Adjust and adapt

Jessica McClure invites us to consider what might need to be modified (or not) to make CBT attractive and workable with youth

Brett is a 32-year-old business executive with anxiety symptoms. He worries about his job performance, and experiences sleep disturbance and nausea the night before his weekly staff meetings. Brett often worries that his colleagues will view his comments during the meetings as 'stupid' or 'ignorant'.

Many therapists would agree that a cognitive approach would be beneficial in conceptualising and treating Brett's anxiety. Cognitive-behavioural techniques for identifying thoughts and feelings, anxiety management, testing thoughts/assumptions, and modifying beliefs would likely decrease Brett's anxiety symptoms and improve his functioning.

Now imagine that instead of a 32-year-old man, Brett is a 10-year-old boy with anxiety. He worries about his school performance, and he often has stomachaches the night before a test. Brett worries that his classmates will think he is 'stupid' if he answers a question incorrectly in class. A cognitive therapist working with adult-Brett would likely feel confident in applying the cognitive model to adult-Brett's treatment. But what about 10-year-old Brett? Therapists treating the young Brett with a cognitive approach may be faced with several questions:

- Would 10-year-old Brett be able to benefit from a cognitive-behavioural approach?
- What modifications to the approach may be needed?
- How will Brett's developmental level impact treatment?
- What role does family involvement play when working with a child this age?

These are important considerations for a therapist, but they do not prevent or hinder effective cognitive-behavioural treatment of 10-year-old Brett. In fact, cognitive therapy has been applied to children for a number of years[1]. And by considering the above questions, a cognitive therapist will have a more complete conceptualisation of the case and be able to use the information to establish an appropriate treatment plan.

Individualising the approach

Cognitive therapy should not be applied in the same manner for every client. Each effective technique may need to be explained and presented to various clients in different ways to facilitate comprehension, engagement in the tasks and follow-through. Clinicians regularly tailor treatment to fit the individual client's context. A therapist treating a 20-year-old college student or a 65-year-old retiree with depression would certainly tailor treatment to each individual. The therapist may choose various metaphors or strategies based on the client's symptom profile, individual presentation and cultural background, while still maintaining the tenets of cognitive-behavioural therapy. The importance of doing so for youth is similar, but may seem more foreign to clinicians who have focused their cognitive work with adults. Numerous books provide fun and creative applications of cognitive therapy interventions for children and adolescents[1,2,3]. Using interventions that include increased activity, fun worksheets, and meaningful metaphors for the young person will help make the cognitive approach a good fit for most of them.

Starting with the moment the child walks into a therapist's office, there is one clear difference from

most adult clients who present for treatment. That is, treatment with young people is most often initiated by someone other than the child – such as a parent, teacher, pediatrician or court. Thus, children are not typically in control of when treatment starts, or when it terminates[3]. Therefore:

- it is important that the therapist assesses the child's perceptions of treatment, and works to establish rapport and collaborative goals to assist in getting the child invested in his or her treatment
- cognitive therapy interventions with children will be enhanced by keeping the sessions active, which in turn increases attention to and recall of strategies, improving the likelihood of higher motivation and follow-through
- at the same time, context and environment are important considerations, as they provide reinforcement and/or punishment, and therefore can play key roles in the maintenance and generalisation of therapy skills, behavioural patterns and cognitive patterns[3]
- keeping in mind that age is a nonspecific variable[4] may help the clinician who feels anxious about embarking on cognitive therapy with younger clients.

Key components of cognitive therapy must be upheld

Although some differences in cognitive therapy with children compared to adults are present, many aspects are quite consistent with adult cognitive treatment[5]. The approach remains

- problem focused
- active
- goal driven.

When beginning treatment with a child or an adult, the therapist will be working on the case conceptualisation, which will then guide the treatment plan and choice of interventions. The case conceptualisation assists the therapist in choosing specific techniques, predicting and overcoming obstacles, and applying techniques in the most beneficial pace and manner. Thus, the case conceptualisation will help the therapist choose which techniques to use when, as well as adapt the strategies to fit the individual child[3]. The basic components of the cognitive model should be considered in conceptualising the case and developing a treatment plan, with age and developmental level being just two of the many variables that impact the child's functioning.

Collaborative empiricism and guided discovery

Two key components of cognitive therapy – collaborative empiricism and guided discovery – are processes through which interventions are adapted to the individual client. Collaborative empiricism refers to the way the cognitive therapist works together with the child in this data-based approach. Guided discovery involves the therapist facilitating the process of the child creating different explanations. Guided discovery and collaboration must be modified to fit the case conceptualisation. For example, younger children will require lower levels of collaboration and guided discovery, while older children may be more ready for higher levels of these components. The levels can be adjusted, based on the client's culture and views about questioning, the child's frustration tolerance, stage of treatment and acuity of symptoms[3]. Of course, collaborative empiricism and guided discovery are important aspects of cognitive therapy with any client – child or adult.

Socratic questioning

Under the cognitive therapy approach, a Socratic method of questioning is used to discover the database for a child's assumptions and beliefs. Socratic dialogues require a gentle and curious stance and ongoing assessment of the child's responses, level of distress, and frustration, as well as consideration of cultural variables and developmental issues. The Socratic method can be applied to children and adolescents of various ages, presenting problems and levels of distress. In addition, the child's maturity level and response to questions, as well as cultural context, will guide the therapist in his or her use of metaphors, crafts and analogies while constructing a dialogue.

Metaphors

Adaptations to cognitive therapy for clients of various ages often come into play when the therapist is choosing metaphors. Metaphors help the therapist explain cognitive techniques in a way the child or adolescent is more likely to understand, be interested in and remember. Choosing meaningful metaphors for youth can be a challenge, as it requires some knowledge of current trends and fads. However, the youth themselves are a good resource for determining what may be a meaningful metaphor. A clinician who demonstrates curiosity about the child's interests and experiences not only facilitates rapport building, but also gathers data for meaningful examples and metaphors to be included in the treatment.

Carla, a 15-year-old with depression, mentioned early in treatment that she disliked playing volleyball and basketball, but enjoyed gymnastics and dance. So sports metaphors tied to her specific interests were more meaningful to her than using examples that included referees and teams. Similarly, 11-year-old Alexa expressed no interest in sports, but was a self-described 'computer-wiz'. Her interests provided useful data to assist the therapist in giving meaningful examples. A therapist working with Alexa might explain cognitive modification techniques using metaphors that include writing a new computer program, whereas the same strategies might be explained to Carla with metaphors or analogies

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that included designing a new dance routine. Such examples and analogies will be more likely to catch the child's or adolescent's attention, and thus make them more likely to recall and use the discussed strategies.

Session structure

Cognitive therapy typically follows a basic session structure. All the components are important to the cognitive approach, but they can be applied in a flexible manner. Session structure offers a template for treatment and can make the treatment more collaborative, as well as goal focused. The components of cognitive therapy session structure are as follows:

- Mood check-in
- Homework review
- Agenda setting
- Session content
- Homework assignment
- Eliciting feedback.

Mood check-in

Mood check-in is the first component of the session structure[6], whether working with adults or children. The mood check-in quickly communicates how the child is feeling, which may impact decisions such as agenda items for the session, as well as what level of collaboration may be needed during certain portions of the session. Rather than a verbal check-in ('What has your mood been like this week?'), children often benefit from creative feeling identification and rating tasks, such as drawing a feeling face, creating and using a feeling-watch, or pointing to a picture of the mood they are feeling[3].

Consider nine-year-old Daniel, for example. Daniel quickly withdrew when asked open-ended questions about his mood (eg 'How have you been feeling this week?'). Such questions seemed to lead to Daniel shrugging his shoulders, avoiding eye contact and sometimes becoming irritable. By starting with a nonverbal mood check-in, Daniel was able to communicate how he was feeling in a more comfortable manner. Although he was bright and had the language skills to discuss his mood, his discomfort with doing so was an obstacle. By considering Daniel's skills and comfort level in the case conceptualisation, the therapist determined that a nonverbal mood check-in might be a more effective and comfortable approach for Daniel. The specific method for check-in can be determined in a collaborative manner. Older children with higher frustration tolerance and verbal skills may respond to open-ended questions such as, 'How should we rate how strong that feeling is?' Younger children, with more acute symptoms, may benefit from being given a choice between two more specific options: 'We can rate the feeling from 0-100 or from 1-10. Which way would work best?'[3]

> "Older children with higher frustration tolerance and verbal skills may respond to open-ended questions while younger children may benefit from being given a choice between two more specific options"

Homework review

After the mood check-in, homework review is a common second step in the cognitive therapy session. Homework review communicates that homework is a key component to treatment, as well as providing opportunities for the therapist to positively reinforce the child's work/task completion[6,7,8]. This portion of the session involves collaboratively reviewing whether the assignment was completed, the content of the responses, and the child's reaction to the tasks. Homework and homework review provide opportunities to practise therapy techniques.

By including parents in homework tasks, the therapist can increase parental awareness of therapy strategies, as well as provide opportunities for parents to prompt and support their child[9]. Parental involvement will increase follow-through since many children need parental assistance and struggle to work independently, and older children/teens may need external motivators or rewards to complete the tasks.

Agenda setting

The next component of the cognitive therapy session involves listing and prioritising the topics or tasks to be completed during the session. As with the other session components, working collaboratively with the young person on agenda setting is important. Agenda setting is likely a new task for many youth, and a Socratic dialogue is often used to assist. Children may be reluctant or unsure of identifying agenda items, which could become an item itself. The therapist's modelling of agenda setting can assist with skill building[3].

Teri was a 14-year-old girl who often responded 'I don't know' when asked about what to put on the agenda. Seventeen-year-old Isaac often started sessions by 'launching' into descriptions of recent events or stressors. In both situations, it is tempting for some therapists to steer away from agenda setting. With the child who struggles to identify specific items, agenda setting can take longer and therefore may be mistakenly viewed as a 'waste' of time. For the talkative adolescent, some therapists may worry about damaging rapport by cutting off the client. By using a kind, goal-directed approach, this can be avoided. So, as Isaac begins a passionate description of a fight at last night's soccer game, the therapist may state, 'I can tell this is a very important issue for you, would you like this to be our first agenda item? How much time should we set aside for this item? What other items should we cover today?' Friedberg and McClure[3] outline specific questions that can help therapists address a child's difficulty setting an agenda:

- What are the pros and cons of setting an agenda?
- What do you gain by setting an agenda?
- What do you gain by not setting an agenda?
- What do you lose by setting an agenda?
- What do you lose by not setting an agenda?

Session content

It is during the session content that specific agenda items are addressed through the use of Socratic questioning, behavioural experimentation, problem solving, identifying automatic thoughts and thought testing[6]. Creative adaptations to traditional adult techniques have been used with children and adolescents of various ages and presenting problems. Active, engaging metaphors, games, stories, and worksheets bring effective cognitive techniques alive for these youth. For example, a child may enjoy pretending to be a 'private investigator' looking for clues during thought testing, or making a 'pizza' responsibility pie[3].

Assigning homework

Therapists must have a clear purpose for each therapy homework assignment. Tasks that are not meaningful, or if the meaning is not adequately communicated to the child, are less likely to be completed. It is important that clinicians keep in mind the collaborative approach when assigning homework. This may be particularly important with adolescents, who may be reluctant to complete tasks 'assigned' to them compared to tasks they have come up with or at least participated in generating[10]. Again, the importance of case conceptualisations is highlighted when assigning homework. The case conceptualisation can assist the therapist in identifying cultural or family variables that may either support or not support completion of the tasks. In many cases, training parents in ways to provide praise and support for homework completion increases success.

Eliciting feedback

A key part of keeping cognitive therapy collaborative is eliciting and incorporating the client's feedback in the session. This component poses challenges when working with some children and adolescents, who may have been taught not to question adults. Eager-to-please youth may be afraid of rejection or reprimand for criticising the therapist. Communicating acceptance, and allocating enough time for feedback, can help facilitate the process. For example, 13-year-old Sarah was a 'rule follower' and feared letting others down. When feedback was elicited at the end of a session, Sarah stated: 'It was a great session, I loved everything.' When such statements appear less than sincere, the therapist can try querying with questions such as:

- If there was something you did not like, would you tell me?
- What might happen if you said something negative?
- How would you feel if you shared something you disliked?

In the case of Sarah, the therapist learned that Sarah feared 'getting in trouble' if she shared that she did not like having to write down her thoughts and feelings. Problem solving was targeted, and a plan was made for Sarah to keep a journal of thoughts and feelings on the computer, rather than in a notebook. The therapist's reaction communicated a true desire to solve the problem, and reinforced Sarah's openness.

Conclusion

It is clear that cognitive therapy is not only effective for a range of adult mental health issues, but that it can also be effectively applied to many childhood disorders. By keeping the core tenets of cognitive therapy, and remaining flexible in applying the techniques within the context of each individual case, therapists will be successful in applying cognitive therapy to individuals of many different ages, backgrounds and presenting problems. ■

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