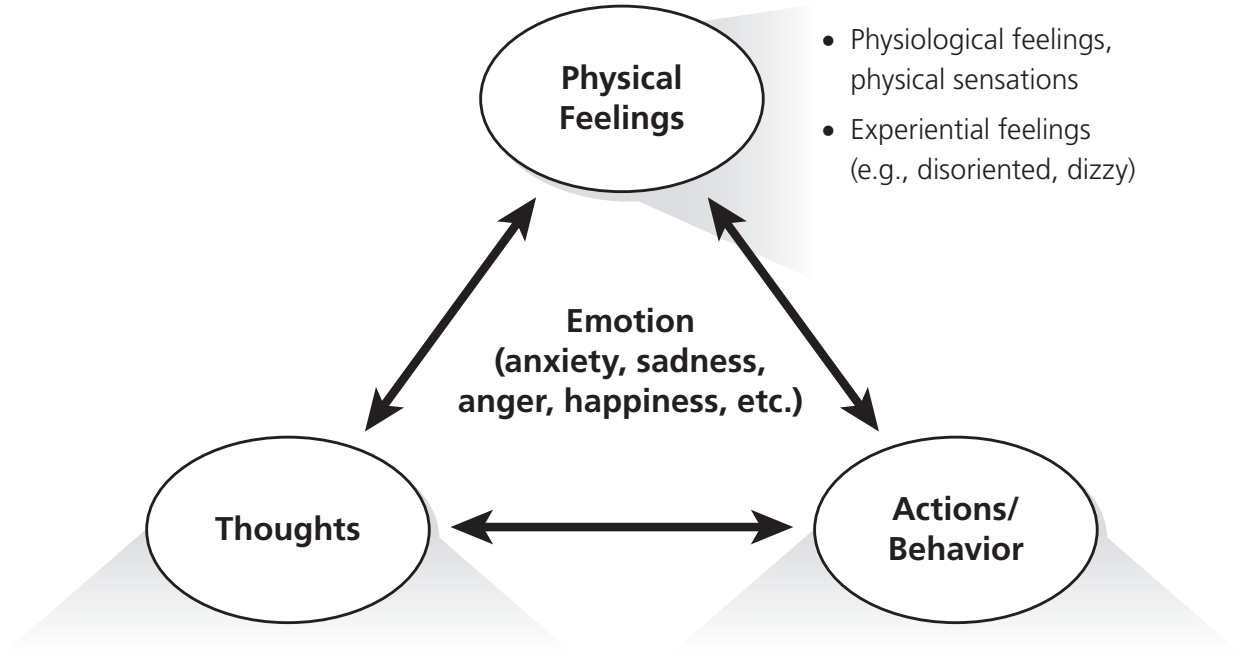
HANDOUT 1. General Cognitive–Behavioral Model

Notice how each of our emotions can be described by our thoughts, actions, and physical feelings and how they interact with each other.



- Physiological feelings, physical sensations
- Experiential feelings (e.g., disoriented, dizzy)

- Content of thoughts, self-statements
- Interpretations, attitudes, beliefs
- Information processing

- Observable actions
- Covert actions
- Cognitive behaviors (e.g., worry, rumination)

HANDOUT 2. Common Thinking Traps That Get Us Stuck

1. **Mind reading (Mind Reader):** You assume you know what other people think without sufficient evidence of their thoughts. "He thinks I'm a loser." "Everyone can see what cheap clothes I'm wearing."
2. **Fortune-telling (Fortune-Teller):** You're positive you know what will happen in the future, but you don't have enough evidence! "I won't know anyone at the party." "I have no chance making the basketball team."
3. **Catastrophizing (Doomsday Predictor):** All you see are the worst-case outcomes! "Now I'm going to fail this class because I got this 'B' on my test." "Everyone will know what a loser I am after I got rejected for the prom."
4. **Jumping to conclusions (The Assumer):** You assume you know something, but you only have a little amount of information. "No one's going to show for my party" (after receiving one or two declines). "My boyfriend is going to break up with me" (after he does not return a phone call).
5. **What if's (Tell Me, Tell Me):** You keep asking question after question because nothing seems to answer the question. "What if they give a pop quiz tomorrow?" "What if they test us on new material?" "What if a substitute doesn't know how the teacher does things?" No answers seem to reassure you, no matter how many times you ask.
6. **Discounting the positives (Nothing Special):** You minimize the positives of a situation or minimize your contributions. You claim the positive actions you take are trivial (e.g., "Anyone could have helped my friend study"). You disregard positive events that may have occurred (e.g., "They invite everyone who's in the honor society to that dinner").
7. **Looking for the negatives (Walking with Blinders On):** All you can see are the negative things happening around you. You can't see the positives. "I couldn't even find anything fun to do while my friend was here." "School is nothing but fake people."
8. **Overgeneralizing (The Big Snowball):** One bad thing happens, and everything will turn out the same. "See? Other kids don't give you a chance to be yourself." "I'm not very good at school—I don't think I have much to look forward to."
9. **All-or-nothing thinking (Black-and-White):** Everything's either all good or all bad. All perfect or all a failure. "If I don't get an 'A,' I'm a failure." "If you miss one party, people will forget about you."
10. **Should statements (Must/Has to Be):** You see events in terms of how things should be, rather than simply focusing on how they are. "I should ace all my exams." "I need to be available to my friends all the time." "My parents don't care about me if they make me go to school [my parents ought to let me stay home]."
11. **Taking things too personally (The Self-Critic):** If something goes wrong, it must be your fault. "We lost the game because of me." "I'll never get better." If someone says anything a little bit negative, it feels like the world is crashing.
12. **Blaming (Hot Potato):** You focus on the other person as the source of your negative feelings, because it is too difficult to take responsibility. "Why won't you let me stay home from school?" "Why is everyone against me?"

HANDOUT 3. "Luggage on a Conveyor Belt" Mindfulness Script

This script is to be used by the therapist to help practice mindfulness with their teen client.

For the next several minutes, we're going to be trying something. It may seem a little different, or even unnatural, but I want you to give it a try. Sometimes, our thoughts get the better of us, and today, we're going to try and just let go of them a little bit.

For this exercise, I'm going to ask you to simply notice your thoughts as they naturally come. The aim will be to watch any thoughts—whatever they may be—come into our mind, notice that they're there, but then allow them to pass through you without a fight. We will try to "accept" your thoughts for what they are, just thoughts. Sometimes, the more we fight our thoughts, the stronger they become.

So, for the next several minutes, I'd like you to imagine a conveyor belt in front of you; just like one you'd see at an airport. Think about how a conveyor belt works—luggage comes down a chute, lies down on the conveyor belt, and then circles around and around. Each piece of luggage gently slides down the chute and then begins its trip around the belt. If you just watched from afar, you'd see that if nobody came to pick up the luggage, the luggage would just go around in circles . . . coming around the front end, circling around, and disappearing around the back end. As you wait, you see the same luggage going around the front end and then back around the back end, slowly but surely circling around.

Well now, as you think of the luggage on this belt, I'd like you to start putting each thought that comes into your head onto a piece of luggage. Just like a label that gets stuck on the luggage. Each thought: gently stick it on the luggage and watch as the thought just stays on the belt, circling around and around. You may feel the urge to do something with the luggage or the thought. You may want to pick it up, put it down on the ground, stop it from circling around and around. You may feel the urge to turn away or distract yourself, to get bored by the circling luggage. When you notice this happening, just turn your attention back to the thought and just appreciate that it is circling gently on the belt in front of you. Sometimes, thoughts will suddenly disappear from the belt. When this happens, simply let them go. No reason to keep a thought on a belt when it doesn't want to be there.

You can either then observe silence as your client practices this, or you can facilitate by asking the client to describe their thought and helping them envision placing it on the luggage and circling around.

Now keep going. I will let you know when to stop. It may seem like a long time, but just allow your thoughts to come as they do.

HANDOUT 4. Facts about Sleep Hygiene

What is sleep hygiene?

Sleep hygiene is a variety of different practices and habits that are necessary to have good nighttime sleep quality and full daytime alertness.

Why is it important to practice good sleep hygiene?

Obtaining healthy sleep is important for both physical and mental health. It can also improve productivity and overall quality of life. Everyone, from children to older adults, can benefit from practicing good sleep habits.

How can I improve my sleep hygiene?

One of the most important sleep hygiene practices is to spend the appropriate amount of time asleep in bed, not too little or too excessive. To help set up good sleep hygiene practices, follow some of these tips:

- *Establish a regular relaxing bedtime routine.* A regular nightly routine helps the body recognize that it is bedtime. This could include taking a warm shower or bath, reading a book, or doing light stretches. When possible, try to avoid emotionally upsetting conversations and activities before attempting to sleep. Don't create to-do lists, do homework, or think of other stressors right before bedtime. Make sure to unplug from electronics at least 30 minutes before bedtime!
- *Avoid typical stressors an hour before bedtime*. Doing homework, writing a to-do list, or having talks about stressful things that came up during the day (or upcoming events) can lead to restless sleep. Cut off homework and worry talk 1 hour before bedtime.
- *Make sure that the sleep environment is pleasant.* Mattress and pillows should be comfortable. The bedroom should be cool, and lights from lamps, phones, and screens should be dimmed or shut off. Consider using blackout curtains, eyeshades, ear plugs, "white noise" machines, humidifiers, fans, and other devices that can make the bedroom more relaxing.
- *Make sure to establish a consistent wake time.* Having a consistent sleep and waking time helps regulate the body to know when it's time to get up and when it's time to go to sleep. Pushing oneself to wake up, even when tired, will help set the tone for a ready bedtime the following night.
- *Limit daytime naps to 30 minutes.* Napping does not make up for inadequate nighttime sleep. However, a short nap of 20–30 minutes can help to improve mood, alertness, and performance.
- *Avoid caffeine and other activating foods close to bedtime.* Drinking caffeinated drinks like energy drinks or coffee close to bedtime make it more difficult to fall asleep and can lead to waking up throughout the night. It might also be wise to avoid heavy or rich foods that have upset your stomach in the past a couple of hours before bedtime.

(continued)

HANDOUT 4. Facts about Sleep Hygiene (p. 2 of 2)

- *Exercise to promote good-quality sleep.* As little as 10 minutes of aerobic exercise, such as walking or biking, can drastically improve nighttime sleep quality. Most people should avoid strenuous workouts close to bedtime, but it's best to find out works best for you.
- *Ensure adequate exposure to natural light.* Getting enough daylight is important to keeping a healthy sleep–wake cycle. This is particularly important for youth who may not venture outside frequently.
- *Reset your sleep–wake cycle.* For those who have already fallen into an unhealthy sleep–wake cycle (staying awake through most of the night only to sleep through most of the day), sometimes it can be helpful to try an experiment. *Force yourself to stay awake* as long as you can. Even when tired, do not let yourself fall asleep at any point during the night. When daylight comes, keep yourself awake. Eventually, your body's natural fatigue will take over, and it will welcome sleep in the next evening or two.
- *Do supplements help?* Some people find natural supplements (e.g., melatonin) helpful in creating a sense of drowsiness that puts them in the right mindset for sleep. If you would like to try such supplements, consult with your family doctor or psychiatrist to assess appropriateness and dosage.

HANDOUT 5. Myths and Facts about Medication

Are medications for anxiety or depression addictive? Will my child ever be able to stop taking them?

Most children and adults taking psychiatric medications for mood and anxiety symptoms eventually stop taking the medications and do so successfully. In fact, a discussion about stopping the meds should take place with your prescriber before any are prescribed. Most approved pediatric medications do not cause tolerance, which is the hallmark of an addictive substance (needing more of a substance to experience the same effect).

Will taking medications affect my child's growth and development?

Side effect profiles vary between different medications and should be considered on a case-by-case basis. Discuss this with your physician or prescriber.

Will these medications have dangerous side effects, like weight gain or suicidal thoughts?

As noted above, side effects may occur and are a reason to change the course of treatment if they are not tolerated. Bring up any concerning side effects to your prescriber. Ask your prescriber about the possibility of suicidal thoughts that might result from the use of antidepressants. The data suggest the benefits far outweigh the risks, but each case is individual.

Will it change my child's personality?

Psychiatric medication should make someone feel more like themself, not less so. A medication that changes a child's personality is a reason for a prescribing physician to stop the medication.

Does taking medications mean there is something wrong with my child? Does it mean they are "abnormal" or disabled?

Think of taking medication for anxiety and mood symptoms as taking medication for a medical condition, like diabetes. Taking the appropriate medication helps your child be healthy and reach their potential, even in the face of medical and psychological conditions.

We're worried the medications are not organic. We don't like to make use of artificial compounds.

Some organic substances may be highly addictive and toxic to our body, and some nonorganic substances may be life-saving. Each situation should be considered case by case, weighing the risks and benefits.

HANDOUT 6. Understanding Anxiety in Your Child or Teen

ANXIETY IS NATURAL

Anxiety is a natural emotion that can be helpful in some circumstances. It can help motivate when needed or keep one from truly threatening situations (e.g., a dark alley at night). However, it leads to trouble when it interferes with a youth's ability to handle a situation (e.g., anxiety distracts them on a test).

AVOIDANCE HURTS MORE THAN IT HELPS

Behavioral avoidance, like procrastination, withdrawal, and escape, also seems natural, but it can be problematic when the youth turns down opportunities because they misinterpret or exaggerate problems in the situation (e.g., turning down a party invitation because they assume they won't know anyone there). Approaching challenging situations can be scary, but repeated exposure to challenges helps build confidence and skills.

LEARNING COPING SKILLS HELPS

While intense feelings are natural, youth can learn how to manage their anxiety or sad feelings. Your therapist will help your child identify the triggers (e.g., situations, people, thoughts) that prompt anxiety and teach them coping skills (active problem solving, brave approach behaviors, activity scheduling, and coping thoughts) that will help youth push through their distressing feelings and reach for desired goals.

PARENTS CAN HELP

Anxious youth bring their own anxiety to the table. It's not something you "did" to them. BUT there are ways you can react to your child that help them build their coping behaviors. This includes active listening, empathizing with their feelings, and encouraging them to focus on active goals.

COGNITIVE-BEHAVIORAL THERAPY CAN HELP

A substantial evidence base has demonstrated that psychological interventions can help reduce anxiety symptoms and improve youth functioning in school, family, and social domains. Strategies that focus on increasing behavioral engagement and more realistic, positive thinking are particularly helpful. In some cases, medication treatment may also provide benefit in combination with behavioral therapies.

HANDOUT 7. Understanding Depression in Your Child or Teen

DISTINGUISH SADNESS FROM DEPRESSION

Sadness is a natural feeling that all of us feel when hard things happen (e.g., a friend moves away, the loss of a loved one, arguments with friends) or when situations do not go our way (e.g., receiving a poor grade on a test, not getting selected for the school play or team, having a privilege restricted). Sadness should draw adult attention when it begins to interfere with a youth's typical functioning (sleeping, eating, socializing) or stops them from pursuing goals and activities they care about because of isolation, withdrawal, and inactivity.

AVOIDANCE HURTS MORE THAN IT HELPS

Behavioral avoidance can seem like a natural response to sad feelings. When a teen is feeling sad or lethargic, it might seem natural for them to withdraw to their room, ignore texts or calls from friends, not go to school or participate in activities. However, repeated avoidance creates a hard habit to break. It deprives the teen of opportunities (every missed soccer practice puts the child further behind) and chances to cope (to see that they can handle the challenge if confronted). Avoidance is also different from self-care or nurturance (e.g., being realistic about demands, taking planful breaks) that is restorative and promotes continued action.

LEARNING COPING SKILLS HELPS

Depression can feel intense (painful sadness, irritable anger) or deflating (low energy, weight on shoulders). Therapy helps the youth learn the skills to manage intense pain with emotion regulation skills and evaluation of negative self-critical thoughts. Decreased activities can also be countered with the scheduling of pleasant activities, active problem solving, and approach behaviors. Together, the youth will be taught to push through the temporary sadness that defines depression.

PARENTS CAN HELP

It is natural for caregivers to feel frustrated or scared by their own child's inactivity. They don't know how to help, motivate, or encourage their child. Therapy helps caregivers understand that a youth's depression is temporary and not necessarily a reflection of the child's innate personality or of the family. In these times, the youth needs a parent's active listening and support to encourage active approach behaviors.

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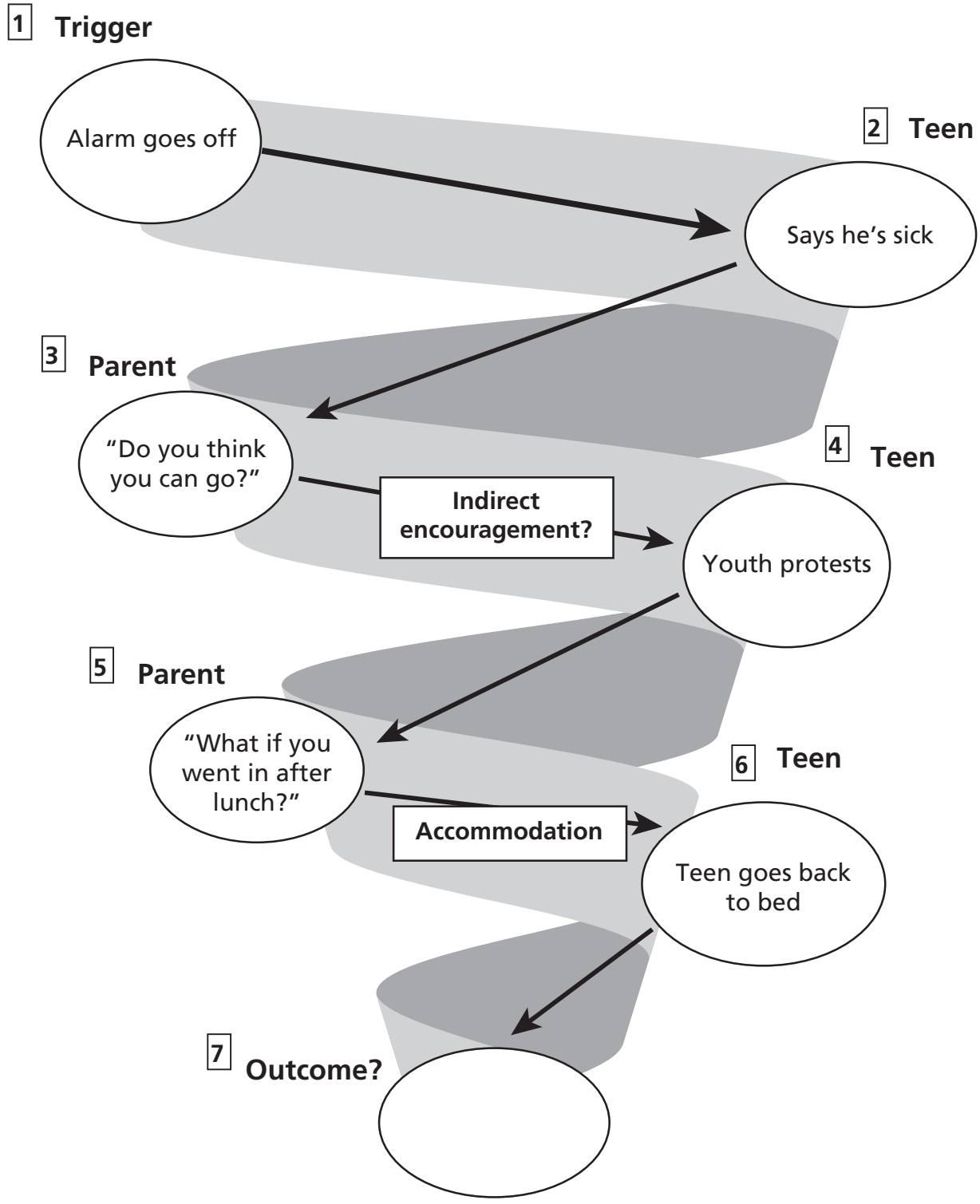
COGNITIVE-BEHAVIORAL THERAPY CAN HELP

A substantial evidence base has demonstrated that psychological interventions can help reduce depressive symptoms and improve youth functioning in school, family, and social domains. Strategies that focus on increasing behavioral engagement and more realistic, positive thinking are particularly helpful. In some cases, medication treatment may also provide benefit in combination with behavioral therapies.

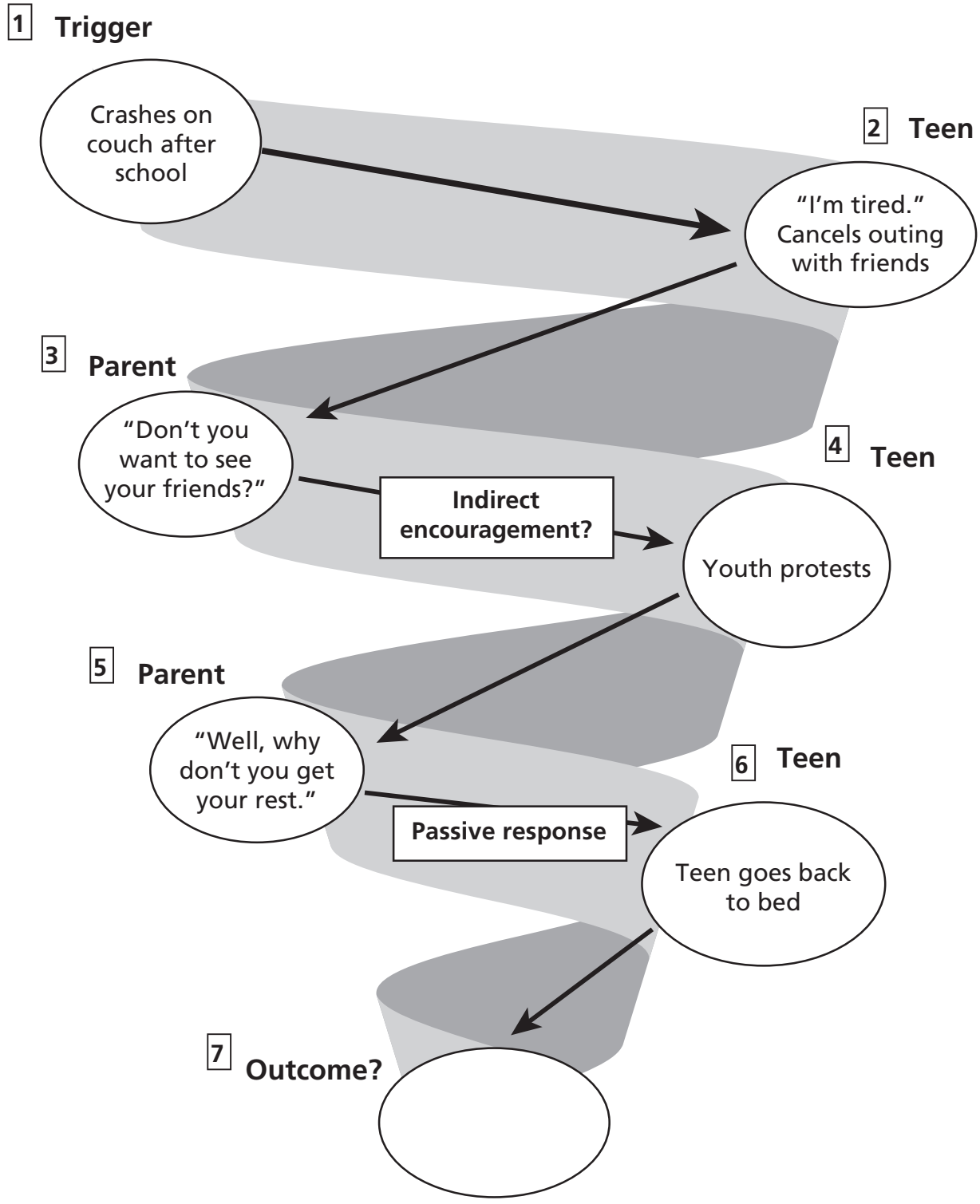
HANDOUT 8. The Accommodation Spiral

Look at the example below to see how accommodation and indirect encouragement can send mixed messages:



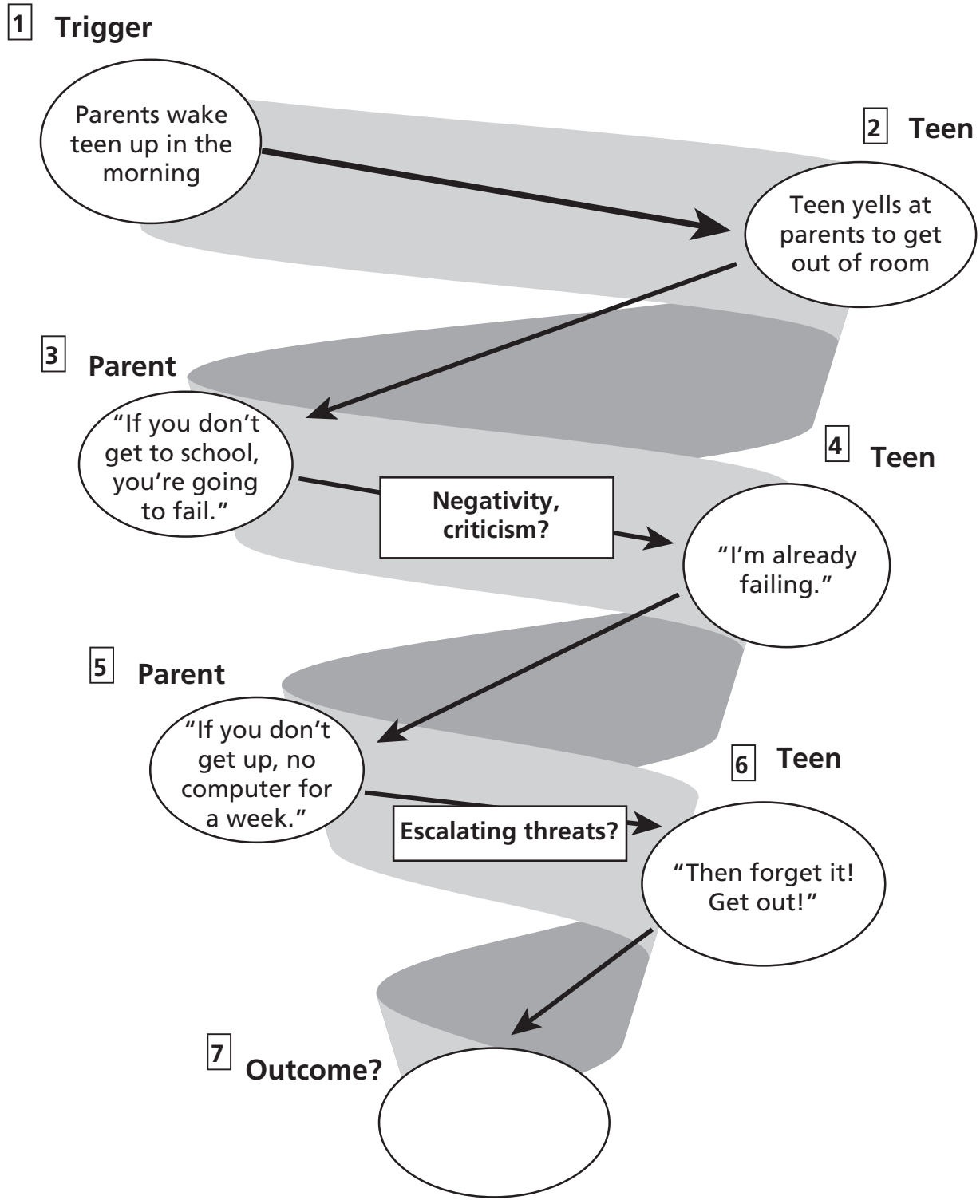
HANDOUT 9. The Passivity–Discouragement Spiral

Look at the example below to see how accommodation and passivity can reinforce discouragement:



HANDOUT 10. The Aggressive–Coercive Spiral

Look at the example below to see how negativity and criticism can escalate aggression and resistance:



HANDOUT 11. Common Parenting Traps and Helpful Solutions

COMMON PARENTING TRAPS

The Accommodation Spiral

Watching your child become upset is difficult. It's a natural instinct to try and soothe them. Some of the ways parents do that is by solving the child's problems for them or rescuing the child. Examples include ordering food for a child in a restaurant or writing a teacher for help when the child will not do so. These actions solve the problem in the short term but keep the child from learning how to do it themself.

The Passivity–Discouragement Spiral

When a child seems down, tired, or unmotivated, sometimes our instinct is to give into their mood: "They seem so tired; maybe it's just better they don't go to soccer practice." This approach might feel compassionate in the moment, but repeated permissions to withdraw and isolate reinforce the idea that withdrawal is the best solution to down moods.

The Aggressive–Coercive Spiral

Caregivers could be forgiven if long-standing anxiety or depression leads to frustration. This can lead to using anger or criticism to try and motivate kids and teens. However, shame and criticism (even if unintentional or well-meaning) make it less likely the youth will comply or feel motivated to problem-solve on their own.

COACH AND APPROACH TIPS THAT CAN HELP

Labeled Praise: Catch Them Being Good

Children and teens are keenly sensitive to caregiver signals and social attention. The best way to motivate change is to show your kids that you are noticing. Make sure you focus on the positive behaviors you want to reinforce because "negative" attention is just as potent as positive attention.

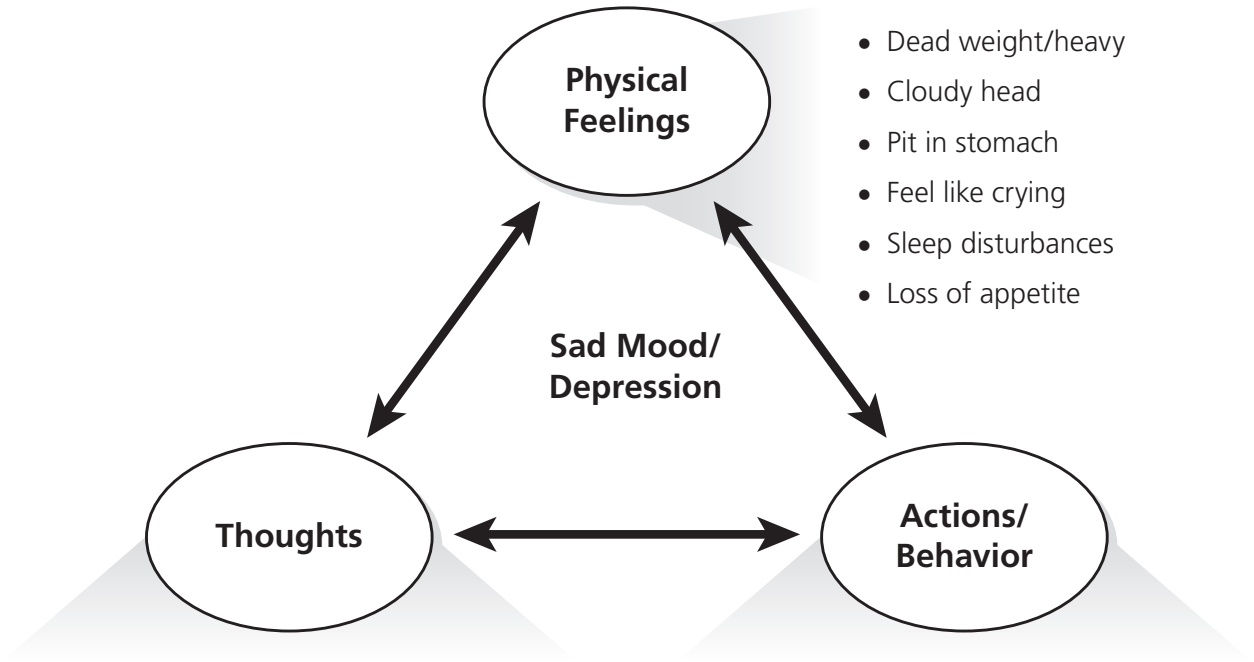
Empathize and Encourage

Caregivers can hone their motivational behaviors by focusing on two key concepts:

- **Empathize:** Make active listening a habit by practicing reflecting and amplifying what your child is saying. For example, "I know getting to school in the morning is really difficult for you."
- **Encourage:** Provide calm encouragement to move forward, emphasizing your child's ability to cope. For example, "And I know you can push yourself over this hump."

Remember to *STOP* after **three** empathize and encouragement statements to prevent falling into any of the parenting traps.

HANDOUT 12. Cognitive–Behavioral Model of Depression



- "I mess up everything."
- "Math is for losers."
- "Nothing will work out."
- "People don't ever help out."
- Unrealistically negative, pessimistic, self-critical, critical of others

- Withdrawal, isolation, pushing others away, avoidance of stressors, inability to get going
- Crying, sleeping, eating changes
- Attention and reassurance seeking, neediness
- Irritability, snapping, using sarcasm
- Rumination

HANDOUT 13. Facts about Depression

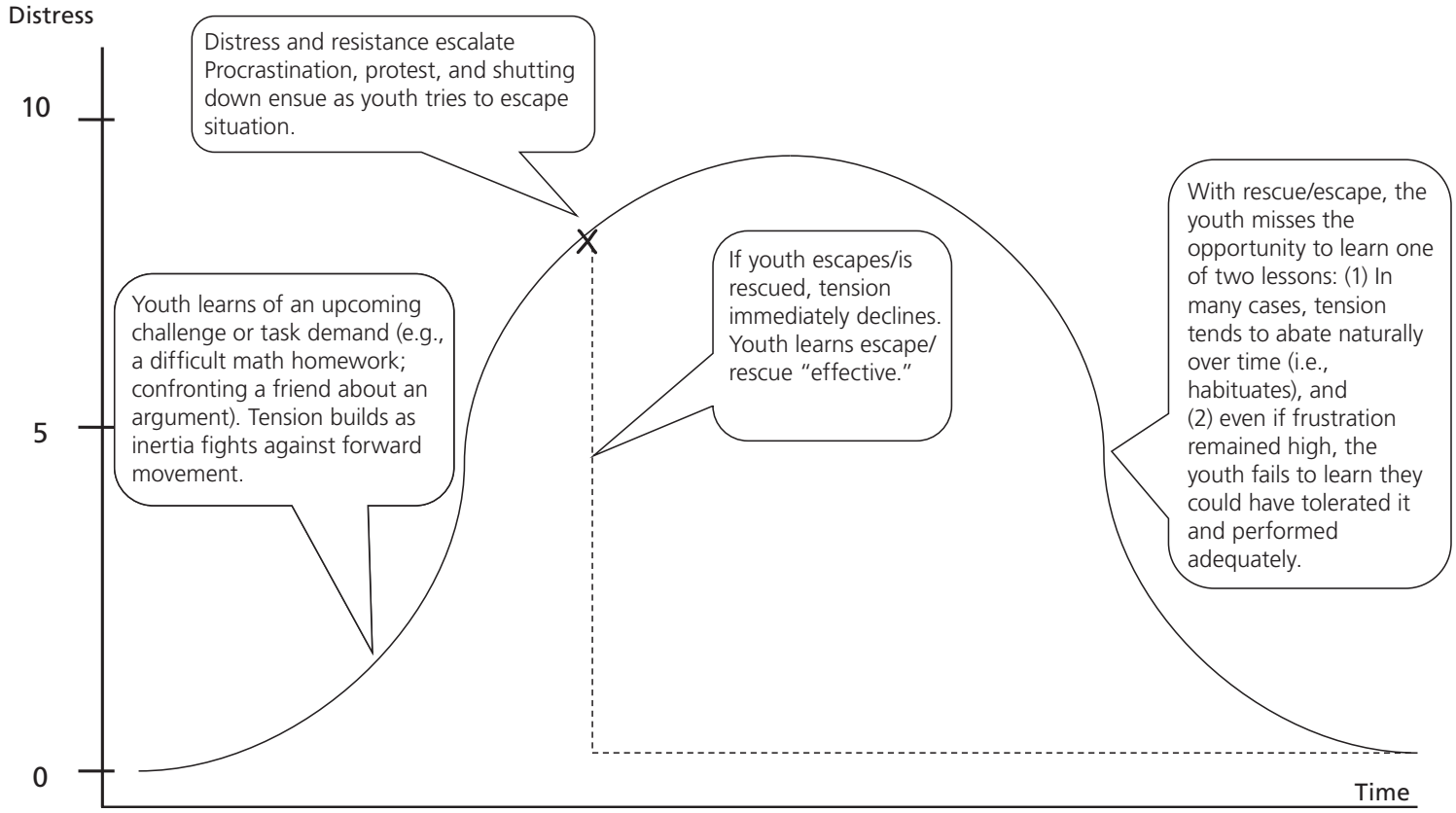
WHAT IS DEPRESSION?

Depression is a common psychological disorder that can impact a youth's social, emotional, academic, and family functioning. Identifying depression early is key to successful treatment, which can include psychological and medical interventions.

- Sadness is a familiar experience for all of us, but prolonged periods of depressed mood, sadness, and tearfulness might be the sign of more significant problems. In children and teens, sadness can mask itself as irritability and negativity.
- Loss of interest in things the youth used to care about is an important change in functioning that should be noticed.
- Sleep disruption, fatigue, change in eating habits, physical symptoms (e.g., headaches, stomachaches, muscle pain), and cognitive changes (poor concentration, slow thinking) are all common.
- Thoughts about suicide should not be dismissed as temporary or attention seeking. Any indication of suicidal ideation deserves further evaluation and potential safety planning.
- Common impairment includes significant impact on the youth's functioning in academics, friendships, and family. Self-care (e.g., maintaining sleeping, eating, and hygiene routines) often suffers as a result of depression.
- The youth does not suffer alone. Depression also impacts family and friends since the affected youth often manifests irritability, anger, and other negative/critical behaviors.
- Psychological interventions have been found to help. Cognitive-behavioral therapy (CBT) and interpersonal therapy have been found useful in individual and group formats.
- Medications can also help. Effective medical interventions, including selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine and sertraline, have been found to be effective in treating depression alone and in combination with CBT.

HANDOUT 14. Habituation Curve

This handout illustrates the effect of rescue/escape on learning in the case of depression. Procrastination and escape are negatively reinforced by the tension that is created by breaking inertia and the frustration caused by the call for sustained effort. Escape prevents the youth from experiencing natural habituation to distress or learning they can tolerate the frustration.



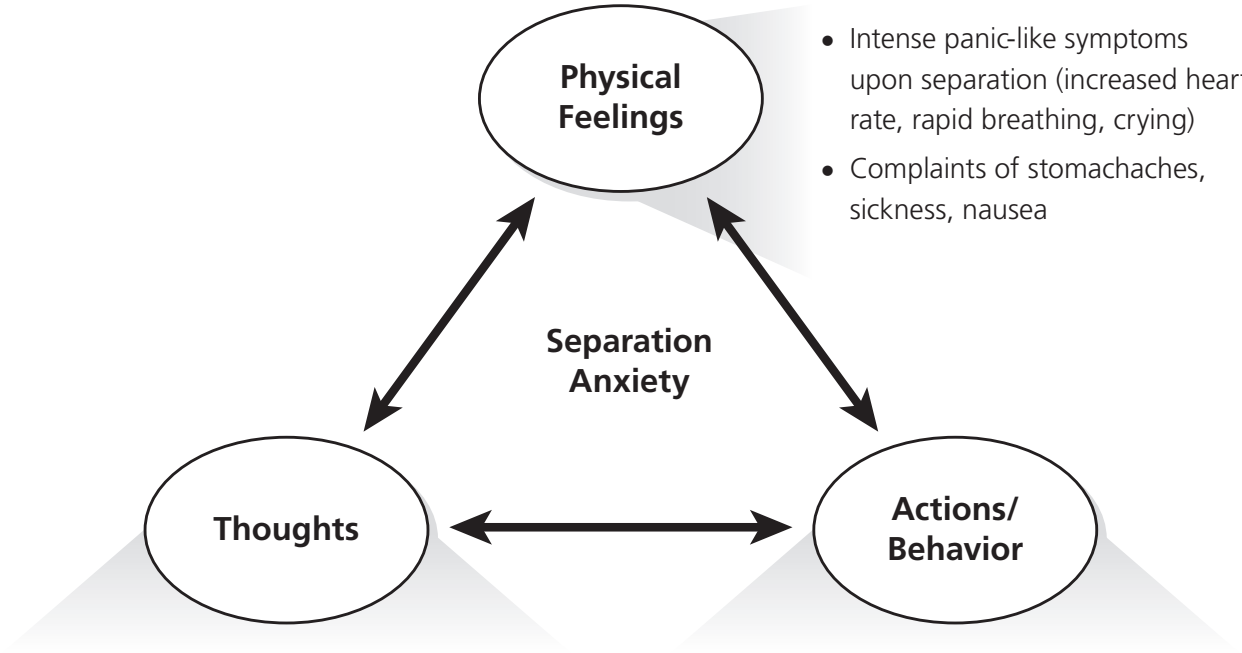
HANDOUT 15. Facts about Suicide and Self-Injurious Thoughts and Behaviors

WHAT ARE SUICIDE AND NONSUICIDAL SELF-INJURY?

Each year about 18% of teens in the United States seriously consider suicide and 9% attempt to kill themselves. Nonsuicidal self-injury, in which one causes bodily harm to themself without an explicit wish to die, has been reported in from 13–45% of teens.

- **Suicidal ideation (SI)** refers to thoughts about killing oneself. Suicidal ideation is characterized by negative, hopeless, and self-critical thinking and can include methods and plans for harming oneself.
- **Suicidal behaviors (suicide attempts, SA)** are actions a youth takes to harm themself that can lead to an injury whereby the youth wants to die. Common methods that teens use in a suicide attempt include prescription and nonprescription drug overdose, firearms, and suffocation/hanging.
- **Nonsuicidal self-injuries (NSSIs)** are self-inflicted injuries caused by a youth when there is no expressed wish to die. These include cuts, scratches, burns, and banging/hitting oneself. A youth might engage in nonsuicidal self-injuries to make themself feel better or stop feeling sadness, anxiety, or anger.
- **Who is at risk for suicide?** More girls attempt suicide, but more boys complete suicide. A prior suicide attempt increases the chances of ultimately completing suicide. Family history of suicide, drug or alcohol abuse, and access to firearms are key risk factors. Sexual minority youth are a particularly vulnerable group, with teens identifying as lesbian, gay, or bisexual reaching 3 times the risk for suicidality; nearly half of trans men and women report a prior attempt.
- **It is OK to ask questions about suicide?** Asking about suicide and self-harm does not increase the chances a youth will make a suicide attempt or experience intense SI. Thus, open communication and education are critical. However, evidence does show that graphic/visual depictions of suicide in the media or recent attempts in the youth's social network can trigger intensified SI. Caregivers should monitor vulnerable youth when such events occur.
- **Warning signs.** Please be alert if a youth shows any of the following signs of increased SI: statements about death or the desire to die; increased and sudden social isolation; giving away personal possessions; intensification of depressed mood, hopelessness, and apathy. Thoughts about suicide should not be dismissed as temporary or attention seeking. Any indication of suicidal ideation deserves further evaluation and potential safety planning.
- **How should we respond?** While suicidal ideation can be severe and frightening, it can also be fleeting. One of the most effective strategies to manage ideation and prevent suicide attempts is to enact short-term *safety planning* that includes: (1) recognizing the signs of SI, (2) accessing internal coping skills and interpersonal supports, and (3) securing the home by cutting off methods that could be used for harm (e.g., medications, firearms, rope, sharps).
- **Cognitive-behavioral therapy (CBT) can help.** Suicidal and nonsuicidal self-injury commonly co-occur in the context of depression and anxiety disorders. The coping skills a therapist teaches can help a youth learn how to manage intense emotions and make effective change in their life for long-term prevention.

HANDOUT 16. Cognitive–Behavioral Model of Separation Anxiety



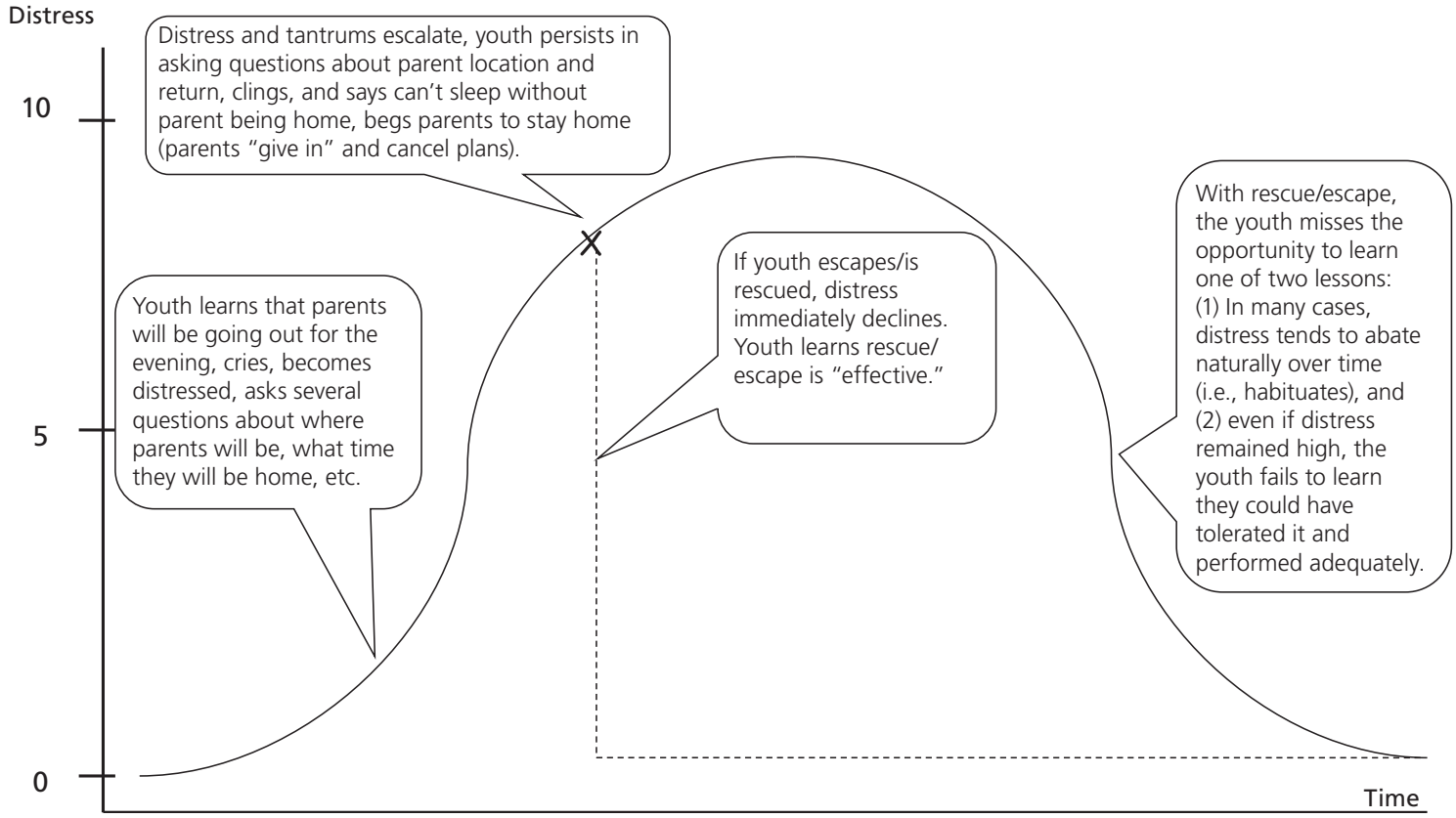
- Intense panic-like symptoms upon separation (increased heart rate, rapid breathing, crying)
- Complaints of stomachaches, sickness, nausea

- "My parents will get into an accident."
- "A robber will break in and steal me."
- "I *can't* sleep on my own."
- Worry about harm to self or parent upon separation, or being able to handle self or problems when separated.

- Clinging behavior, reassurance, and attention seeking
- Protests, arguments, complaints, oppositionality
- Refusal to separate at home, school, or elsewhere

HANDOUT 17. Habituation Curve

This handout illustrates the effect of rescue/escape on learning in the case of a separation anxious youth. Rescue/escape is negatively reinforced by its immediate impact on distress reduction. The youth fails to experience natural habituation of distress and fails to learn distress tolerance.



HANDOUT 18. Facts about Separation Anxiety

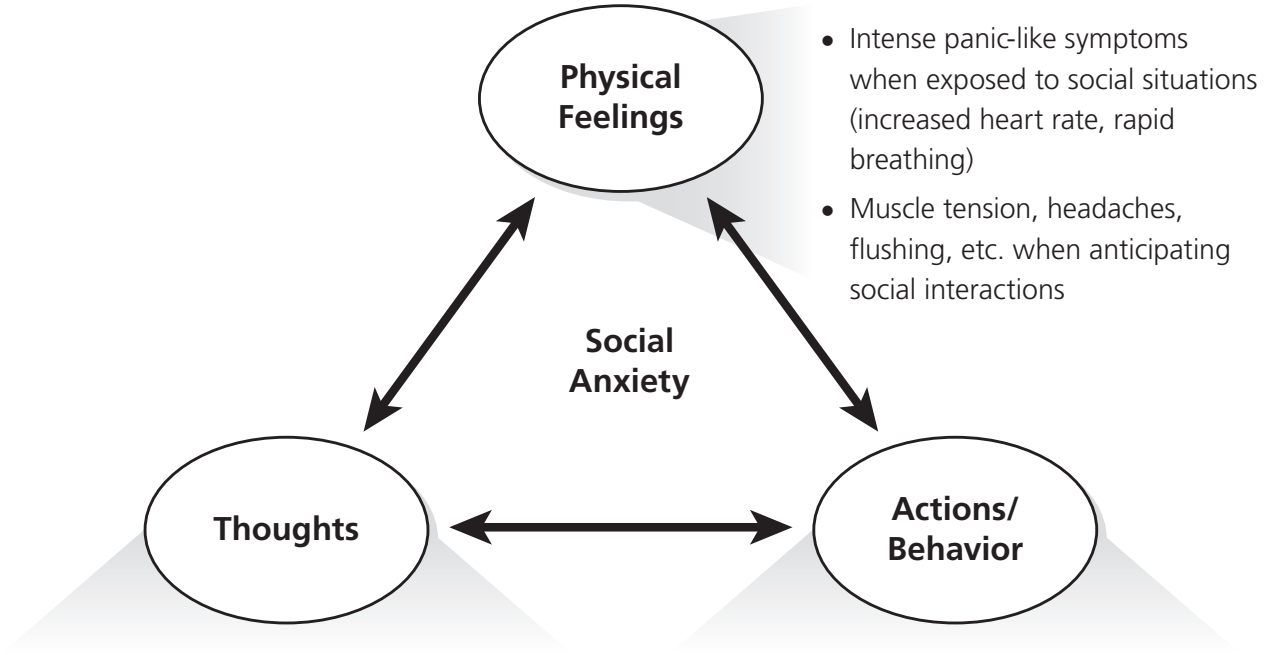
WHAT IS SEPARATION ANXIETY DISORDER?

Separation anxiety disorder (SEP) is a common psychological disorder that most often affects younger children but can be seen in older children and teens. Separation anxiety can lead to significant conflict within the family and prevent the child from activities they would ordinarily enjoy, such as sports, clubs, and spending time with friends. Interventions often include work with both the child and caregivers.

Other features to keep in mind:

- Some anxiety is normal and to be expected as a child faces expectations for greater independence. Fear of separating from caregivers is a normative part of a child's early development and may come about due to transient new challenges (e.g., going to school or being in a new setting)
- Treatment will not eliminate anxiety, or even the natural instinct to prefer familiar settings. Cognitive-behavioral therapy (CBT) aims to help children cope with separation fears so they do not hold the children back from meeting developmental tasks, goals, and opportunities.
- Characteristic thoughts, actions, and physical feelings make up separation anxiety. Knowing these helps demystify the problem and offers goals to aim for.
- Caregivers typically play an important role in helping the child learn new brave behaviors, including the development of their own anxiety management skills.
- Practice is essential for improvement: helping both the child and caregivers adopt new thinking and action patterns.
- Rewarding efforts to cope is essential, as new behaviors will feel unnatural at first.
- Psychological interventions have been found to help. Studies show that cognitive-behavioral therapy, particularly in programs that involve the parents and caregivers, is useful.

HANDOUT 19. Cognitive–Behavioral Model of Social Anxiety



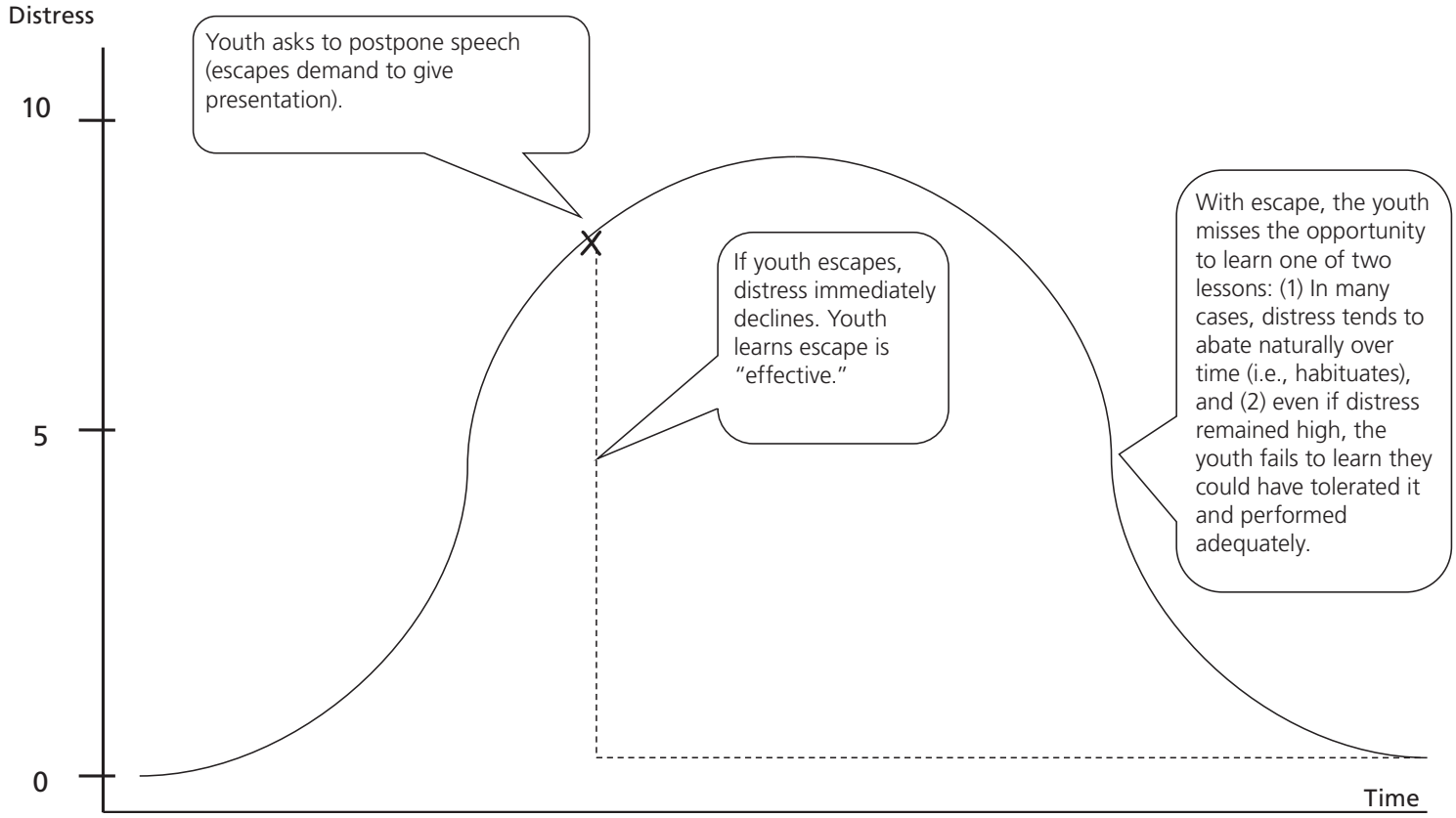
- Intense panic-like symptoms when exposed to social situations (increased heart rate, rapid breathing)
- Muscle tension, headaches, flushing, etc. when anticipating social interactions

- "I'm going to mess up."
- "Everyone will see how bad I am."
- "I'll always be known as a loser."
- Fear of evaluation, embarrassment, and the consequences of poor performance

- Avoidance/refusal/escape of social activities (parties, get-togethers) or demands (classwork, extracurriculars)
- Disruption in performance (self-presentation, awkward social skills)

HANDOUT 20. Habituation Curve

This handout illustrates the effect of escape on learning in the case of a socially anxious youth. Escape is negatively reinforced by its immediate impact on distress reduction. The youth fails to experience natural habituation of distress and fails to learn distress tolerance.



HANDOUT 21. Facts about Social Anxiety

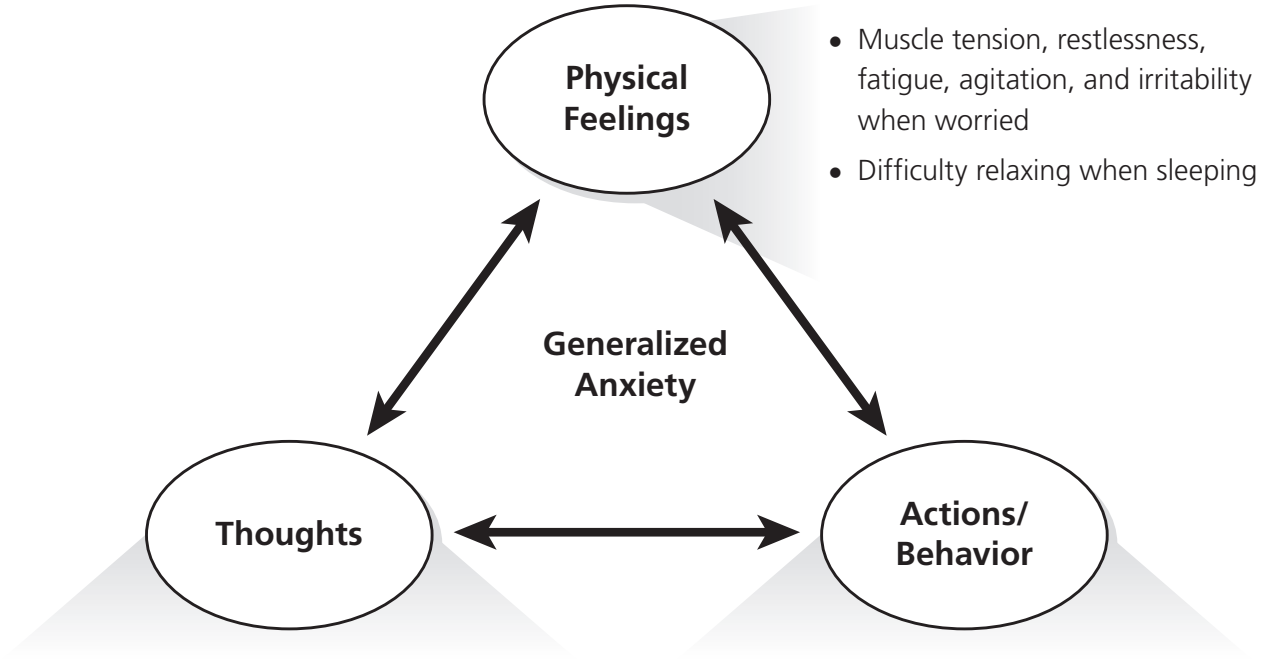
WHAT IS SOCIAL ANXIETY DISORDER?

Social anxiety disorder (SAD) is a common psychological disorder most often identified in youth between the ages of 10 and 13 years. It is marked by intense fear and anxiety in social situations where the youth fears evaluation from, or embarrassment in front of, others. Some anxiety is normal and expected in novel social or performance situations; social anxiety disorder reflects greater difficulty than would be expected for a youth of the same age.

Other features include:

- Shyness is not problematic, but it may become so if it inhibits a youth from engaging in developmental tasks.
- Youth will vary in socialization goals and interests. Some youth will need fewer friends and activities than others and goals can be made around finding key social connections and participation opportunities.
- Treatment will not change anyone's basic personality or temperament. If the youth is naturally more introverted, it is likely they will retain elements of that.
- Cognitive-behavioral therapy (CBT) aims to help such teens manage anxiety so as to not hold themselves back from desired goals, values, experiences, and opportunities.
- Characteristic thoughts (e.g., mind reading, worrying about being evaluated), actions (e.g., avoiding social situations), and physical feelings (e.g., heart racing, blushing) make up social anxiety. Knowing these helps demystify the problem and highlight areas of intervention goals to practice.
- Practice is essential for improvement, both for making new social skills more natural, but also to gather evidence that contradicts fearful assumptions and predictions.
- Caregivers can play an important role in reinforcing skills by arranging plenty of opportunities for practice, and by taking an "empathize and encourage" stance.
- Rewarding efforts to cope is essential, as new behaviors will feel unnatural at first.

HANDOUT 22. Cognitive–Behavioral Model of Generalized Anxiety Disorder



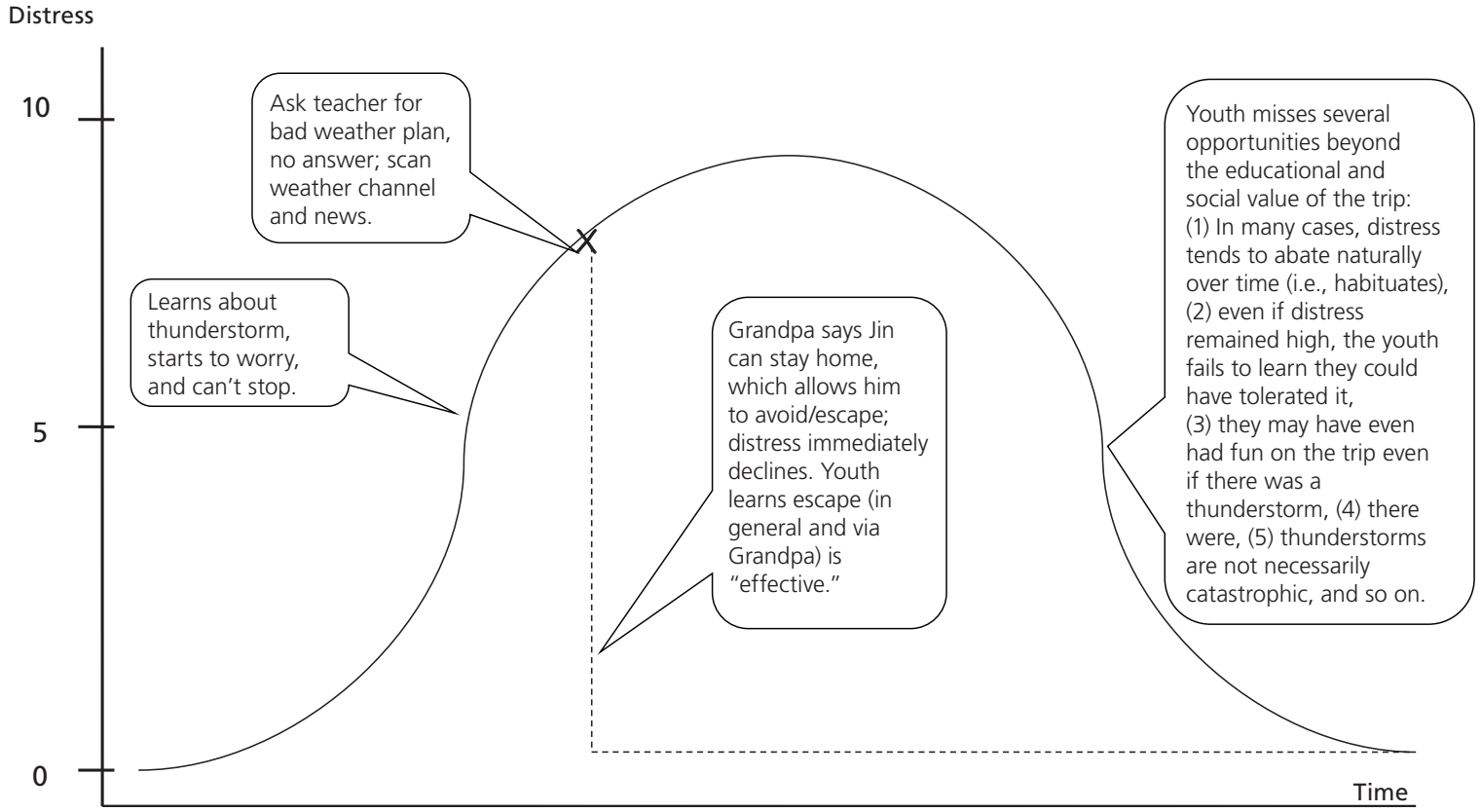
- Muscle tension, restlessness, fatigue, agitation, and irritability when worried
- Difficulty relaxing when sleeping

- Persistent "what if's . . . "
- "Will I be prepared? Safe?"
- "What happens if things go wrong?"
- "I won't be able to recover…"
- Self-imposed perfectionism, rigid sets of rules, worries about self, family, school, health, etc.

- Worry, rumination
- Avoidance, procrastination in managing demands, hassles, or addressing stressors
- Perfectionism, rigidity
- Attention and reassurance seeking, neediness

HANDOUT 23. Habituation Curve

This handout illustrates the effect of escape on learning in the case of GAD in youth. Escape is negatively reinforced by its immediate impact on distress reduction. The youth fails to experience natural habituation of distress and fails to learn distress tolerance.



HANDOUT 24. Facts about Worriers

WHAT IS GENERALIZED ANXIETY DISORDER?

Generalized Anxiety Disorder (GAD) begins to surface in middle childhood and becomes more prominent in the teenage years. It is marked by excessive and uncontrollable worries characterized by numerous "what if" statements and continuous reassurance seeking. Youth with generalized anxiety disorder also tend to report significant muscle tension, sleep problems, and overall distress. The intense worry can interfere with academic performance, social relations, and completing personal or school goals.

Other features to keep in mind:

- Worry is a natural reaction to experiencing anxiety. It reflects one's first attempt at "solving" a problem.
- When worry does not lead to constructive solutions, it no longer serves problem-solving functions. Rather, it reflects a process that is aimed at seeking artificial safety via superstitious beliefs (e.g., perfectionistic, compulsive planning) and temporary emotional relief (e.g., reassurance seeking).
- Reassurance seeking, compulsive planning, and escape provide temporary relief, but they do not solve the original problem and lead to longer-term negative outcomes (e.g., failure to build skills, missing out on helpful experiences).
- The nature of youth worries reflects multiple thinking traps, including overestimates of the occurrence of negative events and catastrophic assumptions about the outcomes.
- Practice is essential for challenging these assumptions and for learning how to tolerate the anxiety that comes with ambiguous situations where the outcome is uncertain.
- Caregivers play an important role in reinforcing skills by encouraging youth to face challenges independently by taking an "empathize and encourage" stance and "catching the positive" when they effectively cope and approach, rather than avoid anxiety-provoking situations.
- Rewarding efforts to cope is essential, as new behaviors will feel unnatural at first.

HANDOUT 25. Facts about School Refusal in Children and Teens

WHAT IS SCHOOL REFUSAL?

A substantial number of middle schoolers (14%) and high schoolers (21%) miss 10% of school days a year or more, qualifying for chronic absenteeism, according to the U.S. Department of Education. School refusal (SR) refers to absenteeism that stems from youth anxiety, depression, and emotion dysregulation. Caregivers are generally aware of the student's absenteeism and the youth shows little evidence of other behavioral problems (such as serious rule breaking, physical altercations at school). School refusal tends to intensify during transitions to new schools, new school years, and after breaks.

What does school refusal look like? It includes any school routine disruption, including:

- Initial tardiness at beginning of day.
- Partial or full absences from school day.
- Frequent trips to school nurse or counselor offices.
- School attendance, but youth exhibits significant dread and distress in school.
- Family fights and arguments centering around school issues.

Why does my child have trouble going to school?

Attendance problems are related to what we call "negative affect," an overall, diffuse feeling of dread, sadness, or anxiety that surfaces when the youth approaches or thinks about going to school. It feels unexplainable to the child or teen. Other ways to describe this are:

- Anxiety, school performance, social anxiety
- Panic/dread when arriving at school, separation from home or loved ones
- Depressed mood, dysphoria, hopelessness about school situation

What is not school refusal?

Poor school attendance can occur due to the following issues, but these are NOT considered school refusal:

- Absences where teen is engaging in illegal or delinquent behaviors
- School suspension for conduct, aggression, or bullying other peers
- Absences are primarily linked to academic problems or school grades

(continued)

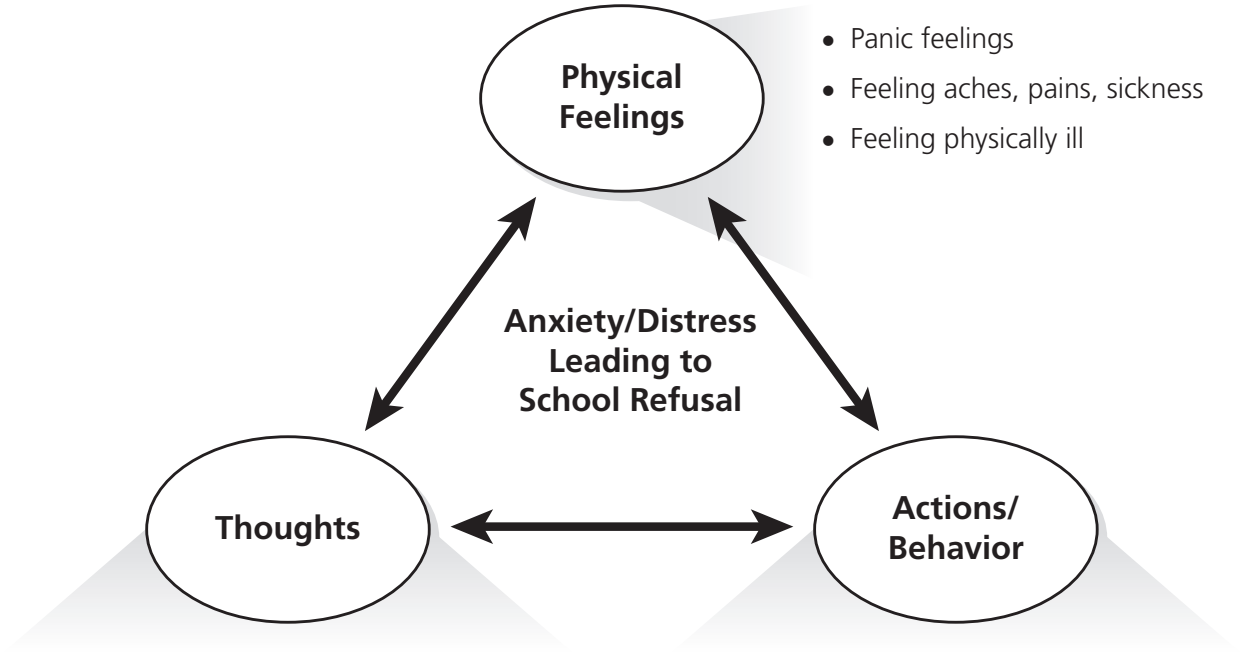
Cognitive-behavioral therapy (CBT) can help.

Your cognitive-behavioral therapist is teaching your child coping skills that can help them learn how to manage intense emotions and make effective change in their life for long-term prevention. Skills like problem solving, developing coping thoughts, behavioral activation, and distress tolerance can help your youth manage the intense negative affect underlying school refusal.

Parents play an important role.

- Parents do not "cause" school refusal. But there are certain messages that we subtly send that can either minimize attendance problems or discourage the youth from trying. Your therapist will help you identify some of those patterns.
- Cognitive-behavioral therapy will help parents gain confidence in structuring a school reentry plan by teaching skills like "empathize and encourage," and building meaningful reward plans.

HANDOUT 26. Cognitive–Behavioral Model of School Refusal Behavior

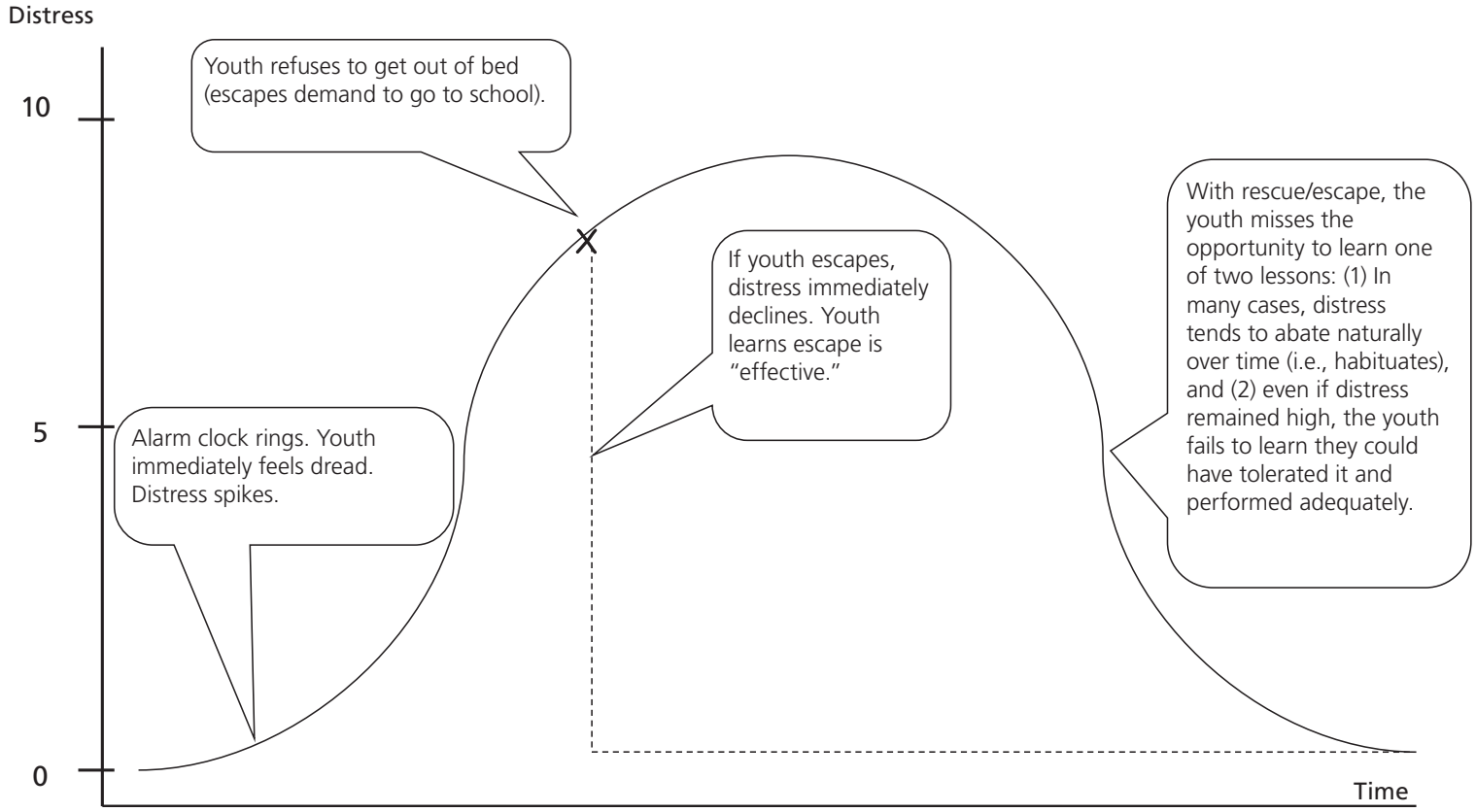


- "School's too hard."
- "The kids and teachers are mean to me."
- "I can't handle it."
- "What will happen at home if I leave?"
- "Why bother—no one cares."

- Resisting, delaying, protesting
- Avoiding, escaping
- Arguing, fighting
- Begging, reassurance seeking

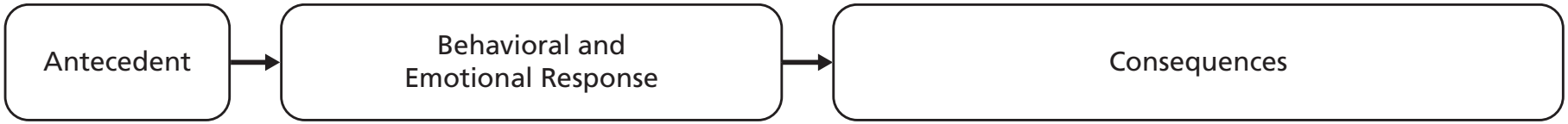
HANDOUT 27. Habituation Curve

This handout illustrates the effect of escape on learning in the case of a school refusing youth. Escape is negatively reinforced by its immediate impact on distress reduction. The youth fails to experience natural habituation of distress and fails to learn distress tolerance.



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?)
Example: *I had to give a speech in class.*	*Fear, panic*	*Asked my teacher if I could go to nurse's office—feeling sick.*	*Teacher said "yes." Huge relief!*	*Now I have to do the speech another time. Teacher was annoyed.*

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?
Example: *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.*

WORKSHEET 3. Change Plan

The therapist and youth can fill this out together (use help from parents as needed) to discuss what they would like to get out of their collaborative work. Using this worksheet, try to identify the youth's goals, and the challenges and supports that are needed to reach those goals.

1) The changes I want to make are:

(e.g., decrease anxiety/sad mood, improve grades, make more friends, do more fun activities)

2) The most important reasons I want to make these changes are:

(e.g., my happiness, my family, my social life, my grades)

3) The steps I plan to take in changing are:

(e.g., come to sessions, try skills at home, practice)

Things that could interfere with the change plan:

4) How much trouble do you think you'll have getting to session each week (e.g., scheduling)?

0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., talk to my teacher)

(continued)

5) How much do you think things will get in the way of you practicing the skills we go over here at home?

0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., use reminders to self to practice each day)

6) How much do you feel as if coming to session each week might be too much work?

0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., talk to my group leaders, make a deal with myself to work hard now for a better future)

7) How much do you feel as if using these skills at home will be too much work?

0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., ask parents for help, make a deal with myself to work hard now for a better future)

8) How much do you feel that a lack of support from others will be a problem for you in using the skills we practice here at home?

0 1 2 3 4
Not at all Very Much

Person: (e.g., parents, friends, group leaders)

Possible ways to help: (e.g., share work, ask group leaders, parents, or friends for more support)

(continued)

WORKSHEET 3. Change Plan (p. 3 of 3)

9) How much do you feel as if these skills will work at home? 0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., remember it takes time and practice, talk to my group leaders)

10) Overall, how comfortable do you think you'll feel practicing these skills with us in session? 0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., practice until I feel more comfortable)

11) How comfortable do you think you'll feel practicing these skills at home? 0 1 2 3 4
Not at all Very Much

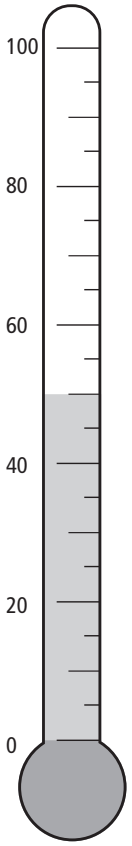
To overcome this, I will: (e.g., practice until I feel more comfortable)

12) How likely do you think it is that you will continue for the entire treatment? 0 1 2 3 4
Not at all Very Much

To overcome this, I will: (e.g., remember initial treatment goal and make sure I meet it)

WORKSHEET 4. Feelings Thermometer

Pick a feeling to describe (e.g., sadness, nervousness, anger). Then try to think about that feeling on a 0–10 scale. What words would you use to describe each rating? Can you remember a time when you've felt that way?



What feeling you are rating:		
How intense is it? (0 "Not at all" to 10 "the worst")	Describe the feeling (in your own words) for each level.	Describe past times you've felt this way.
10		
9		
8		
7		
6		
5		
4		
3		
2		
1		
0		

WORKSHEET 5. Thinking Traps Tracker

What thinking traps do you fall into when feeling sad, anxious, or distressed? For each situation, describe and rate how you feel. Describe your automatic thought (the first thought that comes into your head). What thinking trap might you be falling into? How does that make you feel (the result)?

Trigger	Feeling (rate 0–10: "not at all" to "excruciating")	Thought	Thinking Trap	Result?
Example: *I hear the alarm go off on the day of a big test.*	*Fear, panic (7)*	*"I'm not ready for the test!" "This will kill my grade!"*	*Fortune-telling, catastrophizing*	*Felt worse (9)*

WORKSHEET 6. *In Vivo* Exposure/Behavioral Experiment

Complete this worksheet with the youth as you are preparing for a behavioral experiment.

1. Situation (What's the situation?):

2. Feelings: **Distress Rating:** _____

3. Anxious/Negative Thoughts:	**Thinking Traps (See list below.)**

Thinking Traps: mind reading, fortune-telling, catastrophizing, jumping to conclusions, what if's, discounting the positives, looking for the negatives, overgeneralizing, all-or-nothing thinking, should statements, taking things too personally, blaming.

4. Coping Thoughts (How do you respond to your anxious thoughts?):

Challenge Questions: Do I know for certain that _____? Am I 100% sure that _____? What evidence do I have that _____? What is the worst that could happen? How bad is that? Do I have a crystal ball?

5. Achievable Behavioral Goals (What do you want to accomplish?):

Goal	Accomplished?
a.	
b.	
c.	

6. Rewards:

Reward	Earned?
a.	
b.	
c.	

WORKSHEET 7. Coping Reminders Success Summary

You have learned a lot of great skills during our work together. Take a moment to think through the strategies that work best for you.

Key Negative Thoughts to Watch For:

1.

2.

3.

My Thinking Traps:

1.

2.

3.

My Key Coping Thoughts:

1.

2.

3.

People Who Can Help Me:

1.

2.

3.

Actions and Behaviors That Help Me:

1.

2.

3.

I Remember When I Struggled with _____.

What Helped Me Most Was:

What I Need to Keep Practicing:

My Therapy Take-Home Message:

What Is a Sign That I May Want to Check In:

WORKSHEET 8. Coordination Checklist: Consulting with a Prescribing Physician

Pre-referral	
About Physician	
	Full name (and how the providers would like to be addressed)
	Years of practice (with kids)?
	Subspecialty in psychiatry or otherwise (addiction, forensics, etc.)?
	Is referral for psychopharmacology alone or in conjunction with psychotherapy? You want to be clear that the referral is for psychopharmacological evaluation.
	Office location
	Time/day availability
	Pricing for intake and follow-up sessions
	Any commercial or other health insurance that is accepted
	Types of cases with whom they will not work (eating disorder, suicidal, self-harm, etc.)
	Preferred method of communication
	Offer to present the patient (briefly) and see if the provider thinks they may be a good fit.
	Be prepared to answer any of the above questions about yourself.
About Patient	
	Consent/release of information signed by caregiver?
	General patient information and family demographics
	Chief complaint
	History of presenting disorder
	Course/progression of symptoms
	Pertinent past history; developmental, family, and social history; notable medical history
	Assessment: highlights and diagnosis, main areas of impairment
	Cognitive-behavioral case formulation
	Course of current psychotherapeutic treatment
	Reason for psychopharmacological consultation at this time
	Expectation from the consultation
	Notable patient and family concerns communicated to therapist

(continued)

WORKSHEET 8. Coordination Checklist: Consulting with a Prescribing Physician (p. 2 of 2)

Post-referral	
	Ask for provider's formulation.
	Obtain specific recommendations.
	Understand potential side effects and benefits of offered treatment (or lack of).
	Further medical work up recommended?
	Other diagnostic consideration that may require additional evaluations
	In case of medication recommendation, ask for titration schedule and end goals.
	Collaboration schedule: When would the therapist like to be contacted (increased risk, change in medications, etc.)?
	When would the prescribing psychiatrist like to be contacted?

WORKSHEET 9. Parent–Child Chain Analysis

Can you identify any parenting traps? What alternatives could you try?

	Action/Response	Parenting Trap	Potential Solution or Skills to Use?
Prompting Event			
Child Action			
Parent Response			
Child Reaction			
Parent Response			
Conflict/Problem Behavior			
Outcome 1 (What happened?)			
Outcome 2			
Outcome 3			

WORKSHEET 10. Daily Renewable Rewards Chart

Brainstorm step-by-step goals and rewards to go with each level. Then track success!

Theme:

Goals (incremental levels)	Reward (incremental levels)	Sun	Mon	Tue	Wed	Thu	Fri	Sat	# of Days Achieved

WORKSHEET 11. Goals Tracker

Work with your therapist to brainstorm possible specific, meaningful, and achievable goals. Think through what outcomes you expect to see. And then, keep track of how your child does each week.

Parent Goals	Desired Outcomes	Week 1	Week 2	Week 3	Week 4	Week 5
Example: *Improve sad mood; enjoy life more.*	*Rate sad mood (0–10).* *Rate weekly enjoyment (0–10).*	*Sad: 9* *Joy: 0*				

Youth Goals	Desired Outcomes	Week 1	Week 2	Week 3	Week 4	Week 5
Example: *Looked after my little sister.*						

WORKSHEET 12. Activity Tracker

Example:

Looked after my little sister. 7

Sometimes we don't even know when we're getting stuck. Over the next week, track your activities, mood, and important events that happen each day! Then rate your mood from 0 to 10:
0 = "The worst mood I've ever felt." **5** = "I'm feeling OK but not great." **10** = "The best I've ever felt."

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Lunch							
Afternoon							
After school/late afternoon							
Evening							

Week of: _____

WORKSHEET 13. Getting Active and Building Mastery

We all feel down and get stuck sometimes. When you feel stuck, bored, disengaged, or depressed, think up active, pleasant, or mastery activities to get un-stuck:

- Physical activation: Try physical or mental exercise or exertion.
- Pleasant activities: Try anything that you find fun and pleasant.
- Mastery exercises: Try something that helps you build a skill.
- Problem-solve: Brainstorm solutions to solve the problem, using problem-solving STEPS.

List Situations That Get You Stuck (lead to avoidance, withdrawal, procrastination, quitting, isolation)	**Proactive Pleasant, Mastery, or Problem-Solving Options**

WORKSHEET 14. Goals and Rewards Chart

Whenever we're trying new skills, we should reward ourselves for making the effort. First, brainstorm achievable, meaningful goals. Then decide how you would reward yourself for each accomplishment.

Goals I Can Match Myself	Reward	M	T	W	TR	F	Sat	Sun	# of Days Achieved

Goals I Need Others' Help for	Reward	M	T	W	TR	F	Sat	Sun	# of Days Achieved

WORKSHEET 15. Problem–Solving STEPS

To solve problems, take these steps: say what the problem is, think of solutions, examine each solution, pick one solution and try it, and see if it worked!

Say What the Problem Is:

Think of Solutions	Examine Each Solution		Rank
	Pros	Cons	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Pick One Solution and Try It:

WORKSHEET 16. Coping Thoughts Tracker

Brainstorm coping thoughts that could respond to your thinking trap! Try and come up with coping statements that are more realistic and ask, "How am I not seeing the whole picture?"

Trigger	Thought	Thinking Trap	Coping Thought	Result?

WORKSHEET 17. Suicidal Risk Heuristic: Severity, History, Intent, Plan (SHIP)

Client Name:	Date:
Severity	
Frequency and duration	
Intensity	
History	
Chronicity and history of SI	
NSSI history	
SA history	
Impulsive/risk behaviors	
Chronic stressors/ risk factors	

(continued)

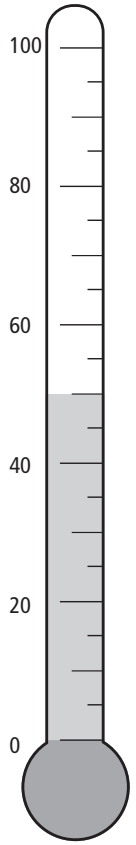
WORKSHEET 17. Suicidal Risk Heuristic: Severity, History, Intent, Plan (SHIP)

Intent	
Stated or inferred intent	
Preparatory acts	
Plan	
Planned methods	
Access to methods	

WORKSHEET 21. Suicidal Ideation Intensity Thermometer

When it comes to thoughts about harming ourselves, it is important that we can describe the feeling and intensity to others. Try to rate the intensity of your suicidal thoughts and feelings on a 0 to 10 scale. What words would you use to describe each rating? Can you remember a time when you've felt that way?

Suicidal Thoughts/ Feeling Intensity



What feeling you are rating:		
How intense is it? (0 "Not at all" to 10 "the worst")	Describe the feeling (in your own words) for each level.	Describe past times you've felt this way.
10		
9		
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2		
1		
0		

WORKSHEET 22. Chain Analysis of Suicidal Ideation and Self-Harm

The goal of chain analysis is to become more aware of the thoughts, emotions, and actions that spiral out of control when you fall into an emotional spiral. Work with your therapist to spell out your emotional spiral and the events that trigger them.

Name:		**Date:**	
Vulnerabilty Factors:			
Prompting Event:			
	Action/ Emotion/ Thought	**What did you do?**	**Potential solution or skills to use?**
Link 1			
Link 2			
Link 3			
Link 4			
What problems does this lead to (e.g., self-harm, SI, risk taking)?			
<u>What happened afterward?</u> **Short-term outcome**			
Long-term outcome			

WORKSHEET 23. Social Skills Checklist

Use behavioral observation and report from the youth, family, and other reporters to assess social skills strengths and concerns.

	Notable Strength	Never a Problem	Sometimes a Problem	Always a Problem	Comment
Nonverbals, Cues, and Posture					
Eye contact					
Expressing interest Smiling, nodding					
Shrinking and hiding					
Hiding behind clothes Hiding behind smartphones, headphones, books, electronics					
Standing in the periphery					
Handshakes					
Spoken Conversations: Starting, Joining, Maintaining					
The conversation volley: responding, reciprocity					
Volume and tone					
Expressing interest					
Written "Conversations": Texting and Social Media Communication					
The conversation volley					
Group chatting					
Social media To like or not to like					
Social media comments					
Writing an email					
Other Target?					

WORKSHEET 24. Weekly Parent–Child Interaction Patterns

Track your interactions with your child over the week and try to identify any parenting traps you fall into. What happened right away (immediate outcome) and then what happened later (long-term outcome)?

Day	Event	Child's Action	Parent's Response	Parent Pattern?	Immediate Result? Did behavior get better or worse right away?	Long-term Result? What happened over the next couple of days?
Example: *Monday*	*Math tutor scheduled for next day.*	*Upset—Rick says he's overwhelmed.*	*Talked with him; canceled math tutor.*	*Accommodation*	*It stopped the complaining.*	*He continued protesting the next couple of days.*

WORKSHEET 25. School–Family Coordination Plan: Role Assignments

Brainstorm with student, parents, teachers, and school liaisons what each person can do to help accomplish the goals of the school reentry plan.

Situation	Child Role	Parent Role	School Role
1. Morning routine	a. b. c.	a. b. c.	a. b. c.
2. School arrival	a. b. c.	a. b. c.	a. b. c.
3. During school day	a. b. c.	a. b. c.	a. b. c.
4. Departure/ after school	a. b. c.	a. b. c.	a. b. c.