Procedures and processes in cognitive behavior therapy with children and adolescents

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Abstract

Development and empirical testing of innovative procedures has a long tradition within cognitive behavioral therapy. However, the discussion of psychotherapeutic processes and their integration with established procedures is a relatively neglected area. This article seeks to remedy this state of affairs and ideally stimulate further dialogue regarding the integration of processes and procedures. This article begins with a brief theoretical introduction and then includes sections on integrating psychotherapy processes with session structure, self-instruction, and rational analysis. Several techniques are described and numerous methods for working with young patients are recommended.

Key Words: cognitive behavioral process; child psychotherapy; patient-therapist relationship.

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Introduction

Cognitive behavioral therapy with children and adolescents is an emerging clinical frontier. Indeed, a variety of treatment protocols, manuals, and procedures have been developed for a variety of disorders including anxiety (Eisen & Schaefer, 2005; Kendall et al., 1992; March & Mulle, 1998; Morris & March, 2004; Silverman & Kurtines, 1996), depression (Clarke, Lewinsohn & Hops, 1990; Stark, 1990; Silverman & Kurtines, 1996; March & Mulle, 1998; Morris & March, 2004; Silverman & Kurtines, 1996), eating disorders (Lock, leGrange, Agras & Dare, 2001), and disruptive behavior disorders (Barkley, 1997; Bloomquist & Schnell, 2002; Larson & Lochman, 2002). Seminar textbooks are devoted to cognitive behavioral psychotherapy with children and adolescents (Reinecke, Dattilio & Freeman, 2004; Friedberg & McClure, 2002; Kendall, 2006). Moreover, new ways to deliver cognitive behavioral therapy to families (Dattilio, 2001; Friedberg, in press; Wood, Piacentini, Southam-Gerow, Chu & Sigman, 2006) have been designed. Despite these advances and innovations, little attention has been paid to integrating cognitive behavioral procedures with psychotherapeutic processes. Accordingly, this paper discusses methods practicing cognitive behavioral therapists may employ to more fully integrate technical procedures with psychotherapeutic processes.

Interpersonal processes in cognitive psychotherapy with adults have received some attention (Beck et al., 1990; Safran & Segal, 1990). However, until only recently psychotherapeutic processes in cognitive behavior therapy with children have been neglected. It has long been an implicit tenet that an effective cognitive behavioral therapist maintains a potent relationship with young patients and their families. However, the literature has ostensibly suffered from a lack of explicit attention to psychotherapeutic processes. Perhaps, this lack of clarity contributes to the pervasive myth that cognitive behavioral therapy is sterile, emotionless, technical, and one-dimensional.

Shirk, Kendall, and Weisz are contemporary cognitive behavioral pioneers who have begun to reverse this trend and provide explicit discussion of the role of psychotherapeutic processes in cognitive behavioral therapy with young patients (Creed & Kendall, 2005; Garcia & Weisz, 2002; Kendall & Southam-Gerow, 1996; Kendall, Chu, Gifford, Hayes & Nauta, 1998; Shirk & Karver, 2003, 2006; Weisz, 2004). Garcia and Weisz (2002) were concerned with high levels of premature termination in cognitive behavioral therapy with youth and studied whether problems in the therapeutic relationship might account for the variance in treatment dropouts. They found that several relationship factors powerfully contributed to drop outs in cognitive behavioral therapy. The factors included perceptions that the therapist was not talking about the right things, the therapist did not address the correct problems, the therapist did not sufficiently involve family members, the therapist did not understand the patient, and the therapist was not likeable. A collaborative relationship which includes a patient and graduated approach, that did not rush the child, was found to be related to positive treatment outcomes (Creed & Kendall, 2005; Kendall & Southam-Gerow, 1996).

Over reliance on technique is problematic in cognitive behavioral therapy. Kendall et al. (1998, p. 179) knowingly noted, “The treatment is driven by the framework not by the specific techniques.” Understanding the conceptual/theoretical model is pivotal in delivering cognitive behavioral therapy. Moreover, adopting the signature stance processes of guided discovery and collaborative empiricism prevents stereotyped and rigid cognitive behavioral therapy. Employing the standard session structure promotes collaboration and clinical attunement that was found to be so valuable in the Creed and Kendall (2006) studies. In sum, Shirk and Karver (2006, p. 407) aptly remarked, “although therapist adherence is critical for ensuring delivery of a protocol, cognitive behavioral therapy requires more from a therapist than reading!”

The role of the cognitive behavioral psychotherapist and the effective integrating of procedures with psychotherapeutic processes are especially crucial for clinical work with children. Children who present at most outpatient settings often do not recognize their problems, disagree with treatment goals, and rarely initiate treatment through their own choices (Creed & Kendall, 2005; Leve, 1995; Shirk & Karver, 2003). Therefore, the relationship with the cognitive behavioral therapist is pivotal (Kendall & Southam-Gerow, 1996). The therapist is well advised to adopt a role as a gentle coach who guides the patient through empathy, Socratic questioning, and skill building toward more adaptive functioning and productive behavior.
Cognitive behavioral psychotherapy should be transparent and include graduated tasks (Shapiro, Friedberg & Bardenstein, 2005). Further, the therapist should “gently persist” when the patient avoids (Newman, 1994, p. 64).

Cognitive behavioral psychotherapy with children has been cogently conceptualized into three inter-related components (Friedberg & McClure, 2002): structure, content and psychotherapeutic process. Structure refers to the things or basic nuts and bolts of cognitive behavioral therapy including agenda setting, homework assignment, eliciting feedback, as well as various self-monitoring, self-instructional, rational analysis, and behavioral techniques. Content refers to the actual material elicited from the treatment structure. Agenda items, automatic thoughts, emotions, behaviors, cognitive distortions and assessment scores, all reflect therapeutic content. Perhaps, the most interesting, albeit misunderstood and underdeveloped, aspect of cognitive behavioral therapy is psychotherapeutic process. Appreciation of psychotherapeutic process adds an extra dimension to the clinical practice of cognitive behavioral therapy. Moreover, it destroys the myth that cognitive behavioral therapy is composed only of tricks, techniques, and procedures.

Friedberg and Crosby (2001, p. 38) wrote, “if content denotes the what of therapy, process symbolizes the how.” Psychotherapeutic process refers to the way youngsters respond to treatment structure. For example, a child may complete a daily thought record (structure) by recording problematic situations with her family and the accompanying thoughts and feelings. However, she may discuss the thought record in a sullen and deceptive manner (psychotherapeutic process). The three aspects co-exist in a dynamic balance. At times, structure is key whereas, at other times, content and process become pre-eminent. Table 1, seen below, summarizes and lists various examples of structure, content, and process variables frequently encountered in cognitive behavioral psychotherapy with youth.

<table>
<thead>
<tr>
<th>Structural Variable</th>
<th>Content Variable</th>
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<td>Homework Assignment/Review</td>
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<td>Self-monitoring (daily thought records)</td>
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<td>Reactions to patient’s self-disclosures (fear, shame, thoughts of losing control, etc.)</td>
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<td>Psychoeducational materials (e.g. lists of distortions)</td>
<td></td>
<td>Perceptions of the therapist (caring, coercive, etc.)</td>
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<td>Cognitive Interventions (Self-instruction, rational analysis)</td>
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<td>Perceptions of therapy in general (“it’s for people who are crazy”)</td>
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<td>Behavioral Interventions (pleasant activity scheduling, social skills training, graduated exposure)</td>
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Session Structure and Psychotherapy Process

Beckian cognitive therapy is punctuated by a trademark session structure, which includes mood checks, homework review, agenda setting, Socratic processing, homework assignment, and feedback summaries (Beck, Rush, Shaw & Emery, 1979; Beck, 1995). While this template represents a general rubric, attending to the psychotherapy process individualizes the procedure. Each patient will likely respond differently to the various parts of session structure. There is a wide range of reactions to session structure that includes but is not limited to passive acceptance, overt rebellion, deference, and antagonism. Working with the idiosyncratic variations makes cognitive psychotherapy personally meaningful to our patients. In this section, I will illustrate several process issues, which erupt during agenda setting, feedback, and homework assignment/review.

Collaboratively setting an agenda reflects the essential partnership in cognitive therapy. However, not all young patients seek this partnership. Some young people want the therapist to do all the work and they are just coming along for the ride. For others, asserting control is crucial and they must dictate the way therapy goes. Thus, agenda setting is not only a way to arrange therapeutic priorities but also a way to work with children’s varying styles of responding to structure.

Like agenda setting, eliciting feedback encourages collaboration between young patients and cognitive psychotherapists. The feedback component to the session structure is a unique opportunity for children and adolescents to give positive as well as critical feedback to an adult authority figure. Some young patients may shrink timidly from the experience while others may grab the chance to level harsh criticisms at an adult. Working with these variations gives therapists and their patients opportunities to process the beliefs that lie beneath a deferential or aggressive stance toward feedback.

Homework in cognitive therapy adds to the portability and generalizability of the psychotherapy. Homework allows the child to “show that I can” (Kendall et al., 1992). Indeed, there are a number of useful homework assignments that a cognitive psychotherapy therapist may apply to children’s difficulties (Kazantzis, Deane, Ronan & L’Abate, 2005; Tompkins, 2004). Similarly to agenda setting and eliciting feedback, children’s responses to homework assignment and review can provide productive moments for intervention.

Attending to and intervening with therapeutic processes associated with children’s responses to homework procedures is also critical in promoting treatment compliance. Children may disdain the idea of homework. They may react with dismay (e.g. “Oh no, more homework, I have too much already.”), anxiety (“I can’t do this.”), or pessimism (“Homework won’t help.”). All these reactions are automatic thoughts and the alert cognitive behavioral therapist should socratically test these assumptions (e.g. “What is the evidence for and against homework not helping? How do you know homework won’t help?”).

Other children may eagerly engage in the homework task and see it as a way to please the therapist. While this may be a more pleasant experience for the therapist than the one associated with the non-compliant child, it should nevertheless be processed. Perfectionistic children often complete homework in remarkable ways. I worked with one perfectionistic child who made an elaborate artistic cover to her thought records. A cognitive behavioral therapist might ask the perfectionistic and approval seeking patient “What goes through your mind when you imagine making a mistake? What if your homework was sloppy and messy? What do you guess I would think of you?”. Once these predictions are elicited, they can be tested for accuracy.

Self-Monitoring and Psychotherapeutic Process

Cognitive psychotherapists employ a variety of self-monitoring procedures such as formal assessment measures, informal assessment methods, activity schedules, subjective units of distress, scaling methods, behavior logs, and daily thought records. Self-monitoring allows young patients to track their thoughts, feelings and behaviors. This tracking in itself can contribute to change (Bateson, 1972; Friedberg & McClure, 2002). Children do not respond identically to self-monitoring. One child I treated responded to the Children’s Depression Inventory (Kovacs, 1992) by scrawling all over it. Indeed, this was a curious process response. When queried, the patient responded, “You can’t understand me through forms. All you care about are these stupid papers”. Working through these
assumptions was key to psychotherapeutic success. Crafting a Socratic dialogue to test these beliefs leads to fruitful psychotherapeutic processing (e.g. “What made you believe I only care about the papers? What’s an alternative explanation?”). The patient’s absolutistic notion that all adults did not care about him and only want to label him emerged. The subsequent Socratic dialogue helped the patient modulate his all or none thinking and learn to more flexibly interpret others’ intentions.

Some children respond to the DTR (Daily Thought Record) with characteristic avoidance or non-compliance. For instance, Sophia, an 11 year old depressed and highly avoidant young girl superficially completed a DTR. When I processed her response to the thought diary (e.g. “What do you guess would happen if you wrote down what was really going through your mind?”), she remarked, “It would make things too real. I would start crying and never stop”. Sophia’s automatic thought in response to the DTR was more emotionally present than any thought she had previously noted. Her hypothesis that genuine written expression on the DTR would lead to a loss of emotional control was a productive starting point for Socratic dialogue testing the accuracy of her prediction. Simply, we began by gradually increasing her level of emotional control. As she realized that disclosure did not lead to emotionally catastrophic consequences, she became more forthcoming and less avoidant.

Self-Instruction and Psychotherapeutic Process

Self-instruction is a procedure whereby maladaptive thoughts are replaced by more adaptive, productive thoughts (Meichenbaum, 1985). As Meichenbaum noted, self-instructional procedures help children traverse difficult situations by coaching them to develop new guides, rules, and templates for behavior. Friedberg, Friedberg and Friedberg (2001) warned that children are apt to develop platitudinous and overly positive self-instruction. Children may respond to self-instructional procedures with positive responses that do not help guide their future behavior. Additionally, they may react to self-instruction with boredom.

Helping youngsters build self-instruction requires “laddering.” Laddering is accomplished through Socratic questions and facilitates action plans. For instance, consider the following dialogue, which illustrates the laddering concept.

Therapist: So you worry that if you make a mistake, no one will like you.
Andrea: Yes.
Therapist: What else could you say to yourself that might help?
Andrea: Well, I guess I could say that I could try to be perfect and then people will like me if they see me trying.

Therapist: That is a possibility but it still seems like you are putting pressure on yourself to be perfect because you think it is the only way to get people to like you. Let’s see if you can attack the idea that being perfect is the only way to please people.
Andrea: Hmm... I guess I could say that I can please people by being nice and doing well in school and in swimming.
Therapist: Does doing well equal being perfect?
Andrea: No, it just means doing my best.
Therapist: Okay. Let’s write this all down on a coping card.

This dialogue illustrates several key points. First, the therapist reinforced the child’s effort at self-instruction. Second, he built on the child’s initial self-instruction and guided her to challenge the notion that perfection is the only way to please others. Third, the therapist helped the child generate alternatives to perfection as a way to please others.

Enlivening self-instructional tasks that are perceived as dull by youngsters requires creativity and flexibility. The use of metaphors and fun activities can help (Kendall et al., 1998). “Changing your tune” (Friedberg et al., 2001) is a self-instructional procedure that adds fun to the psychotherapy process. Automatic thoughts are seen as familiar song lyrics that repeat over and over in a child’s head. The technique is initially introduced with a music CD that includes a song with repetitive lyrics. The children enjoy listening to the song and are asked to identify which lyrics are repetitive. Next, they capture their own self-defeating “tunes” and construct a new lyric.

“Thought crowns” (Friedberg, McClure & Garcia, in preparation) are fun and engaging procedures for younger children. “Thought crowns” are paper headpieces cut in the shape of a crown. Once the crown is completed, a Velcro strip is placed on the front of the crown.
thoughts are then written on pieces of paper shaped like thought bubbles. These bubbles are placed on the crown atop the child’s head yielding the image of the thought “popping” out of his/her minds. Then, a counter thought is written on another thought bubble and the child takes the negative thought out of her head and attaches the counter thought to the Velcro strip located on the crown.

Rational Analysis and Psychotherapeutic Process

Rational analysis is a more depthful cognitive intervention. Rational analysis requires a child to use metacognitive processes and change the way they interpret and construct meaning. Not surprisingly then, the rational analysis procedures are subject to children’s individual psychological processes. DiGuiseppe (1989) aptly noted that many children are likely to interpret Socratic questions as criticism and control. Moreover, many children may interpret the therapist’s procedure or technique as trying to prove them wrong. Thus, it is incumbent on cognitive-behavioral psychotherapists to facilitate rational analysis in a way that decreases the potential for children to think they are being interrogated and become increasingly engaged in psychotherapeutic procedures.

“Real versus false alarms” (Friedberg et al., 2001) is a fun way to do rational analysis with children. Based on the fundamental cognitive therapy notion that the “alarm is worse than the fire” (Beck, Emery & Greenberg, 1985) and anxiety is punctuated by a series of false alarms (Barlow, 2002), Real versus false alarms uses the metaphor of a fire company to challenge children’s inaccurate predictions. Children are encouraged to draw a fire engine or wear a fire fighter’s hat when completing the procedure. Once the child is engaged and recognizes the metaphor, the formal procedure can begin.

The procedure may be divided into three phases. First, the child lists all his/her alarms (worries). Next, he/she collects data over the following week to determine whether the alarm was real or false. Finally, in the third phase, the cognitive behavioral psychotherapist builds a Socratic dialogue consisting of some of the following questions (“How many of your worries were real alarms? How many were false alarms? Did you have more false or real alarms? What did you do to handle the real alarms? If you had more false alarms, what does that mean about whether the things you worry about will come true?”) (Friedberg et al., 2001).

“Sharing the Persian Flaw” (Friedberg, McClure & Garcia, in preparation) is a procedure based on the American television series “Joan of Arcadia”. In one episode, the main character worries about making mistakes, is dismayed by her own imperfection, and is exceedingly distressed by her lack of control over others and events. In the show, the character learns that the distinctive features of Persian rugs are their imperfections. The rug makers adopt this philosophy as a way to express humility. As stated in the program, the Persian Flaw encourages the view that life must be lived and tolerated through its imperfections and unpredictability.

We modified the Persian Flaw for use in cognitive therapy by creating a geometric design, then presenting it to patients and instructed them to complete the design incorrectly. Imperfect completion may include coloring outside the lines, choosing the “wrong colors”, smudging the colors, ripping the paper, crumpling it, or even electing to leave it blank. Once they have included their Persian Flaws, they are to confidentially note their mistakes and rate how visible and awful the mistakes are to other people. Next, they share the flaw with others and record other people’s recognition of the mistakes. Last, they compare their estimate of the visibility and awfulness of their mistakes to other’s responses. In this way, they learn mistakes can be shared, they are often invisible to others, and rarely are they as awful as the children anticipate.

Conclusion

The history of cognitive behavior therapy is replete with well-controlled clinical trials, theoretical discussions, and anecdotal case reports. However, until recently, there has been little mention of the pivotal role psychotherapeutic processes play in cognitive behavioral therapy with children, adolescents, and families. Since cognitive behavioral therapy has grown in empirical stature and clinical popularity due to the study of specific change mechanisms, we now have the opportunity to broaden its application by focusing much needed attention on the non-specific aspects of change.

While some orthodox cognitive behavioral therapists may bristle at the notion of non-specific factors, others embrace the construct. This article was meant to stimulate a rapprochement between practitioners who advocate a
technical approach to cognitive behavioral therapy and those who recommend a more clinical approach. Freeman (1990) cogently made the distinction between “technicians, magicians, and clinicians” and noted that astute clinicians expertly address both the technical aspects of procedures as well as psychotherapeutic processes. Kendall et al. (1998) compellingly stated:

Perhaps, it goes without saying that a manual requires implementation with good clinical skills. Nevertheless, the rampant misunderstanding of treatment manuals, along with the overzealous assumptions about the potency of manuals, combine to reaffirm the need to explicitly state that a manual operationalizes the treatment but practitioners must be able to breathe life into a manual. (p. 197)

It is apparent that cognitive behavioral luminaries such as Freeman and Kendall recognize the need for this rapprochement.

The appeal and beauty of cognitive behavioral therapy is its rich conceptual framework and flexibility. Integrating psychotherapeutic processes into cognitive behavioral psychotherapy adds even greater depth to this multidimensional approach. Moreover, managing psychotherapeutic process issues in treatment may fully enable the transfer of efficacy from the lab to the clinic. Clearly, addressing psychotherapeutic processes may obviate concerns such as lack of opportunity for creativity, lack of individualized treatment, complex cases, co-morbidity, and clinical unpredictability which compromise the translation of gains discovered in the clinical lab to real world practice (Weisz, 2004).

Improving the quality of life for distressed children and adolescents is the goal of all cognitive behavioral psychotherapists. As cognitive behavioral therapy moves into the 21st century, mindfully integrating well-established and innovative procedures with psychotherapeutic processes will likely serve this goal well. Ideally, many children, adolescents, and families will reap the benefits of our efforts.

References
