Course Objectives
By the end of training, participants will be able to:
1. Explain the connection between thoughts, feelings and behavior;
2. Develop a cognitive case conceptualization and understand its relationship to Cognitive Therapy;
3. Choose and apply cognitive interventions appropriate for use with children and adolescents;
4. Choose and apply behavioral interventions appropriate for use with children and adolescents.

The Cognitive Model
“IT'S NOT THE SITUATIONS IN OUR LIVES THAT CAUSE DISTRESS, BUT RATHER OUR INTERPRETATIONS OF THOSE SITUATIONS.”

~AARON T. BECK

General Principles of CBT
Cognitive behavior therapy is:
• Semi-structured, time-sensitive, active;
• Based on a case conceptualization;
• Focused on skill development; and
• Oriented toward a hypothesis-testing approach.

Clinician and child work collaboratively with a focus on a strong relationship.
All interventions aim at cognitive change, which leads to behavioral and emotional change.

Importance of the Therapeutic Relationship
Like most other therapies, the therapeutic relationship is a necessary and critical component of CBT:
• Empathic
• Understanding
• Warm
• Genuine
• Direct and sensitive
The Cognitive Model

Your client has been sent to the office for the 4th time this week. The family has not returned your calls, and the client is refusing to talk to you.

What do you think?
How do you feel?
What do you do?

The situation

The beliefs

The consequences

Client no-shows for his session – again.

“His family situation is so tough right now. It’s really making it hard for him to even get to sessions.”

“His kid is so frustrating. He’s not even trying to get better.”

Frustration

Compassion

The Cognitive Model

General Cognitive Model

Situation

Behavior

Automatic Thoughts

Emotion

Situation

Get a dirty look from another kid

Behavior

Threaten the kid

Punch the kid

Refuse to back down

Automatic Thoughts

He thinks he’s better than me. I have to show him I’m not scared of him!

Emotion

Offended

Offended
Cognitive Components of the CBT Model

General CBT Model

Cognitive Model: Situation
A situation or activating event may be an internal or external event that prompts an automatic thought.

External event: alarm clock ringing, being interrupted, called on in class

Internal event: memory, thought, emotion, sensation

Cognitive Model: Beliefs

AUTOMATIC THOUGHTS
Quick evaluative thoughts

INTERMEDIATE BELIEFS
Rules or assumptions about life
"If ________, then ________"

CORE BELIEFS
Deeply held, rigid beliefs about the self, others, and the world

Automatic Thoughts
Quick, evaluative thoughts or images that are situation specific

Automatic thoughts = interpretations

We are more likely to be aware of the emotion that follows an automatic thought.

Automatic Thoughts
When you notice a strong reaction (emotional, behavioral, physiological), ask yourself:

“What was going through my mind just then?”
A Simple Example

ONE TRAINEE WILL BE CHOSEN TO COME TO THE FRONT OF THE ROOM.
• Instructor will describe a situation.
• Trainee will identify the automatic thought, the emotion that follows the thought, and the behavioral reaction.
• Other trainees will ask questions to determine whether the answers were correct.

Did Anyone Just Have an Automatic Thought?

• Stop and think – did you have a strong emotional reaction?
• Did a quick, evaluative thought pop into your mind just before the emotion?
• Congratulations – you identified an automatic thought!

Intermediate Beliefs

Attitudes, rules, or assumptions that stem from core beliefs and fuel automatic thoughts

Commonly in the form of “if/then” statements
If I can’t do this perfectly, then why bother trying?
If I open up to people, then I will get hurt.

Core Beliefs

MOST CENTRAL, FUNDAMENTAL BELIEFS ABOUT OURSELVES, OTHERS, AND THE WORLD

• Absolute and rigid beliefs (+ or -) in 1-2 words – “I’m worthless.”
• May result in biases in attention, information processing, and memory.
• When activated, we interpret situations through the lens of this belief.
• Not necessarily accurate or helpful

How Core Beliefs Impact Thoughts

Core belief
I am stupid.
Core Belief
I am capable.
Event
Hears that a math test is scheduled for next week
Automatic Thoughts & Images
“This is too hard. I’ll never understand this.”
“I will have to really pay attention and ask for help if I don’t understand something.”
Reaction
Sad, gives up, avoids studying, ultimately fails math test
Feels determined, seeks out help, studies, passes math test

Inaccurate and Unhelpful Beliefs (Self)

UNLOVABLE
I am disgusting.
No one wants me.
People hate me.

WORTHLESS
I am bad.
I am a waste.
I am a burden.

HELPLESS
I am incompetent.
I am vulnerable.
I am not good enough.
Coping Strategies

Behaviors that the child engages in that either support or oppose beliefs

Strategies may involve thinking or doing something.

Coping Strategies

Maintaining Strategies
Support the core belief.

Opposing Strategies
Try to prove the belief is wrong.

Avoiding Strategies
Try not to activate the belief.

Behavior generally makes sense to the person doing it, based on how they see the world, others, and themselves.

Coping Strategies: An Example

Belief
I'm unlovable.

Maintaining Strategy
Acting in a hostile manner

Opposing Strategy
People pleasing

Avoiding Strategy
Isolating

Beliefs and Strategies

NAME SOME CLIENT BEHAVIORS...

What kinds of beliefs might be associated with these behaviors?

WHAT KINDS OF BEHAVIOR MIGHT BE ASSOCIATED WITH THESE BELIEFS?

I'm vulnerable.
I have no control.
Everyone is trying to hurt me.

Working with youth: Who Exactly is the Client?

CT with youth can also involve:

- School staff
- Parents, foster parents, guardians, grandparents
- Siblings, cousins, other children in the home
- Judicial system, foster care system, department of jobs and family services
- Other mental health professionals
- Neighbors
- Peers
- Who else?
Challenges in Involving Families

**Children:**
- May be angry, upset, scared or detached from the family

**Adolescents:**
- Focus less on family and more on peers
- Age at which adolescents can consent for treatment varies from state to state.

Challenges to Involving Families

- Are often under high levels of stress and may be unable to come to the school regularly
- May be concerned about the stigma of having their child seen by a mental health professional
- May feel hopeless about change

Family Impact in CBT

Core beliefs and behavioral patterns often develop early in childhood
- Versions may be passed on across generations

Parental core beliefs often have a big impact on family and child functioning
- Communicated aloud (or not!) to children
- Can complicate treatment if not directly addressed

CBT in the Family

Parents can take an active role in choosing what they want to pass on to their children, and what they want to leave behind.
- Family members learn how their beliefs interact.
- Family members can support each other in testing out beliefs and modifying them as needed.
- Parents can act as coaches and models for kids.

Through the Generations

Grandfather
- Believed that discipline was best maintained through “tough love” and was violent

Mother
- Grew up in a violent home and came to believe that “Anger is dangerous”

Son
- Came to believe that if he shows anger, he will be rejected and unloved

Son
Case Conceptualization

• Foundation of CBT treatment
  • Brings together all the information into one coherent story
  • Takes into consideration life experiences that lead us to think and behave in specific ways
  • Based on here-and-now functioning and symptoms

Why use case conceptualization?

• To better understand behavior
• To increase empathy
• To identify ways to engage clients
• To identify targets for intervention
• To create a shared understanding of a child or adolescent

Cognitive Case Conceptualization

HISTORY

Critical/abusive family members
Undiagnosed learning disability
Neglect

CORE BELIEFS

I’m worthless.
I’m stupid.
Other people will hurt me.

INTERMEDIATE BELIEFS

It is horrible to make mistakes.
If I hurt others first, then they can’t hurt me.

COPIING STRATEGIES AND BEHAVIORS

Avoid challenging situations,
Aggression, isolation, rumination

Vignette: Case Conceptualization
Michele

Please read the vignette about Michele.

When you are finished, try to fill in the boxes in the case conceptualization.

- What are the important facts from her past?
- What are her beliefs?
- Which emotions and behavior does she have, and how are they related to her beliefs?

Please be ready to discuss with the group.

Structure of CBT Sessions

Mood Check and Bridge

MOOD RATING ON A 0-10 SCALE
  • Can be tracked to monitor change and progress.

REACTIONS TO LAST SESSION (BRIDGE)
  • "What do you remember about last session?"
  • "Did anything stand out for you about last time?"
  • "Was there anything that bothered you?"

HOMEWORK REVIEW
  • "Last time, we talked about you doing ___ between sessions. How did that go?"

Session Structure

Mood check & general assessment
Bridge from the previous session
Approximately 5 minutes

Agenda setting
Homework review
Discussion of issues on the agenda
Approximately 5 minutes

Summary and feedback

* periodic summaries and homework assignment

Audio Clip: Bridge

A therapist and client briefly review the last session
Agenda

• An ongoing collaborative process that involves both the therapist and the child
• Prioritizes problems related to treatment goals.
• Provides a roadmap for therapy.
• Instills hope and communicates that life’s problems can be addressed systematically.

Agenda Setting: Common Challenges

IF CHILD HAS DIFFICULTY IDENTIFYING ANY TOPICS:
Review treatment goals and translate them into session topics.

IF CHILD’S SUGGESTIONS ARE VAGUE:
Help the child to focus on concrete ways to work toward the goals. These become the agenda topics.

IF CHILD HAS TROUBLE SLOWING DOWN TO SET AN AGENDA:
Ask the child to think of 1 or 2 things that could be accomplished in the session that would leave the child feeling like progress was made.

Audio Clip: Setting the Agenda

The therapist and client work collaboratively to set an agenda for their session.

Final Summary and Feedback

Ask the child to summarize the main points of the session.
Ask what they found most helpful / least helpful.
Allows for assessment of progress
Provides opportunity to modify focus of treatment and agenda items
Helps guide the action plan

Action Plan

Early in each session, spend a few minutes reviewing what was done (or not done).
Encourages child to practice skills between sessions
Communicates that practices are important
Provides a basis for more discussion of ongoing issues

Choosing Practices

At the end of the session:
“Based on what we’ve been working on, what would you like to try out this week?”

Start homework assignment in session.
Write the assignment down.
Planning the Practice

Can be a relatively small assignment
Better to have a small, do-able assignment than a large one they don't complete.
Set it up so you learn something either way.
If they don't do it, what were the obstacles?
If they try it and it doesn't work, what happened?
If they do something similar, but not quite what was discussed, why the change, and what did they learn?
If they do it as planned, how can it be extended next time?

What Are The Odds?

“On a scale of 1-100, how likely is it that you’ll DO THE PRACTICE?”

If less than 90% confident:
Ask them to recall the collaboratively chose the practice.
What might get in your way?
can we help?
Adjust the plan until 90% reached.

Cognitive Interventions

Overview

Helping Children Identify Feelings vs. Thoughts

Try describing the difference:
a thought is often many words
and
an emotion is usually one word.

Keep a running list of emotions discussed in therapy:
Child’s description (physical sensations)
Related thoughts and triggers

More Feelings vs. Thoughts

Have the child choose the emotions they are feeling from a list of emotions.
Provide pictures or drawings of emotions (especially helpful for younger children or those with literacy problems).
More Feelings vs. Thoughts, cont.

Use comic strips with a situation and an empty thought bubble, and ask the child to guess what the person in the picture is thinking and feeling. Develop other games to do this!

Emotions charades: take acting out emotions
Identify emotions in
Feelings circle

Cognitive Strategies

1. Catching automatic thoughts
2. Checking automatic thoughts
   a. Socratic Questions
   b. Guided Discovery
   c. Discovering Thinking Traps
   d. Thought Records
   e. Behavioral Experiments
3. Changing automatic thoughts/adaptive responding
   A. Cognitive Responses
   B. Behavioral Responses

The 3 C’s: Catching Automatic Thoughts

Working with Automatic Thoughts

Goal of identifying thoughts / feelings is to then demonstrate the links between:

- situations
- thoughts/reactions
- beliefs

(feelings, behavior)

Helps the child develop a sense of mastery in modifying thoughts when necessary.

Catching Automatic Thoughts (ATs)

Remember this question?

“What was going through your mind just then?”

Ask this question when you notice a shift or intensification of emotion.

• Let the emotion guide you: the client is usually more aware of emotions than thoughts.

Have the child describe a situation where there was an emotional shift.

Have the child use imagery to describe an event in detail.

Other Ways to Catch ATs

1. What do you guess you were thinking about?
2. Were you imagining something that might happen or remembering something that did?
3. Did you get a picture in your head?
4. Were you thinking _____?
   (Therapist chooses thought opposite the expected response.)
The 3 C's: Checking Automatic Thoughts

Checking ATs: Guided Discovery
- Guide with questions
  - “What did you find helped when you were so angry? Did going to your room and writing in your journal help? Do you think it might help again if you tried it?”

vs.

- “Go to your room and write in your journal next time you get angry.”

Checking ATs: Thought Records

Thought records:
- Help consolidate learning in session.
- Aid the adolescent in becoming his/her own therapist outside of session.
- Can serve as written responses adolescents can read for homework.

Checking Automatic Thoughts (ATs)
- Therapist should not directly challenge the thought but should use “collaborative empiricism.”
  - Unknown if automatic thought is accurate or helpful
- Therapist and adolescent collaboratively test the thought’s validity or usefulness.
- Empowers adolescents to provide their own answers rather than rely on therapist’s interpretations.

Checking ATs: Guided Discovery

Which of the following can you see yourself using?
- What are the clues that tell you it’s true? What are the clues that it might not be true?
- Are there other ways to look at this situation?
- Is this true for everyone in your situation?
- What should you do about it?
- What would you tell a friend if he/she were in the same situation?
- Can you argue back against that thought?
- Can you give me a specific example?

Introducing Thought Records

Present the thought record as a “test” to see if thoughts and feelings are really linked.

Talk about it as an experiment to see if changing thinking does in fact change feelings and subsequent behavior.
Exercise – Working with our own Automatic Thoughts

Identify an automatic thought that might get in the way for you when working with children or adolescents.

- May be one that came up during the practice exercises
- May be a frequent frustration

Individually, try using a thought record. Is the thought really true? Helpful?

Role Play

- One person plays the child / adolescent who reports that they don’t want to work on their treatment plan anymore because they’re ‘no good.’
- The other person works with the student to catch, check and correct their thought.

Checking ATs: Behavioral Experiments

1. Child takes a negative prediction; therapist proposes that the student test it in session or during the week.
2. Collaboratively decide how, when, where to test it.
3. Can role play a scenario in preparation.
4. Therapist asks the child how she will react if experiment does confirm the thoughts/fears so she can devise a response in advance.
Behavioral Experiment: An Example

Automatic thought: “If I don’t show that I am tough all the time, the other kids will mess with me.”

Experiment: Pick a lunch period where you won’t try to show the other kids you are tough.
   • Figure out what to say.
   • Role play
   • Plan the appropriate timing.
   • Discuss consequences either way.
   – What if the other kids do mess with me? What if no one messes with me?

Checking ATs: But my client is right!

Not all automatic thoughts are wrong or based on cognitive distortions.

What do we do if the child’s thought is accurate?
   • CBT does not just gloss over real problems.
   • Cognitive and behavioral strategies are used to cope with or solve the problems.
   • Sometimes it is necessary to work toward acceptance.
   • Even if the automatic thought is true, is the child’s conclusion may be distorted and can be checked.

The 3 C’s: Changing Automatic Thoughts

Changing Negative ATs

• Based on the evidence collected during the evaluation stage

• The goal is to develop a belief that is:
   A) accurate
   B) helpful

• The goal is not to just put a positive spin on a situation or develop an affirmation.

Changing ATs: Adaptive Responding

Also known as “cognitive restructuring”

Therapist and child collaboratively develop an alternative/adaptive response to automatic thought.

Based on evaluation of 2 dimensions:
   • Accuracy and helpfulness

Yields 2 kinds of change:
   • Cognitive and behavioral

This is NOT just thinking a happier thought!

Adaptive Responding: Coping Cards

• Small card that kids can keep on hand and use to remind them of adaptive behaviors and thoughts

• Gives kids a sense of control

• Can involve reminders, mini action plans, and motivational statements

• Helpful to keep a copy in the child’s chart
Coping Cards

**AUTOMATIC THOUGHT - ADAPTIVE RESPONSE**

Automatic Thought: "I can't do anything right."
Adaptive Response: "Just because one thing I try doesn't work out doesn't mean I can't do anything. I'm doing ok in some subjects, I have a couple friends I like, I am getting better at doing things by myself. So there are things I'm doing right."

**COPING STATEMENTS/STRATEGIES**

Surviving Homework
- "If I do homework one step at a time, I can get it done."
- "I'm a smart kid with a busy brain – I can do this!"
- Chunking my work with breaks in between.
- Taking my medication regularly.

Cards Coping

**Instructions to Activate or Motivate**

Goal: Doing homework each night
1. Write down my assignments and what I need to do them.
2. Make sure I have what I need before I leave school.
3. Get a snack and take a 30-minute break when I get home.
4. Make a plan for what I need to accomplish and how long it will take:
   - 5: Follow my plan, taking a 5 minute break every 15 minutes. (Use a timer.)
   - 6: Reward myself for finishing my homework by playing video games for 20 minutes.
   - 7: Stay up 1 hour late on Friday night if I did my homework all week.

The 3 C's:
If Checking Does Not Create Change

1. Were there other more important automatic thoughts that we missed?
2. Did we evaluate the automatic thoughts thoroughly?
3. Did we discover and look at all the evidence?

Core Belief Work

1. Identifying core beliefs
   A. Downward arrow
   B. Presenting core beliefs
2. Checking core beliefs
3. Changing core beliefs
Identifying Core Beliefs: Downward Arrow Technique

1. Identify a key automatic thought.
2. Generate a hypothesis about a core belief that may underlie the thought, based on patterns.
3. Try if-then questions: “If you have trouble making friends, then what does that mean about you?”
4. Try hanging statements: “That made you so mad because...?”
5. Continue to probe until a meaning is found.
6. Be supportive and empathic as core beliefs are revealed, and use age-appropriate language.

Downward Arrow: Example

My mom asked me if I was getting into less trouble at school...

What went through your mind when she said that?

Oh, she just doesn’t get it. (Automatic thought)

So what does that mean to you?

It means no matter what I do nothing will change.

And what would that tell you?

That my family will keep looking down on me.

And what would that mean?

I’m no good. (Core belief)

Identifying Core Beliefs: Presenting the Belief

Example: “Tisha, we’ve talked about a few different problems this week – your problems with your neighbor, the situation at school, and what to do about your arguments with your mom. It sounds like behind all these problems might be an idea that you have about yourself, that you’re not good enough. I wonder if that might fit with how you see yourself?”

Checking Core Beliefs

Begins after the child:

Has established a collaborative relationship with the therapist.

Learns that some of his/her ideas are inaccurate/unhelpful.

Learns the process of checking and changing automatic thoughts.

Understands that he/she can change unhelpful or inaccurate thinking.

Changing Core Beliefs

- Write down beliefs and rate changes in the degree of certainty about these beliefs over time.
- Find evidence that contradicts the core belief and supports a more adaptive one.
- Write down the modified core belief.
- Complete a coping card.
- Complete a pros and cons list on maintaining the belief.
- Be patient - core beliefs often change very slowly!
Why Think About Behavior?

FEELINGS, THOUGHTS AND BEHAVIOR
ARE INTERRELATED.

Feelings

Thoughts

Behavior

The Role of Behaviors

Many behaviors are done “automatically.”

Behavioral strategies allow us to intervene in unhelpful patterns, which can lead to changes in thoughts and feelings.

An Example of Anxiety

Belief

I’m vulnerable.

Behavior

Mood

Avoidance of anything that is potentially threatening

Anxious

An Example of Depression

Belief

I’m a loser.

Behavior

Mood

Isolate

Sad

Behavioral Strategies

1. Exposure
2. Pros and cons
3. Activity monitoring
4. Activity scheduling
5. Problem solving

Exposure

Systematic approach to treating anxiety

Has key behavioral and cognitive components

Behavioral: Anxiety hierarchy

Cognitive: FEAR steps (Kendall, 1994)
Anxiety Hierarchy: Talking in Class

1. Participate in class one time per week
2. Participate 1x per day, 4 days per week
3. Participate 2x per day, 4 days per week
4. Read a paper out loud in class
5. 3 minute class presentation
6. 10 minute class presentation
7. 15 minute class presentation and take questions

Important Considerations in Creating a Hierarchy

• What specifically makes the child anxious?
  • Adults vs kids? Math class vs science? Reading vs talking spontaneously?

• What makes anxious situations easier or harder?
  • Easier if in a class with best friend? Harder first thing in the morning?

FEAR Steps (Kendall, 1994)

F eeling anxious?
What are the signs in my body / the situation that I might be feeling anxious? These tell me to use the rest of my FEAR plan!

E xpecting bad things to happen?
What am I telling myself is going to go wrong?

A ctions and attitudes that can help
What can I do to help the situation go better? What can I tell myself?

R esults and rewards
How hard did I try? How can I reward myself?

Examining Pros and Cons

Useful when a child:
• Has an important decision to make.
• Is having difficulty taking steps towards a particular goal.
• Needs to organize his or her thoughts about an issue.

Examining Pros and Cons

<table>
<thead>
<tr>
<th>Continue to smoke pot</th>
<th>Quit smoking pot</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
</tbody>
</table>
Activity Monitoring

• Identify which activities the child is currently able to enjoy.

• Depressed clients often limit their activities, describe little enjoyment of activities, and focus more on failure than success.

• Write down activities no matter how mundane using activity monitoring form.

Evaluate:
Fun (f): 0-10 scale
Proud (p): 0-10 scale
Rate overall mood for day

Activity Monitoring Form

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-10</td>
<td>Shower f-2, p-3</td>
<td>Shower f-2, p-3</td>
<td>Shower f-2, p-3</td>
</tr>
<tr>
<td>10-11</td>
<td>Walked dog f-4, p-5</td>
<td>Walked dog f-4, p-5</td>
<td>Walked dog f-4, p-5</td>
</tr>
<tr>
<td>11-12</td>
<td>Watched TV f-7, p-0</td>
<td>Cleaned room f-2, p-6</td>
<td></td>
</tr>
<tr>
<td>12-1</td>
<td>Made/ate lunch (oatmeal) f-2, p-4</td>
<td>Lunch (sandwich) f-2, pa-2</td>
<td>Lunch (sandwich) f-2, pa-2</td>
</tr>
</tbody>
</table>

Overall Mood (0-10)
Overall Mood=4
Overall Mood=5
Overall Mood=2
Overall Mood=6

Reviewing the Activity Monitoring Form

Review form with adolescent collaboratively (guiding with questions).

Goals:
• Help adolescent recognize the link between activities and mood.
• Note pleasant/unpleasant behaviors, themes to expand.

Activity Scheduling:
Scheduling Pleasant Activities

Develop structured activity schedule for engaging in pleasant activities over next week.

Keep it simple and achievable for the specific student – small steps lead to big change!

Relaxing and rewarding activities can reduce the anxiety that may fuel depression.

Activity Schedule

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tues</th>
<th>Weds</th>
<th>Thurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-10</td>
<td>Shower Eat breakfast</td>
<td>Shower Eat breakfast</td>
<td>Shower Eat breakfast</td>
</tr>
<tr>
<td>10-11</td>
<td>Take a 15 min bike ride</td>
<td>Play with my neighbor for 30 minutes</td>
<td>Take a 20 min bike ride</td>
</tr>
<tr>
<td>11-12</td>
<td>Challenge mom to a card game</td>
<td>Listen to music and dance</td>
<td>Play video games with my sister</td>
</tr>
<tr>
<td>12-1</td>
<td>Lunch</td>
<td>Lunch and ice cream cone</td>
<td>Make a new lunch food</td>
</tr>
</tbody>
</table>

Overall Mood (0-10)
## Identifying Pleasant Activities

Brainstorm new rewarding and meaningful activities:
- “Are there any fun things that you used to do that you don’t do any more?”
- Include activities listed on the activity monitoring form.

Fill out a pleasant events inventory.
- Google “pleasant activities list.”

Don’t overlook simple yet pleasant activities.
- E.G., Having hair brushed or braided, taking a bath

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### Activity Scheduling: Motivation

Assess motivation/ambivalence and problem solve as appropriate.

- “How do you feel about doing this over the next week?”
- “How likely is it that you will do this?”
- “What do you think might stand in your way of following the plan?”

---

### Activity Scheduling: Defeatist Attitudes

Testing beliefs through behavioral experiments:
- “I don’t enjoy anything.”
- “I can’t do it because I don’t feel like it.”
- “I have to do things perfectly for them to be fun.”
- Learning to rate things on continuum rather than all-or-nothing

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### Activity Scheduling: Meaningfulness

Assess child’s values or sense of meaning/purpose and match activities to the child’s true sense of self.

- “What is important to you?”
- “What are some words that describe who you are deep down or want to be?”

What are the risks in setting up something very meaningful?

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### Not just solving the problem:

Teaching problem solving

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

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Munoz et al., 2000 (http://medschool.ucsf.edu/latino/manuals.aspx)
Problem Solving

Identify the problem.

Choose one problem. (May need to prioritize.)

Define the problem in concrete, specific terms.

• “Andrew wants to fight after school.”

Problem Solving

Think about possible solutions.

• Brainstorm

Let child take the lead. Don’t judge.

• “I could wait in the school until he leaves.”
• “I could fight him.”
• “I could try talking to him before school ends to work things out.”
• “I could run home as fast as possible.”
• “I could walk home with a group of friends.”

Problem Solving

Choose a solution to implement.

Evaluate the solutions you’ve generated and pick the one that seem most likely to work (and least likely to cause problems).

• “I could hide in the school until he leaves.”
• “I could fight him.” (Has that worked in the past?)
• “I could try talking to him before school ends to work things out.”
• “I could run home as fast as possible.”
• “I could walk home with a group of friends.”

Problem Solving

Choose a solution to implement.

Identify the steps needed to implement your chosen solution(s).

• I could try talking to him before school ends to work things out.
  – Role play what, when, how, where to talk with him.
• I could walk home with a group of friends.
  – Plan which friends to ask, where to meet up with them, what to do if Andrew approaches the group.

Problem Solving

How well did it work?

Evaluate how well your solution(s) worked.

• Well: continue using these strategies.
• Not so well: return to step 1.
  – May need to redefine the problem or brainstorm more solutions.

Cognitive Restructuring or Problem Solving?

• “I’m being bullied at lunch.”
• “Everyone hates me.”
• “I hate school!”
• “My parents are so unfair!”
• “He tried to show me up, so I have to fight him.”
• “My step-dad punched me last night.”
• “My cousin offered me drugs over the weekend.”
• “Nothing ever works out for me.”
Safety Planning

Safety plans

It is important to review the rationale for a safety plan with the child

Safety plans are not meant to “fix” the problems in the person’s life that are causing the crisis...they are meant to help the person survive a crisis.

Safety plans

List of coping strategies for use during suicidal crisis from lower to higher level of intervention

Collaborative process between therapist and child

Brief, easy to read format that uses child’s own words

Involves a commitment to treatment process

Safety plan is NOT a “no-suicide contract”

5 steps of safety plan

1. Recognizing warning signs
2. Using internal coping strategies without the assistance of another person
3. Using social supports to distract child from crisis
4. Using social supports to help child to resolve crisis
5. Contacting mental health professionals

Step 1: Recognizing Warning Signs

Obtain accurate account of the events before, during, and after the most recent suicidal crisis

Ask:

• “How will you know when the safety plan should be used?”
• “What happens when you start to feel really upset or think about suicide?”
• “What changes do others notice?”

List warning signs (automatic thoughts, images, thinking styles, physical symptoms, mood, behavior) using child’s own words
Step 1: Recognizing Warning Signs:

Examples

AUTOMATIC THOUGHTS
• "I am a failure"
• "I can't deal with my problems"
• "Things aren't going to get better"

IMAGES
• Flashbacks

PHYSICAL SYMPTOMS
• Racing heart
• Shortness of breath
• Sweating

THINKING STYLES
• Having racing thoughts
• Thinking about a whole bunch of problems

MOOD
• Feeling depressed
• Intense worry
• Intense anger

BEHAVIOR
• Crying
• Isolating myself
• Over-eating

Step 2: Using Internal Coping Strategies

List activities that the child can do without contacting another person

The activities function as a way to help child take her minds off her problems and prevent suicide ideation from escalating

“What can you do on your own, if you become suicidal again, to help yourself not to hurt yourself?”

EXAMPLES:
Going for a walk
Listening to inspirational music
Taking a hot shower
Walking the dog

Step 3: Social Supports to Distract from Crisis

Instruct the child to use step 3 if step 2 does not resolve the crisis or lower risk

Identify family, friends, or acquaintances who may be a good distraction

“Is there anyone in your life who you like to be with who can help you take your mind off of your problems? You don’t have to tell them about your suicidal feelings.”

List several people
Include phone numbers
Prioritize list

Step 4: Social Supports to Help Solve the Crisis

Instruct the child to use step 4 if step 3 does not resolve the crisis or lower risk

Identify family, friends, or acquaintances who may offer support

“Is there anyone in your life who you could talk to about your suicidal feelings, and who could help when you feel that way?”

List several people
Include phone numbers
Prioritize list

Step 5: Contacting Mental Health Professionals

Instruct the child to use step 5 if step 4 does not resolve the crisis or lower risk

Identify mental health professionals, agencies, emergency rooms, etc. That can be contacted for help during crisis

“Who are the mental health professionals that we should list on your safety plan?”

List several
Include phone numbers
Prioritize list
Step 5: Contacting Mental Health Professionals

Emergency contacts:
Primary clinician
On-call clinician who can be reached after business hours
Primary care physician, psychiatrist, or other physician
24-hour emergency treatment facility
Other local support services that handle emergency calls
1-800-273-TALK

**Reducing the Potential for Use of Lethal Means**

Explore means the child would consider using during suicidal crisis and collaboratively identify ways to secure or limit access to them

Suicide behavior can be very impulsive. Do not ask the child to remove the means themselves. Seek assistance of designated, responsible person — usually family member, close friend, or even the police

Implementation

Review each step
Assess likelihood of using safety plan
Specify location of safety plan
Revise at later sessions as new skills are learned/social network is expanded
May be adapted for brief crisis cards, cell phones or other portable electronic devices — must be readily accessible and easy-to-use

Safety Plans

Break into pairs and practice creating safety plans

Hope Kit

Memory aid consisting of a collection of meaningful items that remind child of reasons to live
Goal: Relapse prevention
Hope Kit

MAY CONSIST OF:
- Pictures
- Letters
- Poetry
- Prayer cards
- Coping cards
- Others

OTHER IDEAS FOR THE IMPLEMENTATION OF THE HOPE KIT:
- Scrapbook
- Collage
- Painting
- Drawing
- Other form of artistic expression

Hope Kit

Benefits of the exercise:
- Can be an enjoyable activity
- Many see it as a meaningful strategy
- Leads to identification of reasons for living that may have been previously overlooked

IMPLEMENTATION:
- Plan carefully—some items may seem appropriate, but may trigger negative emotions
- Help child decide where to keep it
- Recommend regular use even when not in crisis
- Have children visualize themselves using it when in crisis
- Determine whether it might be appropriate for child to share hope kit items with supportive people
- Elicit child's feedback on usefulness of the items

Hope Kit

Bringing It All Together:
Case Conceptualization-Driven Intervention

Case Conceptualization-Driven Intervention
Interventions should be tailored for the individual's strengths and needs, based on case conceptualization.

- Let’s review the vignette about Michele and the case conceptualization we developed for her.
- Based on her case conceptualization, where are potential areas to target with intervention.
- Which interventions would you try for those targets?
Partial List of Interventions

In case you need some help, here are a few interventions we've learned about:

1. Catching
2. Checking
   a. Guided discovery
   b. Thought records
   c. Behavioral experiments
3. Changing / adaptive responding
   a. Cognitive responses
   b. Behavioral responses
4. Exposure
5. Pros and cons
6. Activity monitoring
7. Behavioral activation
8. Problem solving
9. Safety plan
10. Hope Kit

Treatment Non-Adherence

What types of non-adherent behavior do you see most often from clients?

Non-Adherent Behaviors

• Refusing to follow home rules
• Refusing to attend school
• Refusing to go to bed
• Refusing to do homework
• Refusing to take meds
• Refusing to come to therapy

Treatment Non-Adherence

What thoughts might be associated with this type of behavior?

What feelings might be associated with these thoughts?
Cognitive Model: Beliefs

Automatic thoughts
Quick evaluative thoughts

Intermediate beliefs
Rules or assumptions about life
“If_____ then_____.”

Core beliefs
Deeply held, rigid beliefs about the self, others, and the world

Non-Adherence: Automatic Thoughts

“I don’t want to talk to her.”
“He won’t believe me anyway.”
“She’s trying to embarrass me.”
“She thinks I’m stupid.”
“He thinks he’s better than me.”

Non-Adherence: Intermediate Beliefs

“If I don’t say anything, I won’t be wrong.
“If I talk to him, he won’t believe anything I say.
“If I trust her, she’ll just let me down.
“If I tell him, he will see how dumb I am.
“If I admit I was wrong, then she wins.

Non-Adherence: Core Beliefs

“I am powerless.
“I am crazy.
“I am defective.
“My future is hopeless.
“Other people are cruel.
“The world is dangerous.

Non-Adherence: Interventions

Which interventions might you use when working with a non-adherent child or adolescent?

- Engagement
- Guided Discovery
- Pros & Cons
- 3 Cs
- Coping Cards
- Other?

Stages of CBT Treatment
Where Should We Focus in Therapy?

<table>
<thead>
<tr>
<th>Socialization into CT model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
</tr>
<tr>
<td>Assessment, alliance, motivation</td>
</tr>
<tr>
<td>Treatment goals, conceptualization and plan</td>
</tr>
<tr>
<td>Behavioral and Cognitive strategies</td>
</tr>
</tbody>
</table>

Initial Sessions: Overview

- Initial clinical assessment
- Motivational enhancement
- First session: Socialization to CBT
- Establish treatment goals

Initial Clinical Assessment

Beginning from the intake information, learn about how the client sees the world, and how thoughts / feelings / behavior might be getting in the way or causing distress.

Start thinking case conceptualization from the beginning.

Initial Phase Of Treatment: Assessment

Initial Phase Of Treatment: Motivation

Low Motivation in Children and Adolescents

1. Often come to treatment through a referral from the school staff, parents, juvenile justice system, etc.
2. May not be ready to make changes or understand what therapy involves.
3. May not understand that their symptoms are part of a problem.
4. May agree to attend therapy to please a family member or other professional.
# Motivational Enhancement

**Addressing the child's motivation and readiness to change may increase the likelihood that therapy will be successful.**

The goal is to build the child's internal motivation to change rather than agreeing to change because of persuasion, coercion, or external contingencies.

## Motivational Enhancement Strategies

### Identify short-term goals, then compare with their current functioning in these areas:

- **What would you like to change in your life?**
- **What kinds of things might make it hard to reach those goals?**
- **How might therapy help you to achieve those goals?**

### Identify the consequences or impact of their symptoms:

- What problems has the (depression) caused you recently?
- What effect does (worry) have on your life? Does (worry) get in the way of doing things you would normally do? Like what?
- Does the (anger) affect school? Friendships? Life at home? Satisfaction in life?
- Have other people noticed that you seem (sad)? Why did your (family, school) say you needed to come to therapy?

### Identify the benefits of reducing the severity of their symptoms:

- If you were less (angry), how would it be helpful to you? How would your life improve?
- What would life look like if we could wave a magic wand and make the (sadness) disappear?
- What will life look like in (1) year if you do not make changes?

### Assess attitudes and expectations for therapy:

- What do you think therapy would be like? Helpful? Not so helpful?
- Have you ever been in therapy before?
- What happened last time you went to therapy? How was it?

Talking about this may:

- Communicate that you are taking THE CHILD seriously. (Helps build a collaborative relationship)
- Provide information for the case conceptualization and treatment plan.

---

**Initial Phase Of Treatment:**

**Socialization to CBT**
Socialization to CBT

In early sessions, introduce child to:
- Session structure
- Collaborative stance
- Cognitive model
- Goal oriented, here-and-now oriented approach
- Practice assignments (rationale)

Initial Phase Of Treatment: Treatment Goals

Treatment Goals

Identify several target problems for early stages of therapy.
Work with child to rank order the issues.
Formulate high priority issues into treatment goals to guide your interventions.

After every session, a CBT therapist is able to state at least 1 intervention used to help the child get closer to his or her goals.

Treatment Goals

The best CBT goals are SMART:
- Specific
- Measurable
- Attainable
- Realistic
- Timely

It is easier to add something to the system than take it away.
Ex: “More fun times with my mom” is easier than, “Yell at my mother less.”

What are the treatment goals?

<table>
<thead>
<tr>
<th>Broad</th>
<th>Specific (behavior)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I want to not get suspended all the time.”</td>
<td>“I want to find ways to think and act differently with the kids at school so that I get into fewer fights.”</td>
</tr>
<tr>
<td>“I want to not feel so dumb.”</td>
<td>“I’d like to pass each of my classes this semester.”</td>
</tr>
<tr>
<td>“I don’t want to be anxious anymore.”</td>
<td>“I’d like to be able to ride the bus without feeling that someone will attack me.”</td>
</tr>
<tr>
<td>“I’d like to be happier.”</td>
<td>“I’d like to spend more time socializing and playing basketball.”</td>
</tr>
</tbody>
</table>

Middle Phase Of Treatment
Once the Stage is Set: What Should We Work On?

Which problems should be prioritized?

Clients should always have a say in this!
Life threatening behaviors always 1st.
Two trains of thought: start with the easiest or the most important

What should we work on?

When focusing on cognitions...start with automatic thoughts.
• More easily accessed by the client
• Less stable, less rigid, and less firmly believed than core beliefs

May be helpful to use behavioral strategies first.
• Link to cognitive change
• Can revisit behavioral change throughout treatment

Should be at least 1 intervention per session

Tailoring Therapy to Individuals

Based on the case conceptualization, behavioral and cognitive strategies are adapted to the problem and individual.

When beliefs are reality based, the goal is to assist the child in coping with the situation or solving the problem.
Other times, helping the child change his or her perspective or allow in new information leads to more realistic or adaptive beliefs and lower distress levels.

Late Phase Of Treatment

Late Stage of Therapy

Ensure that clients are ready to be “their own therapist” or to transition to next level of care.

• Check in with the child and the family.
• Consolidate what has been learned in therapy.
• Generalize skills learned in session to outside of session.
• Help family to be ready and on board.
• Determine need for booster sessions.

Goals of Relapse Prevention

Planning for termination and relapse helps clients prepare for future.

Anticipate and prepare for future setbacks.

Help clients and families recognize warning signs that they should seek treatment again.

Reduce likelihood they will need future treatment or hospitalization.

"Imagine a problem you had in the past. How would you deal with it now?"
Relapse Prevention Interventions

• Review progress to date.
  What has changed? Which skills have you learned?
• Figure out how often/when skills should be used.
  Cognitive rehearsal, role play
• Solidify a support system.
  At home, school, neighborhood, etc.

Discuss any issues the client still wants to work on and how they will do so.

Relapse Prevention, cont’d.

Normalize relapse.
• Outline warning signs
• Distinguish between normal stress and signs that it is time to return to therapy.

Plan for booster sessions.
Discuss what was helpful/not helpful in therapy (especially if transferring to another therapist).
Discuss reactions to termination of therapy.
Does termination confirm negative beliefs like, “everyone i care about leaves me”?

Developing Competency:
A Review Of The Cognitive Therapy Rating Scale

Cognitive Therapy Rating Scale

EACH ITEM IS RATED ON A CONTINUUM:

0 Poor (absent)
1 Needs Improvement
2 Mediocre
3 Satisfactory
4 Solid Competent Work
5 Very Good
6 Excellent

Useful for identifying strengths and weaknesses in specific areas
Uses behavioral anchors for determining competency on a specific item
Not meant to be used in first or last session
Be mindful of the independence of ratings

Part I:
Agenda
Feedback
Understanding
Interpersonal effectiveness
Collaboration
Pacing and efficient use of time
Cognitive Therapy Rating Scale

PART II:
Guided discovery
Focusing on key cognitions or behaviors
Strategy for change
Application of cognitive-behavioral techniques
Homework

1. Agenda
0 Therapist did not set agenda.
2 Therapist set agenda that was vague or incomplete.
4 Therapist worked with child to set a mutually satisfactory agenda that included specific target problems (e.g., anxiety at work, dissatisfaction with marriage).
6 Therapist worked with child to set an appropriate agenda with target problems, suitable for the available time. Established priorities and then followed agenda.

2. Feedback
0 Therapist did not ask for feedback to determine child’s understanding of, or response to, the session.
2 Therapist elicited some feedback from the child, but did not ask enough questions to be sure the child understood the therapist’s line of reasoning during the session or to ascertain whether the child was satisfied with the session.
4 Therapist asked enough questions to be sure that the child understood the therapist’s line of reasoning throughout the session and to determine the child’s reactions to the session. The therapist adjusted his/her behavior in response to the feedback, when appropriate.
6 Therapist was especially adept at eliciting and responding to verbal and non-verbal feedback throughout the session (e.g., elicited reactions to session, regularly checked for understanding, helped summarize main points at end of session).

3. Understanding
0 Therapist repeatedly failed to understand what the child explicitly said and thus consistently missed the point. Poor empathic skills.
2 Therapist was usually able to reflect or rephrase what the child explicitly said, but repeatedly failed to respond to more subtle communication. Limited ability to listen and empathize.
4 Therapist generally seemed to grasp the child’s “internal reality” as reflected by both what the child explicitly said and what the child communicated in more subtle ways. Good ability to listen and empathize.
6 Therapist seemed to understand the child’s “internal reality” thoroughly and was adept at communicating this understanding through appropriate verbal and non-verbal responses to the child (e.g., the tone of the therapist’s response conveyed a sympathetic understanding of the child’s “message”). Excellent listening and empathic skills.

4. Interpersonal Effectiveness
0 Therapist had poor interpersonal skills. Seemed hostile, demeaning, or in some other way destructive to the child.
2 Therapist did not seem destructive, but had significant interpersonal problems. At times, therapist appeared unnecessarily impatient, aloof, insincere or had difficulty conveying confidence and competence.
4 Therapist displayed a satisfactory degree of warmth, concern, confidence, genuineness, and professionalism. No significant interpersonal problems.
6 Therapist displayed optimal levels of warmth, concern, confidence, genuineness, and professionalism, appropriate for the particular child in this session.

5. Collaboration
0 Therapist did not attempt to set up a collaboration with child.
2 Therapist attempted to collaborate with child, but had difficulty either defining a problem that the child considered important or establishing rapport.
4 Therapist was able to collaborate with child, focus on a problem that both child and therapist considered important, and establish rapport.
6 Collaboration seemed excellent; therapist encouraged child as much as possible to take an active role during the session (e.g., by offering choices) so they could function as a “team”.

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6. Pacing & Efficient Use of Time

Therapist made no attempt to structure therapy time. Session seemed aimless.

2 Session had some direction, but the therapist had significant problems with structuring or pacing (e.g., too little structure, inflexible about structure, too slowly paced, too rapidly paced).

4 Therapist was reasonably successful at using time efficiently. Therapist maintained appropriate control over flow of discussion and pacing.

6 Therapist used time efficiently by tactfully limiting peripheral and unproductive discussion and by pacing the session as rapidly as was appropriate for the child.

7. Guided Discovery

Therapist relied primarily on debate, persuasion, or “lecturing”. Therapist seemed to be “cross-examining” child, putting the child on the defensive, or forcing his/her point of view on the child.

2 Therapist relied too heavily on persuasion and debate, rather than guided discovery. However, therapist’s style was supportive enough that child did not seem to feel attacked or defensive.

4 Therapist, for the most part, helped child see new perspectives through guided discovery (e.g., examining evidence, considering alternatives, weighing advantages and disadvantages) rather than through debate. Used questioning appropriately.

6 Therapist was especially adept at using guided discovery during the session to explore problems and help child draw his/her own conclusions. Achieved an excellent balance between skillful questioning and other modes of intervention.

8. Focusing on Key Cognitions/Behaviors

Therapist did not attempt to elicit specific thoughts, assumptions, images, meanings, or behaviors.

2 Therapist used appropriate techniques to elicit cognitions or behaviors; however, therapist had difficulty finding a focus or focused on cognitions/behaviors that were irrelevant to the child’s key problems.

4 Therapist focused on specific cognitions or behaviors relevant to the target problem. However, therapist could have focused on more central cognitions or behaviors that offered greater promise for progress.

6 Therapist very skillfully focused on key thoughts, assumptions, behaviors, etc. that were most relevant to the problem area and offered considerable promise for progress.

9. Strategy for Change

Therapist did not select cognitive-behavioral techniques.

2 Therapist selected cognitive-behavioral techniques; however, either the overall strategy for bringing about change seemed vague or did not seem promising in helping the child.

4 Therapist seemed to have a generally coherent strategy for change that showed reasonable promise and incorporated cognitive-behavioral techniques.

6 Therapist followed a consistent strategy for change that seemed very promising and incorporated the most appropriate cognitive-behavioral techniques.

10. Application of Cognitive-Behavioral Techniques

Therapist did not apply any cognitive-behavioral techniques.

2 Therapist used cognitive-behavioral techniques, but there were significant flaws in the way they were applied.

4 Therapist applied cognitive-behavioral techniques with moderate skill.

6 Therapist very skillfully and resourcefully employed cognitive-behavioral techniques.

11. Homework

Therapist did not attempt to incorporate homework relevant to cognitive therapy.

2 Therapist had significant difficulties incorporating homework (e.g., did not review previous homework, did not explain homework in sufficient detail, assigned inappropriate homework).

4 Therapist reviewed previous homework and assigned “standard” cognitive therapy homework generally relevant to issues dealt with in session. Homework was explained in sufficient detail.

6 Therapist reviewed previous homework and carefully assigned homework drawn from cognitive therapy for the coming week. Assignment seemed “custom tailored” to help child incorporate new perspective, test hypotheses, experiment with new behaviors discussed during session, etc.
CTRS Practice

The group will listen to a full session.

After the session, we will discuss the CTRS ratings that were given.

Wrap Up

Final Questions or Comments?

As we come to the end of the training and think about how all of these pieces come together, does anyone have specific questions or comments?

Recommended Manuals & Books

- Cognitive behavior therapy: basics and beyond (second addition) (Beck, 2011)
- Cognitive therapy for adolescents in school settings (Creed, Reisweber & Beck, 2011)
- Cognitive behavioral therapy for anxious children (Kendall & Hektke, 2006)
- Treating trauma and grief in children and adolescents (Cohen, Mannarino & Deblinger, 2006)
- Attention deficit hyperactivity disorder: a clinical workbook (Barkley & Murphy, 2005)

Workshop Evaluation

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Certification and Referrals in Cognitive Behavior Therapy
WWW.ACADEMYOFCT.ORG

Beck Scales for Adults and Youth
WWW.BECKSCALES.COM

Cognitive Therapy Worksheet Packet
Designed for therapists to use with Cognitive Behavior Therapy: Basics and Beyond. This packet contains thirteen instruments used in that book, instructions, filled-in examples, and blank copies.
WWW.BECKINSTITUTE.ORG

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