SECOND EDITION

Paul Stallard

A Clinician's Guide to CBT for Children to Young Adults

A Companion to *Think Good, Feel Good* and *Thinking Good, Feeling Better*

with website

WILEY

Table of Contents

CHAPTER EIGHT: F: Formulations

- Provides a coherent and understandable rationale for the use of CBT
- Provides a collaborative understanding of events which links thoughts, emotions, and behaviour (maintenance formulations)
- Provides an understanding of important past events and relationships (onset formulations)
- Includes, as appropriate, the role of parent/carers in the onset or maintenance of the child/young person's problems
- Activities and goals/targets are clearly linked to the formulation
- Common problems

CHAPTER NINE: G: General skills

- Prepares and brings the necessary materials and equipment to the meeting
- Manages the young person's behaviour during sessions
- Ensures that sessions have an agenda and clear goals and are appropriately structured
- Ensures good timekeeping so that all tasks are completed
- Ensures that the session is appropriately paced, flexible, and responsive to the needs of the young person
- Prepares for endings and relapse prevention

CHAPTER TEN: H: Home assignments

- Negotiates home assignment tasks
- Ensures assignments are meaningful and clearly related to the formulation and clinical session

List of Tables

List of Illustrations

A Clinician's Guide to CBT for Children to Young Adults

A Companion to *Think Good, Feel Good* and *Thinking Good, Feeling Better*

Second Edition

Paul Stallard

WILEY

This second edition first published 2021

Edition History
John Wiley & Sons Ltd (1e, 2005)

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

For details of our global editorial offices, customer services, and more information about Wiley products visit us at www.wiley.com.

Wiley also publishes its books in a variety of electronic formats and by print-on-demand. Some content that appears in standard print versions of this book may not be available in other formats.

Library of Congress Cataloging-in-Publication Data

Names: Stallard, Paul, 1955– author.
Title: A clinician’s guide to CBT for children to young adults : a companion to think good, feel good and thinking good, feeling better / Paul Stallard.
Other titles: Clinician’s guide to think good-feel good
Description: Second edition. | Hoboken, NJ : John Wiley & Sons, [2020] | Includes bibliographical references and index.
Identifiers: LCCN 2020022832 (print) | LCCN 2020022833 (ebook) | ISBN 9781119396314 (paperback) | ISBN 9781119395492 (adobe pdf) | ISBN 9781119395461 (epub)
Subjects: LCSH: Behavior therapy for children. | Cognitive therapy for children. | Behavior therapy for teenagers. | Cognitive therapy for teenagers.
Classification: LCC RJ505.B4 S718 2020 (print) | LCC RJ505.B4 (ebook) | DDC 618.92/89142–dc23
LC record available at https://lccn.loc.gov/2020022832
LC ebook record available at https://lccn.loc.gov/2020022833

Cover Design: Wiley
Cover Image: © www.davethompsonillustration.com

About this book

This book provides practical ideas about how to use cognitive behavioural techniques (CBT) with children, adolescents, and young adults. The book is organised around a competency framework and highlights the underlying philosophy, process, and core skills of undertaking CBT with this client group. The ideas can be used as part of an individual intervention for those with psychological problems or as a group-based prevention programme to promote helpful 'life skills' to build resilience.

The CORE philosophy of CBT, namely a Child-centred, Outcome-focused, Reflective, and Empowering approach, is described. Attention is paid to the PRECISE process of working with children, adolescents, and young adults. This is based on Partnership working, pitched at the Right developmental level, promoting Empathy, Creativity, Investigation, and Self-efficacy, and which is Engaging and enjoyable.

Finally, the specific core skills, the ABCs of CBT, are described. These are defined as Assessment and goals, Behavioural, Cognitions, Discovery, Emotions, Formulations, General skills, and Home assignments. Each skill is described with practical examples provided of how these can be applied in work with children, adolescents, and young adults.

When discussing specific skills and techniques, reference is made to relevant worksheets which are available in *Think Good, Feel Good* (TGFG) for children and young adolescents and *Thinking Good, Feeling Better* (TGFB) for older adolescents and young adults.

Acknowledgements

There are many people who have contributed to the ideas contained in this book. Instead of providing an endless list of names, I would quite simply like to thank everyone I have had the privilege to work with. In particular, all the children, young people, and amazing colleagues I have been fortunate to work with during my career. They have inspired and challenged me in equal measure.

I would like to thank my family, Rosie, Luke, and Amy, for their unwavering encouragement, support, and enthusiasm for this project.

Finally, I would like to thank those who read this book. I hope that these materials will help you to develop your practice and to make a real difference to the lives of the young people you work with.

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/cliniciansguide2e

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.

CHAPTER ONE
Introduction and overview

Cognitive behaviour therapy (CBT) is a generic term used to describe a variety of interventions that focus on the relationship between cognitions, emotions, and behaviours. These interventions are based on the shared premise that emotional distress is generated by the way we think about particular events that occur. Some ways of thinking are dysfunctional and unhelpful and can lead to the emergence of psychological problems. These unhelpful patterns are maintained by attention and memory biases, emotional responses, and maladaptive ways of behaving such as avoidance.

Traditional CBT interventions focus on identifying, directly challenging, and reappraising dysfunctional cognitions and through so doing reduce emotional distress and unhelpful behaviours. Recent models, often termed third wave, focus on changing the nature of the relationship with these thoughts rather than changing their specific content. Thoughts are understood as mental activity rather than defining reality, with mindfulness, acceptance, compassion, and distress tolerance helping to minimise the emotional distress they generate.

CBT as an intervention

CBT has been well evaluated and has established itself as the most extensively researched of all the child psychotherapies (Graham 2005). Systematic reviews consistently demonstrate that CBT is effective for the treatment of a range of emotional problems in children, adolescents, and young people, including post-traumatic

stress disorder (PTSD; Gutermann et al. 2016; Morina et al. 2016; Smith et al. 2019); anxiety (Bennett et al. 2016; James et al. 2015); depression (Oud et al. 2019; Zhou et al. 2015), and obsessive-compulsive disorder (OCD; Öst at al. 2016). Research is beginning to document the benefits of third wave CBT interventions such as mindfulness (Dunning et al. 2019; Klingbeil et al. 2017), dialectical behaviour therapy (McCauley et al. 2018), and acceptance and commitment therapy (Hancock et al. 2018).

Brief models of CBT, such as single-session exposure therapy for the treatment of specific phobias, have been found to be highly effective (Öst & Ollendick 2017). Similarly, brief parent-guided CBT has been found to be effective in the treatment of anxiety disorders (Cartwright-Hatton et al. 2011; Creswell et al. 2017). Finally, model-specific interventions, such as cognitive therapy for social anxiety (Leigh & Clark 2018) or single-session exposure therapy for specific phobias (Davis et al. 2019), have found encouraging results.

This substantial and consistent evidence 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, OCD, PTSD, and anxiety. This growing evidence base has also promoted the development of national training programmes in CBT. In the UK, the successful Improving Access to Psychological Therapies (IAPT) programme has been extended to children and young people (Shafran et al. 2014).

CBT as a preventative intervention

In addition to being an effective treatment, CBT has proven to be effective in the prevention of mental health problems

such as anxiety and depression (Calear & Christensen 2010; Neil & Christensen 2009). Preventive programmes offer the potential to reduce the severity of symptomology of those already displaying problems whilst enhancing the resilience of those who are not currently symptomatic. The results of prevention programmes are encouraging and suggest that school-based anxiety and depression prevention based on CBT is effective (Dray et al. 2017; Hetrick et al. 2015; Stockings et al. 2016; Werner-Seidler et al. 2017).

Typically, preventative programmes are provided in schools either to whole classes of young people (e.g. universal approach) or to young people identified as at risk of developing or experiencing problems (e.g. targeted approaches). School-based programmes have good reach, and integrating them into the school curriculum can help to reduce the stigma attached to mental health so that worries and problems can be more openly acknowledged and discussed (Barrett & Pahl 2006). Reviews suggest that classroom-based approaches designed to improve mental health and well-being are effective both as universal and as targeted programmes (Šouláková et al. 2019; Stockings et al. 2016).

There are many CBT anxiety and depression prevention programmes, with the most well evaluated being FRIENDS for Life (Barrett 2010), Penn Resilience Programme (Jaycox et al. 1994), Coping with Stress Course (Clarke et al. 1990), Resourceful Adolescent Program (Shochet et al. 1997), and the Aussie Optimism Programme (Roberts 2006). Whilst the results are generally positive, not all evaluations of these programmes have shown positive effects. The intervention leader requires careful consideration. Whilst teachers and school staff are well placed to deliver these programmes, studies have shown that they may not necessarily be as effective as trained mental health leaders (Stallard,

Skrybina, et al. 2014; Werner-Seidler et al. 2017). It is therefore important to consider the knowledge, support, and supervision of those delivering these programmes.

CBT with younger children

Whilst CBT can routinely be used with children from the age of seven years, comparatively few studies have evaluated the effectiveness of CBT with children under the age of 12 (Ewing et al. 2015). Most studies tend to involve young adolescents aged 12–17. Randomised controlled trials evaluating CBT for the treatment of depression rarely include children under the age of 12 (Forti-Buratti et al. 2016). For example, Yang et al. (2017) undertook a review and meta-analysis of CBT for the treatment of depression in children (defined as under the age of 13) and identified only nine studies, with six of these being conducted before the turn of the century.

In terms of anxiety, a few specific programmes for young children have been developed. These include Being Brave (Hirshfeld-Becker et al. 2010), Taming Sneaky Fears (Monga et al. 2015), and the school-based universal prevention programme Fun Friends (Pahl & Barrett 2010). Results from these studies are limited but nonetheless encouraging.

A few researchers have developed and explored the effectiveness of CBT with young children with PTSD (Dalgleish et al. 2015; Salloum et al. 2016). For example, Scheeringa et al. (2011) reported the feasibility of a trauma-focused CBT intervention with children aged three to six who had experienced a life-threatening event and found a large reduction in PTSD symptoms at six months. Research with OCD is similarly limited, although once again the results are promising. In one of the few studies, Freeman et al. (2014) found that 72% of children aged five

to eight with OCD were assessed as ‘much improved’ after completing a 14-session family-based CBT programme.

It cannot be assumed that because CBT is effective with young adolescents that it will also be effective with young children. Developmental factors need to be considered and the role of parents/carers requires careful attention. Nonetheless, although research is limited, the results are encouraging and are consistent with those obtained with older samples.

CBT with children and young people with learning difficulties

There is evidence that CBT can be effective with young people with learning difficulties, particularly those with high-functioning autistic spectrum disorder (ASD; Perihan et al. 2019). For example, studies have demonstrated that CBT programmes for young people with ASD do have a beneficial effect on reducing symptoms of anxiety (Storch et al. 2013; Van Steensel & Bogels 2015; Wood et al. 2009) and OCD (Vause et al. 2018).

Researchers have highlighted how CBT needs to be modified to accommodate the young person’s specific learning difficulties (Attwood & Scarpa 2013; Donoghue et al. 2011). This involves attending to factors such as communications/language abilities, interpersonal/social abilities, cognitive and behavioural inflexibility, and sensory sensitivities (Scarpa et al. 2017). In terms of communication, adaptations might include the use of simple, precise, and concrete language and the greater use of more non-verbal visual techniques such as pictures, worksheets, or visual prompts (e.g. writing the aim/focus of each session on a board). The young person’s special interests can be integrated into the intervention through

the development of metaphors or use of rewards. Interpersonal skills with young people with ASD maybe more limited, so greater attention needs to be paid to the assessment and development of core skills such as ‘mind reading’ to aid understanding of how people might think and feel. Once again, the process can be made concrete through the use of role plays. Cognitive flexibility can be promoted using self-talk where different options are verbalised and modelled or through multiple choice questions which encourage awareness and consideration of alternative strategies. For behavioural inflexibility, interactions during clinical sessions may need to be modified to be more consistent with the expectations of the young person. For example, Donoghue et al. (2011) note that the usual social exchanges at the start of therapy sessions may create anxiety and suggest that the therapist adopts a more task-focused approach. Similarly, anxiety associated with change can be minimised by using the same room to meet, having a clear session routine/structure, and establishing a clear length for the meeting. In terms of sensory issues, it may be necessary to reduce the length of the session, change the lighting, remove visual material from the room, or use relaxation skills to help reduce sensory overload. Finally, generalisation from clinical sessions to the young person’s everyday environment can be facilitated through the involvement of parents, mobile phones to send prompts and reminders, and digital cameras to capture difficult situations (Donoghue et al. 2011).

Research with young people with other disorders is more limited. For visually impaired young people, tactile prompts can be used to remind the young person of the steps involved in managing anxiety (Visagie et al. 2017). For those with moderate learning difficulties, skills such as problem solving can be broken down into simple steps

(Stop, Plan, Do) and limited decision-making options (e.g. you can do either X or Y).

Technologically delivered CBT

There is increased interest in the use of technology to support and deliver CBT to children and adolescents. Technology offers the potential to reach geographically isolated populations; flexible access; increased convenience; fewer visits to specialist clinics; greater privacy and anonymity; enhanced treatment fidelity; rapid scalability; and low-cost delivery (Clarke et al. 2015; MacDonell & Prinz 2017). It is also very acceptable and particularly appealing to adolescents, who are typically early adopters and regular users of new technologies (Johnson et al. 2015; Wozney et al. 2018).

Internet or technologically delivered CBT programmes have attracted much interest and have demonstrated encouraging results (Grist el al. 2019; Pennant et al. 2015; Vigerland et al. 2016). Digital technologies deliver interventions via computers, or through web-based platforms via mobile tablets or smartphones (Hollis et al. 2017). The structured nature of CBT lends itself well to digital delivery, resulting in several computerised CBT interventions being developed. For example, the face-to-face CBT anxiety programme *Cool Teens* can be effective when delivered via a CD-ROM with minimal therapist support (Wuthrich et al. 2012). Similarly, online CBT anxiety programmes such as *BRAVE* were found to be very acceptable to young people and as effective as face-to-face CBT (Spence et al. 2011). In terms of depression, encouraging results have been reported for *Stressbusters*, a computerised CBT program (Smith et al. 2015; Wright et al. 2017) and a computer game (*SPARX*) when used both as an intervention and as a prevention programme (Merry,

Hetrick, et al. 2012; Merry, Stasiak, et al. 2012; Perry et al. 2017).

Reviews indicate that technologically delivered CBT is effective (Grist et al. 2019) and is now recommended in the United Kingdom as a first line treatment for mild to moderate depression (NICE 2019). Other technologies such as apps, virtual reality, and games have seldom been developed or evaluated.

Involving parents

Parents have a central role in supporting their child, and by involving them in the intervention important parental behaviours and contextual factors can be addressed. Their involvement can therefore facilitate generalisation, practice, and reinforcement of new skills in the young person's everyday life. However, there is no consistent evidence to suggest that involving parents in CBT programmes results in better outcomes (Breinholst et al. 2012). For example, reviews have shown that CBT for anxiety is effective with and without parental involvement (Higa-McMillan et al. 2016; Reynolds et al. 2012). Neither the age of the young person nor whether both parents are involved appears to be related to enhanced outcomes (Carnes et al. 2019; Manassis et al. 2014). Similarly, school-based CBT anxiety prevention programmes have been found to be effective without any parental involvement (Stallard, Skryabina, et al. 2014). However, assessing the benefits of parental involvement is complex and the potential beneficial impact on parents or other family members has seldom been assessed (Breinholst et al. 2012). In addition, whilst the additional short-term benefits may not be evident, parental involvement in CBT may support the longer-term maintenance of treatment gains (Manassis et al. 2014).

There has been less research focusing on parental involvement in depression programmes. In a review, Oud et al. 2019 found that parental (caregiver) involvement may enhance outcomes compared to child-only CBT. The way in which parents are involved in programmes has received limited attention and may explain some of the differences between studies. Stallard (2005) described four models of parental involvement: facilitator, co-clinician, clinician, and co-client. The most limited involvement is that of the facilitator where parents attend one or two review meetings with their child. The focus of the intervention is on the child's problems, with parents receiving information about the intervention and the skills their child will be developing. As co-clinicians, parents are more actively involved in treatment. They attend each session with their child, either for the whole session or joining for the last 15 minutes. The intervention remains focused on the child's problems, but parents have greater awareness of the skills their child is acquiring and so can prompt and encourage generalisation. This role is further enhanced when parents are involved as clinicians. In this role parents are provided with the information and support required to teach their child CBT skills. Finally, parents may be involved as a co-client. This model recognises that parents may be behaving in a way that contributes to their child's problems. The intervention therefore helps the child to develop and practise skills to deal with their anxiety whilst parents learn new ways of encouraging and rewarding their child for facing their worries.

In summary, parental involvement needs to be considered on a case-by-case basis and a decision made about whether parental involvement may be beneficial and, if so, how parents/carers need to be involved (Carnes et al. 2019).

The competencies to deliver child-focused CBT

There are many materials and structured workbooks available which provide helpful ideas about how CBT can be undertaken with children and young people. These include specific manuals such as the Coping Cat programme for young people with anxiety (Kendall 1990); How I Ran OCD Off My Land (March & Mulle 1998), and the Adolescent Coping with Depression Course (Clark et al. 1990). In addition, there are materials to help young people with social skills problems (Spence 1995) and chronic fatigue syndrome (Chalder & Hussain 2002) and anxiety and depression prevention programmes such as Friends for Life (Barrett 2010). There are also books that provide practical ideas about how CBT can be adapted for use with children and young people (Friedberg & McClure 2015; Fuggle et al. 2012; Stallard 2019a) and how CBT can be used as a modular approach which flexes according to how the young person responds (Chorpita 2007). Finally, there are self-help books for parents to help them overcome their child's fears or worries (Cartwright-Hatton et al. 2010; Creswell & Willetts 2018) or to help their depressed teenager (Reynolds & Parkinson 2015)

Such good quality child-friendly materials make available many helpful ideas about how to introduce and use specific CBT strategies with children and young people. However, comparatively less attention has been paid to how these techniques are used, that is, the process of undertaking CBT with children, adolescents, and young adults. Attending to the process of CBT is essential and ensures that the theoretical model and the core principles that underpin CBT are preserved. This will ensure that CBT is used in a coherent and theoretically robust way thereby

avoiding a simplistic approach in which individual strategies are used in a disconnected and uninformed way.

Think Good, Feel Good (Stallard 2002a, 2019a) and *Thinking Good, Feeling Better* (Stallard 2019b) provide a number of practical ideas about how some of the specific techniques of CBT could be conveyed to and adapted for use by children, adolescents, and young adults. This book 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 style. Instead it aims to promote awareness of some of the key issues that need to be considered and integrated into CBT in a way that is engaging and helpful for the young person and their carer whilst maximising the effectiveness of the intervention.

Assessing competence

A clear strength of CBT is the underpinning philosophy and theoretical model. The philosophy underpins the collaborative process of self-discovery whilst the theoretical model informs and guides the use of specific techniques. It is therefore important to develop a good understanding of the basic model and to ensure that the process and rationale for use of specific techniques is understood and competently executed.

The most widely used tool for measuring CBT competence with adults is the Cognitive Therapy Scale–Revised (CTS-R) (Blackburn et al. 2001). This is a revised version of the original Cognitive Therapy Scale developed by Young and Beck (1988). The CTS-R consists of 12 items which assess important generic CBT skills. These include four general skills (feedback; collaboration; pacing and efficient use of time; and interpersonal effectiveness) and seven specific CBT skills (eliciting appropriate emotional expression;

eliciting key cognitions; eliciting behaviours; guided discovery; conceptual integration; application of change methods; and homework setting). The remaining item, agenda setting, overlaps both sets of items and is included in the general and specific sub-scales.

The suitability of the CTS-R to assess competencies when using CBT with children and adolescents has been questioned (Fuggle et al. 2012). In particular, the authors argue that the CTS-R is not appropriate because:

- Important systemic influences on the onset and maintenance of the young person's problems need to be acknowledged and the role of the carers/family in CBT considered.
- The young person's cognitive, emotional, linguistic, and reasoning ability are developing, and CBT needs to be appropriately adapted to be consistent with their abilities.
- Creative non-verbal methods may be required to convey the concepts of CBT to young people in clear and understandable ways.
- The process of undertaking CBT with young people and their carers needs greater specification.

Specific CBT competence scales for use with children and young people have been developed and evaluated. Of those available, the majority assess competence in delivering a specific manualised programme or treatments for specific disorders. For example, Mcleod et al. (2019) developed a scale to assess competence delivering the Coping Cat anxiety programme, Bjaastad et al. (2016) the FRIENDS anxiety programme, and Gutermann et al. (2015) for assessing competence in treating PTSD. Although there are some differences in the competencies that have been

identified, there are several shared dimensions. For instance, in a Delphi study, Sburlati et al. (2011) identified various generic therapeutic competencies (e.g. practising professionally, knowledge of children and adolescents, building a positive relationship, conducting a thorough assessment), CBT-specific competencies (e.g. understanding CBT theory, developing a CBT formulation, working collaboratively), and specific CBT techniques (e.g. managing negative thoughts, changing maladaptive behaviours, managing maladaptive mood). McLeod et al. 2018 identified four categories of competence for delivering anxiety interventions. These are interventions that are common to CBT programmes (e.g. maintaining focus on CBT model, homework review, etc.), interventions specific to anxiety programmes (e.g. relaxation, fear ladder, exposure), how the intervention is delivered (coaching, modelling, rehearsal), and overall ratings of skilfulness and responsiveness. Whilst there are some specific differences, there tends to be a consensus that undertaking CBT with children and young people requires competencies both in the method of delivery (e.g. the therapeutic process) and in the application of specific CBT techniques.

Cognitive Behaviour Therapy Scale for Children and Young People

The absence of a psychometrically robust scale developed specifically to assess general CBT competence with children and young people led to the development of the Cognitive Behaviour Therapy Scale for Children and Young People (CBTS-CYP) (Stallard, Myles, et al. 2014). The aim was to develop a scale to assess the overall quality of CBT, not to assess in detail the way that specific techniques like exposure are conducted.

In terms of development, it was firstly decided to build upon the CTS-R. The CTS-R is widely used and considered to provide a comprehensive overview of the generic skills required to competently practise CBT with adults (Fairburn & Cooper 2011; Kazantzis 2003; Keen & Freeston 2008). Secondly, the CTS-R assesses the specific use of CBT methods as well as general skills that facilitate their effective delivery. It was therefore decided that the CBTS-CYP would contain items that assessed competence both in the application of specific methods and in the process of using CBT with children and young people. Thirdly, upon reviewing the CTS-R, it was decided that all items should be included in the CBTS-CYP, modified as appropriate to reflect the use of CBT with children and young people. Similarly, the framework for defining competence proposed by Dreyfus (1986) and adapted into a seven-point Likert scale on the CTS-R was adopted for use in the CBTS-CYP. Fourthly, the CTS-R is widely used by CBT training courses to assess competence. In order to maintain consistency with the CTS-R, it was decided to adopt the same thresholds for assessing competency, that is, score 2 or more on each item and a total score of 50% or more. Finally, it was decided that the scale would be developed to assess both verbal and non-verbal behaviours and so could be used like the CTS-R to assess both audio and video recordings of clinical sessions. It was anticipated that specific items would not necessarily be mutually exclusive. For example, a formulation requires the development of a shared conceptualisation in which important cognitions, emotions, and behaviours are bound together within the CBT model. The elicitation and identification of key cognitions and processes would therefore be expected to be associated with the formulation. Similarly, CBT typically involves developing an understanding of the links between cognitions, emotions, and behaviours and as such there will