A Clinician’s Guide to 
Think Good – Feel Good 
Using CBT with children and young people

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A Clinician’s Guide to Think Good – Feel Good
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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 has a part-time appointment at the University of Bath as Professor of Child and Family Mental Health, and has received a number of research grants exploring the effects of trauma and chronic illness on children. He has published over 70 peer-reviewed papers and his current research interests include the use of cognitive behaviour therapy with children, post-traumatic stress disorder and the psychological effects of chronic illness.
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On-line resources

All the worksheets and psychoeducational materials are available free and in colour to purchasers of the print version. Visit the Wiley website at http://www.wiley.com/go/cliniciansguide to find out how to access and download relevant sections of the workbook, which can then be used in clinical sessions with your clients. The materials can be accessed and downloaded as often as required.
Child-focused cognitive behaviour therapy (CBT) is a popular form of psychotherapy that is now widely used with a range of mental health problems presented by children and young people. The empirical basis of child-focused CBT has been demonstrated through a number of randomised controlled trials that have resulted in a growing conviction amongst clinicians that CBT is the treatment of choice for many disorders. While research evaluating the efficacy and effectiveness of child-focused CBT is more substantive than that evaluating other psychotherapies, the research base is still limited. The first randomised controlled trial (RCT) of child-focused CBT was not reported until the beginning of the 1990s and it is only recently that RCTs evaluating child-focused CBT for obsessive-compulsive disorder (OCD) (Barrett et al. 2004) and chronic fatigue syndrome (Stulemeijer et al. 2005) have been published. Similarly there is only one published RCT of child-focused CBT for specific phobias (Silverman et al. 1999a) and social phobias (Spence et al. 2000) and none have yet been published exploring the efficacy of child-focused CBT in the treatment of anorexia nervosa.

The results of RCTs are generally positive and highlight that child-focused CBT results in considerable post-treatment and short-term gains when compared with a waiting list or attention placebo condition. However, the longer-term benefits or the superiority of child-focused CBT over other active interventions has received comparatively less attention and has not yet been consistently demonstrated. Similarly the core features that differentiate CBT from behaviour therapy have not been defined; the extent and specific focus within interventions upon the cognitive domain and assumed dysfunctional cognitive processes varies considerably; little is known about the effective treatment components or their sequencing; the optimum way of involving parents in child-focused CBT and their specific role is unclear.

Despite these limitations the interest in child-focused CBT continues to grow and has resulted in a range of materials and structured workbooks becoming available to help the Clinician undertake CBT with children. These include specific manuals such as the Coping Cat programme for children with anxiety (Kendall 1990); Stop and Think workbook for impulsive children (Kendall 1992); Keeping your Cool: the anger management workbook (Nelson & Finch 1996); the Freedom from Obsessions and Compulsions Using Special tools (FOCUS) programme (Barrett et al. 2004) and the Adolescent Coping with Depression Course (Clark et al. 1990). In addition there are materials to help children with social skills problems (Spence et al. 1999), chronic fatigue syndrome (Chalder & Hussain 2002) and through anxiety and depression prevention programmes such as FRIENDS (Barrett et al. 2000a). There are also books that provide the Clinician with general practical ideas about how CBT can be adapted for use with children and young people (Friedberg & McClure 2002; Reinecke et al. 2003; Stallard 2002a).

Materials such as these provide the Clinician with a rich source of ideas that can inform and facilitate their clinical practice of child-focused CBT. This increase in the availability of child-friendly materials is welcomed and serves to highlight the current focus upon what to do (i.e. specific strategies) rather than how (i.e. the process). It is, perhaps, surprising to note
that comparatively less attention has been paid to the process of undertaking child-focused CBT. Attending to the process of child-focused CBT is essential and ensures that the theoretical model and the core principles that underpin it are at the forefront of the Clinician’s thinking. This will help the Clinician adapt and use CBT in a coherent and theoretically robust way and prevent the simplistic approach in which Clinicians simply dip into the model by taking and using individual strategies in a disconnected and uninformed way.

*Think Good – Feel Good* (Stallard 2002a) provided a number of practical ideas about how some of the specific techniques of CBT could be conveyed to, and adapted for use by, children. The book uses three characters to explore the three domains of CBT, cognitions (Thought Tracker), emotions (Feeling Finder) and behaviour (Go Getter). *A Clinician’s Guide to Think Good–Feel Good* 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 model or style for undertaking child-focused CBT. Instead it aims to promote increased awareness of some of the key issues that need to be considered and integrated into therapy in a way that is helpful for the Clinician, the child and the child’s carer while maximising the effectiveness of the intervention.

This book will therefore consider a number of key clinical questions including:

- Is the child ready to actively engage in CBT?
- Can the child’s motivation to change be increased?
- How does one develop a CBT case formulation?
- What sort of formulation framework should be used?
- Should parents be involved in child-focused CBT?
- How should they be involved and does it make a difference?
- What are the core elements of CBT programmes for particular disorders?
- Where does one start?
- How can Clinicians work in partnership with children?
- How can the process of guided discovery be facilitated?

In the course of this book the reader will be referred to some of the materials in *Think Good–Feel Good* (referred to as TGFG). This is done to provide examples of how some of the techniques and ideas of CBT can be adapted to facilitate the process of working with children. Once again the author is not being prescriptive but is instead attempting to direct the reader to materials and practical examples that can be modified and used to inform their clinical work.

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**Engagement and readiness to change**

At the beginning of the therapeutic process the Clinician meets with the child and the child’s carers in order to assess the extent and nature of the current concerns and the outcomes they would like to achieve. This starting point is somewhat easier for Clinicians who work with adults since their clients are often already motivated and prepared to engage in therapy. Children do not usually refer themselves, may not share the concerns identified by their carers, and therefore may not have any ownership in securing any change. The child may therefore present as anxious, unmotivated or disinterested with no agenda for change.

An important first task is to assess the child’s readiness to change and to identify whether they have any problems they would like to address or goals they would like to achieve. The *Stages of Change* model (Prochaska et al. 1992) provides a helpful framework that conceptualises change as a process rather than a dichotomous decision. This framework can be
used to clarify where the child is in the change cycle and to inform the primary therapeutic focus. At the *pre-contemplation* stage the child will not have considered the possibility or, indeed, the need to change. This awareness begins to develop during the *contemplation* stage so that by the *preparation* stage the child has become interested and prepared to make some small change. The major change occurs during the *action* stage with these newly acquired skills being consolidated during the *maintenance* stage. The final stage is that of *relapse* where the child has to cope with any new setbacks or the return of their previous problems, dysfunctional behaviours or cognitive processes.

The model suggests that the primary therapeutic focus will depend upon where the child is in the change cycle. The main therapeutic work, where the child is ready to actively engage in CBT, occurs during the preparation, action and maintenance stages. During the relapse, pre-contemplation and contemplation stages the Clinician is primarily concerned with increasing the child’s motivation, interest and commitment to change. During these stages *motivational interviewing* can provide the Clinician with a number of helpful ideas. Motivational interviewing provides a framework that helps the child to vocalise and resolve their *ambivalence* about possible change. Motivational interviewing is based on the central premise that the desire for change needs to come from the child rather than as a result of external pressure or persuasion. This is achieved by helping the child to *develop discrepancy* between where they currently are and where they would ideally like to be. Confronting or challenging the child’s *resistance* is *avoided* since attempts at direct persuasion, argument or challenging result in a polarisation of views, which only serves to strengthen the child’s position. Instead the Clinician aims to reinforce any signs of self-efficacy or behaviours that might indicate possible self-motivation.

During motivational interviewing the Clinician will be assessing the child’s perception of the *importance* of change, their *readiness* to embark upon an agenda of change and their confidence in *achieving* this.

### Formulations

Once the child has identified possible goals and is prepared to engage in CBT the assessment process continues until a formulation has been developed. The formulation is the *shared understanding* of the child’s problems presented within a cognitive behavioural framework. The formulation serves an important *psychoeducational function* and provides the current *working hypothesis, which informs the intervention*. The formulation is developed collaboratively and provides as much or as little information as necessary to help the child and their carers understand their problems.

There are many different types of formulations. The simplest are *mini-formulations*, which highlight the connection between two or three components of the cognitive model. These can be particularly helpful with younger children who may find it easier to attend to two or three elements at a time rather than simultaneously attempting to grapple with multiple elements spanning different time frames (e.g. important past experiences or current triggering events), concepts (e.g. distinguishing between different levels of cognitions such as core beliefs and assumptions) or domains (e.g. cognitive, emotional and behavioural). A mini-formulation could therefore help a child to see the connection between a situation and how they behave or between their thoughts and feelings. Simple mini-formulations can be developed separately and then combined to provide a descriptive summary of how a child thinks, feels and behaves in a particular situation.

*General cognitive formulations* use the key components of the general cognitive model to organise and structure the formulation. The simplest is the general *maintenance formulation*