Chapter 1
Incorporating Humor, Superheroes, and Improvisational Theatre Exercises into CBT with Youth: "*Just Because Something Works, It Doesn't Mean It Can't Be Improved*"

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Keywords Cognitive behavioral therapy · Youth therapy · Play therapy · Superhero therapy · Cinemedicine · Evidence-based treatment

1.1 A CBT Origin Story

> How many times do I have to teach you: just because something works doesn't mean it can't be improved.
>
> **Shuri, Black Panther (2018)**

Once upon a time a long, long time ago in a place familiar to some, psychotherapy was ruled by two giants. Let's call them Psychoanalysis and Behavior Therapy. These two heavyweights dominated the scientific and clinical landscapes. But a new contender came along to join these kingpins. Hmm…Let's call this outsized dark horse candidate Cognitive Behavioral Therapy (CBT). CBT offered a new direction and therapeutic promise. However, this contender was dwarfed by the big shots. Now, CBT is the gold standard. Indeed, CBT's origin story is a compelling one.

Dozois et al. (2019) reported that CBT first popped onto the psychotherapy scene in the 1970s. Beck, Ellis, Kendall, Kazdin, and Meichenbaum among others were

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R. D. Friedberg, E. V. Rozmid (eds.), *Creative CBT with Youth*,
https://doi.org/10.1007/978-3-030-99669-7_1

the first pioneers. However, scholars and clinicians trace CBT's roots back much farther (Benjamin et al., 2011; Pies, 1997). Pies (1997) noted that ancient philosophers such as Epictetus, Aurelius, Spinoza, and Maimonides form the historical foundations for the phenomenological approach which characterizes modern CBT. Benjamin et al. (2011) emphasized that operant and classical conditioning models shaped the development of the paradigm. Further, the emergence of information processing models and social learning theory with its focus on self-efficacy expectations were powerful influences. Thus, while CBT was somewhat of an upstart, the approach is deep-seated in philosophical, theoretical, and empirical traditions.

In order to earn its place in the psychotherapy universe, CBT needed to empirically demonstrate its effectiveness. Fortunately, over the years, CBT's outcome research portfolio is robust and far-reaching. CBT is effective for childhood anxiety obsessive-compulsive, trauma, and disruptive disorders as well as depression (Chorpita & Weisz, 2009; Davis et al., 2019). The approach appears widely acceptable to diverse problems, settings, and populations (Friedberg & Paternostro, 2019; Norris & Kendall, 2020).

However, despite the far-reaching appropriateness and robust clinical potential, not all youth respond to a traditional approach (Kendall & Peterman, 2015). When deciding to write a book for clinicians, we asked ourselves where the current gaps exist in typical treatments for youth. While cognitive and behavioral therapies are the gold standard treatment for many youth with psychiatric disorders, there are still children and adolescents who receive treatment and do not get better. Early dropout rates, missed sessions, and lack of individualized and engaging treatment account for the lack of symptom improvement. Unfortunately, dropout rates are extremely high, with approximately 33% of patients dropping out after one session and 28–75% of patients prematurely terminating psychotherapy (Olfson et al., 2009; Barrett et al., 2008) with ethnically minority youth having the highest dropout rates (de Haan et al., 2018).

While CBT is the most effective treatment for youth psychopathology, no treatment is perfect. In fact, nothing in life is perfect and we can always do better. Knowing which patient groups respond best to therapy allows the field to accurately assess the gaps and implement changes. Multiple studies found that initial symptom severity determined the strength of treatment gains (Kennedy et al. 2021; Wergeland et al., 2021; Kunas et al., 2021). Further, early to mid-treatment success predicted post-treatment gains (Kennedy et al. 2021). While these studies and meta-analyses revealed mixed findings (e.g., higher symptom severity either led to more or less improvements), it is clear that patient characteristics impact treatment trajectory. While those who enter treatment at higher levels of psychopathology have greater room to improve, Kennedy et al. (2021) suggested that moving to behavioral experiments and exposures more quickly may lead to higher therapeutic gains. Additionally, Kunas et al., 2021 found that parental symptomology significantly impacted anxious youth's treatment gains. Therefore, when parental psychopathology is present, parents should be referred for their own therapy as a means to improve their quality of life and their child's. Last, older youth improved the most over the course of

treatment (Wergeland et al., 2021). One possible interpretation is that older youth have a higher cognitive load and can engage in treatment more similarly to adults; younger children are pre-operational and require more tangible and concrete teaching methods, such as metaphors and play. Overall, CBT is extremely effective in both laboratory studies and routine clinical care. Nevertheless, we have set out to improve the clinical care of youth.

We agree with Shuri, the Princess of Wakanda, that just because something works does not mean, it cannot be improved. Indeed, this is the precise reason we curated this book. CBT's robust theoretical foundations and strong empirical support create launching pads for innovations that augment its muscular procedures. Integrating humor, play, superheroes, and improvisational theatre techniques with CBT represents promising creative applications. In this introductory chapter, we highlight the chapters to follow and emphasize their compelling nature.

1.2 What you Will Discover in this Book?

Chapter 2 provides a humbling reminder that most of the youth who enter treatment only attend a couple of sessions—not nearly enough for adequate change. Castro-Blanco identifies barriers that clinicians face when attempting to engage youth in therapy and demonstrates methods to utilize humor as a vehicle for increasing therapeutic participation. As providers, we all know the trials and tribulations of attempting to captivate a child or adolescent in therapy. Showing our patients that therapy will help improve their quality of life is no easy task. This fundamental chapter reviews the basics of utilizing humor to increase engagement in the therapeutic process. Readers will greatly benefit from the proposed guidelines on using humor with their youth patients.

In dialectical behavior therapy, irreverence is the stylistic tool that most therapists struggle to achieve and strive to perfect. Well-intentioned therapists who use a confrontational tone or express ideas in an unconventional manner fear damaging the therapeutic relationship. Using humor with dysregulated teenagers proves risky at times. In Chap. 3, Buerger and Miller provide a crash course on DBT, case conceptualization of maladaptive behaviors, and recommendations on how to apply humor as a means of strengthening patient-therapist rapport and treatment effectiveness. The numerous clinical examples illustrate the dos and don'ts of irreverence and the specifics on when and why to implement a particular stylistic tool. Working clinicians will greatly benefit from the clearly outlined recommendations on utilizing humor with dysregulated teenagers.

Humor with Pediatric Patients (Chap. 4) illustrates how humor is an effective cognitive behavioral tool to ease the challenging therapeutic nature of pediatric care. In a hospital setting, humor acts as a normalizing mechanism for children seeking medical treatment, enabling laughter as a common bond for the clinician and patient relationship. Stephanou and colleagues claimed that clowns and art therapy are common vehicles of humor to assist youth confronting difficult medical

procedures, such as blood draws and preparation for surgery. From relationship and rapport building, to coping and exposure to medical procedures, humor decreases negative emotions and unites the clinician and patient to a common message. Throughout this chapter, clinicians learn how to leverage humor at the individual level with a cultural lens to improve pediatric-focused patient care.

Cognitive Behavioral Play Therapy (CBPT; Chap. 5*)* instructs readers on the tenets of integrating puppets, stuffed animals, and toys with evidence-based practice. Clinical vignettes augment the expertise of Knell's novel treatment. For example, Knell recruited a stuffed animal bear to assist a five-year-old in mastering toilet training, a usually daunting experience for parents. CBPT is applicable for youth in developmental stages from different cultures and families. This chapter reviews the empirical evidence for CBPT and empowers all clinicians to benefit from Knell's expert guidance with a step-by-step plan on implementing CBPT.

Park and Kim (Chap. 6) propose cogent guidelines as clinicians consider how to prioritize evidence-based treatment with the integration of play and fun. This chapter reviews the appropriateness of when to use play, like in the beginning of treatment to assess youth's symptoms, or during parent coaching to improve the parent–child relationship. Clinicians learn how to adapt play based-CBT treatment in different settings, cultures, and delivery modes. They propose interventions that can be flexibly implemented and incorporate sample treatment plans, examples of play activities based on developmental level, and comics used to demonstrate psychoeducation. Park and Kim's comprehensive chapter leaves most clinicians yearning to be a child therapist!

Young children who unremittingly exhibit aggressive behaviors are at a higher risk for subsequent psychological sequela (Evans et al., 2019). Fortunately, play is an effective medium to teach youth about the roles of emotions and emotion regulation. Turtle Magic Intervention (TMI) developed by Feindler and Schira integrates the use of cognitive behavioral and play therapy within an individual or group setting for aggressive pre-school aged youth. Children learn about the engaging story of Timmy Turtle as they acquire skills about emotional identification, relaxation, positive self-talk, and problem-solving. In Chap. 7, Feindler and Schira provide a detailed account of TMI, a list of materials required to carry out the intervention, as well as the intervention manual. This chapter is an excellent resource for any clinician working with young children who desire a ready-to-use and accessible treatment manual.

Herren et al. describe a family-oriented approach to cognitive behavioral therapy for treating pediatric obsessive-compulsive disorder (Chap. 8). Herren and colleagues promote the use of play to enhance engagement and willingness which paves the way to exposure treatment. This chapter describes typical cognitive behavioral techniques such as psychoeducation, hierarchy building, and relapse prevention while simultaneously highlighting the unique use of art and play to enhance OCD treatment. Interventions such as the Fear Thermometer, Climbing the Fear Ladder, Creating a Sticky Note Ladder, and Video Game Levels are illustrated to equip clinicians with tangible treatment mechanisms. Tangible strategies and games

assist clinicians as they collaboratively work with their youth patients and families to combat pediatric obsessive-compulsive disorder.

While traditional cognitive behavioral therapy approaches are not always relatable to children, Chap. 9 describes how to leverage superhero narratives and characters to improve clinical outcomes. The use of superheroes for youth allows for an accessible, creative, and playful approach to therapy. Clinicians grasp how the intersection of case conceptualization and superheroes drives a more engaged treatment plan. While children have their own personal stories that brought them to therapy, superheroes also have their own tales of highs, lows, and lessons learned. Youth learn their own form of superpowers, which we clinicians call skills, such as coping, problem-solving, and emotional recognition and expression. The work by Pimentel and DeLapp is suited for clinicians looking to put on their CBT cape, and harness new superpowers (or skills) to improve patient outcomes for youth.

In their riveting chapter on using superheroes as the medium to teach youth about conquering their fears with medical procedures, Nabors and Sanyaolu (Chap. 10) present an in-depth discussion on superhero play with a boy who experiences migraine headaches and stress. The authors depict the metaphoric nature of superheroes as youth with chronic illness tackle common medical challenges, overcome obstacles, and achieve success. Readers will discover that a child's struggles parallel the stories that superheroes encounter; superheroes embody the lessons and tools that children can leverage in their real lives. For example, children re-imagine themselves as superheroes- and their skills as superpowers. Alongside superheroes, play via puppets, stuffed animals, and LEGOs create a fun environment where children are amenable and excited about therapy. This chapter offers a broad approach that is easily adaptable for working with children who suffer from fatigue, chronic pain, and medical issues.

Letamendi (Chap. 11) ties together two seemingly disparate topics of Star Wars and Mindfulness in a cognitive behavioral approach to youth anxiety, stress, and mood disorders. The concept of The Force unifies Star Wars fans and practicing clinicians alike in a fun and relatable analogy tackling specific problem areas among children and adolescents. Mindfulness and CBT-based skills are designed to increase resilience and are powerful tools for recognizing and regulating emotions. Mindfulness training, like Jedi training, leads to improvements in self-awareness, expands outward awareness, and acts as a grounding mechanism. After re-watching a few Star Wars movies, readers will be well on their way to incorporate the gems of Star Wars in their therapy sessions.

Steven Universe, a Cartoon Network animated series, tells the story of a boy coming-of-age alongside diverse characters, relationship dynamics, LGBTQ+ representation, and mental health challenges. Steven Universe is an acclaimed series that connects children of all demographics by depicting life lessons, adversity, and success stories. In Chap. 12, clinicians learn to leverage the cartoon's use of gems, weapons, and objects to create illustrative examples of the challenges that young patients face daily. The cognitive behavioral triangle and various worksheets are adapted to the cartoon world of Steven Universe. The inclusive television series offers an approachable medium for clinicians to utilize in their therapy sessions.

In Chap. 13 by Treadwell and Dartnell, you are invited to experience a moment of surplus reality through Cognitive Behavioral Experiential Group Therapy (CBEGT). Through experiential therapy (also known as psychodrama), youth display their inner feelings, desires, struggles, and fantasies through dramatic re-enactments. In this group therapy context, youth learn how to express emotions and effectively problem-solve with the assistance of other group members as they act out of scenes from their lives. Psychodrama is an appealing and fun way for youth to participate in therapy. The group instructor, or clinician, guides the youth through traditional CBT skills with the integration of acting and experiencing activities. In addition to the clear outline of how to run a group therapy session from beginning to end and the detailed CBT worksheets, this chapter demonstrates the application of CBEGT through an intriguing clinical vignette.

Chapter 14 integrates popular culture and improv theatre into the CBT supervisory relationship. The most efficient way to teach the upcoming generation of clinicians is through supervision. How else can we expect providers to seamlessly integrate improvisational theatre, humor, and superheroes into CBT? Not to mention, the beginning stages of becoming a therapist are quite scary and daunting. Friedberg and Rozmid offer compelling vignettes, real-life examples, and exciting improv activities to propel a fun and low-risk learning environment. Recommendations and debriefing questions are provided to assist CBT supervisors as they reflect on the effectiveness of interventions. This chapter is designed for both aspiring and established supervisors.

1.3 Conclusion

As I look back over the past 65 years, my professional life has been filled with what I can best describe as a continual series of adventures. For the most part, the challenges that I've confronted were of my own making: Like Theseus in the labyrinth, whenever I seemed to find a solution to a problem, I was confronted with another problem (Beck, 2019, p. 16).

As you are probably aware, this is not your typical CBT textbook. Aaron T. Beck, MD, the superhero of CBT, epitomizes the notion of trying to continually improve without seeking perfection. In this way, he and Shuri are alike. Further, the current CBT maxim, balancing theoretical fidelity with flexibility, espoused by yet another CBT hero Phil Kendall and his colleagues (2008), is entirely consistent with the idea of extending a successful paradigm through innovations. Flexibility involves the creative application of empirically supported principles and practices to personalize treatment. However, according to Kendall and associates, flexibility is not a blank check to modify CBT in a haphazard manner. The creative applications must remain faithful to a cognitive behavioral case formulation, adhere to treatment goals, and maintain an action-oriented approach to treatment. Throughout this text, the individual chapters meet all these criteria.

We are humbled and honored to introduce the chapters that follow to you. They are filled with creative application of CBT augmented by real world clinical experiences. Readers will find worksheets, exercises, techniques, and resources that ideally will apply to your diverse settings. Enjoy the journey that lies ahead.

References

Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 247.

Beck, A. T. (2019). A 60 year evolution of cognitive theory and therapy. *Perspectives on Psychological Science, 14*, 16–20.

Benjamin, C. L., Puleo, C. M., Settipani, C. A., Brodman, D. M., Edmunds, J. M., Cummings, C. M., & Kendall, P. C. (2011). History of cognitive-behavioral therapy in youth. *Child and Psychiatric Clinics of North America, 20*, 179–190.

Chorpita, B. F., & Weisz, J. R. (2009). *Modular approach to therapy for children with anxiety, depression, trauma or conduct problems (MATCH-ADTC)*. Practicewise.

Davis, J. P., Palitz, S. A., Knepley, M. J., & Kendall, P. C. (2019). Cognitive-behavioral therapy in youth. In K. S. Dobson & D. J. A. Dozois (Eds.), *Handbook of cognitive behavioral therapies* (4th ed., pp. 349–382).

de Haan, A. M., Boon, A. E., de Jong, J. T., & Vermeiren, R. R. (2018). A review of mental health treatment dropout by ethnic minority youth. *Transcultural Psychiatry, 55*(1), 3–30.

Dozois, D. J. A., Dobson, K. S., & Rnic, K. (2019). Historical and philosophical bases of the cognitive behavioral therapies. In K. S. Dobson & D. J. A. Dozois (Eds.), *Handbook of cognitive-behavioral therapies* (4th ed., pp. 1–31).

Evans, S. C., Frazer, A. L., Blossom, J. B., & Fite, P. J. (2019). Forms and functions of aggression in early childhood. *Journal of Clinical Child & Adolescent Psychology, 48*(5), 790–798.

Friedberg, R. D., & Paternostro, J. P. (Eds.). (2019). *Handbook of cognitive behavioral therapy for pediatric medical conditions*. Springer.

Kendall, P. C., & Peterman, J. S. (2015). CBT for adolescents with anxiety: Mature yet still developing. *American Journal of Psychiatry, 172*(6), 519–530.

Kennedy, S. M., Halliday, E., & Ehrenreich-May, J. (2021). Trajectories of change and intermediate indicators of non-response to transdiagnostic treatment for children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 50*, 904–918.

Kunas, S. L., Lautenbacher, L., Lueken, U., & Hilbert, K. (2021). Psychological predictors of cognitive-behavioral therapy outcomes for anxiety and depressive disorders in children and adolescents: A systematic review and meta-analysis. *Journal of Affective Disorders, 278*(1), 614–626.

Norris, L. A., & Kendall, P. C. (2020). A close look into coping cat: Strategies within an empirically supported treatment. *Journal of Cognitive Psychotherapy, 34*, 4–20.

Olfson, M., Mojtabai, R., Sampson, N. A., Hwang, I., Druss, B., Wang, P. S., … Kessler, R. C. (2009). Dropout from outpatient mental health care in the United States. *Psychiatric Services, 60*(7), 898–907.

Pies, R. W. (1997). Maimonides and the origins of cognitive behavioral therapy. *Journal of Cognitive Psychotherapy, 1*, 21–36.

Wergeland, G. J. H., Riise, E. N., & Öst, L. G. (2021). Cognitive behavior therapy for internalizing disorders in children and adolescents in routine clinical care: A systematic review and meta-analysis. *Clinical Psychology Review, 83*, 101918.