

# Overview

Child-focused cognitive behaviour therapy (CBT) is a popular form of psychotherapy that is now widely used with a range of mental health problems presented by children and young people. The empirical basis of child-focused CBT has been demonstrated through a number of randomised controlled trials that have resulted in a growing conviction amongst clinicians that CBT is the treatment of choice for many disorders. While research evaluating the efficacy and effectiveness of child-focused CBT is more substantive than that evaluating other psychotherapies, the research base is still limited. The first randomised controlled trial (RCT) of child-focused CBT was not reported until the beginning of the 1990s and it is only recently that RCTs evaluating child-focused CBT for obsessive-compulsive disorder (OCD) (Barrett *et al.* 2004) and chronic fatigue syndrome (Stulemeijer *et al.* 2005) have been published. Similarly there is only one published RCT of child-focused CBT for specific phobias (Silverman *et al.* 1999a) and social phobias (Spence *et al.* 2000) and none have yet been published exploring the efficacy of child-focused CBT in the treatment of anorexia nervosa.

The results of RCTs are generally positive and highlight that child-focused CBT results in considerable post-treatment and short-term gains when compared with a waiting list or attention placebo condition. However, the longer-term benefits or the superiority of child-focused CBT over other active interventions has received comparatively less attention and has not yet been consistently demonstrated. Similarly the core features that differentiate CBT from behaviour therapy have not been defined; the extent and specific focus within interventions upon the cognitive domain and assumed dysfunctional cognitive processes varies considerably; little is known about the effective treatment components or their sequencing; the optimum way of involving parents in child-focused CBT and their specific role is unclear.

Despite these limitations the interest in child-focused CBT continues to grow and has resulted in a range of materials and structured workbooks becoming available to help the Clinician undertake CBT with children. These include specific manuals such as the Coping Cat programme for children with anxiety (Kendall 1990); Stop and Think workbook for impulsive children (Kendall 1992); Keeping your Cool: the anger management workbook (Nelson & Finch 1996); the Freedom from Obsessions and Compulsions Using Special tools (FOCUS) programme (Barrett *et al.* 2004) and the Adolescent Coping with Depression Course (Clark *et al.* 1990). In addition there are materials to help children with social skills problems (Spence 1995), chronic fatigue syndrome (Chalder & Hussain 2002) and through anxiety and depression prevention programmes such as FRIENDS (Barrett *et al.* 2000a). There are also books that provide the Clinician with general practical ideas about how CBT can be adapted for use with children and young people (Friedberg & McClure 2002; Reinecke *et al.* 2003; Stallard 2002a).

Materials such as these provide the Clinician with a rich source of ideas that can inform and facilitate their clinical practice of child-focused CBT. This increase in the availability of child-friendly materials is welcomed and serves to highlight the current focus upon what to do (i.e. specific strategies) rather than how (i.e. the process). It is, perhaps, surprising to note

that comparatively less attention has been paid to the process of undertaking child-focused CBT. Attending to the process of child-focused CBT is essential and ensures that the theoretical model and the core principles that underpin it are at the forefront of the Clinician's thinking. This will help the Clinician adapt and use CBT in a coherent and theoretically robust way and prevent the simplistic approach in which Clinicians simply dip into the model by taking and using individual strategies in a disconnected and uninformed way.

*Think Good–Feel Good* (Stallard 2002a) provided a number of practical ideas about how some of the specific techniques of CBT could be conveyed to, and adapted for use by, children. The book uses three characters to explore the three domains of CBT, cognitions (Thought Tracker), emotions (Feeling Finder) and behaviour (Go Getter). *A Clinician's Guide to Think Good–Feel Good* looks behind these strategies to focus upon the process that underpins their use. This book is not intended to be prescriptive and does not advocate a particular model or style for undertaking child-focused CBT. Instead it aims to promote increased awareness of some of the key issues that need to be considered and integrated into therapy in a way that is helpful for the Clinician, the child and the child's carer while maximising the effectiveness of the intervention.

This book will therefore consider a number of key clinical questions including:

- Is the child ready to actively engage in CBT?
- Can the child's motivation to change be increased?
- How does one develop a CBT case formulation?
- What sort of formulation framework should be used?
- Should parents be involved in child-focused CBT?
- How should they be involved and does it make a difference?
- What are the core elements of CBT programmes for particular disorders?
- Where does one start?
- How can Clinicians work in partnership with children?
- How can the process of guided discovery be facilitated?

In the course of this book the reader will be referred to some of the materials in *Think Good–Feel Good* (referred to as TGFG). This is done to provide examples of how some of the techniques and ideas of CBT can be adapted to facilitate the process of working with children. Once again the author is not being prescriptive but is instead attempting to direct the reader to materials and practical examples that can be modified and used to inform their clinical work.

### ► Engagement and readiness to change

At the beginning of the therapeutic process the Clinician meets with the child and the child's carers in order to assess the extent and nature of the current concerns and the outcomes they would like to achieve. This starting point is somewhat easier for Clinicians who work with adults since their clients are often already motivated and prepared to engage in therapy. Children do not usually refer themselves, may not share the concerns identified by their carers, and therefore may not have any ownership in securing any change. The child may therefore present as anxious, unmotivated or disinterested with no agenda for change.

An important first task is to assess the child's readiness to change and to identify whether they have any problems they would like to address or goals they would like to achieve. The *Stages of Change* model (Prochaska *et al.* 1992) provides a helpful framework that conceptualises change as a process rather than a dichotomous decision. This framework can be

used to clarify where the child is in the change cycle and to inform the primary therapeutic focus. At the *pre-contemplation* stage the child will not have considered the possibility or, indeed, the need to change. This awareness begins to develop during the *contemplation* stage so that by the *preparation* stage the child has become interested and prepared to make some small change. The major change occurs during the *action* stage with these newly acquired skills being consolidated during the *maintenance* stage. The final stage is that of *relapse* where the child has to cope with any new setbacks or the return of their previous problems, dysfunctional behaviours or cognitive processes.

The model suggests that the primary therapeutic focus will depend upon where the child is in the change cycle. The main therapeutic work, where the child is ready to actively engage in CBT, occurs during the preparation, action and maintenance stages. During the relapse, pre-contemplation and contemplation stages the Clinician is primarily concerned with increasing the child's motivation, interest and commitment to change. During these stages *motivational interviewing* can provide the Clinician with a number of helpful ideas. Motivational interviewing provides a framework that helps the child to vocalise and resolve their *ambivalence* about possible change. Motivational interviewing is based on the central premise that the desire for change needs to come from the child rather than as a result of external pressure or persuasion. This is achieved by helping the child to *develop discrepancy* between where they currently are and where they would ideally like to be. Confronting or challenging the *child's resistance is avoided* since attempts at direct persuasion, argument or challenging result in a polarisation of views, which only serves to strengthen the child's position. Instead the Clinician aims to *reinforce any signs of self-efficacy* or behaviours that might indicate possible self-motivation.

During motivational interviewing the Clinician will be assessing the child's perception of the *importance* of change, their *readiness* to embark upon an agenda of change and their confidence in *achieving* this.

### ► Formulations

Once the child has identified possible goals and is prepared to engage in CBT the assessment process continues until a formulation has been developed. The formulation is the *shared understanding* of the child's problems presented within a cognitive behavioural framework. The formulation serves an important *psychoeducational function* and provides the current *working hypothesis, which informs the intervention*. The formulation is developed collaboratively and provides as much or as little information as necessary to help the child and their carers understand their problems.

There are many different types of formulations. The simplest are *mini-formulations*, which highlight the connection between two or three components of the cognitive model. These can be particularly helpful with younger children who may find it easier to attend to two or three elements at a time rather than simultaneously attempting to grapple with multiple elements spanning different time frames (e.g. important past experiences or current triggering events), concepts (e.g. distinguishing between different levels of cognitions such as core beliefs and assumptions) or domains (e.g. cognitive, emotional and behavioural). A mini-formulation could therefore help a child to see the connection between a situation and how they behave or between their thoughts and feelings. Simple mini-formulations can be developed separately and then combined to provide a descriptive summary of how a child thinks, feels and behaves in a particular situation.

*General cognitive formulations* use the key components of the general cognitive model to organise and structure the formulation. The simplest is the general *maintenance formulation*

in which individual *triggering events* are identified and the resulting *thoughts, feelings and behaviours* tracked. An example of a framework that can be used to develop a simple maintenance formulation is provided in 'The Negative Trap' template. This is developed further in 'The 4-part Negative Trap' template in which feelings and *physiological symptoms* are separated. This is particularly helpful with children who misperceive the physiological changes associated with their feelings as signs of being physically unwell.

*General onset formulations* provide a historical account of the child's problems by highlighting important experiences and their role in shaping the child's cognitive framework. Important *early experiences* are summarised and *core beliefs, assumptions, triggering events, automatic thoughts, feelings and behaviours* specified. Onset formulations can be relatively simple or complex in which a number of specific early events/experiences or parental behaviours are linked to the development of particular core beliefs. An *onset formulation template* is provided.

*Problem-specific formulations* provide a framework in which a cognitive explanatory theoretical model is used to structure and organise the information related to the onset and maintenance of the child's problem. Recent advances in research have resulted in greater knowledge about the specific cognitions, feelings and behaviours associated with particular problems. A problem-specific formulation would, for example, highlight and bring together in a coherent way any of the specific attributions, beliefs, biases and parental behaviours that have been found to be associated with the onset and maintenance of the child's problems.

### ► The Socratic process and inductive reasoning

A key task of CBT is to facilitate the process of guided discovery by which the child is helped to reappraise their thoughts, beliefs and assumptions and to develop alternative, more balanced, functional and helpful cognitions and cognitive processes. This process of self-discovery and the promotion of self-efficacy are facilitated by *Socratic questioning*, a dialogue in which the child is helped to discover and attend to new or overlooked information. The Socratic dialogue utilises a range of questions, each with a different focus, that help the child systematically identify and test their thoughts. The first are *memory questions*, which are concerned with establishing facts and clarifying information about specific events and feelings. *Translation questions* then explore the meaning the child attributes to these events with *interpretation questions* seeking possible similarities, connections or generalisations between and across other events or situations. *Application questions* help the child to draw upon their previous knowledge and to consider past information that might be helpful in considering these current events. *Analysis questions* are then used to help the child systematically evaluate their thoughts, assumptions and beliefs with *synthesis questions* being used to help them consider new or alternative possibilities. The process is completed by the use of *evaluation questions*, which help the child re-evaluate and reappraise their cognitions in the light of their newly discovered knowledge.

Useful ways of helping the child engage in the process of *inductive reasoning* in which they learn to set appropriate boundaries around their universal cognitive definitions or biases are discussed. Inductive reasoning helps the child to consider new or overlooked information and can involve helping the child to consider a *third party perspective*, highlighting *past experiences*, or the use of *metaphors* as a way of engaging in *analogical comparisons*. A second method of inductive reasoning involves a structured process of *eliminative causal comparisons* in which the assumed relationship between events is systematically evaluated. This can involve either *confirming* or *disconfirming* the assumed relationship. A visual way of undertaking this task, the *Links in the Chain* worksheet is provided.

### ► Involving parents in child-focused CBT

Important systemic influences that contribute to the onset and maintenance of the child's problems or which will positively or negatively effect treatment outcome need to be considered and addressed during the intervention. The most important influence is that of parents/carers and Clinicians are increasingly recognising the need to involve parents in child-focused CBT. However, the role of parents and their involvement in child-focused CBT has varied considerably. The most limited role is that of a *Facilitator* in which the parent attends one or two psychoeducational sessions designed to educate them in the cognitive model and to inform them about the skills their child will be learning. The next role is that of the *co-Clinician* where the parent participates in the same treatment programme as their child. The primary focus of the intervention remains the resolution of the child's problems with parental involvement being concerned with facilitating transfer and use of skills to the child's everyday environment. Some programmes have involved parents as *co-Clients* in which their behaviour becomes a direct target of the intervention. In addition to the child receiving CBT to help address their own problems, parents receive help with their own difficulties or learn new skills such as managing or resolving conflict. They may also be helped to address any of their behaviours that have contributed to the development or maintenance of their child's problems. The final model is that where the *parent is the Client* and thus the primary target of intervention and change. The child does not necessarily attend any treatment sessions with the intervention being focused upon addressing important dysfunctional parental cognitions. These may be related to their child, the reasons for their child's behaviour or their parenting efficacy. This may be a precursor to a subsequent intervention which, once important parental distortions and biases have been addressed, may be more likely to be successful.

While there is widespread acceptance amongst clinicians that parental involvement in child-focused CBT is essential, comparatively few studies have examined the important question of whether this enhances the efficacy of the intervention. The results of randomised controlled trials that have investigated this are surprising. Additional gains are sometimes modest but overall provide some limited support that child-focused CBT can be enhanced by parental involvement.

Despite the considerable variability in the role and involvement of parents in child-focused CBT, most interventions share a number of features. All involve *psychoeducation* in which the parents are provided with an understanding of the cognitive model and a cognitive explanation of the child's problems. A psychoeducational handout for children ('What is Cognitive Behaviour Therapy (CBT)?') and parents ('What Parents Need to Know about Cognitive Behaviour Therapy (CBT)') that explains the model, goals and process of CBT are provided. *Contingency management* is emphasised and in particular the need for parents to praise and attend to their child's use of new skills while ignoring any inappropriate cognitions, feelings or behaviours. Those programmes addressing childhood anxiety typically involve a component designed to reduce the *parents' own anxiety*. Important biased and dysfunctional parental cognitions that interfere with or limit the parents' ability to support their child are systematically addressed and challenged as part of a process of *cognitive restructuring*. Finally, many aim to improve *parent-child relationships* by teaching new skills such as conflict resolution, problem solving or general behaviour management.

### ► The process of child-focused CBT

The specific nature of the therapeutic relationship within which child-focused CBT is undertaken has received comparatively little attention. While generally recognised as an important

moderator of treatment outcome, the specific relationship skills that are important have not been identified. A model based upon the *PRECISE* process is proposed as a way of conceptualising some of the skills that will promote the key principles underlying CBT of collaboration and guided discovery.

The first principle is concerned with developing a *Partnership* between the Clinician and child in which an open and collaborative way of working is promoted and the important and active contribution of the child to the therapeutic process is highlighted and encouraged. The intervention then has to be pitched at the *Right developmental level* so that the child can fully engage with the process of CBT. This requires the concepts and strategies of CBT to be adapted so that they are compatible with the child's linguistic, cognitive and social development. *Empathy* is an important part of the process in which the Clinician conveys interest and aims to understand as fully as possible how the child perceives their world and the events that occur. This also conveys a message to the child that their views are important and that the Clinician wants to hear them. *Creativity* is the process by which the Clinician engages and maintains the child's interest as the concepts and strategies of CBT are carefully crafted to the child's particular interests. The idea of guided discovery is promoted through the idea of *Investigation* in which the child is encouraged to identify their beliefs and assumptions and to use behavioural experiments to objectively test them. *Self-discovery and efficacy* promotes the notion of empowerment and encourages the child to build upon their own ideas and to find their own solutions. This involves helping the child to identify and acknowledge previous successful experiences, their strengths or skills and to consider whether they can be used to help with the current situation. Finally, CBT with children needs to be *Enjoyable* so that the process is fun, entertaining and engaging.

### ► Adapting CBT for children

There has been considerable debate about the age at which children can participate in CBT. Essentially this argument focuses around the issue of whether young children have the cognitive platform necessary to engage in CBT or whether CBT has not been sufficiently adapted for them to access. This argument is briefly reviewed and the cognitive demands and capacity of children to engage with CBT discussed.

The need to adapt CBT by using more non-verbal techniques is highlighted. *Games* provide a familiar medium for children, which can be used to highlight some of the key concepts of CBT or to teach and practise specific strategies or problem-solving skills. *Puppets* provide a safe and engaging way of communicating with young children. They can be used for the purposes of *assessment*, to *highlight common problems* or to *model new skills* and to engage the child in role-plays in which they can *practise* using more helpful coping skills. *Story telling* is another familiar way of communicating with children and can be used for different purposes. *Guided* or *open stories* can be used for the purpose of assessment to identify potentially important thoughts or feelings. *Therapeutic stories* can be used to help the child consider and attend to new information that will help them to reappraise and re-evaluate their cognitions. *Visualisation* and imagery also provide a useful medium with imagery being used for *assessment* and *psychoeducation*. Pictures can, for example, serve as visual prompts to elicit possible thoughts or to highlight the connection between thoughts and feelings. Visualisation can also be therapeutic when the image helps to *change the emotional content* of problematic situations. *Emotive imagery* helps the child to develop images incompatible with anger or fear, such as calming or humorous images. Finally, there are a range of other non-verbal methods that can be used to complement and enhance the verbal component of the treatment. *Cartoons and thought bubbles* can be used to assess cognitions or feelings; *diagrams* to highlight helpful and unhelpful ways of coping; *pie charts and rating scales* to quantify feelings or to identify and

reassess attributions; *externalising* problems by drawing them helps to separate the child from their problems and provides a way of making the problem less abstract.

'The Thought Tracker Quiz' provides an example of a simple quiz that can be used to help children to identify the different thinking errors that they might make. Prepared worksheets that list the common emotional and behavioural changes associated with the emotions of *worry, anger and sadness* are provided. An example of a *responsibility pie* and a worksheet to help younger children understand that a thought bubble represents their thoughts ('Sharing our Thoughts') are also included.

### ► Core components of CBT programmes for internalising problems

There is significant variation in the specific treatment components, sequencing and cognitive emphasis of interventions that fall under the general label of CBT. CBT is not a homogeneous intervention delivered in a standardised way but instead embraces a multitude of strategies combined and delivered in different ways to a heterogeneous client group of differing ages and differing cognitive, linguistic and social development. Comparatively little is known about the effective components or whether CBT can be enhanced by directly focusing upon the key cognitions assumed to underlie the child's problems. The number of sessions involved in child-focused CBT vary and little attention has been paid to assessing cognitive change or the assumed relationship with problem resolution.

A three-level approach to undertaking individual CBT is suggested. *Level 1* interventions are primarily *psychoeducational* and aim to develop a clear CBT formulation explaining the onset and/or maintenance of the child's problems. *Level 2* interventions are the next stage of treatment and aim to develop and promote particular skills and strategies that will help the child to *cope with particular problems*. *Level 3* interventions are concerned with identifying, testing and reappraising *general dysfunctional cognitions* and behaviours that pervade a number of situations. In addition, they prepare the child for potential relapse.

The core components of standardised treatment programmes that have been evaluated and used with *anxiety disorders, depression, obsessional compulsive disorder and posttraumatic stress disorder* are reviewed and potentially important cognitions highlighted. Psycho-educational summary sheets for each of these problems which give an overview of common symptoms and some of the specific strategies that might be helpful are provided in 'Beating Anxiety'; 'Fighting Back Depression'; 'Controlling Worries and Habits'; and 'Coping with Trauma'.

