Therapeutic Exercises for Children:
Professional Guide

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CHAPTER 1

Introduction: Goals of This Guidebook

There is a proliferation of workbooks containing various and sundry techniques for clinical work. Practicing therapists tend to be a pragmatic group who enjoy acquiring new tools and applying them in their clinical work. Many workbooks present useful skills but fall short by neglecting vicissitudes involved in using the skills. *Therapeutic Exercises for Children* and this user guide present coping techniques but also discuss many clinical issues related to the workbook techniques.

This guidebook to *Therapeutic Exercises for Children* serves several purposes. First, the guide offers direction to therapists adopting the workbook. Specific examples illustrating ways to apply the techniques are explicated. Secondly, the guidebook provides suggestions and recommendations which enable individualized treatment for specific children. Thirdly, the book alerts readers to salient therapeutic issues, possible pitfalls, and methods for managing various difficulties. Fourth, the guidebook steers therapists through knotty areas by providing contraindications and indications for using *Therapeutic Exercises for Children*. Moreover, the guidebook offers recommendations on cultural adaptations and highlights several central issues relevant to childhood anxiety and depression.

The guidebook functions as a robust resource for additional supporting references. Cognitive-behavioral techniques and the theory underlying their applications are briefly summarized. While the guide provides a skeletal description of cognitive-behavioral procedures with children, it is not a comprehensive text on cognitive-behavioral approaches with children. Accordingly, readers are referred to many recommended resources included in the guidebook.

Therapeutic Exercises for Children is a cognitive-behaviorally based workbook that includes exercises, activities, thought diaries, and thought testing procedures. The materials are designed for 8- to 11-year-old children who are experiencing symptoms of depression and anxiety. Many of the workbook exercises and activities were created for and developed in the Preventing Anxiety and Depression in Youth (PANDY) Program sponsored by the Wright State University School of Professional Psychology in Dayton, Ohio. The PANDY Program is a cognitive-behaviorally based coping skills program for elementary school children who are at-risk for depression and anxiety. The PANDY Program primarily consists of clinic-based and school-based skill training groups. While the exercises were initially implemented with groups of children, they can nonetheless be easily delivered through individual treatment.

THEORETICAL FOUNDATIONS

Therapeutic Exercises for Children adopts a coping skills approach to intervention. "Coping," Kendall (1992) wrote, "is the ability to experience a less than optimal situation, face it and accept it, and proceed forward with an adaptive response" (p. 236). Accordingly, the guide and the accompanying workbook focus on helping children manage distressing situations, modulate their mood, and access skills that facilitate productive responses. *Therapeutic Exercises for Children* and the PANDY Program are based on cognitive-behavioral therapy (CBT). More specifically, the workbook and manual are based on the model of cognitive therapy espoused by Aaron T. Beck in his many writings (Alford & A. T. Beck, 1997; A. T. Beck, 1976; A. T. Beck, Emery, & Greenberg, 1985; A. T. Beck et al., 1979). Moreover, work by Kendall and his colleagues (Kendall, 1990; Kendall et al., 1992, 1997; Kendall & Treadwell, 1996). Seligman and his colleagues (Jaycox et al., 1994; Seligman et al., 1995), and Silverman and her colleagues (Silverman, Ginsburg, & Kurtines, 1995; Silverman & Kurtines, 1996) have fundamentally shaped the material included in the workbook and manual. Finally, workbooks for children by Kendall (1990) and Vernon (1989, 1998) as well as the outstanding workbook and manual for adults by Greenberger and Padesky (1995) inspired this format.

The cognitive model of psychopathology states that when children are depressed or anxious, there are changes in five important and interrelated areas (A. T. Beck, 1985; Padesky, 1986). Environmental stres-

sors such as peer rejection or moving from one school to another may occur. Physiological, mood, behavioral, and cognitive changes ensue and are connected to each other in such a way that a change in one sphere accordingly changes the other three domains. In cognitive therapy, intervention is directed at the cognitive and behavioral spheres. Since the areas are all causally interrelated, change in the cognitive sphere will influence behavioral, physiological, and affective symptoms.

Effective cognitive therapy is predicated on two crucial therapeutic leitmotifs: collaborative empiricism and guided discovery (A. T. Beck et al., 1979; J. S. Beck, 1995). Collaborative empiricism is characterized by a working relationship marked by active participation on the part of the child. The collaborative nature of the relationship allows children to be active agents in their own treatment. As a collaborator, the child is encouraged to provide direction and feedback to the therapist. Collaboration with the child is enhanced by checking in with the youngster during each phase of the treatment process. The empiricism component reflects the stance that the child's beliefs are hypotheses to be tested via data collection. Accordingly, therapists are advised to eschew the prior notion that the child's beliefs are automatically inaccurate (Alford & A. T. Beck, 1997). Accuracy is determined through collaborative data collection and analysis. By adhering to collaborative empiricism, therapists create a curious, questioning atmosphere where therapists and children are detectives checking out clues to problems and their solutions (Kendall, 1990; Kendall et al., 1992).

Guided discovery fuels the data collection and analysis process. In guided discovery, children build a data base upon which to evaluate their thoughts and feelings. The therapist acts as a coach during the guided discovery process. The elements of guided discovery include empathy, Socratic questioning, thought testing, and behavioral experiments. The goal in guided discovery is creating doubt where there was once certainty of belief (Padesky, 1988). The therapists' main task is creating a curious milieu in therapy rather than refuting beliefs or persuading the child to think what the therapist thinks. The more the therapist stimulates curiosity in the child, the more the child may be willing to experiment and take risks in therapy (Rutter & Friedberg, 1999).

Cognitive-behavioral therapy (CBT) with children is a structured and directive form of treatment (Knell, 1993). Most forms of CBT include agenda setting, eliciting feedback, and homework assignments (J. S. Beck, 1995). We encourage therapists using *Therapeutic Exercises for Children* to diligently adhere to agenda setting, eliciting feed-

back, and assigning homework. Chapter 4 deals explicitly with these processes.

Cognitive-behavioral therapy with children has a strong experiential emphasis (Knell, 1993; Ronen, 1997). However, many beginning therapists become overly enamored of techniques and neglect the importance of the experiential component. Perhaps, neglecting the experiential component of CBT is the reason so much therapy goes over children's heads. Maintaining an experiential focus makes abstract concepts real for children.

Neglecting cognitive-behavioral therapy's emphasis on experiential treatment can promote intellectualized or educational therapy. While there is a place for pure acquisition of information, the *Therapeutic Exercises for Children* materials are best applied to children's personal experiences. It is important that children learn to apply the coping skills in context of their own stressors and negative affective arousal. Thus, we recommend that therapists teach the skills acquisition *and* coach the children to experientially apply the skills in meaningful here-and-now contexts. Balancing acquisition and application of the skills is emphasized throughout this guidebook and *Therapeutic Exercises for Children*.

Therapeutic Exercises for Children is geared toward making therapy more fun for the child. In recent years cognitive-behavioral therapy has become more playful (Eisen & Silverman, 1993; Friedberg, 1996a; Knell, 1993; Silverman, Ginsburg, & Kurtines, 1995; Stark, 1990; Stark et al., 1996). Accordingly, we recommend that therapists who use the workbook present the material in an entertaining, fun, and engaging manner. There are numerous suggestions throughout the workbook and manual for ways to increase the fun quotient in therapy.

We recommend that therapists adopt a modular, gradually progressive stance toward treatment (Freeman, 1998). Each skill set represents a module and ideally each module builds upon previous ones. Therapists can design treatment modules that respect each child's individuality. The chapters on working with anxious and depressed children instantiate a modular approach to treatment.

The cultural adaptations and clinical indications and contraindications chapters guide therapists toward fitting the exercises to individual children's needs. The issues presented in these chapters promote therapeutic flexibility. The chapters on working with depressed and anxious children provide valuable information on the nature of these disorders in children, intervention planning, and managing various clinical issues with these populations. Therapists will find numer-

ous specific suggestions for using the workbook with individual children and children in groups. Finally, the parent* involvement and school-based intervention chapters describe ways to include parents and recommendations for conducting school-based groups using the *Therapeutic Exercises for Children* material.

*The terms *parent*, *mother*, *father*, *caretaker*, and *caregiver* are used interchangeably in this book to refer to the child's parents and other responsible caregivers.

CHAPTER 2

Indications and Contraindications

INTRODUCTION

Deliberate considerations of the indications for the *Therapeutic Exercises for Children* material individualize treatment and potentiate treatment success. Clinicians need to consider the child's presenting problem, comorbidity issues, degree of externalizing problems, severity/acuity of problems, chronological age, developmental considerations, family environment, and responsiveness to traditional cognitive-behavioral interventions when using these materials. In this chapter, we will alert therapists to the specific issues within each consideration.

NATURE OF PRESENTING PROBLEM

The *Therapeutic Exercises for Children* skills tend to work best with children who are experiencing anxiety and depressive states. More specifically, we recommend this material for children who have depressive spectrum disorders such as Major Depression, Dysthymia, Adjustment Disorder with Depressed Mood, and subclinical levels of depression. Additionally, the *Therapeutic Exercises for Children* approach is primarily suited to children with Generalized Anxiety Disorder, social anxieties, adjustment disorders with anxious moods, and subclinical levels of anxiety. The coping skills in *Therapeutic Exercises for Children* are not recommended as primary interventions for

externalizing disorders such as Attention-Deficit/Hyperactivity Disorder (ADHD), Conduct Disorders (CD), or other psychological disturbances such as Bipolar Disorder, Obsessive-Compulsive Disorder (OCD), Panic Disorder (PD), Posttraumatic Stress Disorder (PTSD), and so forth. However, therapists might think about the materials as an adjunctive treatment in some cases. If a skill set in the workbook could be applied to the depressive and anxious features of these children's problems, the *Therapeutic Exercises for Children* tools may be integrated into broader treatment packages that are primarily designed to treat these problems.

COMORBIDITY

Pure and uncomplicated depression and anxiety are relatively rare in childhood (Gotlib & Hammen, 1992). Consideration of comorbidity issues is important in determining treatment appropriateness. It is far more common for anxiety and depression to coexist with each other than with an externalizing disorder (Kovacs & Devlin, 1998). In fact, anxiety is 2 to 3 times more likely to be comorbid with depression than to be comorbid with a conduct disorder (Kovacs & Devlin, 1998). In a study of 8- to 13-year-olds, 41% of the sample had comorbid depression and anxiety (Kovacs et al., 1989). Last et al. (1992) found that 49% of the 5- to 18-year-olds in their study diagnosed with Overanxious Disorder had a comorbid depressive disorder. The high comorbidity between Major Depression and Generalized Anxiety Disorder in children may reflect shared genetic risk (Kovacs & Devlin, 1998).

Children with mixed anxiety and depression are likely to be characterized by more negative cognitions than children with either depression and anxiety alone (Malcarne & Ingram, 1994). Epkins (1996) found that socially anxious children and dysphoric children demonstrated specific cognitive distortions. For example, personalization (e.g., assuming too much self-blame) and overgeneralization (e.g., erroneously making far-reaching conclusions) were more common in anxious children than in depressed children. Selective abstraction (e.g., inaccurately attending to a negative detail while neglecting other information) was more common for the depressed children compared to their socially anxious counterparts. Heberlein, Lonigan, and Kistner (1997) found that negative self-concepts were associated with both anxiety and depression. They commented that physiological tension and hyperarousal were uniquely associated with anxiety whereas inac-

tivity, low excitability, and lack of enthusiasm were specifically associated with depression. Thus, addressing multiple distortions is critical when working with children experiencing both depression and anxiety.

Anxiety disorders are frequently comorbid with one another. Several authors (Beidel, Fink, & S. M. Turner, 1996; Silverman & Kurtines, 1996) concluded that since fear of negative evaluation is a common theme, Generalized Anxiety Disorder, Separation Anxiety, and Social Phobia can be classified as one group. Accordingly, fear of negative evaluation is a common treatment target for all three disorders. Focusing on fear of negative evaluation is a well-disposed therapeutic strategy in these cases.

Externalizing disorders such as conduct disorders, oppositional disorders, attention disorders, and substance abuse disorders may also accompany depression and anxiety (Birmaher et al., 1996; Curry & Murphy, 1995; Kovacs et al., 1997; Perrin & Last, 1997). Last et al. (1996) found that during a 4-year period, children with Attention-Deficit/Hyperactivity Disorder (ADHD) developed anxiety disorders at a rate equivalent to anxious children. Perrin and Last (1997) remarked that because ADHD children had frequent worries about school and friendship, they may be at an increased risk for anxiety disorders.

Curry and Murphy (1995) noted that substance abuse is likely more frequent among youngsters with higher levels of anxiety. Prepubertal depression is also associated with alcohol and drug use in adolescence and it seems to precede the substance abuse by 4.5 years (Birmaher et al., 1996). Not surprisingly, Manassis and Hood (1998) recommended that clinicians need to develop treatment plans that not only address anxious symptoms but commonly occurring depression, externalizing behavior, and parental anxiety as well.

In summary, anxiety and depression frequently accompany each other. Moreover, separation anxiety, generalized anxiety disorder, and social phobia are commonly comorbid. Externalizing disorders such as conduct disturbances, oppositional disorders, attention deficit disorders, and substance abuse disorders also have depressive and anxious features. The data on comorbidity have several clinical implications. Birmaher et al. (1996) noted that comorbidity increases the possibility of recurrent depression, lengthens duration, exacerbates suicide risk, truncates responsiveness to treatment, and increases the utilization rates for mental health services. Therapists must carefully evaluate which aspects of these problems will be intervention targets with the *Therapeutic Exercises for Children* materials. Fear of negative

evaluation cuts across several anxiety disorders and represents a core treatment target. Clinical flexibility is necessary in order to address the multiple cognitive distortions which characterize comorbid depression and anxiety. Further, sorting out the mood components associated with an externalizing disorder is essential.

DEGREE OF EXTERNALIZING PROBLEMS

As the comorbidity literature suggests, childhood depression and anxiety may be accompanied by other externalizing-type disorders such as Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder (ODD), and Conduct Disorder. Kovacs et al. (1997) reported that a concurrent externalizing disorder lengthens the duration of a dysthymic episode. Children who were diagnosed with a comorbid externalizing disorder had an average length of Dysthymic Disorder of 6 years whereas the length for a Dysthymic Disorder without an externalizing disorder was 3.7 years. This finding led Kovacs and her colleagues to conclude that "chronic depression may be exacerbated by and/or represent a way of coping with negative social reactions that conduct disturbances elicit" (Kovacs et al., 1997, p. 783). Finally, behavior problems may be a component of anxious or depressive states especially in younger children or children who have difficulty verbalizing their thoughts and feelings. Therefore, therapists must evaluate the degree to which externalizing problems contribute to the child's distress.

Therapeutic Exercises for Children is not designed as a primary treatment for ADHD, CD, or ODD. Moreover, children who are very angry or aggressive will not likely profit much from the *Therapeutic Exercises for Children* techniques. Clinical experience gained from the PANDY Program suggests these youngsters have more difficulty with these approaches. There is only one *Therapeutic Exercises for Children* skill specifically designed for anger management problems (e.g., *Surf the Angry Sea*). Accordingly, treatment packages specifically designed for angry and aggressive youngsters are indicated (Feindler & Ecton, 1986; Feindler & Guttman, 1994; Goldstein et al., 1987). Several *Therapeutic Exercises for Children* skill sets which facilitate identifying thoughts and feelings as well as the development of self-instructional dialogues can augment these other approaches.

SEVERITY/ACUITY OF PROBLEMS

Therapeutic Exercises for Children is intended for children experiencing mild to moderate distress. Thus, children who are experiencing severe and acute distress are not the most suitable clients. For example, while the *Therapeutic Exercises for Children* skills are helpful for pessimistic children, youngsters who are hopeless and suicidal need other types of intervention. Children who are in severe or acute distress may benefit from the *Therapeutic Exercises for Children* materials after their distress has modulated. The skills could be used to help maintain their level of functioning and preempt subsequent acute episodes.

CHRONOLOGICAL AGE

Therapeutic Exercises for Children is designed for children ages 8 to 11 years old. The language, cartoons, and metaphors are most suitable for these ages. While chronological age is an important consideration, there is considerable variability between children within this age range. In fact, variation within this age is more the rule than the exception. Therefore, clinicians are advised to weigh developmental issues as well as chronological age when considering using the *Therapeutic Exercises for Children* material.

DEVELOPMENTAL CONSIDERATIONS

Therapeutic Exercises for Children emphasizes developmental sensitivity. All the activities, exercises, and worksheets are constructed to make cognitive therapy principles more accessible to children (Friedberg et al., 1999). A problem common to all child psychotherapies is that treatment becomes too abstract and goes over children's heads. Consideration of emotional, cognitive, and linguistic development is required. Therefore, therapists should try to match developmental task demands with children's developmental capacities.

The *Therapeutic Exercises for Children* worksheets are geared to a 3rd-grade reading level. Children who do not read at this level will have difficulty with the material. While the reading difficulty is not an absolute contraindication, therapists must carefully consider children's reading and comprehension level. The *Therapeutic Exercises for Chil-*

dren material is heavily reliant on written and oral expression and reading comprehension. Children who do not read at the 3rd-grade level will have a harder time profiting from the exercises and worksheets. Moreover, these exercises may overly frustrate them and further lower an already fragile sense of self-efficacy. In some cases, therapists may consider reading the exercises and text material to the child. However, in our clinical experience, this is a relatively inefficient strategy since the child is unlikely to fully grasp the material.

Children's ability to translate their innermost thoughts and feelings into words is another developmental consideration. Rudimentary levels of emotional, cognitive, and linguistic development are required. Children who have problems putting words to their thoughts and feelings will have difficulty negotiating their way through the skill sets. Conversely, children who readily express their distress through words will have an easier time with the materials. Graduated tasks are especially important for youngsters with expressive difficulties, and more time and effort will be placed on helping these youngsters use their language to modulate their feelings and actions.

Frequently, the behavior problems associated with anxious and depressed children may be a function of their inability to translate their inner experiences into words. Younger children tend to express depression through more behavioral disturbances (oppositionality, somatic complaints) whereas older children tend to demonstrate more classically adult symptoms (Schwartz, Gladstone, & Kaslow, 1998).

Not suprisingly, it is typical to see more impulsivity and conduct problems in younger, depressed children. They have not learned to put words to their thoughts and feelings. Words mediate action and decrease the impulsive behavior. Older elementary school children whose depressive manifestations include behavior problems represent a different problem. These children either may lack capacity to translate their thoughts and feelings into words, lack the opportunities to develop these skills, or lack access to models or reinforcement sources which support expressing thoughts and feelings (Schwartz et al., 1998).

Evaluating the nature of children's expressive difficulties is critical. The alert clinician must use information gained in their analysis to decide how to most appropriately use the *Therapeutic Exercises for Children* materials with these children. If the problem is a skill deficit, graduated task assignments requiring successively increasing verbal skills are indicated. If the child fundamentally lacks the developmental capacity to turn feelings into words, more behavioral tasks which do not place a heavy reliance on verbal skills may be indicated. Fi-

nally, if the child has the skills and the capacity to translate thoughts and feelings into words but lives in a familial context that prohibits expression, adjunctive family treatment seems warranted.

FAMILY FUNCTIONING

Child psychotherapy is always conducted within a family context. Parents and other caregivers hold many reinforcements for children and establish contingencies for these rewards. Therefore, family members need to be involved in any ongoing child psychotherapy. Chapter 8 includes suggestions for enlisting and maintaining parental involvement in the treatment process. Although *Therapeutic Exercises for Children* is not a set of family therapy techniques, therapists who consider the level of family functioning when using the skills, techniques, and exercises are likely to be more effective.

Therapeutic Exercises for Children will likely work well as a stand-alone treatment with children whose family functioning is relatively nonproblematic. For example, family systems characterized by violence, sexual victimization, substance abuse, and strident levels of conflict are unlikely to support gains made by the child in individual therapy. Moreover, enmeshed systems where psychological boundaries are blurred or constricted systems where boundaries are too rigidly defined will also truncate children's gains. In short, if the family system problems seem primary, family therapy is indicated. Some *Therapeutic Exercises for Children* techniques may be used as adjunctive treatments to family therapy to help individual children modulate their mood states.

Psychological disturbance in a parent is a major risk factor for anxiety and depression in children (Beardslee & Wheelock, 1994; Bell-Dolan, Last, & Strauss, 1990; Lee & Gotlib, 1989). Accordingly, clinicians are well-advised to address any parental psychological disturbance. In some cases, recommendations for individual treatment for the parent may be warranted. Limit-setting and parental consistency are additional treatment issues. Many parents are inconsistent with their disciplinary strategies. Indeed, parental inconsistency may contribute to the behavior problems associated with some anxious and depressed children (Beardslee & Wheelock, 1994; Manassis & Hood, 1998). Parental inconsistency can sabotage work with *Therapeutic Exercises for Children*. Therefore, therapists are advised to help parents become better contingency managers.

USE WITH MORE TRADITIONAL FORMS OF COGNITIVE-BEHAVIORAL THERAPY

Traditional applications of cognitive-behavioral therapy abound and enjoy considerable empirical support. Treatment packages for depressed children (Seligman et al., 1995; Stark et al., 1996) are well-constructed and empirically tested. Additionally, cognitive-behavioral approaches for anxious children (Albano & Barlow, 1996; Albano & DiBartolo, 1997; Beidel & S. M. Turner, 1998; Kendall et al., 1992, 1997; Silverman, Ginsburg, & Kurtines, 1995; Silverman & Kurtines, 1996) are similarly well-established. Based on children's responsiveness to the traditional cognitive-behavioral methods, clinicians may elect to use *Therapeutic Exercises for Children* tools in conjunction with these approaches or in lieu of them.

The *Therapeutic Exercises for Children* materials can effectively augment other treatment packages. Due to theoretical and conceptual similarities, *Therapeutic Exercises for Children* techniques may be combined with most other cognitive-behavioral treatment approaches. For example, the materials in *Therapeutic Exercises for Children* may be easily integrated into the self-control components of specific treatment programs such as Beidel and S. M. Turner's (1998) social effectiveness therapy for social phobia or Silverman and Kurtines' (1996) pragmatic approach to anxiety disorders. Mixing *Therapeutic Exercises for Children* skills into empirically based treatment recipes may expand clinicians' repertoires and foster flexibility. Thus, we strongly recommend attempting to integrate the *Therapeutic Exercises for Children* tools with other treatment options especially when specific, empirically tested treatment approaches for discrete disorders (social phobia, obsessive-compulsive disorder, etc.) exist.

CONCLUDING REMARKS

Flexible application of workbook exercises is recommended. Mindful consideration of the indications and contraindications promote facile implementation. *Therapeutic Exercises for Children* can be used as a stand-alone treatment or in combination with other treatment strategies. Therapists' choice regarding the proper application of the material is best made after considering the salient issues presented in this chapter.

The *Therapeutic Exercises for Children* materials represent core treatment components for children ages 8 to 11 years old experiencing mild to moderate depression. In these instances, the level of acuity is low and the family functioning is sufficient to support treatment gains. Further, the youngster demonstrates minimal impairment due to problems with anger or aggression. The child who reads at a 3rd-grade level and is relatively able to translate thoughts and feelings into words is a good candidate for the workbook.

Therapeutic Exercises for Children can supplement treatment in numerous other instances. Based on therapists' thoughtful selection of skill sets, the exercises and activities may be combined with other treatment packages aimed at specific disorders such as Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, Obsessive-Compulsive Disorder, and Social Phobia. The exercises may be used adjunctively in family therapy. In sum, alert therapists review the exercises, select the ones that seem most appropriate at a particular phase of treatment, and then apply the technique in session.