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Effectively Engaging and Collaborating with Children and Adolescents in Cognitive Behavioral Therapy Sessions

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Introduction

Cognitive behavioral therapy (CBT) is a collaborative undertaking that presupposes participant engagement, "collaboration" being seen to consist of working together toward a common goal, and "engagement" referring to one's investment and involvement in the treatment. Collaboration is central to therapy with youth. It has been associated with less attrition, positive treatment outcomes, and a more favorable therapeutic alliance (Chu et al. 2004; Creed and Kendall 2005). Collaboration can be said to create the foundation of the alliance, fostering trust and increasing the child's motivation. Engagement, or involvement, is of particular importance because youth typically do not refer themselves to treatment and may not see their situation as problematic. Accordingly, CBT therapists working with youth engage the child with a goal of making therapy both relevant and enjoyable. Often the CBT therapist uses engagement strategies such as rewards, stories, metaphors, drawings, games, and other interactive methods. Strategies of engagement are also tailored for adolescents.

Key Features of Competencies and Behavioral Markers

Ability to collaboratively set and adhere to the session goals or agenda

Agenda and goals are potentially influenced by the parent, the youth, the therapist, and the treatment manual. Thus a negotiation regarding the goals and the agenda is needed between the involved parties, including the youth. Importantly, collaboratively

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setting goals has been found to relate to a stronger therapeutic alliance, as perceived by the child (Creed and Kendall 2005). Within this collaborative model, the therapist takes the role of a "coach" (Kendall 2012). As a coach, the therapist explains to the child that her role includes some teaching, some practice, as well as providing encouragement and support throughout. The coach is equipped with specialized knowledge about ways to treat the presenting concern and to reach set goals. Equally relevantly, the therapist emphasizes that the child contributes important knowledge about himself, his family, and his experiences and that parents may contribute complementary knowledge. Within collaboration, the therapist highlights that she, the child, and (depending on the treatment manual or the circumstances) the parents work together as a team, each bringing valuable expertise that can be integrated. It is important to keep in mind these complementary roles when setting the agenda and determining goals, and to ensure that each party has a balanced influence on goals and tasks. For example, the therapist can check in with all parties at the end of each session to discuss opinions on progress toward goals.

When using an empirically supported treatment for youth internalizing disorders (Kendall and Hedtke 2006; Stark et al. 2007), much of the therapy agenda will be outlined in the treatment manual. Adherence to the core components of the manual is important, but treatment is also tailored to the individual child; the principle for this is "flexibility within fidelity" (Kendall and Beidas 2007; Kendall, Gosch, Furr, and Sood 2008). Manuals are not to be used in "cookie cutter" fashion, but rather as guides. For example, implementing exposure, behavioral activation, and cognitive restructuring is central to the treatment of anxiety and depression, yet the content and application of these tasks will vary depending on the child's idiosyncratic presentation. By allowing a child to influence the choice of the topic from which he is to learn or practice a new skill, the therapist can ensure that the session is engaging and, through a judicial selection of the options offered by the child, that each session contributes to the overall goals.

Ability to communicate the rationale for each specific CBT technique

Taking the time to explain CBT activities conveys the message that the therapist wants the youth to understand the importance of the intervention rather than blindly follow an authority's orders. Discussing the rationale exemplifies collaboration and motivates the child to "buy in," thereby increasing compliance during in-session and homework tasks. When discussing CBT with youth, it is important to avoid jargon and to use developmentally appropriate language. The use of metaphors can make CBT accessible to young children and provides a simple way to understand complex concepts (Friedberg and Wilt 2010). For example, when introducing mood-regulating strategies – such as relaxation, coping thoughts, or behavioral activation – the therapist could say: "In the upcoming sessions we're going to go through a tool box with lots of different tools you can use when you are feeling upset. Different tools can be used for different situations, just as a screwdriver and a hammer are used for different things. I can help provide you with several possible tools, and then we can decide what works best for you."

In the Coping Cat treatment for youth anxiety (Kendall and Hedtke 2006), the therapist uses the metaphor of a fire alarm to explain somatic reactions in anxiety. For example, the therapist may say:

> When we feel really anxious, it's like our bodies have their own fire alarms. They provide cues when danger may be present. For example, when your body's fire alarm goes off, your heart beats fast, your palms get sweaty, and you may feel butterflies in your stomach. But sometimes a fire alarm goes off because it thinks there's a fire but there really isn't one. This is called a false alarm. Has that ever happened to you at school, when the school fire alarm goes off, but it's just a test … not a real fire? Your body can sometimes do the same thing. You may feel those bodily reactions, like there's a danger, but there is really no danger, it's just a false alarm.

Similarly, stories and appropriate therapist self-disclosure are other methods to explain the CBT rationale and to improve the therapeutic alliance. The therapist should determine if the rationale has been understood by asking youth, in a fun and nonconfrontational way, to explain it back to the therapist or to parents, or by eliciting feedback to assess whether the information was communicated clearly and effectively.

Prior to presenting a rationale to a child, a therapist needs to ensure her own comfort with explaining the relevant details. This can be achieved through practice, by explaining each rationale to people unfamiliar with the treatment, and through analysis of video recordings of sessions focused on a child's reactions and evidence of comprehension.

Ability to elicit and respond to feedback

Delivering feedback can be empowering for the child (Friedberg and McClure 2002) and can illustrate that the therapist and the child are working as a "team." Furthermore, eliciting feedback allows for a more individualized protocol. For example, when constructing a fear hierarchy, it is important to have the child contribute items to the list. Once the hierarchy is established, the therapist can elicit feedback about what makes each item harder or easier (for example social anxiety exposure tasks can involve girls or boys, younger or older children, large or small groups of people); and this will assist in a further application of the skill.

The timing of feedback is important. The end of a session provides a natural time to inquire about feedback, but feedback can also be elicited before, after, and during therapy tasks. The purpose of this feedback is to gather objective evidence regarding what can be learnt from skill implementation, for example by contrasting anxiety before or during and after an exposure, and to compare the child's comprehension or experience of the skill with the intended goal. This latter feedback can be used to identify and address potential ruptures in the session before the agenda – or progress – is derailed. Therapists should also be cognizant of the child's nonverbal feedback. A sudden mood shift, change in body posture, cessation of regular eye contact, or eye-rolling are signals that the therapist should pause and check in with the child. Responding to these

nonverbal cues with questions such as, "I noticed you've been looking away for the past minute or so, what's going on," or "what I just said seemed to upset you, tell me how you're feeling" makes the child feel attended to and provides the therapist with valuable information to guide the next therapeutic interaction. The therapist needs to adjust therapy tasks in response to feedback, in a way that guarantees continued progress toward skill development and goals, while also ensuring that the child remains engaged.

Ability to facilitate in-session collaboration

In addition to working on direct collaboration between child and therapist through goal or agenda setting, by communicating rationales, and by utilizing feedback, incorporating parents into the collaboration has benefits. These include improvement in the internalizing symptoms, greater family participation, and less frequent cancellations (Hawley and Weisz 2005; McLeod and Weisz 2005). The role taken by the parent is determined by the selected manual, the setting of the therapy, and that parent's willingness to be a part of it. All collaboration may occur with the direct involvement of the child or through parent–therapist discussions, conducted independently of the child. The latter are crucial when the matters discussed may be embarrassing or punitive for the child. When working with the parent independently, it is crucial to frame for the child how you will protect his privacy, what the purposes of the discussions are, and how you will use the information you gather.

Kendall (2012) proposed three ways in which parents can contribute to therapy for youth. Parents can be consultants, collaborators, or co-clients. The "consultant" parent provides input on treatment concerns and goals and on progress over time, as well as a different point of view on the success (or otherwise) of skill practice and generalization. "Collaborative" parents help facilitate a "transfer of control" (Silverman, Ginsburg, and Kurtines 1995): for children, the therapist is gradually phased out and parents take charge, to help their child cope (e.g., a parent responds to a child's apparent worry about a school performance by guiding the child to use coping self-talk). With adolescents, the therapist transfers her control to the adolescents themselves, allowing the parents to take a supportive role on request (e.g., when the adolescent requests the parent to facilitate a pleasant event by providing transport). To enable a successful transfer of control, the therapist may include the parent in some sessions during the treatment: in this way she can exchange therapist knowledge and skills with that parent. For instance, at the end of a relaxation training session, the youth would teach the parent, under the therapist's guidance, how to do deep breathing and progressive muscle relaxation; or the therapist would dedicate session time to teach the parent relevant skills, independently. Finally, the parent may be a "co-client" in situations where the direct targeting of parenting behavior is necessitated by a manual (e.g., training in family conflict resolution) or by the fact that the parent's behavior impacts on the child's progress (e.g., the parent's anxiety discourages the child's completion of exposure tasks). Each of these roles can be used to facilitate collaboration with the therapist and child to support treatment progress.

Ability to implement specific CBT techniques flexibly

"Flexibility within fidelity" represents another competency. CBT procedures are optimal when presented flexibly and in sync with the youth's presenting problem, needs, preferences, cultural background, level of emotional and cognitive development, and current mood. For example, Friedberg and Gorman (2007) proposed that clients who are older, motivated, high in hopelessness, afraid of negative evaluation, and more stable (e.g., not in crisis) or who have a high tolerance for frustration may benefit from increased collaboration and less direction and structure. All CBT strategies can be tailored to the needs of the client. For example, therapists may personalize relaxation recordings to reflect visualizations that are meaningful to the client; they may present "thinking traps" and other cognitive restructuring methods via visual or verbal methods in response to the client's preferred learning style; they may adjust the content in problem solving to reflect issues salient to the child's recent experience; and they may introduce visual aids, such as a fear hierarchy or a mood thermometer, which can be decorated according to the child's interests (e.g., Harry Potter themed visual aids). A discussion of modifications recommended for specific disorders and for the developmental level appears later in the chapter.

Although there is no single framework for adapting interventions designed for culturally diverse youth (Crawley, Podell, Beidas, Braswell, and Kendall 2010), culture does impact notions of etiology, treatment, compliance, and goals. Broadly speaking, the therapist benefits from having an awareness of the child's cultural context. For example, a family whose cultural beliefs emphasize respect for the knowledge of experts (as seen in many Asian cultures) may prefer a therapist to be directive rather than collaborative, or may need additional explanations of why collaboration is crucial to progress. Awareness of the child's environmental context is also crucial. For example, during cognitive restructuring, a therapist might test a negative belief by asking: "How likely is it for a feared outcome to occur?" (e.g., fear of being hurt). If the child is living in a dangerous environment, then the concern may not be irrational. Testing its likelihood would be both unproductive and insensitive, given the child's context. Under these circumstances it would be preferable to use problem solving or to evaluate the worst case scenario and devise ways to cope.

Ability to make use of experiential strategies

The ability to make use of experiential strategies so as to implement specific CBT techniques is worth a brief discussion; however, specific examples are provided in each of the CBT technique chapters. Experiential strategies – such as reinforcement, role-play, and modeling – make CBT content accessible to children. Implementation of the more "adult," discussion-based model of CBT may elicit disengagement, boredom, and poor understanding of the concepts of therapy. Reinforcement is particularly important for increasing the factors of motivation and compliance in youth. Unlike adults, most youth do not volunteer to come to therapy and, accordingly, may require external incentives. For example, anxious youth can receive "brave bucks" for completing exposure tasks, and then they can choose how to spend their "bucks" on available rewards and privileges. Importantly, rewards do not

have to cost money and can include privileges – like choosing the family dinner, watching a movie with a parent, or being excused from a disliked chore. Therapists can evaluate the effectiveness of the reinforcement by determining whether it increases the targeted behavior. Modeling and role-play are active tasks that engage a youth in understanding therapy content and in practicing newly learnt skills. For example, a therapist can illustrate the application of a skill by modeling its use in an imagined scenario; the youth then proceeds to roleplay use of that skill. The process may also pull on additional resources, such as watching videos in which others are using a skill, or recording videos to obtain feedback on skill use. The effectiveness of these approaches is evaluated through the child's engagement in the task and the child's ability to complete the behavior, initially with the therapist's assistance, then independently.

Ability to end sessions in a planned manner

A successful therapist aims to accomplish all the session goals without feeling rushed. A therapist can work toward this aim by utilizing a manual's checklist or the agenda set collaboratively at the start of the session to actively keep track of progress during the session. When planning sessions, therapists need to ensure that sufficient time is allowed for any consultation with the parents and for reward activities promised to the child. Sometimes therapists will realize that they still have too much session material to cover in the remaining time and may hurry through the remaining tasks, sacrificing depth of content. Other times therapists may end the session abruptly, without allowing time for crucial feedback processes. In situations where the therapist does not have time to complete the tasks, it is recommended to leave content for the next session rather than rush through material. In the next session the therapist should reorient the child to the material from the prior week. If the therapist promised the child a game at the end, it is important for the therapist to follow through regardless of the amount of uncovered content, so that the therapy relationship is not undermined.

Competence in Treating Specific Disorders

The treatment of specific youth internalizing disorders often requires the use of specialized therapy techniques. Flexibility to adapt standard protocols to meet the particular presentation of an individual child is a highly valuable therapist skill. Ways in which the aforementioned competencies may vary for particular disorders are discussed below.

Youth with generalized anxiety disorder (GAD) or obsessive–compulsive disorder (OCD) are often rigid in their style of thinking and behaving. They commonly have low tolerance for uncertainty. Explicitly structuring the sessions in a predictable manner helps such a child to focus on session content rather than fixate on what will happen next. Noticing that an anxious youth is overly rigid in adhering to a session agenda is an important therapeutic observation, which can be used to inform exposure sessions. In addition, therapists should consider how disruption to a session's routine

(e.g., the need to end a session before covering previously planned session content) may affect such youth and proactively address any concerns. Experiential techniques may be difficult to implement with youth who have rigid thinking styles or who prefer to follow set rules. Rationales may need to be explained in more depth. Therapists may need to encourage these youth to be creative and to remind them that therapy does not have rules, like school (e.g., spelling does not matter) and that there is no "grade." Finally, youth with GAD or OCD may be particularly resistant to change. They may interpret their anxious symptoms as "helpful," which can impact the collaboration between therapist and child. Therapists should be prepared to elicit and respond to negative feedback from the child in order to maintain collaboration.

The impact that social anxiety has on the therapist–client relationship can present a particular challenge to effectively engaging youth in therapy. Youth with social phobia may be inclined to try to please the therapist. This social desirability bias can be problematic for the creation of a therapist–child collaboration, as difficult and at times unflattering situations or events need to be discussed in the session. Sessions, in and of themselves, may be exposures for youth with social phobia, given that speaking with adults is typically anxiety provoking for youth with the disorder. Compounded with the focus on the child's own anxiety symptoms, youth with social phobia may feel quite vulnerable in session. To effectively engage such youth, therapists should be cognizant of the child's potential discomfort and should structure the sessions such that rapport can be built without placing too much burden on the child to initiate conversation. For example, playing a "getting to know you" game or ice-breaker provides more structure than an open-ended conversation and can be less intimidating for socially anxious youth. Therapists may also wish to consider focusing on the experience of anxiety more broadly to begin with – for example, they could start by asking the child to imagine what it's like for a family member or a friend to experience anxiety – thereby normalizing the experience of anxiety. When they obtain feedback, therapists could have the child write or draw rather than carry an oral discussion. Resorting to yes/no and forced choice options or drawing on the parent to provide responses may also be helpful, particularly during the early period of building trust and comfort. Early sessions will likely need to be more heavily guided by the therapist, who can encourage the child's participation and gradually work toward increasing his leadership of the sessions. Engaging in experiential strategies and exposures may prove difficult for youth who fear negative evaluation from the therapist and others. In such instances, the therapist can model "messing up" in front of the child (e.g., by dropping a book in a crowded area), to show the child that even the therapist does embarrassing things at times, which may help the child feel more at ease. Socially anxious youth may also be particularly sensitive to corrective feedback, a point that therapists should be mindful of when they respond to a child's attempts to engage in therapy.

Facilitating collaboration can also be difficult when treating youth with post-traumatic stress disorder (PTSD), particularly if the child is distrustful of adults as a result of the traumatic event, or if feelings of shame and guilt are present. Furthermore, the child may not have shared all the details of the trauma with his parents. The therapist is faced with the challenge of getting the child to feel comfortable about disclosing this information while respecting the child's privacy and at the same time maintaining

collaboration with both the child and parents. Though challenging, building a strong collaboration with the child at the beginning of therapy may be particularly important in treating youth with PTSD.

Youth with separation anxiety disorder (SAD) may present logistical challenges to collaboratively conducting CBT. For example, youth with severe separation anxiety are reluctant to separate from a parent in order to meet with a therapist individually. Therapists can build collaboration by initially allowing the parent to be in the room, or just outside the door, and by rewarding the child for any efforts to increase the amount of separation from the parent. Establishing set breaks from therapy in which the child is allowed to see the parent can get the child to be more engaged in the session and less focused on reunification. Communicating the rationale for exposures may be difficult and upsetting for youth with SAD. They may not be interested in improving their ability to cope with being away from their parent, but rather view always being near the parent as the only solution to their anxiety. Thus, in the exposure phase of the treatment, therapists may encounter difficulties setting a session agenda in a collaborative manner. Allowing these youth to have greater control over other aspects of the session may reduce frustration and maintain the collaborative, team approach.

Special considerations are necessary when treating youth with depressive disorders. These youth may have low levels of motivation, or they may lack the energy needed to change their current functioning. Youth who feel hopeless and have an external locus of control may be difficult to engage in the therapeutic process if they feel they have limited ability to change their situation. Thus, setting session goals may have to be more therapist-guided. In addition, getting a depressed child to implement CBT techniques such as behavioral activation in their daily lives may be particularly challenging. Even if the rationale is clearly communicated, therapists will also need to explicitly hook into factors that may motivate the child to change. The usual luster associated with tangible or social rewards may be lacking among youth who are depressed. Drawing on family members' support to facilitate activity scheduling may be necessary. Furthermore, depressed youth may believe that their feedback is not important and unlikely to bring about change; the therapist can demonstrate that the youth has the ability to effect change by being persistent in eliciting feedback and by responding to such feedback clearly, with corresponding adjustments to therapy.

Developmental Considerations: Competence in Treating Children and Adolescents

The competent implementation of empirically supported treatments requires appropriate responsiveness to the developmental level of the child or adolescent. In terms of setting session goals, younger children may be unable to articulate goals and may require the therapist to keep it simple and take the lead. However, as sessions progress and become more predictable, therapists can have youth draw on their experiences in past sessions to say what they think should be part of the agenda. Adolescents, on the other hand, may have from the very beginning different goals for therapy from those of the therapist and of parents. It is important for the therapist to identify right from

start particular "treatment deliverables" for the adolescent and parents and to balance each person's goals, which may be quite divergent. Issues with peers and family may be particularly important from the adolescents' point of view, and incorporating these topics will increase the likelihood that the youth will be engaged in session.

Similarly, building rapport and collaboration with adolescents looks very different from building rapport and collaboration with children. Younger children often enjoy playing games with the therapist, whereas adolescents find such activities too child-like and prefer getting to know the therapist by simply having a conversation. With adolescents, taking a walk while talking, so that the focus is not on direct eye contact, can often help break down barriers. Finding ways to connect with teens – and ways that are not forced: for example, the therapist could share how she feels after she has a misunderstanding with a friend, when the adolescent recounts a similar event – can enhance the collaboration and demonstrate understanding of the adolescent's perspective. Importantly, therapists need to convey that their sharing with adolescents is genuine, even if this means admitting to a lack of knowledge of, or to a (respectful) dislike for, something the adolescent loves; for adolescents rarely engage positively when they sense deceit or condescension.

Communicating the rationale for specific CBT strategies will also vary with the developmental stage. With children, the goal is to use language that is comprehensible – no jargon or technical terms. Using metaphors, cartoons, and real-life examples can increase the accessibility of concepts. Breaking concepts into smaller, more digestible parts and linking themes across sessions can be helpful. Adolescents, on the other hand, prefer being treated like adults and may be turned off by language or activities that seem child-like in nature. Conveying ideas in a relaxed manner, without seeming overly formal or trying too hard to be like the teen (e.g., avoiding the use of phrases that are popular with teens but sound odd coming from an adult) is appropriate. Eliciting feedback varies according to the client's age: younger children may not have the vocabulary to give detailed feedback. They may be intimidated by the perceived authority of the adult therapist or erroneously concerned that such information will be shared with their parents, who will reprimand them for negative feedback. Specifically asking for feedback on something they enjoyed and something they thought "boring" can help elicit negative feedback. To elicit feedback from adolescents, the therapist can frame giving feedback as an opportunity for the youth to be the boss and decide whether the therapist is meeting expectations.

Experiential strategies require tailoring to developmental level. With younger children, reinforcement may consist in concrete, short-term rewards. Therapists can be creative with visually displaying sticker charts, to make the experience of earning rewards even more enjoyable and interactive. Any handouts should be age-appropriate and may involve cartoons or depictions of concepts and less written material. To keep the child engaged while modeling skills such as relaxation techniques, the therapist and the child can imagine what a superhero would look like if he were taking deep breaths before embarking on a brave adventure. Art projects, acting, and creating videos tend to be more appealing to children than the discussion of concepts, and techniques that require the child to generate the material can also reinforce learning.

Though reinforcements still play an important role when treating adolescents, adolescents may have a more difficult time identifying meaningful rewards or may feel bashful about earning rewards. Coming to session prepared with adolescent-friendly reward options (e.g., gift certificates to the movies or to restaurants) and normalizing the process of earning rewards for hard work (e.g., likening it to earning a paycheck at work) can help adolescents feel at ease. Adolescents' reluctance can show when they are engaging in strategies such as relaxation, which may be perceived as strange, or in experiential strategies such as role-play, which requires them to be creative. Therapists can normalize the youth's concern and be collaborative (e.g., by saying, "I know this might seem strange … I thought it was the first time I did it, too)" and praise adolescents for their efforts to try new things.

Common Obstacles to Competent Practice and Methods to Overcome Them

Much to the chagrin of therapists, obstacles to treatment can be more the rule than the exception. In general, the test of a therapist's competence is not solely in knowledge of the treatment protocol, but also in the reactions needed when challenges arise.

When behavioral disorders such as attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant behavior (ODD) co-occur with internalizing disorders, therapists must draw on skills to maintain fidelity to treatment protocols. Youth with these comorbidities may exhibit more behavioral difficulties in session, and often have difficulty staying on task and complying with directions. When setting session goals, therapists who work with these youth may wish to explicitly note when goals are achieved and to reward the child for on-task behavior. Breaking goals down into more manageable chunks, allowing the child frequent breaks, and incorporating physical activities (such as building an exposure stepladder on the floor) can also be beneficial. When noncompliant or defiant behavior is exhibited by the child, collaboration can be difficult to maintain. Such youth may test the therapist's authority. Maintaining firm expectations and following through with consequences for noncompliance is important in the context of a warm, supportive relationship. Covering session content and ending sessions in a planned manner may be challenging when one is working with youth with attention difficulties. Setting realistic expectations for the session in the basis of the child's presentation is important for maintaining structure and for ensuring that sessions are not rushed at the end.

There are many potential obstacles that have the capacity to undermine collaborative engagement with youth, including the ability to set and adhere to the session goals and agenda. In addition to the challenges presented by ADHD/ODD, at the other extreme are internalizing and detail-oriented children who get too preoccupied with the agenda. For example, anxious youth with high intolerance of uncertainty may ask excessive questions about the details of the session plan. Addressing every question is unproductive and may reinforce reassurance-seeking behavior. Therapists need to redirect the child to the activity at hand and note that some issues will be addressed at a later time. Importantly, there may be times when issues or crises arise that are not part of the planned agenda. The therapist should respond appropriately

to the nature of the issue but also needs to be alert that the child or parent is not introducing issues in an attempt to derail the agenda. This may occur as a strategy to avoid particular therapy components, or it may reflect ambivalence about treatment goals.

The ability to respond to feedback is susceptible to obstacles. The therapist must balance sensitivity with compliance to therapy, particularly when children note that they do not want to participate in a therapeutic task. Disregarding the feedback makes the therapist appear flippant and may detract from the sense of collaboration; yet acquiescence can be counterproductive, and it can even reinforce avoidance. The therapist can validate the child's feelings and thank him for providing their feedback. For example, the therapist could say: "I understand why you think that this might not work for you. Other kids have thought that too, but with practice they saw it differently and became more confident …" Ultimately, the therapist remains resolute that the child will at least attempt the activity. When children are stubborn, therapists can motivate them through rewards for task completion or problem-solving ways to make the activity more acceptable. For example, the therapist can present the choice of two or three tasks of comparable difficulty, from which the child must choose. This choice empowers the child and illustrates that therapy is a collaborative process. Other times, children may refuse to provide verbal feedback but may find alternative methods, such as writing, drawing, texting, or using an anonymous feedback form acceptable.

Difficulties can also arise when one is attempting to facilitate collaboration with parents. Suveg and colleagues (2006) outline several important issues when working with parents. Parents may hinder therapy by being under- or overinvolved. With regard to the former, therapists can try to understand the parent's reasons for being minimally involved. The use of motivational interviewing (e.g., "How do you see your child in five years if nothing changes?") – as well as psycho-education about the treatment model and individual treatment components – can get parents on board with the treatment. A therapist can also invite parents to sessions, to learn concurrently with their children. For parents who are too involved, a discussion of boundaries and an explicit conversation about their role in therapy may be warranted. Regardless of the parents' presentation, goals and expectations should be outlined early in therapy. The therapist may need to provide corrective feedback for unrealistic expectations and goals, particularly within the context of what is developmentally appropriate.

Finally, it is worth noting that therapists need to be cognizant of their own reactions to a youth's engagement, feedback, and cooperativeness during therapy. Some children and adolescents are difficult to work with and can challenge a therapist's confidence. In these situations seeking supervision to discuss concerns and to receive guidance on appropriate management strategies is crucial.

Conclusion

The dissemination of empirically supported treatments has been advanced with the delineation of therapist competencies required to conduct CBT with youth (Sburlati et al. 2011). The competencies can be challenging, given the complexity and individual

variation of children and adolescents. Developmental level, motivation for treatment, and presentation of internalizing disorders can influence a therapist's ability to effectively engage and collaborate with youth. The therapist should have an understanding of the behavioral markers of these competencies, of the ways in which they often need to be tailored to a particular child's presentation, and of the obstacles that are likely to arise; at the same time the therapist should keep an eye on creativity and flexibility. Maintaining this balance puts a therapist in a strong position to engage a child in therapy most effectively and to bring about the success of the treatment.

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