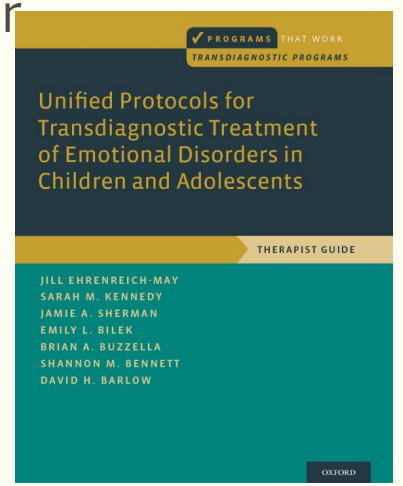
TRANSDIAGNOSTIC TREATMENTS FOR YOUTH EMOTIONAL DISORDERS:

How Can We Get "What Works" to More Children and Adolescents?

Jill Ehrenreich-May, Ph.D.
University of Miami

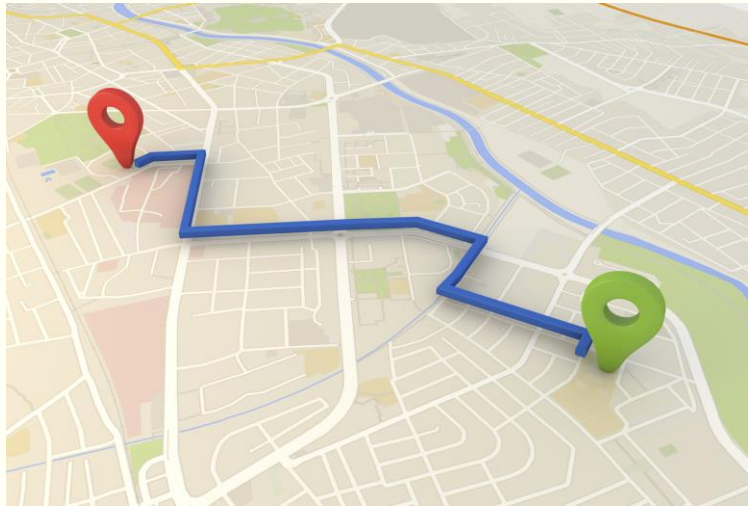
Disclosure

- I am the first author of the therapist guide and workbooks for the *Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents* (UP-C and UP-A) and receive a royalty from these publications from Oxford University Press and a related publication by Guilford Press.
- I also receive payments for UP-C and UP-A clinical trainings, consultation and/or implementation support services.
- Funding for research on the UP-C and UP-A comes from the U.S. National Institutes of Health, Queensland Children's Hospital Foundation, Michael and Susan Dell Foundation, Mental Health Association of America, Ream Foundation, Greater Houston Community Partnership and other persons/agencies.



Road Map

- The Cost of Youth Emotional Disorders
- Barriers to Implementation of Evidence-Based Therapies for Youth
- Advantages and Types of Transdiagnostic or Multi-Diagnostic Approaches to Evidence-Based Therapy for Emotional Disorders in Youth
- Description of One Transdiagnostic Approach: *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents (UP-C and UP-A)*
  - *Caregiving components of the UPs*
- Research on the UP-C and the UP-A



YOUTH EMOTIONAL DISORDERS

Let's Imagine for a Moment

Youth Emotional Disorders are a Huge Problem

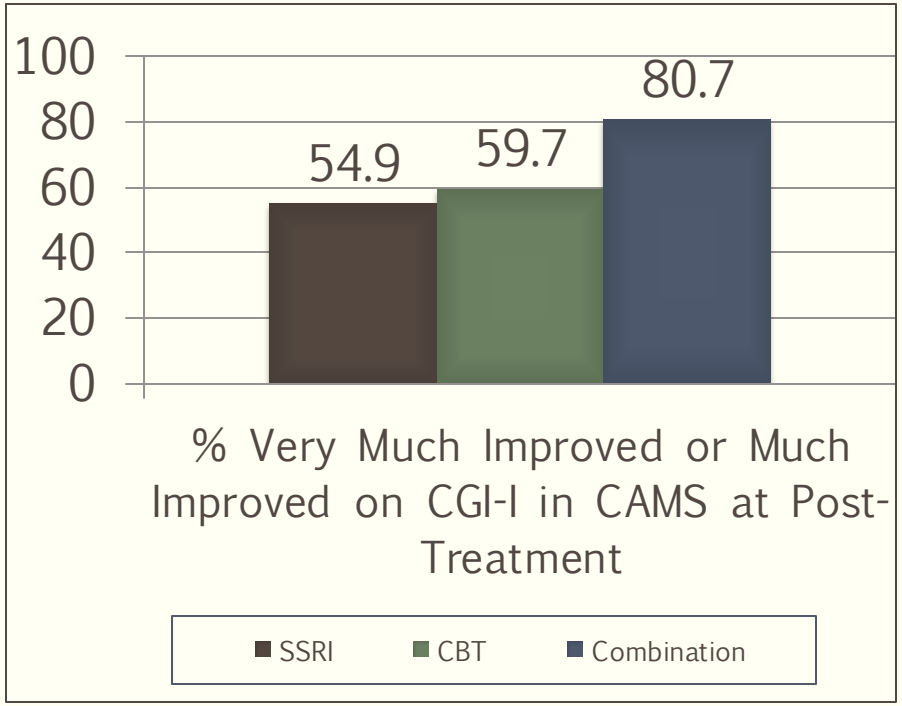
- Anxiety and depressive disorders are the most prevalent mental health disorders.
- They start during *childhood and adolescence.*
- They impair youth – *at home, at school, with peers.*
- They persist into adulthood and predict negative outcomes – *future illness, poorer education, substance use, suicidal behavior.*

Youth Emotional Disorders are a Global Health Crisis (WHO, 2016)

- Close to 10% of the world's population is affected by depression and anxiety.
- These problems increased in frequency between 1990 and 2013 nearly 50% - from *416 million to 615 million* people.
- Depression and anxiety disorders cost **one trillion dollars** annually.
- Every $1 invested in scaling up treatment for depression and anxiety leads to a return of $4 in better health and occupational outcomes.
- Using brief, evidence-based strategies to address anxiety and depression in youth seems like an obvious solution to this crisis.

The Evidence Base for Treatment of Youth Anxiety, Depression, OCD and Anger is *Pretty Good*

- CBT for anxiety disorders and CBT/IPT for adolescent depression are *well-established treatments* with strong effect sizes (Walkup et al., 2008; Weersing et al., 2017).
- Family-based and individually-directed CBT for pediatric OCD are *probably efficacious* treatments (Franklin et al., 2014).
- Parent-management training and CBT are effective in reducing anger and aggression in youth (Sukhodolsky et al., 2016).



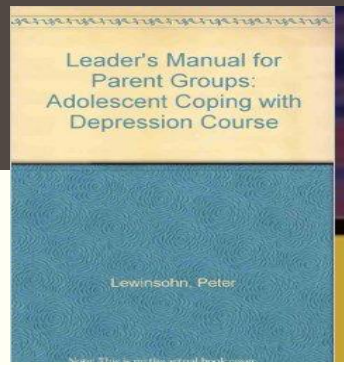
So, this all seems great….

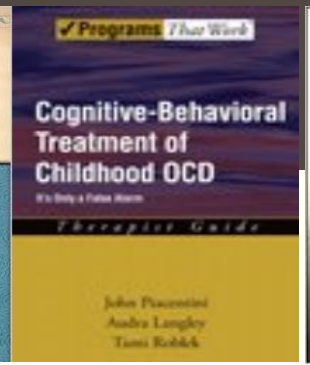
But, we need to consider ***where and with whom*** *these studies were conducted.*

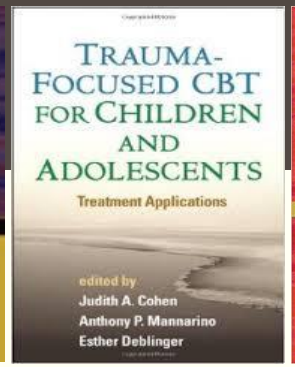
Let's come back to this point!

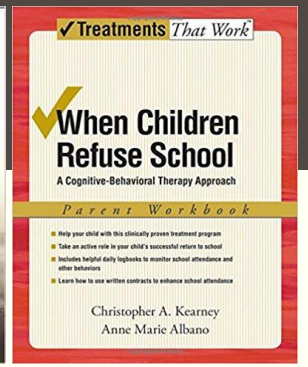
Practitioner Barriers to Evidence-Based Treatment (EBT) Use

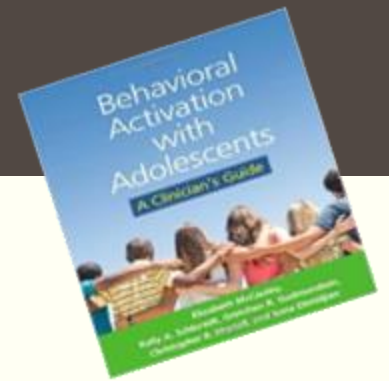
- Few providers are trained in EBTs
  - Variable or no training in some degree programs
  - Limited time for training post-degree program
  - Limited availability of supervision/support in new EBTs
- Costs of new training
  - Logistical barriers (competing work demands, child care, transportation)
  - Financial barriers (workshops, videos, etc. are costly)
  - The stress of doing something “new” (e.g., doing CBT/ACT/DBT when mostly trained in Family Therapy)





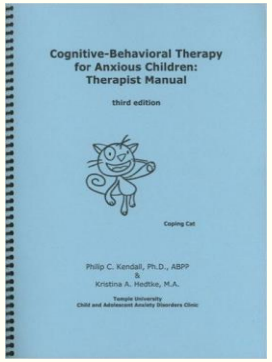


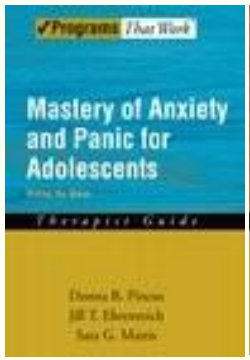


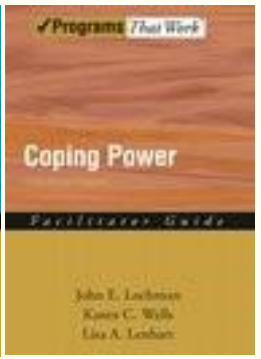


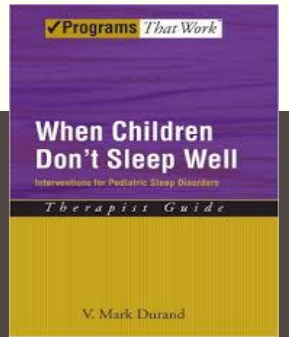
AN UNEXPECTED BARRIER TO EVIDENCE BASED PRACTICE USE

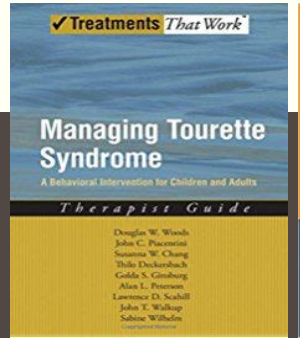
We have a lot of *treatments that work* for youth
-Not consistent with how most children present
-Nor the flexibility with which providers deliver treatment

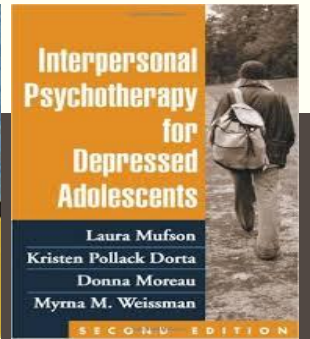




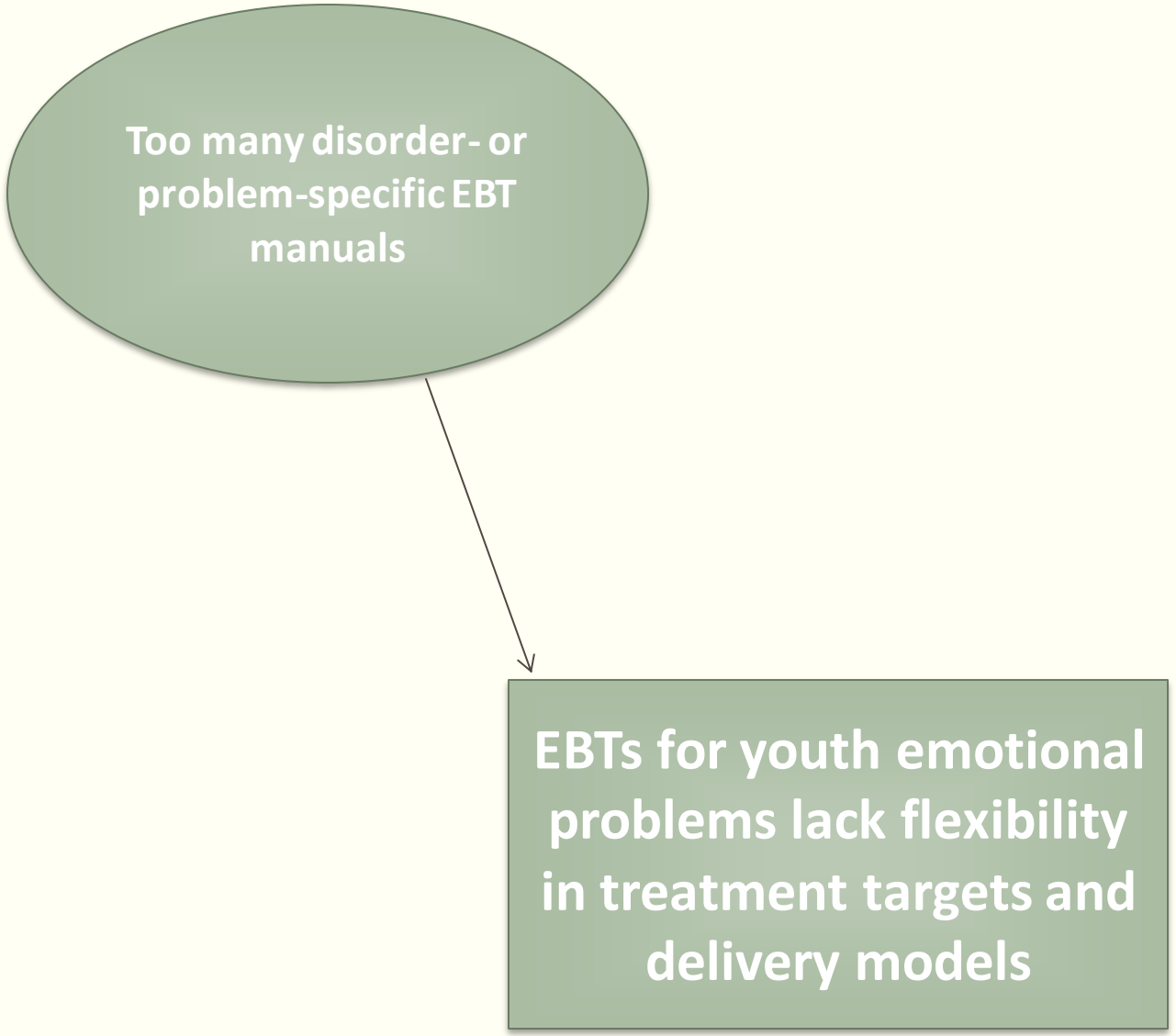








Problem- or Disorder-Specific EBTs Lack Flexibility



But, Multi-Problem Youth are the Norm

- Up to *75%* of children with an emotional disorder diagnosis have *concurrent* comorbid diagnosis (Costello et al. 2003; Beesdo, Knappe & Pine, 2009; Lavigne et al., 2015; Storch et al., 2016).
- Problems also co-occur *over time* (Garber & Weersing, 2010)
- True both within (multiple anxiety disorders) and between types of problem (e.g., co-occurring anger problems and major depressive disorder).
- Makes matching problems to most existent EBTs an issue

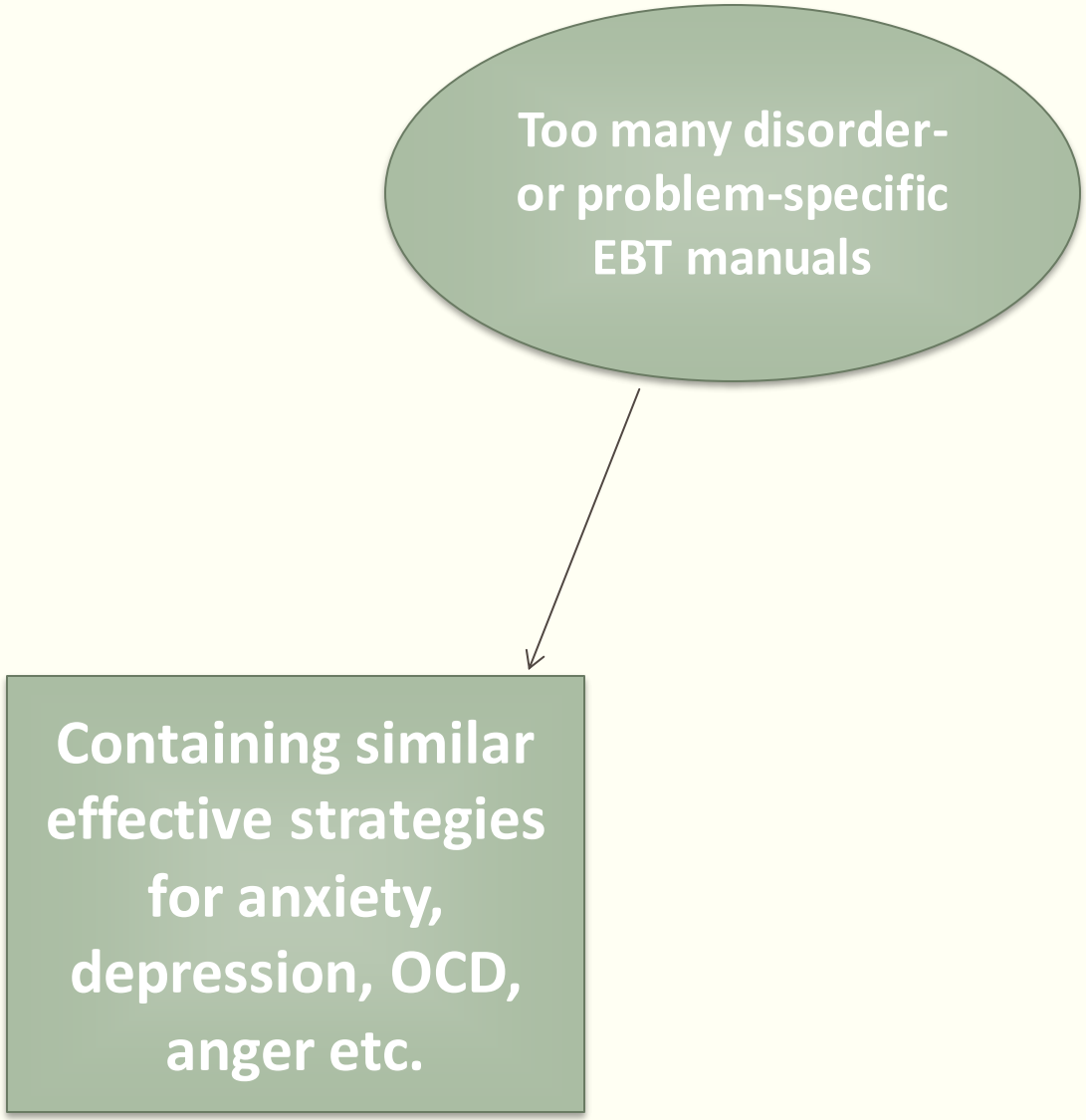
Comorbidity and Emotional Disorders

- Shared symptoms across different problems or disorders
  - Problem with our systems of classification (e.g., the DSM, ICD, etc.)
- Shared determinants of emotional disorders
  - Anxiety and depression share genetic, neurobiological and environmental factors
  - **Negative Affect Syndrome** (Barlow, Allen & Choate, 2004; Norton & Paulus, 2016)
  - Transdiagnostic mechanisms underlying emotional disorders like *rumination, intolerance of uncertainty, anxiety sensitivity* common to many disorders.

Treatment Flexibility

- Benefit from more targeted treatments for youth emotional disorders **may be more modest or limited** when applied in real-world clinical care settings (Weisz et al., 2017; Weisz, Jensen-Doss, & Hawley, 2006).
- Problems also shift or change in intensity **during** treatment for emotional disorders in youth (Marchette & Weisz, 2017)
- **Increased flexibility** in the *way we deliver our evidence-based treatments* may be needed to address these challenges.

Techniques in EBT Manuals May Not Differ that Much



Shared Psychosocial Treatment Components for Youth Emotional Disorders

- Focus on *emotion identification* and affective labeling
- Education about how *emotions impact behavior*, prompting avoidance, escape, aggressions, compulsions, etc.
- *Cognitive strategies*: restructuring, mindful awareness, behavioral experiments
- *Opposite action strategies*: behavioral activation, problem-solving, exposure
- *Parent or caregiver strategies*: psychoeducation, strategies for adjusting parenting behaviors that impact child emotional disorders

TRANSDIAGNOSTIC TREATMENT APPROACHES TO EMOTIONAL DISORDERS IN YOUTH

Potential Advantages of a Transdiagnostic Approach to Treatment

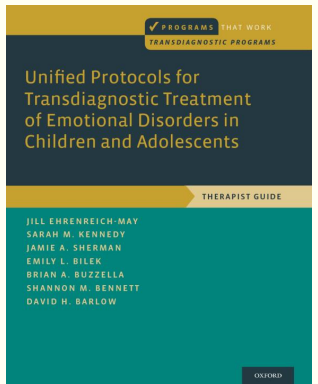
- Increased efficiency of training in and dissemination of evidence-based practices
- Reduced training costs for practice organizations and practitioners
- Improved fit to the way practitioners function in everyday practice
- Improved fit to client characteristics in real-world settings
- Increased clinician and client satisfaction with treatment

Three Main Approaches to Transdiagnostic Treatment

Three main approaches to transdiagnostic or "multi-diagnostic" treatment.

They overlap greatly:

1. Common Elements Approaches
2. Principle-Guided Approaches
3. Core Dysfunction Approaches



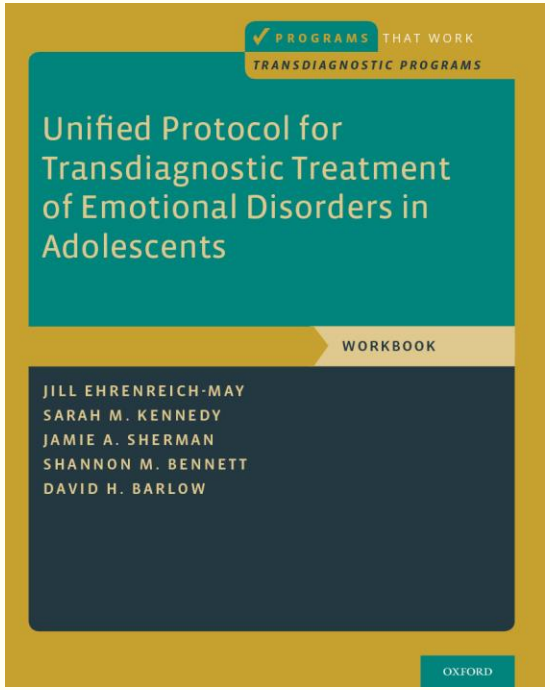
Common Elements Approach – Addressing multiple forms of psychopathology by bringing together therapeutic procedures commonly (e.g., Chorpita & Weisz, 2009).

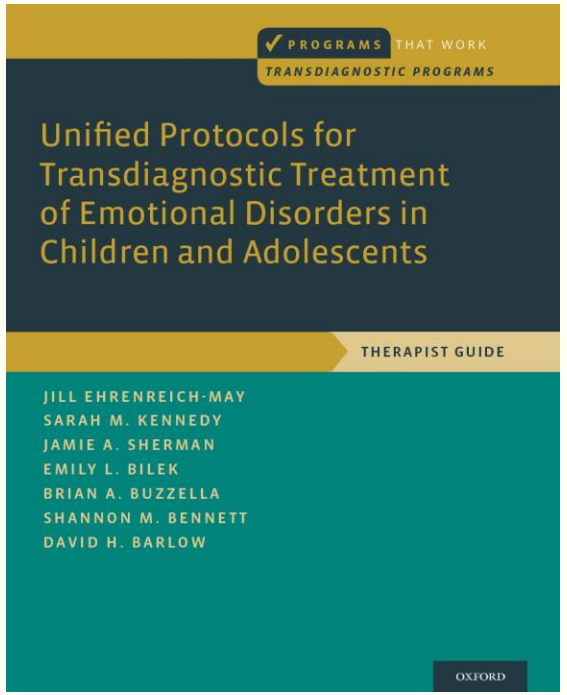
Principle-Guided Approach – Addressing multiple forms of psychopathology by combining mechanisms of therapeutic change that can be applied to each (e.g., Weisz, Bearman, Santucci & Jensen-Doss, 2017).

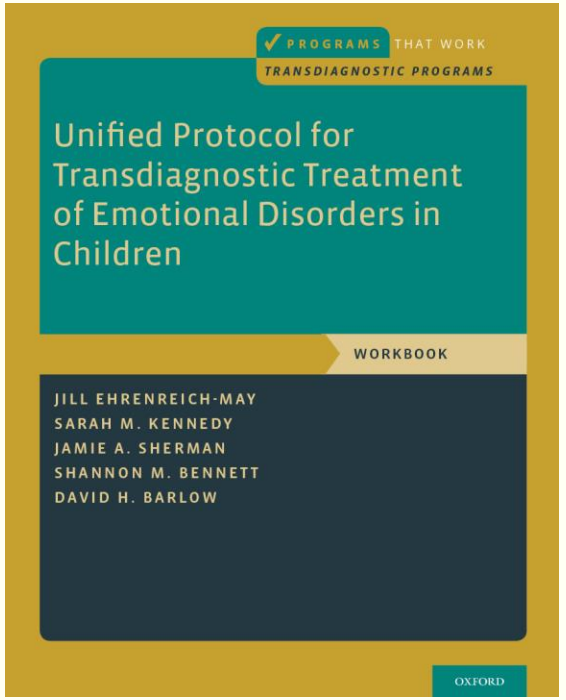
Core Dysfunction Approach – Addressing multiple forms of psychopathology by addressing a hypothesized common higher order or underlying form of dysfunction (e.g., Ehrenreich-May et al., 2018).

The Unified Protocols for Treatments of Emotional Disorders in Children and Adolescents

- A *core dysfunction approach* that also features a **modular structure** (UP-A) and **core or common treatment principles** that may be **flexibly applied** to a range of emotional disorder conditions by focusing on excess fear, anxiety, sadness *and/or* anger in youth during treatment delivery.







What is this *Core Dysfunction* believed to cut across emotional disorder presentations?

Neuroticism

The trait-like tendency to experience negative emotions and the intensity of that experience

The Unified Protocols

- *For which emotional disorders?*
  - All anxiety disorders
  - Obsessive-compulsive disorders (e.g., OCD)
  - Adjustment disorders with depressed mood or anxiety
  - Depressive disorders
  - Emerging evidence for: **PTSD** (Gallagher, 2017; Varkovitzky et al., 2018), **eating disorders** (Thompson-Brenner et al., 2018; Eckhardt et al., in press), **borderline personality features and disorder** (Sauer-Zavala, Bentley, & Wilner, 2016; Tonarely et al., under review), **bipolar disorder II** (Ellard, Deckersbach, et al., 2012), **anger and irritability** in youth (Malmberg, Kennedy & Ehrenreich-May, in press; Grossman & Ehrenreich-May, in press), **early onset serious mental illness** (Weintraub et al., in press)
- Although they may look different, *these disorders may be maintained by similar processes*

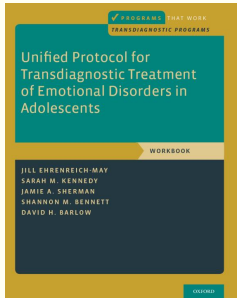
Unified Protocol Case Conceptualization Model

Those with ANY emotional disorder/significant symptoms may experience:

- Frequent and intense experience of their emotions
- Aversive/distress reactions to intense emotion experiences ("I shouldn't feel this way!"; "This is bad.")
- Frequent efforts to **control, avoid and/or suppress** intense emotions
  - Situational avoidance (avoid school, dark places)
  - Cognitive avoidance (repetitive negative thinking, suppression, distraction)
  - Subtle behavioral avoidance (carrying cell phone, avoiding eye contact in hallways, reassurance seeking)
  - Other action tendencies? Withdrawal behaviors? Aggression?
- Negative reinforcement and poor emotional self-efficacy embedded in dysregulated, intense emotions

The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Adolescents (UP-A)

- *Modular* approach for emotional disorders in adolescents (ages 12+)
  - Skills presented in general context of emotions (e.g., fear, joy, sadness, anger, etc.), rather than any particular disorder
- A *time-limited* treatment targeting core dysfunction of neuroticism and conforming to overarching principles of change across emotional disorders
- The UP-A has a *flexible, modular application* that allows clinicians to respond to heterogeneity in emotional disorder severity and presentation
  - No set number of sessions



The UP-A Modules

M1: Building and Keeping Motivation (1-2 sessions recommended)

M2: Getting to Know Your Emotions and Behaviors (2-3 sessions)

M3: Introduction to Emotion-focused Behavioral Experiments (1-2 sessions)

M4: Awareness of Physical Sensations (1-2 sessions)

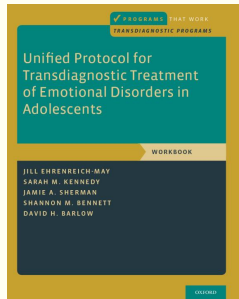
M5: Being Flexible in Your Thinking (2-3 sessions)

M6: Awareness of Emotional Experiences (1-2 sessions)

M7: Situational Emotion Exposure (1+ sessions)

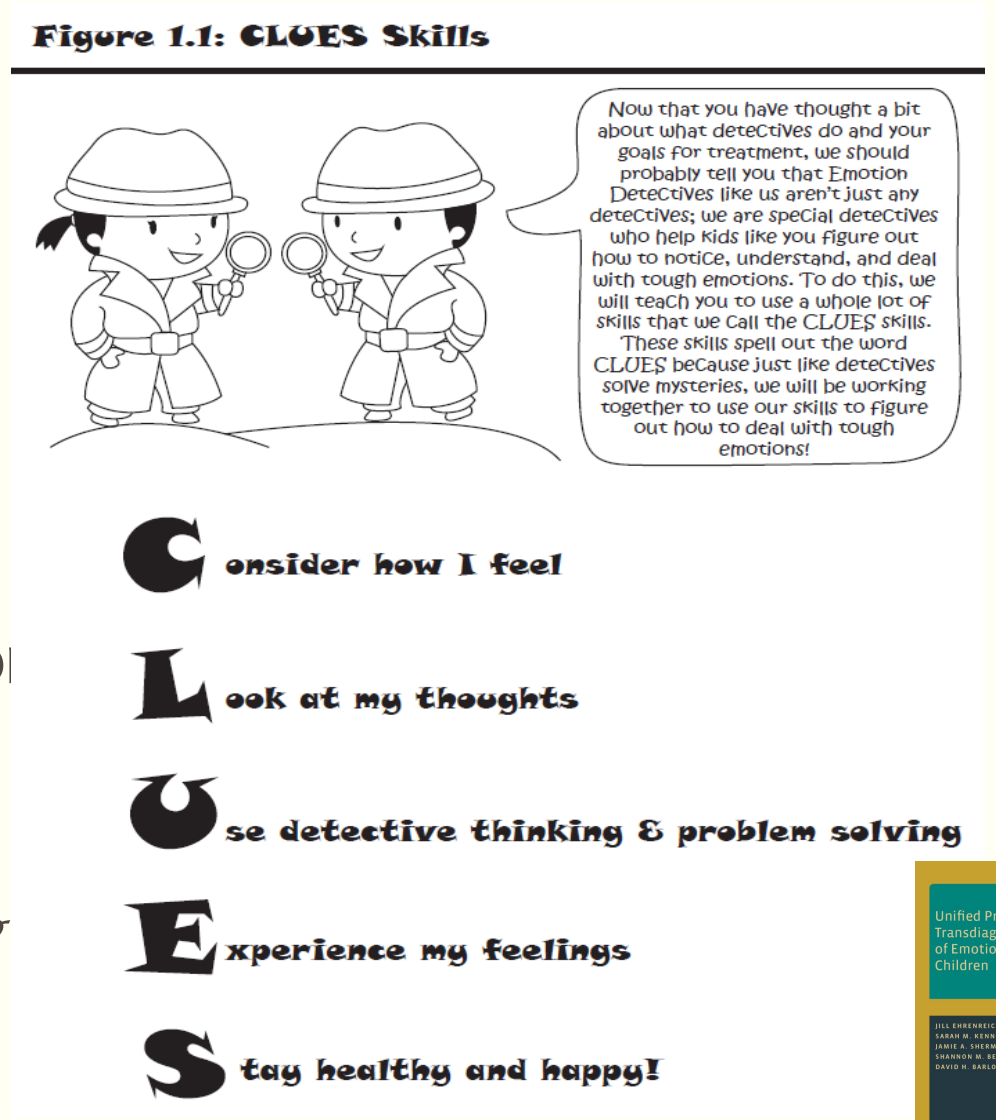
M8: Reviewing Accomplishments and Looking Ahead (1 session)

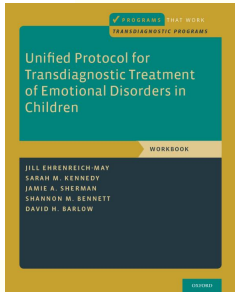
MP: Parenting the Emotional Adolescent (As Needed)



The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Children (UP-C)

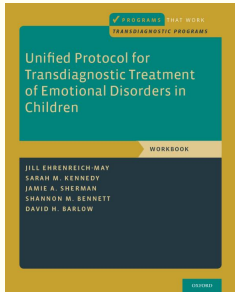
- The UP-C is a 15-session emotion-focused group treatment for children ages 6-13
- *Can also be delivered as a modular individual therapy*
- "Emotion Detectives" metaphor
- Full parent and child curriculum
- Participants learn the **CLUES or Emotio Detective Skills**:
  - *Consider how I feel*
  - *Look at my thoughts*
  - *Use detective thinking and problem solving*
  - *Experience my emotions*
  - *Stay healthy and happy*





UP-C Session by Session Content

S1:	Introduction to the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Children (C)
S2:	Getting to Know Your Emotions (C)
S3:	Using Science Experiments to Change our Emotions and Behavior (C)
S4:	Our Body Clues (C)
S5:	Look at my Thoughts (L)
S6:	Use Detective Thinking (U)
S7:	Problem Solving and Conflict Management (U)
S8:	Awareness of Emotional Experiences (E)
S9:	Introduction to Emotion Exposure (E)
S10:	Experience our Emotions—Part 1 (E)
S11-14:	Experience our Emotions—Part 2 (E)
S15:	Wrap Up and Relapse Prevention (S)



Differences Between the UP Manuals

	UP-C	UP-A	UP
Age Range	6-13	12-18	18+
Number of Sessions	15 when presented as 1.5 hour group	No set # of sessions, but average is 16	No set # of sessions, but range is 12-18
Structure	Skills presented within the metaphor of the Emotion Detectives' CLUES skills	Skills presented in order of 8 core modules (+ Module P)	Skills presented in order of 8 core modules
Handouts	Child Workbook and Parent Workbook	Child Workbook and Parent-Directed Module Summary Forms at end of each module of the therapist guide	Workbook

UP-C (Sessions; CLUES Skills)	**UP-A** (Modular)	**UP** (Modular)
C (Consider How I Feel) Skill: Intro to the UP-C; Top Problems and Goals	Module 1: Building & Keeping Motivation (*1-2 sessions*)	Session 1: Functional Assessment & Introduction to Treatment
C Skill: Getting to Know Your Emotions	Module 2: Getting to Know Your Emotions and Behaviors (*2-3 sessions*)	Module 1: Setting Goals & Maintaining Motivation (*1-2 sessions*)
C Skill: Using Science Experiments to Change our Emotions and Behavior	Module 3: Emotion-focused Behavioral Experiments (*1-2 sessions*)	Module 2: Understanding Emotions *(1-2 sessions)*
C Skill: Our Body Clues	Module 4: Awareness of Physical Sensations (*1-2 sessions*)	Module 3: Mindful Emotional Awareness (*1-2 sessions*)
L Skill: Look at My Thoughts	Module 5: Be Flexible in your Thinking (*2-3 sessions*)	Module 4: Cognitive Flexibility (*1-2 sessions*)
U Skill: Use Detective Thinking		
U Skill: Problem-Solving & Conflict Management		
E Skill: Awareness of Emotional Experiences	Module 6: Awareness of Emotional Experiences (*1-2 sessions*)	Module 5: Countering Emotional Behaviors (*1-2 sessions*)
E Skill: Introduction to Emotion Exposure	Module 7: Situational Emotion Exposures (*1+ sessions*)	Module 6: Understanding & Confronting Physical Sensations
E Skill: Experience our emotions (*5 sessions*)		Module 7: Emotion Exposures (*2+ sessions*)
S Skill: Wrap Up and Relapse Prevention	Module 8: Reviewing Accomplishments & Looking Ahead	Module 8: Relapse Prevention

Content of the UP-C, UP-A and Adult UP

Caregiving Practices and Behaviors Associated with Emotional Disorders

- Caregivers of youth with emotional disorders may *also* fall into patterns of behavior that reinforce the youth's intense experience of strong emotion or unhelpful coping strategies.
- Therefore, core *emotional caregiving or "parenting" behaviors* are also targeted in the UP-A and the UP-C:

1. Excessive criticism
2. Overcontrol/overprotection
3. Modeling of distress and avoidance
4. Inconsistent reinforcement and discipline patterns

Evidence for the Choice of these Caregiving Behaviors in the UP

- Parental overprotection may play a unique role in children's cortical stress response (Vergara-Lopez et al., 2016)
- Parental overcontrol is key mechanism in longitudinal outcomes related to avoidance and coping in youth with anxiety (Borelli, Margolin & Rasmussen, 2015)
- Psychologically critical behaviors may be associated with risk for depression (Gargurevich et al., 2016), borderline features (Whalen et al., 2015), ADHD (Richards et al., 2014) and other problem behaviors
- Inconsistent reinforcers and discipline are associated with disruptive behaviors, and may be particularly relevant for those with co-occurring emotional and behavioral concerns (Kim et al., 2003)
- Current research is examining benefits of mindful behavior and a non-judgmental stance in terms of communicating parental emotions to youth (e.g., Duncan et al., 2009)

UP-C Session by Session – Additional Caregiver Content

- S1-S4: Consider How I Feel for Caregivers
  - Functional Assessment of Caregiver Response to Child Emotion
  - Opposite Actions for Criticism; Expressing Empathy
  - Positive Reinforcement for Attempts at Effective Coping
- S5: Look at My Thoughts for Caregivers
  - Opposite Actions for Inconsistent Reinforcement and Discipline
- S6-S7: Use Detective Thinking and Problem-Solving for Caregivers
  - Opposite Actions for Overprotection/Overcontrol
  - Management of Reassurance-Seeking
  - Collaborative Problem-Solving
- S8-S14: Experience My Emotions for Caregivers
  - Applying Mindful Awareness to Caregiving Context
  - Opposite Actions for Modeling of Emotional Distress
  - Supporting Behavioral Practice at Home Effectively
- S15: Stay Healthy and Happy for Caregivers
  - Review of Emotional Caregiving Behaviors, Progress Monitoring Outcomes
  - Relapse Prevention

Concepts to Keep in Mind While Discussing Emotional Caregiving Behaviors

1. These four emotional caregiving behaviors are extremely common (even in caregivers of children without emotional disorders) and often arise out of *well-intentioned efforts* to reduce the child's distress.
2. All caregivers can benefit from learning more effective ways to manage their child's distress. The strategies discussed in this treatment may not come naturally to all caregivers, *but they are helpful to learn.*
3. Empathize: Caregiving is overwhelming, exhausting, and anxiety-provoking at times. **Caregivers are allowed to have their emotions too**.
4. Caregivers are not expected to use these strategies perfectly

UP as a Caregiver-Only Curriculum

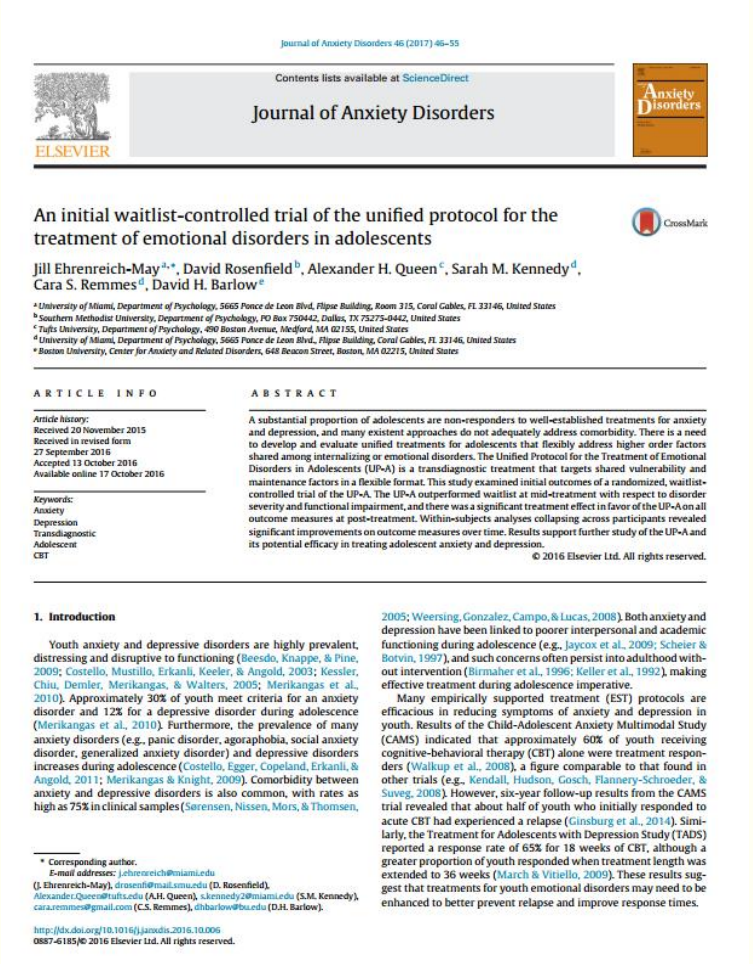
- Evidence for the benefits of carer- or parent-directed interventions for anxiety disorders is emergent (SPACE; Lebowitz et al., 2019).
- We use caregiver-directed or *mostly caregiver-directed* UP-C with younger children in our research clinic
- Pursuing funding currently to study brief parent-directed UP-C in community settings and collecting pilot data to support this stepped-care approach.

RESEARCH SUPPORT FOR THE UP-A AND UP-C

Outcomes, Mechanisms and Adaptations

Evidence Base for the UP-A

- Feasibility of the UP-A supported by:
  - *Multiple baseline* (Ehrenreich, Goldstein, Wright, & Barlow, 2009)
  - *Open trial* (Trosper, Buzzella, Bennett, & Ehrenreich, 2009; Queen, Ehrenreich-May, & Barlow, 2014)
  - *and RCT studies* (Ehrenreich-May et al., 2017)
- All trials investigated effects with adolescents with both a range of emotional disorders (anxiety, depression, OC, etc).
- **Large effect sizes observed** on some measures, but comparators weak (waitlist) or non-randomized designs
- Currently funded effectiveness trials in US and Australia
- Recently completed RCT of UP-A as universal prevention (Garcia-Escalera et al., 2017; in press)



Journal of Anxiety Disorders 46 (2017) 46–55

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

An initial waitlist-controlled trial of the unified protocol for the treatment of emotional disorders in adolescents

Jill Ehrenreich-May[a,*], David Rosenfield[b], Alexander H. Queen[c], Sarah M. Kennedy[d], Cara S. Remmes[d], David H. Barlow[e]

[a] University of Miami, Department of Psychology, 5665 Ponce de Leon Blvd, Flipse Building, Room 315, Coral Gables, FL 33146, United States
[b] Southern Methodist University, Department of Psychology, PO Box 750442, Dallas, TX 75275-0442, United States
[c] Tufts University, Department of Psychology, 490 Boston Avenue, Medford, MA 02155, United States
[d] University of Miami, Department of Psychology, 5665 Ponce de Leon Blvd., Flipse Building, Coral Gables, FL 33146, United States
[e] Boston University, Center for Anxiety and Related Disorders, 648 Beacon Street, Boston, MA 02215, United States

ARTICLE INFO

Article history:
Received 20 November 2015
Received in revised form
27 September 2016
Accepted 13 October 2016
Available online 17 October 2016

Keywords:
Anxiety
Depression
Transdiagnostic
Adolescent
CBT

ABSTRACT

A substantial proportion of adolescents are non-responders to well-established treatments for anxiety and depression, and many existent approaches do not adequately address comorbidity. There is a need to develop and evaluate unified treatments for adolescents that flexibly address higher order factors shared among internalizing or emotional disorders. The Unified Protocol for the Treatment of Emotional Disorders in Adolescents (UP-A) is a transdiagnostic treatment that targets shared vulnerability and maintenance factors in a flexible format. This study examined initial outcomes of a randomized, waitlist-controlled trial of the UP-A. The UP-A outperformed waitlist at mid-treatment with respect to disorder severity and functional impairment, and there was a significant treatment effect in favor of the UP-A on all outcome measures at post-treatment. Within-subjects analyses collapsing across participants revealed significant improvements on outcome measures over time. Results support further study of the UP-A and its potential efficacy in treating adolescent anxiety and depression.

1. Introduction

Youth anxiety and depressive disorders are highly prevalent, distressing and disruptive to functioning (Beesdo, Knappe, & Pine, 2009; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Merikangas et al., 2010). Approximately 30% of youth meet criteria for an anxiety disorder and 12% for a depressive disorder during adolescence (Merikangas et al., 2010). Furthermore, the prevalence of many anxiety disorders (e.g., panic disorder, agoraphobia, social anxiety disorder, generalized anxiety disorder) and depressive disorders increases during adolescence (Costello, Egger, Copeland, Erkanli, & Angold, 2011; Merikangas & Knight, 2009). Comorbidity between anxiety and depressive disorders is also common, with rates as high as 75% in clinical samples (Sørensen, Nissen, Mors, & Thomsen, 2005; Weersing, Gonzalez, Campo, & Lucas, 2008). Both anxiety and depression have been linked to poorer interpersonal and academic functioning during adolescence (e.g., Jaycox et al., 2009; Scheier & Botvin, 1997), and such concerns often persist into adulthood without intervention (Birmaher et al., 1996; Keller et al., 1992), making effective treatment during adolescence imperative.

Many empirically supported treatment (EST) protocols are efficacious in reducing symptoms of anxiety and depression in youth. Results of the Child-Adolescent Anxiety Multimodal Study (CAMS) indicated that approximately 60% of youth receiving cognitive-behavioral therapy (CBT) alone were treatment responders (Walkup et al., 2008), a figure comparable to that found in other trials (e.g., Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008). However, six-year follow-up results from the CAMS trial revealed that about half of youth who initially responded to acute CBT had experienced a relapse (Ginsburg et al., 2014). Similarly, the Treatment for Adolescents with Depression Study (TADS) reported a response rate of 65% for 18 weeks of CBT, although a greater proportion of youth responded when treatment length was extended to 36 weeks (March & Vitiello, 2009). These results suggest that treatments for youth emotional disorders may need to be enhanced to better prevent relapse and improve response times.

* Corresponding author.
E-mail addresses: j.ehrenreich@miami.edu (J. Ehrenreich-May), drosenfi@mail.smu.edu (D. Rosenfield), Alexander.Queen@tufts.edu (A.H. Queen), s.kennedy2@miami.edu (S.M. Kennedy), cara.remmes@gmail.com (C.S. Remmes), dhbarlow@bu.edu (D.H. Barlow).

http://dx.doi.org/10.1016/j.janxdis.2016.10.006
0887-6185/

Evidence Base for the UP-C

- **Open trial** findings (Bilek & Ehrenreich-May, 2012)
  - d = 1.07-1.38 for global severity and primary disorder change
- **RCT** (*n*=47; Kennedy, Bilek & Ehrenreich-May, 2018) compared UP-C to a standard psychotherapy manual for the group treatment of anxiety disorders in children, Cool Kids (Lyneham, Abbott, Wignall, & Rapee, 2003).
- **Results generally support equivalence between treatments**.
- Some evidence suggests that the UP-C may be more robust to symptom recurrence at 6-month follow-up and in terms of co-occurring *depression symptoms*, parent-reported *sadness dysregulation* and *cognitive reappraisal* in this small trial.
- Only one primary predictor of lesser outcomes – youth social anxiety (Kennedy et al., 2018)
- Efforts to personalize UP-C by looking at trajectories of change (Kennedy, Halliday & Ehrenreich-May, under review)

UP-C AND UP-A STUDIES IN PROGRESS

Examination of Possible Mechanisms of Change, Considering the Delivery Model

Recent and Ongoing Work Examining Mechanisms of Change in the UP-A

Single-case experimental design

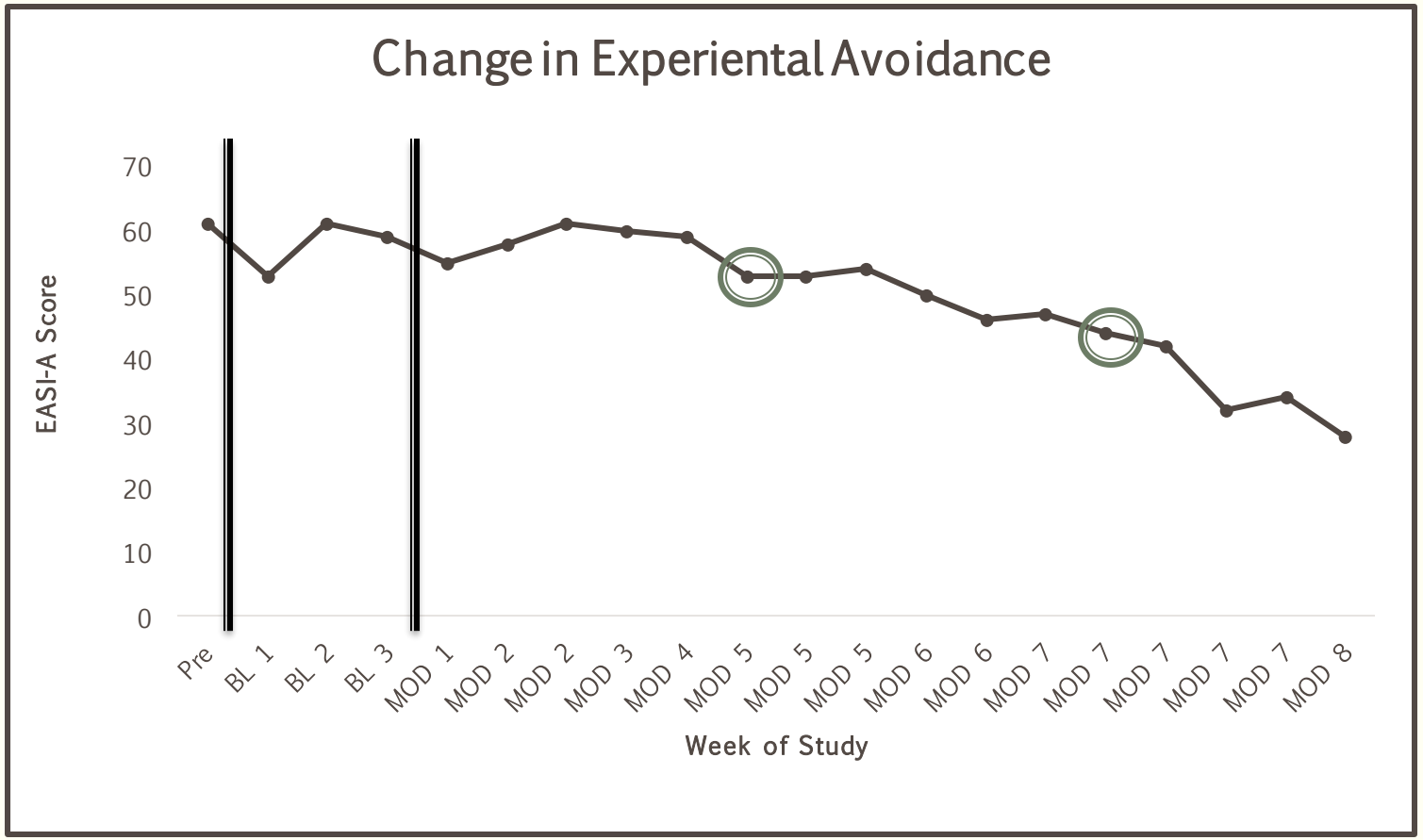
Using a non-concurrent, multiple baseline design study to examine change in **cognitive flexibility, distress tolerance** and **avoidance** during the UP-A, with 9 adolescents (Sherman & Ehrenreich-May, under review).

Randomized, multi-site, effectiveness trial

Funded via RFA-MH-16-415 (Clinical Trials to Test the Effectiveness of Treatment, Preventative and Service Interventions [Collaborative R01])

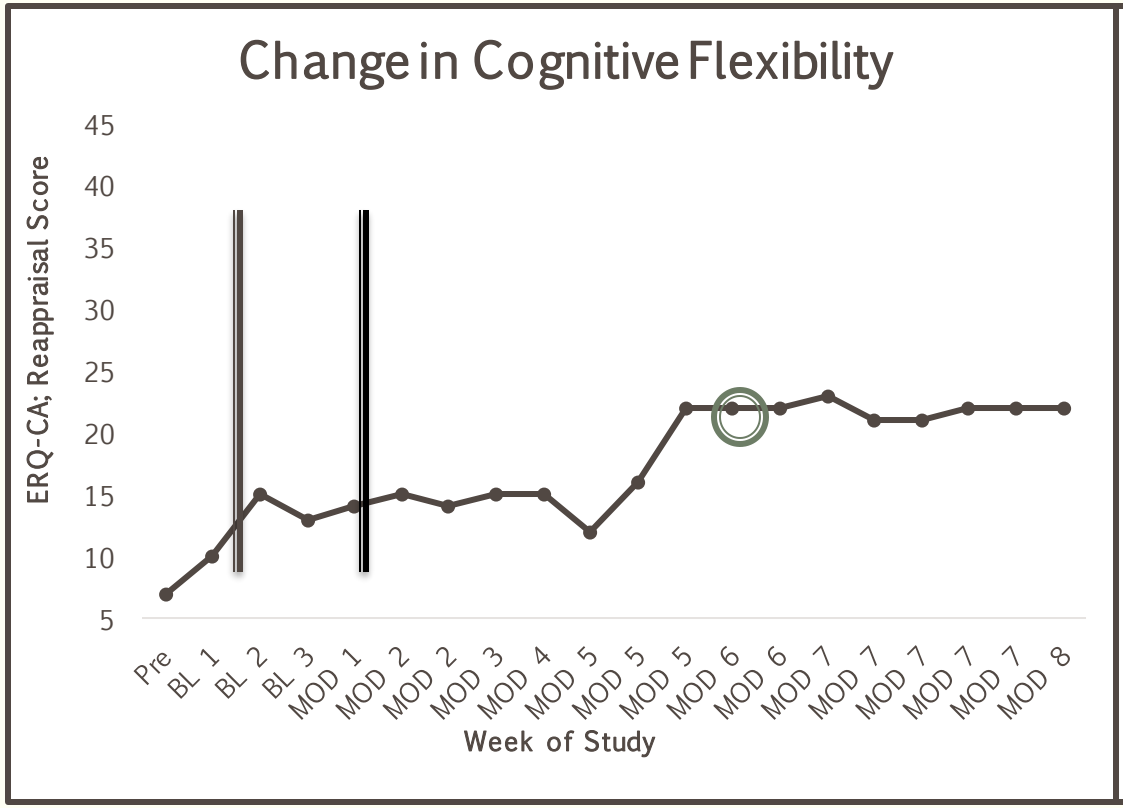
The *Community Outcome Monitoring Study of Emotional Disorders in Teens* (COMET; MPI: Ehrenreich-May, Jensen-Doss & Ginsburg) examines **distress tolerance** and **avoidance** targets of the UP-A in community mental health centers (CMHCs).

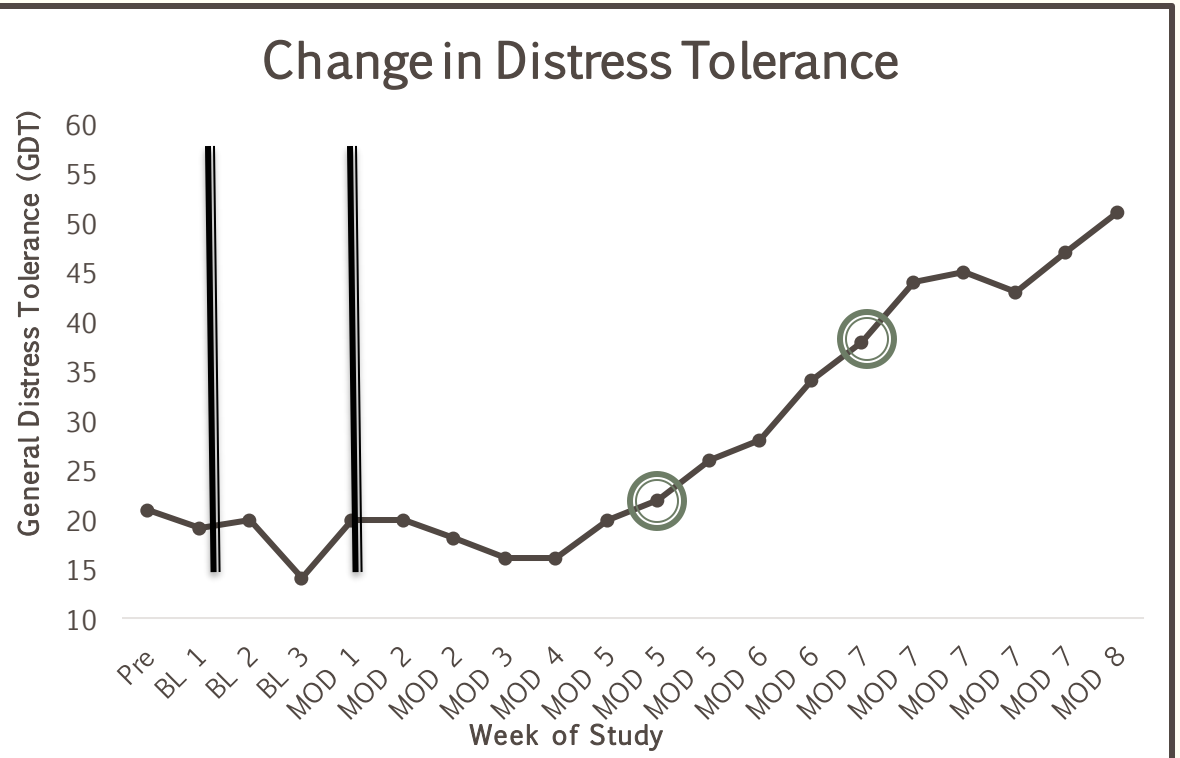
UP-A Case Example



Decreases in experiential avoidance occurred at expected times following module 3 (opposite action) and module 7 (exposure)

UP-A Case Example

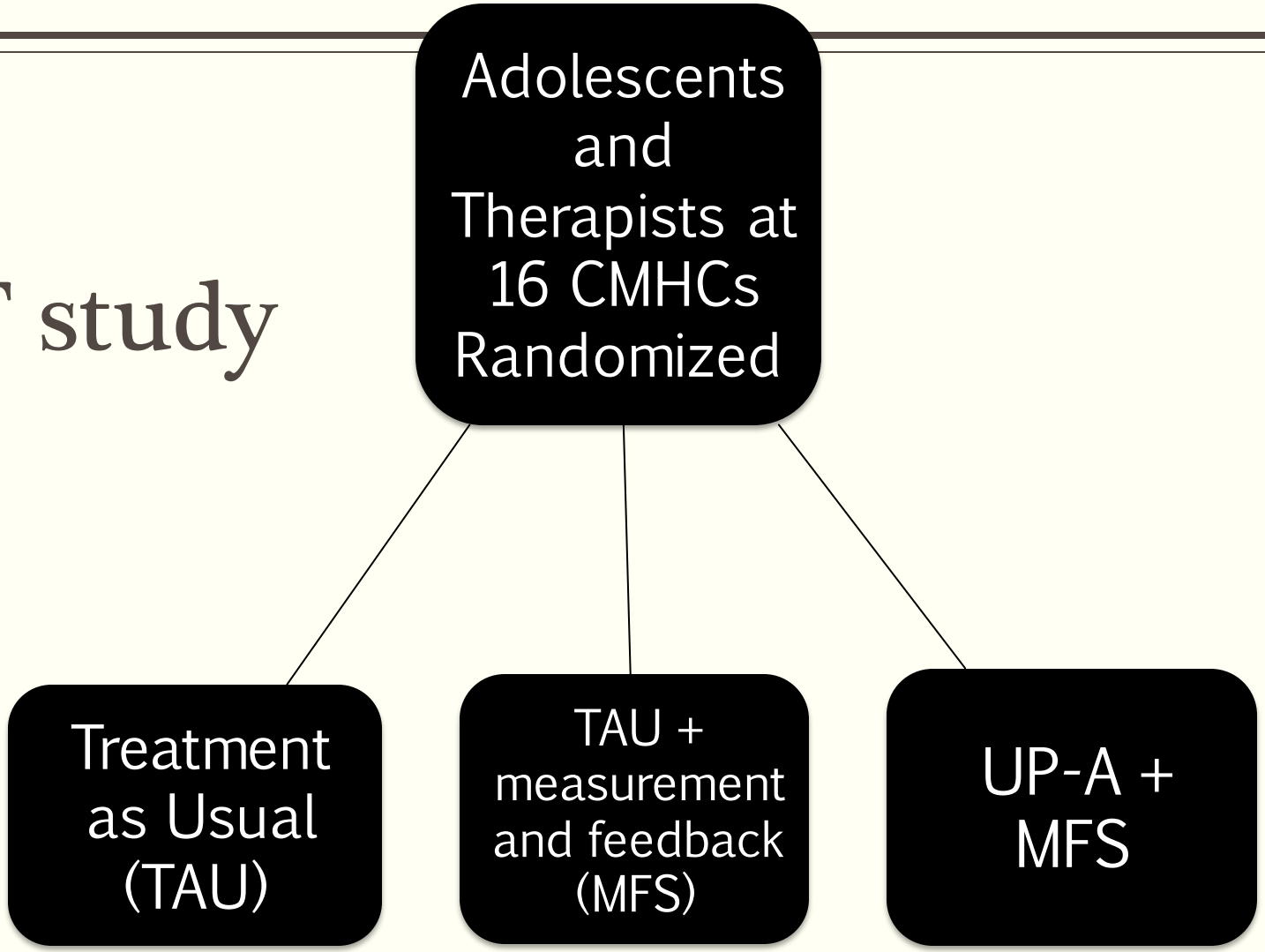




Increases in cognitive flexibility (reappraisal) at expected time following module 5 (thinking traps, detective thinking, problem-solving)

Increases in distress tolerance at expected times following module 4 (sensational awareness and exposure) and module 6 (present-moment and non-judgmental awareness)

COMET study design



COMET Study Features (Jensen-Doss et al., 2018)

- 222 youth across CMHCs serving low-resource families in Miami, FL and Hartford, CT
  - ~200 youth currently recruited to trial; recruitment on-going through 2019
- Adolescents typically very low-income with multiple life stressors
- Agencies vary greatly in service context (home- and school-based vs. office-based), with services generally provided by Masters-level clinicians.
- Huge issues with staff turnover and organizational buy-in encountered (over 150 therapists have also been randomized during the course of 4-year trial).
- ***Distress tolerance*** and ***avoidance*** as potential targets of the UP-A in COMET.

Moving Forward with our Transdiagnostic Research Efforts

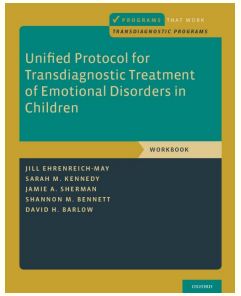
- Projects underway center on evaluation of this model in a wider variety of treatment settings and conditions (stepped care, telehealth, school-based).
- Several application projects exist to better specify the UP-C and UP-A strategies for certain populations (ARFID, child maltreatment, disruptive behaviors, misophonia, early SMI) of youth.
- Translated materials in Spanish (UP-C and UP-A, coming in 2021). Book of UP adaptations in Spanish available at: https://www.alianzaeditorial.es/libro.php?id=5629530&id_col=100508&id_subcol=100518

Example: UP-C for Disruptive Behaviors

(Malmberg, Kennedy & Holzman, in press; Grossman & Ehrenreich-May, in press)

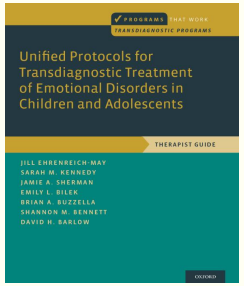
- **Goal:** Retain basic structure and elements of UP-C (e.g., CLUES skills, detective theme, opposite and emotional parenting behaviors), but enhance/adapt behavior management strategies for disruptive behaviors
- Modified from a 15-session curriculum to a 10-session curriculum
- Enhanced the use of examples related to anger, aggression, and frustration
- Introduce exposures for frustration, anger, and irritability earlier on in treatment (session 3) and incorporate parents in these exposures (Weeks 3-10)
- Enhance the Parent Management Training elements of the parent curriculum
- Initial results in a pilot sample of 19 children show significant decrease in irritability and disruptive behaviors (Malmberg et al., in press).

You can download the PDFs of UP-C and UP-A worksheets and forms at the Oxford Clinical Psychology website for FREE.



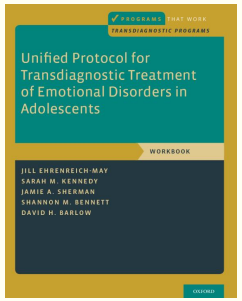
UP-C Workbook Forms:

- http://www.oxfordclinicalpsych.com/view/10.1093/med-psych/9780190642952.001.0001/med-9780190642952-appendix-1



UP-C and UP-A Therapist Guide Forms:

- http://www.oxfordclinicalpsych.com/view/10.1093/med-psych/9780199340989.001.0001/med-9780199340989-appendix-1



UP-A Workbook Forms:

- http://www.oxfordclinicalpsych.com/view/10.1093/med-psych/9780190855536.001.0001/med-9780190855536-appendix-2

Feel free to contact me with any questions at: j.ehrenreich@miami.edu

- Thank you to Dr. David H. Barlow
- Collaborators Drs. Amanda Jensen-Doss, Eric Storch, Adam Lewin, Vanessa Cobham, Daniel Le Grange and others
- The many current and former staff, students and postdoctoral fellows that have contributed to the UP-C and UP-A at the *University of Miami:*
  - Elizabeth Halliday, Ashley Karlovich, Stefania Pinto, Dylan Braun, Niza Tonarely, Rebecca Grossman;
  - Drs. Sarah Kennedy, Jamie Sherman, Cara Remmes, Emily Bilek and Alexander Queen, Monica Nanda and Ashley Shaw
- and *Boston University:*
  - Drs. Lauren Santucci, Shannon Bennett, and Brian Buzzella (amongst others)