



**18th Canadian Collaborative
Mental Health Care Conference (2017)**

Connecting People in Need with Care

June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario

Cognitive Behavioral Therapy in Children/Teens
Katharina Manassis, MD, FRCPC

PRESENTER DISCLOSURE

- ▶ Presenter: Katharina Manassis, MD, FRCPC
- ▶ Relationships with commercial interests:
 - ▶ Grants/Research Support: None
 - ▶ Speakers Bureau/Honoraria: Shire, Janssen (unrestricted)
 - ▶ Consulting Fees: None
 - ▶ Other: **Book Royalties from Barron's Educational, Routledge Publishing, and Guilford Publishing**



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Department of Family Medicine
Department of Psychiatry



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MITIGATING POTENTIAL BIAS

- Presenter: Katharina Manassis, MD, FRCPC
- Mitigation of conflict: **I have written a book “Cognitive Behavioral Therapy with Children: A Guide for the Community Practitioner, 2nd Edition” with Routledge Publishing. I get royalties from this book and might refer to it in this talk. However, I also plan to refer to many other CBT resources to mitigate this bias.**
- I may refer to the use of selective serotonin reuptake inhibitors in children as these are often combined with CBT in this population, but please note that their use in children <18 is off-label.



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LEARNING OBJECTIVES

- 1) Learning Objective 1: Explain the rationale for providing adapted CBT and CBT-based interventions to children and adolescents in primary care;
- 2) Learning Objective 2: Integrate CBT principles to case vignettes representing young patients that may benefit from these interventions;
- 3) Learning Objective 3: Evaluate the need for further study of how to best use CBT-based interventions for children in primary care settings.



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Take-home points

- ▶ CBT can be adapted for children with different comorbidities, cultural backgrounds, and cognitive levels
- ▶ A 10-minute visit may allow teaching either parent or child a CBT-based strategy for ONE component process of anxiety or depression and drawing their attention to appropriate self-help resources
- ▶ Any contributing environmental factors need to be addressed or the child will not benefit
- ▶ Developmental level dictates both nature of intervention and degree of parental involvement

Barriers to CBT Access for Children

- ▶ Limited numbers of trained therapists
 - ▶ Distance to trained therapists
 - ▶ Cost of non-physician mental health providers
 - ▶ Patient volumes
 - ▶ Case complexity
-
- ▶ Adapted and modular approaches suggest ways of addressing these barriers to care!
 - ▶ **Adapted works well when you are doing ‘standard’ therapy appointments;**
modular when you do short office visits

Adapted CBT or ‘Pseudo-CBT’?

- ▶ CBT is directive (without alienating the patient/parents)
- ▶ CBT is structured and focused on skills
- ▶ CBT includes work outside the office for child & parent (whether you call it homework or not)
- ▶ CBT includes follow-up and fine tuning
- ▶ The specific content is flexible!

Family Problems that are ‘Red Flags’

- ▶ Ongoing custody & access dispute
- ▶ Open file with CAS
- ▶ Severe parental psychopathology
- ▶ Severe family conflict
- ▶ Multi-problem families that cannot prioritize appointments
- ▶ Current family crisis (e.g., death in the family, recent separation)
- ▶ **Parents who expect you to “fix the child” with little work on their part**
- ▶ Driving distance >1/2 hour each way (unless very high motivation for weekly visits & willing to compromise work/school)

Address the exacerbating factors (children are very context-dependent)

- ▶ What to tell other kids when you return to school after absence
- ▶ How to catch up on academics after absence
- ▶ Optimize school support, with supportive letters/communication as needed
- ▶ Assess & address learning problems
- ▶ Assess & address medical/psychiatric comorbidities
- ▶ Address bullying and encourage hanging out with friends to reduce the risk
- ▶ Increase healthy lifestyle routines (sleep, nutrition, physical activity, homework, limited gaming)

The context at home

- ▶ Decrease family conflict
- ▶ Increase parental consistency
- ▶ **Help parents see the child's strengths**
- ▶ Help parents manage their own mental health
- ▶ Decrease exposure to frightening shows or games
- ▶ Encourage good family health habits
- ▶ Make sure expectations are developmentally appropriate and focused on small gains from baseline
- ▶ **“Case Formulation with Children & Adolescents”** Manassis, 2014

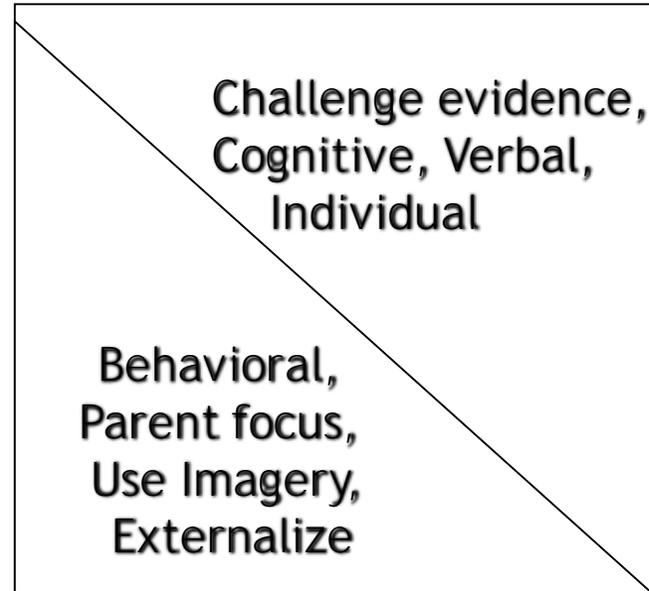
NOW we can Adapt to Child Differences!

Favorite Resources

- ▶ CHEO toolkits for providers, parents & youth (<http://www.shared-care.ca/toolkits>)
- ▶ www.anxietybc.com
- ▶ www.workbookpublishing.com (Camp Cope-a-Lot; Taking ACTION, Coping Cat/CAT Project)
- ▶ What to Do When You Worry Too Much (D. Huebner); for 6-8 years to read with parent
- ▶ Keys to Parenting Your Anxious Child, 3rd Edition (Manassis, **2016; Barron's Educational**)
- ▶ Talking Back to OCD (March & Benton, 2007, Guilford Press)
- ▶ If Your Adolescent Has an Anxiety Disorder (Foa & Wasmer-Andrews, 2006, Oxford U. Press)
- ▶ Helping Your Child With Selective Mutism (Mcholm et al., 2006, New Harbinger)—n.b., chronic cases usually need SSRI as well (off-label)
- ▶ Free download: Steady Adolescent Workbook by Clarke et al.
- ▶ **It's better to read 1 chapter with follow-up** re: implementation than several books of strategies that are never applied!

Cognitive Limitations

Level of
Functioning



Age or Cognitive Level

Externalizers

- ▶ Comorbid ADHD is ideally done individually (disruptive in groups) and with child well-medicated so he/she can attend & learn during sessions
- ▶ If still symptomatic, redirect often, work in short intervals with breaks, use **“when/then” for talking time, reduce quantity as long as principles learned,** use imagery & visual reminders to reduce working memory load
- ▶ ODD, CD, DMDD: Contain the externalizing behavior with good parent/school management before doing CBT focused on internalizing problems
- ▶ **Don’t get sucked into doing CBT for “underlying anxiety” with parents expecting CBT to improve behavior (usually, it doesn’t)**
- ▶ Exception: oppositionality that occurs ONLY when the child is trying to avoid feared situations can be managed in CBT with parental involvement

Extreme Internalizers

- ▶ Very withdrawn depressed children/teens may need focus on basic behavioral activation (getting out of bed, leaving room daily, etc.) before they can benefit from CBT strategies
- ▶ Reinforce every minor sign of engagement in therapy (e.g., eye contact, **nodding**) and be more playful so they don't fear "failing" at therapy tasks, try getting them to "help a friend" so it seems less personal/threatening, use multiple choice rather than open ended questions
- ▶ Selectively mute children may need a parent and/or mental health provider in the school setting to generalize gains, and usually need SSRI medication if age 7 or above (Oerbeck et al.,)

Cultural Differences

- ▶ Be flexible on the language used for reading & writing in CBT
- ▶ **Learn about (and respect if possible) the child/family's culture and values**, especially how they see the role of the therapist/parents/community and treatment expectations (e.g., individualistic focus of CBT may seem foreign)
- ▶ Be aware of degree of acculturation of child and of parents
- ▶ **Illustrate concepts using symbols relevant to their culture (e.g., 'Medicine Wheel' rather than cognitive triad; coping animal that fits cultural context)**
- ▶ Avoid exposures that are not culturally sanctioned (e.g., in OCD)
- ▶ **In oral traditions, or those where 'Western' education has had a negative influence historically**, de-emphasize manuals/writing in favor of communicating concepts in other ways (e.g., telling stories)

Preschoolers are just “upset”

- ▶ Relaxation: smell the flower/blow out the candle; squeeze lemons; make the book move up and down with your tummy
- ▶ Give the problem a nickname to externalize it and catch it early; find a character the child admires and encourage thinking/acting like him/her
- ▶ Use relaxation, distraction, support seeking at the first sign of the problem
- ▶ Work with parents around behavior management ONE situation at a time (gradual exposure for anxiety, activation for depression, consistent disengagement for tantrums)
- ▶ Positively reinforce NOT acting out, as well as any desirable behaviors **targeted (parents usually can't track >2 at a time)**
- ▶ See www.katharinamanassis.com re: resources and tip sheets for parents

What about teens?

- ▶ Engagement is often a challenge
- ▶ They can do relaxation/box breathing
- ▶ They often prefer CBT self-help & checking the evidence to generic statements
(see resource list...apps for anxiety CBT are also being developed)
- ▶ It is harder for parents to motivate them re: exposure and activity; need to plan it with them rather than for them
- ▶ **They appreciate parental positives & role modeling, even if they won't admit it**
- ▶ They are at increased risk for depression (esp. females) which may need medical treatment
- ▶ They may self-medicate with substances (pot & alcohol most likely)
- ▶ They really need to keep going to school consistently, regardless of diagnosis!

Is there evidence for brief CBT-based interventions?

- ▶ Not specifically
- ▶ **However...’state of the art’ CBT for children with complex presentations is now emphasizing the use of several brief modules focused on specific skill-sets, rather than disorder-focused manuals**
- ▶ **See: ‘Modular Cognitive Behavioral Therapy for Childhood Anxiety Disorders’, Bruce F. Chorpita, Guilford, 2006**
- ▶ Most of the children you see in the community will have complex **presentations; ‘squeaky-clean’ research candidates are rare outside academe**
- ▶ **Think of what I am about to present as ‘simple modules’**
- ▶ Follow up to make sure children (and parents) are using what you teach

Component Processes

Anxiety

- ▶ Feeling Awareness
- ▶ Physiological Arousal
- ▶ Catastrophic Thinking
- ▶ Behavioral Avoidance
- ▶ Poor Problem-Solving

Depression

- ▶ Feeling Awareness
- ▶ Anhedonia
- ▶ Negative Thinking
- ▶ Inactivity
- ▶ Poor Problem-Solving

Feeling Awareness

- ▶ Having an “early warning system” for anxiety which clearly signals the youth that it’s time to use their strategies—these never work if you wait until anxiety is extreme
- ▶ ID the times and places where your mood typically dips—monitor for a week if not sure using a 1-10 rating before school, AM, PM, after school, & evening
- ▶ Record physical feelings and events at low times (e.g., lethargy, restlessness, cravings, pain; experiencing criticism/ridicule, facing work, being alone)
- ▶ Awareness of depression triggers and signals allow you to plan for safety and for ways of coping *before* **you are in the “depths”**

An 'early warning system' for anxiety

- ▶ **Briefly explain the 'fight or flight' response and some anxiety symptoms that can relate to it (e.g., tummy-ache from blood rushing away to big muscles)**
- ▶ Use a body drawing to have the child point to places where he/she notices anxiety symptoms
- ▶ Ask which symptoms are the earliest
- ▶ Ask if there are thoughts/feelings that come up even earlier
- ▶ Include the earliest signal on a coping card (see below), so the child knows when to use strategies

“Panic” in anxious situations (i.e., hyperventilation)

- ▶ Box breathing: 4 in, 4 hold, 4 out, 4 wait & repeat
- ▶ Focus is on counting rather than anxiety; breathing is slowed; no regular practice needed
- ▶ If at school, have a quiet room for the child to calm down & then return to class when calm (usually a few minutes; half hour at most)
- ▶ Discourage calls home/parents picking up unless fever or vomiting
- ▶ Discourage the adults from talking/reassuring too much (adrenaline will **subside with time if you don't fuel it further**)
- ▶ What if they prefer to do yoga, mindfulness, Eli Bay, or some other version of **relaxation? If they're willing to practice daily, tell them to go for it!**

Rationale for Coping Thoughts

- ▶ The class is told there's a big test coming up next week
- ▶ Ben says to himself "That's awful. I'm going to spend the whole weekend studying, and then I'll freak out when I see it. What if I fail? My parents will be so disappointed. I wish I didn't have to go to school."
- ▶ Charlie says to himself "Oh good. I'm not doing great in this course, but if the test is worth a lot of marks and I do well, I could really pull up my grade."
- ▶ How does Ben feel?
- ▶ How does Charlie feel?
- ▶ Which attitude is more helpful?

Generic self-talk for anxiety

- ▶ I've done this (or something similar) before, so I can do it now
- ▶ I can't predict the future, so I might as well hope for the best
- ▶ **It's my worried mind talking**
- ▶ I know I will be OK
- ▶ I know I can deal with this when the time comes
- ▶ Things are often not as dangerous as they seem to me
- ▶ I can focus on something else
- ▶ I can ask for help if needed
- ▶ There are many explanations that have nothing to do with what I fear
- ▶ **What's the worst that could happen? (if the feared outcome is non-lethal)**

Using self-talk for anxiety: the coping card

- ▶ Pick favorites and put on a card or slip of paper to be kept in the backpack (or wherever child gets anxious), encourage decorating it/personalizing it
- ▶ People do not think on the spot when anxious, so need concrete reminders
- ▶ Including a favorite picture or other reminder of home is helpful for some
- ▶ Serves as a transitional object as well as a reminder
- ▶ The more realistic the fear, the more the emphasis needs to be on personal strength rather than probabilities
- ▶ **It doesn't have to be fancy, it just has to facilitate exposure**
- ▶ Emphasize personal competence rather than probabilities in children facing realistic threats

Problem-Solving

- ▶ Pick ONE problem or situation
- ▶ Brainstorm possible alternative solutions/actions for that situation
- ▶ Evaluate the alternatives from 1 to 10 (terrible idea versus terrific idea), remembering that some things are very helpful for symptoms in the short term but unhelpful in the long term (e.g., smoking pot); other things are the opposite (e.g., doing homework)
- ▶ Choose an action(s) that is/are likely to be helpful
- ▶ Try it in the situation & see what happens
- ▶ Report back and problem-solve again if needed
- ▶ **“Problem Solving in Child & Adolescent Psychotherapy”** Manassis, 2012

Anhedonia

- ▶ Inability to appreciate or enjoy the positive elements of life
- ▶ **ACTION suggests “Catch the Positives” exercise**
- ▶ Attend to small sensory experiences that are not unpleasant—list your favorites (sight, smell, taste, sound, touch/feeling)
- ▶ Attend to moments in the day that are not entirely miserable—review at the end of the day and identify at least one (e.g., the school day finally ended; my mother stopped nagging me)
- ▶ Attend to your own accomplishments, no matter how small (e.g., even getting out of bed in a very debilitated youth)
- ▶ **Read “The Book of Awesome” (Pasricha, 2010)**

Negative Thinking

- ▶ Depressive thinking is: self-critical, hopeless about the future, and focused on **negative interpretation biases of current events** (e.g., “She’s frowning so she must hate me”)
- ▶ **Extremes abound: “always” and “never” statements**
- ▶ Positives are ignored (anhedonia)
- ▶ Easiest to elicit by talking about a situation where mood got worse

Self-talk for Negative Thinking

- ▶ Things may look different by tomorrow
- ▶ I may not get complimented on how I look, what I do, etc. but it may still be good
- ▶ **I can still do some things today, even if I don't feel great**
- ▶ **One bad result doesn't mean it will be this way forever**
- ▶ **It's a problem, not a permanent part of my personality**
- ▶ There are lots of reasons why people frown (or get impatient, or raise their **voices, etc.): it doesn't mean they hate me**
- ▶ Even if not everyone likes me, I still have some friends
- ▶ **Even if I didn't do great on this test, I can still pass**
- ▶ **I will run my own race: I don't have to compare myself to others**
- ▶ **There are many roads to success: I may not take the most direct one but I'll get there eventually**

More Self-Talk

- ▶ **It's not the end of the world**
- ▶ I may not be the best (or best-looking, smartest, most athletic, etc.), but I have good qualities
- ▶ I can take my mind off this, at least for a little while
- ▶ **I won't let my mind keep spiralling down**
- ▶ **Many people struggle with their moods: I'm not alone**
- ▶ **Even if I can only take a small step, I'm still further ahead**
- ▶ My depression saps energy, so I can be proud of every little thing I do
- ▶ **I won't base my opinion of myself on what one person thinks**
- ▶ Choose favorites, and when **in doubt, asking "What's the Evidence?" is usually best**

Exposure

- ▶ The only aspect of CBT that has been consistently associated with improvement in all age groups
- ▶ Gradual versus immediate: gradual is tolerated better, but immediate may be needed if there is urgency (e.g., school avoidance, severe family conflict around co-sleeping or other anxiety issues)
- ▶ Immediate: 1. Co-sleeping changes when parents are in agreement on what needs to happen and do it consistently; a bit of positive reinforcement for the **child for 'good nights' is nice, and setbacks must be ignored**
- ▶ 2. School avoidance is easy in 5-year-olds (take them in their **pj's**) and gets more difficult with age & longer time away; use non-family escorts and interception by teacher in the school yard whenever possible; medication **helps but doesn't cure; calm perseverance by everyone is needed**

Exposure (2)

- ▶ Gradual exposure is doable for almost all anxieties if you can find a small step to start with, and positively reinforce ignoring setbacks
- ▶ Many kids can do anxious situations with parent present initially, and then you can gradually decrease parental support
- ▶ Parental involvement is key: have them read Manassis' **“Keys to Parenting Your Anxious Child”** or similar book by Ron Rapee
- ▶ Social anxiety may need some training/rehearsal beforehand as kids lose social skills year by year through avoidance;
- ▶ Try some conversation starters: comment on shared sensory experiences; ask the person what they are doing/just did/are about to do
- ▶ Inhibited kids will never be naturally outgoing, but often do well with scripts and practice (try drama); large, unstructured social groups usually remain difficult

Exposure (3)

- ▶ Unassertiveness is a common parental concern:
- ▶ Have them keep a stiff upper lip (vs. weepy/angry reaction) & hang around with friends to minimize bullying; distinguish telling & tattling
- ▶ Fake it till you make it—encourage walking tall, looking in the eye, firm handshake with adults, ending statements firmly vs. upward voice inflection, **for teasing state the facts (e.g., “that is a rude thing to say”) & walk away, asking with “I need” statements, when in doubt say “I’ll think about it”**
- ▶ There is no exposure for GAD, right?—in younger kids no, in teens they can **recognize the need to tolerate uncertainty & that’s their exposure (e.g., not checking their Facebook multiple times during the night)**
- ▶ Many anxious youth find the AA motto helpful: Each day, change what you can, accept (with reassuring self-talk) what you cannot change, and know the difference—the rest will have to wait till tomorrow

Parental Pearls

- ▶ **Don't sweat the small stuff**
- ▶ Work on one or two situations at a time consistently, with empathic encouragement (“I know this seems hard, but you can do it!”)
- ▶ **Use charting so you don't forget & to show the child he/she is making progress;** attach a small reward to it if needed
- ▶ **Expect ‘2 steps forward 1 step back’ and focus on the ‘forward’**
- ▶ Less talk, less negative emotion
- ▶ **It doesn't matter if it's anxiety or behavior: if you want to encourage it,** praise it; if you want to discourage it, ignore it (unless severe--and then use time out, privilege withdrawal, natural consequence, etc.)
- ▶ **When in doubt, just breathe (kids can't think when highly anxious so talking just makes it worse)**

Inactivity

- ▶ Explain the rationale: avoiding depressive rumination; endorphin effect
- ▶ **Clarke's manual has some nice exercises for this issue:**
- ▶ Charting mood in relation to various activities;
- ▶ Identifying activities you used to enjoy (they provide a long list if nothing comes up);
- ▶ Setting activity goals that are just a bit more than your baseline;
- ▶ Identifying potential rewards of engaging in certain activities;
- ▶ Identifying attitudes/obstacles that prevent activities.
- ▶ Parents may need to set limits on gaming and other in-room pursuits; youth often become more active when doing activities with family/friends

Checklists for self-soothing

- ▶ Kids worry, ruminate, even self-harm more when they have too much unstructured time
- ▶ Have them list favorite calming sensory experiences, favorite mental foci (e.g., imagery, memories, prayers), and favorite people to call or text
- ▶ If OK, share with parents
- ▶ Provide a number in case things get worse

- ▶ Encourage self-reward with pleasant activities or just being proud of a job well done for ALL coping efforts regardless of result

Component Processes: How would they apply in the following cases?

Anxiety

- ▶ Feeling Awareness
- ▶ Physiological Arousal
- ▶ Catastrophic Thinking
- ▶ Behavioral Avoidance
- ▶ Poor Problem-Solving

Depression

- ▶ Feeling Awareness
- ▶ Anhedonia
- ▶ Negative Thinking
- ▶ Inactivity
- ▶ Poor Problem-Solving

Jorge (social anxiety)

- ▶ In Grade 5, does well academically but has always been reluctant to participate in class
- ▶ Not athletic or popular but has two friends that share interest in chess; stays home on weekends
- ▶ Usually not invited to birthday parties, hates group work, and bullied when younger
- ▶ Very nervous about presentations & avoids them
- ▶ **Won't answer the phone or talk to clerks/servers**
- ▶ **Parents described him as “polite and well-behaved, but shy.”**

Cindy (generalized anxiety)

- ▶ **Getting B's in Grade 4, but struggling to complete** assignments & **“freezes” on tests**
- ▶ Popular and chatty in class
- ▶ Frequently asks teacher repetitive questions about new material
- ▶ Argues about starting homework; needs to have big assignments **‘chunked’**
- ▶ No significant learning weaknesses on testing;
- ▶ Many worries, especially in the evening causing initial insomnia
- ▶ Parents were divorced with stable custody arrangements; mother describes **Cindy as “high strung, just like me.”**

Allison (depression)

- ▶ Allison first became depressed at the start of Grade 9, when she realized none of her friends were going to the same, large high school
- ▶ **She felt “lost and lonely” and couldn’t join any school clubs as she was bussed**
- ▶ In October, she met Matt in her English class and he became her first serious boyfriend; they were inseparable, and her mood improved dramatically
- ▶ Over the Christmas break, however, Matt met another girl and broke up with Allison; she was devastated, and her mood plummeted
- ▶ Allison avoided school, stayed in bed most of the day, overate, and was isolated apart from some online contact with friends from her previous school
- ▶ **Allison’s parents took her to the doctor, convinced “that boy must have given her Mono!” but all investigations were negative**

Allison (continued)

- ▶ Allison reported “Matt says I was too clingy. He’s right. I’ve never done anything by myself. I’m just fat and useless.”
- ▶ When asked what she still enjoyed, Allison replied “Cupcakes. I just want to go into a sugar coma.”
- ▶ When asked what she thought would help her feel better, Allison answered “For my parents to stop bugging me about going to school...and maybe a dog to snuggle with.”

Possible answers:

- ▶ Jorge shows lots of behavioral avoidance, so should start practicing a social situation that is not too difficult; he may also need coaching/problem-solving on what to say & how to act in this situation
- ▶ Cindy needs to challenge her catastrophic thinking, especially regarding school assignments and tests; she could also benefit from some regular **relaxation practice to improve sleep and baseline (“high strung”) anxiety**
- ▶ Allison needs all of the components for depression, and probably some antidepressant medication as well, but would do best starting with behavioral activation and at least partial school attendance, as rumination at home makes depression worse (note: trying cognitive strategies too early can sometimes result in further rumination); tracking her mood in relation to activities may also improve feeling awareness

Let's hear about your cases!

What about OCD?

- ▶ Exposure & response prevention is key, in small steps
- ▶ Reducing family accommodation is also done step by step and is important
- ▶ Self-talk often focuses on labeling & fighting the illness (choose favorites):
- ▶ **“It’s my OCD talking”**
- ▶ **“I’m in charge: I can choose not to listen to OCD”**
- ▶ **“I will do my best to do as little OCD stuff as possible”**
- ▶ **“What OCD says doesn’t make sense”** -assuming some insight
- ▶ **“I can let OCD thoughts come and go, until the discomfort settles”**
- ▶ **“I can give OCD a time out”** (i.e. postpone it)
- ▶ See **“Talking Back to OCD”** for more detail re: regaining control from OCD

What about PTSD?

- ▶ Physical relaxation and exposure to trauma reminders can be done, as for other anxieties
- ▶ There is no 10-minute solution to the cognitive aspects—the trauma narrative & imaginal exposure are key, but these require additional training & time
- ▶ Reference:

Treating Trauma & Traumatic Grief in Children & Adolescents; Cohen et al., 2006, Guilford Press

School Refusal (no magic treatment)

- ▶ Identify contributing factors (home, school, peers) and address these, r/o truancy
- ▶ School avoidance is easy in 5-year-olds (take them in their **pj's**) and gets more difficult with age & longer time away;
- ▶ Medication **helps but doesn't** cure
- ▶ >1month usually needs gradual re-entry
- ▶ Desensitization is key, but adding medication may improve results
- ▶ Home instruction rarely helps, routines do (esp. sleep)
- ▶ Reduce the affect in the system; calm perseverance by everyone is needed
- ▶ Help parents with contingency management
- ▶ Involve neutral parties to escort the child & have teacher intercept
- ▶ Consider motivational interviewing for teens