Paul Stallard

Thinking Good, Feeling Better

A Cognitive Behavioural Therapy Workbook for Adolescents and Young Adults

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This edition first published 2019

Edition History
John Wiley & Sons Ltd (2002)

Registered Offices
John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, USA
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Office
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

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Library of Congress Cataloging-in-Publication Data
Names: Stallard, Paul, 1955- author.
Title: Thinking good, feeling better : a cognitive behavioural therapy workbook for adolescents and young adults / Paul Stallard, Professor of Child and Family Mental Health, University of Bath, UK and Head of Psychological, Therapies (CAMHS), Oxford Health NHS Foundation Trust, UK.
Description: Hoboken, NJ : John Wiley & Sons, 2019. | Includes bibliographical references and index. |
Identifiers: LCCN 2018023895 (print) | LCCN 2018035282 (ebook) | ISBN 9781119396284 (Adobe PDF) | ISBN 9781119397281 (ePub) | ISBN 9781119396291 (pbk.)
Subjects: LCSH: Behavior therapy for children. | Cognitive therapy for children. | Behavior therapy for teenagers. | Cognitive therapy for teenagers.
Classification: LCC RJ505.B4 (ebook) | LCC RJ505.B4 S72 2019 (print) | DDC 618.92/89142–dc23
LC record available at https://lccn.loc.gov/2018023895

Cover Design: Wiley

Set in 10/13pt Legacy Sans by Thomson Digital, Noida, India

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About the author

Paul Stallard is Professor of Child and Family Mental Health at the University of Bath and Head of Psychological Therapies (CAMHS) for Oxford Health NHS Foundation Trust. He has worked with children and young people for over 30 years since qualifying as a clinical psychologist in Birmingham in 1980.

Clinically, Paul continues to work within a specialist child mental health team where he leads a Cognitive Behaviour Therapy (CBT) clinic for children and young people with a range of emotional disorders including anxiety, depression, obsessive compulsive disorder (OCD), and post-traumatic stress disorder (PTSD).

He is an international expert in the development and use of CBT with children and young people and has provided training in many countries. He is the author of the widely used *Think Good Feel Good: A Cognitive Behaviour Therapy Workbook for Children and Young People* and Editor of the book series *Cognitive Behaviour Therapy with Children, Adolescents and Families*.

He is an active researcher and has published widely in high-impact peer-reviewed journals. Recent research projects have included large school-based CBT programmes for depression and anxiety and the use of eHealth with children and young people.

Acknowledgement

There are many people who have directly and indirectly contributed to the development of this book.

First, I would like to thank my family, Rosie, Luke, and Amy for their encouragement and enthusiasm. Despite many long hours working, writing, and travelling, their support for this project has been unwavering.

Second, I have had the good fortune to work with many amazing colleagues during my career. A number of our clinical discussions have informed the ideas in this book. Of my colleagues, I would particularly like to thank Kate and Lucy who I have had the privilege to work with in our CBT clinic for over a decade. Their patience, creativity, and thoughtfulness have helped me to develop and test the ideas contained in this book.

Third, I would like to thank the children and young people I have had the honour to meet. Their determination to overcome their challenges continues to inspire and motivate me to find ways in which effective psychological interventions can be made more available.

Finally, I would like to thank those who read this book. I hope that these materials will help you to help a young person make a real difference to their life.

Online resources

All the text and workbook resources in this book are **available free, in colour, to purchasers** of the print version. To find out how to access and download these flexible aids to working with your clients visit the website

www.wiley.com/go/thinkinggood

The online facility provides an opportunity to download and print relevant sections of the workbook that can then be used in clinical sessions with young people. The materials can be used to structure or supplement clinical sessions or can be completed by the young person at home.

The online materials can be used flexibly, and can be accessed and used as often as required.

Cognitive behaviour therapy: theoretical origins, rationale, and techniques

Cognitive behaviour therapy (CBT) is a generic term used to describe a family of psychotherapeutic interventions that focus upon the relationship between cognitive, emotional, and behavioural processes. The overall aim of CBT is to facilitate an awareness of the important role of cognitions on emotions and behaviours (Hofmann, Sawyer, and Fang 2010). 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.

Cognitive Behaviour Therapy focuses upon the relationship between what we think (cognitions), how we feel (emotions), and what we do (behaviour).

The first randomised controlled trials demonstrating the effectiveness of CBT for children and adolescents emerged in the early 1900s (Lewinsohn et al. 1990; Kendall 1994). Numerous trials have since been reported resulting in CBT becoming established as the most extensively researched of all the child psychotherapies (Graham 2005). Reviews have found CBT to be an effective intervention for children and adolescents with a range of problems including anxiety (James et al. 2013; Reynolds et al. 2012; Fonagy et al. 2014), depression (Chorpita et al. 2011; Zhou et al. 2015; Thapar et al. 2012), post-traumatic stress disorder (Cary and McMillen 2012; Gillies et al. 2013), chronic pain (Palermo et al. 2010; Fisher et al. 2014), and obsessive compulsive disorder (Franklin et al. 2015). The substantial body of knowledge demonstrating effectiveness has resulted in CBT being recommended by expert groups such as the UK National Institute for Health and Clinical Excellence and the American Academy of Child and Adolescent Psychiatry for the treatment of young people with emotional disorders including depression, obsessive compulsive disorders, post-traumatic stress disorder, and anxiety. This growing evidence base has also prompted the development of a national training programme in the United Kingdom in CBT, Improving Access to Psychological Therapies (IAPT), which has now been extended to children and young people (Shafran et al. 2014).

CBT is an empirically supported psychological intervention.

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The foundations of CBT

CBT describes a family of interventions that have evolved over time through three main phases or waves. The first wave was behaviour therapy which focused directly on the relationship between behaviour and emotions. Through the use of learning theory, new behaviours could be learned to replace those that are unhelpful. The second wave, cognitive therapy, built upon behavioural therapy by focusing on the subjective meanings and interpretations that are made about the events that occur. Directly challenging and testing the content of the biases that underpin these cognitions results in alternative, more helpful, balanced, and functional ways of thinking. Third wave CBT focuses on changing the nature of our relationship with our thoughts and emotions rather than actively attempting to change them. Thoughts and feelings are observed as inevitable mental and cognitive process rather than evidence of reality. Third wave models include Acceptance and Commitment Therapy (ACT), Compassion Focused Therapy (CFT), Dialectical Behaviour Therapy (DBT), and Mindfulness-based Cognitive Behaviour Therapy (MCBT).

First wave: behaviour therapy

One of the earliest influences on the development of CBT was that of Pavlov (1927) 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). The work demonstrated that emotional responses, such as fear, could become conditioned with specific events and situations such as snakes or crowded places.

Emotional responses are associated with specific events.

Classical conditioning was extended to human behaviour and clinical problems by Wolpe (1958) who developed the procedure of systematic desensitisation. By pairing fear-inducing stimuli (e.g. watching a snake) 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 changed.

The second major behavioural influence was the work of Skinner (1974) who highlighted the significant role of environmental influences upon behaviour. This became known as operant conditioning and focused upon the relationship between antecedents (setting conditions), consequences (reinforcement), and behaviour. In essence, if a particular behaviour increased in occurrence because it is followed by positive consequences, or is not followed by negative consequences, then the behaviour has been reinforced. Behaviour could therefore be changed by altering the consequences or the conditions that evoked them.

Altering antecedents and consequences can change behaviour.

Recognition of the mediating role of cognitive processes was noted by Bandura (1977) and the development of social learning theory. The role of the environment was recognised, but behaviour

therapy was extended to highlight the importance of the cognitions that intervene between stimuli and response. The theory demonstrated that learning could occur through watching someone else and proposed a model of self-control based upon self-observation, self-evaluation, and self-reinforcement.

Second wave: cognitive therapy

Behaviour therapy proved very effective, although it was criticised for failing to pay sufficient attention to the meanings and interpretations that are made about the events that occur. This stimulated interest in the development of cognitive therapy with a direct focus on the way individual's process and interpret events and the effect of these on emotions and behaviour.

This phase was heavily influenced by the pioneering work of Ellis (1962) and Beck (1963, 1964). Ellis (1962) developed Rational Emotive Therapy which was based upon the central relationship between cognitions and emotions. The model proposed that emotion and behaviour arise from the way events are construed rather than by the event per se. Thus activating events (A), are assessed against beliefs (B) that 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.

Cognitions and emotions are linked.

The role of maladaptive and distorted cognitions in the development and maintenance of depression was developed through the work of Beck culminating in the publication of *Cognitive Therapy for Depression* (Beck 1976; Beck et al. 1979). The model proposes that emotional problems arise through biased cognitive processing in which events are distorted in negative and unhelpful ways. Underlying these biased ways of thinking are core beliefs or schemas. These are global, fixed, and rigid ways of thinking that are assumed to develop during childhood. Beliefs are activated by events reminiscent of those that produced them, and once activated, attention, memory, and interpretation processing biases filter and select information to support them. Attention biases result in attention being focused upon information that confirms the belief, whilst neutral or contradictory information is overlooked. Memory biases result in the recall of information that is consistent with the belief, whilst interpretation biases serve to minimise any inconsistent information.

Biased and distorted cognitions generate unpleasant emotions.

Once activated, fixed beliefs produce a range of automatic thoughts, the most accessible level of cognitions. Automatic thoughts or 'self-talk' represent the involuntary stream of thoughts that race through our heads providing a continuous commentary about the events that occur. These automatic thoughts tend to be about the self, the world, and the future, commonly referred to as the cognitive triad.

Beliefs are functionally related to automatic thoughts, resulting in biased and distorted beliefs producing negative automatic thoughts. Negative automatic thoughts are very self-critical and generate unpleasant emotional states, e.g. anxiety, anger, unhappiness, and unhelpful behaviours such as social withdrawal or avoidance.

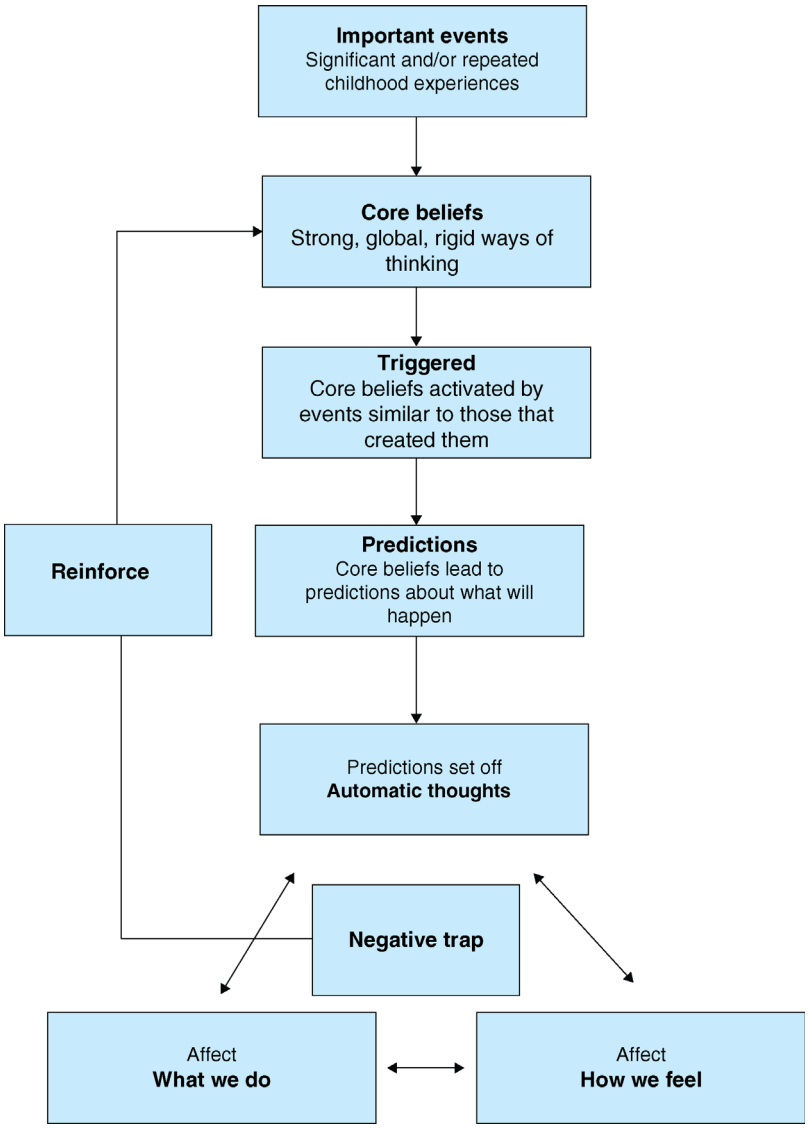
The unpleasant feelings and unhelpful behaviours associated with these dysfunctional cognitions and processing biases serve to reinforce and maintain the original beliefs as the individual becomes trapped in a self-perpetuating negative cycle. The relationship between cognitive processes and other emotional states and psychological problems has been well documented (Beck 2005).

Interventions aim to identify and challenge the specific content of biased cognitions and processes in order to develop more functional and balanced cognitions. These in turn improve mood and result in less avoidance and withdrawal.

> Cognitive biases generate unpleasant emotions and affect how we behave.

The cognitive model

Based largely on the work of Beck, the way in which dysfunctional cognitive processes are acquired, activated, and effect behaviour and emotions is summarised diagrammatically in the model below.



Early experiences and parenting are hypothesised to lead to the development of fairly fixed and rigid ways of thinking, i.e. core beliefs/schemas. These beliefs/schemas are activated by events similar to the ones that established them and form a framework for perceiving the world. New information and experiences are assessed against these core beliefs/schemas and lead to predictions about what will happen (i.e. assumptions). For example, a core belief such as 'I am a failure' may be

activated by an important event such as 'taking exams'. This may result in an assumption such as 'No matter how hard I work I will never get a good mark'. Beliefs and assumptions produce a stream of automatic thoughts. These are related to the person ('I must be stupid'), their performance ('I can't do this'), and the future ('I'll never pass these exams'). These automatic thoughts effect how we feel (e.g. anxious and unhappy) and what we do (e.g. stop revising and not motivated), and in turn strengthen the original belief that 'I am a failure'.

In addition to understanding the different levels of cognitions, CBT also pays attention to their specific content and the nature of the processing deficits and biases. There is an assumption of specificity, i.e. that specific processing deficits and biases are associated with particular emotional problems. However, they are not mutually exclusive, although there are some general trends (Garber and Weersing 2010). In general, young people who are anxious tend to have cognitions and biases towards the future and personal threat, danger, vulnerability, and inability to cope (Schniering and Rapee 2004; Muris and Field 2008). Depression tends to be related to cognitions concerning loss, deprivation, and personal failure with rumination increasing feelings of hopelessness (Kendall, Stark, and Adam 1990; Leitenberg, Yost, and Carroll-Wilson 1986; Rehm and Carter 1990). Aggressive young people tend to perceive more aggressive intent in ambiguous situations, selectively attend to fewer cues when making decisions about the intent of another person's behaviour, and generate fewer verbal solutions to problems (Dodge 1985; Lochman, White, and Wayland 1991; Perry, Perry, and Rasmussen 1986).

Interventions addressing cognitive distortions are concerned with increasing the young person's awareness of biased and unhelpful cognitions, beliefs, and schemas and, 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.

Challenging and changing cognitions can improve mood.

An extension of this work, Schema-Focused Therapy, was developed by Young (1994) for those who failed to respond or relapsed following traditional CBT. Schema-Focused Therapy was based on the recognition that some people seem to develop life-long self-defeating patterns of behaviour that are repeated throughout life. Young proposed that this was the result of early maladaptive schemas, strong and rigid ways of thinking that are formed during childhood and which are resistant to change. These are associated with particular trauma and parenting styles and 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) with subsequent research identifying the presence of cognitive schemas in adolescents and children as young as eight (Rijkeboer and Boo 2010; Stallard 2007; Stallard and Rayner 2005). Schema-Focused Therapy pays greater attention to the past and understanding these lifelong patterns rather than upon specific situations and events.

Maladaptive cognitive schema/beliefs develop during childhood.

Third wave: acceptance, compassion, and mindfulness

Whilst the second wave Cognitive Therapies have proven very effective they do not work for everyone. Some people do not find the process of actively challenging and re-appraising specific cognitions easy or acceptable. Similarly, a number of studies have highlighted that changes in cognitions are not necessarily related to improved emotional well-being. Changes occur without directly and explicitly challenging the content of cognitions. This led to a third wave of CBTs