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## CHAPTER 1

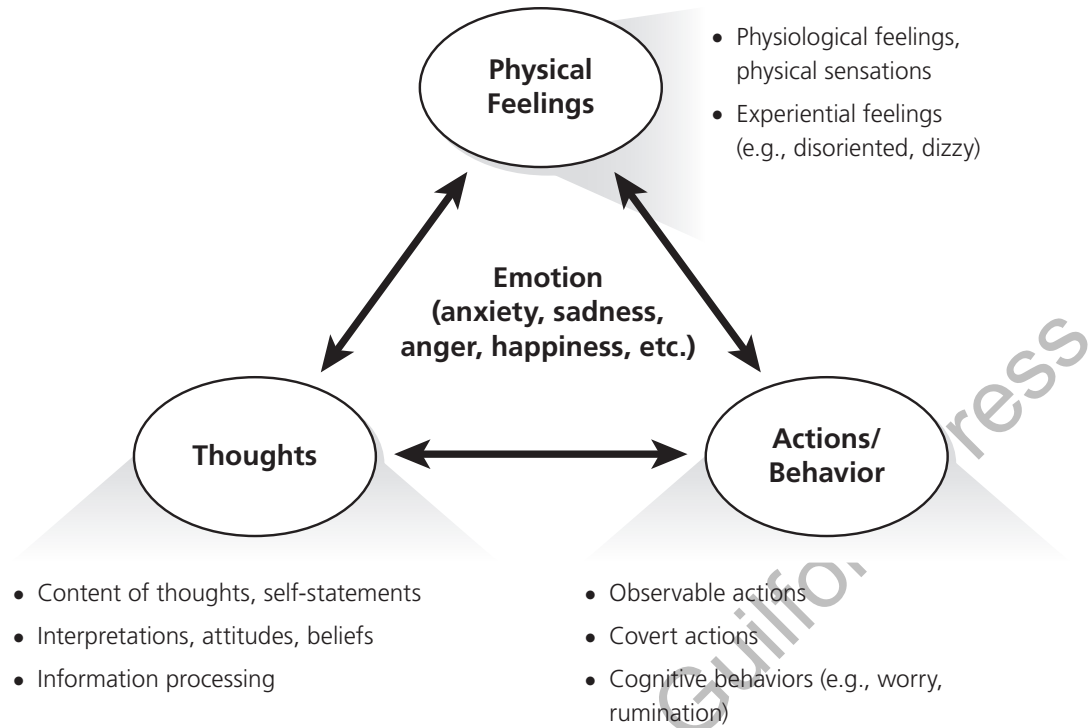
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# The CBT Model and Early Treatment Phase

This chapter reviews the overall CBT model and the components that the early phase of treatment usually comprises. Collecting comprehensive multimodal, multireporter assessment is critical to developing a holistic picture of your client. Assessment data are then used to develop a case formulation that highlights the cognitive, behavioral, and interpersonal processes maintaining the youth's anxiety and depression. The therapist subsequently plans the course of treatment and selects specific interventions based on this understanding of the youth's strengths and needs. Collecting and reviewing progress data help inform the clinician's treatment planning and improves therapy outcomes. Progress monitoring can include symptom reports or achievement of goals. Each of these activities is soundly grounded in the overarching CBT model. Over the next three chapters, we discuss CBT in the early, middle, and later phases of treatment to help orient the clinician. However, CBT proceeds in an iterative fashion, implementing interventions based on initial and then ongoing assessment, formulation, and treatment goals. Rarely is treatment linear, but there are common elements across CBT cases that tend to occur in phases.

### THE COGNITIVE-BEHAVIORAL THERAPY MODEL

The cognitive-behavioral therapy (CBT) model attempts to clarify emotional states (e.g., sadness, anxiety, shame, happiness, anger) that can often feel diffuse and uncontrollable into more observable and describable components: cognitions, physical feelings, and behaviors (Badin, Alvarez, & Chu, 2020). This CBT triangle, or thoughts–physical feelings–action cycle, has abundant utility. The clinician can use the framework to interpret objective and subjective (client or parent impression) data presented by the client to build a case conceptualization of how the client responds to stressors in the environment. It can also be used to provide psychoeducation to the client by describing the unique and interrelated roles of thoughts, feelings, and actions. The triangle construct holds whether considering clinical or more commonplace content. The triangle graphic (see Figure 1.1; a reproducible version is available as Handout 1 in Appendix A) often helps kids of diverse ages to understand their own emotional cycles. Finally, it helps set up treatment planning. As you analyze a client's idiographic responses to a trigger, you can note particular strengths and weaknesses. As you recognize where the client is getting stuck (e.g., pervasive negative thoughts,



**FIGURE 1.1.** General cognitive-behavioral model.

severe physiological symptoms, freezing or escape behavior), you can then prioritize CBT interventions that target the client's weak spots.

### Cognitive Components

The cognitive components of the model can be viewed at any level in the hierarchy of cognitive processes, from basic executive functioning (e.g., attention, memory), to information processing (e.g., conscious automatic thoughts, interpretations, distortions), to abstract meta-thinking (e.g., intermediate and core beliefs). The information processing and abstract thinking levels tend to focus on the *content* of thought. For example, when a youth is depressed, cognitive content tends to be unrealistically negative (“Soccer is for losers!” “My teacher has it out for me”), pessimistic (“Why bother trying when things never work out?”), and self-critical (“I mess up everything”). For a socially anxious youth, cognitive content tends to overfocus on a lack of control or self-efficacy (“I’ll never be prepared for that talk!” “I can’t handle the pressure”) and an exaggerated estimation of risk (“I know I’ll flub in front of everyone”) and magnitude of negative consequences (“Everyone will laugh at me!” “I’ll be known as the loser of the school”).

In addition to understanding the content of thoughts, evaluating cognitive *processes*, like worry, rumination, and distraction, can be helpful (Aldao & Nolen-Hoeksema, 2010; Chu, Chen, Mele, Temkin, & Xue, 2017). The benefit of treating cognitions as a process is that they can be viewed in terms of their behavioral functions. As a brief example, when a depressed teen is ruminating, it is critical to identify the triggers and consequences that surround that rumination. If a

teen reports substantial rumination while doing homework after school, it is critical to examine the initial triggers (opening a math book) and reactions (negative thoughts and feelings about the day) that lead to a cascade of rumination. This ruminative process helps the teen avoid their homework and helps us understand the *avoidant functions* of rumination. Being clear about the distinction between cognitive content and cognitive processes will help clients distinguish the distinct roles and consequences of behaviors, physical feelings, and emotions in their daily lives.

## Behavioral Components

Behavioral components can also be viewed at multiple levels. Observable actions are most associated with the term “behavior” (Chu, Skinner, & Staples, 2014). They consist of controllable, overt behaviors such as, talking, walking, socializing, exercising, sleeping, arguing, freezing, escaping, smiling, and laughing. But intentional behaviors can include discrete, covert behaviors that are not obvious to outside observers, such as muscle tensing, staring blankly, and the like. Sometimes it is difficult to identify the behaviors associated with emotional states because the intensity of emotions attracts our attention. For example, feeling love generally includes acting in a loving way even when the emotional sensations of love feel most salient. Acting lovingly could include attending to one’s partner when they are talking, holding hands, or thinking about the person during the day. You can select from a cornucopia of behaviors. Every emotional state offers the same diversity of options. Being “wakeful and alert” includes sitting up straight, breathing evenly, making eye contact with a conversation partner, exchanging thoughts and reciprocating attention. Feeling “lonely” might include withdrawal, isolation, self-pity, cascading rumination, pushing away available social resources and invitations. How any client acts happy, sad, mad, or anxious provides an idiographic behavioral conceptualization of that person. The more specifically and accurately one can identify the client’s unique behavioral response with various emotions, the more accurate one’s case conceptualization will be.

## Physical Components

The physical components of the model tend to refer to automatic physiological responses and other physical sensations that the body has in reaction to stressors. Physiological indices include heart rate, breathing rate and depth, galvanic skin response (leading to sweaty palms), dilated or constricted pupils, and blurry vision. Physical feelings that imply physiological reactions include: headaches, dry mouth, lump in the throat, tightness in the chest, stomachaches, muscle tension, coldness, feeling flush, muscle cramping, sweating. Such components can also include experiential feelings, such as disorientation, derealization, and depersonalization. The client will describe these feelings as automatic and out of their control (though we know that many of these responses can be put under the client’s control; Badin et al., 2020).

## How the Components Interact

There are several key aspects to the CBT model that bear emphasizing. First, no one component takes priority over the others in terms of understanding a client’s concerns. Second, the relations among thoughts, feelings, and actions are mutually reciprocal and bidirectional. Third, emotional

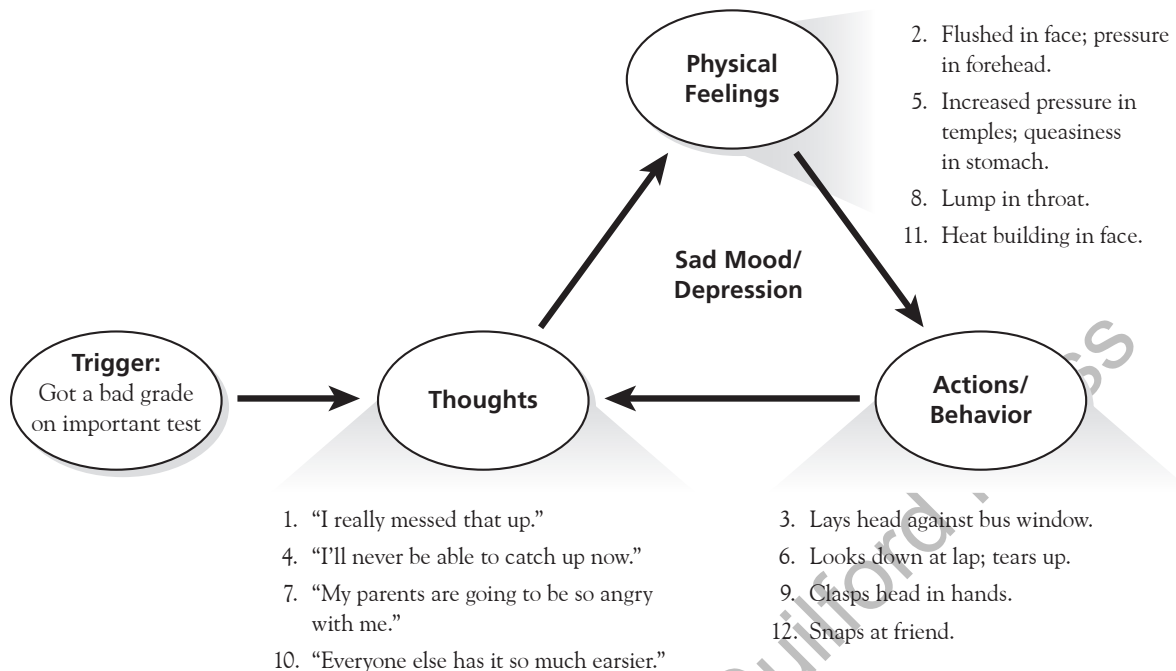
cycles do not stop naturally after one cycle of thoughts, actions, and behaviors. Emotional cycles are frequently self-perpetuating unless intervention is used.

### *All Components Are Equally Important*

A common misperception when applying a CBT framework is that thoughts, particularly the negative content of thoughts, are the key element to understand and to intervene with. However, as shown in Figure 1.1, the triangular shape of the model gives the same weight to each component, implying that each component contributes equally to the overall emotional experience for the individual. The particular salience of one component over the others will be completely individual. One depressed youth may be particularly aware of their negative thoughts and embrace cognitive restructuring as a way to challenge negative thoughts. Another depressed youth might be especially sensitive to the fatigue and somatic symptoms that come with their sadness. In this case, relaxation exercises may help alleviate the tension and increased physical activity may help address the fatigue. Yet another teen may not be aware of their pessimistic thinking or of any particular physical symptoms. Instead, they note that they are most depressed when they retreat to their room after school and crash on their bed, avoiding family and friends for the rest of the day. The CBT model encourages the therapist to identify the individual profile that reflects each youth's emotional experience. It also encourages affective education to teach youth to be able to differentiate among the components and to label thoughts, feelings, and actions. In this way, the general CBT model can be individualized, creating an idiographic understanding of how the youth expresses their particular depression. When designing a treatment plan, this individualized case formulation lends itself directly to choosing the most appropriate intervention strategies.

### *Thoughts, Feelings, and Actions Are Bidirectionally Influential*

The second key aspect to this model is the bidirectional nature of the thoughts–feelings–action components. When an individual encounters a trigger, any component can be activated “first.” In reality, each component works in simultaneous, rapid sequencing that escapes human observation. For clinical purposes, the clinician or client will often (but not necessarily) notice one component responding first. From there, each of the other components become activated and can reciprocally affect the first component as well. The bidirectional arrows reflect these reciprocal, mutually causative relations among all three components. This is best illustrated by tracing a person's reaction to a trigger around the thoughts–feelings–actions triangle. For example (see Figure 1.2; a reproducible version of a general CBT model is available in Handout 12 in Appendix A), the first thought a depressed teen who has received a bad grade on a test might have is “I really messed that up,” upon which they notice feeling a little flushed in their face and some pressure in their forehead (physical feeling). They then put their head against the school bus window on the ride home (action). This triggers a second thought, “I'll never be able to catch up now,” leading to increased pressure in the youth's temples and a slight queasiness in their stomach. They look down at their lap and begin to tear. “My parents are going to be so angry with me” is their next thought before feeling a lump in their throat and clasping their head in their hands. The teen is thinking, “Everyone else has it so much easier than me,” and feels heat build in their face right before they snap at a friend who has asked if everything is all right. The result of this downward spiral is the experience of sadness or depressed mood.



**FIGURE 1.2.** Individualized CBT conceptualization for depressed youth.

### *Emotional Cycles Can Be Self-Perpetuating*

The above example highlights the reciprocal and self-perpetuating nature of emotional cycles. Such sequences are often called the "distress spiral," "depression cycle," or "feelings tornado" (Badin et al., 2020). These terms highlight the cycling, seemingly unstoppable nature of thoughts, feelings, and actions after one is activated in high emotional situations. These feelings snowball from seemingly innocuous starting points to become seemingly uncontrollable emotional catastrophes. It would not have mattered whether the cycle "started" with feelings, actions, or thoughts; once it starts, it self-perpetuates until stopped. Thus, all components carry equal weight with regard to impacting emotions, and most emotional cycles do not stop naturally after one trip around the cycle.

Different emotional experiences, and hence different psychological disorders, are characterized by different expressions of thoughts, feelings, and actions. Disorders that are more experientially similar will also have more similar thoughts, feelings, and actions. For example, depression and persistent depressive disorder (formerly called "dysthymia") have a number of common expressions of each component, with slight variations in feelings and actions that reflect the more persistent but less acute nature of persistent depressive disorder. If one compares the CBT model for depression to the model for social anxiety disorder (see Chapters 6 and 9), one will notice greater differences. Social anxiety is characterized by acute fear or panic-like symptoms when exposed to social situations. Thoughts are characterized by fears of embarrassment or evaluation and of catastrophic consequences of failure. Socially anxious individuals have less difficulty getting moving (anhedonia) like a depressed individual, but are prone to freezing and escaping frightening situations. If one were to look at the CBT model for generalized anxiety disorder (GAD), one sees commonalities in both depression and social anxiety disorder. One recognizes the diffuse

negative affect that is common to depressed youth, and the increased muscle tension that is common to socially anxious youth. A worried youth with GAD might have trouble getting going like a depressed teen due to procrastination and perfectionism, but they might also seek substantial attention and reassurance that is common in most anxious youth.

Tables 1.1 and 1.2 summarize the emotional, physiological, cognitive, and behavioral features of the various anxiety and mood disorders. The disorders are loosely grouped to highlight which have more overlapping features. These tables are designed to help you learn the common and distinguishing features of the various mood and anxiety disorders. In learning these patterns, you will become better prepared to assess for and filter information that any client reports and then more accurately classify them into a useful diagnostic category. Knowing where clients' responses fit helps you know how they will react to stressors.

### **Role of Avoidance in Maintaining Emotional Distress and Maladaptive Behavior**

A critical mechanism that the CBT triangle does not fully cover is the role that *avoidance* plays in maintaining distress and maladaptive emotional-behavioral patterns. Behavioral escape and avoidance refer to an individual not entering, or prematurely leaving, a fear-evoking or distressing situation. These are types of "action." Cognitive forms of avoidance can include maladaptive coping attempts, such as distraction and thought suppression. Automatic emotional processes can also serve the function of avoidance, such as when an individual experiences numbing, dissociation, or freezing. The individual engages in these activities either with or without control as attempts to cope with distress.

Avoidance can present a number of problems in adequately processing emotions and learning (Chu, Skinner, & Staples, 2014; Harvey, Watkins, Mansell, & Shafran, 2004). According to the emotion-processing model of anxiety (Foa, Huppert, & Cahill, 2006), pathological fear structures contain associations among a stimulus, response, and meaning representations that distort reality. Repeated avoidance prevents sufficient activation of the fear network, precluding new, anti-anxiety information from being learned. Likewise, according to the habituation model, prolonged exposure to a feared stimulus is required to decrease anxiety (brief exposure periods may "sensitize" patients to feared stimuli). In both the habituation and emotion-processing models, avoidance prevents prolonged exposure (Figure 1.3).

In terms of learning theory, avoidance has a number of impairing functions. First, avoidance behavior is often negatively reinforced because it provides immediate relief through escape. Second, avoidance denies the person opportunities for positive reinforcement and contributes to a deprived environment (Hoffman & Chu, 2019; Ferster, 1973; Jacobson, Martel, & Dimidjian, 2001). Third, it may exacerbate self-focused attention and ruminative thinking because avoidance narrows the person's interests and reduces their exposure to external stimuli. From a cognitive perspective, avoidance removes the opportunity to disconfirm negative beliefs (Salkovskis, 1991). Finally, avoidance behavior is intrinsically functionally problematic because it can result in increased absence from school, work, and social opportunities. By contrast, preventing avoidance can increase a sense of self-control and self-efficacy that promotes approach behavior. Working with youth often requires working with caregivers to catch how their actions may promote youth escape or avoidance of distressing situations. No matter the theory, behavioral, emotional, and cognitive processes are impacted when avoidance is used as a solution to a stressful trigger.

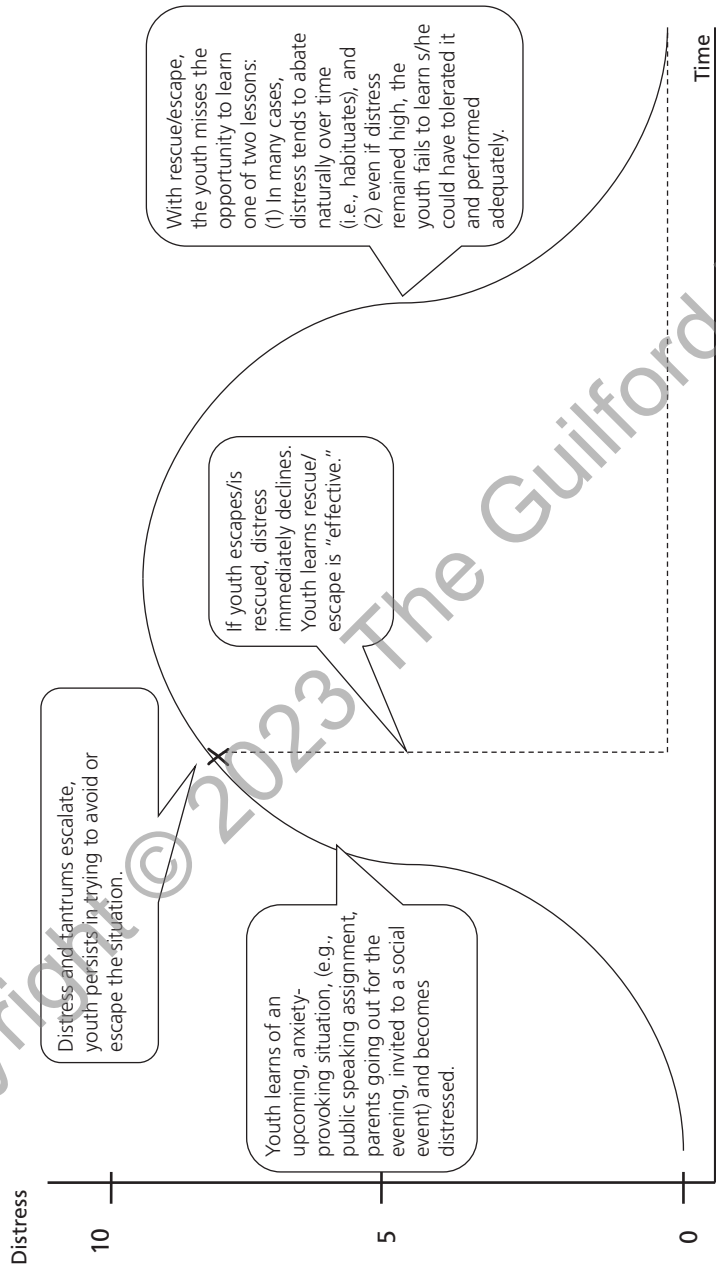
**TABLE 1.1. Distinguishing Features of Youth Anxiety Disorders**

Disorder	Emotional experience	Physiological experience	Cognitive experience	Behaviors
Generalized anxiety disorder	<ul style="list-style-type: none"> <li>• Apprehension and anxiety about friends, family, future, physical health, etc.</li> <li>• Diffuse negative affect</li> </ul>	<ul style="list-style-type: none"> <li>• Muscle tension, fatigue, restlessness, agitation when worried</li> <li>• Difficulty relaxing, particularly during sleep</li> </ul>	<ul style="list-style-type: none"> <li>• Persistent “What ifs”</li> <li>• Self-imposed perfectionism; rigid rule sets; worries about self, family, school, health, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Worry, rumination</li> <li>• Avoidance/procrastination</li> <li>• Reassurance seeking, neediness</li> <li>• Perfectionism, rigidity</li> <li>• Excessive planning</li> </ul>
Separation anxiety disorder	<ul style="list-style-type: none"> <li>• Fear/panic at separation and apprehension in advance</li> </ul>	<ul style="list-style-type: none"> <li>• Panic-like symptoms upon separation (increased heart rate, rapid breathing, crying)</li> <li>• Complaints of stomachaches, sickness, nausea</li> </ul>	<ul style="list-style-type: none"> <li>• Worry about harm to self or parent upon separation, inability to handle self during separation</li> </ul>	<ul style="list-style-type: none"> <li>• Clinging behavior, reassurance seeking</li> <li>• Protests, arguments, complaints, oppositionality</li> <li>• Refusal to separate at home, school, or elsewhere</li> </ul>
Social anxiety disorder	<ul style="list-style-type: none"> <li>• Fear and anxiety of social situations and social evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Tension, sickness when anticipating social setting</li> <li>• Panic-like symptoms in social situations</li> </ul>	<ul style="list-style-type: none"> <li>• Fear of evaluation, embarrassment, and the consequences of poor performance</li> </ul>	<ul style="list-style-type: none"> <li>• Avoidance/refusal/escape of social activities or demands</li> <li>• Disruption in performance and social presentation</li> </ul>
Specific phobia	<ul style="list-style-type: none"> <li>• Fear/panic of specific objects: animal, heights, darkness, blood, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Panic-like symptoms in presence of specific trigger</li> </ul>	<ul style="list-style-type: none"> <li>• Fear of catastrophic outcomes (e.g., bodily injury) or inability to control oneself</li> </ul>	<ul style="list-style-type: none"> <li>• Avoidance, escape of feared object</li> <li>• Endure under great duress</li> </ul>
Panic disorder	<ul style="list-style-type: none"> <li>• Acute panic attacks plus worry of future attacks</li> </ul>	<ul style="list-style-type: none"> <li>• Persistent anxious arousal worrying about next attack</li> <li>• Panic symptoms and fear of death or losing control</li> </ul>	<ul style="list-style-type: none"> <li>• Persistent/acute fears of catastrophic outcomes of having attack and being trapped</li> </ul>	<ul style="list-style-type: none"> <li>• Avoidance, escape of contexts where panic occurred</li> <li>• Withdrawal, isolation</li> </ul>
Obsessive–compulsive disorder	<ul style="list-style-type: none"> <li>• Distress-inducing obsessions that compel repetitive/idiosyncratic compulsions</li> </ul>	<ul style="list-style-type: none"> <li>• Intense distress, discomfort triggered by intrusive thoughts</li> <li>• Relief at completion of compulsive act</li> </ul>	<ul style="list-style-type: none"> <li>• Idiosyncratic fears of catastrophic consequences if compulsions aren’t completed</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral and mental rituals (e.g., washing, checking, ordering, repetitive behaviors)</li> </ul>

**TABLE 1.2. Distinguishing Features of Youth Unipolar Depression Disorders**

Disorder	Emotional experience	Physiological experience	Cognitive experience	Actions
Depression	<ul style="list-style-type: none"> <li>• Depressed mood</li> <li>• Sad, down, blue</li> <li>• Persistent enduring sadness</li> <li>• Heavy, “weight of the world” feeling or pit in the stomach pain.</li> <li>• Irritability, anger</li> <li>• Hopelessness, helplessness</li> </ul>	<ul style="list-style-type: none"> <li>• Pit in the stomach, pressure in chest, feeling like crying (teary), weight on shoulders</li> <li>• Feeling heavy, fatigued, like a dead weight</li> <li>• Cloudy head, unfocused</li> <li>• Eating/appetite problems</li> <li>• Restlessness/sleeping disturbances</li> <li>• Psychomotor retardation</li> <li>• Anxiety, tenseness</li> </ul>	<ul style="list-style-type: none"> <li>• Difficulty thinking, concentrating, focusing</li> <li>• Negativity</li> <li>• Self-criticism</li> <li>• Hopelessness, helplessness</li> <li>• Negative automatic thoughts/cognitive distortions (e.g., all or nothing; blaming self; catastrophizing; discounting positives)</li> </ul>	<ul style="list-style-type: none"> <li>• Rumination, worry</li> <li>• Social withdrawal, isolation, pushing others away, poor assertiveness</li> <li>• Avoidance of stressors, hassles, poor problem solving</li> <li>• Passivity, poor self-direction, inability to get going</li> <li>• Limited self-reward, limited seeking of pleasant activities and rewards</li> <li>• Repetition of passive and unrewarding behavior</li> <li>• Diffident, unengaging social skills</li> <li>• Negative behavior toward others (rejecting, neediness, complaining)</li> <li>• Peer and family conflict</li> </ul>
Persistent depressive disorder (dysthymia)	<ul style="list-style-type: none"> <li>• “Down in the dumps,” lazy, heavy, dragging</li> <li>• Bored, apathetic</li> <li>• Drowsy</li> <li>• Poor connectedness to experience and others</li> </ul>	<ul style="list-style-type: none"> <li>• Lazy, heavy, dragging</li> <li>• Cloudy, hazy, unfocused</li> <li>• Poor appetite/eating</li> <li>• Restlessness/sleeping disturbances</li> <li>• Tired, fatigued</li> </ul>	<ul style="list-style-type: none"> <li>• Low self-esteem</li> <li>• Difficulty thinking, making decisions</li> <li>• Negativity</li> <li>• Hopelessness, pessimistic about future</li> </ul>	<ul style="list-style-type: none"> <li>• Rumination, worry</li> <li>• “Lazing” around, anhedonia, inability to get going</li> <li>• Withdrawal, isolation</li> <li>• Avoidance of challenges/hassles, low motivation to strive, pursues low-effort activities</li> </ul>





**FIGURE 1.3.** Habituation curve: effect of rescue/escape on learning. Rescue or escape is negatively reinforced by its immediate impact on distress reduction. The youth fails both to experience natural habituation of distress and to learn distress tolerance.

## CONDUCTING AN INITIAL ASSESSMENT

The first step in applying the CBT model to an individual client is conducting an initial assessment. Take an evidence-based approach that consists of diagnostic, symptom, and functional assessment of the individual youth within their full interpersonal (family, community) context. This approach is consistent with the recommendations of the American Psychological Association (APA) for evidence-based psychological practice in that it starts with a comprehensive understanding of the identified client and then prioritizes available research in selecting potential interventions (APA Presidential Task Force on Evidence-Based Practice, 2006). An evidence-based assessment (EBA) approach for children and adolescents includes the following characteristics:

1. Ground your assessment in the child's or adolescent's presenting problem and target problems. The goal of any therapy is to help youth achieve the goals that are most meaningful for them. Choosing assessment tools focused on the domains that bring the youth to therapy are most likely to engage them, their caregivers, and enhance their motivation to participate.

2. Assess multiple domains, the different aspects of a youth's functioning to obtain a holistic sense of their strengths, limits, and impairment. This can include diagnosis of psychological disorders, measurement of symptoms (e.g., anxiety, depression), and evaluation of functional impairment (performance at school, in extracurriculars, with friends). Within each of these levels, assessing multiple domains (e.g., social anxiety, fear of evaluation) can be more informative than assessing one global dimension (e.g., anxiety). Choose measures and measure subscales that match the child's primary problems.

3. Obtain data from multiple reporters. Youth exist within multiple social systems. Obtain input from the individual youth, caregivers, and when possible other collaterals who may have pertinent information about the youth's functioning (e.g., teachers, coaches, other adults living with the youth).

4. Take social context into account. As youth are embedded in multiple social systems, collect data about the adults, siblings, and peers with whom the youth lives or interacts; understanding the youth's community and school provides valuable data for case conceptualization.

5. Use developmentally and culturally appropriate measures. They should assess constructs that are relevant and should be written at the appropriate reading level for the youth. For example, having a teen complete a questionnaire that asks about bedwetting may immediately reduce a clinician's credibility in the youth's eyes. If youth or caregivers are non-English-speaking, therapists should find measures that have been translated to the preferred language when possible.

6. Make use of psychometrically sound measures when comparisons count. When assessing broad symptoms or constructs that benefit from national or international comparisons, it is essential to use psychometrically sound measures. For example, evaluating a youth's anxiety, depressive symptoms, academic competence, or social skills may benefit from normative comparisons. This allows you to compare the youth's functioning against other individuals who are the same age, sex, or other important trait.

7. Use idiographic measures to assess and monitor individual goals. Idiographic tools (e.g., fear hierarchies, top problems lists) are sometimes best to capture specific functional impairment that might be lost by broad symptom measures. These are particularly useful to measure weekly changes that are tied to the client's treatment goals.

Several resources exist to help clinicians obtain and use EBA tools. For those with access to scholarly journals, there are several excellent issues and articles that span a wide range of domains. These include Mash and Hunsley's (2005) special issue on EBA, key resource articles (Beidas et al., 2015; Becker-Haimes et al., 2020) that list publicly available assessment tools, and the article by Youngstrom and colleagues (2015) that provides case examples of how clinicians can use EBA in everyday clinical practice. Publicly available online resources also exist to aid clinicians. Some professional organizations curate freely available assessment tools that are published in the public domain. Helping Give Away Psychological Science (HGAPS) has created an online assessment center where caregivers, adolescents, and adults can complete mental health screeners and get immediate feedback ([www.hgaps.org/ac.html](http://www.hgaps.org/ac.html)). The APA's Society of Clinical Psychology has created a repository for EBA instruments ([www.div12.org/assessment-repository](http://www.div12.org/assessment-repository)). Here, the practicing clinician can find a broad range of downloadable EBA tools that assess various problems across age groups. The Society of Clinical Child and Adolescent Psychology (SCCAP, Division 53 of APA) has developed a website ([www.EffectiveChildTherapy.com](http://www.EffectiveChildTherapy.com)) that has freely available resources, including informational fact sheets, brief informational videos for families, didactic seminars for professionals, and full-length workshops for professionals. The Association for Behavioral and Cognitive Therapies (ABCT) website also includes a special page on self-help resources that have received the organization's stamp of approval ([www.abct.org/SHBooks](http://www.abct.org/SHBooks)).

Collaborative learning projects, like Wikiversity, additionally provide a public resource where therapists can obtain and share knowledge. For example, SCCAP has developed tutorials to guide therapist planning around EBA (e.g., planning, selection of measures, interpreting data, and emphasis on incremental assessment). See, for example, [https://en.wikiversity.org/wiki/Evidence\\_based\\_assessment](https://en.wikiversity.org/wiki/Evidence_based_assessment) and <https://en.wikiversity.org/wiki/Category:Vignettes>. Online collaboratives allow content to be updated continuously to reflect growing knowledge, a common barrier to dissemination by more traditional means.

## CASE CONCEPTUALIZATION

Once a set of assessment tools has been selected and administered, you can use the information to inform a case conceptualization, also called "case formulation." Case conceptualizations represent the therapist's working explanation of the factors contributing to and maintaining the youth's presenting problems (Christon, McLeod, & Jensen-Doss, 2015; Persons, 2006). It is grounded in the CBT model and incorporates knowledge about triggers (e.g., events, interpersonal interactions) and consequences (functional outcomes) for the individual youth. Case formulation begins the moment clinicians meet their clients, and they revise their formulations continuously as new data present themselves. For example, cognitive-behavioral theory attributes significant maintenance roles for unrealistic negative thinking, inactivity, behavioral avoidance, skills deficits, and physiological reactivity in youth pathology. When operating within a principles-based CBT approach, it is up to the therapist to tailor strategies to the individual youth by: (1) identifying the unique triggers that precede depressed moods, (2) assessing which specific mechanisms (e.g., thoughts, avoidance, problem solving) are most critical, and (3) observing what consequences maintain the maladaptive behavior. Based on this individualized conceptualization (i.e., functional assessment), the therapist emphasizes some strategies over others. If the youth responds to perceived failures (e.g., getting into a fight with a friend at school) with withdrawal and isolation (i.e., avoidance), the therapist might choose to focus on behavioral activation and behavioral experiments to foster problem-solving and

approach behaviors. Even when the crisis of the week shifts from session to session, the formulation keeps the therapist focused on the core mechanisms (avoidance, unrealistic thinking). In the presence of complicating comorbidities (e.g., drug use), the therapist might choose supplemental interventions that complement the ongoing formulation, such as motivational interviewing (MI), which has a focus on encouraging personalized goal-oriented behaviors. In this way, a therapist can view daily challenges from a consolidated lens that narrows the number of choices that need to be made.

Data should be collected continuously throughout treatment to test out the therapist's thinking about maintaining mechanisms. It is critical to view this thinking as a working hypothesis, not a fixed theory. The therapist must then revise the case conceptualization as new information becomes available and treatment progresses. This process has been described as the assessment-treatment dialectic (Weisz et al., 2011). In other words, clinicians continuously integrate new information in an ongoing feedback loop of Assessment → Case formulation → Treatment planning → Strategy implementation → and Outcome monitoring and Assessment. Successful interventions can be used with greater intensity or dose. Unsuccessful interventions can be discontinued.

Certain commonalities emerge within a diagnostic classification. Youth diagnosed with social anxiety disorder will express much of their fears around performance evaluation and social comparison. Social settings (e.g., parties, meeting novel people, answering questions in class) reflect a common context that evokes fear, and within these contexts, similar specific triggers will precede fear (e.g., making eye contact with a stranger; the teacher calling on them). Youth with social anxiety will then respond with common internal and behavioral responses (e.g., upset stomach, avoidance of social settings, escape from uncomfortable situations) and have similar thinking patterns (e.g., unrealistic predictions and evaluations of their performance). At the same time, any two individuals who meet criteria for the same diagnosis can look fairly different. For example, one teen with social anxiety disorder may have a very critical parent, while another might have a parent who is overly accommodating (*context*). One teen's fear may be triggered by the parent claiming they will never amount to anything, while a second teen may be triggered by a party invitation that comes via text (*triggers, antecedents*). The *maintaining mechanism* for one teen may be catastrophic negative thoughts ("I'll never amount to anything") and it may be an overwhelming physiological reaction for another teen. The immediate consequence for each might be the relief they feel when escaping the stressful scene. However, the long-term consequences may differ in that the first teen may compensate for their fears by studying really hard and acing their exams. The second teen might become intensely isolated.

The two examples illustrate the centrality of case conceptualization. Each story is plausible (indeed, highly common) among youth with social anxiety. Knowing that each youth qualifies for a diagnosis of social anxiety helps narrow the field. Individualized case conceptualization helps develop a specific, working model to pick interventions tailored to each child. The layout of the current book aims to facilitate both. Treatment plans are grouped by diagnostic category, but individualized case formulation is highlighted in each chapter to emphasize the diversity of cases that appear within each disorder.

## Building an Individualized Case Conceptualization

How does a clinician make use of the CBT and avoidance models to form a conceptualization? The first step is to create a target problems list from the youth's major areas of impairment. Goals are then developed for these areas of impairment, and the impairments are subsequently broken

down into smaller problems. The functional assessment of each problem can then identify its maintaining mechanisms. Thoughts are next integrated into the conceptualization along with interpersonal contexts. Each of these steps is described in greater detail below.

### *Goals and the Target Problems List*

To set treatment goals, the therapist, youth, and caregivers collaboratively develop a target problems list based on the youth's major areas of functional impairment. The therapist summarizes information from the multidomain, multireporter assessment to provide feedback to the family about possible areas of concern (e.g., intense symptomatology, skills deficits). The youth and caregivers identify concrete areas where change would improve the youth's functioning. Together, a joint target problems list provides a clear sense of the outcomes the youth, family, and therapist care most about. The therapist can use the following common prompt: "If you had the power to change three things, what would they be?" Above all, treatment goals should focus on real-life changes the client and family want to see in the child's life.

If the targets on the list appear too broad (e.g., "too anxious," "feeling better about myself"), the therapist encourages the family to break the goals into smaller, specific goals. The therapist helps the family concretize broad emotional states and take the first steps toward achievable goals. You can help the family visualize the kind of day-to-day change they would like to see in meaningful life domains (school, peers, family, health). How would the parents know if the youth was feeling less "anxious" or "sad"? How would the youth be acting if they "felt better about themselves"? What would be different on a daily basis? After devising this list, the therapist can use functional assessment to identify triggers, mechanisms, and consequences of problematic behaviors.

As an example, the lists of parent and youth goals below show a mixture of diffuse emotional goals ("decrease anxiety," "not be afraid or overwhelmed"), as well as more concrete, achievable goals ("Go to a party and talk to people—don't hide in a corner"). The broader goals offer a general domain to work on, but we also need to identify concrete, observable goals that give more direction to the work.

#### *Parents' Goals for Their Child*

- Decrease anxiety [too broad].
- Stop worrying so much [too broad].
- Spend more time with friends; get out of the house more [moderately specific].
- Improve sleep [moderately specific].
- Make schoolwork a priority by completing homework before dinner [mostly specific].

#### *Child's Goals for Themselves*

- Not be afraid or overwhelmed so much [too broad].
- Make friends and accept more invitations to go out [moderately specific].
- Spend less time in my room and more time hanging out with the family [moderately specific].
- Have my parents stop nagging me to talk to other kids [moderately specific; also common].
- Be able to ask my teachers for help when I need to [mostly specific].
- Go to a party and talk to people—don't hide in a corner [mostly specific].

After devising a reasonably specific target problems list, the therapist can use functional assessment to identify the mechanisms maintaining the problematic behaviors.

### *Identifying Maintenance Mechanisms through Functional Assessment*

The purpose of forming a case conceptualization is to understand the origin and maintenance of a client's problems. A CBT conceptualization connects the dots between problematic situations (contexts) and the individual's distress response (thought–feeling–action) to give the clinician direction on where to intervene. In CBT conceptualizations, the *maintaining mechanisms* serve as targets for treatment. They are the client's cognitive, physiological, or behavioral patterns that perpetuate maladaptive cycles.

How does one identify maintaining mechanisms? By conducting functional assessment! This is one of the most flexible and robust CBT techniques. “Functional assessment” means assessing *antecedent–behavior–consequence* (ABC) sequences, also called “behavioral chains” (Kazdin, 2001; Rizvi & Ritschel, 2014). An “antecedent” is any trigger or circumstance (e.g., person, place, object, event, thought, feeling, action) that has some kind of meaning to the individual. “Behavior” refers to any client response (action, cognition, emotion, physiological response) that follows the antecedent. The “consequence” refers to any outcomes that follow the client's response. Figure 1.4 (a blank version is available as Worksheet 1 in Appendix A) illustrates the ABC functional assessment model. In the dialogue below, the clinician conducts a series of assessments to determine the triggers, behavioral responses, and environmental responses that characterize a client's problematic behavior.

THERAPIST: I'd like to get to know you better and learn what situations seem to get you stuck.

Can you think of a situation where you've felt sad or anxious this past week?

CLIENT: Well, I had to give a speech in class, and I was freaked out.

THERAPIST: Oh, yes, that can be a scary challenge for any of us. Was this a spontaneous speech or a talk you had been planning for a while?

CLIENT: Well, it was assigned a while ago, but I could never push myself to really prepare.

THERAPIST: And so, on the day of the talk, you felt really unprepared?

CLIENT: Yeah.

THERAPIST: And what feeling did you feel in class that day?

CLIENT: Pure panic! I was for sure certain the teacher would yell at me in class and embarrass me.

THERAPIST: What did you do?

CLIENT: Well, we didn't know who the teacher was going to call on. You know, there were more people who had to go than could fit in the class. So, I kept trying to keep my head low, so the teacher wouldn't see me. . . .

THERAPIST: How'd that work?

CLIENT: I don't know—but I just kept freaking out and couldn't think of anything other than how I was going to fail.

THERAPIST: How did you end up getting through?

## WORKSHEET 1. Trigger and Response

Tell us about your triggers and how you reacted. Describe your feelings, what you did (action), what happened right away (immediate outcome), and then what happened later (long-term outcome).

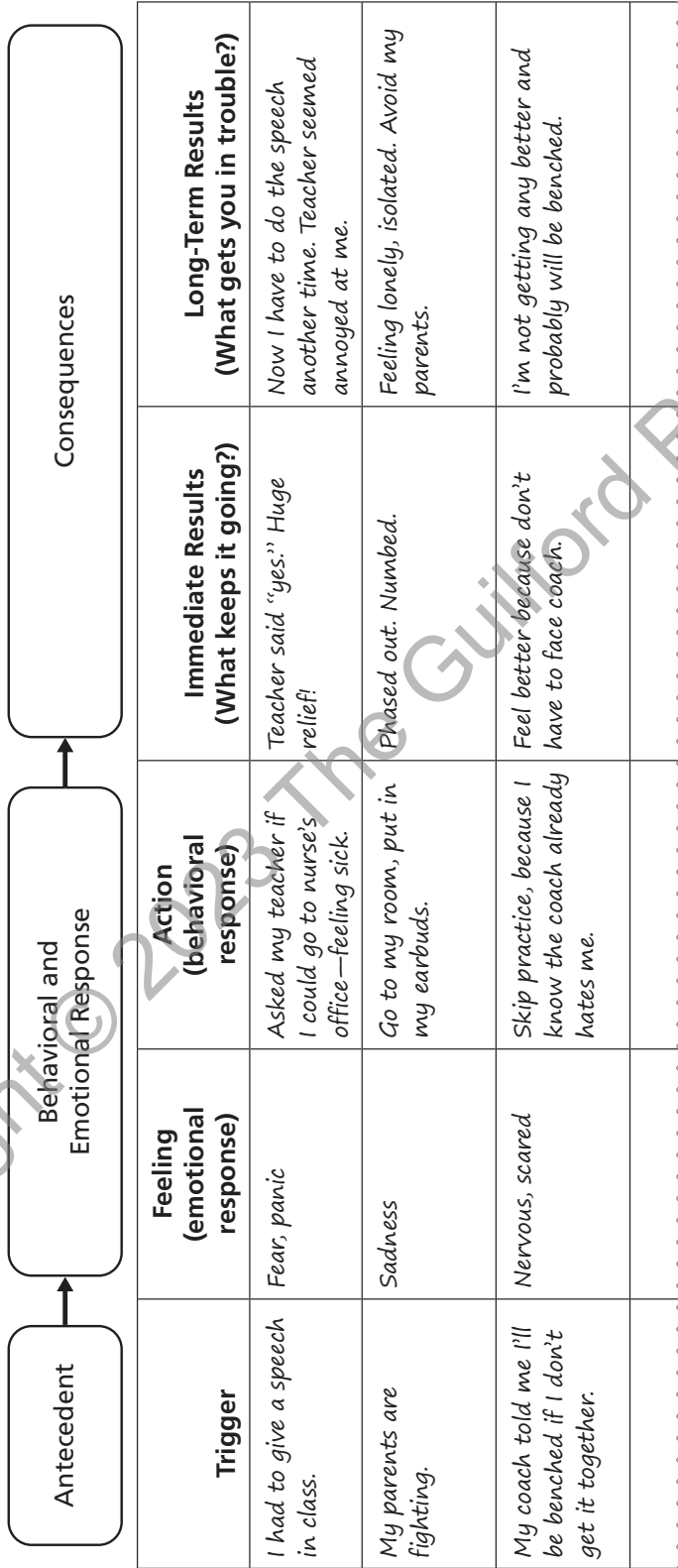


FIGURE 1.4. Functional assessment of multiple moods and actions.

CLIENT: I finally just asked if I could go to the nurse. Like, I had a bad stomachache or something.

THERAPIST: And?

CLIENT: The teacher kind of looked at me weird—like kind of annoyed. But then they said, “OK.” I was so excited!

THERAPIST: So, you were pretty relieved.

CLIENT: Yeah, I got out of there as soon as I could.

THERAPIST: (*laughing*) OK, so it seemed to get you out of giving your speech that day. I guess that solution worked for the moment. . . .

CLIENT: Uh, yeah.

THERAPIST: I wonder, has anything happened since? Have you noticed any positive or negative outcomes coming from this? I mean, did it work totally?

CLIENT: Well, I’ve kind of been avoiding my teacher since, and she’s always looking at me kind of annoyed. And I’ll have to give the speech eventually. And I’m still not prepared!

This dialogue illustrates how a therapist could conduct an ABC assessment in a very conversational manner, yet can accrue the information necessary to understand how the client responds to the trigger of speech giving and what outcomes typically result in the client’s natural environment. Figure 1.5 (a blank version is available as Worksheet 1 in Appendix A) demonstrates the flexibility of an ABC assessment to cover a variety of triggers and emotional responses. Eventually, a clinician might want to group behavioral sequences into “themes,” sorted by either common emotional responses or behavioral patterns (see below). At first, it is suitable to simply collect data and learn more about the client’s natural response patterns.

#### ANTECEDENTS SHOULD BE SPECIFIC

There are several challenges in conducting useful functional assessments. First, when identifying antecedents, the clinician should try to identify as specific a trigger as possible. “When my parents fight” is OK to the extent that the youth responds in similar ways whenever their parents argue. However, we recommend identifying a specific event (“My parents fought about my poor grades [on Wednesday]”). It is true that there are rarely “right” or “wrong” answers to pinpointing the one single event prompting a response (Rizvi & Ritschel, 2014). Nevertheless, identifying a specific trigger on which the client and family can focus helps give a starting point for intervention.

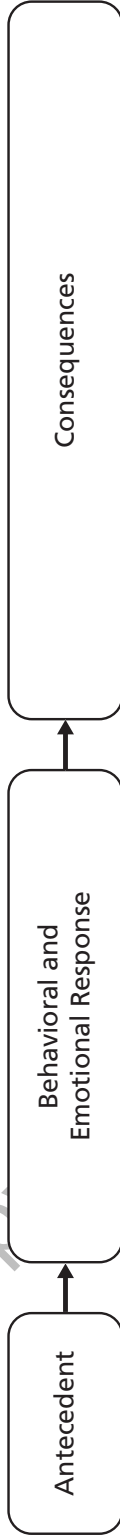
#### ORGANIZE ASSESSMENTS BY EMOTION

A second challenge is that clients can experience multiple emotions in response to a single distressing trigger. We recommend creating a separate ABC row for each distinctive emotion, because each usually indicates distinctive reactions that lead to distinctive behavioral responses. The youth may not be aware of how each emotion triggers unique responses, but explicitly separating these emotions helps clarify the complexity of the response and stimulates varying solutions to address maladaptive patterns. Figure 1.5 helps demonstrate the value of clarifying separate ABC sequences for distinct emotions. In the first row, there are too many emotions to understand, and



## WORKSHEET 1. Trigger and Response

Tell us about your triggers and how you reacted. Describe your feelings, what you did (action), what happened right away (immediate outcome), and then what happened later (long-term outcome).



Trigger	Feeling (emotional response)	Action (behavioral response)	Immediate Results (What keeps it going?)	Long-Term Results (What gets you in trouble?)
My parents fought about my bad grades.	Sadness, fear, nervousness, anger	Didn't do my homework, didn't talk to friends. Fought with parents.	Everyone's angry at me.	Still failing.
Separate the first row into three separate ABC sequences based on distinct feelings!				
My parents fought about my bad grades.	Sadness	Went to my room, put in my earbuds.	Phased out. Numb.	Feeling lonely, isolated. Avoid my parents.
My parents fought about my bad grades.	Fear, nervousness	Nothing . . . can't think of what to do. Didn't do my homework.	Didn't do homework.	Fail the class.
My parents fought about my bad grades.	Anger	Yell at my parents—tell them I'm not studying any more.	Parents stop fighting	Get punished for yelling. Fall further behind in class.

**FIGURE 1.5.** Functional assessment by emotion. Focus on just one emotion per row to keep the functional analysis clear. In the first row, there are too many emotions to understand; in the second, you can gain insight by analyzing each set of emotions.

this does not provide the therapist or the client with clear next steps for intervention. The second and third rows are separated into two sets of more specific feelings (sadness and fear/nervousness). Sadness is characterized by the youth avoiding other people and phasing out, which leads to growing isolation from family members. Nervousness is characterized by avoiding homework, which leads to incomplete homework and poor grades. The more specific ABC sequences give the clinician specific leads of what behaviors to target (avoiding people and homework) and what outcomes to pursue (social isolation, poor grades).

#### DEFINE SHORT- AND LONG-TERM CONSEQUENCES

Third, you can expect multiple outcomes (consequences) to result from the youth's behavioral response to any distressing challenge. Consequences comprise any specific events, thoughts, and emotions that occur after the behavior of concern (Rizvi & Ritschel, 2014). The therapist seeks to identify factors that might influence the recurrence of the behavior or that might be helpful in preventing future occurrences. These consequences fall into the categories of positive and negative reinforcers and punishers [for a full review of reinforcers and punishers, see Kazdin (2001) or Yoman (2008)]. Briefly, a "reinforcer" is any consequence that increases the likelihood of the behavior occurring again in the future, and a "punisher" is any consequence that decreases the likelihood of the behavior occurring again (Rizvi & Ritschel, 2014). Clinically, you can assess the reinforcing and punishing effects of outcomes by inquiring about both the positive and negative consequences that follow any antecedent-behavior sequence.

Some outcomes are apparent in the short term, and others only become apparent in the long term, after some time has passed. Returning to our example above, sadness may lead to the youth self-isolating, contributing to the short-term outcomes of isolation and failure to receive necessary social support. In the long term, the parent-youth relationship may deteriorate (the youth learns they cannot count on their parents) and the youth's grades may suffer. When a youth reacts angrily, they get their parents to stop fighting but also are punished for yelling. In this case, the short- and long-term outcomes diverge depending on the youth's immediate reaction in the moment. Specifying the short-and long-term consequences of the youth's choices help make clear the costs of choosing each behavioral path. The information can be used for goal setting and motivational interviewing as treatment planning begins.

#### TRIGGERS AND RESPONSES CAN BE BOTH INTERNAL AND EXTERNAL

Be mindful that triggers *and* responses can include both internal and external events (Kazdin, 2001; Rizvi & Ritschel, 2014). Most people commonly associate triggers with external events, such as learning bad news, having a difficult discussion with a friend or family member, receiving criticism or a bad performance review. However, internal stimuli, like thoughts, memories, and physiological feelings, can trigger further emotional response as well. The behavioral link in the ABC chain also refers to any individual response to the trigger; it is not limited to overt behaviors. Instead, be interested in knowing what youth thoughts, behaviors, and physiological feelings occur following the trigger. It may be unusual to view feelings and thoughts as behaviors at first, but from a learning theory point of view, these various responses are indistinguishable in terms of their potential role in a functional assessment. You should only be concerned about the *function* that the response plays in either maintaining or minimizing distress. Does the response serve to

minimize distress, gain attention or support, garner some instrumental gain, avoid stressors, or punish aversive stimuli? The overt form (thought, feeling, behavior) of the behavior is less significant for the purposes of knowing the client better. To understand the function of the response better, it is critical to detail the short- and long-term consequences that follow. Is the youth's response reinforced (increased) or punished (decreased)? Knowing the immediate and secondary consequences will help reveal what factors are maintaining maladaptive behavior in the face of apparent impairment.

Conducting functional assessments accomplishes several clinical goals (Rizvi & Ritschel, 2014). It gives the youth (and family members) an opportunity to disclose intimate details of problematic behavior and gain insight into the triggers and emotional reactions that precede problematic behavior. A functional assessment acts as an essential assessment tool, as it helps the client, family, and therapist identify which behavioral chains lead to the most concerning problem behaviors and most impairing consequences. These will begin to illuminate details and patterns that lay the groundwork for case formulation and opportunities for intervention.

### *Integrating Thoughts into the Conceptualization*

So far, our discussion of functional assessment has focused on emotions and behaviors. But thoughts play a key role in the CBT model. Assessing thoughts using one of the functional assessment tools (see also Worksheets 1 and 2 in Appendix A) can be easy. Figure 1.6 integrates thoughts with the functional analysis that we conducted previously with the youth whose parents were fighting over the youth's poor grades. In this example, when the youth feels sad, the primary thought that surfaces is "I'm causing my parents to fight with each other," leading the youth to isolate in their bedroom, feel guilty, and avoid their parents. When the youth feels frustration or anger, persecutory automatic thoughts surface: "They don't care how much I studied," which might lead the youth to act out against their parents. Knowing that the youth has two distinct response patterns helps the youth and therapist develop specific game plans for each occurrence. When the youth feels nervous, anxious thoughts are triggered: "I'm going to fail this class," leading to freezing and failing to complete their homework. In each ABC sequence, exploring the automatic thoughts that underlie the youth's emotions provides information about the specific fear or barrier that is keeping the youth from responding healthfully.

### *Integrating Interpersonal Contexts into the Conceptualization*

A substantial evidence base highlights the role of interpersonal context and social interactions in triggering and maintaining anxiety and mood disorders in youth. In depression, interpersonal conflict and rejection are some of the most salient negative events to trigger depressive episodes and self-harming behaviors (Hammen, 2009; King & Merchant, 2008). Other research shows that depressed people both reject and end up being rejected by others in their lives (Joiner, 2000). The increased isolation and withdrawal also contribute to a decreasingly narrow social network from which to garner support when needed. Family members are frequently found to be facilitating anxious behaviors in youth by transmitting anxious information, by reinforcing anxious responding via rescue and escape, and by accommodating the fears of anxious youth.

Thus, assessing how the youth interacts with others is critical to understanding how the problematic behavior is being maintained. You will want to keep interpersonal contexts in mind when

## WORKSHEET 2. Thoughts, Feelings, and Actions Tracker

What kind of thoughts do you have when feeling sad, anxious, or distressed? How do you act when thinking that way? What happens (outcome) from thinking that way?				
Trigger	Feeling	Thought	Action	Outcome?
My parents fought about my bad grades.	Sadness	"I'm causing my parents to fight with each other."	Go to my room, put in my earbuds.	Feeling lonely, isolated. Avoid my parents.
My parents fought about my bad grades.	Frustration	"They don't care how much I studied."	Yell at my parents—tell them I'm not studying any more.	Get punished for yelling. Fall further behind in class.
My parents fought about my bad grades.	Fear, nervousness	"I'm going to fail this class."	Nothing . . . can't think of what to do.	Fail the class.

**FIGURE 1.6.** The same event can trigger multiple unique thought–feeling–action sequences.

generating problems lists, understanding the maintaining mechanisms (case formulation), and planning out the intervention. We provide examples of doing this in each of the disorder-specific chapters.

## TREATMENT PLANNING

Armed with a multidimensional assessment, case conceptualization, and list of target problems, the therapist can then plan interventions to address the youth's concerns. Each disorder-specific chapter (Chapters 6–11) provides a treatment plan that contains common interventions for each problem area. Research suggests significant overlap in the interventions used across evidence-based programs for anxiety and depression in youth (Chorpita & Daleiden, 2009). There remains limited research to suggest the order or dose of specific treatment elements. Some research suggests that social skills and problem solving are among the most potent interventions for depressed adolescents (Kennard et al., 2009) even as behavioral activation and cognitive restructuring remain key elements (Oud et al., 2019). Other research supports programs that contain exposure-based interventions as the most efficacious treatments for anxiety in youth (Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016). When such evidence is available, it makes sense to present social and problem-solving skills early in treatment, and we will highlight these decisions in upcoming disorder-specific chapters when relevant.

At the same time, match interventions to the client's particular profile (Chu, 2019). Youth who are primarily presenting with anhedonia, isolation, and limited activation would likely benefit from behavioral activation and exposure. For youth whose negative assumptions lead to protracted rumination or for those who report more diffuse self-esteem issues, cognitive restructuring may be helpful. Youth who experience significant conflict with family members require parent intervention.

Based on selected strategies, the therapist can then provide an overview of the treatment plan to the family, including a general sequence and time frame. Research suggests that involving youth and caregivers in this process improves attendance, treatment engagement, and ultimate outcomes (Langer & Jensen-Doss, 2018). Thus, making treatment selection a collaborative decision process can start off the therapy from a good place.

## PROGRESS MONITORING

Cognitive-behavioral therapists ensure they are moving toward their clients' goals by monitoring progress routinely through therapy. Growing evidence suggests that the process of obtaining and reviewing regular outcome data can be an effective intervention in itself (Bickman, 2008; Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Lambert et al., 2003; Lambert Harmon, Slade, Whipple, & Hawkins, 2005). In these studies, clinicians who received feedback routinely (e.g., alerts related to current symptoms) have clients who demonstrate improved outcomes (Bickman et al., 2011), less deterioration (Lambert et al., 2005), and greater therapy engagement (Jensen-Doss & Weisz, 2008) compared to the clients of clinicians who did not receive feedback. Furthermore, visual feedback that graphically depicts provider or student behaviors has been associated with promising intervention outcomes (Hawkins & Heflin, 2011; Nadeem, Cappella, Holland, Coc-

caro, & Crisonino, 2016; Reinke, Lewis-Palmer, & Martin, 2007). Similar systems have been implemented in schools (e.g., Deno et al., 2009) as requirements for greater accountability call for active progress monitoring (U.S. Department of Education, 2001). Thus, monitoring and feedback systems may be useful and acceptable across youth intervention settings.

Monitoring systems can include tracking of standardized outcome measures (e.g., RCADS, SCARED, CES-DC), idiographic behavioral goals, or individualized “top problems” (Weisz et al., 2011). Feedback can consist of scale scores, graphs of outcomes over time, or simple indicators that the treatment is not progressing. For example, in a series of studies examining monitoring and feedback systems in adults, therapists simply needed to receive a colored dot (e.g., red = client not progressing as expected; green = client making expected progress) to self-correct and engender better outcomes (Lambert et al., 2003). There are commercial systems available for this (e.g., *www.practicewise.com*), but simple Excel graphs can also suffice. Smartphone apps are also quickly proliferating that help keep track of individual client data as part of treatment (see <https://psyberguide.org> for a guide of relevant smartphone apps).

## SUMMARY AND KEY POINTS

The initial stages of CBT include the initial assessment and case formulation that help the clinician choose appropriate interventions and plan the course and sequence of therapy. Critical elements include:

- A firm grounding in the CBT model, with an understanding of the reciprocal relations among thoughts, physical feelings, emotions, and actions
- A holistic but focused initial assessment that evaluates multiple domains of functioning and obtains the perspective of multiple participants in the youth’s life
- A case conceptualization that integrates the theoretical model with assessment data
- A treatment plan that takes into account the youth’s individual target goals and data from their functional assessment that identifies specific antecedents and maintaining mechanisms
- A plan for monitoring progress over time, including standardized and idiographic assessments