



A UNIFIED PROTOCOL FOR THE GROUP TREATMENT OF CHILDHOOD ANXIETY AND DEPRESSION

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Abstract: Childhood anxiety and mood disorders are common and are associated with high levels of impairment. These disorders share a common etiology and risk factors, and are often experienced concurrently. While evidence-based interventions for youth anxiety and depressive disorders do exist, children experiencing this common comorbidity tend to experience weaker treatment outcomes in anxiety or depression focused treatments as compared to youth suffering from either disorder alone. Researchers are now investigating transdiagnostic interventions, which have potential to target common vulnerability factors and address a wider range of concerns. The Unified Protocol for the Treatment of Emotional Disorders in Children: Emotion Detectives (UP-C: ED) is a transdiagnostic treatment that implements a set of core principles to address common factors underlying youth anxiety and depressive disorders in a group setting. Theoretical underpinnings of the UP-C: ED are discussed along with an in-depth presentation of treatment content. A case study is also presented detailing initial intake, treatment conceptualization, treatment, and treatment outcomes using this modality.

Keywords: Transdiagnostic; group treatment, anxiety, depression, school-age children.

Protocolo unificado de grupo para el tratamiento de la ansiedad y la depresión en la infancia

Resumen: Los trastornos de ansiedad y del estado de ánimo son comunes y están asociados a niveles elevados de perturbación. Estos trastornos comparten etiología y factores de riesgo comunes, y frecuentemente son experimentados al mismo tiempo. Aunque existen intervenciones basadas en la evidencia para el tratamiento de los trastornos de ansiedad y del estado de ánimo en jóvenes, los niños que experimentan esta comorbilidad obtienen peores resultados terapéuticos, a través de los tratamientos focalizados en la ansiedad o en la depresión, que los niños que sólo sufren de uno de estos trastornos. Recientemente se han investigado los tratamientos transdiagnósticos, los cuales tienen la capacidad de centrarse en los factores de vulnerabilidad comunes y abordar un conjunto amplio de problemas. El *Unified Protocol for Children: Emotion Detectives (UP-C: ED)* es un tratamiento transdiagnóstico de grupo, que implementa un conjunto de principios básicos, pensado para abordar los factores comunes que subyacen a los trastornos de ansiedad y depresión infanto-juveniles. Se discute la estructura teórica del UP-C: ED junto con una presentación exhaustiva del contenido del tratamiento. También se presenta un estudio de caso detallando la evaluación inicial, la conceptualización del tratamiento, el tratamiento y los resultados obtenidos.

Palabras clave: Transdiagnóstico; tratamiento de grupo; ansiedad; depresión; niños; adolescentes.

Anxiety disorders are among the most common psychiatric conditions experienced by chil-

dren and adolescents, with one-year prevalence rates estimated between 10-21% (Costello et al., 2003). Unipolar mood disorders (i.e., major depressive disorder [MDD], dysthymic disorder [DD], and depressive disorder not-otherwise-specified [DDNOS]) are also common, with prevalence rates of 3-6% during childhood and adolescence (Axelson & Birmaher, 2001).

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Without treatment, childhood anxiety and mood disorders tend to be chronic conditions persisting into late adolescence and adulthood (Birmaher et al., 1996; Keller, Lavori, Mueller, Endicott, Coryell, Hirshfeld, & Shea 1992). In addition, childhood anxiety and mood disorders are associated with poorer school and social functioning (Brunstein-Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007; Messer & Beidel, 1994; Sheeber, Davis, Leve, Hops, & Tildesley, 2007).

Youth anxiety and mood disorders, which are associated with high prevalence rates and impairment when experienced individually, also frequently co-occur (Costello et al., 2003; Ford, Goodman, & Meltzer, 2003). In a meta-analysis conducted by Brady and Kendall (1992), the authors found that across multiple clinical venues (e.g., pediatric clinics, inpatient facilities), approximately 16-62% of children and adolescents met criteria for at least one anxiety disorder and a co-occurring mood disorder. High rates of comorbid anxiety and mood disorders are particularly observed among treatment-seeking youth (Brady & Kendall, 1992). In addition, there is evidence that anxiety and mood disorders are more strongly associated with one another than with other forms of childhood psychopathology (e.g., behavior problems; Angold, Costello, & Erkanli, 1999). Among the anxiety disorders, a particularly strong association has been observed between generalized anxiety disorder (GAD) and depression (Kendler, Prescott, Myers, & Neale, 2003; Trosper, Whitton, Brown, & Pincus, 2012). Indeed, despite its classification as an anxiety disorder, some studies have found GAD to be more strongly related to depression than to other anxiety disorders (Kender et al., 2003; Krueger, 1999).

Childhood anxiety and mood disorders also share a number of underlying risk factors and emotional features. Several biological risk factors, including neurotransmitter and neuroendocrine dysregulation (Fox et al., 2005; Flores et al., 2004; Dahl et al., 2000; Weems, Zakem, Costa, Cannon, & Watts, 2005), as well as a behaviorally inhibited temperament (Caspi et al., 1996; Gladstone et al., 2005; Perez-Edgar & Fox, 2005) are common to both youth anxiety and depression. In addition, anxiety and depres-

sion share environmental and psychological risk factors, such as negative early life experiences (Chorpita & Barlow, 1998), and a general sense of uncontrollability in one's life (Barlow, 2000).

Beyond these biological and environmental risk factors, researchers have become increasingly interested in the shared, underlying affective characteristics of anxiety and mood disorders. Research within this area has generally examined two dimensions of temperament—negative affect (NA) and positive affect (PA)—as shared and differential affective characteristics of anxiety and depression. NA refers to subjective feelings of distress and spans several emotional states, including fear, anger, sadness, and anxiety (Watson et al., 1988). In contrast, PA is characterized by feeling enthusiastic and highly engaged with one's environment (Watson et al., 1988). The tripartite model (Clark & Watson, 1991) proposes that high levels of NA are common to anxiety and depression, whereas concurrent low levels of PA are more specific to depression. In addition, Clark and Watson (1991) added a third dimension, physiological hyperarousal (PH), which is theorized to be specific to anxiety disorders.

The tripartite model has generally held up to empirical testing (for a more comprehensive review, see Anderson & Hope, 2008). For instance, using exploratory factor analysis (EFA) and confirmatory factor analysis (CFA), Trosper et al. (2012) found that a single, higher-order factor of NA provided the best fit to the data in explaining the shared variance of depression and anxiety disorders among a clinical sample of children and adolescents ($N = 423$). Other studies have also demonstrated that both anxiety and mood disorders may load onto a higher-order factor of NA (Brown, Chorpita, & Barlow, 1998; Chorpita & Daleiden, 2002; Tully, Zajac, & Venning, 2009). Furthermore, PA has shown the strongest associations with depression and social phobia, as compared to the other anxiety disorders, whereas PH is most specific to panic disorder and posttraumatic stress disorder (Brown et al., 1998; Brown & McNiff, 2009; Mineka, Watson, & Clark, 1998).

Thus, research to date has supported an underlying vulnerability factor (i.e., negative affectivity) to childhood anxiety and mood disorder.

ders. In addition to generally experiencing high levels of NA, children with anxiety and mood disorders also experience difficulty regulating affect across emotions (e.g., fear, anger, sadness). Although understudied in child populations, evidence suggests that youth with anxiety and/or depression tend to exhibit poorer emotional awareness (Penza-Clyve & Zeman, 2002) and higher levels of emotional inhibition (Zeman, Shipman, & Suveg, 2002). Individuals with anxiety and mood disorders also show greater avoidance and suppression of «uncomfortable» emotions, including sadness, anger, and worry (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Tull & Roemer, 2007). In addition to suppression of negative emotions, depression is associated with attenuated reactivity to pleasant emotions (Allen, Trinder, & Brennan, 1999; Sloan, Strauss, & Wisner, 2001).

Evidence for the high co-occurrence and shared vulnerability factors of childhood anxiety and mood disorders provides rationale for the development of psychosocial interventions that target either condition, or that can be used for youth with both anxiety and depression. However, evidence-based interventions for youth anxiety and depression have traditionally been disorder- or domain-specific (e.g. Kendall, 1994; Weisz, Thurber, Sweeney, Proffitt, & Legagnoux, 1997), and individuals experiencing this common comorbidity have often been excluded from trials investigating the efficacy of these interventions. For example, the largest clinical trial for childhood and adolescent anxiety disorders (the Child/Adolescent Multimodal Study [CAMS]; Walkup et al., 2008), excluded youth with a comorbid depressive disorder (Kendall et al., 2010). When anxious youth with comorbid depression are included in studies examining the efficacy of anxiety-focused cognitive behavioral treatments (CBT), these youth tend to show weaker treatment response as compared to youth without comorbid depression (Berman, Weems, Silverman, & Kurtines, 2000; Crawley et al., 2008; Suveg, Sood, Comer, & Kendall, 2009). Poorer response to individual and family CBT for youth anxiety has also been noted among anxiety-disordered children with subclinical depression

but elevated depressive symptoms (O'Neil & Kendall, in press). Additionally, there is some evidence that depressed youth with a co-occurring anxiety disorder demonstrate poorer response to CBT for youth depression (Curry et al., 2006; Brent et al., 1998), although one study found that comorbid anxious adolescents demonstrated equivalent outcomes to depression-focused CBT as those without comorbid anxiety (Rohde, Clark, Lewinsohn, Seeley, & Kaufman, 2001).

In addition, despite evidence that individuals with anxiety and mood disorders demonstrate difficulties with regulation across emotional domains (e.g., Campbell-Sills et al., 2006; Penza-Clyve & Zeman, 2002), disorder-specific CBT protocols typically only address a singular emotion domain (e.g., fear or sadness). Perhaps as a result of this specificity, disorder-specific treatments have shown efficacy in improving regulation for the targeted emotion domain, but minimal effect on regulation of other emotions. For instance, CBT for youth anxiety has shown to improve worry regulation, but not sadness or anger regulation (Suveg, Sood, Comer, & Kendall, 2009). Thus, even youth who show improvements in one domain may still suffer from dysregulation of other emotions.

Therefore, transdiagnostic treatments for emotional disorders target common vulnerability factors for anxiety and depression, and by addressing regulation across multiple emotion domains, may improve treatment efficacy, particularly among comorbid youth. Two transdiagnostic CBT protocols—the Unified Protocol for the Treatment of Emotional Disorders (UP; Barlow et al., 2010) and the Unified Protocol for the Treatment of Emotional Disorders in Adolescents (UP-A; Ehrenreich et al., 2008)—have been developed for the treatment of emotional disorders in adults (UP) and adolescents (UP-A). The UP and UP-A draw upon similar skills within CBT for anxiety and depression and include: psychoeducation, cognitive restructuring, exposure-based treatment, and behavioral activation. However, a unique feature of these protocols is that CBT skills are applied across multiple emotion domains (e.g., fear, anger, sadness), all within a theoretical framework of improving broad emotion regulation.

Within this model, emotions are theorized to consist of experiential, physiological, and behavioral reactions to external and internal stimuli. Traditional CBT skills are applied to the following five emotion strategies outlined within Gross and Thompson's (2007) modal model of emotions: (1) *situation selection*: approaching situations that elicit positive emotions and avoiding situations that evoke uncomfortable emotions (e.g., avoidance of threat, social withdrawal); (2) *situation modification*: changing the situation to reduce emotional intensity experienced (e.g., use of safety objects, excessive reassurance-seeking); (3) *attentional deployment*: directing attention towards positive emotions or away from uncomfortable emotions (e.g., worry, rumination); (4) *cognitive change*: reframing thoughts to raise or lower the emotional significance of a situation; and (5) *response modulation*: directly changing one's emotional experience through physiological or behavioral methods. Through applying CBT skills across these emotion regulation strategies, the UP and UP-A target three core components relevant to emotional responding: (1) altering cognitive appraisals of emotion-provoking stimuli in the antecedent condition; (2) modifying action tendencies associated with emotion-driven behaviors (EDBs); and (3) preventing emotional avoidance.

Both the UP and UP-A have demonstrated preliminary efficacy as transdiagnostic approaches to treating adult and adolescent anxiety and mood disorders (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Ehrenreich-May, Queen, Bilek, Remmes & Marciel, in press; Trooper, Buzzella, Bennett, & Ehrenreich, 2009). One particularly promising set of findings is that comorbidity status was not associated with treatment outcome with either the UP (Davis, Barlow, & Smith, 2010) or UP-A (Ehrenreich-May & Remmes, 2010). This is in contrast to previous findings of poorer treatment outcomes among comorbid youth in disorder-specific CBT for anxiety or depression (Berman et al., 2000; Curry et al., 2006; Suveg et al., 2009). These findings suggest that a transdiagnostic approach to the treatment of the emotional disorders is efficacious, particularly for comorbid youth.

THE UNIFIED PROTOCOL FOR THE TREATMENT OF EMOTIONAL DISORDERS IN CHILDREN: EMOTION DETECTIVES

Given promising results from trials with adults and adolescents, the Unified Protocol for Children: Emotion Detectives (UP-C: ED; Ehrenreich-May & Bilek, 2009) was developed as a downward extension of the UP and UP-A for younger children (ages 7-12) with anxiety and/or depressive disorders. The UP-C: ED shares the same three core treatment components as the UP and UP-A (i.e., altering antecedent cognitive appraisals, modifying EDBs, and preventing emotional avoidance), and similar to the adult and adolescent protocols, these skills are applied to emotions more broadly. However, the UP-C: ED is developmentally adapted for younger children, both in content delivery and treatment structure. For example, whereas the UP and UP-A are administered in individual sessions, the UP-C: ED is delivered in group sessions, and incentivizes learning through the use of experiential and engaging activities (e.g., Santucci, Ehrenreich, Trooper, Bennett, & Pincus, 2009).

In addition, parental involvement is more extensive in the UP-C: ED than in the UP-A. Each session has both a child and a parent group component, with separate clinicians assigned to each. The structure of most treatment sessions is as follows: families meet with the treatment clinicians at the beginning of the session for a brief check-in and to review homework assignments from the previous week. After fifteen minutes, the parents and their assigned clinicians adjourn to a separate room, where they meet for approximately sixty minutes. During this time, both the parent and child groups cover session-specific content for the week. The parents rejoin the children for the final fifteen minutes of the session, and this time is dedicated to reviewing skills and assigning homework for the upcoming week. Additionally, each clinician is assigned several specific families within the group, and the final moments of the session can be used for individual check-ins between therapists and participants.

Furthermore, treatment skills are introduced concretely and broken down into a simple mne-

monic device, the CLUES skills, which stand for: **C**onsider how I feel, **L**ook at my thoughts, **U**se detective thinking, **E**xperience my fears and feelings, and **S**tay healthy and happy (see Table 1 for a breakdown of core principles and treatment sessions associated with each CLUES

skill). Each skill incorporates engaging activities and addresses specific goals that introduce new treatment components while building off of the skills and techniques that the group has previously learned.

Table 1. CLUES Skills, Associated Content and Session Breakdown

| <i>Skill Title</i> | <i>Core Principle</i> | <i>Number of Sessions</i> |
|-------------------------------|---|---------------------------|
| Consider How I Feel | Prevention of emotional avoidance Modifying EDBs | 5 |
| Look at My Thoughts | Altering cognitive appraisals | 1 |
| Use Detective Questions | Altering cognitive appraisals | 2 |
| Experience Fears and Feelings | Prevention of emotional avoidance Modifying EDBs | 6 |
| Stay Healthy and Happy | Review of all principles | 1 |

Thus, the UP-C: ED incorporates a variety of family-friendly practices geared toward maximizing the uptake and generalization of material, as well as participant motivation. Along with providing a developmentally appropriate learning environment, the UP-C: ED also functions with a great deal of flexibility. All group treatments may require some degree of flexibility. However, in addition to accommodating participants spanning a large range of ages, maturity, and ethnicities, the UP-C: ED is unique in that it must also accommodate participants presenting with a large range of emotional disorders and symptoms. To demonstrate how the UP-C: ED addresses these specific concerns, as well as a range of other disorders and concerns, we turn now to a description of the goals, experiential activities, and transdiagnostic content associated with each section of treatment. Following this, a case study is presented for a participant with co-occurring anxiety and depressive symptoms who recently completed the UP-C: ED.

SESSION CONTENT IN THE UNIFIED PROTOCOL FOR CHILDREN: EMOTION DETECTIVES

Consider how I feel (Sessions 1-5)

The goals of the «C» skill are three-fold: to provide general psychoeducation about emo-

tions, to introduce participants to behavioral activation, and to teach introductory mindfulness techniques to the participants. In order to teach these somewhat complex skills to a young and diverse audience, the UP-C: ED employs engaging and interactive activities that emphasize experiential learning and practice. There are several activities that are used to demonstrate and elaborate upon the UP-C: ED content, including those corresponding to psychoeducation about a range of emotion states; representative experiential activities that correspond to increasing emotion awareness, behavioral activation and mindfulness skills are described below.

Experiential activities

Throughout the UP-C: ED, participants are frequently asked to rate the intensity of emotional experiences on a scale, or «feelings thermometer» ranging from 0-8, with anchors at 0 (no intensity), 2 (a little), 4 (some), 6 (a lot), and 8 (extreme). To get experience using this scale, during the «C section» of treatment, participants play the «Feelings Thermometer» game (adapted from Smith & Conaway, 2009). Clinicians provide a large thermometer drawn on butcher paper with numbers ranging from 0 to 8 on the side. Participants are asked to listen to emotional scenarios and to stand by the number that corresponds to the intensity of the emo-

tion that each scenario evokes for them. For example, participants are asked how sad they might be if a good friend moved away, or how angry they would be if they lost a soccer game. In addition to providing opportunities to practice using a rating system that will be employed throughout the course of treatment, this activity reinforces the normalization of emotions. During the activity, clinicians encourage participants to look around and notice that no one situation evokes the same intensity from everyone, and that it is normal for one situation to make one individual very angry/sad/worried/embarrassed etc., as they may feel less intensity in a different situation.

To introduce the concept of behavioral activation (BA), a treatment component targeting behavioral withdrawal symptoms that are common to depressive disorders (Spates, Pagoto & Kalat, 2006), participants are asked to first conduct an experiment about their mood. Children are asked to formulate a hypothesis about whether they think activities are related to their mood. Then, each participant ranks their mood on a scale from 0 (very low mood, depressed) to 8 (very high mood, elated). The clinicians then announce an impromptu «dance party» and turn on an upbeat song lasting approximately three to four minutes. The participants are instructed to keep moving until the «dance party» is over. After the song ends, participants are asked to re-rank their mood, giving explanations for any changes that they might have observed. Through this experiential activity, participants get first-hand experience establishing a link between activity and mood. This provides a strong foundation for understanding the rationale for BA, and generalizing to other activities or behaviors.

The final goal of the «C» skill is to provide an introduction to mindfulness and nonjudgmental awareness. These skills were incorporated into the UP-C: ED in response to the evidence suggesting that children with emotional disorders experience broad deficits in emotion regulation, and specifically have a tendency to over use maladaptive regulation strategies, such as avoidance and suppression (Campbell-Sills, et al., 2006; Tull & Roemer, 2007). In order to practice this skill, participants engage in a Gen-

eralized Emotion Exposure (GEE; Ehrenreich et al., 2008), during which they are exposed to emotionally evocative stimuli. GEEs are distinct from typical emotional exposures in that they are not targeted to a given participant's hierarchy of distressing or avoided stimuli. Rather they are intended to evoke emotional experiences more generally, either positive or distressing. Within the UP-C: ED, participants are asked to watch video clips from an emotionally evocative, but age-appropriate film, such as those depicting separation from caregivers. For each GEE, participants are told to focus on experiencing the emotion without avoidance or suppression and to pay attention to the changes in the intensity of their emotional state before, during and after the exposure. Thus, GEEs allow participants to increase their awareness of, and tolerance for, emotional experiences while simultaneously providing a basic framework for understanding the in-vivo exposures that will be conducted in the latter half of treatment.

Transdiagnostic content

Within the context of psychoeducation, the transdiagnostic nature of the UP-C: ED is emphasized by teaching participants about the function and components of many emotions, including fear, sadness and anger. Emphasis in the UP-C: ED is placed upon the adaptive nature and universality of these emotions.

While all children can probably benefit from participation in pleasant and rewarding activities, BA is included within the UP-C: ED to specifically address the needs of the high percentage of participants experiencing depressive diagnoses or heightened levels of depressive symptoms. The primary purpose of introducing BA is to teach all participants an approach-oriented skill to cope with behavioral withdrawal and negative affect, a trait common to both anxiety and depressive disorders. Because depressive symptoms and diagnoses have been associated with high rates of treatment dropout (Arnou et al., 2007), this strategy is included within the first section of treatment to increase participant engagement for any participants who are lacking treatment motivation. Clini-

cians are encouraged to continue assigning BA related homework throughout the course of treatment for any participants who need additional practice.

Mindfulness and nonjudgmental awareness are taught within the UP-C: ED to demonstrate that the participants can tolerate their emotions without avoidance or suppression. To address this, participants in the UP-C: ED are given instructions on how to experience a wide range of emotions without trying to alter their experience. Specifically they are taught that, while fully experiencing uncomfortable emotions can be distressing, it is not dangerous. Thus, this section fits in nicely with the overarching aim of the «Consider How I Feel» section of treatment, which is to teach participants to better understand that emotions are normal, natural, and can be tolerated without avoidance, escape behaviors or chronic withdrawal.

Look at my thoughts (Session 6)

The main goal of the «L» skill is to introduce participants to antecedent cognitive reappraisal. The first goal in introducing cognitive reappraisal strategies is to teach participants to practice flexible thinking, or to evaluate ambiguous situations from multiple perspectives. Children are taught to recognize the cognitive errors, or «thinking traps» that other individuals engage in. Participants then begin to practice identifying thinking traps in their own experiences.

Experiential activities

To introduce the concept of flexible thinking and looking for alternatives, clinicians ask the participants to examine several optical illusions. Each picture can be interpreted in multiple ways (e.g. an illusion that depicts both an older and a younger lady, depending on how it is viewed), although there is usually one interpretation that an individual will notice first. After each participant is asked to share an initial interpretation, the group discusses the variety of potential interpretations within the scene. This activity provides an opportunity for participants to real-

ize that, in some situations, a first interpretation may not be the only possible one, which sets the stage for a discussion of cognitive reappraisal.

After being introduced to the concept of flexible thinking, the children are then taught about cognitive errors, or «thinking traps». To maximize the uptake of material and engagement in this lesson, each thinking trap is associated with a cartoon character that is especially susceptible to a specific error. For example, participants meet Disaster Dan, who always thinks the worst (catastrophizing). They learn about Jumping Jack who jumps to conclusions (probability overestimation), and Psychic Susan who thinks she knows what everyone else is thinking (mind reading). Finally, there is Negative Nancy who never sees the good in any situation (ignoring the positive). Once the participants are familiar with each character and his or her thinking trap, the children listen to different vignettes and try to guess whether the story is depicting a Disaster Dan, Jumping Jack, Psychic Susan, or Negative Nancy.

Transdiagnostic content

Cognitive reappraisal is easily applied to a transdiagnostic group, as there are a number of thinking traps that are relevant to a wide range of emotional experiences. For example, probability overestimation can apply to fear, if a child assumes that his mother, who is late to pick him up, has gotten in a car accident. The same thinking trap also applies to sadness, for the child who believes that she has no friends and will never be truly liked. Finally, it can also be applied to anger when a child believes other children are making fun of him, and decides that he must retaliate. In this vein, the participants are taught to recognize thinking traps across a variety of emotional situations and practice identifying these traps in their own daily lives across emotional stimuli.

Use detective thinking (Sessions 7-8)

During the «U» skill, participants expand upon the cognitive skills taught in «Look at my

thoughts» and practice reevaluating emotionally charged situations and challenging their automatic interpretations. The main goals of this section are to teach the participants both detective thinking and problem-solving skills.

Experiential activities

To teach the steps for both detective thinking and problem-solving, children are asked to implement these steps in a non-emotional context. For example, before being introduced to detective thinking, the participants play a mystery game (adapted from Santucci et al., 2009). They are asked to solve the mystery of the clinic; the participants must discover how many departments are located within the clinic building. Participants are told to generate a hypothesis, and then are broken up into groups. Each group is led to a different location within the building to search for clues, or evidence of their hypothesis. The groups then reconvene to discuss what evidence they found and what answer they decided on. Typically, each group comes up with a slightly different answer based on the information they have received from their sources (e.g. one group discovers only a few larger departments, while another reports a larger number of sub-departments). This leads to a discussion of how multiple answers can be simultaneously true, both in the context of solving this mystery, as well in solving emotional mysteries. Thus, this activity provides a strong foundation for applying the same detective steps to reevaluating emotional thoughts.

Transdiagnostic content

Detective thinking is a natural extension of the flexible thinking skills that are taught in the «L» section of treatment; in the same way that participants learned to identify thinking traps for a variety of emotions in the last section of treatment, so too can participants examine evidence and look for alternatives for sad, fearful, and angry thoughts.

During the «U skill» participants are also taught to engage in effective problem-solving of

both emotional and non-emotional concerns. For example, participants are encouraged to use the problem-solving skills to address any conflicts they may be experiencing among friends or within their family. Additionally, there is evidence suggesting that children with anxiety and depressive disorders are at greater risk for experiencing bullying or peer victimization (Reijntjes, Kamphuis, Prinzie, & Telch, 2010). Furthermore, being a victim of peer victimization puts youth at risk for the development of anxiety and mood disorders later in development (Reijntjes et al., 2010; La Greca & Harrison, 2005). Given this cyclical relationship between internalizing disorders and peer victimization, the UP-C: ED takes time to apply the problem-solving skills directly to peer victimization and bullying situations. Participants are asked to use the problem-solving steps to create an action plan to address any bullying or teasing that they might experience; special attention is given to helping the participants identify what different types of responses (e.g. ignoring, sticking up for yourself, running away, telling a responsible adult, etc.) are appropriate for different levels of victimization.

Experience my fears and feelings (Sessions 9-14)

In many ways, the «E skill» is the heart and soul of the UP-C: ED. Although all the previous sections teach participants critical coping skills, it is during the «E» section of treatment that much of the practice is put into action. During this section, participants develop emotional avoidance hierarchies and engage in group, as well as individually tailored, emotional exposures to approach previously avoided situations. The goals of this section of treatment are to: provide the rationale for emotional exposures and to complete relevant exposures on each participant's hierarchy.

Experiential activities

Aside from the didactics associated with teaching the rationale for exposures, the «E» skill is almost entirely comprised of «emotion

exposures»—including interoceptive, imaginal, and situational exposures, as appropriate. However, in the transdiagnostic context, emotion exposures may also be inclusive of other non-anxiety related EDBs, including anger and sadness-related behaviors. Regardless of the behavior, the primary goal in the E section of treatment is to engage in more appropriate and adaptive actions when faced with emotion triggers. These exposures are, by design, difficult and distressing for the children. In order to highlight the importance of these exposures, and demonstrate that they are not dangerous, the «E» skill is first introduced by having participants engage in so-called «sensational exposures.» Like experiential activities from other sections of treatment, sensational, or interoceptive, exposures provide an opportunity for participants to practice the mechanics of completing emotional exposures without the emotional load. To begin sensational exposures, participants are asked to pay close attention to their bodily sensations and to rate their subjective units of distress (SUDS) while they are at rest. The clinicians then present a variety of activities designed to elicit physical symptoms that often accompany emotional exposures. For example, participants may be asked to run in place for thirty seconds (to increase heart rate), to spin for 60 seconds (to induce dizziness and nausea), or to breathe through a narrow straw (to replicate feelings of having difficulty breathing). During and after each exposure, the participants are asked to track their SUDS and to report when they notice them decrease. Special emphasis is placed on the notion that the SUDS will decrease by themselves and that the participant does not have to engage in distraction or avoidant behaviors to return to baseline. Although each sensational exposure is uncomfortable, none is dangerous (when conducted correctly), and all replicate the physical discomfort associated with experiencing intense fear, sadness or anger. Thus, sensational exposures serve to demystify the highly anticipated emotional exposures, while also allowing participants to practice experiencing one of the most distressing components of exposure, uncomfortable physiological arousal, without the association of emotional distress.

Transdiagnostic content

One of the main goals of the «E» section of treatment is to teach both child and parent participants the importance of altering EDBs, or maladaptive behavior tendencies. This section of treatment can be especially tricky to navigate as each participant presents with slightly different concerns. However, despite the unique applications, during this section of treatment, each participant works toward the common goal of reducing behavioral avoidance, escape and withdrawal behaviors, as well as other maladaptive behavior patterns. Thus, the rationale for exposures is presented in a broader emotional context, and then elaborated upon with examples for each individual. Later, within the context of in-vivo exposures, each participant is given the opportunity to complete emotional exposures relevant to their unique concerns.

For example, an individual struggling with coping with anger or frustration may have difficulty with confrontation or when things do not go his way. This individual might be asked to watch a confrontational video clip, to discuss a conflict with a family member, or to lose at a competitive game. The goal of each exposure would be to encourage the participant to actively acknowledge the uncomfortable feelings, and to implement cognitive reappraisal as well as nonjudgmental awareness to acknowledge these thoughts and feelings without acting in a way to avoid them (e.g. running away from an argument or becoming dysregulated in response to a loss). In this way, in-vivo exposures, coupled with exposures scheduled to be completed for homework, can help reduce behavioral avoidance of not only fearful, but also uncomfortable or otherwise avoided stimuli associated with emotional impairment.

Stay healthy and happy (Session 15)

Finally, the «S» section provides an opportunity for participants to reflect on the progress they have made throughout treatment. Goals for this section include: reviewing the skills of treatment and encouraging the maintenance of gains through relapse prevention.

Experiential activities

The «S» skill is limited to one treatment session, and focuses primarily on preparing participants for termination. Within the parent group, parents are asked to reflect upon their child's accomplishments over the course of the UP-C: ED in anticipation of the award ceremony that is held at the end of the session, when the parents and children reunite. During the award ceremony, each participant receives a certificate of achievement and parents share what they are most proud of their child for accomplishing during the course of treatment. All participants receive warm applause from the group, and the group celebrates with refreshments.

Transdiagnostic content

While the parents are still meeting independently, the child participants are asked to review the skills that they have found most helpful throughout the course of treatment. With regard to relapse prevention, participants are asked to consider any goals they still want to accomplish, and are asked to choose which skills they can use to pursue these goals, and how they would apply. Thus, participants are given one final opportunity to review the CLUES skills and apply them flexibly across a range of emotions.

CASE STUDY

Alexa¹, an 11-year-old Caucasian female, was referred to the UP-C: ED program due to a recent worsening of anxiety and depressive symptoms. Alexa's intake assessment included a semi-structured diagnostic interview completed with both the child and the parent (the Anxiety Disorders Interview Schedule for the DSM-IV, Child Version, Child and Parent Report Forms; ADIS-IV-C/P; Silverman & Albano, 1996). Additionally, both Alexa and her mother completed self-report questionnaires

¹ Names and relevant demographics have been changed to protect patient confidentiality.

regarding Alexa's current anxiety and depressive symptoms.

The primary concerns reported during the intake included both excessive worry and depressive symptoms. Specifically, Alexa and her mother reported that Alexa frequently worried about her school performance, social impressions, and her family. With regard to depressive symptoms, Alexa reported that she often felt hopeless about her ability to do well in school, and be well liked. She and her mother reported that Alexa felt intermittently guilty and worthless, had trouble sleeping and had difficulty concentrating. She also reported having intermittent thoughts about death and dying. However, Alexa reported that she never experienced any suicidal intent.

Alexa was also reportedly experiencing significant social concerns and reported that she was often afraid that she would be perceived as incompetent in social situations. These cognitions led to significant anxiety in a number of social situations including: reading aloud in class, asking the teacher for help, working in a group, inviting a friend to get together, and speaking to new or unfamiliar people. As a result of this interview, Alexa was diagnosed with several emotional disorders at a clinically significant severity (clinical severity rating [CSR] of 4-8 out of a possible 0-8 rating scale). Specifically, she met criteria for generalized anxiety disorder (GAD; CSR= 6), depressive disorder, not otherwise specified (DDNOS; CSR = 6), and social phobia (CSR = 5). Alexa and her mother also reported that Alexa was experiencing elevated symptoms of anxiety and depression on the self- and parent-report questionnaires administered at intake (see Table 2 for raw scores).

Case conceptualization

Alexa's mother characterized her as a girl who had always experienced heightened levels of perfectionism. Alexa's perfectionism made her vulnerable to excessive stress and worry about social impressions. Although she had a small group of loyal friends, she felt internal pressure to also be well liked by peers, acquaintances,

Table 2. Questionnaire Scores at Pre-treatment and Post-treatment for Alexa

| Questionnaire | Elevated raw score | Child-Report | | Parent-Report | |
|---|--------------------|---------------|----------------|---------------|----------------|
| | | Pre-treatment | Post-treatment | Pre-treatment | Post-treatment |
| CDI (Children's Depression Inventory; Kovacs, 1992) | 12 | 31 | 20 | 16 | 8 |
| SCARED (Screen for Child Anxiety Related Emotional Disorders; Birmaher et al., 1997) Total Score | 25 | 54 | 32 | 46 | 24 |
| SCARED - Generalized Worry Subscale | 9 | 18 | 12 | 17 | 10 |
| SCARED - Social Anxiety Subscale | 8 | 11 | 7 | 11 | 6 |

tances and strangers. Alexa frequently worried about saying the right thing, and was concerned that, if she said or did something imperfect in a social setting, she would be branded as a «loser» among her peers, and that this label would last indefinitely. This worry about social impressions, and the assumed negative consequences associated with not meeting a very high standard, negatively impacted Alexa's confidence in her social abilities. Although she still participated in extra-curricular activities, she became more withdrawn at school, further cementing her own perception of her poor social skills, which contributed to her heightened negative affect.

Alexa's perfectionism also applied to her performance and achievement within the school environment. Placing a high degree of importance on her performance allowed her to attain high levels of achievement from an early age, not only within the realm of schoolwork, but also in a number of extra-curricular activities. Her early success in these areas led to praise from family members, and increased perceptions of self-worth, which she began to tie to her achievement. However, in middle school, the schoolwork became more challenging, and this led Alexa to experience heightened anxiety about her ability to meet her own high expectations, and challenged her perceptions of self-worth. She became vulnerable to thinking errors about her competence, and frequently engaged in catastrophic thinking and probability overestimation. Questioning her ability and worth caused her to avoid working on difficult assignments, which served to substantiate her worry

and low self-esteem about her academic abilities. Finally, her reluctance to participate in class, due to social anxiety, further disrupted her school performance, which fueled catastrophic cognitions about her competence. Overall, Alexa and her mother reported that they were seeking treatment to help Alexa better manage her worry, improve her self-confidence and reduce her anxiety in social situations.

Consider how I feel (Sessions 1-5)

Alexa suffered from high levels of NA and low levels of PA at pre-treatment, thus the clinicians made sure to emphasize the importance of behavioral activation with her and the other participants. However, despite the fun and engaging nature of the «dance party», it is not a perfect fit for each participant. Alexa's self-consciousness, perfectionism and social anxiety interfered with her ability to fully engage in the activity. Given that it was meant to be a pleasurable activating experience and not an exposure, the activity was revised to allow the participants to face the wall and move in place. With these instructions, Alexa was able to be more actively involved and reported a moderate improvement in her mood after the completion of the activity.

Alexa also initially demonstrated some difficulty in generating ideas for pleasant activity scheduling outside of treatment. She and her mother reported that, despite her depressed mood, Alexa continued to be engaged in a num-

ber of extra-curricular activities, including Girl Scouts. However, noting Alexa's reluctance to participate during the dance party activity, the clinicians emphasized the importance of quality rather than quantity with regard to activation. Alexa and her mother set a goal of active participation, rather than just attendance at these activities, to maximize the benefits of the activating situations. This goal was maintained throughout treatment, and participation in social situations was included on her emotional avoidance hierarchy, to be tackled as explicit emotional exposures during the latter half of the protocol.

In addition, Alexa needed to be given a slightly revised assignment with regard to her GEE. In line with her symptoms of depressed mood, she indicated that she enjoyed experiencing sad emotions, and that she frequently watched sad movies with the purpose of letting the sad feelings wash over her. While this is the express goal of GEE activities, it might be counterproductive for an individual with a depressive diagnosis to seek out situations to ruminate on sad feelings or thoughts. Thus it was suggested that Alexa limit her GEE homework to pleasant or positive emotions, an experience that may occur rarely for individuals experiencing depression (Gross & Muñoz, 1995).

Look at my thoughts (Session 6)

Alexa identified strongly with the cognitive portion of treatment and, after a short introduction to thinking traps, she was able to identify several that she engaged in with some frequency. Specifically, she reported that she commonly engaged in mind reading («Psychic Susan») and catastrophic thinking («Disaster Dan»). For homework, she was able to provide several examples of times when she had experienced these thinking errors. She reported that she becomes «Psychic Susan» when she is afraid to speak up in class, because she thinks the other students believe she is dumb. She reported that she then becomes «Disaster Dan» when she worries that being perceived as dumb would lead to her becoming a social outcast at school, forever. Alexa demonstrated good insight into her de-

pressed and worried cognitions and reported having a high level of motivation to consider alternative interpretations.

Using detective thinking (Sessions 7-8)

Within the context of the «U» skill, Alexa was encouraged to look for evidence about her negative appraisals, such as being branded as a loser and becoming a social outcast. Alexa reported that her middle-school peers could indeed be cruel, and that some students did get labeled as being stupid or a loser after saying or doing something embarrassing. However, when asked to think about how long these labels typically lasted, she reported that her peers also tended to have short memories. Alexa was able to note that, while she might get called a loser in the moment, this label was unlikely to persist. Alexa was then challenged to think about whether she would be able to cope with the worst possible outcome, and was specifically asked to reflect on her social support group. Alexa reported that she had a small group of loyal friends, who she believed would stand by her, even if she did receive a lasting negative label from her larger peer group. This detective thinking process allowed Alexa to see that there were other more likely results than her feared outcome, and that she indeed did have the social skills and support to handle with a small amount of social fallout, if it were to occur.

It is important to note, however, that on occasion, children with anxiety and mood disorders do struggle to make or sustain friendships. When this is the case, it is important to help the child identify any peers outside of the school context who provide social support. Herein lies another benefit of the group structure of the UP-C: ED. By this section of treatment, the participants have gotten to know each other very well in the context of a safe and supportive environment; any children who do not have excessive social support at school or in other social contexts can be encouraged to spend time outside of treatment sessions with the UP-C: ED group members to increase their support system. This scheduled time with supportive peers can also serve to help the child

develop and improve any social skills that may be hindering their social acceptance in other environments. Thus, the detective thinking section of treatment provides opportunities to help children reevaluate overly narrow conceptualizations while simultaneously allowing clinicians and parents an opportunity to identify and problem solve any true deficits, social or otherwise.

Experience my fears and feelings (Sessions 9-14)

Although many exposures focus on helping participants approach feared stimuli, exposures are also conducted for sadness or anger. For example, during this section of treatment, Alexa continued to work on engaging in pleasurable activities. Although she had made progress in actively participating at Girls Scouts, she continued to struggle with participation in school. Thus, through a series of emotional exposures, Alexa practiced entering social situations both within the clinic, as well as at home and school. This included approaching unfamiliar peers and asking mundane questions (e.g. asking for the time, asking about a homework assignment) as well as pushing herself to participate more significantly at school. One of Alexa's goals at the top of her hierarchy was to be able to share personal information in her creative writing class. Although she enjoyed writing, she was worried about being judged, and had been reluctant to write personal stories that she might be asked to share with the class. To gradually approach this goal, she practiced sharing personal information with confederates at the clinic, and reported that this experience was not as difficult as she had anticipated. By the end of the «E» skill, she had begun raising her hand to offer personal opinions in class, and had made a goal to eventually share a story she had written in her creative writing class. Thus, her exposures helped her to overcome her worries about school performance and social participation, while simultaneously addressing her depressed mood by helping her to become more actively engaged in activities that she reportedly enjoyed.

Treatment outcome

Alexa made significant progress during the course of treatment. Not only was she reappraising and approaching previously avoided situations, she had also become a leader within the treatment group. Similar to her own report of her participation within other settings, she had been initially reluctant and withdrawn in the group, present but not actively participating. However, she very quickly understood many of the skills that were presented throughout treatment, and seemed to apply them to her own emotions and experiences without difficulty. With a little encouragement, Alexa was usually willing to share her experiences with the group. By the end of the program, she was often the first participant to share personal examples, and when others were reluctant to try, she would gently urge them and provide encouragement. During the final section of treatment, the clinicians and Alexa's mother took care to highlight all of her growth, paying special attention to Alexa's transformation into her own therapist.

After she completed the the UP-C: ED, Alexa and her mother returned to the clinic to complete a post-treatment assessment consisting of the same interview and questionnaires administered at pre-treatment. The results of this assessment demonstrated that the UP-C: ED was successful in reducing the severity of both Alexa's anxiety and depressive diagnoses. On the ADIS-IV-C/P, Alexa no longer met diagnostic criteria for an anxiety or mood disorder at a clinical level. At the post-treatment timepoint, Alexa's mother reported no elevated symptoms of depression or anxiety, demonstrating a significant improvement from her pre-treatment functioning. However, Alexa continued to report elevated symptoms on self-report questionnaires. Despite this elevation, her report of both depressive and anxious symptoms was significantly reduced from her pre-treatment report symptoms (see Table 2 for raw scores at pre- and post-treatment). Finally, Alexa was given a rating of «much improved» on the Clinician Global Impression scale (CGI; Guy, 1976), a clinician rating of clinical improvement.

In addition to completing the diagnostic interview and symptom questionnaires adminis-

tered at pre-treatment, Alexa and her mother also completed a treatment satisfaction questionnaire at the post-treatment assessment. Along with reporting high levels of overall treatment satisfaction, Alexa made the following comments: «I thought the program was a good experience in helping me to be able to handle my fears and worries lots better.» Alexa's mother noted: «The discovery process of ... emotions helped me to realize that many of my teen's (daughter's) anxiety, I also mirrored ... at that age. So, I am overjoyed with the program and the positive change I see in my daughter. Thank you!»

Together, these results suggest that the UP-C: ED was successful in reducing the severity of Alexa's emotional disorders and symptoms. Additionally, given the range of comorbidity that Alexa presented with at pre-treatment, she and her mother appeared to benefit from the flexibility of the protocol. Alexa's case study demonstrates the potential of the UP-C: ED to provide more generalized treatment for emotional disorders.

THE UP-C: ED RESEARCH AND FUTURE DIRECTIONS

Recently, an open trial of the UP-C: ED was completed with 21 families from ethnically diverse backgrounds (Bilek & Ehrenreich-May, in press). Results from this study indicate that the UP-C: ED is associated with significant improvements in the severity of principal anxiety diagnosis, as well as the severity of comorbid emotional disorders at a post-treatment assessment. Additionally, in contrast to studies of domain-specific treatment protocols (e.g. O'Neil & Kendall, in press), results from this open trial indicated that severity of co-occurring depressive symptoms did not predict significantly worse treatment outcomes. With regard to symptomatology, parents reported a significant reduction in the severity of child depressive symptoms from pre- to post-treatment, while children reported only reductions in symptoms of anxiety during this interval.

However, this study was limited in that it only included participants with a principal

anxiety diagnosis, as opposed to either a principal anxiety or depressive disorder. Thus, the effects of this protocol on a truly transdiagnostic sample are not yet known. An important next step in future studies will be to include participants with either principal anxiety or depressive disorders, and to examine treatment outcomes across disorder status. In addition, although participants with and without depressive disorders demonstrated equivalent outcomes in this small open trial, future randomized controlled trials with larger samples should examine whether comorbid youth who receive the UP-C: ED demonstrate additional benefits compared to those receiving domain-specific CBT. This will be a particularly important next step in establishing if such transdiagnostic treatments hold incremental utility for comorbid youth, as compared to current «gold standard» treatments. Finally, pending data establishing the efficacy of the UP-C: ED, another important step will be to examine the effectiveness of this protocol within community settings where diagnostic and emotional heterogeneity are common.

CONCLUSION

Youth anxiety and depressive disorders co-occur with high frequency, and share a number of common vulnerability factors, including high negative affectivity. Given evidence for the shared emotional features of anxiety and depression, adult and adolescent transdiagnostic treatments for the emotional disorders have previously been developed and shown promising efficacy. In line with the goal of targeting emotional disorders more broadly, the UP-C: ED was developmentally adapted from these treatment protocols as a group treatment for younger children with anxiety disorders, with or without co-occurring depression. While further research must be conducted to verify the efficacy, incremental utility, and effectiveness of the UP-C: ED among a transdiagnostic population, initial results are promising. Preliminary findings suggest that the UP-C: ED may be associated with reductions in diagnostic severity and symptomatology. Future research

will determine whether the UP-C: ED, or other transdiagnostic treatments, has the potential to provide cost-effective and accessible treatment, particularly for youth who present with multiple emotional concerns.

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