

# Where's the Beef? Concrete Elements When Supervising Cognitive-Behavioral Therapy With Youth

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The 1980s iconic Wendy's commercial starring Clara Peller as an irascible elderly woman demanding, "Where's the beef?" to perplexed fast food workers is a memorable image. Nowhere in our fast-paced professional lives as clinician-educators is the search for meaty basics more important than in supervision. Accordingly, this brief Clinical Perspectives article highlights 4 essential points: cognitive-behavioral therapy (CBT) with youth is different than with adults; patient formulation is key; adhering to the Socratic method is imperative; and exposures and experiments are indispensable procedures too infrequently applied.

## CBT WITH YOUTH IS NOT PSYCHOTHERAPY WITH SHORT ADULTS

An early, important mentor of mine, Dr. Eric Minturn, emphasized the principle that clinical work with children is different from work with adults when he joked, "It is very hard to contemplate the philosophical contributions of Binswanger when you are sitting in a child-sized chair." CBT with children necessarily looks unlike CBT with adults for various reasons. Few children are self-referred for treatment. Rather, they are brought to therapy by powerful others or institutions who see their behavior as problematic. In consequence, they commonly enter the process equating it with punishment. Once they are in treatment, talking about private emotional experiences with an unfamiliar adult authority figure is quite understandably scary. Further, they typically do not know the difference between psychiatrists or psychologists (e.g., "feelings doctors") and their pediatricians (e.g., "shot doctors"). Frequently, children worry that if they say something is wrong, then they might have to taste some nasty medicine or face a needle.

Children also possess different language, social cognitive reasoning, emotional competence, and perspective-taking abilities than adults. Moreover, their brain and neuro-circuitry are still early in their development. Remembering these capacities are dimensional (e.g., on a continuum) rather than categorical (e.g., either-or) factors is important. Children live in and must navigate complex contexts such as families, schools, and neighborhoods. Most children learn best through hands-on experiences and prefer action to discussion.

These distinctions yield specific practice implications designed to make CBT more child friendly and accessible. With younger children, CBT adopts a playful tone, including

exercises augmented by cartoon graphics, metaphors, various media and technology, and fun activities. Contextual variables are addressed by including caregivers in family CBT or "coaches" in child-focused treatment and regular collateral consultations with systems such as schools.

## PATIENT CONCEPTUALIZATION: THE NUCLEUS OF PRACTICE

CBT is defined by its theoretical paradigm and not by any single technique or set of techniques.<sup>1</sup> The approach is rooted in the biopsychosocial model emphasizing learning theory and including unique concepts such as the hierarchical organizational model and the content-specificity hypothesis (CSH).<sup>1,2</sup> The CSH and hierarchical organizational model are robust constructs that double as particularly handy clinical guides. Table 1 presents a brief summary and description of these constructs.

After residents learn these focal concepts, teaching patient formulation continues with helping child psychiatrists categorize the information they already collect into theoretically meaningful clusters. The conceptual model acts as an organizational template that links disparate data points together. The paradigm integrates developmental background, cultural context, learning history, and causally interactive symptom domains, such as physiologic functioning, emotions, cognitions, and behaviors. The process resembles a pattern recognition task that becomes operationalized by identifying common themes and translating them into a simple patient profile simply summarized by "I \_\_\_ in a \_\_\_ world where people \_\_\_\_."<sup>3</sup> A recent supervisee conceptualized a very depressed adolescent female patient in the following way: "I am invisible, alone, and don't matter in a cold, distant world where others are harsh, critical, and judgmental." Beginning CBT clinicians are encouraged to record these provisional statements in the chart, refer to them before sessions, and amend these hypotheses when new data disconfirm them.

Patient conceptualization guides selection of treatment targets, sequencing of interventions, and ways to address avoidance and treatment noncompliance. In the example presented earlier, the resident was taught to identify the most emotionally relevant part of the formulation for this patient (e.g., "I'm invisible"), capture and re-engineer automatic thoughts related to this theme, and eventually craft behavioral experiments to reinforce more adaptive beliefs. Although treatment was successful, it was not without

**TABLE 1** Summary of Concepts and Procedures

Element	Purpose/Definition	Example	Resource
Developmental adaptations	Modifications to standard procedures and processes to make CBT more accessible to younger patients	Workbooks, games, activities, cartoons, playful applications	Friedberg RD, McClure JM, Garcia JH. <i>Cognitive Therapy Techniques for Children and Adolescents</i> . New York: Guilford Press; 2009.  Kendall PC, Hedtke KA. <i>Coping Cat Workbook</i> . 2nd ed. Ardmore, PA: Workbook Publishing; 2006.  Stallard PC. <i>Think Good, Feel Good: A Cognitive Behavioural Workbook for Children and Young people</i> . Chichester, UK: John Wiley; 2002.
Hierarchical structural organizational model	Explains layering of different tiers of cognitive structures and products according to their emotional intensity, learning history, and accessibility  Automatic thoughts lie at the outermost stratum tied to the lowest degree of emotional intensity, situational specificity, and easy accessibility. They are situationally specific and in general can be accessed by asking, "What is going through your mind?" at the moment of a mood shift.  Schemata are linked to individuals' core identities, developed over time, and loaded with supreme emotional intensity. Schemata are always absolutistic, and most individuals have positive and negative schemata.	Automatic thoughts: I will never get into college. I am stupid. I am an ugly dork. I will become an old cat lady living alone in a smelly home. People are cold and critical. Others are mean and nasty. No one will ever approve of me. Schema propelling the automatic thoughts: I am an unlovable loser who lives in an isolated world where others reject me.	Beck JS. <i>Cognitive Therapy: Basics and Beyond</i> . 2nd ed. New York: Guilford Press; 2011.  Beck AT, Rush AJ, Shaw BF, Emery G. <i>Cognitive Therapy for Depression</i> . New York: Guilford Press; 1979.
Content-specificity hypothesis (CSH)	The CSH posits that different emotional states are marked by distinct cognitive content.  Anger = hostile attributional biases, perceptions of unfairness, violation of personal imperatives, and labeling others.  Anxiety = overestimation of the magnitude and/or probability of danger, neglect of rescue factors, ignoring coping resources.	Situation: got an 81 on a test Feeling: depressed Thought: I am an idiot  Situation: my mom took away my cell phone and all screen privileges Feeling: angry Thought: This is totally unfair. She is a controlling b___.	Beck AT. <i>Cognitive Therapy and the Emotional Disorders</i> . New York: Penguin; 1979.

**TABLE 1** Continued

Element	Purpose/Definition	Example	Resource
	<p>Depression = negative views of self, others and experiences, and the future.</p> <p>Panic = catastrophic misinterpretation of normal bodily sensations.                      Social anxiety = fear of negative evaluation.</p>	<p>Situation: going to my first tennis team meeting                      Feeling: anxious                      Thought: This will be awkward. I won't know what to do, and the other kids will think I am weird.</p>	
Socratic methods (SM)	<p>The SM is based on the empirical and phenomenological roots of CBT. It is designed to help young patients craft their own conclusions. Rather than interpreting experiences for them, therapists adopt a curious stance propelled by the search for alternative explanations.</p> <p>The SM transcends disputation and refutation, focusing instead on fostering cognitive dissonance through guided discovery.</p>	<p>Types of SM include:                      Investigating the evidence.                      Pursuing alternative explanations                      Mitigating catastrophic predictions                      Exploring universal definitions                      Completing cost-benefit analyses</p>	<p>Overholser JC. Elements of Socratic questioning: I. Systematic questioning. <i>Psychotherapy</i>. 1993;30:67-74.</p> <p>Overholser JC. Elements of Socratic questioning: II. Inductive reasoning. <i>Psychotherapy</i>. 1993;30:75-85.</p>
Exposures and experiments	<p>Young patients put their acquired skills into action by completing behavioral experiments and exposures. In this way, they learn to tolerate their discomfort. These procedures change behavioral patterns, rigid thinking, and perceptions of emotions themselves. Children and adolescents learn to persist and engage in productive action despite their distress.</p>	<p>Fears of contamination: touching contaminated surfaces                      Social anxiety and fear of negative evaluation: volunteering to do an improvisational theater exercise in front of a group                      Generalized anxiety: reading through a newspaper highlighting frightening events                      Anger or aggressive behavior: tolerating a peer's criticism</p>	<p>Peterman JB, Read KL, Wei C, Kendall PC. The art of exposure: putting science into practice [published online ahead of print March 12, 2014]. <i>Cogn Behav Pract</i>.                      Kendall PC, Robin J, Hedtke K, Suveg C, Flannery-Schroeder E, Gosch E. Considering CBT with anxious youth: think exposures! <i>Cogn Behav Pract</i>, 2005;12:136-150.</p>

Note: CBT = cognitive-behavioral therapy.

bumps in the road. The patient tested the resident with initial noncompliance and emotional avoidance. The resident navigated through these crucibles by using the formulation. In consequence, she was able to elicit and modify the patient's automatic thoughts about the therapy and thoughts rooted in overgeneralized summations of others as distant, harsh, and critical that buttressed the avoidance.

Completing a daily thought record with young patients seems like a deceptively simple task without full appreciation of the CSH. However, if child psychiatrists attempt the procedure without grasping the CSH, then patients and therapists likely will be left unsatisfied. Reviewing a daily thought record without considering the CSH risks focusing on emotionally peripheral and intellectually sanitized assumptions. There cannot be a missing link between thoughts and feelings, so supervisors should work with trainees to match feelings with congruent cognitive content.

## POWERING GUIDED DISCOVERY THROUGH SOCRATIC METHODS

Clinicians learning CBT often try to get young patients to simply think something else when conducting cognitive restructuring. This practice tends to be frustrating to therapists and off-putting to patients. Meaty CBT supervision focuses on teaching trainees to scaffold a systematic Socratic dialog, which prompts a self-discovery process in which children form their own conclusions. Socratic methods and different examples of Socratic questions are described and listed in Table 1.

The first step is appreciating foundational evidence by genuinely grasping young patients' points of view and then becoming curious about how they reached a conclusion. The basis for the belief is revealed, the patient feels understood, and the initial footstone for the Socratic path is laid. Once residents learn this step, they are ready to cast reasonable doubt on patients' appraisals through gentle, often playful questions designed to broaden perspectives. The perspective-flexing process then concludes with juxtaposing the confirming data alongside the disconfirming evidence to spark cognitive dissonance or reasoned doubt.

Below is a brief example of a hypothetical Socratic dialog with a 12-year-old female patient struggling with anxious and depressive symptoms.

Therapist: "Julia, would it be OK if we took a closer look at your belief that you are a weak baby who will never amount to anything?"

Julia: "I guess."

Therapist: "So first, what is it that someone who is a weak baby and won't amount to anything does that you would never do?"

Julia: "Hmm ... I guess they cry all the time. I only cry a little. They probably would stay home all the time and never do anything without their mom and dad. They would have their parents do their homework for them ..."

Therapist: "I'll write all this down on this sheet. Here's another question. What do you do that a weak baby would never do?"

Julia: "I don't know. I'm not sure."

Therapist: "Let me see if I can help you a bit. What skills do you have that a weak baby does not have?"

Julia: "Oh ... I am really good at soccer and I am in advanced Spanish. I am in the school choir."

Therapist: "I see. Would someone who is a weak baby and will amount to nothing have any of these skills?"

Julia: "I guess not."

Therapist: "What about friends?"

Julia: "Oh, I have a ton of friends ... I love to go to sleepovers, and going to camp in the summer is one of my favorite things."

Therapist: "I will write down all these things too. ... Here comes the hard part. ... Read over these two columns where I wrote down what you said. What do you make of them?"

The dialog illustrates several salient points. First, the therapist began by collaborating and obtaining Julia's permission to test the thought. Second, the therapist asked 2 simple concrete questions to shift Julia's perspective. Third, after Julia's responses were recorded, the therapist asked her a synthesizing question to facilitate Julia forming her own conclusions.

## EXPERIMENTS AND EXPOSURES: "A LITTLE LESS CONVERSATION, A LITTLE MORE ACTION, PLEASE"

Exposure and behavior experiments are among the most powerful psychosocial interventions.<sup>4,5</sup> Table 1 provides a rationale and examples of behavioral experiments and exposures. During exposures and experiments, patients face down what they previously have avoided owing to their anxiety, shame, depression, anger, or any other distressing feeling. Rather than talking about change, young patients take productive action during exposures and experiments. Without them, psychotherapy with young patients risks becoming merely an intellectual exercise.<sup>5</sup> Exposures and experiments are carried out in a graduated, stepwise manner. Distressing emotionally provocative situations are scaled from lowest to highest intensity. Young patients are coached to encounter these experiences and persist despite their discomfort. For example, an irritable, impulsive child with low frustration tolerance might be encouraged to pick out the longest clinic reception line, wait, and then ask for a lollipop while applying his acquired coping skills. After the experiment, the child and therapist process the experience. In this way, genuine mastery experiences are realized.

However, fewer than optimal numbers of clinicians elect to use these procedures. Most reasons for underuse are biased attitudes and clinical myths.<sup>4,5</sup> Although some child psychiatrists might correctly avoid conducting exposures from genuine knowledge and skill deficits, others might eschew the procedure owing to inaccurate beliefs such as "Therapy must always be comfortable," "Using exposure damages treatment alliances," and "Negative feelings should always be avoided."

So, how to help reluctant trainees embrace exposures? Demystifying the procedure often helps supervisees feel more comfortable. In addition, debunking the procedure

by teaching trainees that exposure is about wading rather than diving into the avoidance pool is useful. Teaching supervisees that exposures and experiments can be fun also encourages their use. Although exposures and experiments are emotionally evocative procedures, they do not have to be unpleasant. The literature is replete with examples of fun exposures and experiments.<sup>4</sup> A favorite exposure exercise for social anxiety I frequently teach trainees is called "Let's Go Shopping." This behavioral experiment involves making play money out of paper and then walking around the clinic area "purchasing" various small toys. Clinic staff are enlisted as "shopkeepers" and supplied with toys from a party store. Staff members are coached to bargain with the children so that young patients have to negotiate the price to get the toys. Children earn experience interacting with unfamiliar authority figures and, owing to their "bravery," win a prize as a natural consequence of their coping behavior.

Further, relating exposure to germ theory, in which immunities are built from repeated encounters with germs, facilitates supervisees' appreciation of the approach. Moreover, there is no substitute for doing exposures with supervised practice. Authentic coping requires applying acquired skills in emotionally provocative situations in which children concretely discover they are competent and capable.

Seeing children successfully face what they heretofore found excruciating is a transformative clinical experience.

Supervisors working with child psychiatrists need to provide the beef to their supervisees. Mindful fidelity to the core rudiments of patient formulation is a must. A healthy dose of CBT supervision involves helping trainees coherently link procedures with patient conceptualization. Considerable attention to teaching Socratic methods is another hearty ingredient. Further, coaching supervisees to include powerful, high-intensity exposures and behavioral experiments in treatment adds essential action-based elements. Then, there is no question of "where's the beef?" &

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