helped. Do you think that might have helped if you had thought about it."
- Try this first -- "Did writing in your journal help last time you felt anxious? Do you think that might help again." then give direct suggestion -- "Next time you're anxious, just write in your journal."

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Other Ways to Guide

- "Can you give me a specific example?"
- "What would you tell a friend if s/he were in this same situation?"
- "What could you do to help with this situation?"
- "Are there other ways to look at this situation?"
- "Have you looked at this same situation in different way in the past? Did that help?"
- "What are the clues that tell you it's true or not be true?"
- "Is this true for everyone in your situation?"

Exercise – Cognitive Restructuring

- **Practice guided discover to help the "client" find the restroom in this building. I'll go first.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells ''client'' whether to play the client ''easy,'' ''medium,'' or ''hard.''
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the ''client'' roleplayer.

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Stages of Treatment

Stages of of Cognitive-Behavior Therapy

Early
- Engage and set goals
- Socialize to structure of session, rationale for approach
- Educate regarding cognitive model
- Gather information and begin conceptualization process

Middle
- Conceptualize case and plan treatment
- Implement cognitive strategies
- Implement attentional training

Late
- Implement behavioral exposure strategies
- Develop relapse prevention plan

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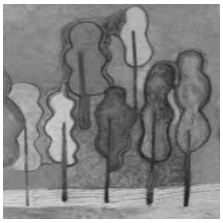
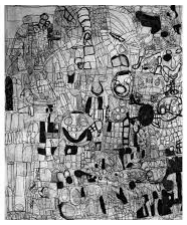
Session Structure





Rationale for Structured Session

- Assists therapist in using therapy time efficiently so as to carry out interventions and to accomplish treatment goals.
- Models the types of skills and behaviors that are being taught in therapy (i.e., goal-oriented, active, problem solving focused on concrete specific problems).

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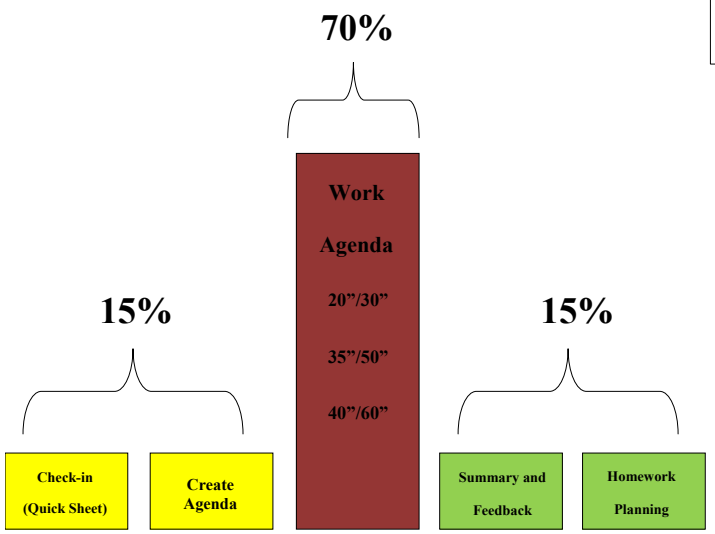
Structure of CBT Session



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Check-in

- Mood check-in (0-10) provides information on possible benefits of last session and treatment progress in general.
- Reactions to last session -- "What do you remember about last session?" "Did anything stand out for you about last time?" "What did you find yourself thinking about after our last meeting?" "Was there anything that bothered you?"
- Homework review – "Last time we agreed that you would try … How did that go?"

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+ Guidelines for Successful Check-In

- Strive for brevity (2-5 minutes).
- Distinguish check-in from body of therapy session.
- Look for opportunities to make a check-in item an agenda item.
- Use to debrief from last session, particularly if session was difficult.
- Use to bridge from last session.

+ Agenda

- Agenda is short list of topics that client and therapist agree will be focus of therapy session.
- Agenda is created collaboratively to enhance willingness of client to participate in work of session.
- Agenda is linked to treatment goals and provides a roadmap for therapy.
- Agenda models for client that problems can be solved when approached collaboratively and systematically.
- Agenda focuses on session and therapy anchors (new and old situations or problems, thoughts or emotions); or any point or matter about the therapy itself (e.g., changes in meeting time, reports from the client about a meeting with an adjunct therapist).

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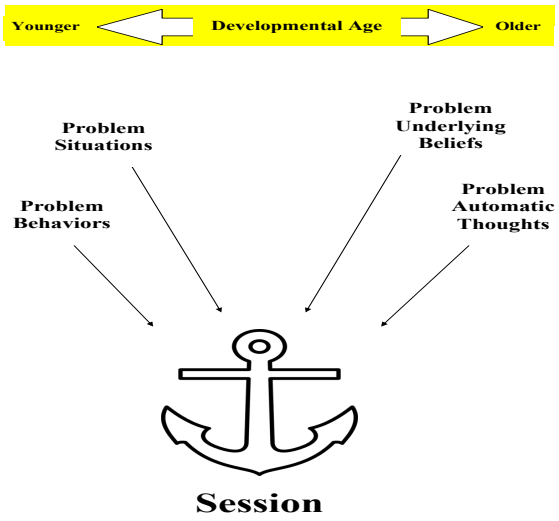
Session Anchors Direct Therapy



Guidelines for Successful Agenda Setting

- Agenda is set collaboratively but keep eye on treatment goals; then prioritize.
- Keep treatment goals in mind – if client has trouble identifying agenda item, review goals.
- Agenda items are clear and specific – if client is vague, ask for concrete ways to work toward goals.
- Be realistic – ask client to identify 1 or 2 things that s/he could accomplish in the session that would help him/her feel better and give a sense of progress.

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+ Homework (Action) Plan

- Homework helps client learn and strengthen new skills between sessions.
- Homework helps client practice newly learned skills in natural environments.
- Homework communicates practice, perseverance, and patience is important.

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+ Summary and Feedback

- Summaries at end of session helps client focus on and remember what is important and strengthens collaboration; summaries at end of session underscore what was learned and why this was important.
- Ask client to summarize main points of session.
- Ask client what was most/least helpful.
- Enables therapist to shift or modify focus of session.
- Helps guide development of action plan.

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Putting it All Together - Structuring a CBT Session

- Check-in.
- Setting the agenda.
- Working the agenda.
- Assigning homework.
- Soliciting feedback.

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Goal Setting

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+ Guidelines for Setting Goals

- Identify several target problems and work with client to prioritize.
- Translate high priority problems into treatment goals.
- Link work of session, rationale for all interventions, and for any practice assignment to the client's treatment goals.
- Convert stop problems or behaviors (fighting with my friends) to start problems or behaviors (spending more easy and fun time with my friends).

+ General vs. Specific Goals

General – I don't want to feel dumb.
Specific – I want to pass math this semester.

General – I want to be happier.
Specific – I'd like to hangout with my friends and play basketball

General – I don't want to freak out when I go outside.
Specific – I don't want to be afraid of spiders when I see them three feet away.

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Cognitive-Behavioral Model of Adults with Neurodevelopmental Disorders and Comorbid Psychiatric Disorders

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Types of Thoughts and Beliefs

- Automatic thoughts – quick evaluative thoughts or images that are situation specific.
- Intermediate beliefs – rules or assumptions about life "If __ , then __ ."
- Core beliefs – deeply held, rigid beliefs about self, others, and the world.

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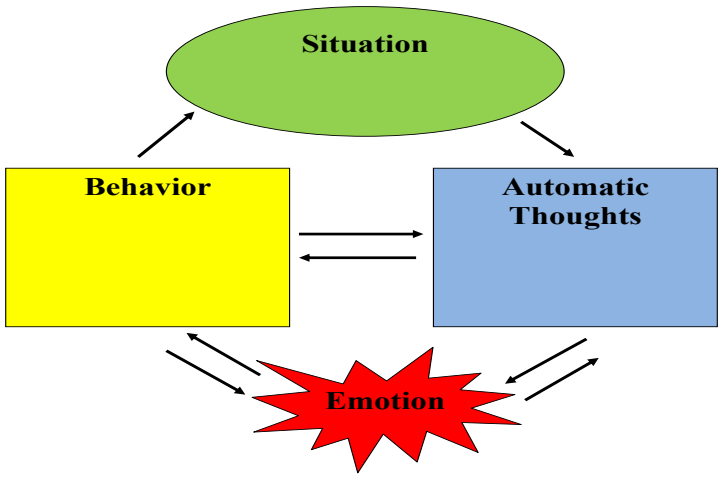
Automatic Thoughts

- Generally arise spontaneously, are brief and fleeting; co-exist with more manifest stream of thoughts, and often unnoticed; client more likely to notice emotion, somatic sensations, or problem behaviors that automatic thoughts; may be in verbal or imaginal forms.
- When you notice a strong response (emotional, behavioral), ask client – "What was going through my mind just then."
- Associated with specific emotions that depend on their content and meaning; thoughts can become next situation (e.g., when client has negative thoughts about his or her thoughts or reactions.
- Even when recognized, client generally accepts automatic thought as true, without reflection.

General Cognitive Model



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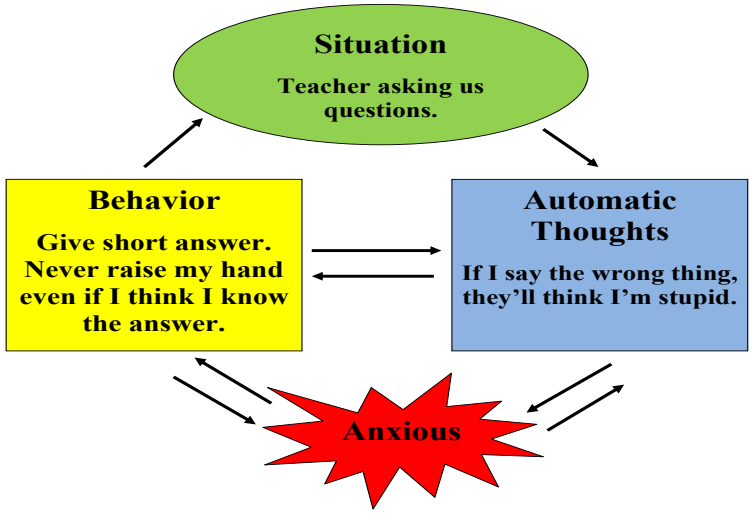
Cognitive Model for Anjanae



Exercise – Relationship between Automatic Thoughts and Emotions or Behaviors

Which automatic thoughts might be associated with which emotion or behaviors?

- Situation:
- Automatic Thoughts:
- Emotion(s):
- Behavior(s):

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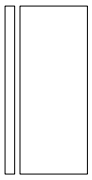
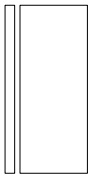
+ Conditional Assumptions and Rules (Intermediate Beliefs)



- Often the most difficult category of belief to identify accurately; intermediate beliefs are the link between core beliefs and coping strategy (maladaptive behaviors).
- Attitudes, rules, assumptions that stem from core beliefs and fuel automatic thoughts.
- Often, if the form of if-then statements. If (I do my coping strategy), then (I'll be okay). If (I don't do my coping strategy), then (my core belief may be true) (e.g., "If I can't do this perfectly, they why bother trying?" "If I open up to people, then they'll hurt me.").

+ Core Beliefs



- Most central, fundamental beliefs about ourselves, others, and the world.
- Three typical categories of core beliefs: incompetent, unlovable, worthless.
- Absolute and rigid, usually in 1-2 words – "I'm worthless" "I'm fragile."
- May result in biases in attention, information processing, and memory.
- When activated, core beliefs are the lenses through which we interpret situations.

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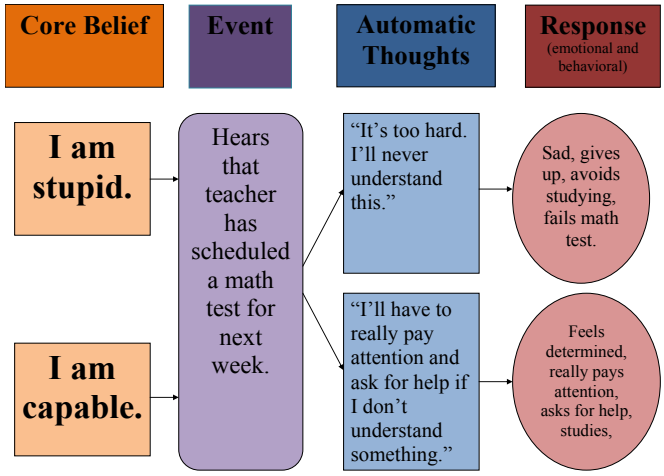
Core Beliefs Influence Thoughts



Adapted from Creed, Reisweber, & Beck (2011). Cognitive therapy for adolescents in school settings. New York: Guilford Press.

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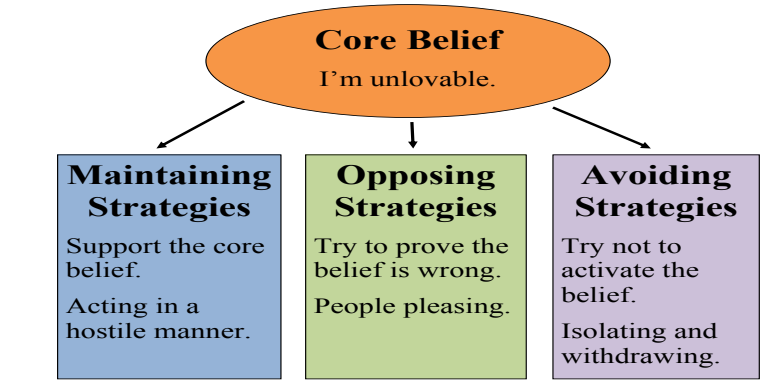
Compensatory (Coping) Strategies

Actions (behaviors) or thought actions that either support or oppose beliefs:



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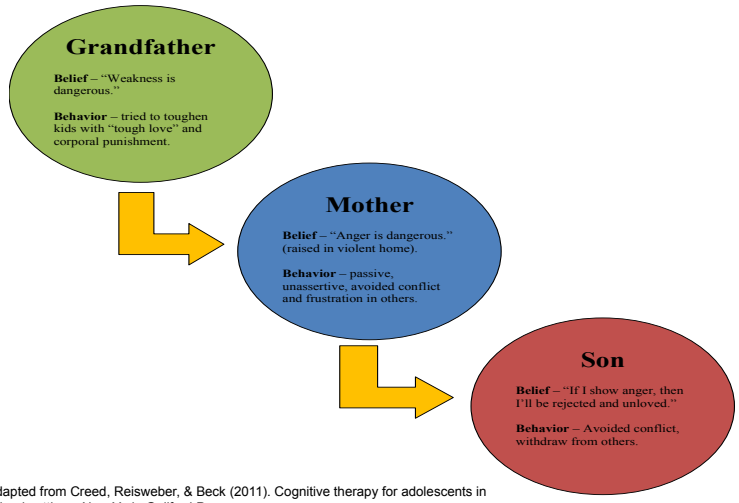
+ Environmental and Social Factors in Development of Beliefs and Compensatory Strategies

- Core beliefs and behavioral patterns often develop in childhood and sensitive to the transmission from the family and in response to repeated social and environmental events.
- Family members communicate maladaptive thoughts and beliefs to client ("I'm a mess.") and model maladaptive behaviors (compensatory strategies) that client observes.
- Adults with NDD likely have experience both factors – family transmission of maladaptive beliefs and behaviors and in response to social and environmental consequences that result from their atypical cognitive and behavioral style.

+ Transmission of Maladaptive Beliefs Through Generations



Adapted from Creed, Reisweber, & Beck (2011). Cognitive therapy for adolescents in school settings. New York: Guilford Press.

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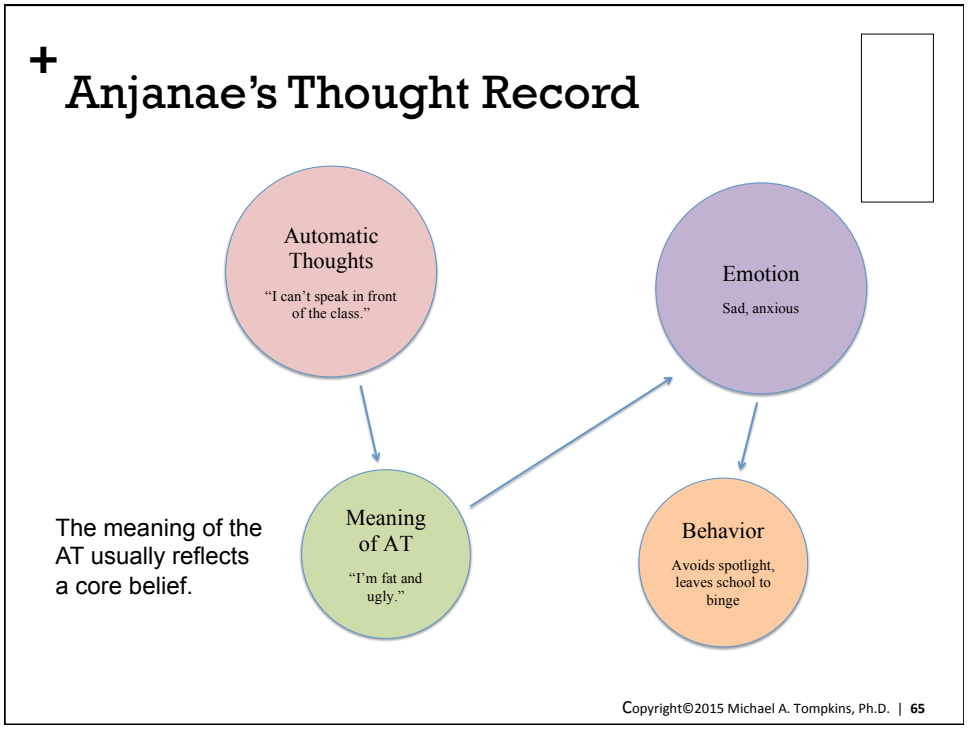

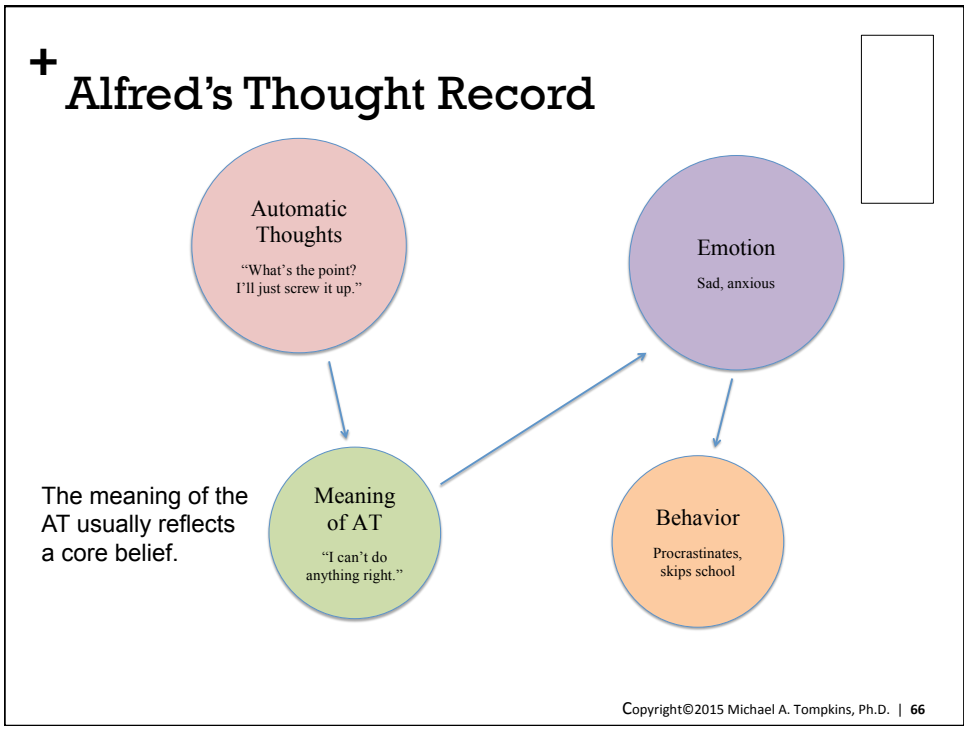

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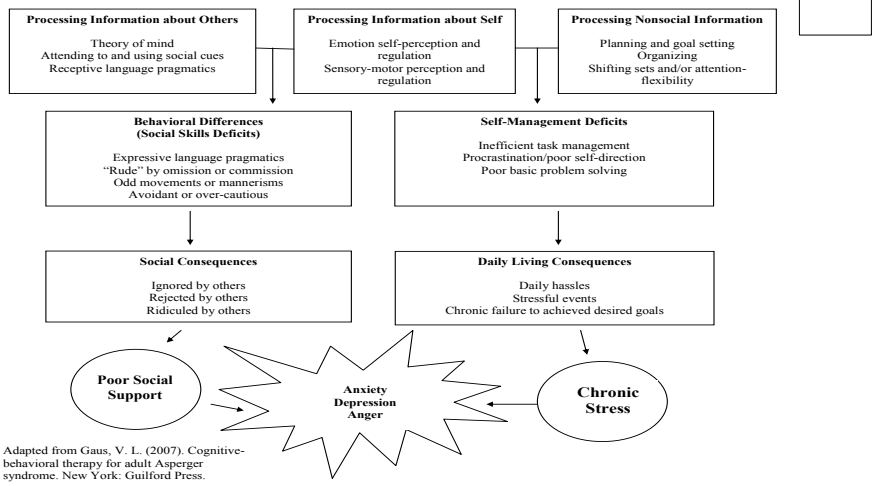
Neurocognitive Factors and Case Conceptualization for Adults with NDD



Adapted from Gaus, V. L. (2007). Cognitive-behavioral therapy for adult Asperger syndrome. New York: Guilford Press.

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Cognitive-Behavioral Case Conceptualization with Adults with Neurodevelopmental Disorders

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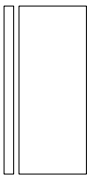
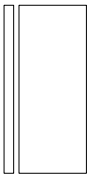
+ Definition of Case Conceptualization



- A theory that explains or accounts for a particular client's symptoms and problems, here and now.
- Considers life experiences that lead client to think and behave in certain ways in certain situations.
- Case conceptualization guides the treatment process.
- Case conceptualization describes session anchors that focus the session and the treatment.
- Case conceptualization includes the client's strengths and weakness and focuses on relevant treatment goals.

+ Rationale for Case Conceptualization



- Assists therapist in treatment process.
- Assists therapist and client to understand problem behaviors in and out of session.
- Enhances collaboration, understanding, and willingness.
- Guides treatment, including problems in the treatment itself.
- Focuses therapist and client on relevant topics for a session and for homework.

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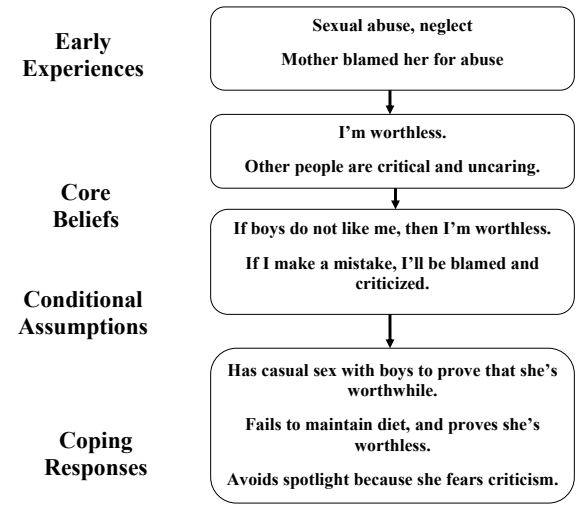
+ Anjanae's Basic Case Conceptualization



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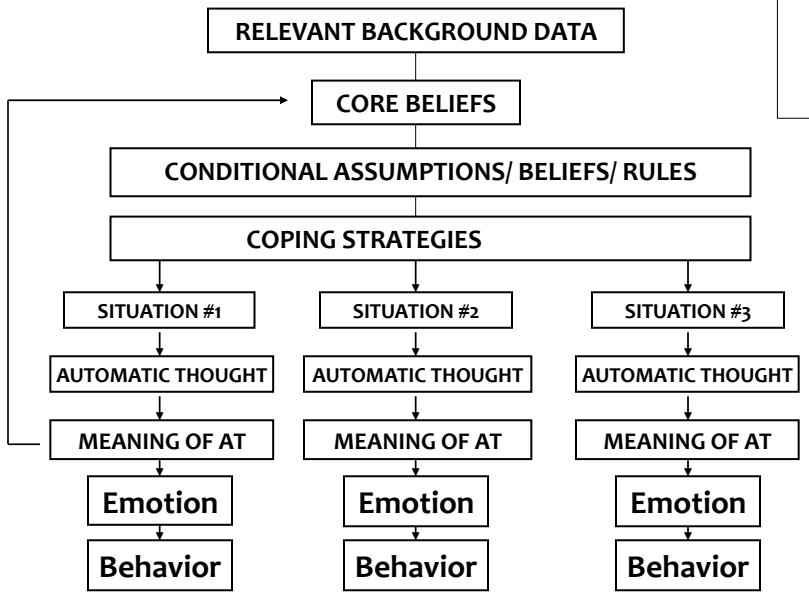
+ Case Conceptualization Diagram



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+ Exercise – Develop Case Conceptualization for a Favorite Character

- **Break into groups (minimum of three people) and as a group, and develop a case conceptualization for a favorite character** from literature or a movie (e.g., Harry Potter, Hermione Granger, Annie in the musical, Pip in Great Expectations, Peter Pan, Charlie in Charlie and the Chocolate Factory) or, from a character from a favorite movie or television show (“Orange is the New Black,” “Breaking Bad”).
- Complete the CCD for the character and include at least two typical situations (trigger, AT, meaning of AT, emotion, behavior).

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+ Exercise – Develop a Case Conceptualization for an NDD Adult

- **Break into groups (minimum of three people) and develop a case conceptualization for Jose or Sandra.**
- Or, one member of the group present a real client and develop a case conceptualization for him or her.
- Complete the CCD for the client and include at least two typical situations (trigger, AT, meaning of AT, emotion, behavior).

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Psychoeducation and Affect Education

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Definition of Psychoeducation

- Psychoeducation is an essential intervention in cognitive-behavior therapy as it sets the stage for all that follows.
- Psychoeducation begins the process of assisting the client to become curious about his or her psychological process.
- Psychoeducation can take many forms but its primary goal is to educate the client about the general cognitive-model and how it applies to his or her clinical problems, as well as orient the client to cognitive-behavior therapy itself.

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+ Rationale for Psychoeducation

- Assists client to "unpack" emotional response to provide perspective or distance on emotional response itself.
- Assists client to connect thoughts, feelings, and choices (adaptive behaviors).
- Assists client to learn the cognitive model and to begin to build a feeling vocabulary.
- Assists therapist in developing a case conceptualization and plan treatment.

+ Using Thought Record to Teach Cognitive Model

- Explain thought record to client and assist client to fill in copy of thought record with you.
- Use whiteboard and begin with a specific situation.
- Focus on at least two situations and complete two thought records that target a problem emotion and or behavior.
- Focus on a situation in which the client felt good (absence of problem emotion) or did not engage in problem behavior to illustrate influence of different thoughts on emotion and behavior.

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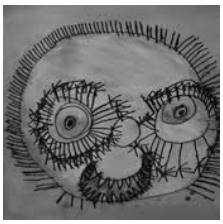
Eliciting Automatic Thoughts



Follow the Affect

- **When you notice or infer change in affect (e.g., grimace, trembling lips) or change in behavior (e.g., arguing, mumbling), ask:**
- What was just going through your mind?
- What were you thinking?
- Were you thinking [supply opposite thought]?
- Were imagining something or did a picture just go through your mind?
- Were you remembering something?
- What did the situation mean to you?

VIDEO CLIP

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When Client Cannot Identify Automatic Thought

- Ask about images.
- Try to access through a roleplay to evoke memories of situation.
- Shift to feeling vocabulary.
- Try to access through imagery.

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Modifying Automatic Thoughts

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+ Examining the Evidence for Automatic Thoughts

- List evidence for an against the validity of an automatic thought or other cognition.
- Evaluate each piece of evidence together.
- Remember that the therapist encourages the client to take an curious stance to his or her thoughts, and this is the stance that the therapist takes too.
- Patience is essential when examining the evidence of automatic thoughts.

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+ Modifying Automatic Thoughts

- Collaborative empiricism is essential.
- Use a 5-column thought record to organize the process.
- Do not rush through this process. If it takes a full session or several sessions, it's more important to do one thing well than to do two or three things less well.

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+ Generating Rational Alternatives

- Use guided discovery as much as possible but offer suggestions when client is stuck.
- Use any strategy that works (e.g., going back in time to think like your old self; third person view point).
- Use a Thought Record worksheet to organize this process for the client.

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+ Coping Cards

- Index card client uses to prompt for adaptive cognitive (Attitudes) and behavioral (Actions) responses.
- Role play situation and ask client to read through coping cards during role play, inquire about affect change, coping confidence.
- Ask client to read through coping cards daily, at specific times, or prior to triggering situation.
- Set up as behavioral experiment to test usefulness.

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+ Coping Card for Adaptive Attitudes

Automatic Thought	Adaptive Attitudes
■ "I can't do math."	■ "Just because math is hard for me, doesn't mean I can't do it." ■ "I can do math but not like the students who are good at it. It's better to be realistic about what I can do, but I can do it."

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+ Coping Card for Adaptive Actions

Maladaptive Action	Adaptive Actions
■ Procrastinate starting my job application.	■ Just do the first page and reward myself with 10 minutes of "me" time. ■ Take my focus medicine, it helps. ■ Ask Jay to help me. He's filled out applications before and knows how.

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Eliciting Core Beliefs

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Identifying Core Beliefs

- Identify a key automatic thought.
- Try if-then questions, "If you have trouble making friends, then what does that mean about you?"
- Try hanging statements, "That made you so sad because …?
- Watch for affect that signals core belief.
- Downward arrow technique.

VIDEO CLIP

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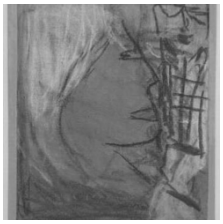
Identifying Influence of Core Beliefs on Problematic Patterns

- Alice, you've felt sad several times this week, when your friend didn't respond to your text, when you got a C on your English quiz, and when your mom shouted at you to clean your room. I'm thinking that perhaps there's a pattern here. Do you think that all these situations may have triggered that belief we've identified that you're not good enough. I wonder if that fits for all these things? What do you think?

Modifying Core Beliefs



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Modifying Core Beliefs

- Begins after client is comfortable with therapist and is well socialized into the cognitive model.
- Begins after client has become curious and skeptical about his or her beliefs.
- Begins after client has learned and mastered checking and changing automatic thoughts.
- Many techniques to modify core beliefs.
- Patience is the key – core beliefs change slowly, invite client to watch for changes in the belief through monitoring.

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Techniques to Modify Core Beliefs

- Exploring pros and cons of maintaining core belief.
- Courtroom technique.
- Double-standard technique.
- Examining evidence that disconfirms core belief and supports a more adaptive one.
- Continuum techniques.

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Examining the Evidence for Schemas

- Briefly explain the procedure and use an empirical approach to engage client in process at taking an honest look at the validity of the core belief.
- Use a worksheet to organize the process, collect as much information as possible, and continued as a homework assignment.
- Be creative in generating evidence against the maladaptive core belief and keep at it. Clients will have a fixed view that takes much of your energy and imagination to help them shift this view.
- Be patient, after years of reinforcement of negative or dysfunctional outcomes, the client may be able to generate considerable evidence that the core belief is true.

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Rehearsing a Modified Core Belief

- There are a variety of ways to assist the client to practice a modified core belief:
- Develop a written plan to try out a new or revised core belief.
- Use imagery to rehearse the plan.

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+ I' m a Loser

I believe _____ I'm a total loser _____ .

100%	75%	50%	25%	0%
Total Loser				**Total Winner**
Always in trouble at school, every teacher thinks he's the worst and a minute doesn't go buy that a teacher doesn't criticize him. Kicked off baseball team and can't even walk without stumbling, no kid will pick him for a team. His mom and dad are divorced, in fact, his parents left him and didn't give him a thought. He smells bad, his clothes are rags. Gets Fs in every class, on every test, on every quiz, no points on anything.		Half the time he wins and half the time he loses a game. Half the time he gets a good grade and half the time he gets a bad grade. Half the time teachers praise him and half the time teachers correct him. Half the time he looks cool and half the time he looks tired and uncool. Half the time his mom and dad argue and half the time they are happy with each other.		Never gets in trouble at school, not even for scratching his nose. Pitches or plays first base, or any position he wants. His mom and dad are together and never argue or even disagree. Gets As in everthing, even stuff that's really hard. He dresses cool and all the girls, every single one of them, thinks he's "the dude".

100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
		James	Alex	Curt Jack Austin	Zack Ted Ben Alec Jose Russ	Me	Pete Todd		Jamal	

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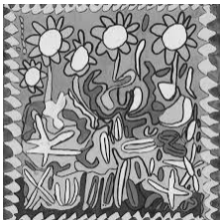
Developing Effective Homework Assignments and Overcoming Homework Non-Adherence



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+ Guidelines for Effective Homework

- An effective homework assignment takes time to develop and set up, so manage therapy time so that you have time to develop and implement.
- Be specific and concrete.
- Tie assignment to work in session – "Based on what we have worked on today, what would you like to try out this week?"
- Start homework assignment in session and write precise set of homework instructions.
- Anticipate obstacles and develop plan to solve.

+ Enhancing Willingness to Try Homework Assignment

- Better to have a small doable assignment than one that client does not complete; break tasks down, and lower barriers to adherence.
- Set up as a "no lose" lesson – "Whether you complete it or not or whether it's successful or not, we'll learn something important that will help you."
- Assess confidence – "On a 0-100 scale, how likely are to you to practice this as we set it up?" Try for 90%.
- If less than 90%, ask client to suggest a modification – "I hear you saying that you're 70% confident that you'll do the practice. What could we change that would bump your confidence up to 90%?"
- Rehearse in imagination, and adjust if necessary.

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Cognitive-Behavior Therapy for Homework Non-adherence

- First, give the client the benefit of the doubt – "Did I plan and develop the homework assignment correctly?
- Use thought records to identify homework non-adherence thoughts and beliefs.
- Use strategies to modify non-adherence thoughts and beliefs.

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Homework Non-Adherence Automatic Thoughts

- "I don't want to do this and you can't make me."
- "What's the point?"
- "You're just waiting to tell me that I didn't do it right."
- "You think this little piece of homework is going to help me? You don't get me."

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Homework Non-Adherence Intermediate Beliefs

- "If I try the homework, then I'll just screw it up."
- "If I don't do the homework right, then you'll shame, embarrass, or criticize me."
- "If I don't try the homework, then I won't be wrong."
- "If I try the homework, then you'll just let me down."
- "If I do the homework, then you win and I lose."

Homework Non-Adherence Core Beliefs

- I am defective.
- I am powerless.
- Others are cruel.
- Others are dangerous.
- World is dangerous.
- World is harsh and unbearable.

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Strategies to Enhance Motivation

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Strategies to Enhance Engagement

- Collaborative case conceptualization.
- Explaining therapy and how it works.
- Reverse role plays.
- Pluses and minuses.
- Unpacking the experience (affect education).
- Cognitive restructuring (placing a question mark behind what the client believes).
- Breaking down tasks, other strategies to lower barriers to change.

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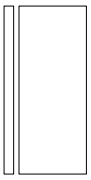
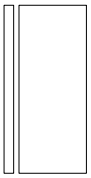
+ Explain and Explore Meaning of Therapy



- Assess expectations for therapy and explain what therapy is about.
- Have you ever been in therapy before? How was it? What did you work on? What would you change about the last therapy to make this one better for you?
- What do you think therapy would be like? Helpful or not so helpful and why?

+ Reverse Role Play



- Assesses and may enhance motivation.
- Change seats (therapist as client).
- Clinician role plays client's thinking pattern.
- Use to assess client's ability to catch, check, and correct.
- Use to help client practice adaptive responses.

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+ Pluses and Minuses of Change

Minuses of No Change	Pluses of Change
■ Has (the problem) been on your back recently? How?	■ If (the problem) was on your back less, how would your life look? Would that be better?
■ Let's make a hassle list. How has (the problem) made your life hard this week?	■ If (the problem) keeps hassling you, how will your life look in a year?
■ Does (the problem) get in the way of doing things? Does (the problem) make it hard for you to hang out with your friends or your family?	■ If we could wave a magic wand over your land, what would your land look like?

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+ Five Minute Reflection

- Think back over the day:
- What feature of a structured session (e.g., setting agenda, soliciting feedback, summarizing) would you like to try next time you meet with a client?
- From the discussion of case conceptualization, is there a client that you are thinking a little differently about today?
- What strategy do you wish to try next time you assign a client a homework task?

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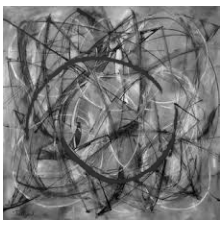
Thank You!

I look forward to seeing you tomorrow when we will cover CBT for anxiety in adults with neurodevelopmental disabilities.



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Cognitive-Behavior Therapy with Adults with Neurodevelopmental Disabilities and Comorbid Anxiety Disorders (Day 2)

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Westside Regional Center – Third Floor Board Room
5901 Green Valley Circle, Los Angeles, CA 90230

 | 1

+ Agenda

- Anxiety and anxiety disorders in adults with neurodevelopmental disabilities.
- Cognitive-behavioral model of anxiety.
- Gathering information and self-monitoring strategies.
- Case conceptualization.
- Typical cognitive strategies.
- Planning and conducting exposures.
- Overcoming roadblocks to effective exposures.

 | 2

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Five Minute Reflection

- What is the most common anxiety problem for your clients with neurodevelopmental disabilities?
- What strategy has been the most helpful for your anxious clients with neurodevelopmental disabilities?

Anxiety in Adults with Neurodevelopmental Disorders

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Anxiety and Fear

- Anxiety is a future-oriented state characterized by worry, tension, and hypervigilance about a perceived and possible future threat (not an evident and imminent threat); anxiety focuses our attention and cognitive and physical resources to identify presence of threat and to moderate our exposure to that threat.
- Fear is the emotion an individual experiences when directly confronted with threat or danger and is associated with strong, protective behavioral action tendencies (fight or flight); panic is the occurrence of fear when there is no objective threat.

Anxiety Disorders (DSM-5)

- Generalized anxiety disorder.
- Panic disorder (agoraphobia).
- Social anxiety disorder.
- Obsessive-compulsive disorder.
- Specific phobia.
- Post-traumatic stress disorder.

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Anxiety Disorders in Adults with Neurodevelopmental Disorders

- 51% of adults with ADHD have a comorbid anxiety disorder (Kessler et al., 2006).
- High rate of anxiety disorders with ASD makes differential diagnosis a complex task (Tsai, 2006).
- Social anxiety disorder and obsessive-compulsive disorder are common anxiety disorders in adults with NDD.
- Anxiety disorders may develop in response to cognitive, social, and behavioral deficits common in adults with NDD.

Cognitive-Behavioral Model of Anxiety

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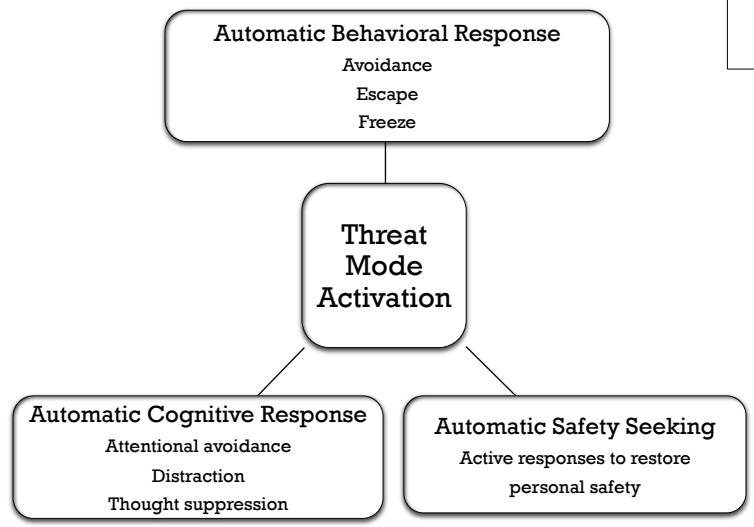
+ Primal Threat Mode Activation



From: Clark, D. A., & Beck, A. T. (2010). Cognitive therapy of anxiety disorders: Science and practice. New York: Guilford Press.

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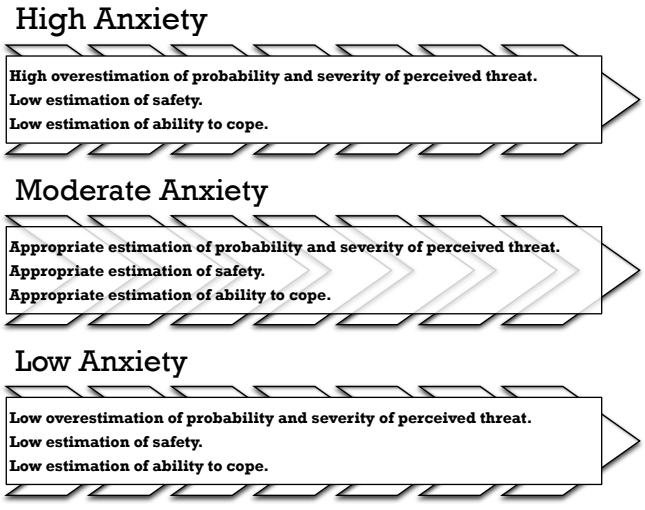
+ Secondary Elaborative Response



Adapted from: Clark, D. A., & Beck, A. T. (2010). Cognitive therapy of anxiety disorders: Science and practice. New York: Guilford Press.

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Focus of Worry and Nature of Threats

- Differential diagnosis aided by identifying focus of anxious apprehension (worry).
- Anxiety disorders are maintained by repeated misappraisals of probability and severity of threat, and perceived vulnerability and degree of safety.

Gathering Information

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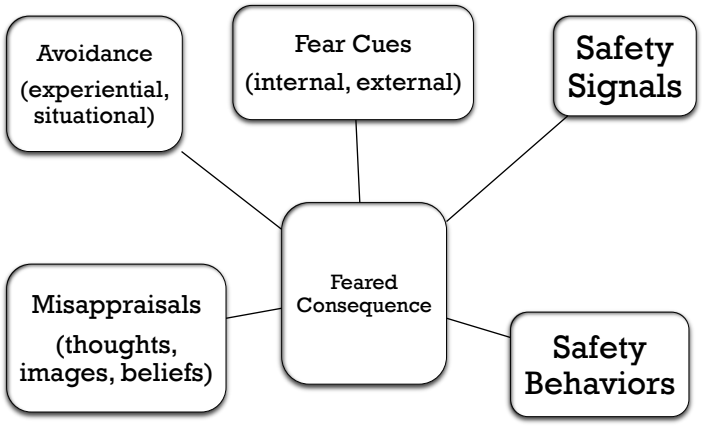
+ Assessment Rationale

- Identify relevant factors to develop case conceptualization to guide treatment plan.
- Identify fear cues to focus exposure interventions.
- Identify factors that reinforce avoidance and other maladaptive anxious behaviors (tantrums, reassurance seeking) in order to fade and eliminate.
- Identify contexts that influence anxiety symptoms in order to generalize treatment gains.
- Identify stressors that may influence course of treatment and increase risk of relapse.

+ Assessment Targets



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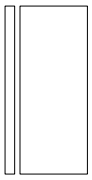
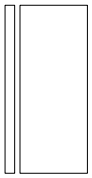
+ Assessment Strategies



- Clinical interview.
- Behavioral observation (BAT).
- Standardized measures.
- Self-monitoring.

+ Interview Client and/or Support Person(s)



- History of symptoms.
- Fear cues (internal and external).
- Misappraisals (thoughts, images, predictions, beliefs).
- Feared consequence.
- Safety behaviors and safety signals.
- Avoidance (experiential and situational).

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+ Behavioral Avoidance Test (BAT)

- Permits observation of client's behavior and anxious response.
- Measures the distance (or time) a client can approach (or remain in the presence of) a fear-evoking object or situation.
- Useful adjunct to subjective measures of anxiety.

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+ Conducting Behavioral Avoidance Test

- Introduce fear thermometer (SUD scale) and use to rate fear during BAT.
- Client asked to confront fearful object or situation for 5 minutes; client may stop BAT at any time, but encouraged to attempt task for as long as client can.
- Assess time client participates in task or how close client approaches object.

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Examples of Symptom Measures

- Beck Anxiety Inventory (Beck & Steer, 1990).
- Hamilton Rating Scale of Anxiety (Guy, 1976).
- State-Trait Anxiety Inventory (Spielberger et al., 1983).
- Cognitions Checklist (Beck et al., 1987).
- Penn State Worry Questionnaire (Meyer et al., 1990).

Typical Self-Monitoring Strategies

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+ Rationale for Self-monitoring

- Increases awareness of situation-cognition-emotion-behavior and thereby "unpacks" anxious experience.
- Provides data for treatment planning.
- Provides measure of treatment progress.

+ Begin with Psychoeducation

- Focus on recent anxious episodes and break down experience into cognitions-feeling-behaviors; repeat until client demonstrates correct features of anxious response.
- Use flow diagram for more concrete description of sequence.

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ARC of Anxiety

- **A**ntecedent – event that triggers anxious response.
- **R**esponse – the anxious response itself (anxious mind, anxious body, anxious actions).
- **C**onsequences – of avoidance and neutralization strategies (anxious actions).

Rationale for ARC

- Client learns the features of anxious response (thoughts, feelings, behaviors)
- Client learns to step out of secondary anxious response to observe not react.
- Client learns that secondary anxious response is predictable and manageable; and learns when to apply strategies to manage anxious response.
- Client learns consequences of anxious actions.

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+ Typical Self-monitoring Strategies

- Panic and worry log.
- A-C and A-B-C logs.
- C-C-C log.
- Obsessions-Responses log.

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+ A-B-C Thought Record

- **A**ntecedents – triggering event or situation.
- **B**eliefs – what went through youth's mind just before experiencing consequences.
- **C**onsequences – problematic emotions or behaviors.

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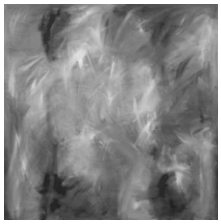
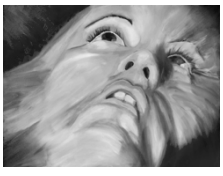
+ Catch It, Check It, Correct It

- **Catching** – invites youth to pay attention to thoughts and their relationships to situation, emotion, and behavior.
- **Checking** – enhances skepticism and curiosity about beliefs and what is "true," distances youth from emotional storm through perspective.
- **Correct** – youth learns to develop alternative beliefs in order to feel and do better.

+

Case Conceptualization





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Nomothetic Formulations of the Anxiety Disorders

- Nomothetic refers to general scientific laws or principals.
- Nomothetic formulation assumes same maintaining variables for every client with a particular anxiety disorder.
- Ideographic formulation begins with a nomothetic formulation and individualizes relative to the particular client and his or her circumstances.

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Avoidance

- Full avoidance – avoid objects, situations, activities, sensations linked to anxious response.
- Partial avoidance – safety behaviors to decrease anxiety when full avoidance not possible.
- Experiential avoidance – avoiding central features of anxious response (thoughts and body sensations) by avoiding the objects, situations, activities linked to the anxious response.

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Anxious Actions

- Cognitive and behavioral actions directed by client to neutralize anxiety.
- Caring a water bottle to stay well hydrated or to eliminate feared sensation of dry mouth.
- Seeking reassurance from partner, parents, or therapist.
- Cognitive neutralizations such as reassuring self, repeatedly analyzing events, reviewing or checking actions and memory.

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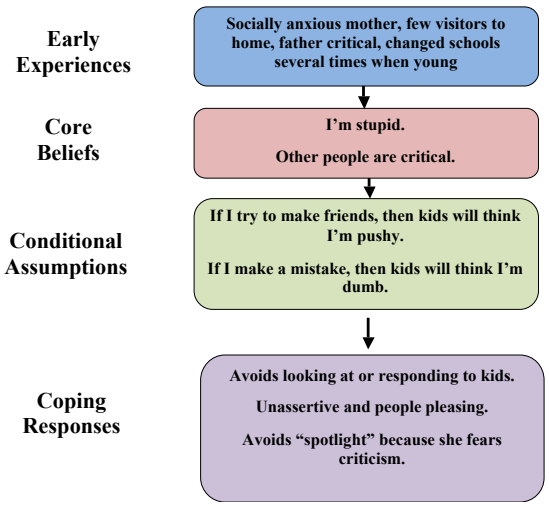
Simple Case Conceptualization



Adapted from Creed, Reisweber, & Beck (2011). Cognitive therapy for adolescents in school settings. New York: Guilford Press.

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+ Identify Key Misappraisal (Core Fear)

- Key misappraisal that fuels anxious response.
- Downward arrow (Burns, 1980).
- Train client to identify core misappraisal using thought record, guided discovery, ARC worksheets.

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+ Treatment Planning

- External fear cues.
- Internal fear cues.
- Feared consequence.
- Avoided fear cues (emotions, situations, thoughts, images).
- Safety behaviors and safety signals.
- Other factors that maintain avoidance and fearfulness.

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+ Conceptualizing a Case

- Let me show you how to conceptualize a case and identify hypothesized internal and external fear cues, feared consequence, avoided fear cues, safety behaviors and signals.
- Now you try it, select a case and develop a case conceptualization that includes hypothesized internal and external fear cues, feared consequence, avoided fear cues, safety behaviors and signals.

+

Planning Graduated Exposure Treatment

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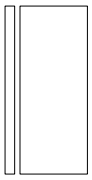
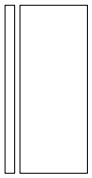
+ Exposure Hierarchy or Ladder



- List of objects, situations, images, thoughts, body sensations that evoke anxiety ranked from least to most anxiety evoking.
- Use SUD scale to rank exposure tasks.
- Hierarchy guides treatment and used to titrate level of anxiety client experiences.

+ Guidelines for Identifying Exposure Targets



- Target the right stimuli – balcony vs. ladder? supervisor vs. coworker?
- Shape exposure – what factors make a particular exposure easier or harder (With therapist, with best friend, in morning?).
- Identify safety behaviors and fade these as part of the exposure ladder.
- Anticipate obstacles in doing exposure and remaining in exposure long enough to benefit.

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Building an Exposure Ladder

- Step 1 – List situations that trigger anxious response by client report and self-monitoring data; include situations, objects, and internal content (thoughts, images).
- Step 2 – Adjust situations based on what influences intensity of anxious response.
- Step 3 – Rank situations from least anxiety evoking to most anxiety evoking.
- Step 4 – Identify anxious actions (safety behaviors) to resist, or include on steps of ladder.

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Typical Cognitive Strategies for Anxiety

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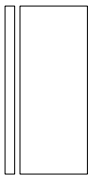
+ Psychoeducation



- True alarms vs. false alarms.
- Features of anxious or fearful response.
- Goals of therapy.
- Process of graduated exposure using metaphors.
- Objective of skills to manage anxiety – in service of showing that you can face your fear.

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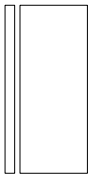
+ Objectives of Cognitive Interventions



- Target anxious thoughts, appraisals, and beliefs hypothesized to maintain anxiety and avoidance, based on case conceptualization, particularly the core fear.
- Goal is to shift client's perspective from one of disproportionate danger and personal vulnerability to acceptable threat and perceived ability to cope.

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+ Targets of Cognitive Interventions

- Probability estimates – Overestimating likelihood or perceived threat or danger.
- Severity estimates – Overestimating impact of feared outcome or anxious response itself.
- Vulnerability estimates – Beliefs about ability to cope with feared outcome or anxious response itself.
- Safety estimates – Safety information that is ignored or undervalued that decreases perceived safety?

+ Catching Automatic Thoughts

- "Did you get a picture in your head?"
- "Other people in that situation who were upset might think ____ . Did you think that?"
- "Were you thinking ___ ?" (select thought opposite of expected response)
- "How about if I guess? Could you have been thinking ___ ?"

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+ Checking Automatic Thoughts

- Is this thought helpful or unhelpful?
- Is this thought unique to this situation or does it occur in other situations?
- Is this thought new or is it familiar?
- Never argue, lecture, or debate (G and D in guided discovery stands for Get Dumb).
- Practice the Cs (Careful, Curious, and Collaborative).

+ Overestimating Likelihood of Perceived Threat

- A-B-C and C-C-C forms.
- Monitoring prediction validity.
- Shifting predictive bias (View from the Balcony).
- Validity quotient.

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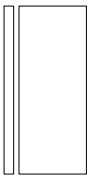
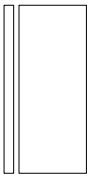
+ Exercise – Cognitive Restructuring



- **Practice assisting the "client" to evaluate his or her prediction regarding probability of a negative outcome.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells "client" whether to play the client "easy," "medium," or "hard."
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the "client" roleplayer.

+ Validity Quotient



- Builds on monitoring frequency of anxious predictions.
- Validity quotient evaluates true tendency to jump to scary conclusions.
- Step 1 – Clarify prediction.
- Step 2 – Q1 = Number of times prediction made in past five years.
- Step 3 – Q2 = Number of times prediction was correct in past 5 years.
- Step 4 – Validity Quotient = Q2/Q1 x 100%

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Overestimating Impact of Perceived Threat

- How client coped in the past.
- Develop plan to increase client's confidence that client can cope in the future were the event to occur.

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Strategies to Calm an Anxious Body

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+ Relaxation Strategies

- Diaphragmatic breathing.
- Progressive muscle relaxation.
- Meditation.
- Mindfulness.

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+ Mindfulness

- Attention focused on the here-and-now.
- Observe without judgment.
- Attention directed and re-directed to an internal or external anchor.
- Decreases likelihood that client will use relaxation strategy as safety behavior (or an action that reinforces experiential avoidance).

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Benefits of Mindfulness

- Invites client to step out of cycle of interacting thoughts, feelings, and behaviors in order to see things as they really are.
- Clients learn the features of their emotional responses (rises, and falls), which decreases fear and avoidance of emotional response itself.
- Clients learn alternatives to suppressing, escaping, or avoiding unpleasant emotion that maintains problematic behavior.
- Mindfulness is difficult to use as a safety behavior.

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Conducting Graduated Exposure

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Graduated Prolonged Exposure

- Key ingredient in treating anxiety disorders.
- Systematic approach that targets both behavioral (avoidance) and cognitive (misappraisals) that maintain problematic anxiety.
- Exposure facilitates inhibitory learning (new learning that overrides old learning).

Advantages of Prolonged Exposure

- Client gains more "control" over the anxious response, not less "control".
- Client learns that s/he can handle or cope with the anxious response.
- Client learns that s/he can break the pattern of anxious thinking.
- Client learns that anxious actions are not necessary.

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Features of Effective Exposure

- Intentional
- Frequent
- Sufficient
- Full

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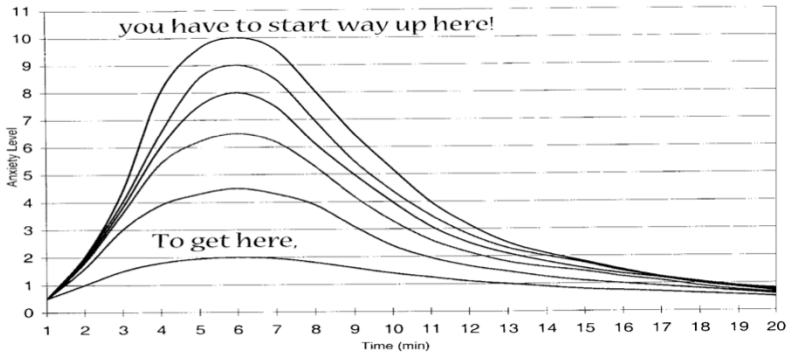
Exposure Results in Less Fear



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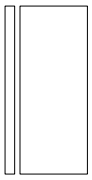
+ Guidelines Prolonged Exposure



- Grade exposure items based on fear thermometer or SUD scale; begin with easy exposures to build client's confidence in treatment, in therapist, and in self.
- **Practice exposures in office first** to familiarize client with model, to assess client's motivation, and to troubleshoot potential problems; i**nclude response prevention** to block avoidance strategies that perpetuate anxiety symptoms.
- Review exposure homework to identify problems and develop possible strategies for next time, and to reinforce adherence.

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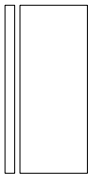
+ FACE It



- **F**ace anxious response and watch it.
- **A**nchor to the present moment.
- **C**heck or resist anxious actions.
- **E**ndure anxious response.

From: Tompkins, M. A. (2013). Anxiety and avoidance: A universal treatment for anxiety, panic, and fear. Oakland, CA: New Harbinger Publications.

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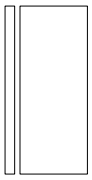
How to Step Toward Discomfort



- Warm up – practice watching and waiting with anchor before turning attention to anxious response.
- FACE it.
- Repeat it – set aside 30-40 minutes per day, at least 3-4 times per day to practice.
- Continue exposure until anxious response decreases 50% or more from maximum.

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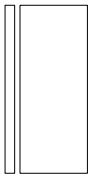
Types of Prolonged Exposure



- **Situational (in vivo)** -- confront anxiety evoking or phobic objects or situations in structure "real life" exercises.
- **Interoceptive** – confront anxiety evoking physical sensations.
- **Imaginal** -- confront anxiety evoking or phobic objects or situations in structured imaginal exercises.

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+ Situational Exposure

- Prolonged exposure to specific situations or activities.
- May pair situation exposure with interoceptive exposure.
- May include therapist assistance initially but then fade to client-directed exposures.
- May shape approach behavior.
- Generalize to real-life situations.

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+ Interoceptive Exposure

- Clients with anxiety disorders are often fearful of the physical sensations that are part of their anxious response.
- Interoceptive exposure targets the experiential avoidance due to feared physical sensations.
- Interoceptive exposure a primary strategy in the treatment of panic disorder but may be useful to clients with other types of anxiety disorders.

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Imaginal Exposures

- Ask client to "hold a picture in mind".
- Train client to image (if necessary).
- Include as much detail as possible in script, client reads script or listens to recording of script.
- Give equal emphasis to descriptions of external cues and internal cues.
- Use imaginal exposure as "warm-up" to situational exposures.
- Block cognitive coping/avoidance strategies.
- Ensure imaginal exposure long enough.

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Exercise – Imaginal Exposure

- **Practice scripting an imaginal exposure with the "client" and then instruct the "client" through the imaginal exposure.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells "client" whether to play the client "easy," "medium," or "hard."
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the "client" roleplayer.

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Behavioral Experiments

- To test validity of client's existing beliefs about self, others, and world.
- To construct and/or test new, more adaptive beliefs or alternative perspectives.
- To contribute to the development and verification of the case conceptualization.
- "So how can we test that out?"

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Exposure or Behavioral Experiment

- Different theoretical assumptions and goals – habituation vs. testing beliefs.
- Different approach – repeated prolonged exposures vs. repeated BEs.
- Different targets – BEs directly target safety behaviors.
- BEs useful in treating other emotional disorders (not just anxiety).

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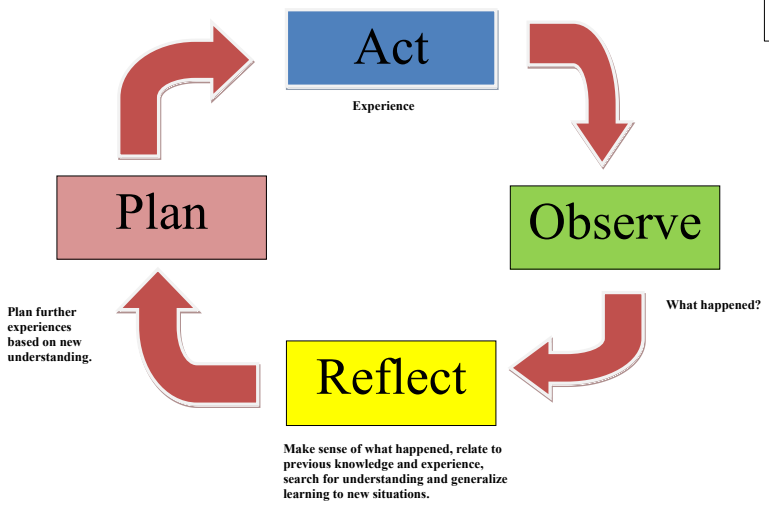
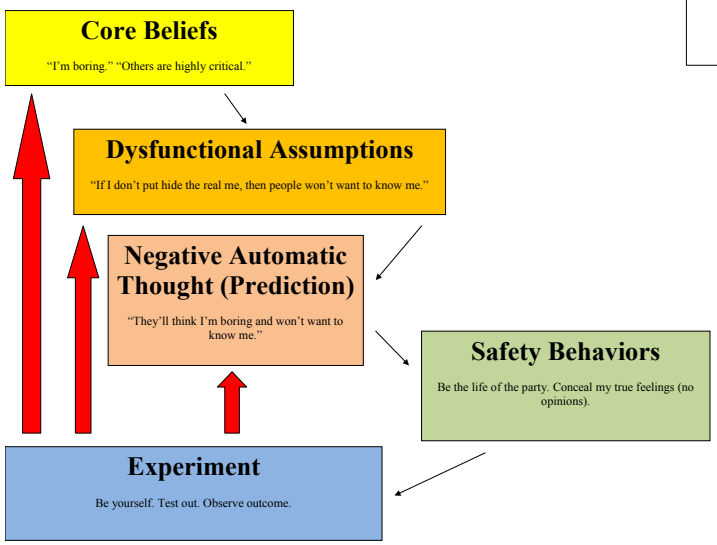
Experiential Learning Circle



BEs Target Multi-level Change



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+ Types of Behavioral Experiments

- Active experiments – real or simulated (roleplays).
- Observational (discovery) experiments – direct observation, surveys, data gathering from sources other than people (e.g., internet).

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+ Exercise – Behavioral Experiment

- **Practice setting up a behavioral experiment with the "client" to test his or her prediction.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells "client" whether to play the client "easy," "medium," or "hard."
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the "client" roleplayer.

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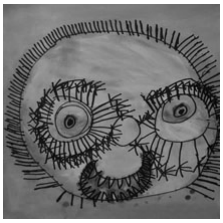
Relapse Prevention and Generalization of Gains



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Rationale for Relapse Prevention

- Anxiety disorders are chronic conditions that wax and wane and are sensitive to stress, therefore every client, regardless of how much they improved, is at risk of relapse.
- Clients who manage lapses are less at risk for relapse, therefore essential to include this aspect of training in treatment.

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+ Relapse Prevention

- Conduct generalization practice.
- Review all strategies learned in treatment; identify strategies not taught and whether adaptive or maladaptive; focus on strategies that increase willingness to step toward discomfort and remain in the situation.
- Educate about lapse and relapse, increase awareness of slips (Signs I'm Slipping), and prepare for anticipated stressors.

- Develop practice plan; include graded exposure to possible triggers; assign practice plan and monitor.

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+ Develop a Practice Plan

- Practice strategies that helped the most – practice even when not anxious to build a habit.
- Practice stepping toward discomfort – include top third of practice ladders.
- Difficulty of each practice may vary depending on stress level for the day.
- Prepare for new situations, upcoming stressors, and develop plan to manage.

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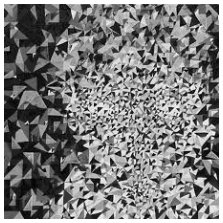
Overcoming Roadblocks to Effective Exposures



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Typical Roadblocks

- Decreased willingness to participate in out-of-session exposure practice -- review contingency management plans, break-down exposure steps, added practice of cognitive strategies, imaginal exposures as warm ups.
- Decreased willingness to participate in in-session exposure practice – motivational interviewing, modify in-session reinforcement plan.

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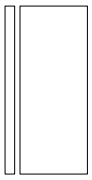
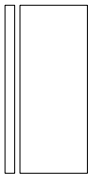
+ Typical Roadblocks



- Decrease in approach behavior or increase in reassurance-seeking, push-back behavior -- review parental response to full and partial avoidance, review parent strategies to manage problem behaviors.
- Incomplete habituation during exposure - assess use of neutralization strategies during exposure.
- Incomplete response to exposure – focus exposures on focal fear, block partial avoidance, refocus on most disruptive fear.

+ Summary



- Cognitive-behavior therapy is the psychological treatment of choice for individuals with anxiety disorders.
- Cognitive and behavioral interventions are founded on same principles but adjust to the developmental age of the client.
- Primary curative factor in treatment of anxiety disorders is exposure.

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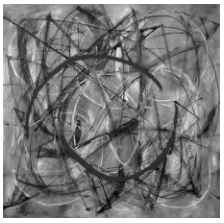
Thank You!

I look forward to seeing you tomorrow when we will cover CBT for depression in adults with neurodevelopmental disabilities.



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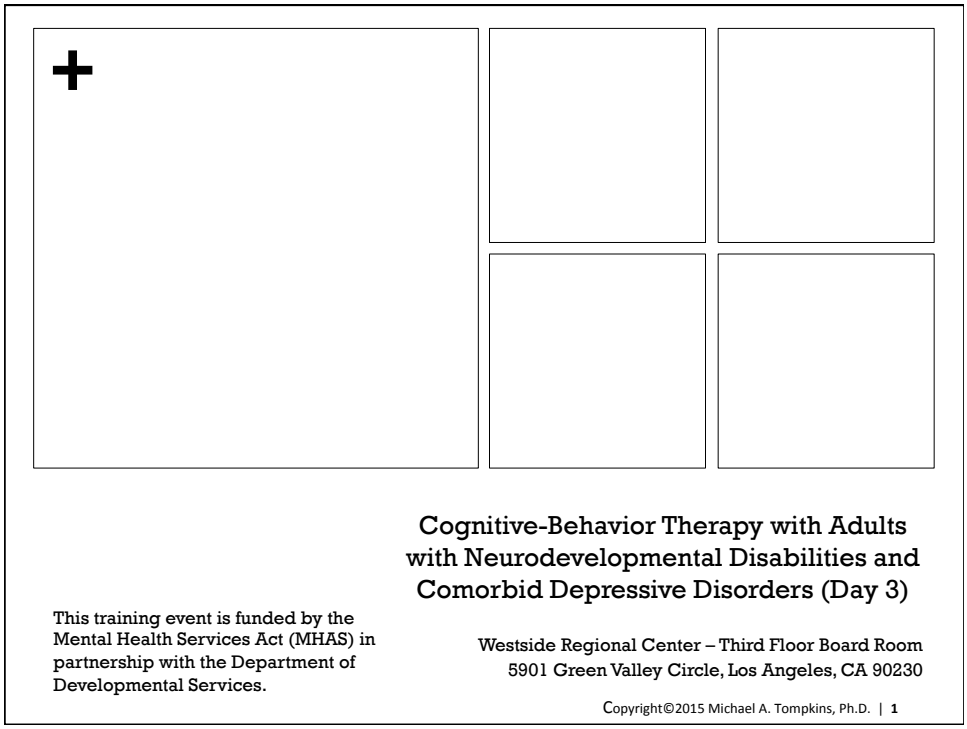

Cognitive-Behavior Therapy with Adults with Neurodevelopmental Disabilities and Comorbid Depressive Disorders (Day 3)

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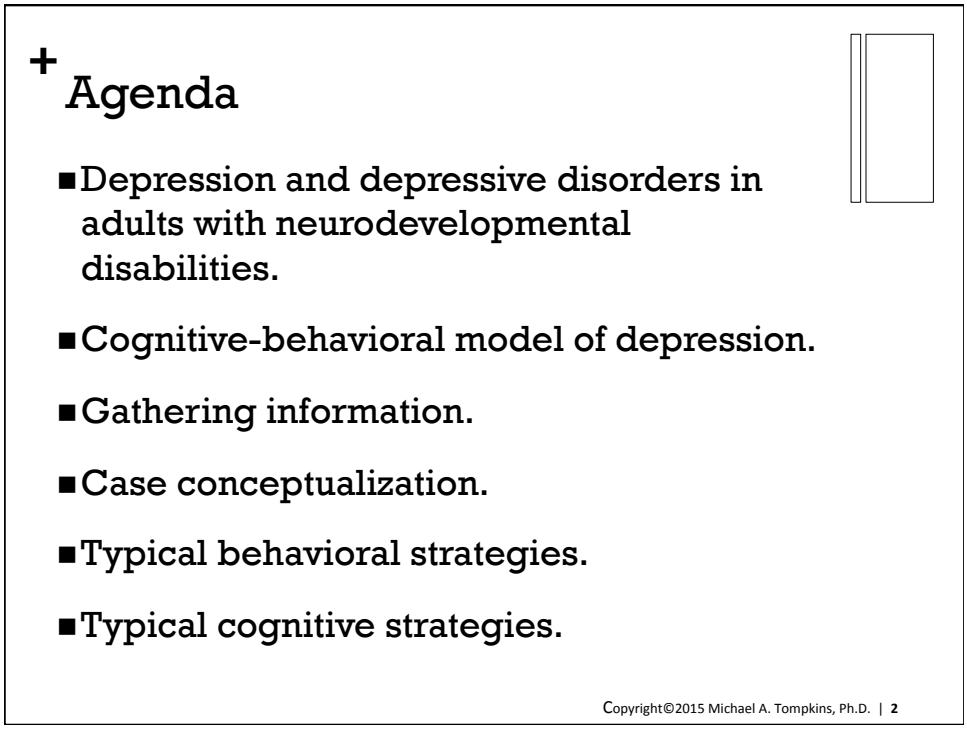
Westside Regional Center – Third Floor Board Room
5901 Green Valley Circle, Los Angeles, CA 90230



Agenda

- Depression and depressive disorders in adults with neurodevelopmental disabilities.
- Cognitive-behavioral model of depression.
- Gathering information.
- Case conceptualization.
- Typical behavioral strategies.
- Typical cognitive strategies.

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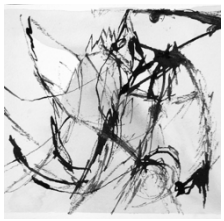
Five Minute Reflection

- What is the most reason your clients with neurodevelopmental disabilities become depressed?
- What strategy has been the most helpful for your depressed clients with neurodevelopmental disabilities?

Depression in Adults with Neurodevelopmental Disorders



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+ Depressive Disorders (DSM-5)

- Major depressive disorder.
- Persistent depressive disorder (Dysthymia).
- Premenstrual dysphoric disorder.
- Substance-Medication-Induced depressive disorder.
- Depressive disorder due to another medical condition.
- Unspecified depressive disorder.

+ Depressive Disorders in Adults with Neurodevelopmental Disorders

- 44-57% of adults with intellectual developmental disorder (IDD) have a depressive disorder (McCabe et al., 2006; McGillivray et al., 2007).
- Frequency of depression in IDD adults is twice as high as in the general population and symptoms of depression occur in 10% of IDD adults (Tsakanikos et al., 2006).
- Depression that often accompanies the social isolation and peer rejection that is secondary to the social consequences of idiosyncratic information processing style.

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Cognitive-Behavioral Model of Depression

Cognitive Model of Depression

EARLY EXPERIENCE
Abusive, neglectful, angry mother and absent father
Critical older siblings
Child must fend for herself

↓

FORMATION OF BELIEFS
I'm incompetent.

↓

FORMATION OF DYSFUNCTIONAL ASSUMPTIONS
If I make a mistake, it will show how incompetent I am.
If I do everything perfectly, I'll be okay.

↓

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+ Cognitive Model of Depression

CRITICAL INCIDENTS
Good (not excellent) rating by supervisor
Critical coworker
Physical illness persists

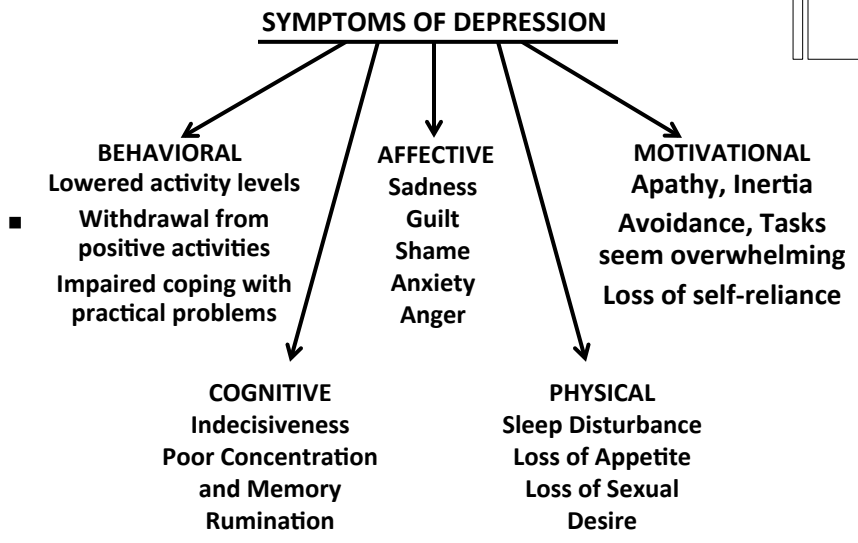
↓

NEGATIVE AUTOMATIC THOUGHTS
(COGNITIVE TRIAD)

I can't do anything right.
I'll probably get fired.
I'll never get better.

↓

+ Cognitive Model of Depression



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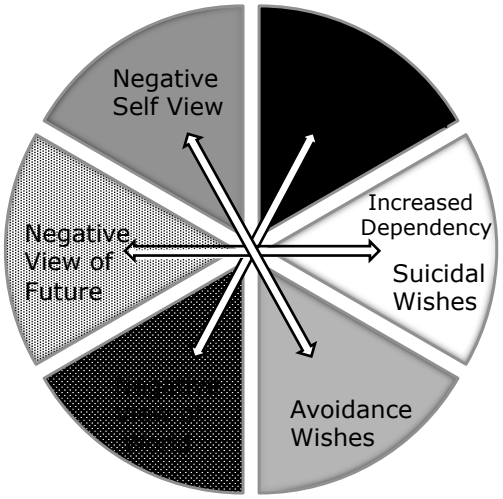
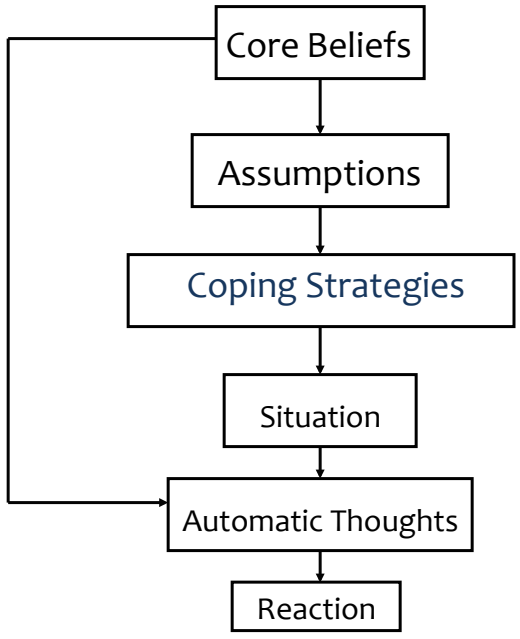
+ Cognitive Triad of Depression





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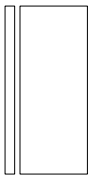
+ Helpless Core Beliefs



- I am inadequate, ineffective, incompetent, can't cope.
- I am powerless, out of control, trapped, vulnerable, likely to be hurt, weak, needy.
- I am inferior, a failure, a loser, not good enough, defective, don't measure up.

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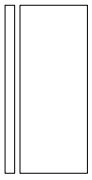
+ Unlovable Core Beliefs



- I am unlikable, unwanted, will be rejected or abandoned, always be alone.
- I am undesirable, unattractive, ugly, boring, unimportant, have nothing to offer.
- I am different, defective, not good enough to be loved by others, a nerd.

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+ Worthless Core Beliefs

- I am worthless, unacceptable, bad, crazy, broken, nothing, a waste.
- I am hurtful, dangerous, toxic, evil.
- I don't deserve to live.

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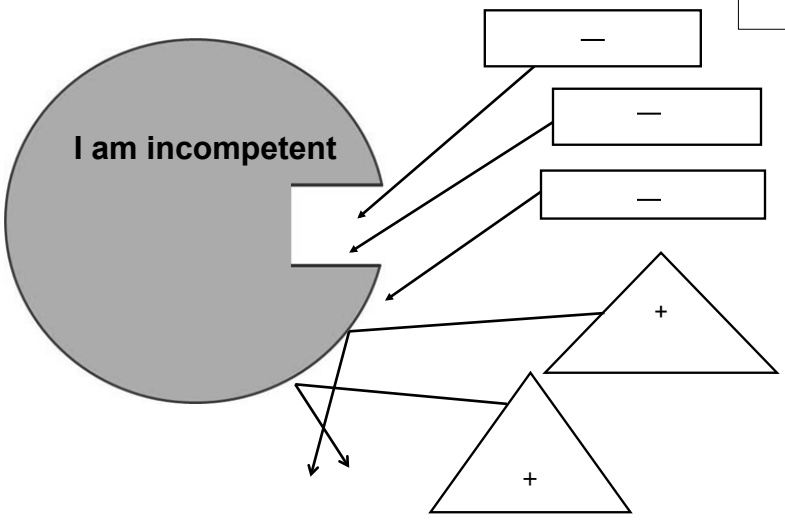
+ Maintenance of Core Beliefs



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+ Five Minute Reflection

- What core beliefs do your depressed clients frequently have:
- About other people?
- About themselves?
- About the world?

+

Phases of Cognitive-Behavior Therapy for Depression

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Phases of of Cognitive-Behavior Therapy for Depression

Early
- Engage and set goals
- Socialize to structure of session, rationale for approach
- Educate regarding cognitive model
- Gather information and begin conceptualization process

Middle
- Conceptualize case and plan treatment
- Implement behavioral strategies, such as graded task assignment, pleasant activity scheduling, problem solving training
- Elicit, modify, respond to automatic thoughts
- Elicit, modify, respond to core beliefs

Late
- Continue cognitive and behavioral interventions
- Prepare client for termination
- Develop relapse prevention plan

Phases of of Cognitive-Behavior Therapy Session

Early
- Greeting and mood check
- Orient to problem solving and agenda setting
- Bridge from previous session and work of session
- Gather information and begin conceptualization process

Middle
- Conceptualize case and plan treatment
- Implement behavioral strategies, such as graded task assignment, pleasant activity scheduling, problem solving training
- Elicit, modify, respond to automatic thoughts
- Elicit, modify, respond to core beliefs

Late
- Continue cognitive and behavioral interventions
- Prepare client for termination
- Develop relapse prevention plan

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+ Early Phase of Session

- Agenda setting -- "What problems do you want to work on today?" "What problems do you want to solve today?"
- Bridge – Summarize for client focus of last meeting, what was learned, what was practiced, the link of that work to client's treatment goals, homework assignment that came out of that session.
- Update -- "What happened between last session and now that I should know?....What positive things happened or when did you feel even a little better?" "What's coming up between this session and next that I should know about?"
- Homework Review – "How did the homework go. Shall we take a look now at what you learned?"
- Socialize client to cognitive model.

+ Using Thought Record to Teach Cognitive Model

- Introduce client to thought record.
- Focus thought record on a specific problem that is linked to client's treatment goals.
- Help client to distinguish between thoughts that precede mood induction and follow mood induction.
- Ask questions to elicit data for each column (situation, thoughts, emotions, responses).

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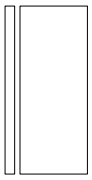
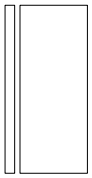
+ Middle Phase of Session



- Collaboratively prioritize problems and get buy in from client to move ahead with working on the first problem on the agenda.
- Collaboratively complete a thought record for the problem (situation, thoughts, emotional and behavioral responses).
- Collaboratively decide strategies to use (e.g., problem solving training focused on problematic situation; behavioral strategies (e.g., skills training); emotional response (e.g., emotion regulation skills).

+ Middle Phase of Session (cont.)



- Use frequent summaries to highlight important information or ask client to summarize – "Would you please summarize what we just worked on?" "What's the main message here?"
- Ask client to repeat rationale for intervention -- "Would you please tell me why you think pleasant activity scheduling might help you improve your mood?"
- Ask client for ideas for action plans – "So, what do you think would help you this week?" "What ideas do you have for something to do to practice what we worked on today?"
- Develop action plan that includes adaptive cognitive and behavioral responses.

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End Phase of Session

- Review action plan (homework assignment) assess likelihood of completion, troubleshoot barriers to completion, practice in session if you can.
- Elicit feedback about what was learned -- "What's your number one take away from this session?" "If someone asked you what you worked on today, what you tell them?"
- Elicit feedback about session itself – "What did you think about the session today – helpful or not so helpful?" "Anything you would like us to do a bit differently next time?"
- Elicit feedback about therapist – "Did I say or do anything today that bothered you or that you would want me to do differently next time?" "What could you share with me that will make me a better therapist for you next session?"

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Gathering Information and Planning Treatment

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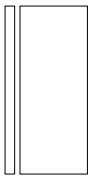
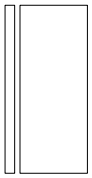
+ Guidelines for Successful Self-Monitoring



- Provide rationale for self-monitoring.
- Collaboratively define phenomena to be monitored.
- Give concrete examples of target phenomena.
- Emphasize immediacy in self-recording.
- Identify potential barriers and problem solve.

+ Self-Monitoring Strategies



- Thought records.
- Mood logs.
- Standardized measures of depression.
- Activity schedules.

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Goal Setting

Guidelines for Effective Goal Setting

- Focus on core values – What is or has been important to them in life? (e.g., family, creating a home, friends, work, intellectual pursuits, spirituality, hobbies-interests, sports, community, politics, etc.).
- Emphasize behavioral goals and ensure goals are realistic and specific.
- Ensure that goals are under control of client (e.g., "say hello and smile at people" vs. "get people to like me".

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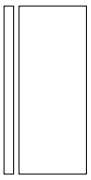
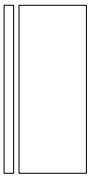
+ Questions to Clarify Goals



- How would you like your life to be different as a result of therapy?
- What would you like to be doing differently?
- If you were feeling better, what would you like to be doing differently (at home-work) (with friends, family, co-workers) (with your spiritual or physical life) (with your leisure time)?

+ Exercise - Goal Setting



- **Set concrete, behavioral, and realistic goals with a client.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells ''client'' whether to play the client ''easy,'' ''medium,'' or ''hard.''
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the ''client'' roleplayer.

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Case Conceptualization

+

Rationale for Individualized Case Conceptualization

- A theory that explains or accounts for a particular client's symptoms and problems.
- A systematic method of adapting the standardized protocol to individual case.
- An empirical, hypothesis-testing approach to the single case.
- Assists therapist in treatment process.

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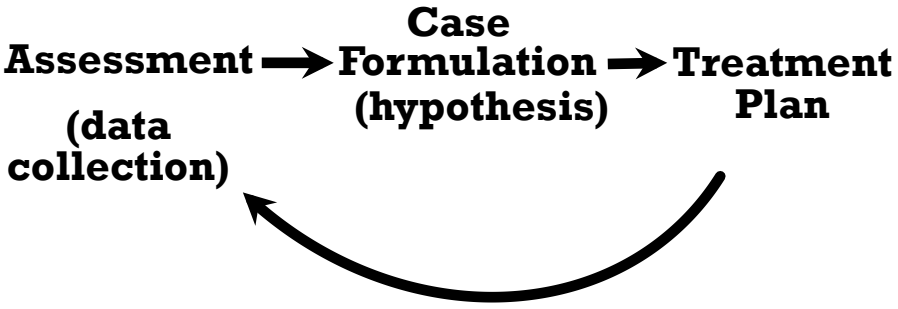
Empirical Approach to Single Case



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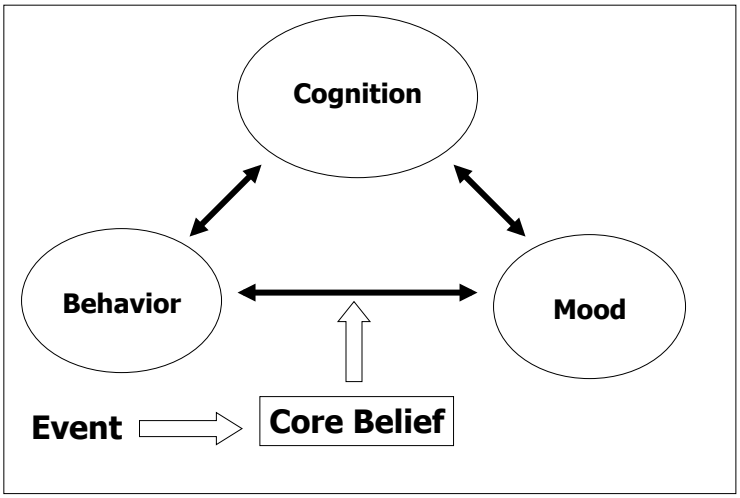
Cognitive Theory of Depression



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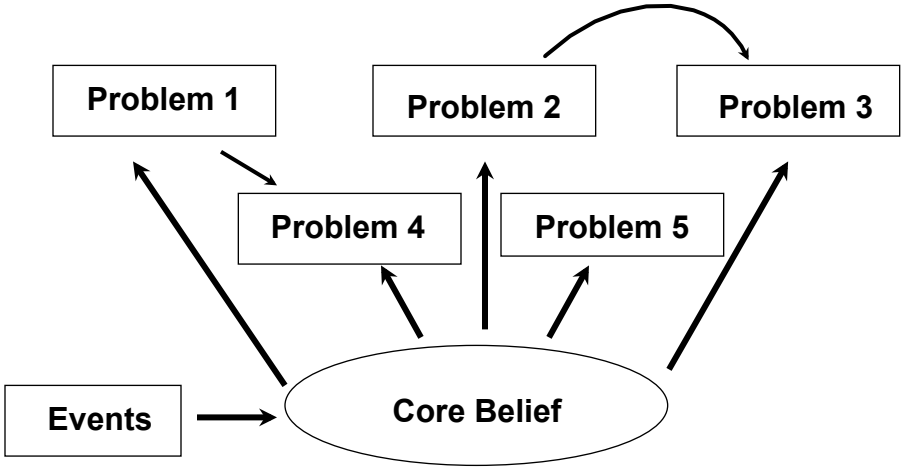
Applying Beck Cognitive Model to Multi-Problem Case



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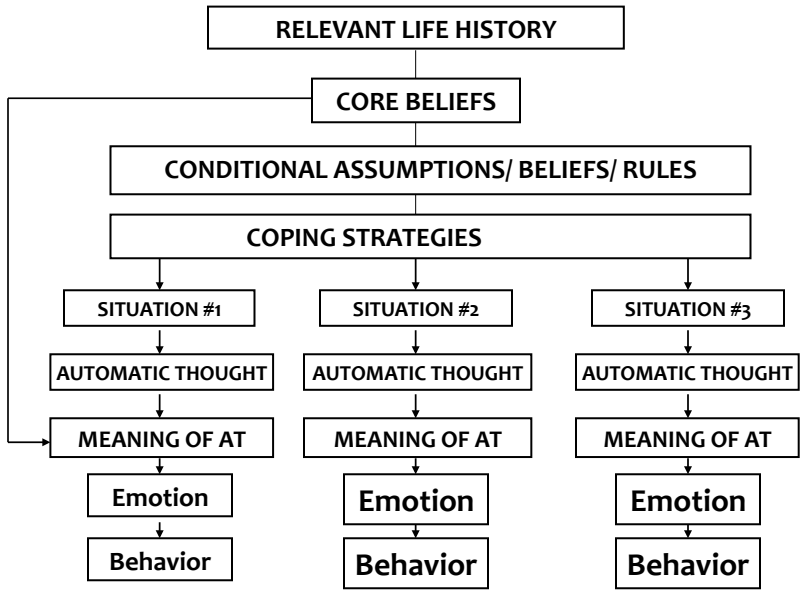

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+ Guidelines for Developing a Problem List

- Strive to be exhaustive, include client's chief complaint.
- Offer a 1-2 word description.
- State problems in concrete, behavioral terms.
- Describe mood, behavioral, and cognitive components of problems.
- Quantify problems whenever possible.
- Use the client's words whenever possible.
- Strive for a mutually agreed upon problem list.

+ Common Problem Domains

- Psychological symptoms, problems, disorders.
- Medical symptoms, problems, disorders.
- Interpersonal difficulties.
- Work difficulties.
- Financial difficulties.
- Housing difficulties.
- Legal difficulties.
- Leisure difficulties.

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+ Definition of Conceptualization Hypothesis

- A "story" that describes how the client developed certain core beliefs that are now being activated by certain life events to cause the symptoms and problems on the client's Problem List.

+ Components of Conceptualization Hypothesis

- Problems (expressed in terms of automatic thoughts, emotional, physiological, behavioral responses).
- Core and intermediate beliefs.
- Maladaptive compensatory (coping strategies).
- Activating situations.
- Origins.

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Strategies for Developing Belief Hypotheses

- Attend to automatic thoughts, particularly those that occur repeatedly.
- Attend to automatic thoughts that occur across a variety of situations.
- Use downward arrow technique.

Using Thought Record to Collaborative Formulate Case

- Focus on specific situation when client was feeling down or depressed.
- Connect situation to thoughts to emotion to response with arrows on the thought record.
- Complete thought records for several situations when client's mood dipped.
- Therapist may wish to complete a thought record when client's mood improved to demonstrate the role of thoughts in lifting mood.

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+ Exercise – Develop a Case Conceptualization for an NDD Adult

- **Collaboratively develop a case conceptualization with a client.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe; therapist in charge of roleplay and tells "client" whether to play the client "easy," "medium," or "hard."
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, Sandra in the case vignette, or a real client of the "client" roleplayer. **Use a blank thought record to focus the conceptualization exercise.**

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Typical Behavioral Strategies for Depression

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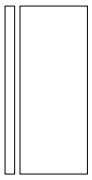
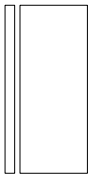
+ Activity Scheduling



- Therapist works with client to schedule enjoyable and goal-directed activities to increase activity level and thereby improve mood and allow clients to obtain evidence to disconfirm negative views.

+ Rationale for Activity Scheduling



- Helps combat the withdrawal, passivity, and sedentary life-style associated with depression.
- Helps to distract client from preoccupation with negative thinking.
- May lead to cognitive restructuring.

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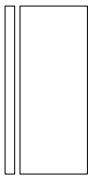
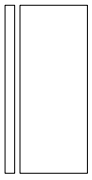
+ Clients who Benefit from Activity Scheduling



- Clients who are passive, immobilized.
- Clients who are procrastinating, avoiding or feeling "stuck."
- Clients who are having trouble getting moving because the are overwhelmed and have too much too do.
- Clients struggling with suicidal thoughts or impulses.

+ Select Focus for Activity Scheduling



- Select a time of the day or week when client not using his or her time well.
- Select a time of day or week when client most at risk or most depressed.
- Select an activity to improve personal care.
- Select an activity to increase socialization, pleasure, or treatment compliance.

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+ Features of Activity Scheduling

- Activity monitoring.
- Identifying pleasant and-or mastery activities.
- Activity scheduling.
- Pleasure predicting.

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+ Activity Monitoring

- Identify which activities client is currently enjoying or is proud of when accomplished (refer to Pleasant Activities List).
- Identify which activities that were once fun and made client proud.
- Enter activities (no matter how small) on the Activity Scheduling Form.

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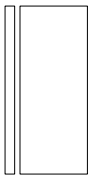
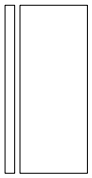
+ Brainstorming Pleasant Activities



- "Were there times when you felt good, even a little?"
- "This activity you're suggesting, did you enjoy it in the past?"
- "Is this an activity you want to do or think you should do?"
- "Sometimes the little things can be surprisingly fun, do you want to test that out?"
- "Do you think this might be more fun for you if you included someone?"

+ Review Activity Monitoring Form



- Review collaboratively the completed Activity Schedule Form.
- Focus client on link between activities and mood to increase curiosity and willingness to schedule more activities.
- Look for activity themes to expand.
- Review daily overall mood ratings.

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+ Guidelines for Effective Activity Scheduling

- Provide a rationale.
- Use guided discovery as much as possible.
- Start where the client is, not where client thinks s/he should be.
- Include cognitive rehearsal and contracting
- Be specific and concrete.
- Plan ahead for obstacles.

+ Overcoming Obstacles to Scheduling Activities

- Use cognitive rehearsal to identify barriers to trying activity and brainstorm solutions (use problem solving strategy).
- Assess confidence level -- "How likely is it that you'll do this?" "What do you think might get in the way of following the plan?"
- Test problematic beliefs with behavioral experiments: "I don't enjoy anything." (pleasure predicting); "I can't do it because I don't feel like it." (breaking down task); "I have to do things perfectly for them to be fun." (identify activities that can be fun, even if done "imperfectly").
- Focus on core values -- client more willing to try something if it fits his/her values or sense of purpose: "What is important to you?"; "Is this something you want to stand for?''; "What are some words that describe who you are deep down or want to be?''

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+ Exercise – Activity Scheduling

- **Schedule 4-6 pleasant or mastery activities for the depressed client.**
- Divide into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells ''client'' whether to play the client ''easy,'' ''medium,'' or ''hard.''
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the ''client'' roleplayer.

+ Pleasure Predicting Experiment

- Often included in the activity scheduling process.
- Depressed clients typically underestimate amount how much fun they will have.
- This underestimation of pleasure decreases likelihood that client will engage in pleasant activities and reinforces social isolation and low activity level.

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Graded Task Assignment

- Provide rationale for intervention.
- Select specific task that client is interested in trying.
- Avoid trap of helping client break down a task that the client thinks he or she should do rather than a task the client wants to do.

Problem Solving Training

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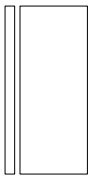
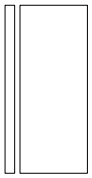
+ Problem Solving



- Ability to problem solve effectively influenced by developmental age.
- Ability to problem solve effectively influenced by affect.
- Ability to problem solve effectively influenced by cultural context.

+ The Problem Solving ITCH



- Identify the problem.
- Think about possible solutions.
- Choose a solution to implement.
- How well did it work?

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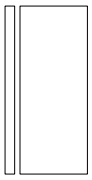
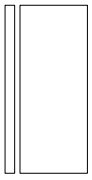
+ Identify the Problem



- Easier said than done and perhaps the most critical step.
- Select one problem, prioritize multiple problems if necessary.
- Define the problem in concrete, specific terms, e.g., "No one talks to me at lunch."

+ Think of Possible Solutions



- Brainstorm all possible solutions and be neutral "That's a solution," versus "That's a great solution"
- Encourage client to lead.
- Ask permission to throw out an idea.
- If client stuck, model with a problem you encountered recently.

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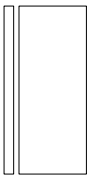
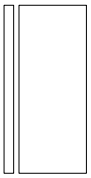
+ Choose a Solution to Try



- Evaluate pluses and minuses of each solution.
- Select solution most likely to work and least likely to cause problems, set up as experiment.
- Identify steps required to implement the selected solution.
- Include in the solution steps that would make solution more likely to work and avoid problems, e.g., "Talk to Ms. Jansen but ask her to not tell my parents unless I'm in danger."

+ How Well Did It Work?



- Evaluate how well solution worked, examine the pluses and minuses.
- "Didn't even come close" – repeat ITCH.
- "Missed the mark but close" – modify based on what was learned and try again.
- "Bulls eye" – Continue the solution.

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Problem or Problem of Perception

- "Everyone hates me" – client is disliked because of inappropriate behaviors or client is sensitive and believes benign neglect means people hate him.
- "School is boring" – client is bored because curriculum not challenging or client will not try because he fears he might fail.
- Use cognitive and behavioral interventions that target these thoughts or beliefs.

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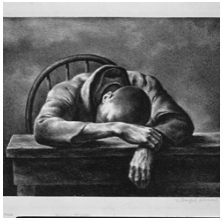
Typical Cognitive Strategies for Depression Focused on Automatic Thoughts



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Thought Record to Promote Change

- Thought record is a tool clients can use to arrive an an alternative view of a problematic situation that allows them to feel and function better.
- Step 1 – Examine usefulness of client's cognitions in a problematic situation (advantages vs. disadvantages).
- Step 2 – Identify cognitive distortions.
- Step 3 – Examine the evidence.

Guidelines for Thought Record to Promote Change

- Use guided discovery as much as possible.
- Select focus for thought record (problem emotion or behavior).
- Focus on a concrete, specific situation.
- Follow the affect.
- Encourage client to use thought record.

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+ Cognitive Rehearsal

- Use to rehearse use of rational responses.
- Use to anticipate obstacles or barriers when scheduling activities, developing action plans (homework assignments), when planning application of any skill to a new or typical situation.
- Increases confidence and thereby increases likelihood client will try and succeed.

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+ Time Machine

- Diffusion strategy that enhances client's perspective on an emotion or situation.
- Decreases likelihood of rash emotional decision making or responding.

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Typical Cognitive Interventions Focused on Beliefs

Core Beliefs

- Deep cognitive structures that enable an individual to interpret his or her experiences in a meaningful way (Beck, 1976).
- Core beliefs can be activated in many situations.
- Core beliefs include both positive and negative information.
- Core beliefs determine what we notice and remember.

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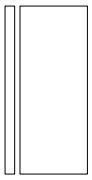
+ Rationale for Belief Change Strategies



- Designed to restructure deep cognitive structures (beliefs) assumed to contribute to depressive symptoms.
- Weaken maladaptive beliefs.
- Developing and/or strengthening more adaptive beliefs.

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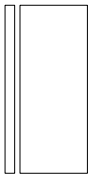
+ Guidelines for Identifying Negative Beliefs



- Follow the affect.
- Identify (if possible) all three types of core beliefs and specific intermediate beliefs.
- Use client's personal language to express belief.
- Identify beliefs (positive and negative) that client expresses in absolute terms (e.g., I am worthless).

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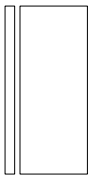
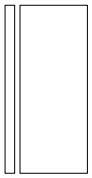
+ Methods for Identifying Negative Beliefs



- Thought records.
- Downward arrow technique.
- Sentence completions.
- Belief questionnaires.

+ Core Belief Change Methods



- Positive data log (Padesky, 1994).
- Continuum methods (Padesky, 1994).
- Historical test of schema (Young, 1990).
- Core belief worksheet (Beck, J., 1995).

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+ Positive Data Log

- Log of evidence in support of an client's positive or balancing belief.
- Teaches client to notice the multiple situations in which beliefs are activated.
- Helps client strengthen the positive or balancing belief.
- Helps the client notice and overcome biases in processing information that are driven by core beliefs.

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+ Guidelines for Setting Up a Positive Data Log

- Provide a rationale.
- Identify the balancing core belief.
- Start the positive data log in session.
- Instruct client to enter evidence on the positive data log as soon as possible.
- Instruct client to enter all evidence, no matter how small, and place a question mark next to evidence that client doubts is appropriate.

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+ Positive Data Log Probe Questions

- Why don't you walk me through the day? Let's see if we can find something that you missed.
- Tell me about the interactions you've had with people this week? Let's see if we can find something that you may have missed.
- If people thought you were ……. (alternative belief) what might they notice about you? Did you do anything like that this week?
- If you really believed you were ……. (alternative belief) what might you be doing or saying? Did you do anything like that this week?
- Can you think of someone who has a lot of this quality we've called ……. (alternative belief)? What do you do or say that makes you think they' re ……. (alternative belief)? Did you do anything like that this week?

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+ Guidelines for Reviewing a Positive Data Log

- Review the positive data log.
- Reward small steps.
- Watch for activation of maladaptive core belief when reviewing positive data log.
- Watch for opportunities in session to add items to the positive data log.

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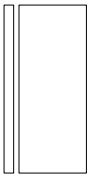
+ Exercise – Positive Data Log

- **Set up positive data log for a depressed client.**
- Break into triades and decide who will play the therapist, who will play the client, and who will observe.
- Therapist in charge of roleplay and tells "client" whether to play the client "easy," "medium," or "hard."
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the "client" roleplayer.



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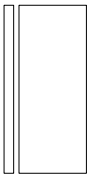
+ Continuum Techniques

- Targets black-and-white thinking.
- Helps client discriminate degrees of a characteristic (responsible, selfish, horrible).
- Focuses on behaviors while creating extremes, builds a middle point too.
- For example, Responsibility Pies -- Can be used in many ways, but particularly helpful for inflated responsibility "It's all my fault."
- For example, graphing strategies – I'm a loser.



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+ Historical Test of Schema

- Developed by Jeffrey Young (1990).
- Strategy to test the evidence for and against a negative core belief (schema) across the client's lifetime.
- Since core beliefs (schemas) formed over a lifetime, a lifetime of data needs to be considered.

+ Guidelines for Implementing Historical Review of Schema

- Step 1 – identify maladaptive core belief (schema).
- Step 2 – Separate life span of client into specific age periods.
- Step 3 – Develop list of confirming and disconfirming objective evidence for each age period.
- Step 4 – Write summary of data for each age period and include qualifications for evidence that confirms maladaptive core belief (schema).

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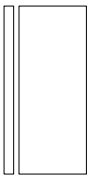
Exercise – Historical Review of Schema

- **Select an age range and review a maladaptive schema. Include evidence confirming, disconfirming, and a summary statement.**
- Divide into triades and decide who will play the therapist, who will play the client, and who will observe; therapist in charge of roleplay and tells "client" whether to play the client "easy," "medium," or "hard."
- Therapist decides whether client is to play same client shown in a demonstration roleplay, a video, or a real client of the "client" roleplayer.



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Relapse Prevention

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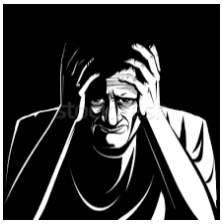
Guidelines for Effective Relapse Prevention

- Review successful cognitive and behavioral change strategies.
- Distinguish between relapse and flare-up; develop picture of client's idiosyncratic relapse pattern and establish mechanism for monitoring.
- Develop relapse prevention plan and share with family and others involved in client's care.
- Consider the client's preferred mode of terminating relationships and use this to terminate effectively.

Thank You!

Please complete the course evaluation before you leave.



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