

Making Cognitive Behavioral Therapy User-Friendly to Children

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This article outlines several innovative cognitive behavioral approaches to treating children's problems. A variety of "playful" ways to teach children self-monitoring and thought-testing skills are presented. Examples of workbook exercises and videotapes based on the newly developed Preventing Anxiety and Depression in Youth (PANDY) project are also introduced. Clinical implications for practitioners of all these exercises and activities are discussed.

COGNITIVE BEHAVIORAL THERAPY (CBT) with children is a rapidly developing area. A variety of researchers and clinicians have described ways in which cognitive behavioral spectrum approaches can be successfully applied to children's problems (Finch, Nelson, & Ott, 1993; Friedberg, 1996; Kendall, 1991; Ronen, 1992, 1997; Spence, 1994; Weiss & Weisz, 1995). More specifically, CBT has been successfully applied to depressive (Jaycox, Reivich, Gillham, & Seligman, 1994; Kazdin & Weisz, 1998; Lewinsohn, Clark, Rohde, Hops, & Seeley, 1996; Stark, Swearer, Kurowski, Sommer, & Bowen, 1996) anxiety (Albano & Barlow, 1996; Albano & Di Bartolo, 1997; Eisen & Kearney, 1995; Eisen, Kearney, & Schaefer, 1995; Kazdin & Weisz; Kendall, 1990; Kendall et al., 1992; Kendall, Panichelli-Mindel, Sugarman, & Callahan, 1997; Kendall & Treadwell, 1996; Silverman, Ginsburg, & Kurtines, 1995; Silverman & Kurtines, 1995, 1996), and aggressive (Feindler & Ecton, 1986; Feindler & Guttman, 1994; Kazdin & Weisz, 1995; Lochman & Lenhart, 1995) disorders in children and adolescents.

Nonetheless, both clinical experience and research applications suggest that not every child will respond identically to traditional CBT methods. Therefore, to move toward meeting the needs of distressed children and attenuating youngsters' nonresponsiveness, creative and innovative modifications of the empirically supported cognitive-behavioral methods must be developed. Consistent with other flexible applications of CBT (Kendall, 1990; Knell, 1993; Seligman, Reivich, Jaycox, & Gillham, 1995; Vernon, 1989), this paper presents several ways in which CBT can be used with children to further enliven its appeal.

Several authors have delineated the general features that characterize CBT with children (Finch, Nelson, & Ott, 1993; Kendall, 1991; Knell, 1993; Ronen, 1992; Spence, 1994): namely, attention is placed on identifying and modifying inaccurate beliefs that contribute to problematic feelings and behaviors; therapeutic stance and process variables, such as collaborative empiricism and guided discovery, shape CBT with children; and therapy is structured and directive (Knell). Thus, most cognitive behavioral therapists agree that agenda and goal setting, client feedback, and homework assignments are central components to the therapeutic work. The therapist also explicitly reinforces the child's efforts toward progress. Finally, CBT with children has an experiential focus (Knell).

Despite the promise CBT holds for clinical work with children, child clinicians who are uninformed about the nature of CBT may eschew the approach for several reasons. Further, some child therapists may believe CBT is too structured and directive. Others may worry that CBT is developmentally insensitive and that the techniques frequently exceed children's capacities. Moreover, some child therapists may be concerned that direct refutation of children's maladaptive thoughts is unnecessarily off-putting to children. Lastly, clinicians working with children may argue that CBT fundamentally neglects children's affect.

These arguments against the use of CBT with children raise important issues. We argue that these heretofore mentioned problems reflect difficulties in the clinical application of the approach rather than inherent flaws in

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 **Continuing Education Quiz located on p. 293.**

the treatment model. Cognitive behavioral therapists themselves have occasionally acknowledged that children might find the therapy dull and boring (Stark et al., 1996). In order to obviate the possibility that CBT is dull and boring to children, it is incumbent upon cognitive behavioral therapists to develop creative and engaging ways to deliver these skills to children. We recommend that coping skills be represented in a simple fashion that is easily understood by the children. Moreover, these skills need to be applied in the context of negative affective arousal (Robins & Hayes, 1993): By using simple yet emotionally arousing and meaningful tasks, CBT maintains developmental sensitivity and avoids applying an overintellectualized or affectless approach to children's problems.

We also recommend that clinicians conducting CBT with children adhere to the notions of collaborative empiricism and guided discovery.

Collaborative empiricism represents a partnership between therapist and child wherein the child's beliefs are viewed as hypotheses to either be confirmed or disconfirmed by behavioral experiments.

These are fundamental tenets in cognitive therapy and serve as leitmotifs that pervade all aspects of treatment (A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 1995). Collaborative empiricism represents a working partnership between therapist and child wherein the child's beliefs are viewed as hypotheses to either be confirmed or disconfirmed by behavioral experiments. Guided discovery is the process whereby the child learns to create and evaluate the database for his or her beliefs. This self-discovery process,

which includes analyzing and modifying thoughts, is gently coached by the therapist. Thus, when child therapists remain faithful to collaborative empiricism and guided discovery, thought testing is less likely to be off-putting.

The pressure to perform in a socially desirable fashion and the natural tendency to avoid anything that "smells" of homework are natural responses for children. Children tend to be quite eager to please their therapists. Due to social reinforcement factors, they may respond in a socially desirable fashion or offer a response they predict the therapist wants to hear rather than with responses that promote greater self-control. Additionally, homework assignments are often daunting tasks for youngsters. When the specter of homework is raised, children will commonly form negative associations between schoolwork, grades, performance pressures, and the psychotherapy process.

Placing the therapy techniques in the context of nega-

tive affective arousal can help to obviate problems associated with social desirability and perceptions of homework. When children are encouraged to practice the skills in graduated exposures that elicit dysphoric feelings, they seem less apt to offer purely intellectualized or socially correct responses. Moreover, homework assignments that are emotionally meaningful and able to reduce distress tend to be more engaging. If the therapeutic approach is fun and entertaining, children may be less likely to experience the pressure to please the therapist and homework may be seen as less onerous. Our clinical experience suggests most children easily acquire the coping skills presented in the cognitive behavioral approach. However, it seems fewer youngsters easily and readily apply these acquired skills in in-vivo contexts. Coping skill application seems best facilitated by helping children apply their skills when they are genuinely distressed and by encouraging consistent homework practice.

This article presents several engaging ways CBT can be applied to children's problems. First, "playful" modifications of CBT are described. Second, several techniques from the Preventing Anxiety and Depression in Youth (PANDY) program are presented. PANDY, a skills-based approach to helping children develop ways to cope with anxious and depressed feelings, is founded on the seminal work of Seligman and his colleagues (Jaycox et al., 1994; Seligman et al., 1995), Kendall and his colleagues (Kendall et al., 1992), and Silverman and her colleagues (Silverman & Kurtines, 1995, 1996). The use of PANDY thought records, which are simplified and developmentally sensitive versions of adult thought diaries, are explained. One innovative approach used in the PANDY program is the development of entertaining and informative videotaped vignettes starring a child actor who teaches children coping skills. The development and application of these tapes is described in detail in the paper. Finally, sample confabulated transcripts, which reflect our experiences working with a variety of children, are included to illustrate salient points.

"Playful" Applications of CBT

Playing games is a familiar activity to all children. Moreover, the value of play in child therapy is a well-documented maxim (Axline, 1969; Moustakas, 1959). However, cognitive behavioral play therapy is a rather recent development (Knell, 1993). Nonetheless, various cognitive behavioral clinicians advocate playfulness and creativity when working with children (Eisen & Silverman, 1993; Friedberg, 1996; Knell; Silverman et al., 1995; Stark, 1990; Stark et al., 1996). Playfulness enables clinicians to use developmentally sensitive and experiential methods to connect cognitions, affect, and behavior. Games and play activities are also nonthreatening ways of

helping children challenge their inaccurate assumptions. Moreover, games and play activities are simple and fun for both clinicians and children. Accordingly, this section describes “playful applications” of CBT that clinical experience has revealed to be appealing to children.

Separating situations, feelings, and thoughts can be a difficult task for children. Additionally, the task can be quite dull for youngsters. Accordingly, the Sorting Game is an entertaining method of helping children distinguish among situations, thoughts, and feelings. In one version of the Sorting Game, developmentally appropriate thoughts, feelings, and stressful situations are written on index cards. The game is most effective if the thoughts, feelings, and situations are derived from the child’s own life. As a way to prepare for the game, the child is taught ways to identify thoughts, feelings, and situations. The therapist gives examples and a practice trial to make sure the child understands the differences between the three categories. The cards are shuffled and placed facedown in one pile. The therapist titles three cards with the words “Thoughts,” “Feelings,” and “Situations.” The objective of the game is to place as many thoughts, feelings, and situations in the appropriate category in 1 minute. The time pressure is stimulating to children and they seem to profit from organizing their experiences into the relevant categories.

The Sorting Game may be augmented by having the child process their experience of playing the game. The therapist could ask the children whether the categorization made a difference to them (e.g., “Does it help you to know the difference between thoughts, feelings, and events?”). The children could then be helped to see which of these things they had more control over (e.g., “How able are you to change events? thoughts? feelings?”).

Some anxious and depressed children might experience some performance pressure associated with the game. If the performance pressure is moderate, the anxiety can become a therapeutic target. The game could become a mini-exposure trial where anxietyogenic or depressogenic cognitions are identified and subsequently challenged. For example, the following sample confabulated transcript illustrates the way the Sorting Game may be processed as a mini-exposure trial.

CHILD: I can’t do this right. [Looks down, shuffling, wiggly in seat.]

THERAPIST: How are you feeling?

CHILD: Frustrated, I guess.

THERAPIST: Any other feelings?

CHILD: I don’t know. [Pause.] Worried.

THERAPIST: Which feeling is stronger?

CHILD: The worried ones, I guess.

THERAPIST: So you feel worried and “I can’t get this right” goes through your mind.

CHILD: Uh-huh.

THERAPIST: Let’s say you don’t get this right, what bad thing would happen then?

CHILD: You would think I’m stupid.

THERAPIST: So you guess that I would think poorly of you. You guess that I would think you are stupid.

CHILD: Yeah. I think that a lot.

THERAPIST: Now, if I thought you were stupid, then what would happen?

CHILD: You wouldn’t want to be around me anymore.

THERAPIST: I’d reject you and wouldn’t want to talk with you or play with you. Is that like what you guess the kids at school or your parents will do?

CHILD: Uh-huh.

THERAPIST: So it’s kinda the same fear with me. You think everyone will reject you if you make mistakes. Can I ask you a hard question?

CHILD: Okay.

THERAPIST: Are you sure?

CHILD: I think so.

THERAPIST: Would you be willing to act like a detective and snoop around and see if what you fear will happen really happens?

CHILD: I guess so.

THERAPIST: Good. Let’s see if we can play the Sorting Game and then we’ll count all your mistakes.

CHILD: And see how stupid I am!

THERAPIST: No. I know this is a little scary. But let’s continue to be detectives, okay? We’ll count all your mistakes and then we’ll see if after you make mistakes, something bad, like I reject you, will happen.

CHILD: Okay. [They play the Sorting Game.]

THERAPIST: Okay. Time’s up. What was that like to do?

CHILD: Kind of fun and kind of not fun.

THERAPIST: What was the fun part?

CHILD: Trying to see how many I could do.

THERAPIST: And the not fun part?

CHILD: Worrying that I would make a mistake.

THERAPIST: Well, let’s see what happened. You check the piles and see if you made any mistakes.

CHILD: Yes, I did. I put a thought in the feeling pile. I messed up.

THERAPIST: Yes. You’re right. This thought belongs in the other pile. So you made a mistake. Now, let’s see if what you guessed would happen really happened. What did I do when you made a mistake?

CHILD: Nothing, really.

THERAPIST: What did I do to show you I didn’t want to play or talk with you anymore?

CHILD: Nothing.

THERAPIST: If I really thought badly about you and didn’t want to play with you anymore, would I talk to you about this?

CHILD: No.

THERAPIST: What would I do if I thought really negative things about you?

CHILD: Yell. Tell me I'm stupid. Say that I have to leave and never come back here.

THERAPIST: Which of these things am I doing?

CHILD: [Laughs.] None of them.

THERAPIST: Would you say then that your guess or estimate that I would reject you because you made a mistake was on target?

CHILD: No, it was off target.

THERAPIST: Do you think it's possible that if you were off target with this guess about what others might think about you during a game, you might also be off target in your other estimates of what people might think about you?

The Thought Shop is an activity where children can learn about cognitive distortions and develop ways to replace maladaptive thoughts with more constructive perceptions. The Thought Shop metaphor allows the child to see the similarities between thought testing and shopping. For instance, the therapist and children discuss the way the child goes about buying a present for someone. Sometimes children buy things for others based on inaccurate assumptions and cognitive distortions, such as jumping to conclusions, mind reading, and emotional reasoning. For instance, in order to buy a shirt that will fit somebody, you have to know their size. Thus, proper shopping decisions are data-based!

Thought Shopping can help the child learn to exchange inaccurate thoughts for more accurate ones. Further, the shop can be divided into different departments. The child can go to the Depression Department in the store and exchange an inaccurate negative thought for a more adaptive response. Children learn that they "returned the thought" because it just was not right for them.

My Thought-Feeling Organizer Book is a potentially useful task that can occur later in the treatment process. Sample contents of *My Thought-Feeling Organizer Book* are included in Figure 1. The activity can serve as a helpful reminder to children that they can manage their internal states and overt behavior. Creating *My Thought-Feeling Organizer Book* reinforces the processes and techniques the children learn through therapy. Moreover, *My Thought-Feeling Organizer Book* may promote greater perspective as children learn to view their subjective experiences from a more objective stance. Finally, *My Thought-Feeling Organizer Book* can complement the relapse prevention and termination phase of treatment. It can be used as a "good-bye book" that summarizes the work completed in therapy and can act as a reference guide for future coping skills.

My Thought-Feeling Organizer Book includes a table of contents reflecting different categories of thoughts. Chapter headings could include home problems, school

MY THOUGHT-FEELING ORGANIZER BOOK

SCHOOL

Grades

Negative thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Friends

Negative thoughts
 Mouse Traps (Distortions)
 New & Improved Thoughts

HOME

Parents

Negative thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Sister

Negative thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Brother

Negative Thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Feelings

Anger
 Negative thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Depression

Negative thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Worry

Negative thoughts
 Mouse Traps (distortions)
 New & Improved Thoughts

Figure 1. Sample of *My Thought-Feeling Organizer Book*.

problems, friend problems, as well as angry, sad, scared, and/or worried feelings. For more sophisticated children, the various distortions (J. S. Beck, 1995; Burns, 1980), called "Mouse Traps" in the PANDY program, could be added as headings or subheadings. Additionally, children could be encouraged to add magazine pictures, drawings, or photographs that illustrate the distortions or negative feelings, pictures and drawings emphasizing how their feelings changed after they modified their thoughts. Presenting *My Thought-Feeling Organizer Book* as a craft activity will likely increase the fun quotient. Children can design the cover and create their own unique titles to the chapter headings.

Modified Thought Records

Automatic Thought Records (ATR) are a staple in cognitive-behavioral therapists' repertoires. The 5-column

thought record developed by A. T. Beck et al. (1979) is well known and widely used. In this record, patients identify situations, feelings, and automatic thoughts in columns 1 through 3 and then develop alternative thoughts and re-rate their mood in columns 4 and 5. Greenberger and Padesky (1995) expanded the 5-column method to a 7-column record by including 2 columns that test the evidence of the automatic thought. While completing thought records is relatively routine with adult patients, using automatic thought records with children presents challenges to clinicians. Children are likely to see the technique as tedious and uninviting. Moreover, making distinctions among thoughts, feelings, and situations may be exceedingly difficult for children. Finally, having to come up with an alternate or rational response to the inaccurate thought may also be a daunting task for youngsters. Thus, clinicians working with children are well-advised to present the ATR in a simple, systematic, and inviting manner.

The concept of collaborative empiricism is especially salient when working with children to complete a thought record. Children have control of few aspects of their daily lives. Teachers, parents, and other authority figures mandate the many what's, when's, and why's of children's activities during the day. Hence, if a therapist enlists a child's active participation by collaboratively involving them in the therapy, children are less likely to avoid treatment or become passive recipients. A short vignette illustrates a collaborative approach to completing a Thought Diary.

THERAPIST: Now that together we have learned how to catch your thoughts and feelings, which ones do you want to capture on your own?

CHILD: I don't know. I guess the ones when I feel weird.

THERAPIST: Weird?

CHILD: You know. Like when the kids at school make fun of me. It makes me feel embarrassed.

THERAPIST: Okay. So we'll capture thoughts that go along with embarrassed. What goes through your mind when you feel embarrassed?

CHILD: The kids think I'm weird.

THERAPIST: Wow. You're really capturing your thoughts and feelings. So what happens is the kids make fun of you, you feel embarrassed, and you think they see you as weird. Am I understanding?

CHILD: Yup.

THERAPIST: How much do you think writing these things down on a PANDY Thought Diary will help?

CHILD: I dunno.

THERAPIST: Okay. That's honest. Would you be willing to try it out?

CHILD: Maybe, I dunno.

THERAPIST: Well, we could try it out and experiment with it. If it works well, we'll do it more, or if it doesn't, we'll try something else. How does that sound?

CHILD: Okay.

THERAPIST: Okay. Sounds good. Let's try one out together. Now, being embarrassed. Is that a thought or feeling?

CHILD: Feeling.

THERAPIST: Right. Which column should we put it under?

In the vignette, the therapist worked assiduously to engage a somewhat reluctant child in the self-monitoring process. Emphasis was placed on inviting the child's participation rather than simply using direct instruction. Further, the therapist attempted to get the child to design a way to assess effectiveness. Additionally, the therapist checked on the child's comprehension and agreement throughout the process.

Kendall and his colleagues (1992) and Seligman and his colleagues (1995) have developed child-friendly thought records. These thought records are very entertaining and make complex thought-feeling connections more understandable to young children. Nonetheless, completing an entire thought record, including situations, feelings, thoughts, counter-thought responses, and a column re-rating one's mood, can be overwhelming even for a high-functioning adult. Therefore, a graduated approach to completing a thought record has considerable merit (J. S. Beck, 1995). Indeed, the advantages of breaking a thought record down into its smaller constituent parts may be most pronounced with younger children.

In our work with the PANDY materials, we invite a child to complete the feeling first by drawing a "feeling face" on PANDY and then writing the feeling underneath it. Next, the child completes an intensity rating of the feeling by coloring in the feeling "signal" (red = *intense*, yellow = *moderately intense*, and green = *low*). Finally, the child fills in a thought bubble or thought cloud to record automatic thoughts. The PANDY thought record (Friedberg, Friedberg, & Friedberg, 2000) is presented in Figure 2.

The PANDY 3-column thought record has several potential advantages. First, the child draws a feeling face on the PANDY cartoon figure. This shapes and directs the child's attention to internal states in a fun, nonthreatening way. Then, the child labels the affective state with a feeling word (e.g., worried), using a traffic-signal graphic

Thought records are very entertaining and make complex thought-feeling connections more understandable to young children.

**CATCHING FEELINGS AND THOUGHTS
DIARY**

EVENT (what happened): _____


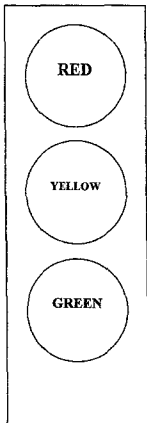
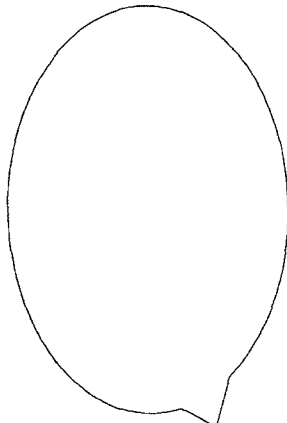
PANDY'S FEELING:	PANDY'S FEELING SIGNAL	PANDY'S THOUGHT BUBBLE
_____ 		
		Date: <input style="width: 80px; height: 20px;" type="text"/>

Figure 2. Pandy 3-column thought diary. From *Therapeutic Exercises for Children: Guided Discovery Using Cognitive-Behavioral Techniques*. Copyright 2000 by Professional Resource Press. Reprinted by permission.

to illustrate the varying levels of emotional intensity. A traffic signal is an already familiar icon to elementary school children. Coloring in a level on the signal is simpler than making an estimate of their feelings on a 1-to-10 scale. The use of the thought bubble or think cloud is a method used frequently by cognitive-behavioral clinicians working with children (Bernard & Joyce, 1984; Friedberg & Dalenberg, 1991; Kendall, 1990; Padesky, 1986; Seligman et al., 1995). Moreover, recent empirical research has documented that even very young children (e.g., preschoolers) readily understand what thought bubbles signify and are able to supply appropriate cognitive content (Wellman, Hollander, & Schult, 1996).

In the PANDY program, we demonstrate to children how to complete the 3-column thought record, and we also show them examples of thought records completed

by other children (Friedberg et al., 2000). This serves important functions. First, by seeing a completed 3-column record by another child, children begin to realize it is possible to capture their thoughts and feelings. Thus, they gain a sense that the task can be completed. Second, when they see the record completed in another child's handwriting, they recognize other children also have inaccurate thoughts. Moreover, they realize other children have used this exercise! This sense of universality can attenuate children's sense of isolation. The handwritten examples communicate to the children that completing a thought record is "kid stuff." Finally, the handwritten examples by children are legible but not entirely neat! As such, they provide examples of modeling coping as opposed to mastery. An example of a model 3-column diary is presented in Figure 3.

The PANDY program includes other thought records designed to modify children's inaccurate thinking. Each of these subsequent thought records are presented in a graduated fashion and include the PANDY character and skills. The Thought Digger worksheet is an illustrative example (Friedberg et al., 2000). The notion of being a "thought digger" is introduced via the videotaped series. The children learn that a thought digger is a "cognitive archaeologist" who digs for clues regarding the accuracy of thoughts. Questions are the products of the "digging process." The questioning process is simplified for the children through the Thought Digger worksheet. Actual questions are provided for the youngsters. They simply

need to check which question they ask themselves and include their answers in the construction of an alternative response. The Thought Digger worksheet is presented in Figure 4.

Use of Videotapes

Delivering cognitive-behavioral skills to children via videotaped instruction offers considerable intuitive appeal. Similar to games and stories, children are familiar with videotapes and are likely to find them entertaining. Teaching coping skills can be quite dry; any approach that is eye-catching to the MTV generation may command greater attention. Children may be more easily taught by an entertaining child "character" than by adult clinicians who directly profess to the child. Moreover, using video-

tapes to teach cognitive-behavioral principles to children offers the opportunity for a child character to model the skills. A videotaped series concentrating on cognitive-behavioral skills in which a child teaches the skills to other children incorporates the well-known principles inherent to observational learning (Bandura, 1977, 1986).

The use of videotaped modeling as an intervention technique is well-documented in the literature (Bandura, 1977, 1986; Dorrick, 1991; Hammond & Yung, 1996). However, the PANDY videos are relatively unique and differ from most other videotaped modeling displays. The central model is a "character" rather than a child. In the tape series, the lead character is a mouse named Pandy. The child actor dressed in a mouse costume teaches children cognitive-behavioral skills. The tapes are designed to be both educational and fun. Various camera angles and backdrops were used to create visually engaging stimuli. Care was taken to choose costume colors and props that were eye-catching. The child actor (age 8) was regularly consulted on the scripts and action in the vignette. When the action or words did not seem right or were confusing to the actor, scripts were rewritten and simplified.

At present, there are 12 completed PANDY videotapes. They include vignettes describing delay of gratification skills, identifying thoughts and feelings, thought-testing techniques, anger-management skills, tools for reattribution, and problem-solving techniques. The vignettes use pithy phrases designed to prompt recall and retention. For example, learning to identify problematic situations is called "What's Happening." Further, the vignettes invite the children to play along and experience the skills Pandy demonstrates. For instance, in "Pandy Says," the mouse plays a version of the game Simon Says with the children as a way to teach them the stop-and-think process.

Clinical experience with these tapes indicates that generally children attend, recall, and acquire skills through these tapes. Moreover, the children seem entertained by the tapes. "Catching Thoughts and Feelings" and "Thought Digger" are two of the more entertaining vignettes. In "Catching Thoughts and Feelings," Pandy enters with a baseball glove and animatedly discusses the mechanics of completing a PANDY Thought Diary (Figure 2). To illustrate the points and add humor, Pandy breaks into a rap and helps kids rate their level of feelings (e.g., "Color it

**CATCHING FEELINGS AND THOUGHTS
DIARY**

EVENT (what happened): Didn't have a partner for a group project in class.


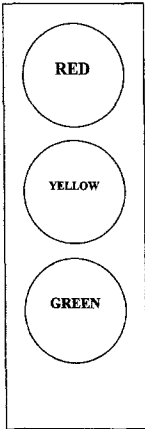
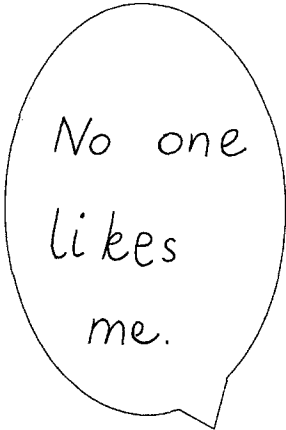
PANDY'S FEELING:	PANDY'S FEELING SIGNAL	PANDY'S THOUGHT BUBBLE
<p><u>s a d</u></p> 		
		<p>Date: </p>

Figure 3. Example of completed Pandy 3-column thought diary. From *Therapeutic Exercises for Children: Guided Discovery Using Cognitive-Behavioral Techniques*. Copyright 2000 by Professional Resource Press. Reprinted by permission.

red if it's really hot and you feel it a lot, color it yellow if it's kinda mellow and you feel it in the middle, color it green if it's kinda serene and you feel it a little.")

Thought Digger is one of the more humorous vignettes in the series. In the vignette, Pandy teaches children how to use the Thought Digger Worksheet (Figure 4):

THOUGHT DIGGER (DIALOGUE)

Hi. Do you know what an archeologist is? An archeologist is a scientist who digs for clues.

Sometimes when you have negative thoughts you have to think them over and dig for clues. You have to become a THOUGHT DIGGER!

When you are a THOUGHT DIGGER, you ask yourself questions like:

What things about myself am I ignoring?



EVENT	FEELING	THOUGHT	THOUGHT DIGGER QUESTIONS
			<ul style="list-style-type: none"> • Are there other ways to think about the event? • What good things about myself am I ignoring? • Am I using my feelings as facts? • Am I looking at all the facts? • Am I expecting too much from myself? • Am I expecting too little from myself? • Am I blaming others? • Am I expecting too much from others? • Am I expecting the worst to happen? • Am I thinking something is permanent when it is really temporary? • Am I blaming myself or am I taking responsibility? • How do I know for sure this will happen?

Figure 4. Thought Digger worksheet. From *Therapeutic Exercises for Children: Guided Discovery Using Cognitive-Behavioral Techniques*. Copyright 2000 by Professional Resource Press. Reprinted by permission.

What things about myself am I paying too much attention to?

How do I know for sure that my thoughts are true?

Go ahead and read your worksheet and come up with THOUGHT DIGGER questions to use.

Happy hunting!

Pandy uses the metaphor of an archeologist to explain the thought-digging process. Additionally, Pandy rhythmically chants “thought digger!” while pantomiming shoveling action. The children who watch this tape seemingly get a big kick out of this and readily imitate the chant and action. This imitation enables therapists to cue the children to use their thought-digging skills by either mimicking the Thought Digger cheer or the digging action.

We plan to make the Thought Digger videos available to therapists, counselors, teachers, and parents. The pilot series is being tested for effectiveness as well as entertainment value. In the final version of the series, different

backgrounds, graphics, and costumes will be employed. We expect the final series to be available in approximately 2 years.

Treatment Considerations

Clinicians are well-advised to consider several issues before implementing the PANDY strategies. These considerations tend to be based on the presenting problem, the child’s developmental level and cultural background, responsiveness to direct verbal interventions, and the treatment modality used. The salient questions and issues are summarized in Figure 5.

We expect the PANDY materials will be most effective with children ages 8 to 11 years old experiencing primarily anxiety and depression. Moreover, children particularly responsive to more indirect playful forms of CBT would seem most likely to profit from these materials. Nonetheless, the worksheets and exercises require at least a second-grade reading level. The child’s responsive-

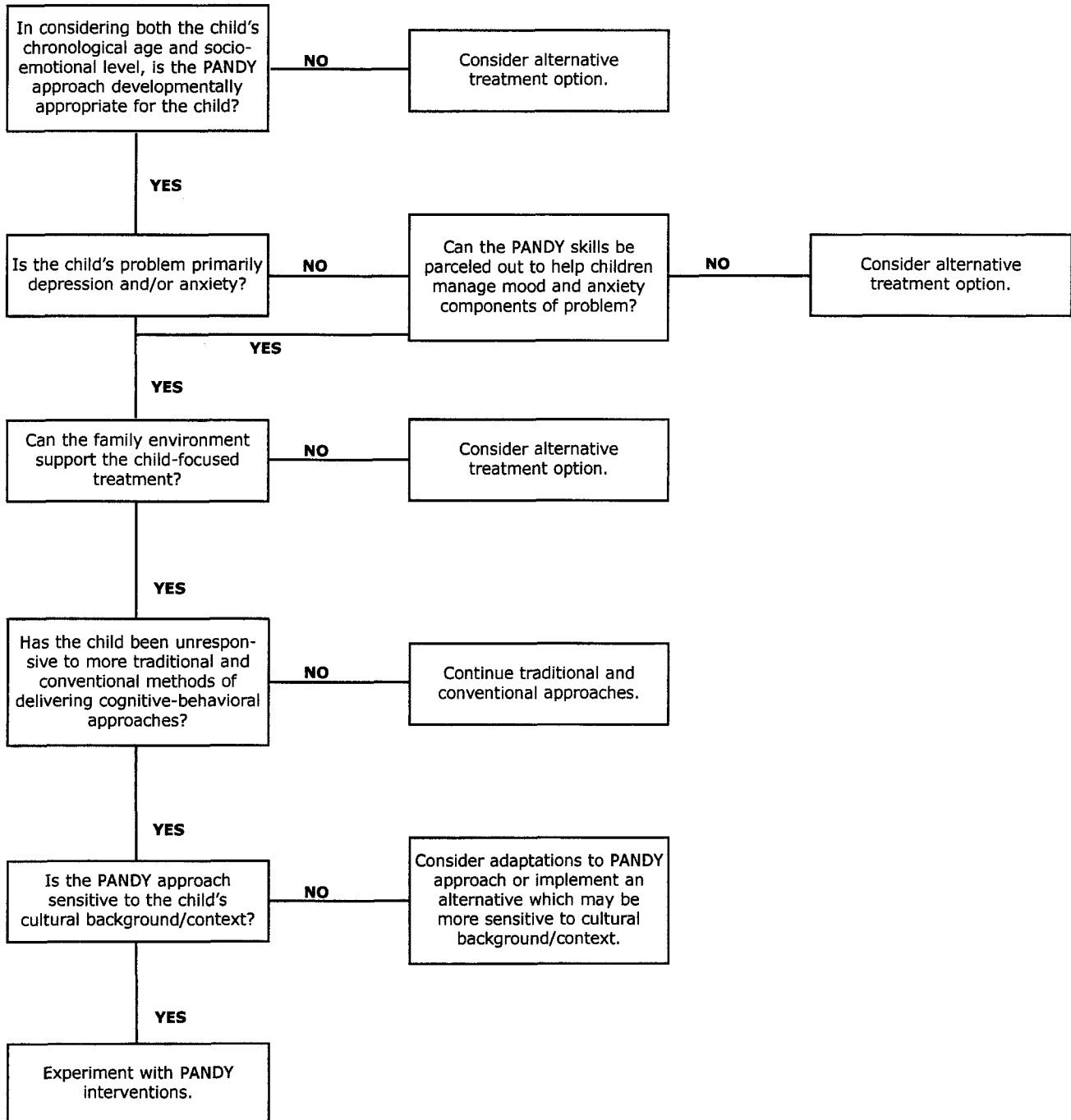


Figure 5. Salient considerations in implementing PANDY approach.

ness to more traditional cognitive behavioral methods is, of course, a consideration. However, if the child is relatively unresponsive to traditional methods, the PANDY materials may offer a fun, concrete, and simple yet conceptually similar alternative.

A child's developmental level and cultural background are further considerations. While PANDY is designed for 8- to 11-year-old children, a very mature and

psychologically sophisticated 10-year-old may find the materials too simplistic. On the other hand, a very immature 12-year-old who reads at a 9-year-old level may become quite engaged with the materials. In making decisions about treatment appropriateness, we recommend considering developmental level as well as chronological age. Additionally, younger, less sophisticated children are likely to be more responsive to the mouse character than

more sophisticated children (D. B. Beidel, personal communication, Sept. 21, 1997).

Clinicians are well-advised to attend to multicultural considerations. Indeed, culturally sensitive interventions make therapy more user-friendly. When the videos and exercises were initially created, we decided to rely on a character rather than a child model as a way to broaden the project's appeal. Accordingly, we thought children of different ethnicities, races, and genders would identify with Pandy. During the pilot demonstration phases of the project, most of the children referred to our program have been white male youths. These youngsters appear to respond well to the videotapes despite the obvious fact that Pandy is a "girl mouse." A small number of African American children ($n = 2$) also have responded relatively favorably to the vignettes. Moreover, the worksheets and

The worksheets and exercises that include the PANDY icon apparently allow for some transportability across gender and race.

exercises that include the PANDY icon apparently allow for some transportability across gender and race. For example, an African American child in the program altered Pandy's coloring, ostensibly so she could more readily identify with the character. Working with children in a group format may also increase identification with the character. Nonetheless, in the final version of the PANDY series, Pandy will be more fully disguised by costuming and will interact with other "mice" who represent different genders, races, and ethnicities (J. S. Beck, personal communication, March 2, 1998).

Despite PANDY's potential applicability to different groups of children, attention should be directed toward multicultural considerations. If it appears that the vignettes or exercises are too culture-bound for an individual child, the therapist can make modifications if indicated or eschew the approach. For instance, if skill labels such as "thought digger," "surfing the angry sea," and "taking command" do not fit for the particular child, the alert clinician might invite the child to replace these skill labels with ones that are more meaningful.

The coping skill set included in the current PANDY package seems best suited to depression and anxiety. These affective disturbances are commonly comorbid with other externalizing disorders such as attention-deficit/hyperactivity disorder and conduct disorders (Bernstein & Borchardt, 1991; Kovacs, Obrosky, Gatsonis, & Richards, 1997). While PANDY is not recommended as a primary intervention for these youngsters, therapists might consider parceling out some of the PANDY skills to treat the anxious and depressive features of externalizing disorders.

Clinicians who treat children readily recognize that parents' active involvement in treatment is essential to maintaining progress and facilitating greater generalization. While parents are educated about the nature of the PANDY approach, there is no formal parent training or family therapy component. Accordingly, the ideal candidates for this treatment are children whose parents possess an adequate level of parenting skills and whose family functioning is relatively functional and adaptive. In those instances where parent training and/or family therapy is indicated, we recommend combining child-focused sessions using the PANDY skills with parent training/family sessions.

Concluding Remarks

Making CBT user-friendly to children involves the integration of existing cognitive behavioral techniques with innovative approaches. The challenge for this integration is maintaining theoretical integrity and adhering to the empirically validated basic principles within the approach. Kendall et al. (1997) rightly contended that clinicians and researchers should be concerned with "transportability" (p. 36). How applicable are cognitive-behavioral techniques to different populations, settings, and contexts? Certainly, these techniques should appreciate cultural and developmental variations between children. Fortunately, recent research has shown that cognitive-behavioral techniques have transportability across gender and race (Treadwell, Flannery, Schroeder, & Kendall, 1995). "The underlying assumptions of the cognitive-behavioral interventions," Treadwell et al. wrote, "appear to apply to a wide variety of 9- to 13-year-olds" (pp. 381-382).

Creative adaptations of more traditional techniques may counteract some potentially negative perceptions of psychotherapy, such as children's view of the work as being boring and dull. Further, the use of play and video is likely to more fully engage children in the therapeutic process. User-friendliness is potentiated by therapeutic tasks that are well within children's repertoires. Simple, fun activities punch up the effectiveness of cognitive behavioral techniques. Finally, multiculturally sensitive applications of cognitive therapy with children may also increase effectiveness.

Kendall and his colleagues (1997) aptly remarked that "children with disorders may not maximally benefit until increased communication between research and service practitioners includes a collaborative discussion reflecting the practitioner's needs" (p. 37). Many of the ideas presented here are based on either anecdotal clinical experience or are currently under development in the PANDY project. The project seeks to close the gap between research clinic findings and service-oriented delivery systems.

Ideally, the suggestions presented here will stimulate

increased clinical practice with the techniques as well as empirical research projects documenting their effectiveness. For instance, evaluating whether children treated with these methods experience a reduction in symptoms is an important first step. After general treatment outcome efficacy is assessed, conducting molecular levels of analyses on treatment processes would also be interesting. For example, how do these videotapes impact the children? Do they increase children's attention and retention of the skills? Are homework compliance and depth of processing increased by these videotapes and workbook exercises? Greater communication between clinicians and academicians will improve the quality of clinical services delivered to children and expand the practice of CBT (Kendall et al., 1997). The PANDY techniques and other approaches in this article strive to promote this important development.

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Integration of Cognitive Techniques Into an Individualized Application of Behavioral Treatment of Blood-Injection-Injury Phobia

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A case is presented to illustrate integration of cognitive and behavioral techniques in treating blood-injection-injury phobia. The 11-session treatment is depicted with particular attention to details that seem critical for success but are underemphasized in behavioral approaches to treatment for blood-injection-injury phobia. This case highlights the benefit of supplementing exposure-based treatment with cognitive conceptualization and explicit challenges to maladaptive beliefs. In addition, social-skills training was an important component of treatment for this client.

THE CASE presented here involves successful treatment of a common disorder, blood-injection-injury phobia, using a variety of behavioral and cognitive techniques (e.g., Beck & Emery, 1985; Masters, Burish, Holton, & Rimm, 1987). In treating this case, the therapist felt that there was a paucity of information in the literature on integrating cognitive techniques with widely used behavioral approaches such as systematic desensitization (Wolpe, 1958, 1990), applied relaxation (Öst, 1987), and applied tension (Öst & Sterner, 1987). Most published cases that provide some details about individualized treatments focus on behavioral approaches but do not adequately address how to modify standard treatments for atypical presentations. For our client, called

Dee, explicitly addressing idiosyncratic maladaptive beliefs seemed to be critical for success. It was not likely that Dee would have concluded, based on exposure alone, that receiving or viewing injections and minor injuries was not a catastrophic experience because she interpreted the slightest discomfort as disastrous, due to her belief that she could not tolerate any pain or discomfort. Furthermore, Dee believed that expressing her pain or discomfort would lead to abandonment by others.

Empirically Informed Approaches to Treating Blood-Injection-Injury Phobia That Were Considered for Use in This Case

Two popular behavioral approaches for treating phobias are systematic desensitization (Wolpe, 1958) and applied relaxation (Öst, 1987). Each of these approaches involves coupling exposure to feared stimuli with relaxation. Each treatment begins with progressive-relaxation training. The goal of progressive-relaxation training, according to Öst, is for the client to recognize

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 **Continuing Education Quiz located on p. 295.**