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1 Introduction

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In his historical account of the development of cognitive behaviour therapy (CBT), Rachman (1997) describes three stages: the emergence of behaviour therapy in the UK and the USA between 1950 and 1970, the growth of cognitive therapy in the USA from the mid-1960s and the merging of behaviour and cognitive therapy into CBT in both Europe and North America in the late 1980s. The development of CBT in childhood and adolescence followed a similar, but not identical course. First, behavioural therapies were developed rather earlier in the children's field than with adults. For example, Mowrer and Mowrer (1938) described a conditioning treatment for nocturnal enuresis before the Second World War. Even earlier than this, Mary Cover Jones (1924) treated childhood phobias with techniques such as desensitization. However, as in the adult field, such techniques did not really become established until the 1950s and 1960s when they were widely investigated and applied, especially with habit and phobic disorders.

In contrast to the adult field, it is difficult to discern separate development of purely cognitive therapy for children before the emergence of CBT. This may be because it was assumed that children did not have the cognitive maturity to benefit from a purely cognitive approach. However, in the mid- and late-1980s, CBT for children and adolescents rapidly became established as a distinctive form of therapy, especially after the publication of Philip Kendall's influential textbooks on the subject (Kendall and Braswell, 1985; Kendall, 1991).

Although it may be difficult to discern a separate development of cognitive therapy in the children's field, the 1970s and 1980s saw a considerable increase in the study of cognitive development. Piagetian psychology, largely developed between the 1930s and the 1950s, was subjected to considerable critical attention (Bryant, 1976). The modest expectations of children's cognitive abilities that

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emerged from Piaget's work were revised when it became clear that children could succeed in tasks in their natural environment much earlier than in the psychological laboratory. As Derek Bolton makes clear in Chapter 2 of this volume, the importance of distinguishing competence from performance was recognized, as was the significance of earlier experience and of context in the level of performance children were able to demonstrate. As O'Connor and Creswell suggest in Chapter 3, there is also much greater variation in the competence of children of the same age than Piaget acknowledged.

Despite the considerable modifications that have been made to Piagetian theory, as O'Connor and Creswell point out, recourse to this theory is still so widespread it could almost amount to an automatic thought among those considering the cognitive development of children. Yet, as they say, it is more appropriate to consider 'what cognition is involved in the production/maintenance of the problem in this particular case'. Such an approach would discourage the tendency to discount the possibility that CBT can be helpful with younger children merely because of their cognitive immaturity. If, as Stallard in Chapter 8 indicates, there is evidence that, by the age of 7 years, children are able to reflect competently on their own cognitive processes (Salmon and Bryant, 2002), there is no reason to think that they cannot participate in those frequently employed CBT techniques that require this particular cognitive capacity. Indeed, Stallard's chapter on the use of CBT with younger children suggests that, when comparing the effectiveness of CBT in children of different ages, there are no consistent findings that the young benefit less; sometimes, they seem to benefit more.

Since the first edition of this book was published in 1998, a number of other developments have occurred in the children's CBT field, some of which further differentiate it from that of adults. In particular, and this is not surprising in the light of the enormous growth of family therapy between the 1960s and 1980s, there is an increasing tendency to take account of the influence of other members of the family, especially parents, in the course disorders take. Wolpert, Doe and Elsworth, in Chapter 7, emphasize especially the ethical issues that arise in CBT when the views and interests of children and parents differ. But they also suggest that family therapy techniques, such as systemic interviewing, may have a useful part to play in the initial stages of therapy when exploring differences in perception between family members as to what they see as the problem and what they want done about it. These authors report on their own experience that other family techniques, such as reframing, may also be helpful in the application of CBT.

Working collaboratively with parents is seen as a central focus in the cognitive behavioural treatment of a number of disorders discussed in this book. But the

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involvement of parents goes further than involving them in the treatment of the child. Many of the chapter authors point to the need to work on the cognitions of parents if there is to be a successful outcome for the child. For example, Douglas, in Chapter 12 on feeding and sleeping disorders in young children, points to the need to correct parental irrational or distorted cognitions about food, cleanliness and patterns of sleep. Bailey takes a similar view when considering oppositional behaviour in Chapter 13, incorporating parent management training into the therapeutic repertoire required to help disobedient and aggressive younger children.

In a similar vein, Allen and Rapee, in Chapter 18 on anxiety disorders, point to the vicious cycle of transmission of fear from parent to child and from child to parent, often making it impossible to determine where the primary problem lies. (Incidentally, these authors also acknowledge the significance of genetic factors in the causation of anxiety disorders, which is another perspective that distinguishes the children's from the adult field.) Both they and Heyne, King and Ollendick, in Chapter 19 on school phobia, point to the importance of assessing parent and family functioning in the assessment of the presenting symptoms. Turk, in Chapter 15 on CBT in the management of children with developmental disabilities, proposes that family members should always be employed as co-therapists in treating the child, or indeed may be the focus of therapy themselves. Finally, Herbert in Chapter 11, discussing the management of distress and disorder in the children of separating and divorcing parents, puts parent training and counselling at the centre of his management approach, with such emphasis that one wonders whether he sees there is a place at all for therapy directed towards the children of separating parents.

Those using CBT with children are also obliged to take into account the context in which disorders occur if they are to have real hope of success. While the adult approach sometimes seems to be applied to adults as though they were living in a social vacuum, those dealing with children consistently manage the environment as much as they manage the child. The involvement of school staff in cases of school refusal and of the staff of inpatient units as those described by Green in Chapter 9 are the most obvious examples of situations in which the context has to be at the forefront of attention, but other chapter authors describe similar, if more attenuated, attention to family, school and the wider environment.

The differences between CBT approaches to children and adults should, however, not be exaggerated. Many of the authors in this book describe CBT approaches to children which are very similar to those used with adults. Reading the chapters by Harrington on depressive disorders (Chapter 16), March,

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Franklin and Foa on obsessive disorders (Chapter 17), Chalder on chronic fatigue syndrome (Chapter 22), Arjundas and Gilvarry on substance and alcohol abuse (Chapter 26), Goodman and McGrath on pain management (Chapter 24) and Yule, Smith and Perrin on post-traumatic disorder (Chapter 20), one is struck not only by the similarity of symptomatology in children and adults but by the similarity of treatment approaches. All authors point to the necessity of using parents as co-therapist and to the relevance of context, but they all give primacy to the targeting of the child's or adolescent's symptomatology.

Another similarity between CBT in children and adults is the tension between treating the child as a unique individual and following a protocol that has been shown to be effective if applied in a standardized manner. Donovan and Spence, in Chapter 23, quote Hansen *et al.* (1998) who suggest that, when interventions are not tailored to the individual child, there is a reduced likelihood that: (1) the goals selected will be agreed upon by the child, parents and teacher; (2) the treatment will be fully explained and understood by all parties; (3) all parties will find the treatment agreeable; (4) the procedures will be gender and culture sensitive; and (5) achievement of the goals will lead to real improvement in the child's life. The resolution of this dilemma would seem to lie in researchers incorporating individualizing features of treatment into their standardized protocols.

Reading the chapters in this book, one is struck by the diversity of approaches that come under the broad rubric of CBT. Indeed, there seems to be significant overlap between CBT, behaviour therapy, interpersonal psychotherapy, problem-solving skills training, social skills training and family therapy. Nor are psychodynamic therapeutic skills irrelevant to the delivery of CBT. Schmidt, in Chapter 5 on motivational interviewing, describes techniques such as reflective listening for which a training in psychodynamic interviewing would be advantageous. Further, the evidence for the importance of non-specific factors, such as directiveness, warmth and a positive therapist–client relationship, so well described by Weersing and Brent in Chapter 4, is compelling.

The need to combine CBT with other forms of therapy is also evident from many of the contributions in this book. As far as the eating disorders are concerned, CBT alone may be sufficient in bulimia, in anorexia nervosa family therapy is a well-evaluated form of treatment that can be combined with CBT (Stewart, Chapter 21). In attention deficit hyperactivity disorder, medication is the first line of treatment for pervasively affected children, but CBT, often combined with stimulants, can be seen as the preferred approach where the condition is situation specific and associated with other disorders (Pelham and Walker, Chapter 14). The very promising results reported in the prevention and management of conduct disorders by McMahon and Rhule (Chapter 27) suggest

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that combinations of approaches, especially with intensive family case work or specialist foster care, can be effective in reducing recidivism.

Overlap between different forms of therapy there may be, but the last 6 years since the publication of the first edition of this book have seen further authoritative confirmation of the evidence for the effectiveness of CBT and allied approaches (often in comparison with other forms of therapy) in a wide range of conditions (Carr, 2000; Fonagy *et al.*, 2002). Hopefully, the next few years will see an expansion of training opportunities for therapists who wish to use this approach.

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Part I

Developmental cognitive theory and clinical practice

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2 Cognitive behaviour therapy for children and adolescents: some theoretical and developmental issues

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2.1 Introduction

The term cognitive behaviour therapy (CBT) is used to cover a wide range of interventions in child and adolescent mental health, including (in no particular order) psychoeducation, anger management, anxiety management, behavioural operant methods, behavioural exposure methods, self-instruction methods, graded exercise, relaxation, social skills training, some kinds of parent training and cognitive restructuring in the style of adult CBT. There is a genuine question whether and in what sense this range and variety can be usefully seen as expressions of a unified model. In any case, it is common for authors on the theory and practice of CBT for children and adolescents to point out that the treatment model should take into account developmental issues, although it is less common for there to be detailed elaboration on what the developmental issues are that are crucial in relation to CBT for children and adolescents.

It turns out, this author believes, that there is a range of complicated theoretical issues, as well as a lack of data, underlying the question of developmental context of CBT. These issues include questions such as: given that behavioural methods can be used with children and can work well in some kinds of case, what is involved in adding 'cognitive' therapy? What is the real difference – in methods, or in the underlying models – between behaviour therapy for children and cognitive therapy? Is there a reasonable sense in which behaviour therapy modifies cognition and, therefore, is (a kind of) cognitive therapy? What does *talking* have to do with it? What kind of cognition does talking address that behaviour change does not? What kind of cognition does CBT with adults involve? Do children have that kind of cognitive capacity, and at what ages?

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These issues are approached in this chapter by considering, first, what kind of cognition is involved in CBT with adults and CBT models of adult psychopathology and, secondly, the implications of cognitive developmental theory and research. It is apparent that the literatures involved in such an undertaking are very large indeed as well as complex, so what is presented here is selective and partial, and raises more questions than it suggests answers.

2.2 The theory of CBT as applied to adults

For detailed accounts of CBT theory, see, for example, Beck (1976), Beck *et al.*, (1985), Clark and Fairburn (1997), Clark and Beck (1999) and Salkovskis (1996b). A common characterization of the theory behind CBT, consistent with its background in cognitive psychology, is that behaviour is regulated by *appraisals of stimuli*, rather than by the stimuli themselves. 'Stimuli' mean events in the world, but also events within the body, and mental states of others and of the self. Appraisals may be verbal, but they may also be in sensori or sensori-motor code (e.g. threat perception is an appraisal that does not require verbal coding). 'Behaviour' involves motor behaviour, but also affective responses. A way of expressing the core working assumption of CBT is thus that appraisals – the meaning assigned to stimuli, or the way they are represented – are critical in the regulation of affect and behaviour.

CBT applies this working assumption to clinical problems, supposing that for problematic behaviour and emotion what is critical is regulation by appraisals. These maladaptive appraisals are of various kinds and levels, with technical names such as negative automatic thoughts, cognitive distortions, dysfunctional attitudes, core beliefs and compensation strategies including safety behaviours. Content varies according to the presenting problem and individual differences. Key maladaptive appraisals linked to problematic affect and behaviour may include, by way of illustration, the following: in antisocial behaviour, attribution of malign intent in the other and devaluation of the victim; in low mood and inactivity, the conviction 'I will fail/always have failed'; in anxiety and avoidance, various exaggerated perceptions of threat; and so on. A further crucial aspect of many CBT models is emphasis on the importance of appraisals that are secondary to the original behaviours, and the effects of these secondary appraisals. For example, a person may blame herself for being frightened to go out on her own and being dependent on others; or, again, a person may be self-critical because he seems to himself to be unable to make a lasting relationship. The secondary appraisals lead to further emotions and behaviour, such as shame and limiting of life-style, which commonly, and among other things, exacerbate the original problem.

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The general CBT model may be applied to various kinds of presenting problems, including depression (Beck, 1976), various anxiety disorders such as social phobia, panic disorder and post-traumatic stress disorder (Clark, 1999), obsessive compulsive disorder (Salkovskis, 1999), hypochondriasis (Salkovskis, 1996a), bulimia (Vitousek, 1996), chronic fatigue (Sharp, 1997) and schizophrenia (Garety *et al.*, 2001).

Given a background model – at least the general model, or better, if available, a model for a specific kind of condition – how does CBT proceed? Assessment is conducted with the model in mind, to test out whether the model, or at least a part of it, is a reasonably good fit in the particular person's case and, if so, to elicit the details of its expression. This means trying to identify specific kinds and contents of negative automatic thoughts, the critical situations that trigger them, cognitive distortions, dysfunctional attitudes, core beliefs and safety behaviours, secondary appraisals and their further consequences and the functional relationship between them all (or as many as possible). The origins of false beliefs might also be considered – e.g. that they did make sense in the family of origin. The point of considering origins of beliefs, however, is secondary to the main point of assessment, which is to identify what has to change for the problematic affect and behaviour to change. Typically, in accord with the model, this will be an appraisal, a representation of reality, the self or of others, involving more or less of the kinds of thoughts and styles of cognition outlined in the general model – perhaps one core belief, perhaps a pattern of negative thinking or both.

As assessment proceeds, the model as applied to the particular person's case is gradually formulated, as much as possible in the client's own style and idiom, and shared between the therapist and the client. As the model is refined in a cooperative venture, the crucial appraisals driving the problems and hence what has to change are identified. Methods of change in CBT include variations on the following main themes: considering alternatives to problematic assumptions (appraisals), re-examining apparent evidence and counter-evidence in the light of these alternatives and carrying out experiments to test them – this latter theme including but not being restricted to behaviour therapy methods such as exposure, as interpreted in the cognitive model.

2.3 Relevance of early models of cognitive development: Vygotsky and Piaget

For detailed reviews of cognitive developmental theory, see, for example, Demetriou (1998), McShane (1991), Sameroff and Haith (1996) and Weinert and Perner (1996). Application of cognitive developmental theory to issues in CBT

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for children are rare, with notable exceptions including Ronen (1997), Holmbeck *et al.* (2000) and Piacentini and Bergman (2001). Two founding models of cognitive development, those of Vygotsky and Piaget, both remain highly influential, and both are highly relevant to the theory behind CBT, specifically in relation to the assumption of *fundamental linkage between cognition and action*.

In the developmental model developed by Vygotsky, cognition and action are seen as fundamentally *social*, and from this perspective there is an insight very close to the core theory behind CBT – namely, that *language has a key role in the regulation (or control) of action*. On this, Vygotsky said, for example (1981, pp. 69–70):

> Children master the social forms of behavior and transfer these forms to themselves. With regard to our area of interest, we could say that the validity of this law is nowhere more obvious than in the use of the sign. A sign is always originally a means used for social purposes, a means of influencing others, and only later becomes a means of influencing oneself. According to Janet, the word initially was a command to others and then underwent a complex history of imitations, changes of functions, etc. Only gradually was it separated from action. According to Janet, it is always a command, and that is why it is the basic means of mastering behavior. Therefore, if we want to clarify genetically the origins of the voluntary function of the word and why the word overrides motor responses, we must inevitably arrive at the real function of commanding in both ontogenesis and phylogenesis.

In Piaget, the fundamental linkage between cognition and action is most clear in the sensori-motor stage, where they practically coincide, but it remains true in subsequent stages, including the mature formal operational attained during adolescence, characterized by abstraction, logic, theory and beliefs about beliefs, and which forms the basis of cultural practices of science, politics and so on. It is plausible to say that, in this development, the balance of influence shifts; at the beginning, cognition is very closely tied to action, and is made possible by action. By the time of maturity, however, cognition makes the practice possible.

While both developmental theories affirm the close connection between cognition and behaviour, they also both recognize that in development there is a loosening of cognition from action, so that in fact the former can in some sense run free of the latter, and this is particularly so as cognition develops from its sensori-motor origins by using conventional symbolism, i.e. language. Early in the development of language, cognition as verbally encoded can run free, at the level of grammatical or word play, in flights of fancy and in cultural practices of story-telling, spoken and written. The relationships of these kinds of representation to reality are complex and varied. The relevance of this point to CBT is that cognition in verbal code may be on a particular occasion divorced from sensori-motor and affective responses and, in this case, talking runs the risk of