CHAPTER 1

Beginnings

This book offers practicing cognitive-behavioral clinicians a wide range of techniques and procedures to make practice easier and more effective for both children and therapists. It is designed to serve as a companion to our previous book, *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts* (Friedberg & McClure, 2002). The first book presented the basics of treatment. Here, we go beyond to present more techniques and approaches to target those hard-to-reach clients, difficult-to-treat problems, and more complex cases. We offer a modular approach to help clinicians choose the right technique to fit the client. The book is also designed to bridge the gap between empirically supported treatment manuals and what we find in typical clinical practice.

In this chapter, we present some of the findings from the literature to help orient clinicians to ways to use components found effective in empirically supported or informed treatment. In addition, we explore the modular approach to treatment, and how it can offer benefits to working in typical clinical settings.

Research supporting cognitive-behavioral therapy (CBT) with children is methodologically rigorous and has yielded significant efficacy results. These promising findings have led to calls for empirically supported or at least empirically informed practice. Yet many practitioners remain skeptical about using research protocols in clinical practice (Southam-Gerow, 2004; Weisz, 2004). Indeed, efforts at disseminating effective treatment to the community have been largely unsuccessful (Addis, 2002; Carroll & Nuro, 2002; Chambless & Ollendick, 2001; Edwards, Dattilio, & Bromley, 2004; Gotham, 2006; Schulte, Bochum, & Eifert, 2002; Seligman, 1995). There are a number of reasons for this situation.

Clinicians confront many challenges that research protocols work hard to avoid. For example, clinicians generally treat severely distressed patients with greater comorbidity who are highly likely to drop out of treatment (Weisz, 2004). Yet participants recruited into research protocols are often volunteers and are often paid for their participation. In typical clinics, parents seeking treatment for their children rarely recog-

nize their problems, commonly disagree with treatment goals, and infrequently seek services on their own (Creed & Kendall, 2005; Shirk & Karver, 2003). Clinical populations generally suffer from greater family psychopathology, and sadly many of these children may suffer from some form of abuse (Weisz, 2004). In addition, clinicians are often deluged by burdensome productivity demands, bureaucratic requirements, forms, and paperwork (Southam-Gerow, 2004; Weisz, 2004). Southam-Gerow (2004) astutely noted that manual developers incorrectly view clinicians as passive consumers or "end users." He asserted that clinicians should be viewed as creative codevelopers who are able to make intelligent decisions. As Jones and Lyddon (2000, p. 340) wrote, "Developing practice guidelines is not a process carved in stone, rather a continually evolving one." In other words, research can point clinicians in the right direction but individual clinicians working in the real world must find specific ways to get to the destination.

The modular approach to CBT offered in this book gives clinicians an attractive alternative to manuals by balancing the precision of the protocol with flexibility and clinical creativity. We cannot say with certainty that a modular approach is a better path than a manual-driven therapy. The data are not yet in on this issue. However, the promise of a modular approach lies in its potential for real-world practicality.

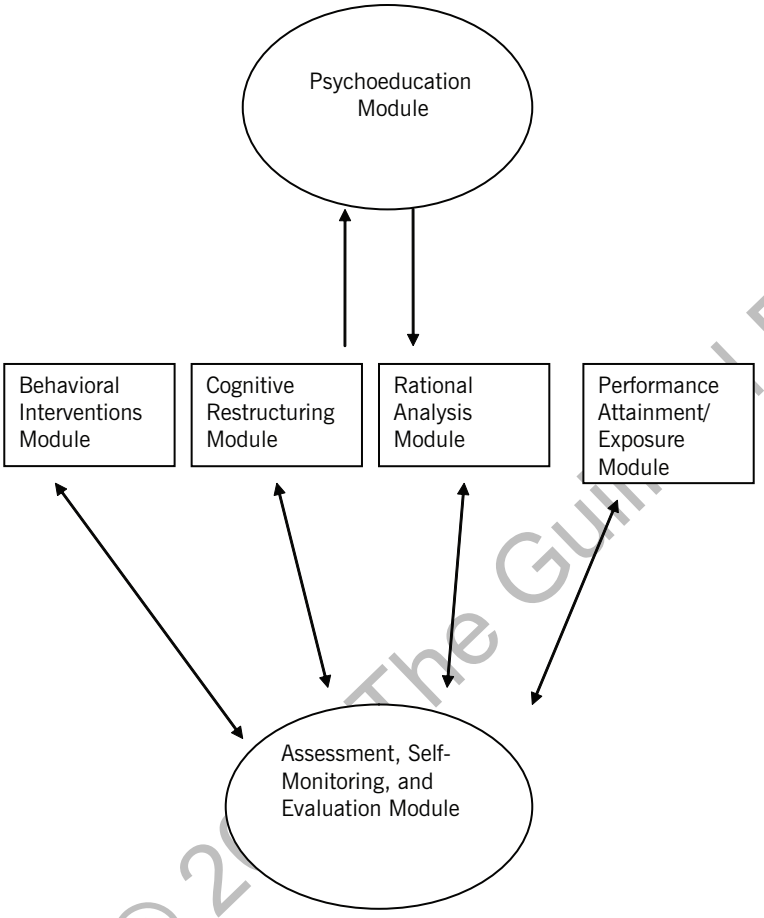
A MODULAR APPROACH TO CBT

A modular approach to intervention is skills based and applicable to a variety of children and adolescents presenting with multiple complaints (Van Brunt, 2000). Chorpita, Daleiden, and Weisz (2005b, p. 142) defined *modularity* as "breaking complex activities into simpler parts that function independently." The modular approach we have used for this book consists of distilling individual techniques and procedures from empirically supported treatment manuals and grouping them by therapy task into modules (Chorpita, Daleiden, & Weisz, 2005a; Curry & Wells, 2005; Rogers, Reinecke, & Curry, 2005). The techniques and procedures in this volume are organized into six modules covering the following areas: psychoeducation, assessment and behavioral interventions, self-monitoring, cognitive restructuring, rational analysis, and exposure/experiential methods. All of the techniques within a module share a common therapeutic purpose (e.g., psychoeducation), but they may differ in developmental appropriateness (child or adolescent), target population, and modality (individual, group, or family therapy).

Constructing an individualized case formulation is a key step in implementing the modular approach presented in this book. Kendall, Chu, Gifford, Hayes, and Nauta (1998) correctly asserted that CBT with children is directed by a theoretical rationale rather than by techniques. Readers from different theoretical orientations will likely recognize some techniques traditionally associated with other therapeutic paradigms. The ties that bind the diverse techniques in this book are conceptual ones. Remember: what makes a technique cognitive is its theoretical context and proposed conceptual mechanism of change (J. S. Beck, 1995).

Figure 1.1 shows the modules and their relation to each other over the course of a treatment. Assessment and psychoeducation are the first two modules. While you begin with assessment and psychoeducation, the bidirectional arrows allow you to return to these techniques throughout the treatment process as you proceed to behavioral, cognitive restructuring, rational analysis, and performance attainment procedures.

FIGURE 1.1. Modular approach to CBT.



The techniques in the assessment, self-monitoring, and evaluation module direct patients and therapists to appropriate clinical targets as well as provide data on how treatment is going. For instance, if the patient is high in anhedonia, pleasant activity scheduling may be initiated. If social skills are lacking, then training in these areas is a logical treatment strategy. In some instances, self-monitoring and other assessment methods may indicate the need for a cognitive restructuring intervention. A technique can then be tried and evaluated. If the data indicates the intervention was successful, the therapist may move on to a more advanced cognitive restructuring procedure, or to a procedure in the subsequent rational analysis or exposure modules. If evaluation reveals lack of success, then another cognitive restructuring technique may be selected or an intervention from the preceding behavioral module. Chapter 2 presents various assessment and self-monitoring methods.

Psychoeducation gives children, adolescents, their families, and therapists a common understanding of the therapy process. Frank (1961) aptly stated that all psychotherapies include a rationale that explains illness and recovery. More specifically, Frank stated:

> The therapeutic rationale finally enables the patient to make sense of his [or her] symptoms. Since he [or she] often views them as inexplicable which increases their ominousness, being able to name and explain them in terms of an overarching conceptual scheme is powerfully reassuring. The first step in gaining control of any phenomenon is to give it a name. (1961, p. 328)

Chapter 3 offers many specific psychoeducational techniques.

There are four intervention modules: behavioral interventions, cognitive restructuring, rational analysis, and performance attainment/exposure. The modules are sequenced according to how skill building proceeds: from simple task to complex task. In general, behavioral interventions (Chapter 4) are easier for children to acquire and apply whereas the more cognitive interventions such as cognitive restructuring (Chapter 5) or rational analysis (Chapter 6) are somewhat more sophisticated skills. Exposure and other performance attainment methods (Chapter 7) are placed later in the sequence to allow the building of coping skills that can facilitate progress toward experiential/exposure tasks.

CASE CONCEPTUALIZATION IS CRUCIAL

Reliance on case conceptualization separates clinicians from technicians (Freeman, Pretzer, Fleming, & Simon, 1990). A case conceptualization increases the flexibility of treatment strategies, allows the therapist to recognize what techniques work and which procedures fall flat, and facilitates productive troubleshooting when treatment is stymied. Although a full discussion of case conceptualization is beyond the scope of this chapter, we will nonetheless provide a rubric for conceptualizing patients. For readers who require more background on the fundamentals of case conceptualization, we recommend work by J. S. Beck (1995), Friedberg and McClure (2002), Kuyken, Padesky, and Dudley (2009), and Persons (2008).

Friedberg and McClure (2002) outlined the critical elements of case conceptualization, which include developmental history, cultural context, behavioral antecedents, cognitive structures, and presenting problems. Presenting problems are the issues that bring young people into treatment. While these are crucial and often urgent, they represent only part of the picture. In our model, presenting problems are best understood in the context of past learned history, cultural factors, systemic influences, and developmental variables. These variables have a bidirectional influence on the presenting problems. They shape and in turn are shaped by the presenting complaints. In order to conceptualize a case and successfully implement a treatment package, you will need to obtain relevant patient data as follows.

Developmental milestones regarding self-regulation (e.g., eating, sleeping, toileting), responsiveness to changes in routines, and adjustment to school should be considered. Further, a youngster's *school functioning* should also be queried (e.g., academic performance; attendance; disciplinary history such as detention, suspension, and expulsions; and experiences in the cafeteria, gym, and recess). *Social functioning* is also very important (Who are the patient's friends? How are friends acquired? How long do the friendships last? What is the patient's dating/sexual history? Does the patient go to birthday parties? Sleepovers? Dances?). You should collect specific data on the *family*

functioning (parents'/siblings' psychiatric and medical history; What disciplinary techniques are employed?; Is domestic violence present?; Do parents agree on discipline?; How does the child see the family organization?; Who is in charge?; Who is peripheral?). Of course, the child's *substance use* (illicit drugs, alcohol, food, laxatives, over-the-counter medicines), *medical conditions*, and *legal history* should be obtained.

Ethnocultural data should also be collected. Levels of acculturation, ethnocultural identity, and specific ethnocultural beliefs should be considered. You should ask about cultural beliefs about the presenting problem and treatment. Any experiences of prejudice, discrimination, oppression, and marginalization should be funneled into the conceptualization.

After collecting and synthesizing all this data, you begin the inferential process. We agree with Persons (1995) that simple formulations are preferred to complex ones. A simple rubric suggested by Persons is to use patient data to formulate a view of the self (e.g., "I am … "), a view of the world ("The world is … ," "The environment is … "), and a view of other people ("People are … "). These pieces combine into a whole picture that reads "I am _____ in a world _____ where other people are _____."

The "world" and "other people" components directly affect the way the young patient sees therapy and the therapist. For instance, a patient who sees others as rejecting, critical, uncaring, and/or controlling will fear negative evaluation and coercion by the therapist. On the other hand, a young patient who sees others as inferior, subordinate, and/or undeserving will devalue the therapist, see treatment as a waste of time, and act to "get one over" on the therapist.

USING THE CASE CONCEPTUALIZATION TO GUIDE MODULAR CBT

In order to see how the case conceptualization impacts modular CBT, let's look at some examples. Consider a 10-year-old girl who sees herself as ineffective ("I am helpless.") in a world where others are coercive and the world is rejecting. These beliefs about the world and other people will fundamentally shape the child's perception of the therapist and therapy. This youngster will be prone to interpret interventions as coercive, and Socratic questions as implicit criticism. Your initial challenge is to place the modular interventions in a context that fosters autonomy, control, and collaboration, and that communicates understanding. Hence, psychoeducation is pivotal. The modular interventions themselves should focus on decreasing this patient's sense of hopelessness. As treatment progresses, you can move toward addressing her views of others and the world. As you achieve treatment success, her views of others as coercive and the world as being rejecting will be disconfirmed.

In another case example, a 17-year-old held the view "Unless I am always in perfect control of myself, others, and the world, I am incompetent because the world is dangerous and others are both unpredictable and domineering." For this patient, absolute control equals safety and competence. Consistent session structure and collaboration will ease his harsh views of others and the world. However, to prove his competence, he must preserve absolute and certain control of everything. Modular interventions aimed at looking at the advantages and disadvantages of perfect control, evaluating alternate

determinants of "competence," testing the evidence of whether competence is related to control, and behavioral experiments where the client "loses" some control yet maintains competence are recommended.

We believe theoretical coherence is essential to good clinical practice. The choice of procedures and techniques needs to be guided by cognitive-behavioral theory. Cognitive-behavioral case conceptualization prevents theoretical drift. Moreover, reliance on conceptualization allows you to access mechanisms of change. You can then see why treatment works well or is moving slowly or not at all. In this way, obstacles can be overcome.

INTEGRATING PROCEDURES WITH PSYCHOTHERAPEUTIC PROCESSES

As any clinician readily recognizes, psychotherapy is fundamentally an interpersonal enterprise (Southam-Gerow, 2004). We believe that the relationship is essential but not sufficient for therapeutic change. Accordingly, we recommend that each procedure be mindfully integrated with psychotherapeutic processes (Shirk & Karver, 2006). The treatment relationship and intervention are not independent. Procedures and relationship building are contemporaneous tasks. They work in concert to establish powerful working alliances. Simply, interventions build good relationships and strong alliances make interventions effective.

Collaboration between patient and therapist enhances the therapeutic alliance. Creed and Kendall (2005) found that rushing the patient and behaving too formally predicted lower alliance ratings. Therapists' curiosity often stimulates collaboration. Curious therapists often induce curiosity in their young patients and behavioral experimentation is dependent on curiosity. Kingery et al. (2006) encouraged therapists to invite young people to integrate aspects of their personal life (friends, interests, hobbies) into therapy. Gosch, Flannery-Schroeder, Mauro, and Compton (2006) recommended that therapists employ appropriate self-disclosure with their young patients. The disclosure not only enhances rapport but also sets the therapist up as a coping model.

Friedberg and McClure (2002) designed a clinically useful rubric for integrating psychotherapeutic structure, process, and content variables, as shown in Table 1.1. *Structure* refers to the procedures and techniques that characterize CBT. These elements include, but are not limited to, session structure, psychoeducation, assessment, self-monitoring, behavioral tasks, social skills training, cognitive restructuring, rational analysis, and exposure. For example, Beckian cognitive therapy uses a consistent session structure (A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 1995) that involves mood check-in, feedback from previous sessions, homework review, agenda setting, processing session content, homework assignment, and feedback/summaries. It is important to remember that session structure should be maintained over the course of therapy when employing the procedures described in this text.

Content is the direct therapeutic material elicited via the structure. The individual patient's automatic thoughts, emotions, responses on assessment measures, coping thoughts, and results from behavioral experiments all represent content.

Process adds a third dimension. It refers to the way children respond to the structure and content of the session. No one reacts identically to the same procedure. Children's

TABLE 1.1. Examples of Therapeutic Structure, Content, and Process

Structure	Content	Hypothesized process
Agenda setting	"I don't know—you decide."	Submissiveness, passivity, perfection, fear of negative evaluation, fear of change.
Feedback	"You stink as a therapist. Did you even graduate from high school?"	Provocation, competitiveness, independence seeking.
Homework assignment/ review	"Perfect completion" with no cross-outs or mistakes.	Fear of negative evaluation, approval seeking.
Self-monitoring/ assessment	Ripped up the forms and said, "You are more interested in these forms than me."	Patient sees the therapist as mechanical, uncaring, and lacking in understanding.
Cognitive restructuring	Platitudinous and pollyannaish coping thoughts: "Nothing bad will happen to me."	Avoidance, intolerance of negative affect.
Behavioral experiments/exposure	"It's silly. Why would I want to get more worried or nervous?"	Avoidance, low self-efficacy.

idiosyncratic reactions to cognitive-behavioral procedures are important aspects of understanding the treatment process. Pos and Greenberg (2007) noted that patients display problematic cognitive, behavioral, and emotional states while in session. Attending to the therapeutic process facilitates recognition of these markers, which are opportunities for intervention. Yontef (2007, p. 23) rightly recommended, "The therapist has to recognize openings and learn the sequence of what must come before what." Children's process markers can include responses such as teariness, flushing, a shifting posture, a shaking foot, changing topics, climbing under a table, cynicism, smugness, irritation, pessimism, eagerness to please, dismissiveness, and superficiality.

Weaving procedures and process into a coherent psychotherapeutic fabric is key. Consider a few clinical examples. An aggressive 13-year-old girl named Tanya believed she was under siege from most other people. She routinely misinterpreted benign actions as deliberate threats. Since the possibility of assault always seemed imminent, she was primed for preemptive counterattacks. In session, she responded to an innocuous comment ("It must be hard to think you are totally on your own.") with a stinging angry response ("You are really pissing me off. You are insulting. Go _____ yourself."). With this clear process marker, the therapist intervened by asking, "What went through your mind just when I said that?" In a moment of insightful awareness, Tanya commented that she saw it as a criticism implying she was too weak to handle the stresses in her life.

In another example, Chloe, a 16-year-old patient with anorexia, habitually inhibited her thoughts and feelings. She believed power was best attained through secrecy. Thus, sharing her thoughts and feelings with a therapist was a tough task made even more difficult by her sense that disclosure was defeating. Chloe brought very superficial thought diaries to her sessions. They lacked emotional meaningfulness and were overly intellectual and impersonal. The therapist then used the thought diaries to capture dysfunctional beliefs about disclosure and expressing feelings. Chloe identified beliefs such as

"People will reject and coerce me. If I hide myself, I am less of a target"; "Being secretive gives me control and the more control I have, the more acceptable I am"; and "No one will give me what I want. I have to trick them into it." Once these beliefs were recorded, the therapist progressed toward a test of evidence ("What convinces you I will reject or coerce you?"; "What makes you doubt I will reject and coerce you?") and reattribution procedures ("What are other ways to be competent and acceptable in addition to hiding away your thoughts and feelings?"). By weaving together Chloe's process (where she inhibited thoughts and feelings as protection against potential coercion, and believed deception is the best way to get what I want.) with therapeutic procedures (such as test of evidence and reattribution), the therapist was able to test Chloe's assumptions.

APPLY TECHNIQUES IN THE CONTEXT OF PATIENTS' EMOTIONAL AROUSAL

It is vital that clinicians apply techniques and procedures in the context of patients' negative affective arousal. Emotional arousal is the lifeblood of CBT. Procedures lay lifeless when they are delivered in an emotionally sterile environment. The recommendation to apply therapy in an emotional context has been made often (Burum & Goldfried, 2007; Castonguay, Pincus, Agras, & Hines, 1998; Frank, 1961; Friedberg & McClure, 2002; Goldfried, 2003; Greenberg, 2006; Greenberg & Paivio, 1997, 2002; Robins & Hayes, 1993; Samoilov & Goldfried, 2000). Gosch et al. (2006, p. 259) noted, "A key ingredient to successful CBT is making the therapy content child-focused and the process experiential." Good therapy is like live theater (Kraemer, 2006): it reveals and deals with the drama of patients' lives. At their most inspiring, both theater and therapy form an experiential bond between audience (therapist) and performer (patient) forged in an emotional furnace sparked by genuine expression, sound reflection, and true creative action.

Clinicians need to use procedures when patients are experiencing problematic emotions—otherwise therapy becomes an abstract intellectual exercise. When therapists elicit and sensitively process patients' deeply felt emotions, treatment takes off. The challenge and excitement of CBT with young people is to make use of intensely charged emotional moments in the present (Friedberg & Gorman, 2007).

Enduring change is facilitated when treatment is embedded in emotional arousal (Robins & Hayes, 1993). Indeed, we argue that when properly executed, CBT is a truly experiential form of therapy. Kraemer (2006, p. 245) emphasized that "learning from experience means being affected by the here and now." Thus, CBT with children is not an intellectual exercise.

Hayes and Strauss (1998) employ the concept of destabilization in processing patients' in-session emotional arousal. *Destabilization* refers to creating dramatic shifts in beliefs, behavior, and feelings. Samoilov and Goldfried (2000) suggested that destabilization is fostered by narrowing patients' attention to their here-and-now experience and amplifying their emotional arousal. This intense experience leads to greater change in meaning structures and changes in depressive symptoms (Hayes & Strauss, 1998).

Cotterell (2005) has likened CBT to sculpting steel. In order to bend steel and create change, intense heat and fire are necessary. Emotions represent the "heat" in CBT. Cognitions that are associated with increased emotional arousal are referred to as "hot cog-

nitions" (Samoilov & Goldfried, 2000). Recent advances in affective neuroscience also support this view of emotional arousal. Brain changes in CBT for obsessive–compulsive disorder are "due to activation of relevant basal ganglia, cingulate, and OFC [orbito frontal cortex] circuits during exposure and habituation to anxiety-provoking stimuli, thereby permitting the formation of novel (and more adaptive) cortical and subcortical neural patterns of stimulus-linked information processing" (Ilardi & Feldman, 2001, p. 1077).

The proper use of many of the techniques and methods described in this book requires emotional arousal. The more procedures are applied in moments of affective arousal, the more they will take hold or stick.

APPLYING THE TECHNIQUES IN GROUP AND FAMILY FORMATS

Most of the procedures in this book can be readily applied in group and family formats as well as in individual therapy. Individual case formulations need to dictate if and when a group and/or family format will be used. As with individual therapy, integrating the procedures with therapeutic processes is essential, as is applying them in the context of emotional arousal. However, cognitive therapy becomes more complicated when there are more people in the room. In such cases, it is important that each person be an active participant. Everyone should be involved! This requires you to be able to divide your attention between the various people in the room.

When there are multiple people in the room, each person's thoughts, feelings, and behaviors have an impact on those of the others. Family CBT recognizes the reciprocal interaction of family members' cognitions, emotions, actions, and relationships (Dattilio, 1997, 2001). Friedberg (2006, p. 160) noted that the "family environment is the milieu where children and parents' cognitions are played out." Family processes initiate, exacerbate, and maintain dysfunctional thinking, feeling, and action patterns. More specifically, families may collude to avoid negative affect (Barrett, Dadds, & Rapee, 1996; Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004). Ginsburg et al. (2004) commented that parents may see anxiety as catastrophic, view their parental value and competence in being able to protect their child, and inadvertently undermine their youngsters' fragile sense of self-efficacy.

Because all the family or group members have thoughts and feelings about what is going on in the room, comparing thought records is an excellent idea. Some people may have similar records while others may have records that are uniquely personal. Dealing with points of convergence and divergence makes group and/or family CBT come alive.

The group or family context is a robust circumstance for testing, modifying, and/or problem solving dysfunctional beliefs. For example, children with interpersonal anxieties about negative evaluation, humiliation, and/or embarrassment will emit characteristic cognitions, emotions, and behaviors in the group context. This allows for the immediate therapeutic processing and modification of these problematic states. Similarly, families challenged by an identified patient will show the therapist their distress and reveal dysfunctional patterns. When problems become more transparent, you can more readily intervene with cognitive and behavioral procedures to help patients change their actions, thoughts, and feelings. The family therapy context allows the members to col-

lectively witness and participate in each other's change process. Finally, applying CBT with groups and families may further the generalization process by teaching patients to use their skills in relevant circumstances.

A WORD ABOUT OUR TRANSCRIPTS

In order to protect the confidentiality of our patients, all of the case examples are fictionalized or disguised clinical accounts. They represent a combination of our many cases.

CONCLUSION

This book's modular format offers some of the guidance of a manualized approach, with flexibility for selecting and modifying interventions to match individual clients' case conceptualizations. Each module's techniques and procedures can be applied to numerous symptom sets at various points in therapy. This approach allows clinicians to choose interventions based on patients' age, developmental level, presenting problem, severity of symptoms, interests, intervention modality, and skill set. We outline tools for clinicians to make informed choices about how to proceed in treatment. The creativity in the drawings and presentation style of these interventions keeps patients interested and engaged in treatment, as well as gives clinicians more options to choose from, adding to the individualization of the treatment protocol. By using eye-catching illustrations and interesting metaphors, the ideas come alive for clinicians and patients.

BOX 1.1. Tips for Using the Techniques in This Book

- Embed *everything* in a cognitive-behavioral case conceptualization.
- Maintain the traditional session structure.
- Integrate procedures with psychotherapeutic processes such as therapeutic alliance, collaboration, and guided discovery.
- Remain emotionally alert and present when implementing procedures.
- Apply the techniques in the context of emotional arousal.

BOX 1.2. Tips for Using These Techniques with Families and Groups

- Get everyone actively participating by dividing your attention among the individuals.
- Each person's thoughts, feelings, and behaviors affect those of everyone else.
- Be wary of individuals colluding to avoid negative affect.
- Make effective use of the interpersonal contexts by applying thought diaries, cognitive restructuring methods, and experiential learning.