Think Good – Feel Good

A Cognitive Behaviour Therapy Workbook for Children and Young People

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Consultant Clinical Psychologist, Royal United Hospital, Bath, UK

JOHN WILEY & SONS, LTD

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About the author

Dr Paul Stallard graduated as a clinical psychologist from Birmingham University in 1980. He worked with children and young people in the West Midlands before moving to the Department of Child and Family Psychiatry, Bath, in 1988. He is a visiting research fellow at Bath University, and has received a number of research grants exploring the effects of trauma and chronic illness on children. He has published over 50 peer-reviewed papers and is currently leading a research trial exploring the use of cognitive behaviour therapy in the treatment of post-traumatic stress disorders.

On-Line Resources

All the text and workbook resources in this book are **available free, in colour, to purchasers** of the print version. Visit the website **http://www.wileyeurope.com/go/thinkgoodfeelgood** to find out how to access and download these flexible aids to working with your clients. The on-line facility provides an opportunity to download and print relevant sections of the workbook that can then be used in clinical sessions with children. The on-line materials are in colour, which may prove more attractive and interesting to younger children. The materials can be used flexibly, and can be accessed and used as often as required.

In addition to the printed medium, *Think Good – Feel Good* can be used as an interactive computer programme. The on-line version of *Think Good – Feel Good* can be downloaded and the exercises completed and saved on a computer. This may be particularly appealing to adolescents and computer-minded children who may be more motivated and interested in using this format. The materials can be used to structure or supplement clinical sessions or can be completed by the young person at home. Relevant sections of the workbook can be given to children on floppy disc to take home, which can then be reviewed during clinical sessions with the therapist.

Finally, the therapist is also able to edit some of the worksheets so that the exercises can be tailored to the particular child. For example, the therapist could edit and amend the "IF/THEN quiz" or "common beliefs" and type in their own questions for the child to answer. The completed forms can then be printed, saved and used as many times as required.

Cognitive behaviour therapy: theoretical origins, rationale and techniques

Cognitive behaviour therapy (CBT) is a term used to describe psychotherapeutic interventions that aim to reduce psychological distress and maladaptive behaviour by altering cognitive processes (Kaplan *et al.*, 1995). CBT is based on the underlying assumption that affect and behaviour are largely a product of cognitions and, as such, that cognitive and behavioural interventions can bring about changes in thinking, feeling and behaviour (Kendall, 1991). CBT therefore embraces the core elements of both cognitive and behavioural theories, and has been defined by Kendall and Hollon (1979) as seeking to:

> preserve the efficacy of behavioural techniques but within a less doctrinaire context that takes account of the child's cognitive interpretations and attributions about events.

There is growing interest in the use of CBT with children and young people. This interest has been encouraged by a number of reviews which have concluded that CBT is a promising and effective intervention for the treatment of child psychological problems (Kazdin and Weisz, 1998; Roth and Fonagy, 1996; Wallace *et al.*, 1995). CBT has been found to be effective in treating generalized anxiety disorders (Kendall, 1994; Kendall *et al.*, 1997; Silverman *et al.*, 1999a), depressive disorders (Harrington *et al.*, 1998; Lewinsohn and Clarke, 1999), interpersonal problems and social phobia (Spence and Donovan, 1998; Spence *et al.*, 2000), phobias (Silverman *et al.*, 1999b), school refusal (King *et al.*, 1998) and sexual abuse (Cohen and Mannarino, 1996, 1998), and in the management of pain (Sanders *et al.*, 1994). In addition, CBT has been advocated as producing positive effects with a range of other problems, including adolescent conduct (Herbert, 1998), eating (Schmidt, 1998), post-traumatic stress (March *et al.*, 1998; Smith *et al.*, 1999) and obsessive-compulsive disorders (March, 1995; March *et al.*, 1994).

Cognitive behaviour therapy focuses on the relationship between the following:

- cognitions (what we think);
- affect (how we feel);
- behaviour (what we do).

Cognitive behaviour therapy has demonstrated positive effects in the treatment of a number of common child psychological problems.

The empirical foundations of cognitive behaviour therapy

The theoretical basis for cognitive behaviour therapy has evolved through a number of significant research influences. A review of this research is beyond the remit of this book, although it is important to note some of the key concepts and approaches that have underpinned and shaped CBT.

One of the earliest influences was that of Pavlov and classical conditioning. Pavlov highlighted how, with repeated pairings, naturally occurring responses (e.g. salivation) could become associated (i.e. conditioned) with specific stimuli (e.g. the sound of a bell). This research demonstrated that emotional responses (e.g. fear) could become conditioned by specific events and situations.

- Emotional responses can become conditioned to specific events.

Classical conditioning was extended to human behaviour and clinical problems by Wolpe (1958), who developed the procedure of systematic desensitization. By pairing fear-inducing stimuli with a second stimulus that produces an antagonistic response (i.e. relaxation), the fear response can be reciprocally inhibited. The procedure is now widely used in clinical practice and involves graded exposure, both *in vivo* and in imagination, to a hierarchy of feared situations whilst remaining relaxed.

- Emotional responses can be reciprocally inhibited.

The second major behavioural influence was the work of Skinner (1974), who highlighted the significant role of environmental influences in behaviour. This became known as operant conditioning, and focused on the relationship between antecedents (setting conditions), consequences (reinforcement) and behaviour. In essence, if a certain behaviour increases in frequency because it is followed by positive consequences, or is not followed by negative consequences, then that behaviour has been reinforced.

- Behaviour is affected by antecedents and consequences.
- Consequences that increase the likelihood of a behaviour are reinforcers.
- Altering antecedents and consequences can result in changes in behaviour.

An important extension of behavioural therapy to account for the mediating role of cognitive processes was proposed by Albert Bandura (1977), with the development of social learning theory. The importance of the environment was recognized, while at the same time the mediating effect of the cognitions that intervene between stimuli and response was highlighted. The theory emphasized that learning could occur by watching someone else, and it proposed a model of self-control based on self-observation, self-evaluation and self-reinforcement.

A more significant focus on cognitions emerged from the work of Meichenbaum (1975) and the development of self-instructional training. This approach highlighted the concept that much behaviour is under the control of thoughts or internal speech. Changing self-instructions can lead to the development of more appropriate self-control techniques. The model adopts a developmental perspective and reflects the process by which children learn to control their behaviour. A four-stage process involving observing someone else undertaking a task, being talked through the same task by another person, talking oneself through the task out loud, and finally whispering instructions/silent talk, was described.

- Behaviour is influenced by cognitive events and processes.
- Changing cognitive processes can lead to changes in behaviour.

The link between emotions and cognitions was outlined by Albert Ellis (1962) in rational emotive therapy. This model proposed that emotion and behaviour arise from the way in

which events are construed, rather than by the event *per se*. Thus activating events (A) are assessed against beliefs (B) which result in emotional consequences (C). Beliefs can be either rational or irrational, with negative emotional states tending to arise from and be maintained by irrational beliefs.

The role of maladaptive and distorted cognitions in the development and maintenance of depression was developed through the work of Aaron Beck, culminating in the publication of *Cognitive Therapy for Depression* (Beck, 1976; Beck *et al.*, 1979). The model proposes that maladaptive thoughts about the self, the world and the future (cognitive triad) result in cognitive distortions which create negative affect. Particular attention is payed to core assumptions or schemas – that is, the fairly fixed beliefs developed in childhood against which events are assessed. Once activated, these fixed beliefs produce a range of automatic thoughts. These automatic thoughts and beliefs may be subject to a range of distortions or logical errors, with more negative cognitions being associated with depressed mood.

- Emotional affect is influenced by cognitions.
- Irrational beliefs/schemas or negative cognitions are associated with negative affect.
- Altering cognitive processes can lead to changes in affect.

The relationship between cognitive processes and other emotional states and psychological problems has now been documented (Beck *et al.*, 1985; Hawton *et al.*, 1989). More recent interest has led to further exploration of the relationship between beliefs/schemas in the development and maintenance of psychological problems. This is encapsulated in the schema-focused work of Young (1990), who proposed that maladaptive cognitive schemas that are formed during childhood lead to self-defeating patterns of behaviour which are repeated throughout life. The maladaptive schemas are associated with certain parenting styles, and they develop if the basic emotional needs of the child are not met. Evidence to support the presence of 15 primary schemas has been reported (Schmidt *et al.*, 1995).

- Maladaptive cognitive schemas develop during childhood, and may be associated with parenting styles.

Empirical testing of this prediction is still required. However, if substantiated, it would set an exciting challenge for child workers in identifying whether more adaptive cognitive processes can be promoted and future mental health problems minimized.

The cognitive model

Cognitive behaviour therapy is concerned with understanding how events and experiences are interpreted, and with identifying and changing the distortions or deficits that occur in cognitive processing.

Based largely on the work of Aaron Beck, the way in which dysfunctional cognitive processes are acquired, activated and affect behaviour and emotions is summarized diagrammatically in the model shown in Figure 1.1.

Early experiences and parenting are postulated to lead to the development of fairly fixed and rigid ways of thinking (i.e. core beliefs/schemas). New information and experiences are assessed against these core beliefs/schemas (e.g. ‘I must be successful’), and information that reinforces and maintains them is selected and filtered. Core beliefs/schemas are triggered or activated by important events (e.g. taking exams), and these lead to a number of assumptions

[Image not available in this electronic edition.]

Figure 1.1 The cognitive model.

(e.g. 'I can only get a good mark if I study all day'). These in turn give rise to a stream of automatic thoughts which are related to the person (e.g. 'I must be stupid'), their performance (e.g. 'I'm not working hard enough') and the future ('I'll never pass these exams and get to university'), often referred to as the cognitive triad. In turn, these automatic thoughts can result in emotional changes (e.g. anxiety, sadness), behavioural changes (e.g. staying in, constantly working) and somatic changes (e.g. loss of appetite, difficulty in sleeping).

Cognitive deficits and distortions

Cognitive behaviour therapy assumes that psychopathology is a result of abnormalities in cognitive processing. In particular, difficulties are assumed to be associated with cognitive distortions or deficits.

Cognitive distortions have been reported in children with a range of difficulties. Children with anxiety disorders have been found to misperceive ambiguous events as threatening (Kendall *et al.*, 1992). They tend to be overly self-focused and hypercritical, and to report increased levels of self-talk and negative expectations (Kendall and Panichelli-Mindel, 1995). Similarly, aggressive children perceive more aggressive intent in ambiguous situations, and selectively attend to fewer cues when making decisions about the intent of another person's behaviour (Dodge, 1985). Depressed children have been found to make more negative attributions than non-depressed children, and they are more likely to attribute negative

events to internal stable causes and positive events to external unstable causes (Bodiford *et al.*, 1988; Curry and Craighead, 1990). They have distorted perceptions of their own performance, and they selectively attend to the negative features of events (Kendall *et al.*, 1990; Leitenberg *et al.*, 1986; Rehm and Carter, 1990).

Interventions that address cognitive distortions are concerned with increasing the child's awareness of dysfunctional and irrational cognitions, beliefs and schemas, and with facilitating their understanding of the effects of these upon behaviour and emotions. Programmes typically involve some form of self-monitoring, identification of maladaptive cognitions, thought testing and cognitive restructuring.

Deficits in cognitive processes, such as an inability to engage in planning or problem solving, have been found in children and young people with problems of self-control such as attention deficit hyperactivity disorder (ADHD), and also in children with interpersonal difficulties (Kendall, 1993; Spence and Donovan, 1998). For example, aggressive children have been found to possess limited problem-solving skills and generate fewer verbal solutions to difficulties (Lochman *et al.*, 1991; Perry *et al.*, 1986). Children with social phobia have been found to present with social skill deficits, and antisocial children demonstrate poor social perception skills (Chandler, 1973; Spence *et al.*, 1999).

Cognitive behaviour therapy interventions that address cognitive deficits are primarily concerned with the teaching of new cognitive and behavioural skills. Programmes often involve social problem solving, learning new cognitive strategies (e.g. self-instructional training and positive/coping self-talk), practice and self-reinforcement.

Understanding how children and young people cognitively interpret events and experiences is a fundamental requirement of CBT, and should inform the nature of the cognitive intervention that is provided. However, comparatively little is known about the cognitive deficits or distortions that underpin many childhood problems. Advances in work with adults suffering from post-traumatic stress and obsessional-compulsive disorders highlight the importance of understanding the way in which the trauma or compulsion is appraised (Ehlers and Clark, 2000; Salkovskis, 1999). Persistent post-traumatic stress disorder (PTSD) may be associated with distorted cognitive processes that result in the trauma being appraised as a serious current threat (Ehlers and Clark, 2000). Similarly, the cognitions that underpin many obsessive-compulsive disorders relate to distorted cognitions and appraisals regarding an inflated responsibility for harm (Salkovskis, 1999). Whether these distortions also apply to children has not yet been determined, although it is clear that further work is required to improve our understanding of the cognitive processes that underlie the psychological problems and disorders of children.

- Children with psychological problems present with cognitive deficits and distortions.
- There is a need to understand more about the cognitive processes associated with psychological problems in children.

Core characteristics of cognitive behaviour therapy

The term *cognitive behaviour therapy* is used to describe a range of different interventions, although they often share a number of core features (Fennel, 1989).

CBT is theoretically determined

CBT is based on empirically testable models which provide both the rationale for the intervention (i.e. that affect and behaviour are largely determined by cognitions) and the focus and

nature of the intervention (i.e. challenging distortions or rectifying deficiencies). CBT is a cohesive, rational intervention – not simply a collection of disparate techniques.

CBT is based on a collaborative model

A key feature of CBT is the collaborative process by which it occurs. The young person has an active role with regard to identifying their goals, setting targets, experimenting, practising and monitoring their performance. The approach is designed to facilitate greater and more effective self-control, with the therapist providing a supportive framework within which this can occur. The role of the therapist is to develop a partnership in which the young person is empowered to achieve a better understanding of their problems and to discover alternative ways of thinking and behaving.

CBT is time limited

It is brief and time limited, often consisting of no more than 16 sessions, and in many cases far fewer than this. The brief nature of the intervention promotes independence and encourages self-help. This model is readily applicable to work with children and adolescents, for whom the typical period of intervention is considerably shorter than that for adults.

CBT is objective and structured

It is a structured and objective approach that guides the young person through a process of assessment, problem formulation, intervention, monitoring and evaluation. The goals and targets of the intervention are explicitly defined and regularly reviewed. There is an emphasis on quantification and the use of ratings (e.g. the frequency of inappropriate behaviour, strength of belief in dysfunctional thoughts or degree of distress experienced). Regular monitoring and review provide a means of assessing progress by comparing current performance against baseline assessments.

CBT has a here-and-now focus

CBT interventions focus on the present, dealing with current problems and difficulties. They do not seek to 'uncover unconscious early trauma or biological, neurological and genetic contributions to psychological dysfunction, but instead strive to build a new, more adaptive way to process the world' (Kendall and Panichelli-Mindel, 1995). This approach has high face validity for children and young people, who may be more interested in and motivated to address real-time, here-and-now issues, rather than understanding their origins.

CBT is based on a process of guided self-discovery and experimentation

It is an active process that encourages self-questioning and challenging of assumptions and beliefs. The client is not simply a passive recipient of therapist advice or observations, but is encouraged to challenge and learn through a process of experimentation. The validity of thoughts, assumptions and beliefs is tested, alternative explanations are discovered, and new ways of appraising events and behaving are tried and assessed.

CBT is a skills-based approach

CBT provides a practical, skills-based approach to learning alternative patterns of thinking and behaviour. Young people are encouraged to practise skills and ideas that are discussed