Spoke in the works

Charlotte Wilson shows how CBT focuses on the child's agenda and works collaboratively with child and family to intervene in the cycle of maintenance

Cognitive-behavioural therapy (CBT) appears to be the flavour of the moment[1]. The Government has pledged £170 million over three years to support the roll-out of psychological therapies to adults with anxiety and depression[2] and is recommending evidence-based therapies for this work – those recommended by the National Institute for Health and Clinical Excellence (NICE). Currently there are NICE guidelines for treatment of depression, eating disorders, bipolar disorder, obsessive compulsive disorder, body dysmorphic disorder, post-traumatic stress disorder and ADHD in young people. CBT is often recommended for these disorders as it has the most robust scientific evidence across many psychological disorders[3] although other therapies are also recommended. In addition, CBT is a relatively short intervention and therefore cost effective for NHS services. However, both researchers and clinicians know that CBT doesn't work for all children. There are also controversies over what CBT with children and families is, and whether simply applying cognitive techniques is actually CBT.

It is undeniable that following a CBT manual with a practitioner can help many children[4]. However, many other children need a more individualised therapy. In this case, it is important that we go back to the fundamentals of CBT. And at the very centre of CBT is the case conceptualisation or formulation[3]. This is how the therapist and client collaboratively understand the origins, development and maintenance of the difficulties the client is presenting with. Although this might sound straightforward, there are aspects to it that need unpacking.

1 The formulation is developed collaboratively

Collaboration is central to CBT throughout the process of therapy. As described by Beck and Emery[5], 'the cognitive therapist implies that there is a team approach to the solution of the patient's problem' and 'the therapist fosters the attitude "two heads are better than one" in approaching personal difficulties'. This is particularly important when using CBT approaches with children and young people, given the even larger power differentials between the young person and therapist and also the potential for children to be brought to therapy rather than choose it. Edwards[6] states: 'It is important to form a collaborative relationship with the child on mutually agreed goals. Therapy cannot be initiated if the child has been coerced into therapy and does not perceive any advantages of engaging in it. Of course, this principle applies to adults as well, but it is less often that adults are brought to therapy by more powerful family members.'

It is sometimes possible, depending on the context for therapy, for the family to work independently using a CBT approach to think about their role in maintaining the problem as they see it

Tom was struggling with a number of different issues. He seemed to be low and had lost his concentration. He was occasionally losing his temper at school and was spending more and more time on his own. As well as this being noticed by school, his mum had noticed that at home he was checking that doors and windows were locked at night and had become picky about food. When mum asked him about it, he was embarrassed but said he did have things he wanted help with. He agreed to go and see someone and talk it through.

2 The difficulties the client is presenting are the focus of the therapy

As described above, the goals of the therapy are developed collaboratively between the therapist and young person, which means that the problem as the young person sees it is the problem that is the focus of the therapy. Of course, the therapist might be able to identify other things that might be helpful to the young person, but these are only introduced if the work on the young person's identified problem is stuck or changes from session to session. This can cause tensions when the family wants one thing, for example 'he needs anger management' and the young person wants another: 'I want to get on better with my friends.' It is sometimes possible, depending on the context for therapy, for the family to work independently using a CBT approach to think about their role in maintaining the problem as they see it. Again, a formulation is developed collaboratively with the family and goals are set for their own behaviour and reactions.

Tom met with a therapist. They decided together to first meet without his mum and then invite her in at the end. They talked about what Tom thought the problem was. Tom was mainly fed up with feeling fed up. He didn't feel like being with his friends and was worried about how Mum was at home and whether she was safe. He also thought that Mum might be more worried about him not eating. Tom wasn't worried about this; he just didn't feel like eating at the moment. He wasn't sure what he wanted out of therapy because he didn't know what it could do. They decided together that Tom would take the week to try and notice what had changed that he wanted to change back and anything else he wanted. In the next session, Tom decided that his goals were to spend more time with his friends and to feel happier. He also wanted to

be able to go to bed without checking things, although this was less important to him.

This leads to the third issue:

3 The formulation might be narrow (individual maintenance cycle) or wide (family maintenance cycle and hypothesised development of this)
A formulation often starts with the maintenance cycle. This is usually the interplay of thoughts, feelings, behaviours and bodily reactions that keep the problem going. This helps engagement of the young person as it helps them make sense of the different aspects of the problem and hopefully helps them see that there is a way out. In many problems there are cycles that keep the problem going and so lots of different ways to change things (figure 1).

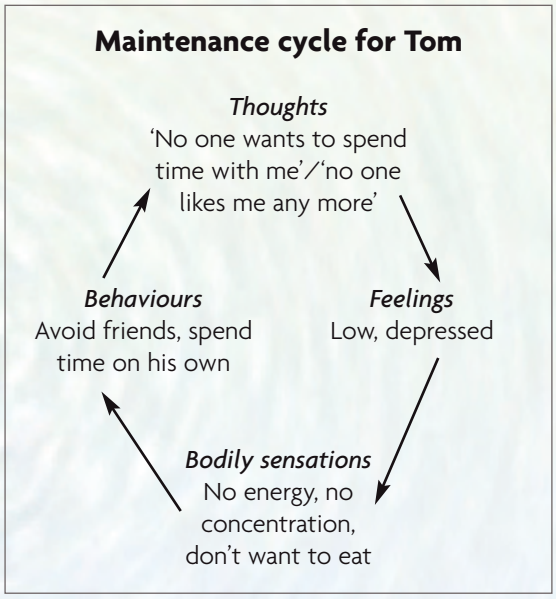

Figure 1

A second step might be to include the family in the formulation. For some problems, this might be crucial at step one, but often it is a second step. This can identify the behaviours the family do that keep the problem going and the thoughts and feelings that result from the young person's problems. These often work together and seeing this can help engage the whole family in working as a team (figure 2).

In some cases, the young person and family might benefit from understanding how the problem arose in the first place. As most problems have multiple causes that interact, and also have causes that are lost in the mist of time, then this might be a best guess. However, if this process is collaborative, the formulation should make sense to the young person and can open up new areas for work (figure 3).

Once a collaborative formulation has been developed and it has been decided who is part of the working team, then work can begin. Some other fundamentals of CBT then become relevant. Part of the collaborative relationship is being clear

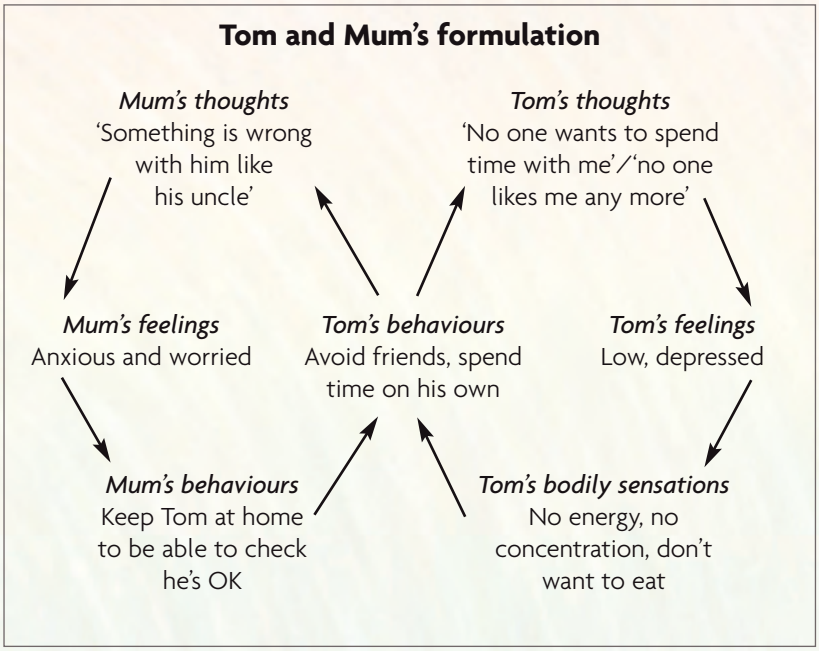

Figure 2

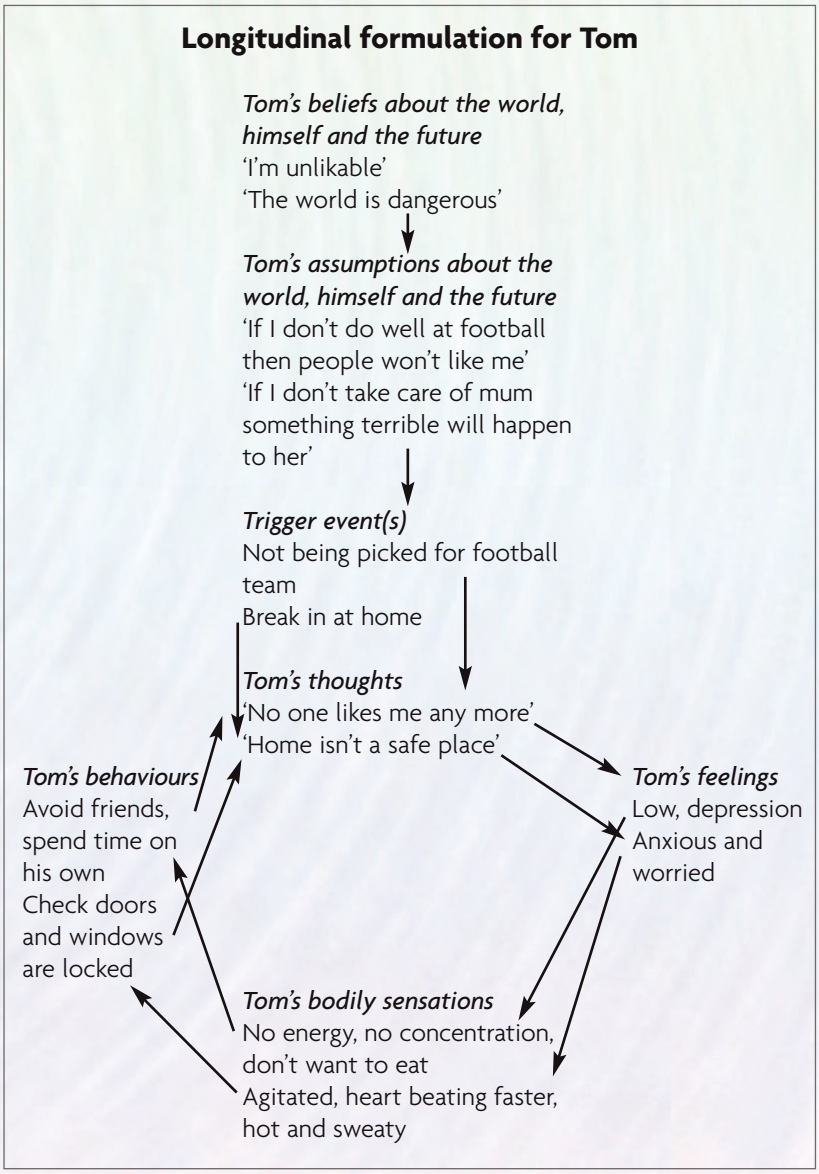

Figure 3

about what CBT is, what it isn't and what will be expected of the young person. This may involve some information-giving about CBT and how it works; it may involve some mini-experiments about how thoughts affect feelings and about how these affect behaviours.

Tom wasn't sure he understood about the thoughts, feelings, behaviour cycle, so the therapist did a mini thought experiment. The therapist asked Tom to imagine that he was walking along the road and a good friend was walking in the opposite direction on the other side. Tom was asked to imagine that he waved and said hello, but his friend didn't say anything or respond. Tom was asked why he thought this was. Tom said that he thought maybe the friend didn't see him. He was then asked how he would feel about this. Tom looked a bit puzzled and said he would be fine about it. He was then asked what he would do the next time he saw his friend. Again, Tom looked puzzled and said he would just say hello. They then went back to the start of the story. The therapist asked Tom to think about any other reasons his friend might not have responded. He said that maybe he had upset his friend and he wasn't talking to him. Again Tom was asked how he would feel and what he would do if this happened. He smiled and said he would feel upset and would probably avoid his friend next time he saw him. Tom now said he understood how thoughts, feelings and behaviours might be linked.

Perhaps the most powerful technique the cognitive-behavioural therapist has is the behavioural experiment

Once work has begun, CBT sessions often have the same structure. The session starts by developing a collaborative agenda of what will be discussed in the session. If appropriate, the young person's mood and functioning over the week will be reviewed and it is common to ask if they had any thoughts or comments on the last session. Reviewing homework tasks comes next, followed by working through the agenda. Towards the end of the session new homework tasks are set and feedback on the session is elicited. Finally, feedback to parents or carers, if appropriate, takes place. All these processes promote collaboration and the engagement of the young person in the therapeutic process, and display transparency about this process. Many young people will need help developing agendas and other young people will need help developing agendas that help them progress towards their goals.

The work itself follows directly from the case formulation and it is at this stage only that cognitive techniques are implemented. As the maintenance cycle involves thoughts, feelings, behaviours and bodily sensations, all these can be a focus of the intervention. Indeed, getting the young person to identify where they would like to start can be helpful in checking out whether they still believe in the formulation, can be helpful in engaging them in new and potentially uncomfortable tasks and can be helpful in identifying which parts of the problem are most problematic to them.

Tom decided that he wanted to work on his goal of spending more time with his friends so Tom and his therapist agreed to start therapy with the individual maintenance cycle above. He decided that he wanted to start with his thoughts as they were difficult to get rid of and he accepted that they kicked off the whole process.

Cognitive techniques include catching thoughts, identifying thinking errors, thought challenging, collecting evidence for thoughts, and using pie charts to discover alternative thoughts (see Stallard[7] for lots of ideas and child-friendly worksheets). Techniques for managing feelings may include relaxation techniques, exercise, and brainstormed strategies the young person feels work for them, for example chatting to friends or playing on the PlayStation. Behavioural techniques include behavioural activation (trying to do a little more each day) trying out new behaviours, trying new strategies or activities and problem solving (see Stallard[7] and Friedberg and McClure[8] for ideas and examples).

Perhaps the most powerful technique the cognitive-behavioural therapist has, however, is the behavioural experiment[9]. These experiments link thoughts, feelings and behaviours and they are a technique for testing out expectations or beliefs and constructing new more adaptive expectations or beliefs. After identifying the belief or expectation, an experience that could test it out is discussed and decided upon. The exact expectation is clarified and exactly what will be done is agreed. Within behavioural experiments, young people may be asked to do something differently, or asked to observe something while they do something they usually do. This could be done as a homework task or done with the therapist within or outside the therapy session.

Tom felt strongly that if he messed up during a football match, no one would talk to him again. He decided with his therapist to test this out using a behavioural experiment. They decided together that Tom would go to his next football match and observe what happened to someone when they missed a goal or didn't save one, or didn't pass when they should. Tom believed 90 per cent that if this happened, no one in the team would talk to that person in the locker room afterwards. He and his therapist decided that on Wednesday Tom would play football as usual and pay attention to any mistakes people made. He would notice who made mistakes and what happened to them after the match and report back. What Tom noticed was that most people made a mistake during the match and that everyone was talking to everyone else afterwards. He still believed 50 per cent that if he made a mistake, people wouldn't talk to him afterwards, but he was brave enough to try another experiment where he made a small deliberate mistake himself and saw what happened next.

As therapy progresses, different problems can be worked on in the same way. Furthermore, if the therapy focusing on the here-and-now problems doesn't seem to be moving the young person on, or the young person is keen to work on some of the underlying issues, further techniques can be used to work at a deeper level.

In many ways, CBT with children and young people can be similar to CBT with adults. However, as has been alluded to above, there are some crucial differences:
1 The family may need, or want, to be involved.
2 The power differential between the young person and the therapist may be wider and needs to be acknowledged and carefully worked within.
3 Developmental aspects of the difficulties need to be understood. For example, in young children some magical thinking is normal.

Tom saw his therapist for 10 sessions. He reported that he was feeling better and found it easier to spend time with his friends. He was enjoying his football more and both school and his mum had noticed that he was brighter, wasn't spending as much time on his own as before and wasn't losing his temper. He was still checking the doors occasionally, but this was reducing and he didn't see it as a problem. Tom's mum was very happy with the progress he had made and had supported him in his friendships. She was happy that he was eating again and was doing her best to reassure him that she was OK and Tom didn't need to look after her.

Charlotte Wilson is a clinical psychologist and lecturer in clinical psychology. Email Charlotte.Wilson@uea.ac.uk

References

1 See, for example: Help yourself. Anxiety? Depression? Life problems? You need cognitive-behavioural therapy. The Times, 16/12/07. http://tinyurl.com/5s4gl9

2 Johnson announces £170 million boost to mental health therapies. DH, 10/10/07. http://tinyurl.com/5g4pje

3 Sanders D, Wills F. Cognitive therapy: an introduction. 2nd ed. London: Sage Publications; 2005.

4 Kazdin A, Weisz J. (eds) Evidence-based psychotherapies for children and adolescents. New York: Guilford Press; 2003.

5 Beck AT, Emery G. Anxiety disorders and phobias: a cognitive perspective. New York: Basic Books; 1985.

6 Edwards D. Case study research: the cornerstone of clinical theory and practice. In: Reinecke M, Dattilio F, Freeman A. (eds) Cognitive therapy with children and adolescents: a casebook for clinical practice. New York: Guilford Press; 1996.

7 Stallard P. Think good, feel good: a cognitive therapy workbook for children and young people. London: Wiley; 2002.

8 Friedberg R, McClure J. Clinical practice of cognitive therapy with children and adolescents: the nuts and bolts. New York: Guilford Press; 2002.

9 Bennett-Levy J, Butler G, Fennell M, Hackmann A, Mueller M, Westbrook D. Oxford Guide to behavioural experiments in cognitive therapy. Oxford: Oxford University Press; 2004.