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# Integrating Culture, Pedagogy, and Humor in CBT With Anxious and Depressed Youth

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Among the many innovations introduced by cognitive–behavioral therapy (CBT), the use of adjuncts to therapy in the form of conceptual (e.g., psychoeducation) and concrete tools (e.g., worksheets) figures prominently. Moreover, the employment of structured, preplanned activities within and beyond the therapy hour that address clients' particular needs has been a hallmark of CBT. Manuals for treating children and adolescents with anxiety and/or depression based on CBT's nomothetic principles have popularized some CBT tools. Nonetheless, tailoring these conceptual and concrete tools in an idiographic manner to build upon clients' unique strengths has remained a challenge. This article examines some of the existing conceptual and concrete tools within CBT to treat children and adolescents experiencing anxiety and/or depression. It then supplements those tools by offering detailed cultural considerations, pedagogical principles, and the use of humor in the treatment of these youth. Specifically, the role of culture is discussed at every step of treatment to individualize CBT; pedagogical principles are emphasized to facilitate treatment engagement; and the use of humor in therapy is exemplified as a powerful tool that facilitates adaptive empathic alliance, relaxation, and coping. These additional tools are intended to aid practitioners in their aspirations to best serve diverse clients in contemporary U.S. society. They are designed to build a strong working alliance through a culturally grounded empathic appreciation of youth clients' strengths and difficulties while extending therapeutic application and generalizability.

***Clinical Impact Statement***

Youth experiencing anxiety and/or depression can benefit significantly from a thoughtful use of tools within and outside therapy. These tools, as well as all steps within treatment, are to be tailored to clients' cultural preferences. Therapists can incorporate these tools in their work and do so in an intentional manner that is likely to increase clients' treatment engagement and therapists' work satisfaction.

*Keywords:* cognitive–behavioral therapy, treatment tools, anxiety, depression, children and adolescents



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Internalizing disorders such as depression and anxiety are the most prevalent diagnoses among youth and are related to a number of increased mental health issues, such as mood and substance related disorders, rejection by peers, and suicide, later in life (Fryers & Brugha, 2013). It is estimated that 12.3% of children ages 6–12 years and 11%–25.1% of adolescents ages 13–18 are diagnosed with an anxiety disorder (Merikangas & Nakamura, 2011). With respect to depressive disorders, approximately 3% of children are diagnosed with a depressive disorder, whereas 5.7% of teens meet criteria for the diagnosis (Merikangas & Nakamura, 2011).

Anxiety and depression are highly comorbid with one another (Angold, Costello, & Erkanli, 1999). In co-occurring disorders such as a depressive disorder and an anxiety disorder, anxiety disorder is likely to be an antecedent to depression. For example, Essau (2008) found that, of the youth who had both depression and anxiety, 72% from a community sample and 62% from a clinical sample had anxiety prior to depression. Although evidence-based treatments for anxiety have consistently shown promising outcomes over the last 50 years, studies of youth diagnosed with depression or comorbid depression and anxiety have been largely discouraging. In their extensive review of treatments for depression and anxiety in children and adolescents encompassing 447 studies and spanning 50 years with over 30,000 youth, Weisz and colleagues (2017) concluded that, in addition to symptoms of depression's not being affected in a majority of studies, in some conditions symptoms of depression significantly increased after treatment. Additionally, youth with comorbid depression and anxiety also had worse treatment outcomes than did youth with only an anxiety disorder.

A considerable amount of evidence has supported the use of cognitive–behavioral therapy (CBT) as an effective treatment for depression and anxiety in children and adolescents. CBT as a stand-alone treatment is effective in reducing symptomology in children and youth with mild to moderate depression, even in the presence of comorbidity (Birmaher et al., 2007). CBT provides a cost-effective (e.g., Dickerson et al., 2018) and evidence-based (e.g., Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016) approach to treating children and youth diagnosed with depression and/or anxiety. Nonetheless, youth diagnosed with comorbid depression and anxiety, especially those who are ethnic minorities, may be underserved by present treatment interventions (Alegria, Vallas, & Pumariega, 2010; Huey & Polo, 2008). Specifically, some interventions have not been culturally adapted, resort to outdated worksheets that exclude gender and sexual minorities, or include stereotypes. Considering that approximately 45% of children and adolescents in the United States are ethnic minorities, there is a sizable need for culturally sensitive counseling techniques, materials, and practices. It seems timely to not only review the existing CBT tools for working with youth diagnosed with anxiety and/or depression but also entertain innovative ways of integrating cultural considerations, pedagogical principles, and the use of humor to maximize access and improve utilization of psychotherapy. In other words, to enhance therapy with youth it is important to tailor treatment to maximize its effects (Huey, Tilley, Jones, & Smith, 2014), improve generalizability through active learning (Crosling, Heagney, & Thomas, 2009), and employ humor to increase understanding and decrease resistance (Borcherdt, 2002).

## CBT Tools for Treating Anxiety and Depression in Youth

This section discusses some of the CBT tools available to therapists working with children and adolescents with anxiety and/or depression. First, it addresses tools for working with children and adolescents experiencing anxiety, then tools for working with youth who are depressed, and finally tools taking on both disorders.

### CBT Tools for Anxiety in Youth

The Coping Cat Program (Kendall & Hedtke, 2006) is one of the first evidence-based treatment manuals for anxiety disorders in children and adolescents ages 7–13. The manualized treatment program utilizes conceptual (e.g., metaphors) and concrete (e.g., games) tools to make treatment accessible. One of the metaphors to implement progressive muscle relaxation training is that of "The Robot and the Rag Doll." This exercise consists of having children tense their muscles as if they were robots and

then loosen them as if they were rag dolls. Additionally, Kendall and Hedtke (2006) recommended the use of relaxation combined with imagery; for example, children are invited to imagine that they are filming a movie and to include in it whatever is relevant to them. Kendall (2007) suggested that when engaging in cognitive restructuring, the concept of self-talk can be introduced with cartoons or pictures in which children provide examples of thoughts that correspond with the pictures before they practice identifying their own thoughts. Kendall (2007) recommended that while the child and the therapist are brainstorming solutions during problem-solving, the therapist offer humorous solutions (e.g., if you cannot find your shoes, "walk on your hands all day," p. 15) to build rapport and encourage the child to engage in more flexible thinking. Moreover, Kendall (2007) suggested using the image of a traffic light to translate the abstract idea of level of risk to the concrete picture. The use of metaphor, imagery, art, and humor simultaneously make therapy with youth more engaging understandable and, thus, more effective.

The Coping Cat Program has been shown to be effective in the treatment of separation anxiety, social anxiety, and generalized anxiety disorder (Kendall & Hedtke, 2006). Follow-up studies have shown that gains can be seen even after 7 years of receiving treatment (Kendall, Safford, Flannery-Schroeder, & Webb, 2004).

## CBT Tools for Depression in Youth

There are a variety of empirically supported treatments for treating depression in children and adolescents. ACTION is an empirically supported treatment manual for girls with depression (Stark, Streusand, Krumholz, & Patel, 2010). ACTION uses metaphors such as "The Good and the Bad Detective" (Stark, Streusand, Arora, & Patel, 2012). Specifically, this metaphor seeks to teach youth that bad detectives solve cases using limited evidence, whereas good detectives look for evidence from many areas and consider facts that both support and contradict their ideas. It is important to note that this strategy does not suggest that everything is positive but rather creates a metaphor for how children can learn to question their own negative thoughts.

The Coping With Depression Course for Adolescents (CWD-A) by Clarke, Lewinsohn, and Hops (1990) targets the needs of adolescents 14–18 who are experiencing depression. CWD-A uses several therapeutic tools such as the metaphor of the "The Wheel of Negative Thoughts" and "Doing Weights With Sadness" and employs examples relevant to youth such as movies and TV shows. Moreover, CWD-A incorporates humor through comic strips for the purpose of increasing treatment engagement (Clarke et al., 1990).

The manuals highlighted above include the utilization of relaxation techniques, because it has been useful for reducing anxiety symptoms and because 75% of depressed adolescents also present a comorbid anxiety disorder (Angold et al., 1999). However, strategies that specifically target co-occurring anxiety and depression are limited in these manuals.

## CBT Tools for Co-occurring Anxiety and Depression in Youth

To treat co-occurring depression and anxiety, two approaches have been developed: the unified protocol and the modular approach for treating children and adolescents (MATCH). *The unified protocol* is based on a transdiagnostic conceptualization of anxiety and depression where both are thought of as emotional disorders with common features. Treatment strategies of the unified protocol for youth include awareness of emotional experience, reattribution, identifying and preventing behavioral and emotional avoidance, and engaging in exposure (Ehrenreich-May & Bilek, 2012). Research has shown that the unified protocol has led to symptom improvements in clients presenting with comorbid disorders (McEvoy, Nathan, & Norton, 2009).

*MATCH* consists of specific modules that address key components of evidence-based treatments for depression, anxiety, trauma, and conduct problems (Chorpita & Weisz, 2009). MATCH allows therapists to access all the components needed for a comprehensive treatment in one manual. It enables therapists to apply specific interventions catered to the needs of clients' at each moment of the treatment rather than require therapists to follow a strict, structured treatment protocol. The modular approach relies primarily on therapists' knowledge of

how to implement treatment with "flexibility within fidelity" (Kendall, Gosch, Furr, & Sood, 2008, p. 987). That is, it requires therapists' fidelity to evidence-based treatment principles utilized in the manual and therapists' flexibility to adjust treatment to meet the specific needs of each client. This flexible approach facilitates the application of evidence-based strategies in day-to-day practice.

MATCH utilizes the common practice elements built into empirically supported treatments and delivers these practice elements through treatment tools. For example, for treating anxiety and depression there are activities such as Cognitive STOP, Cognitive B-L-U-E, and Cognitive TLC that help children counter their maladaptive thoughts (Chorpita & Weisz, 2009). *Cognitive STOP* is an acronym that stands for *s*cared, *t*houghts, *o*ther thoughts, and *p*raise; it is designed to aid in identifying and challenging negative thoughts and reinforcing other, more adaptive thoughts. *Cognitive B-L-U-E* uses the metaphor of comparing negative thoughts to seeing the world through dark glasses in an effort to facilitate the understanding and identification of negative thoughts; the acronym *B-L-U-E* stands for *b*laming myself, *l*ooking for bad news, *u*nhappy guessing, and *e*xaggerating. *Cognitive TLC*, which stands for *t*alk to a friend, *l*ook for a silver lining, and *c*hange channels, seeks to provide children with ideas about how to cope when bad things occur (Chorpita & Weisz, 2009).

The modular approach has been shown to outperform usual care and standardized treatment manuals (Weisz et al., 2012). Although there is evidence of the utility of this approach, there is a need for additional strategies that may help therapists conduct more efficacious and effective treatments with anxious and depressed youth. Weisz and colleagues (2017) showed that the treatment of anxiety disorders yields larger effect sizes (.61) compared to those for other disorders in children and adolescents. However, the effect sizes for depression were less than half of the effect size for anxiety (.29). Furthermore, treating multiple disorders yielded a lower effect size than did any other single disorder (.15; Weisz et al., 2017). Therefore, refining treatments for anxiety and developing better treatments for depression, particularly when comorbid with anxiety, should be a priority.

Other contemporary approaches (e.g., Bunge, Mandil, Consoli, & Gomar, 2017) have suggested a modified version of Chorpita and Weisz's (2009) modular approach. Bunge et al. (2017) recommended the use of modules focusing on specific aspects of anxiety (e.g., fear hierarchy) or depression (e.g., downward spiral), and/or some common modules (e.g., relaxation strategies) as needed. These modules are not structured to be applied in a particular order; therapists select different worksheets and tools depending on clients' needs and therapists' preference. Although manualized treatments, unified protocols, and modular approaches have been shown to be efficacious for youth with anxiety and/or depression, the following section seeks to enhance them through the careful consideration of culture, the application of pedagogical principles, and the use of humor.

## Innovations in the Treatment of Anxiety and Depression in Youth

Innovations do not occur spontaneously but rather combine previous contributions to yield novel outcomes. It is important to examine previous contributions, build upon their strengths, and address their limitations to systematically improve treatment. Therefore, the innovations articulated next have been built upon many of the contributions detailed before. These innovations, expressed in the form of conceptual and concrete tools, integrate cultural perspectives, pedagogical principles, and the use of humor into CBT as ways to increase effectiveness in day-to-day practice. The innovations proposed seek to make a difference in the lives of children and adolescents experiencing anxiety and/or depression while motivating practitioners to embrace their creativity and cultural selves.

### Cultural Considerations

Among the many innovative practices in psychotherapy with children and adolescents living with anxiety and/or depression, cultural considerations are paramount (Hays, 2009). Research has shown that tailoring psychotherapy to incorporate and address cultural diversity leads to increased treatment effects (Huey et al., 2014) and that culturally adapted psychotherapy is more effective than is unadapted treatment (Benish, Quintana, & Wampold, 2011). Fur-

thermore, culturally competent and humble therapists play a significant role in treatment outcomes when they approach and treat their clients as individuals rather than based on generalizations of a given racial, ethnic, or cultural group (Sue, Zane, Nagayama Hall, & Berger, 2009).

**Honoring multiple perspectives.** Psychotherapy is a scientific endeavor within the healing practice traditions that is sanctioned by a professional framework and, most important, by a sociocultural context that gives meaning to it. Therapists, young clients, and their parents come to treatment with their own ideas about psychopathology, well-being, and healing based on their cultural backgrounds, such as life experiences, education, traditions, values, and beliefs. Honoring, respecting, and addressing candidly possible similarities and differences while eschewing assumptions can be a crucial component of the treatment. Furthermore, therapists explore the social representation that their young clients and their families have about psychotherapy as a healing practice and seek to build a shared understanding of what it is, what it is not, and how it can facilitate change while affirming clients' growth and development.

It is particularly helpful to ask anxious and depressed children and adolescents about their understanding of presenting problems and how their families view their fears and mood difficulties. Appreciating how clients' families view treatment can strengthen the therapeutic alliance and help family members to both accept treatment and become allies in it. Joining with clients in exploring possible cultural premises that may influence their problem and entertaining solutions that are culturally congruent is also recommended. For example, among clients and families that are Spanish speakers, common ways of gaining perspective on life issues that are likely to be discussed in therapy involve the use of *dichos* or *refranes* (sayings, metaphors, or proverbs), such as the expression *no hay mal que por bien no venga*, which can be translated as "there is nothing bad from which good does not come" or "this is a blessing in disguise" (e.g., Comas-Díaz, 2006). It may be particularly useful to encourage clients to reflect on the dichos or refranes because in the past they may not have paused to ponder their meaning. Similarly, children and adolescents may find their problems and even solutions reflected in the lyrics of songs or by characters in movies, books, or *cuentos* (folktales). In fact, Costantino, Malgady, and Rogler (1986) have developed a successful approach for Latinx youth that relies on relatable folktales (Ramirez, Jain, Flores-Torres, Perez, & Carlson, 2009).

Joining with children and adolescents in creating a shared understanding of the presenting and related problems is vital. Even the acknowledgment of a problem can be a challenge when youth have experienced shame due to stigma associated with having an identified mental disorder. Similarly, it can be a challenge to admit difficulties when there are cultural expectations involved, such as self-sufficiency. In such circumstances, therapists may approach internalizing disorders such as anxiety and depression by focusing more on the external factors of the problem (environment) rather than the internal–personal factors (thoughts, emotions, behaviors). Therapists can join with anxious and/or depressed youth by discussing what the optimal behaviors, feelings, and reactions are to cope with certain expectations or environmental factors. For example, therapists can ask questions such as these: What is it like for you to be in therapy? When others find out you are in therapy, what do they say to you? What kind of expectations do you see placed upon you as a (e.g., boy, girl, gay, lesbian, transgender, queer, adolescent, Latinx, African American, Asian American, Native American–American Indian, European American youth)? Considering that your (parents, siblings, teachers, friends) are not supportive of your choices of (e.g., friends, who you want to hang out with, how you want to be), what types of thoughts do you have in those situations? What would you want to tell them? How would that help?

**Privacy and self-disclosure.** Some people and cultural groups may value privacy more than or just differently from others, and young clients may expect various levels of self-disclosure from their therapists. The degree and type of personal information that young clients share in therapy will depend on how they see and value privacy and intimacy, how they view therapy, and how they experience the inherent power differential within treatment. Therapists should be mindful of these issues when anticipating how much information clients will share. Some clients may consider certain topics too intimate to be discussed with anyone else, even

if that person is a therapist. Therapists should not assume that clients are necessarily being distant or resistant if they refuse to share personal information. Closely related to this, some topics, such as adolescents' experiencing anxiety surrounding intimate relationships, may be more difficult than others to bring up. The presence of culturally inclusive symbols in a therapist's office can serve as bridges to dialogues about difficult matters. In certain social contexts where traditional, stereotyped values of gender identity are emphasized, being gay, lesbian, bisexual, transgender, or queer may be a risk factor for depression. In some circumstances, a respectful exploration of the young client's internalized homophobic beliefs may facilitate the client's identity formation (Duarté-Vélez, Bernal, & Bonilla, 2010).

**Cultural sensitivity of materials.** All materials recommended or used as part of therapy, including books, websites, homework, or worksheets, need to be assessed with respect to their cultural sensitivity to all groups. Therapists would need to mind their psychotherapy lexicon not only to reduce possible misunderstandings but to decrease the chances of coming across as insensitive. For example, a common expression utilized during the initial sessions with children and adolescents with anxiety or depression is "the miracle question," which some clients or parents may either not understand or find offensive. Therapists should be sensitive to this and may want to use alternative terms such as *magic* ("If we could do a magic trick . . .") or *a scientific experiment* (e.g., "If there were a scientific experiment that could solve our problems . . .").

**Psychoeducation.** This important component of psychotherapy with children and adolescents experiencing anxiety and/or depression is also shaped by cultural and socioeconomic variables. Specifically, some clients may associate anxiety or depression with weakness. For example, some clients who live in dangerous neighborhoods may see courage as an asset and may experience anxiety or depression as humiliating. Therapists may want to discuss the idea that bravery and anxiety can come together: "It is not brave if you aren't scared" (from the movie *Bounce;* Roos, 2000). In addition, therapists can explain that courage is useless without wisdom and can make the point that wisdom implies the capacity to recognize potentially dangerous situations. They can then note that the ability to be alert to danger comes from the ability to use fear constructively. It is also worth it to keep in mind that some safety measures, such as carrying a good-luck charm or praying to help cope with an anxiety-provoking situation, are considered normative in some cultural groups. Therapists do not need to address such behaviors unless they cause significant impairment or disruption in clients' lives. Among cultural groups that emphasize family ties and relationships, parents may expect to be more involved, particularly in the psychoeducation process. Therapists are encouraged to remain open, to validate, to use approaches that include clients' social networks in treatment, and to actively consider clients' preferences and cultural group affiliations.

**Relaxation.** While keeping in mind that some cultural groups may be more familiar with breathing techniques and the use of imagery than are others, therapists would want to tailor relaxation strategies to each client's cultural approaches to relaxing and achieving calm. For clients whose families expect a high achievement level, relaxation could be negatively viewed, as in "it is a waste of time." Faced with such circumstances, therapists could reframe relaxation as "refueling" or "replenishing," to overcome the negative connotations. The use of metaphors may be of help: for example, even the tallest trees need water from time to time. Furthermore, if high achievement or success expectations are part of the problem, discussing with parents ways to create some flexibility by expanding the repertoire of possible successful outcomes and other ways to go about helping their children would be timely.

**Cognitive restructuring.** The extent to which cognitive restructuring is needed depends on many factors, including a client's belief system, culture of origin, religion, and other characteristics. As with all interventions, cognitive restructuring should be done respectfully, bearing such factors in mind. When therapists believe that clients' thoughts may be related more to family norms, cultural premises, or religious beliefs than to an anxiety disorder, per se, it is best to enlist the help of parents or consult with someone knowledgeable about the particular cultural group, such as another therapist or a religious or community leader within that group, while also honoring confidentiality.

Many times, these colleagues or authority figures can help therapists restructure clients' catastrophic thoughts based on a more flexible understanding or interpretation of the norms, premises, or beliefs in question rather than the strict ways in which the clients may have understood these. The aim of a cognitive restructuring intervention ought to be to expand the repertoire of possible meanings or attributions rather than to challenge specific beliefs.

Therapists would want to systematically consider contextual and environmental factors in cognitive restructuring. Many problems, including racial, ethnic, or cultural intolerance, stereotyping, discrimination, and oppression, are outside clients' control. Wondering jointly about the helpfulness of the clients' thoughts, beliefs, images, or even actions rather than their validity may be a more fruitful and productive approach (Hays, 2009). It is particularly important for therapists to be cautious when assessing and addressing thoughts and beliefs concerning abuse or discriminatory events experienced by any client, especially minority clients. For clients to be affected by such events is not only expected but also adaptive. Therapists are to maintain a supportive stance during exploration of these events and, in many instances, ought to go beyond support by engaging in advocacy (Ratts, Toporek, & Lewis, 2010). Rather than questioning clients' thoughts associated with such an event (e.g., "this is terrible"), it may be more productive to focus on clients' thoughts related to coping skills (e.g., ". . . and there is nothing I can do about it"). Resonating empathically with clients' emotional reactions can be validating and ultimately healing.

**Exposure.** When building exposure hierarchies with clients, therapists should actively consider culturally congruent activities. For example, when an adolescent Latina client dealing with social anxiety was invited to set up an exposure hierarchy, she placed attending an upcoming *quinceañera* (celebration of a girl's 15th birthday) at the top. The purpose of the activities within a hierarchy exposure is not to challenge cultural beliefs but rather to expand the repertoire of possible behaviors that are still culturally congruent. Clients and therapists can work together to prioritize the redressing of behaviors that are most disruptive or taxing.

**Behavioral activation.** Behavioral activation aims to increase the amount of rewarding behaviors that are likely to improve clients' thoughts, mood, and overall well-being while actively interdicting avoidance behaviors to increase the probability of exposure to personally meaningful rewarding experiences (Hopko, Lejuez, Ruggiero, & Eifert, 2003). This may be a particularly beneficial approach to circumvent the stigma associated with depression and anxiety in some cultures, because it puts the emphasis on how specific behaviors may influence the way one feels rather than on the mental or cognitive aspects. Such emphasis may make the interventions less stigmatizing for certain clients and their families and may fulfill their expectations for a more directive approach on the part of therapists. For example, Emily, age 16, a Chinese American passionate about art, struggled with depression and increasing isolation. Her therapist worked with her and her family to identify potentially enjoyable outings, including visiting a new exhibition by young artists at a local museum and attending an art lecture at a neighborhood bookstore that was followed by a social gathering where she committed to talking to at least one other youth.

**Problem-solving.** When therapists and clients are generating and assessing alternative solutions to a problem, it is important for therapists to consider options that go beyond the concrete cost–benefit ratio; namely, options that are associated and congruent with clients' particular core values. Clients from more collectivistic cultures may prefer to affirm the will of the group rather than to achieve individual goals. For example, some clients may emphasize harmony and getting along with others rather than having their individual way, even at what could be (mis)construed as a personal cost. For instance, a girl may agree to play baseball with her friends, even if she does not really like baseball, because she finds it rewarding to be part of the group.

**Social skills.** Social skills vary within and across cultural groups and contexts. Such skills may also change depending on power dynamics among individuals and groups. For example, eye contact may not only be appropriate but expected in some cultures and situations. In other cultures or environments, it may be perceived as intrusive, inappropriate, or even aggressive. Similarly, extraversion and introversion may be viewed differently, depending on the cultural group and the specific context.

**Anger.** Although anger is a basic emotion experienced by people in all cultures, anger expression and regulation can vary significantly, depending on cultural norms, rules, and contexts. Many other factors, including triggers, coping strategies, and social approval or disapproval (depending on who expresses anger and who is on the receiving end), interact to make the assessment and treatment of anger a complex therapeutic undertaking. Therapists can consider nomothetic and idiographic dimensions to tailor anger management interventions to clients' characteristics and preferences, while weighing contextual expectations (González-Prendes, 2013).

**Termination.** Although termination is markedly influenced by psychotherapy culture, transitions and closures tend to be shaped by cultural norms. Therapists would want to be attuned to their clients' preferences and choices when it comes to the end of treatment and to engage in proactive dialogue about such a phase. Some clients may be inclined to bring gifts for their therapists, but professional norms or agency policies may prevent the acceptance of some gifts. Careful attunement to how culture impacts treatment is crucial throughout the course of psychotherapy, including the final sessions.

## Pedagogical Principles

When considering how to facilitate the acquisition of new skills as well as the maintenance and generalization of the therapeutic progress over time, the field of pedagogy is an important source for insights and guidance. CBT with children and adolescents experiencing anxiety and depression involves learning adaptive coping strategies and unlearning maladaptive ones. Therefore, therapists assess what clients do and how they have learned to do it. The complexity of psychotherapy requires that therapists also assess what the usual and preferred ways in which their clients learn are. Furthermore, therapists themselves have usual and preferred ways in which they fulfill the learning and unlearning that goes on in psychotherapy. Therefore, an important set of considerations involves the pedagogical principles that inform the therapeutic work, particularly when working with children and adolescents presenting anxiety or depression.

Many of the therapeutic techniques utilized when conducting CBT with youth rely on young clients' acquiring novel skills. In school, children and adolescents learn not only course content but also critical thinking and do so during class time and through homework. Similar principles are in place to ensure that children and adolescents diagnosed with anxiety or depression receiving CBT can learn the skills during sessions, outside of sessions, and throughout the life span. Thus, it is important to rely upon empirically supported and evidence-based principles and theories, particularly from the field of pedagogy, when considering how best to engage and help clients.

Active learning, with its core elements of collaborative, cooperative, and problem-based learning (Bonwell & Eison, 1991; Prince, 2004), is now a method employed in most classrooms in the United States, including science, technology, engineering, and math education (Freeman et al., 2014). It is a learning technique that emphasizes student engagement in activities *during* class time to enhance learning outcomes; it helps improve motivation, retention of material, and development of thinking skills (Prince, 2004).

Congruent with pedagogical research and active learning, therapists may utilize specific resources such as structured activities, presented in a manner that may be appealing to children and adolescents, to engage clients during sessions. For example, cognitive–behavioral tools can be explained as "experiments" or "adventures" (Bunge et al., 2017). As with students (Crosling et al., 2009), it is vital for engagement and lifelong learning that clients find the in- and out-of-session activities relatable and personally meaningful.

If youth are not actively engaged, they may begin to lose focus, which can also be influenced by the level of perceived difficulty of a given activity. Thus, to increase "buy-in," treatment must be easily understood and believed in by clients, which can be accomplished through straightforward and age-appropriate activities. Although therapists may find it challenging to provide psychoeducation and an explanation of effective techniques, there are a number of tools that can facilitate doing so. For example, a 9-year-old experiencing generalized anxiety may significantly benefit from challenging catastrophic thinking. However, given the limited

attention span in youth, the explanation of challenging thoughts must be brief and easy to understand. To aid in comprehension, therapists can provide age-appropriate explanations and illustrations of objects or situations youth may already be familiar with outside the therapy room. For example, one could use the metaphor of a "stairway to bravery" to briefly and effectively explain the nature of catastrophic thinking and rumination to a 9-year-old (Bunge et al., 2017, pp. 128–131). Pairing this metaphor with a literal illustration may better help therapists and clients in identifying catastrophic thinking and developing a step-by-step approach to solving a problem.

Images and characters may aid in the learning process. Utilizing social learning theory, therapists may resort to popular characters when illustrating concepts or developing worksheets with and for their clients. Seeing popular, inspiring, or easily relatable characters involved in activities and then experiencing positive outcomes may further client engagement with treatment and facilitate observational learning. For example, Bunge et al. (2017, pp. 89–93) used "The Teachings of the Master Ninja" activity to connect the calm nature of a martial arts master with relaxation strategies. This approach may motivate youth to emulate the master ninja. Further, Heidig, Müller, and Reichelt (2015) found that illustrations can evoke emotional responses from learners, potentiating and aiding in the learning process. Again, therapists can utilize comic strips, characters, and illustrations to normalize emotions for clients or help clients and families name and discuss the problems through relatable narratives and scenarios.

Integral to both learning and therapy is the ability to reflect upon experiences. Therapists can use relatable and accessible worksheets and activities in vivo with clients to process the activity and reflect it back to them. A suggested technique is the use of karate belts to explain fear hierarchies (Bunge et al., 2017, pp. 123–127), of which the following is an example:

Therapist: So, you told me that you are afraid to attend school because you think something bad will happen to your mother while you are in class.

Client: Yes.

Therapist: Do you think you might want to try an activity with me that could make going to school a little easier?

Client: I do not think going to school will ever be easy. I do not know if I can ever go again. I get sick every time I go.

Therapist: That sounds very difficult. You mentioned that you like karate. How about if we think about going to school as getting a black belt in karate. That is the ultimate belt that you can achieve, but, as you know, they do not just give it to you on your first day. There are a lot of little steps that it takes to go from belt to belt.

Client: Okay.

Therapist: So, let's pretend that you're a karate apprentice, and you're going to get your black belt. What we're going to do is that we are going to take your big fear, going to school, and try to break it into little steps. We will start with the white belt and then start getting higher.

Client: Okay.

Therapist: So, let's start. If the hardest part is going to school, what is something on the way to school that might be easy for you?

Client: Well, I am able to get out of bed in the morning. But then I cannot leave my mom's room and I do not let her get ready for work.

Therapist: Okay . . . so to earn your white belt, you're going to have to stay out of your mom's room. Do you think

we might be able to come up with some ways to do that?

Client: We can try.

This process would then be continued, creating a fear and accomplishment hierarchy and slowly determining what the client would need to overcome to achieve each goal. By doing so, pedagogical principles including active learning are enacted, increasing the likelihood of adhering to treatment and opportunities for learning and relearning.

## Humor

An important challenge when conducting psychotherapy with children is making abstract psychological concepts concrete; humor has been identified as an effective tool in aiding understanding. Research has indicated that humor significantly increases knowledge and comprehension in a learning context (Hackathorn, Garczynski, Blankmeyer, Tennial, & Solomon, 2012). Humor not only increases understanding but also decreases resistance (Borcherdt, 2002). Furthermore, a study by Garner (2006) found that curriculum-specific humor not only improves learning outcomes in college students but also results in more positive instructor ratings. Such findings underscore that humor facilitates teaching and learning and suggest that using humor in therapy may strengthen the therapeutic alliance.

Humor is a tool that can help build the therapeutic alliance and can also aid client–therapist collaboration and the achievement of client's treatment goals. Specifically, in psychotherapy, humor can be used as a way of "joining" (i.e., to convey understanding of the client's perspective) while simultaneously reframing the client's perspective, in what Panichelli (2013) refers to as a "auto-double-bind" (p. 438): Humor strengthens the therapeutic alliance and, at the same time, facilitates the challenging of the client's maladaptive cognitions.

In therapy, humor can reduce tension, improve personal relationships, and increase insight (Dziegielewski, 2003). Humor may alleviate the burden associated with psychopathological labels, validate clients' experiences, and normalize anxiety and depression. Furthermore, humor has been identified as a trait of a more effective therapist (Yonatan-Leus, Tishby, Shefler, & Wiseman, 2017). Finally, humor has gained more attention through positive psychology, and building on the character strength of humor has been recommended for counseling youth (Park & Peterson, 2008).

Many different treatments for children and adolescents utilize humor throughout therapy. For example, Chorpita and Weisz's (2009) MATCH suggests ending sessions with a "Leave 'Em Laughing" activity. These fun activities help the child feel positive about what was accomplished in the session. Similarly, Kendall and Khanna's (2008) CBT4CBT recommends ending the session doing fun activities, such as playing video games. When conducting CBT with children and adolescents, utilizing humor makes therapeutic techniques more memorable and enjoyable (Friedberg & McClure, 2015). Although it is valuable to apply humor at the end of a session, it seems even more valuable to strategically use humor throughout treatment, because it increases memorability, and thus likely generalizability, and actively builds rapport throughout the session rather than just at the end of it. For example, when teaching how to identify and challenge automatic thoughts as part of cognitive restructuring, it can be useful to use a comic strip. Specifically, therapists could use the following comic strip of a child who believes she is falling apart because of the loss of a tooth (Bunge et al., 2017, p. 42):

Therapist: (while showing the comic strip) What thoughts is this girl having?

Client: She is nervous.

Therapist: It does seem like she is nervous. What might she be thinking?

Client: She thinks that she is going to fall apart.

Therapist: Yeah. What would you say to the child to challenge that thought and make them feel better?

Client: The tooth fairy will come!

Therapist: Yeah, though if the tooth fairy comes and you fell to

pieces you wouldn't be able to enjoy it, would you?

Client: She could say to herself to keep calm.

Therapist: (smiles) Now, would you be able to keep calm if you truly believe you are falling to pieces?

Client: Well they can think they are growing up.

Therapist: I think you're onto something, yet right now the girl only knows that parts of her body are falling out.

Client: Well, she probably has many friends at school who have lost teeth.

Therapist: That's a great point! What if everyone else at her school is also falling apart and they just do not know it? Can you think of any other evidence?

Client: Hmm . . . Well I've seen pictures of my parents as kids without teeth . . . they grew up fine and didn't fall apart.

Therapist: Wow! That's a really great point. And you know what, if you look in your mouth where you lost your tooth you might even see a little bit of white coming out.

This process of identifying automatic thoughts and their relationship to emotions and then challenging the automatic thoughts associated with the situation through cognitive restructuring can be done using readily available cartoon strips or, better yet, by ones developed by clients or by clients and therapists jointly.

Therapists may also want to consider using a more playful approach to exposure. Juan, a 7-year-old client, had an aversion to plastic bottles even though they were used regularly at his school, during after-school activities, and at home. We engaged Juan in a hierarchical exposure through play. We first played soccer with a plastic bottle cap, because soccer was Juan's favorite sport. Then, we played basketball with a small plastic ball in our office. After that, we played with water bottles as light sabers. Once Juan grew accustomed to playing with the plastic light sabers, we played in the office with his parents, and later he played with his parents at home. Eventually, Juan was asked to pour water into everyone's cup with the plastic light saber. Using humor and play to conquer specific phobias and anxiety can make overwhelming tasks accomplishable and perhaps even enjoyable.

To effectively utilize humor as a therapeutic tool, it must be applied sensitively and strategically (Bernet, 1993). As Meyer (2000) elucidated, the three theories of humor (i.e., the relief, incongruity, and superiority theories) combine together to serve as a uniting or as a dividing force among communicators. When humor is implemented successfully, it can unite communicators and release tension, but when it is not applied appropriately, it can damage the relationship and harm the child. For example, considering the tooth fairy example, if the therapist had used superiority humor and responded by laughing and stating, "That's ridiculous!" the child may have felt shamed and would not have engaged in cognitive restructuring.

It is pertinent to caution against the use of inappropriate humor in therapy. Put-downs and inappropriate humor, particularly when based on cultural stereotypes, can have a negative impact on learning (Wanzer, Frymier, & Irwin, 2010). When utilizing humor in therapy it is important to target the belief, not the child (Friedberg & McClure, 2015). Furthermore, it is important to be sensitive to the child's development, cultural background, and symptoms to determine when humor is most likely to be effective in therapy. To be able to competently apply humor in treatment, therapists must understand developmentally appropriate humor (e.g., slapstick humor may be better than sarcasm, especially with younger children) and cultural differences and have a good sense of humor themselves.

## Conclusion

In this article we proposed the integration of cultural considerations, the intentional adoption of pedagogical principles, and the use of humor in therapy as three possible conceptual and concrete innovative tools that can further CBT's

effectiveness. Moreover, these three innovations are likely to deepen the working alliance, better meet the diverse needs of clients', and improve treatment outcomes. In short, culturally competent therapists are sensitive to their clients' unique backgrounds yet refrain from treating them as representatives of any given culture. Addressing the role of cultural norms, values, and beliefs can promote understanding and reduce the chance that therapists may appear insensitive. Because CBT involves learning, it is crucial that therapists examine the pedagogical principles they employed in or affirmed through their work. Minding clients' learning patterns and reinforcing adaptive thinking patterns through active learning is more likely to facilitate clients' treatment adherence and gains. Finally, the use of humor further aids learning because a playful approach can make complex therapeutic concepts more understandable and relatable and therapy more accessible for clients and even more enjoyable for practitioners.

In terms of future directions for research and practice, it would be worth it to intentionally combine the dimensions identified in this article to assess the collective difference they make to treatment process and outcome. Although much of the research has relied on dismantling approaches by studying single dimensions to demonstrate efficacy, it seems worthwhile to incorporate cultural considerations, pedagogical principles, and humor simultaneously in an effort to further CBT's effectiveness.

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