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CLINICAL FORUM

Developmentally Sensitive Implementation of Core Elements of Evidence-Based Treatments: Practical Strategies for Youth With Internalizing Disorders

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MANY TREATMENT APPROACHES for psychological disorders among children and adolescents are downward extensions of adult treatment models. According to Barrett (2000), when treatments for childhood disorders are based on cognitive behavioral models of adult disorders, clinicians may make inaccurate assumptions, such as viewing children as “little adults,” thereby failing to adjust treatment terminology for children and ignoring contextual factors such as families and peers. Subscribing to adult models may also result in a lack of awareness of research findings in the field of developmental psychology (e.g., cognitive abilities, social skills, emotion regulation) and, consequently, implementation of treatment strategies in a similar manner across levels of development (e.g., assuming all children possess the same level of meta-cognitive skills). As Kingery and colleagues (2006) emphasize, simply utilizing a treatment that has been developed for youth is not sufficient. Particularly when implementing manual-based CBT for youth with internalizing disorders, clinicians must be knowledgeable, creative, and flexible, taking each child’s individual cognitive, social, and emotional skills into consideration to provide the most developmentally appropriate intervention.

According to Holmbeck, Devine, and Bruno (2010), “. . . although many authors suggest possible adaptations of treatment manuals to make them more developmentally sensitive, few provide methods for doing so” (p. 29). The present article aims to address this gap in the literature by out-

lining developmental modifications for several key components of CBT for anxious and depressed youth. As a starting point, we turn to general guidelines provided by Holmbeck et al. (2010) for therapists who want to practice in a developmentally sensitive manner. These authors suggest that clinicians stay up-to-date with research published in developmental psychology journals (e.g., *Child Development*, *Developmental Psychology*, *Development and Psychopathology*, *Journal of Research on Adolescence*), take each child’s cultural background as well as contextual factors (e.g., parents, peers school environment) into consideration, use developmentally appropriate therapy strategies (e.g., drawing, puppets, other hands-on activities for young children), incorporate developmental tasks relevant for each child into treatment (e.g., begin by focusing on symptoms that are most problematic from a developmental standpoint), educate parents about normative developmental expectations, and plan for children’s upcoming developmental milestones and transitions during treatment (see Holmbeck et al. for further information and a summary table of key developmental milestones across age groups).

For this article, we present developmental adaptations to core treatment elements that frequently occur in empirically based treatments for youth with internalizing disorders. Recent research focused on identifying common treatment elements across evidence-based treatments for youth has found that 50% or more of the protocols for

childhood depression share the following elements: psychoeducation, cognitive/coping, problem solving, activity scheduling, skills building/behavioral rehearsal, social skills training, communication skills, maintenance/relapse prevention, relaxation, and self-monitoring (e.g., Chorpita, Becker, & Daleiden, 2007; Chorpita & Daleiden, 2009). Many of these elements are also present in evidence-based treatments for childhood anxiety. Consistent with this approach, the present article focuses on a few of the core elements that are shared across treatments for internalizing disorders among youth (i.e., psychoeducation, relaxation techniques, praise and rewards, cognitive strategies, self-monitoring). For each element, we provide a brief definition, followed by adaptations appropriate for younger children and then suggested modifications for older children and adolescents. Our goal is to provide concrete and practical strategies for developmentally sensitive implementation that are useful to both graduate students and clinicians with varying levels of experience.

Psychoeducation

It seems appropriate to begin this discussion with psychoeducation as it is commonly the first component in treatments for youth with anxiety and/or depression. Psychoeducation refers to the sharing of useful information related to the disorder, such as prevalence, symptoms, course, etiology, and common treatment approaches. When working with youth, this treatment element usually involves caregivers (typically parents), as family psychoeducation may facilitate mood monitoring, treatment adherence, and family response to the illness (Brent, Poling, McKain, & Baugher, 1993). To deliver psychoeducation, the clinician first establishes rapport, next assesses children’s and parents’ current level of understanding regarding the disorder and available treatment, and then adds to the existing knowledge.

Fortunately, psychoeducation is easily adapted for use with different ages and cognitive abilities. With younger children, an interview game that involves taking turns asking questions while passing a microphone back and forth may be a fun and engaging way to assess current knowledge. When sharing new information about anxiety or depression, it is important to use age-appropriate language and clear examples or metaphors. For instance, in discussing prevalence rates, the clinician can use the child’s class and/or school to con-

cretize the example (e.g., “This means that about one student in each classroom in your school worries more than he or she needs to”). Discussions of the cause of the disorder should stress that nobody is “at fault” and neurobiological theories of etiology may be simplified by talking about a “brain hiccup” (March & Mulle, 1998). Sharing information about treatment can be done in simple language (e.g., “we are going to talk about how you feel,” “things you can think about,” “things that you can do that may help you feel better”) and/or by drawing cartoons about what children will be doing in therapy. Finally, for younger children, it may be helpful for the clinician to first share information with a parent and/or the family. In this way, a parent may act as a treatment “coach” and continue the psychoeducation process at home in between treatments sessions (Freeman & Garcia, 2008).

In contrast, older youth may benefit from engaging in psychoeducation with the clinician first, and then sharing the information with their family. This process allows for passing information throughout the family, but also supports the growing independence of older youth. In general, the content of psychoeducation for older youth is more sophisticated. When reviewing common symptoms, older youth may benefit from looking over a checklist of diagnostic criteria with the clinician, identifying symptoms experienced, and talking about how the same disorder can have different symptom presentations. Similarly, older youth are more likely to understand prevalence rates and different theories of etiology. During this process, it is important to be open to questions and to have handouts and/or brief videos to supplement the discussion. In presenting information regarding treatment, older youth may be curious about efficacy and about the rationale for different treatment ingredients. More advanced youth may also benefit from talking about medication interventions and other possible treatments in case the current one is not effective.

Relaxation Techniques

Relaxation techniques (e.g., guided imagery, progressive muscle relaxation, deep breathing, meditation, biofeedback) are used to help youth increase awareness of tension, reduce physiological symptoms of stress, gain control over achieving a state of relaxation, and potentially facilitate engagement in other components of treat-

ment (e.g., exposure tasks; Clarke & Debar, 2010). As deep breathing and progressive muscle relaxation (PMR) are the most commonly used relaxation techniques, this section will focus on those two approaches. Deep breathing involves slowly breathing through the diaphragm, which is in contrast to the rapid, upper chest breathing often associated with anxiety. PMR refers to the process of systematically tensing and releasing muscle groups.

Deep breathing and PMR, often used in conjunction with each other, are easily adapted and have been used with a broad range of ages and developmental differences. For example, it may be helpful to present the relaxation techniques in shorter pieces when working with children with shorter attention spans (Beidas, Benjamin, Puleo, Edmunds, & Kendall, 2010). Deep breathing may be simplified as “belly breathing” or instructing to “fill a balloon in your belly” to remind the younger child of the importance of making the diaphragm inflate and deflate. In addition, pinwheels or bubbles may help the younger child learn the technique and remain engaged with the process (Cautela & Groden, 1978). Prior to teaching PMR, it is important to conduct an assessment of muscle awareness and motor ability. Depending on ability, the clinician can focus on a few gross-motor muscle groups (e.g., shoulders and arms, legs and feet) as this approach may be easier than learning to control fine-motor areas (e.g., facial features, hands; Cautela & Groden). Whole body tension and relaxation may also work with younger children. For instance, having the child pretend to be a “robot” with stiff arms and legs, and then a “rag doll” who flops around with no tension in the body may be a playful and engaging way to increase awareness of muscle tension and relaxation (Kendall & Hedtke, 2006).

Relaxation techniques used with adolescents tend to be more sophisticated than the approaches described above; however, this age group may comprise a range of developmental levels, so it is still wise to assess cognitive and attention abilities. Adolescents may be interested in more details about the physiological stress response and how relaxation techniques work to combat that response. Some adolescents may respond to briefer methods like deep breathing, in contrast to the lengthier PMR (Curry et al., 2000). If engaging in PMR, the length and depth of the intervention can be adapted depending on the abilities and interest of the adoles-

cent. For example, Ollendick and Cerny (1981) suggest using short and to-the-point directions (e.g., pull your shoulders up and try to touch them to your ears), and clinicians can choose to focus on fewer, larger muscle groups for a shorter intervention. In contrast, it may be helpful to use a PMR script designed for use with adults, which includes directions to tense and relax more specific muscle groups.

Praise and Rewards

Broadly speaking, praise and rewards are behavioral strategies that apply positive reinforcement (e.g., verbal praise, small prizes, tokens/points, enjoyable activities), which can be used by clinicians, parents, or teachers to increase desired behaviors among children and adolescents (King & Ollendick, 1997). As a treatment component in CBT programs, youth learn the basic principles of praise and rewards, including developing a list of possible rewards for treatment progress, monitoring progress, and eventually learning to self-administer earned rewards. From a developmental perspective, clinicians should consider three key aspects related to the implementation of praise and rewards: types of rewards, frequency and timing of rewards, and extent of parent involvement. This section will discuss each of these issues as they apply to developmentally younger children and then to older children and adolescents.

To increase motivation and treatment compliance, Kingery and colleagues (2006) suggest that clinicians develop reward lists collaboratively with youth to ensure that the types of rewards closely match each child’s developmental level and his or her individual interests and preferences. Younger children tend to enjoy concrete rewards such as candy, school supplies (e.g., pencils, pens, erasers, notebooks), Matchbox cars, bubbles, stickers, and other small prizes. In terms of rewarding activities, individual time with a parent (e.g., playing a game, baking, reading, building with Legos), choosing a special outing (e.g., going to a frozen-yogurt shop, choosing a favorite book from the library), or arranging a play date are often used. In addition to making sure that the types of rewards are appropriate for younger children, clinicians need to pay careful attention to the frequency and timing of rewards. For example, Freeman and Garcia (2008) highlight that in contrast to older youth with OCD, younger children need to receive positive consequences more frequently

(e.g., rewards given for resisting hand washing before each meal rather than for an entire day). Due to their cognitive abilities, younger children usually respond best to concrete rewards given immediately after a positive behavior, rather than points that must be saved and exchanged for a prize later. Younger children may also need a desired behavior to be broken down into smaller steps (e.g., first tell salesperson you would like to purchase the item, then pay for it) with a reward provided after each step or even a reward provided for partial success if the task is too challenging at first. Finally, parents of younger children play a crucial role in helping to develop reward lists, keeping track of prizes earned, and administering rewards when target behaviors are accomplished outside of therapy sessions (Kingery et al.).

In contrast, older children and adolescents have different interests and preferences that impact the types of rewards used during treatment. For example, iTunes gift cards, teen-focused magazines, gift cards for a clothing store or manicure, or additional screen time tend to be popular with older youth. In terms of activity-oriented rewards, although they may still enjoy an occasional activity with parents, teens tend to gravitate toward activities with peers (e.g., going bowling, ice skating, or to a sporting event). It is important for clinicians to keep in mind that expensive rewards may be stressful or impossible for some families. Social rewards, such as earning the privilege of going to bed later, staying out later with friends, or simply extra time spent “hanging out” with a friend, are low- to no-cost alternatives that can be very motivating for older youth. Regarding the frequency and timing of rewards, with older or more developmentally advanced youth it is common to use points or tokens that can be “saved up” and exchanged for a larger prize later on. Clinicians can teach older youth to self-evaluate and reward fairly independently, using only occasional verbal assistance from parents (e.g., reminders about the reward system, praise for accomplishing target behaviors).

Cognitive Strategies

Cognitive strategies, such as Socratic questioning, testing the evidence, cognitive modeling, decatastrophizing, and the downward arrow technique, are a group of therapeutic tools used to teach youth with internalizing disorders to identify negatively distorted thoughts that may be maintaining their symptoms of anxiety or

depression. Cognitive strategies involve two main goals. First, clinicians help youth develop an awareness of maladaptive thoughts. Then, clinicians use cognitive restructuring to guide youth through the process of challenging the validity of their thoughts and generating more rational or adaptive coping thoughts (Kendall & Suveg, 2006).

To deliver cognitive strategies in a developmentally sensitive manner, clinicians must begin by evaluating (either formally or informally) each youth’s cognitive abilities in areas such as causal reasoning, memory, attention span, and metacognitive awareness. Although youth in early to middle childhood often have difficulty identifying and reflecting on their own thoughts (e.g., Kane & Kendall, 1989), this does not necessarily mean that their thoughts related to anxiety or depression cannot be accessed. When working with younger children, clinicians can use cartoon strips of favorite superheroes to provide children with a more concrete way to express their thoughts. Other strategies that may be effective with younger children include externalizing the source of upsetting thoughts to a fictional character (e.g., “Worry Monster,” “Nervous Bug,” “Sadness Cloud”), or comparing the child’s attitude toward a stimulus with that of a peer (e.g., excitement versus anxiety about riding a roller coaster at an amusement park) and discussing the thoughts that correspond with these contrasting feelings. When presenting questions to help youth access their thoughts, Friedberg and McClure (2002) suggest using open-ended questions that promote imagery (e.g., “What popped/flew into your mind?”; “What did you say to yourself”), rather than “What are you thinking?” (p. 91). After identifying thoughts, cartoons or drawings can be used to help youth restructure their thoughts (e.g., picture of child in a feared situation with two thought bubbles above his/her head—one for the anxious thought, the other for the more adaptive or coping thought; Kendall & Hedtke, 2006). To simplify the cognitive restructuring process, clinicians can help young children write brief self-statements (e.g., “I can do it!”) on index cards that can be posted in key places at home (e.g., mirror, refrigerator) or carried in a pocket for a tangible reminder. Finally, younger children typically need direct instruction from clinicians with completing daily thought records, and also may need assistance from caregivers with recognizing and challenging maladaptive thoughts outside of ther-

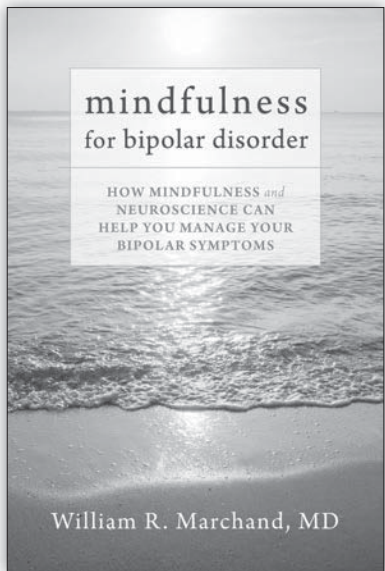
apy sessions. For example, parents can offer brief supportive statements (e.g., “It sounds like your OCD is giving you a hard time,” p. 1192) to remind youth to use their cognitive coping strategies (Piacentini & Langley, 2004).

Several of the strategies mentioned in the previous paragraph (e.g., cartoon strips, externalizing the source of upsetting thoughts) can be adapted to match the interests and developmental level of older children and adolescents. For example, an adolescent who enjoys ballet could brainstorm coping thoughts that her favorite dancer might use in an anxiety-provoking situation, or clinicians can ask youth to imagine assisting a friend in generating coping-focused thoughts for a particular situation. Metaphors can also be used to help youth become more aware of their thoughts. For teens interested in sports, the clinician could apply a “ticker” analogy (Mychailyszyn, 2015), explaining that our thoughts come and go like updates in the ticker that runs across the bottom of the screen on ESPN. Just as we might focus on a certain piece of negative news (e.g., favorite team lost a game) and disregard other information running across the ticker, we tend to focus on negatively biased and ignore contrary evidence in a similar manner. The metaphor of a detective who is working to gather evidence for negative thoughts (i.e., testing the evidence) can facilitate cognitive restructuring. Clinicians ask questions to help youth to gather facts that support their beliefs (e.g., “What makes you 100% sure that your prediction is true?”) and that do not support their beliefs (e.g., “What else might happen in this situation?”; Friedberg & McClure, 2002; Kendall & Hedtke, 2006). Teens who have difficulty answering these questions could be prompted further with the question, “What would your friend say about ____?” By reviewing the facts and reflecting on alternative ways to view a situation, youth are able to come to a new conclusion and generate coping thoughts.

Self-Monitoring

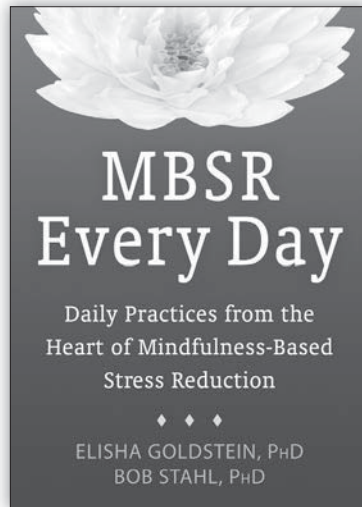
Self-monitoring, a treatment component involving self-observation in the form of tracking thoughts, behaviors, or feelings, is included in most empirically supported treatments for youth with internalizing disorders. Implementation of self-monitoring requires selecting the variable to be monitored (e.g., sadness), deciding on the self-monitoring method (i.e., format, frequency), creating the method with the

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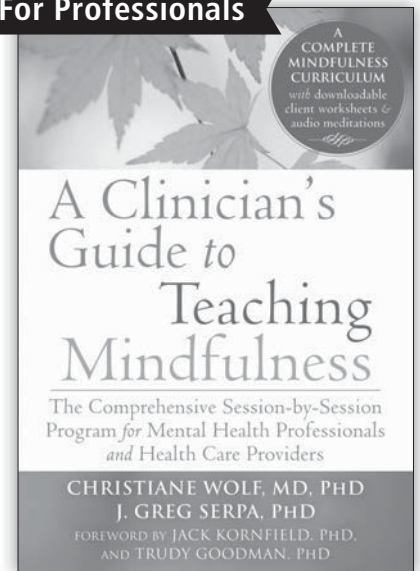
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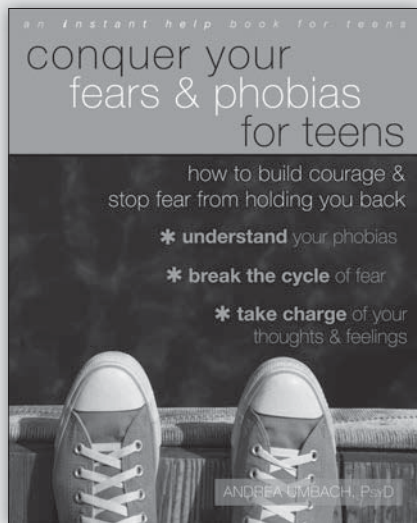
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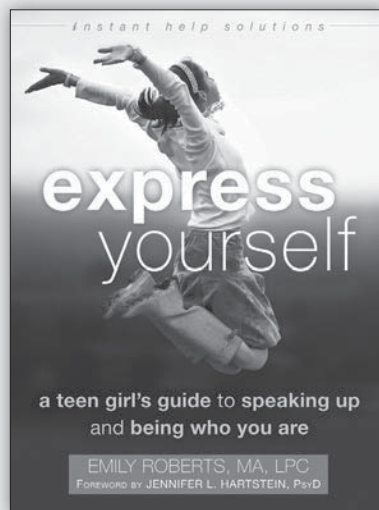
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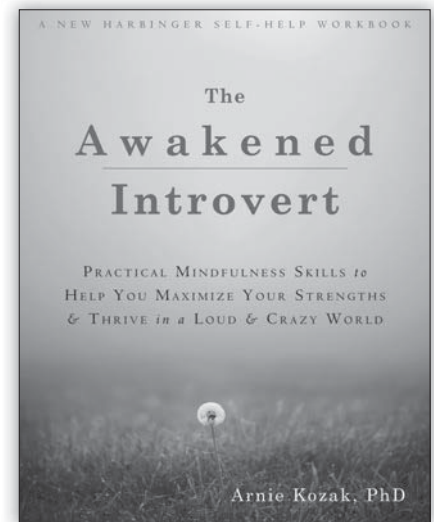
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youth, identifying reinforcers for compliance, and practicing the process. In addition, the self-monitoring log is typically reviewed in future sessions to assess change of emotions over time, identify antecedents of mood changes, challenge automatic thoughts, or problem solve more adaptive behaviors.

Although self-monitoring is more frequently included in treatments for older youth and adolescents, there are several adaptations for youth at earlier developmental levels. Younger youth may benefit from using pictures to aid in the self-monitoring of thoughts, behaviors, and feelings. For example, a photo of the youth with a friend could be placed on a self-monitoring chart that tracks number of playdates for a socially anxious child. Similarly, young children may have an easier time keeping a log of feelings faces (e.g., happy, neutral, sad) instead of mood ratings. Parental involvement and modeling may provide needed scaffolding for youth at earlier developmental levels. Indeed, an anxiety intervention designed for youth ages 4 to 7 (i.e., Kiddie Cat; Hughes, Hedtke, Flannery-Schroeder, & Kendall, 2005) encourages parents to help the child monitor feelings of anxiety and avoidant behaviors. In addition, the forms commonly used for self-monitoring may be simplified for younger youth. Feelings rating scales can be four or five points and anchored by concrete descriptions or feelings faces. Language can also be adapted on the self-monitoring log. For example, the term “thinking traps” may be more easily understood than the term “cognitive distortions” on a thought monitoring log (Kendall & Hedtke, 2006).

The ability to accurately recognize, label, and report thoughts, feelings, and behaviors tends to increase with age (King, Ollendick, & Murphy, 1997); thus, self-monitoring is typically easier for older or more cognitively advanced youth. Therefore, older youth may prefer to complete self-monitoring tasks without parental involvement (e.g., Clarke, Lewinsohn, & Hops, 1990). Older youth often feel comfortable with written self-monitoring logs and more detailed rating scales. For example, a number-based 10- or 100-point scale (e.g., Subjective Units of Distress Scale; SUDS) may be used with adolescents (Heard, Dadds, & Conrad, 1992). Similarly, while a young child may be able to keep a log of only their feelings, more advanced youth can record the preceding situation, resulting feelings, thoughts, the accuracy of those thoughts, and the consequences

(Clarke et al., 1990). Some studies have examined the use of technology (e.g., palm pilots, iPod Touch) in facilitating self-monitoring of anxious symptoms (Suveg, Payne, Thomassin, & Jacob, 2010); however, additional research is needed to determine the effectiveness of computer-assisted self-monitoring. Nevertheless, the use of technology to help with self-monitoring may be an attractive option for older youth.

Conclusion

Throughout this article, we present a variety of specific ways to tailor several core elements of CBT to each youth’s developmental level. Before implementing these adaptations, we strongly recommend that clinicians evaluate each child’s level of functioning in the cognitive, social, and emotional domains of development, either formally as part of the pretreatment assessment or informally during the first several treatment sessions. As Kingery et al. (2006) emphasize, these developmental skills can impact a child’s ability to engage in and ultimately benefit from treatment. In addition to being creative and flexible, the developmentally attuned therapist is knowledgeable about developmental principles and integrates them in an ongoing manner into his or her clinical practice. According to Holmbeck et al. (2010), clinicians treating youth may need to focus not only on presenting symptoms, but also age-appropriate skills (e.g., emotion regulation, social skills) that may be lagging as a result of the child’s psychopathology. To accomplish this, clinicians must acquire the necessary knowledge and skills through graduate-level clinical training that incorporates developmental principles, by following published developmental psychology research, or via continuing education workshops. In addition, clinicians need to apply this developmental knowledge in the therapy session. Finally, Barrett (2000) recommends taking the role of a child’s cultural background into careful consideration, as the extent to which a particular behavior is considered developmentally appropriate is often defined by a given family’s cultural background.

It is also our hope that this article helps to bring developmental issues to the forefront for researchers who evaluate the effectiveness of manual-based treatments for youth. Although it has been suggested that tailoring treatment according to a child’s developmental level should lead to more favorable outcomes, much more

research is needed to inform effective implementation of developmental modifications. Holmbeck et al. (2010) recommend that researchers not only examine the role of chronological age in treatment outcome studies, but also include specific developmental variables (e.g., cognitive ability, emotion regulation, social skills, friendship quality) to evaluate mediators and moderators of treatment effects. As most research focuses on the effectiveness of treatment manuals as a whole, more component research is also needed to evaluate the effectiveness of individual treatment elements such as those discussed in this article. Overall, systematic research examining the role of developmental factors in treatment outcome will help to provide empirically informed recommendations for adapting treatments such as manualized CBT to fit each child’s unique developmental needs and skills.

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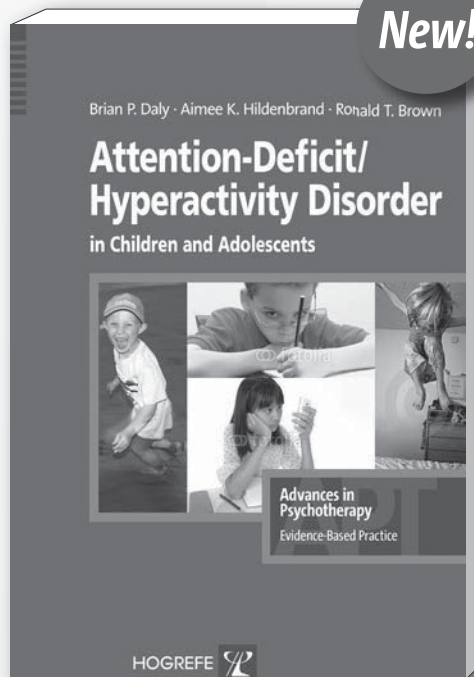
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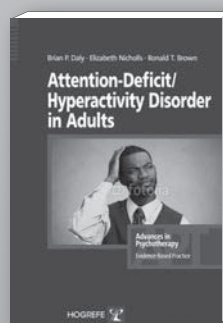
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Erratum

Due to editorial error, Jessica Armstrong and Victoria Ameral were not listed as authors of "First Generation Students in Professional Psychology: Challenges and Training Recommendations" in the March 2015 issue of *the Behavior Therapist*. The editor regrets this omission. The correct citation is: Palm Reed, K. M., Armstrong, J. L., & Ameral, V. (2015). First generation students in professional psychology: Challenges and training recommendations. *the Behavior Therapist, 38*, 74-77.