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Child and Adolescence Problems

by

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Biographical Note

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INTRODUCTION

The framework, set out in Figure 1 outlines the stages of brief CBT with children and adolescents from the initial receiving of a referral letter to the point where the case is closed. In the first stage a plan for conducting the intake interview is made. The second stage is concerned with the processes of engagement, alliance building, assessment and formulation. In the third stage, the therapeutic contract, the completion of a therapy plan and the management of resistance are the primary issues addressed. In the final stage, disengagement or recontracting for a further episode of intervention occurs.

Insert Figure 1 about here

Within the context of this stage-based model of consultation, brief CBT is usefully conceptualized as a developmental and recursive process. At each developmental stage, key tasks must be completed before progression to the next stage. Failure to complete the tasks of a given stage before progressing to the next stage may jeopardize the consultation process and lengthen treatment unnecessarily. For example, attempting to conduct an assessment without first contracting for assessment may lead to co-operation difficulties if the child or parents find the assessment procedures arduous. Brief CBT is an episodic and recursive process insofar as it is possible to move from the final stage of one episode of brief CBT to the first stage of the next.

Episodes of brief CBT with children and adolescents are time-limited to between 6 and 10 sessions.

STAGE 1. PLANNING

In the first stage of brief CBT the main tasks are to plan who to invite to the initial assessment session and what to ask them.

Network analysis

There is often confusion about who to invite to an intake interview in cases where children or adolescents have multiple problems, are from multiproblem families, or are involved with multiple agencies. In these cases a network analysis may be conducted. For network analysis, it is essential to find out from the referral letter or through telephone contact with the referrer who is involved with the problem and tentatively establish what roles they play with respect to it. With some cases this will be straightforward. For example, where parents are concerned about a child's enuresis, it may be sufficient to invite the child and the parents. In other cases, where school teachers, hospital staff or social services personnel are most concerned about the case, the decision about who to invite to the first interview is less straightforward. In these complex cases it is particularly important to analyze network roles accurately before deciding who to invite to the first session. Most network members fall into one or more of the following categories.

- The *referrer* to whom correspondence about the case should be sent
- The *customer* who is most concerned that the referral be made
- The *child* or children with the problem
- The legally responsible *guardians* who are usually the parents but may be a social worker or other representative of the state
- The primary *caregivers* who are usually the parents but may be foster parents, residential child care staff or nursing staff
- The child's main *teacher*

- The *social control agents* such as social workers or probation officers
- *Other involved professionals* including the family doctor, the pediatrician, the school nurse, the parent's psychiatrist etc.

Certain key network members constitute the minimum sufficient network necessary for effective case management (Carr, 1995). These include the customer, the legal guardians, the caregivers and the referred child. Ideally, all members of the minimum sufficient network should be invited to an intake meeting. If this is not possible, then individual meetings or telephone calls may be used to connect with these key members of the network. Where cognitive behaviour therapists are working as part of multidisciplinary teams, often the main customer for CBT is another team member. In such instances it is often useful to meet with the parents of the child and the referring team member briefly to clarify the reason for the referral and the implications of engaging in brief CBT or declining to do so. Failure to convene such meetings often results in confusion or co-operation difficulties.

From this discussion of network analysis, it is clear that brief CBT is a highly contextual approach to clinical practice. Sensitivity to the problem-maintaining and problem-resolving potential of the child or adolescent's social context contributes to the brevity of therapy. The approach to brief CBT described in this chapter is family-oriented rather than individually-focused.

Agenda planning

In planning an agenda for an intake meeting, a routine intake interview and a core test battery may be supplemented by questions and tests which take account of the specific features of the case. The routine interview should cover the history of the presenting problems. This typically involves questions about the nature, frequency and

intensity of the problems; previous successful and unsuccessful solutions to these problems; and different family members' views on the causes of these problems and possible solutions that they have tried or suspect may be fruitful to explore in future. In addition the intake interview should inquire about the child's individual physical, cognitive and psychosocial developmental history and an assessment of the family's development and functioning with particular reference to parent-child relationships; interparental relationships and the wider social network within which the family is embedded. Assessment of unique features of the case should be based on a preliminary formulation which contains hypotheses about possible antecedents, beliefs and consequences associated with the presenting problems. These hypotheses may be based on information given in the referral letter or phone call and the literature on the particular problem in question. For example, if a youngster presents with conduct problems, then important hypotheses to consider are that the possibility that the parent and child are engaged in a coercive cycle of interaction (Patterson, 1982) and the child has a hostile attributional bias (Crick & Dodge, 1994). If a child, on the other hand, presents with school refusal, a hypotheses deserving consideration are that the child is experiencing separation anxiety, is being inadvertently reinforced for school non-attendance and has a cognitive bias for interpreting ambiguous situations as threatening or is being bullied at school (Blagg, 1987).

To develop a thorough understanding of the presenting problems and related issues a number of different types of assessment meetings may conducted. These may include some or all the following depending upon the case: child centered assessment interviews and testing sessions; parental interviews; nuclear family interviews; school interviews; extended family interviews and interviews with other involved professionals. It is usually more fruitful and more time-efficient to conduct a

child centered assessment, once the views of significant adults in the child's network are known, since it is then possible to ask the child how they respond to their parents' and teachers' views of the problem.

A *core battery* of psychosocial measures that I have found to be particularly useful in clinical practice include the Child Behaviour Checklist (Achenbach, 1991) or the Strengths and Difficulties Questionnaire (Goodman, 1994); the Battle Culture Free Self-Esteem Inventory (Battle, 1992); the Nowicki Strickland (1973) Locus of Control Scale and the Family Assessment Device (Kabacoff et al, 1990). These measures give baseline information on specific behaviour problems, self-esteem, self-regulatory beliefs and perceived family functioning. Assessment instruments for use with specific childhood problems and disorders are catalogued in Carr (1999) and Graham (1998).

STAGE 2. ASSESSMENT AND FORMULATION

Establishing a contract for assessment; working through the assessment agenda and recursively refining the preliminary formulation in the light of the information obtained; dealing with engagement problems; building a therapeutic alliance; and giving feedback are the more important features of the assessment and formulation stage which may span one or two sessions.

Contracting for assessment.

At a cognitive level, contracting for assessment involves the therapist, the child or adolescent and significant network members clarifying expectations and reaching an agreement to work together. The first task is to explain what assessment involves and to offer the parents, the child and each relevant member of the network a chance to accept or reject the opportunity to complete the assessment. With children and

teenagers, misconceptions need to be dispelled. For example, some children believed that when referred for brief CBT they may be involuntarily admitted to hospital or placed in a detention centre. In some instances, children may not wish to complete the assessment, but their parents may be insistent. In others, parents may not wish to complete the assessment but a referring physician or social worker may forcefully recommend attendance. In such situations, the therapist may facilitate the negotiation of some compromise between parties. The contracting for assessment is complete when family members have been adequately informed about the process and have agreed to complete the assessment.

Recursive reformulation.

The assessment phase of the overall consultation process involves conducting interviews or administering tests to check out the accuracy of the formulations and hypotheses made during the planning phase and modifying the formulations or hypotheses in the light of the information gained in the interview or testing sessions. In practice, the first round of interviewing and testing may not only lead to a modification of the preliminary formulation but may raise further hypotheses that need to be checked out with further interviews or tests. The process comes to an end when a formulation has been constructed that fits with significant aspects of the child's problems; with network member's experiences of the child's problems; and with available knowledge about similar problems described in the literature. This formulation should inform the construction of a treatment plan. Building blocks for treatment plans are described below. A CBT formulation is a mini-theory that explains the way in which particular situational antecedents; beliefs about these, the problem and related issues; and consequences for problematic behaviours maintain the

presenting problem. A formulation may also highlight factors which predispose the child or adolescent to developing a particular presenting problem.

Here is an example of a formulation for a child who presents with oppositional defiant disorder. John is a 5 year old boy with a difficult temperament and this predisposes him to have difficulty with rule-following. In situations where he is tired, hungry or excited he has great difficulty following instructions from parents and teachers. He believes that such instructions are personal criticisms rather than requests for co-operative behaviour. At home and at school his parents and teachers typically respond to his unco-operative behaviour by either offering explanations and attention which positively reinforces his lack of co-operation or by withdrawing, which negatively reinforces his lack of co-operation by removing what he perceives to be an aversive stimulus, i.e. instructions and directions for rule following.

The following is an example of a formulation for a case of separation anxiety. Paula is a 9 year old girl who has had difficulty attending school for 3 months. On those mornings when her father has left early for work and her mother has taken her to school she notices her mother's intense concern for her well being when she complains of mild headaches or stomach aches. In response to this, she has thoughts about possible dangers that may befall her mother, while she (Paula) is at school. These thoughts lead to strong feelings of anxiety, headaches and abdominal pains. When she inisists that she cannot attend school because of these feelings and symptoms her mother comforts her and returns her to bed, thereby reinforcing the separation anxiety. This pattern does not occur when her father takes Paula to school, because he does not display intense concern for Paula's wellbeing or reinforce school avoidance. Paula may have been predisposed to developing separation anxiety because of a genetic vulnerability to anxiety (suggested by a family history of anxiety

disorders) and a family culture, particularly within the mother's family of origin, in which there is a high sensitivity to illness.

Alliance building

In addition to providing information, the process of assessment also serves as a way for the therapist, the child, the parents and members of the network to build a working alliance. Building a strong working alliance with the child and key members of the child's family and network is essential for valid assessment and effective therapy. ***All other features of the consultation process should be subordinate to the working alliance*,** since without it, clients drop out of assessment and therapy or fail to make progress. The only exception to this rule is where the safety of child or family member is at risk and in such cases protection takes priority over alliance building. Research on common factors that contribute to a positive therapeutic outcome and ethical principles of good practice point to a number of guidelines which therapists should employ in developing a working alliance (Bergin & Garfield, 1994):

- When communicating with the child, parents and network members, warmth, empathy and genuineness should characterize the therapist's communication style (Rogers, 1957)
- The therapist should form a collaborative partnership with the child, the parents and other members of the child's network (Beck,1976)
- An invitational approach should be adopted in which children and family members are invited to participate in assessment and therapy procedures (Kelly, 1955)
- The inevitability of ambivalence about change becoming an issue within the therapeutic relationship should be acknowledged (Anderson & Stewart, 1983).

Warmth, empathy and genuineness allow clients to have the experience of being accepted and understood rather than blamed. While parents may create a context within which children's problems develop, usually this occurs inadvertently. Where it occurs intentionally, typically wider social or historical factors have created a context within which the parents intention to harm a child has evolved. Blaming is a concept useful in the judicial system where seeking justice is the primary goal, but not within a therapeutic system where understanding and negotiation of behavioural change are the main goals.

The therapist should form a collaborative partnership with the child, the parents and other members of the child's network so that responsibility for the tasks of assessment and case management may be shared. Therapists and families with whom they work are both experts, but in different areas. Family members are experts on the specific features of their own family and details of their unique problems. Therapists are experts on general scientific and clinical information relevant to child and family development and the broad class of problems of which the client's is a specific instance.

The invitational approach allows family members to have the experience of choosing to participate in activities which constitute the consultation process and to avoid the experience of being neglected through excessive non-directiveness or coerced through excessive directiveness. This experience of choice associated with an invitational approach increases the probability that family members will co-operate with arduous assessment and treatment tasks.

Often children, parents or network members do not follow through on tasks that they have agreed to complete; fail to turn up to appointments; or insist on prolonging the consultation process apparently unnecessarily. This occurs despite their avowed wish to solve the presenting problems. The possibility that co-operation difficulties and

resistance may occur and that this will require careful analysis deserves recognition from the outset.

The assessment is complete when the presenting problem and related difficulties are clarified; related antecedent situational factors, beliefs and consequences have been identified; a formulation has been constructed; possible goals have been identified; options for case management or treatment have been identified; and these have been discussed with the family.

Feedback

Giving feedback is a psychoeducational process. Children and their parents and siblings are given both general information about the type of problem they face (such as ADHD or encopresis) and specific information about the way this relates to the formulation of their own presenting problems. Simplicity and realistic optimism are central to good psychoeducation. It is important not to overwhelm parents and children with information, so a good rule of thumb is to think about a case in complex terms but explain it to clients in as simple terms as possible. Put succinctly:

- *Think complex-Talk simple*.

Good clinical practice involves matching the amount of information given about the formulation and treatment plan to the client's readiness to understand and accept it. A second important rule of thumb is to engender a realistic level hope when giving feedback by focusing on strengths and protective factors first, and referring to etiological factors later. Put succinctly:

- *Create hope- Name strengths*

In providing psychoeducation about the general type of problem the family face, information on clinical features, predisposing, precipitating, maintaining and protective

factors may be given along with the probable impact of the problem in the short and long term on cognition, emotions, behaviour, family adjustment, school adjustment and health.

The formulation is fed back to the family as a basis for a therapeutic contract. The process of constructing a formulation is the process of linking academic knowledge of theory and research to clinical practice. If the working alliance is the engine that drives the therapeutic process, the formulation is the map that provides guidance on what direction to take and what building blocks should be included in the brief CBT plan.

In some cases, the process of assessment and formulation releases family members' natural problem-solving skills and they resolve the problem themselves. For example, some parents, once they discuss their anxiety about handling their child in a productive way during a family assessment interview, feel released to do so.

STAGE 3. THERAPY

When parents and their children have completed the assessment stage, have accepted the formulation, and are aware of the broad therapeutic possibilities, it is appropriate to progress to the therapy stage. The central tasks of this stage are contracting for therapy to achieve specific goals; participating in the completion of the agreed therapy plan; and troubleshooting resistance. If at this stage, it is apparent that other family problems such as parental depression or marital discord require attention, referrals for this work may be made and it may be conducted concurrently with the brief CBT programme which focuses explicitly on the child's problems. Alternatively, addressing these problems may be postponed until after the child-focused difficulties have been resolved.

Contracting for therapy

The contracting process involves inviting children or adolescents and their parents to make a commitment to pursue a specific therapeutic plan to reach specific goals. This plan may be constructed from one or more of the building blocks outlined below. Clear, realistic, visualized goals that are fully accepted by all family members and that are perceived to be moderately challenging are crucial for effective therapy (Carr, 1997; Snyder, Michael & Cheavens, 1999). Goal setting takes time and patience. Different family members may have different priorities when it comes to goal setting and negotiation about this is essential. This negotiation must take account of the costs and benefits of each goal for each family member. It is usually a more efficient use of time to agree on goals first, before discussing the details of how they might be achieved.

In this context it is important to give parents and children clear information about research on the costs and benefits of psychological interventions and the overall results of outcome studies (Carr, 2000). Broadly speaking, most CBT interventions which have been developed for children and adolescents, are effective in only 66-75% of cases and about 10% of cases deteriorate as a result of such interventions. The more protective factors that are present in a given case, the more likely it is that therapy will be effective. If therapy is going to be effective, most of the gains are made in the first 6-10 sessions. Relapses are inevitable for many types of problems and periodic booster sessions may be necessary to help children and families handle relapse situations. A statement of the sacrifices that the child and family will have to make to participate in the brief CBT plan also deserve mention. Common sacrifices include, attending a series of consultation sessions; discussing difficult issues openly; completing homework assignments; being prepared for progress to be hampered by setbacks; learning to live with ongoing residual difficulties; accepting that episodes of

therapy are time-limited; accepting that at best, the chances are only 2 out of 3 that therapy will be helpful.

The contracting session is complete when all involved members of the child's network necessary for implementing the therapeutic plan agree to be involved in an episode of consultation to achieve specific goals.

At this point, or indeed earlier in the consultation process, children or parents may point out that they have been through unsuccessful treatment programmes in the past, and that it appears that the psychological assessment or treatment programme being offered is similar to that which failed before. History of previous treatment, will have been assessed during assessment so you will be familiar with the material the family wish to discuss, if it is raised at this point in the consultation process. However, it may be useful for concerned family members to be invited to give their views on previous unsuccessful treatment programmes. It may also be appropriate to invite family members to ventilate the feelings of fear, anger or demoralization that have led them to question the value of embarking on yet another treatment programme. Against this backdrop, the similarities and differences between those unsuccessful programmes and the services that are now being offered may be outlined. In many instances there will be many similarities since most psychosocial interventions involve meeting regularly and talking about problems and their solution using some type of psychosocial or biomedical model as a problem solving framework.

However, there are some important differences between contextually based brief CBT and other therapeutic approaches. The approach assumes that children's problems are complex and deserve thorough assessment. This assessment takes account of the clinician's observations of the child but also those of the parents, teachers and other involved professionals. All of the information is integrated into a

formulation, which is a map of how the problem evolved and is maintained. Treatment plans are based on this map and on evidence about the types of treatments that have been shown to work in scientific studies of similar sorts of problems. Where therapeutic interventions that have failed in the past are recommended as part of a brief CBT programme, it may be that in the past they were tried for too short a time; at too low an intensity; at an inappropriate time in child's development; or used alone rather than as part of a brief CBT therapeutic package. For example, the use of a reward system in isolation for a week to treat encopresis in a 5 year old may be ineffective. However, a reward system used over a period of months may be one component of an overall effective treatment programme for encopresis in a 7 year old. Children and their families may find it useful to explore these comparisons between previously ineffective treatment experiences and those being offered before committing themselves to a treatment plan.

Therapy plans

Brief CBT plans are constructed from the following building blocks (Carr, 1999; Graham, 1998):

- A family-based approach
- Redefinition
- Monitoring problems
- Communication training
- Problem solving training
- Supportive play
- Reward systems
- Behavioural control systems

- Tension reduction
- Cognitive restructuring
- Self-instructional training
- Home-school liaison.

The practices entailed by these building blocks will be detailed below with reference to examples.

Family-based approach

In brief CBT with children and adolescents, unless there is good reason for doing otherwise, a family-based approach is typically taken because of the many therapeutic advantages this approach confers. A family-based approach to children's psychological problems helps family members communicate clearly and openly about problems and related issues; decreases the emotional intensity of negative family interactions related to the problem; encourages joint problem-solving with respect to the child's difficulties; optimizes family support for the child; and optimizes the family's use of healthcare resources and support groups. Where fathers are unavailable during office hours, it is worthwhile making special arrangements to schedule at least a couple of family sessions which are convenient for the father, since the participation of fathers in their children's therapy programmes is associated with a positive outcome (Carr, 2000). Where parents are separated or divorced, it is particularly important to arrange some sessions with the non-custodial parent, since it is important that both parents adopt the same approach in understanding and managing the child or adolescent's difficulties.

Redefinition

Commonly the definitions that children and their families hold of the problems and related issues that prompt them to seek professional help are of limited value in helping them to resolve their difficulties. Redefinition of presenting problems and related issues is therefore central to all brief CBT plans. Separating the problem from the person, reframing and relabelling are three specific redefinition techniques that are used throughout brief CBT with children, adolescents and families.

Separating the problem from the person. Here the child's difficulties are defined as distinct from the child's identity and the child is described as being aligned with the parents and other network members in requiring a solution to the problem. Thus the child and parents may be described as a team who are working together to find a way to deal with a fiery temper, a difficult temperament, ADHD, anxiety, depression, encopresis, diabetes, addiction or whatever the problem happens to be. With young children, the problem may be externalized and personified and the child and family's task defined as defeating the personification of the problem. For example, obsessive compulsive disorder may be personified as *Mr Too-tidy,* enuresis may be personified as *Mr Wet-bed*. The parent's role becomes supporting the child in running Mr Wet-bed or Mr Too-Tidy out of the child's life. This strategy has been pioneered by the narrative therapists White and Epston (1990) and incorporated into the brief CBT of obsessive compulsive disorder in children by March and Mulle (1996). The process of separating the problem from the person and then externalizing the problem, counter's the destructive tendency to label the child as the problem.

Reframing. Here children and their families are offered a new framework within which to conceptualized a sequence of events, and this new way of conceptualizing the sequence of events makes it more likely that the problem will be resolved rather than maintained. For example, where a mother and child become involved in heated arguments

about the child's reluctance to apologize for hitting his sister, the mother may frame this as evidence that the child is intrinsically delinquent and say that this is the reason that she usually leaves these situations in frustration while her child is still screaming at her. This situation may be reframed by pointing out that the child looks to the parent to learn self-control, and it is difficult to learn self-control if uncontrolled behaviour like screaming may be used to obtain relief. That is, the relief provided by the mother withdrawing from the situation before the child has stopped screaming and apologized to his sister. From this example, it may be seen that, here, reframing provides a rationale for the mother using a reward system for increasing positive behaviour (like apologizing) or a behavioural control system for decreasing negative behaviour (such as screaming). With reframing, the problem is redefined as part of an interactional process rather than as an intrinsic characteristic of the child.

Relabelling. This is way of altering parent's and children's negative or pessimistic attributions and cognitive biases. With relabelling, the therapist routinely offers positive or optimistic labels for ambiguous behaviour as a substitute for negative or pessimistic labels. So where a parent says *He was standing there **lazy and stupid** doing nothing, so I **told** him to get on with it,* the therapist may relabel this by saying *When he was there **thinking through what to do next**, you **encouraged** him to start his homework.* Where a parent says *She needs to be at home when she is this **ill,*** the sentiment may be reframed as *while she is **recovering**, she needs to spend some time at home.* With relabelling, children and families are offered optimistic ways of construing events which open up possibilities for collaboration and problem-solving as an alternative to pessimistic constructions of the problem which engender polarization and problem maintenance.

Monitoring problems

For most difficulties, it is useful to train children and parents to regularly record information about the main presenting problems, their antecedents, consequences, related beliefs and impact of particular brief CBT interventions. A monitoring chart for positive and negative target behaviours is given in Figure 2. This may be used where the central difficulty is a child or adolescent's behaviour. For example, it may be useful for youngsters with conduct problems or sleep problems.

Insert Figure 2 about here

When assessing a problem using this monitoring chart, events that typically precede and follow target behaviours are recorded in the second and fourth columns respectively. This information may suggest ways in which the frequency or intensity of negative target behaviours may be altered by inviting children and their parents to change the antecedent events that trigger problems or the consequences that reinforce them. The impact of these therapeutic interventions may be monitored using the same chart.

Where the chart in Figure 2 is used to monitor positive target behaviours, it may throw light on the antecedent events that trigger these positive behaviours and the consequences that reinforce them and so suggest ways that the frequency of positive target behaviours might be increased.

Insert Figure 3 about here

A monitoring chart for use when the main problem is altering negative mood states is given in Figure 3. This chart may be used where children present with anxiety, depression, pain and other negative mood states. The first 5 columns of this chart may be used during the assessment phase when identifying antecedent situations and related beliefs that underpin negative mood changes. During treatment, coping strategies learned during brief CBT (and detailed below) may be recorded in the sixth column and their impact on mood states noted in the seventh column.

Insert Figure 4 about here

Communication skills

Where parents and children have difficulties communicating clearly with each other about how best to manage the presenting problems, communication training may be appropriate (Falloon et al, 1993). A common problem is that parents have difficulty listening to their children and children have difficulties clearly articulating their views to their parents. A second common communication problem is the difficulty parents have in listening to each others views about how best to manage the child's difficulties in a non-judgmental way. In some instances parents and children have never learned communication skills. In others, good communication skills have been acquired but intoxication or intense emotions such as anger, anxiety or depression prevent parents and children from using these skills. Training in using communication skills is appropriate in the former situation but in the latter the key problem to be solved is how to arrange episodes of communication which will be uninfluenced by intoxication or negative mood states. Communication skills may be artificially subdivided into those

used for listening and those used for telling somebody something. These skills are listed in Figure 4. Parents and children need, first, to be given an intellectual understanding of these skills. Then the therapist should model the skills for the clients. Clients should at this point be invited to try using the skills to discuss a neutral topic in the session. Let the episode of communication run for five or ten minutes, and take notes of various difficulties that occur. Then give feedback and, in the light of this, ask clients to complete the episode again. Typical mistakes include interrupting before the other person has finished, failing to summarize what the other person said accurately, attributing negative malicious intentions to the other person when they have not communicated that they hold such intentions, failing to check that the message was accurately sent, failing to check that the message has been accurately received, blaming and sulking. Once clients can use the skills to exchange views on a neutral topic, they may then be used to exchange views on emotionally loaded issues in the session first and later at home. Communication homework assignments should be highly specific, to prevent clients from lapsing into poor communication habits. Thus, specific members of a family should be invited to find out the other person's views on a specific topic. A time and place free of distractions should be agreed and a time limit of no more than twenty minutes set for initial communication assignments.

Insert Figure 5 about here

Problem-solving skills

When it is apparent that parents or children need to take a more systematic approach to resolving problems, problem-solving skills training is appropriate (Falloon et al,

1993). Joint problem-solving training for parents is useful where parents have difficulty co-operativley developing plans for solving children's difficulties. Joint problem-solving training for adolescents and parents may be useful where parents and teenagers are having difficulty negotiating about the youngster's increasing autonomy. Individual problem-solving training for youngsters may be helpful when children have specific peer group or academic problems that they repeatedly fail to solve, such as joining in peer activities without aggression or managing homework assignments set by their teachers. As with communication difficulties, clients may have difficulties solving problems because they lack the skills or because intoxication, negative mood states or other factors interfere with the use of well developed skills. Where such factors are present, therapy should focus on removing these obstacles to effective problem-solving. In problem-solving training, the sequence of stages described for communication training should be followed with a progression from explanation of the skills listed in Figure 5, to modelling, to rehearsal in the session with the focus on a neutral topic. Feedback should be given during rehearsal until the skills are well developed. Then clients may be invited to use the skills to solve emotionally laden problems. When families are observed trying to solve emotionally laden problems, often the first pitfall they slide into is that of problem definition. Many clients need to be coached in how to translate a big vague problem into a few small, specific problems. A second pitfall involves trying to solve more than one problem at a time. A third area of difficulty is helping clients to hold off on evaluating the pros and cons of any one solution until as many solutions as possible have been listed. This is important, since premature evaluating can stifle the production of creative solutions. Often families need to be coached out of bad communication habits in problem-solving training such as negative mind reading where they attribute negative thoughts or feelings to others,

blaming, sulking and abusing others. Where families with chronic problems successfully resolve a difficulty, a vital part of the coaching process is to help them celebrate this victory.

Insert Figure 6 about here

Supportive play

For children, particularly those with conduct problems, who have become embroiled in coercive problem maintaining interaction patterns with their parents, an important intervention is to train parents in providing their children with support. Parents may be coached in joint sessions with their children in how to do this. The guidelines for supportive play set out in Figure 6 are first explained. Next, the therapist models inviting the child to select a play activity and engaging in child-led play, while positively commenting on the child's activity, praising the child regularly and avoiding commands and teaching. Then the parent is invited to copy the therapist's activity and feedback is given to parents on what they are doing well and what they need to do more of. Finally, the parent and child are invited to complete a 20 minute daily episode of child-led play to increase the amount of support the child experiences form the parent.

Insert Figures 7, 8 & 9 about here

Reward systems

Where the goal of treatment is to help children learn new habits such as complying with parental instructions, going to bed on time, taking medication, playing co-operatively with a sibling or coping with anxiety provoking situations, reward systems may be used (Herbert, 1987). Guidelines for using rewards systems are presented in Figure 7. It is critical that the target behaviour is clearly defined, is monitored regularly, rewarded promptly, using a symbolic system of points, tokens, stars or smiling faces that is age appropriate and acceptable to the child. Examples of smiling face and points charts are given in Figures 8 and 9. The symbolic reward system must be backed by tangible rewards or prizes which are highly valued, so that the child may buy these with points or tokens after they have accumulated a sufficient number. When points systems are ineffective, it may be that some adult in the child's environment such as a non-custodial parent in the case of children from separated families, is not committed to implementing the system. In other instances, the target behaviours may be ambiguous or the number of points required to win a prize too high. Trouble-shooting these difficulties is a routine part of coaching families in using reward systems.

Insert Figure 10, 11 & 12 about here

Behavioural control systems

Where parents have difficulties helping children to avoid engaging in aggressive and destructive behaviour, training in behaviour control skills is appropriate (Herbert, 1987). Guidelines for a behavioural control programme are set out in Figure 10. The programme should be framed as a way for helping the child to develop self-control skills. Specific negative or aggressive behaviours are defined as targets for which time-out from

reinforcement is given. When these behaviours occur, the parent gives a command to the child to stop and this may be followed up by two warnings. If children comply they are praised. If not they are brought to time-out without any display of anger or any reasoned explanation being given at that time. The time for reasoned explanation is at the outset of the programme or when it is being reviewed, not following misbehaviour. During time-out, the child sits on a chair in the corner of the kitchen, the hall or their bedroom away from family activities and interesting or reinforcing events or toys. Following a period of two to five minutes (depending upon the child's age), the child is invited to rejoin family activities and is engaged in a stimulating and rewarding exchange with the parent. If children misbehave or protest aggressively while in time-out, they remain there until they have been compliant and quiet for 30 seconds before rejoining family activities and engaging in a stimulating interaction with the parent.

Running a behavioural control programme for the first two weeks is very stressful for most families. The normal pattern is for the time-out period to increase in length gradually and then eventually to begin to diminish. This pattern may be tracked using the time-out monitoring chart in Figure 11. During this escalation period when the child is testing out the parents resolve and having a last binge of self-indulgence before learning self-control, it is important to help families maintain the unconditionally supportive aspect of family life. There are two important interventions that may be useful here. First, spouses may be invited to set aside special time where the focus is on mutual marital support. Second, parents may plan episodes of supportive play with the children. The important feature of spouse support is that the couple set aside time to spend together without the children to talk to each other about issues unrelated to the children. In single parent families, parents may be helped to explore ways for obtaining support from their network of friends and members of the extended family.

With adolescents, a points system, such as that given in Figure 9 coupled with a privileges and fines system, such as that given in Figure 12 may be used as the cornerstone of a behavioural control programme.

Insert Figure 13 about here

Tension reduction

Training in tension reduction skills, such as progressive muscle relaxation exercises, breathing exercises and visualization may be included in treatment programmes where physiological arousal associated with anxiety, anger or other emotions is a central problem (Davis, Robbins-Eshelman, & McKay, 1988). Children are coached in these skills until they are well developed. In a carefully planned way which maximizes the chances of success, they are then encouraged to use them to reduce arousal in situations which evoke anxiety, anger, pain or other negative mood states.

With adolescents it may be appropriate to offer training in these tension reduction skills directly to the youngster alone. With children, parents may be coached, in the consulting room, in helping youngsters to work though these tension reduction routines and the parent and child may then practice the exercises at home.

A set of relaxation exercises is given in Figure 13. With adolescents, customized relaxation tapes are a useful adjunct to direct instruction but relaxation tapes without instruction are of little clinical value. Customized relaxation tapes may be made by recording sessions in which adolescents are instructed in relaxation exercises.

When coaching parents in relaxation instruction, model the process first by going through the exercises with the child while the parents observe. Use a slow calming tone of

voice and repetition of instructions as required to help the child achieve a relaxed state. Before and after the exercises check out with the child how relaxed he or she feels on a 10 point scale where 1 reflects complete relaxation and 10 reflects extreme anxiety. Most children will report that even on their first trial, they achieve some tension reduction. This should be praised and interpreted to the child and the parents as an indication that the child has the aptitude for developing and refining their relaxation skills. The parents may then be invited to instruct the child in completing the exercises daily and to praise the child for completing the exercises.

For a minority of adolescents and children, relaxation exercises lead to increased tension. This may occur because the child is made aware through completing the exercises of body tension that is normally ignored. Alternatively it may occur because focusing attention on somatic processes during the exercises induces anxiety. With youngsters who have had panic attacks, this is particularly common because they are sensitized to construing fluctuations in physiological functioning as signaling the onset of a panic attack. In such instances, work on only one or two muscle groups at a time and keep the training periods very short. Also request regular anxiety ratings (on a 10 point scale) from the child and when increases in anxiety occur, distract the child by asking him or her to engage in the visualization exercise described in Figure 13. With some such children it may be necessary to abandon the muscle-relaxation exercises completely and concentrate on training them in visualization or focusing on an external repetitive calming visual or auditory stimulus as a means of attaining a relaxed state. (For some of my clients I have used such stimuli as music, children's hanging mobiles, candle light, and a bowl of goldfish!!). The important thing is to find a routine that the child can reliably use to reduce the subjective sense of anxiety as indicated by their status on a 10 point anxiety rating scale. Some children find the scene described for the visualization exercise given in Figure

13 is not relaxing. In such instances, ask the child to describe an alternative relaxing scene such as being in a wood or on top of a mountain and use this as an alternative.

Cognitive restructuring

Cognitive restructuring involves learning to reinterpret ambiguous situations in less pessimistic, depressing or threatening ways (Reinecke, Dattilio, & Freeman, 1995). In brief CBT with children and adolescents who have problems with anxiety, depression or other negative mood states, CTR (challenge-test-reward) training and reattribution training are two techniques that may be used to facilitate cognitive restructuring.

CTR. In challenge-test-reward (CTR) training youngsters learn the skills required to **C**hallenge negative thoughts by asking themselves what the other possible interpretations of the situation are; to **T**est out what evidence there is for the negative outcome entailed by the negative thought and the other less threatening outcomes; and to **R**eward themselves for testing out the less negative interpretation of the situation. For example, a child who has a dog phobia who has been coached in CTR may carry out this internal dialogue:

Negative thought: *He's dangerous and will bite me*

Challenge: *No an alternative view is he wants to be my friend*

Test: *I will not run away. There I didn't run and he didn't bite me. He did want to be friendly*

Reward: *Well done.*

CTR cognitive restructuring is derived from Beck's cognitive therapy for depression and anxiety (Beck, 1976; Beck, Emery & Greenberg, 1985). Where CTR skills are taught within a family session, parents may be trained to prompt the child to use these coping skills in depressing or frightening situations, and to offer support and reinforcement for using them effectively. Where family members, particularly parents, have depression or anxiety

problems, they can be coached in avoiding passing on their habits of *thinking pessimistically or dangerously* to their children by using CTR skills themselves.

Reattribution training. Challenging depressive attributions is a second strategy for reducing the impact of negative thoughts. In particular failure situations, which have led to negative thoughts, the youngster and parents are asked to rate the degree to which the negative thought reflects an internal, global, stable attribution: For example the negative thought *I couldn't do the problem because I've always been completely stupid* might receive the following ratings

Internal Due to me	**(1)** 2 3 4 5 6 7 8 9 10	External Due to circumstances
Global To do with many situations	1 **(2)** 3 4 5 6 7 8 9 10	Specific To do with this situation
Stable Is permanent	**(1)**2 3 4 5 6 7 8 9 10	Unstable Is temporary

An alternative thought - *I couldn't do the problems because its very hard and I'm having a bad day* - might receive the following ratings which characterize an optimistic rather than a pessimistic cognitive style

Internal Due to me	1 2 3 4 5 6 7 8 9 **(10)**	External Due to circumstances
Global To do with many situations	1 23 4 5 6 7 8 **(9)** 10	Specific To do with this situation
Stable Is permanent	1 2 3 4 5 6 7 8 9 **(10)**	Unstable Is temporary

Youngsters and their parents may be trained to ask of each internal, global, stable explanation for failure, if alternative external, specific or unstable alternative explanations may be offered which fit the available evidence. Reattribution training is based on the reformulated model of learned helplessness (Abramson, Seligman & Teasdale, 1978).

Self-instructional training

This may be used, particularly with children who have ADHD, to improve academic skills. Initially the therapist models the use of self-instructions by completing a task while saying self-instructions aloud. Children are next guided by therapist instructions in the completion of academic and social tasks and later by self-instruction which is faded to a whisper and then to internal speech (Meichenbaum, 1977). Tasks chosen for self-instructional training should initially be well within the child's competence and once self-instructional skills have been developed, increasingly challenging tasks may be used. Self-instructions should include self statements to clarify what the task demands are (*What do I have to do?*); to develop a plan (*I have to draw a picture*); to guide the child through the plan (*I'll hold the pencil and work slowly*); to cope with distraction (*I'll ignore that noise and stick to the job*); and to self-reinforce on-task behaviour (*Well done*).

Home-school liaison

Where children show school based problems, liaison with the school is a vital element of brief CBT. Failure to address significant school related issues may unnecesserily protract therapy. The most effective way to conduct school liaison is to communicate with the child's school teacher by letter, phone or in person during the assessment phase and then, it appropriate, meet with the child's teacher and parents together during the treatment phase if school based intervention is required. Two of the most

common situations where home-school liasion is vital are (1) conduct problems with comorbid learning problems and (2) school refusal.

Home-school liaison in cases of conduct and comorbid learning problems. Children with ADHD, oppositional defiant disorder and conduct disorder commonly have home and school based conduct problems with comorbid learning difficulties. The school based conduct and learning problems may be addressed in a home-school reporting system which is consistent with and runs concurrently with a home based behavioural control programme (DuPaul, Guevremont & Barkley, 1991). Specific target behaviours and academic goals are set jointly by the teacher, child, parent and therapist and a points system (similar to that given in Figures 9 and 12) agreed. Points from this system may be used to buy items from a reinforcement menu at home or to achieve specific agreed privileges in school.

When setting academic targets, the materials should be pitched at the child's attainment level and broken into small units, with reinforcement given for completion of specific academic tasks (such as completion of a work sheet) rather than process behaviours (such as sitting still). Repetitive tasks should be avoided where possible. When setting behavioural targets for which the child can earn reinforcers, they should be highly specific and typically centre on following instructions to behave in a positive way rather than cease behaving in a negative way. Fines (such as those given in Figure 12) should be used for rule violations, so that the child looses the number of points he would have gained for complying with the instruction.

Reinforcers (in the form of tokens for children under 8 and ticks on a report card for older children) should be delivered immediately and frequently following the execution of target behaviours. When reinforcers are being given or response costs are being implemented, it may be more effective if this is conducted quietly and without drawing the

attention of the class to the process, since the class's response may make both receiving and losing points equally reinforcing. There should be set times when the child can exchange tokens for items off the home or school reinforcement menu.

Once children show that they can respond to a continuous reward system such as this, written contingency contracts may be used where the child agrees to carry out certain listed target behaviours and in return the teacher and parents agree to certain rewards if the targets are met and certain response costs where targets are not met.

Insert Figure 14 about here

With older children and teenagers, a daily report card system such as that presented in Figure 14 may be used. Following each class, the teacher rates the child's performance on the four or five listed behaviours and initials the card. The points obtained may be used either at home or in school to purchase items from a reinforcement menu.

Where the demands of implementing this type of system are beyond the resources of the school, the therapist may make representations to educational authorities through the appropriate channels to help the school obtain resources to implement such programmes.

Home-school liaison in cases of school refusal. Where a child refuses to go to school, factors related to the child, the family, and the school deserve careful assessment and an eventual return to school plan based on a clear formulation of the problem may involve home-school liasion (Blagg, 1987).

Child related factors in cases of school refusal include separation anxiety; depression; other psychological adjustment problems; and physical ill health notably viral

infections. Children may also refuse to go to school because of fear of specific events at school. Children with learning difficulties and attainment problems may develop a fear of academic failure and this may underpin their school refusal. Children with physical disabilities or physical co-ordination problems which lead to poor performance in athletics may refuse to go to school because of their fear of athletic failure. Children with physical characteristics about which they are embarrassed such as delayed physical maturity or obesity may refuse to go to school because of fears of being taunted by peers during athletics because of their physical characteristics. Family factors that may contribute to school refusal include parental confusion, anxiety or anger over the meaning of the child's school refusal and related somatic complaints and parental conflict about the management of the situation. Parents may inadvertently reinforce school refusal by insisting on school attendance but relenting when the child escalates his or her protests to a dramatic level. Parents may mismanage school refusal because they derive secondary gains from the child staying at home. For example, the child may provide the homemaker (usually the mother) with companionship. Parents may also mismanage school refusal because parental psychological adjustment problems may compromise their capacity to manage the child's difficulties. Such parental problems may include anxiety, depression, substance abuse or learning difficulties. Wider family stresses such as bereavement, unemployment, separation, birth of a child or moving house may place such demands on parents that they have few personal resources remaining to help their child develop a pattern of regular school attendance. Children from families in which siblings have a history of school refusal may develop school refusal themselves by imitating their older siblings behaviour. School based factors which may contribute to the development of school refusal include bullying by peers, victimization by teachers, threatening events occurring while travelling to or from school, poor academic performance, and poor athletic performance. Important factors in

the wider professional system which may contribute to school refusal include poor co-ordination among members of the professional network in the management of the child's school refusal and poor communication between these professionals and the family. The assessment of these factors should involve interviews with the child, the parents, the child's teachers and involved professionals.

From this information, factors that predisposed the child to develop school refusal may be identified. Those factors that precipitated the occurrence of the episode of school refusal may be pinpointed. Finally, factors that are currently maintaining the condition may be clarified.

Where separation anxiety is present, the next step involves explaining to child, the parents and the teacher that the somatic symptoms (headaches and stomach aches) and the associated worries that cause them can only be resolved by children proving to themselves that they are brave enough to attend school and tolerate the anxiety and discomfort that causes. It should be pointed out that a month or two of regular school attendance will resolve most of these symptoms. However, attempts to resolve the anxiety and somatic complaints first, and then return to school will actually make the condition worse since the child will not overcome the fear that cause these symptoms without facing the feared situation, i.e. going to school.

Where factors at school such as bullying, victimization or academic failure are contributing to the school refusal these issues must be altered before return to school can be arranged. With bullying or teacher victimization, the bullies or teachers must be confronted and subsequently monitored so that a recurrence will not occur. With academic failure, additional remedial tuition may be provided. Where wider family factors such as parental psychological adjustment problems are a concern, referral to an appropriate agency for concurrent treatment may be arranged.

With this groundwork laid, the precise details of a return to school programme may be planned. This should specify, the date and time at which the child will return; whether the child will have an immediate or gradual return building up from a few hours a day to a full to day over a period of a week or two; who will escort the child to school; who will meet the child at school; which peers will be appointed as buddies to make the child feel welcome; and which teacher will act as a secure base for the child if he experiences anxiety while in school. The child will require some opportunity to rehearse precisely how the return to school will be managed and to plan how he or she will cope with all major difficulties that may occur.

In addition to this return to school programme a reward system should be set, using the principles given in Figure 7, to give the child an incentive to tolerate the anxiety that will inevitably be experienced during the first few days at school. The reward system should allow the child to earn a concrete daily reward that is received immediately following school each day and a point system which allows the child to accumulate points that may be used to obtain a more substantial reinforcer each week.

The mornings following holidays, illnesses and weekends are times when relapses are most likely and specific plans for arranging an escort to school and a contingency management programme on those occasions needs to be made to prevent relapses occurring. Ideally the child should be accompanied to school and received by peers or a class teacher on arrival and rewards given for managing any separation anxiety experienced on such occasions.

Troubleshooting resistance

It is one of the extraordinary paradoxes of psychotherapy, that clients go to considerable lengths to seek professional advice on how to manage their difficulties

and often do not follow through on such advice or other responsibilities entailed by the treatment contract. This type of behaviour has traditionally been referred to as non-compliance or resistance. Accepting the inevitability of resistance and developing skills for managing it, is central to the effective practice of brief CBT (Anderson & Stewart, 1983).

Clients show resistance in a wide variety of ways. Resistance may take the form of not completing tasks between sessions, not attending sessions, or refusing to terminate the therapy process. It may also involve not co-operating during therapy sessions. For clients to make progress with the resolution of their difficulties the therapist must have some systematic way of dealing with resistance (Carr, 1995). First describe the discrepancy between what clients agreed to do and what they actually did. Second, ask about the difference between situations where they managed to follow through on an agreed course of action and those where they did not. Third, ask what they believed blocked them from making progress. Fourth, ask if these blocks can be overcome. Fifth, ask about strategies for getting around the blocks. Sixth, ask about the pros and cons of these courses of action. Seventh, frame a therapeutic dilemma which outlines the costs of maintaining the status quo and the costs of circumventing the blocks.

When resistance is questioned, factors that underpin it are uncovered. In some instances unforeseen events -Acts of God- hinder progress. In others, the problem is that the clients lack the skills and abilities that underpin resistance. Where a poor therapy contract has been formed, resistance is usually due to a lack of commitment to the therapeutic process. Specific convictions which form part of clients' individual, family or culturally based belief systems may also contribute to resistance, where the clients values prevent them from following through on therapeutic tasks. The wish to

avoid emotional pain is a further factor that commonly underpins resistance.

Questioning resistance is only helpful if a good therapeutic alliance has been built. If clients feel that they are being blamed for not making progress, then they will usually respond by pleading helplessness, blaming the therapist or someone else for the resistance, or distracting the focus of therapy away from the problem of resistance into less painful areas.

STAGE 4. DISENGAGING OR RECONTRACTING

The process of disengagement begins once improvement is noticed. The interval between sessions is increased at this point. The degree to which goals have been met is reviewed when the session contract is complete or before this, if improvement is obvious. If goals have been achieved, the family's beliefs about the permanence of this change is established. Then the therapist helps the family construct an understanding of the change process by reviewing with them the problem, the formulation, their progress through the treatment programme and the concurrent improvement in the problem. Relapse management is also discussed (Marlatt & Gordon, 1985). Family members are helped to forecast the types of stressful situations in which relapses may occur; their probable negative reactions to relapses; and the ways in which they can use the lessons learned in therapy to cope with these relapses in a productive way. In brief CBT disengagement is constructed as an episodic event rather than as the end of a relationship. It is recognized that further episodes of brief CBT may be required in the future to address other specific problems.

If goals are not reached, it is in the clients' best interests to avoid doing *more of the same* (Segal, 1991). Rather, therapeutic failures should be analyzed in a systematic way. The understanding that emerges from this is useful both for the clients

and for the therapist. From the clients' perspective, they avoid becoming trapped in a consultation process that maintains rather than resolves the problem. From the therapists' viewpoint it provides a mechanism for coping with burnout that occurs when multiple therapeutic failures occur.

Failure analysis

Failures may occur for a number of reasons (Carr, 1995). First, they may occur because of the engagement difficulties. The correct members of the child's network may not have been engaged. For example, where fathers are not engaged in the therapy process, dropout is more likely. The construction of a formulation of the presenting problem which does not open up possibilities for change or which does not fit with the family's belief systems is a second possible reason for failure. A third reason why failure occurs may be that the therapy plan was not appropriately designed, the therapeutic alliance was poorly built, or the therapist had difficulties in offering the family invitations to complete the therapeutic tasks. Problems with handling families' reservations about change, and the resistance that this may give rise to, is a fourth and further source of failure. Disengaging without empowering the family to handle relapses is a fifth possible factor contributing to therapeutic failure. Finally, failure may occur because the goals set did not take account of the constraints within which family members were operating. These constraints include biological factors such as illness, psychological factors such as intellectual disability, economic factors such as poverty, social factors such as general life stress, and broader socio-cultural factors such as minority-group membership. The analysis of treatment failure is an important way to develop therapeutic skill.

SUMMARY

In brief CBT the consultation process may be conceptualized as developmental and recursive process involving the stages of planning; assessment and formulation; therapy; and disengagement or recontracting. In the planning stage network analysis provides guidance on who to invite to the intake interview. The minimum sufficient network necessary for an assessment to be completed includes the customer, the legal guardians, the caregivers and the referred child. In planning an agenda, a routine intake interview and a core test battery may be supplemented by questions and tests which take account of the specific features of the case.

Establishing a contract for assessment; working through the assessment agenda and recursively refining the preliminary formulation in the light of the information obtained; building a therapeutic alliance and giving feedback are the more important features of the assessment and formulation stage which may span on or two sessions. At the end of the assessment phase a formulation is constructed. A formulation is a mini-theory that explains why the presenting problems developed and persist. The formulation is fed back to the family as a basis for a therapeutic contract. A therapeutic contract, based on the formulation begins with goal setting. The costs and benefits of goals to involved members of the network must be considered as part of the contacting process. Brief CBT plans are constructed from the following set of building blocks: a family based approach; redefinition of problems; monitoring problems; communication training; problem solving training; supportive play; reward systems; behavioural control systems; tension reduction; cognitive restructuring; self-instructional training; and home-school liaison. A systematic method for analyzing resistance and resolving it is required to complete brief CBT plans. Disengagement is considered when the end of the therapeutic contract is reached. If goals have not been

achieved, this should be acknowledged and referral to another agency considered. Where goals have been reached, relapse management and the options for future booster sessions considered.

FURTHER READING

Carr, A. (1999). *Handbook of Clinical Child Psychology: A Contextual Approach.* London: Routledge.

Graham, P. (1998). *Cognitive-Behaviour Therapy for Children and Families.* Cambridge, UK: Cambridge University Press.

REFERENCES

Abramson, L., Seligman, M. and Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology,* 87, 49-74.

Achenbach, T. (1991). *Integrative Guide for the 1991 CBCL/4-18, YSR and TRF profiles.* Burlington, VT: University of Vermont Department of Psychiatry.

Anderson, C. & Stewart, S. (1983). *Mastering Resistance.* New York: Guilford.

Battle, J. (1992). *Culture-Free Self-Esteem Inventories. Examiner's Manual* (Second Edition). Austin, Texas: Pro-ed.

Beck, A. (1976). *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press.

Beck, A., Emery, G. & Greenberg, R. (1985). *Anxiety Disorders and Phobias.* New York: Guilford.

Bergin, A. & Garfield, S. (1994), *Handbook of Psychotherapy and Behaviour Change* (Fourth Edition) . Chichester: Wiley.

Blagg, N. (1987). *School Phobia and its Treatment.* London: Croom Helm.

Carr, A. (1995). *Positive Practice: A Step-by-Step Approach to Family Therapy.* Reading. Harwood.

Carr, A. (1997). *Family Therapy and Systemic Practice.* Lanham, MD: University Press of America.

Carr, A. (1999). *Handbook of Clinical Child Psychology: A Contextual Approach.* London: Routledge.

Carr, A. (2000). *What Works With Children and Adolescents? A Critical Review of Research on Psychological Interventions with Children Adolescents and their Families.* London: Routledge.

Crick, N. & Dodge, K. (1994). A review and reformulation of social information processing mechanisms in children's social adjustment. *Psychological Bulletin,* 115, 74-101.

Davis, M., Robbins-Eshelman, E. & McKay, M. (1988). *The Relaxation and Stress Reduction Workbook* (Third Edition). Oakland, CA: New Harbinger Publications

DuPaul, G. Guevremont, D. & Barkley, R. (1991). Attention deficit hyperactivity disorder. In T. Kratochwill & R. Morris (eds.), *The Practice of Child Therapy* (Second Edition, pp. 115-144). New York; Pergamon.

Falloon, I. Laporta, M., Fadden, G. and Graham-Hole, V. (1993). *Managing Stress in Families.* London: Routledge.

Goodman, R. (1994). A modified version of the Rutter Parent Questionnaire including extra item on children's strengths: A research note. *Journal of Child Psychology and Psychiatry,* 35, 1483-1494.

Graham, P. (1998). *Cognitive-Behaviour Therapy for Children and Families.* Cambridge, UK: Cambridge University Press.

Herbert, M. (1987) *Behaviour Treatment of Children with Problems* (Second edition) . London: Academic Press.

Kabacoff, R. Miller, I., Bishop, D., Epstein, N. & Keitner, G. (1990). A psychometric study of the McMaster Family Assessment Device. *Journal of Family Psychology*, 3, 431-439.

Kelly, G. (1955) *The Psychology of Personal Constructs. Volumes 1 and 2.* New York: Norton.

March, J. & Mulle, K. (1996). Banishing OCD: Cognitive-behavioural psychotherapy for obsessive-compulsive disorders. In E. Hibbs & P. Jensen (eds.), *Psychosocial Treatments for Child an Adolescent Disorders. Empirically Based Strategies for Clinical Practice* (pp. 83-102). Washington, DC: APA.

Marlatt, G. & Gordon, J. (1985). *Relapse Prevention.* New York: Guilford.

Meichenbaum, D. (1977). *Cognitive-behaviour Modification: An Integrative Approach.* New York: Plenum Press.

Nowicki, S. & Strickland, B. (1973). A locus of control scale for Children. *Journal of Consulting and Clinical Psychology*, 40, 148-155.

Patterson, G. (1982).*Coercive Family Process.* Eugene, OR: Castalia.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103.

Reinecke, M., Dattilio, F. & Freeman, A. (1995). *Cognitive Therapy with Children and Adolescents.* New York: Guilford.

Segal, L. (1991) Brief Therapy: The MRI approach. In A. Gurman & D. Kniskern (eds.), *Handbook of Family Therapy* (Volume 2, pp. 17-199). New York: Brunner/Mazel.

Snyder, C., Michael, S., Cheavens, J. (1999). Hope as a therapeutic foundation of common factors, placebos and expectancies. In M. Hubble, B. Duncan & S. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy* (pp.179-200). Washington, DC: APA.

White, M. & Epston, D. (1990). *Narrative Means to Therapeutic Ends.* New York: Norton.

Figure 1. Stages of brief CBT

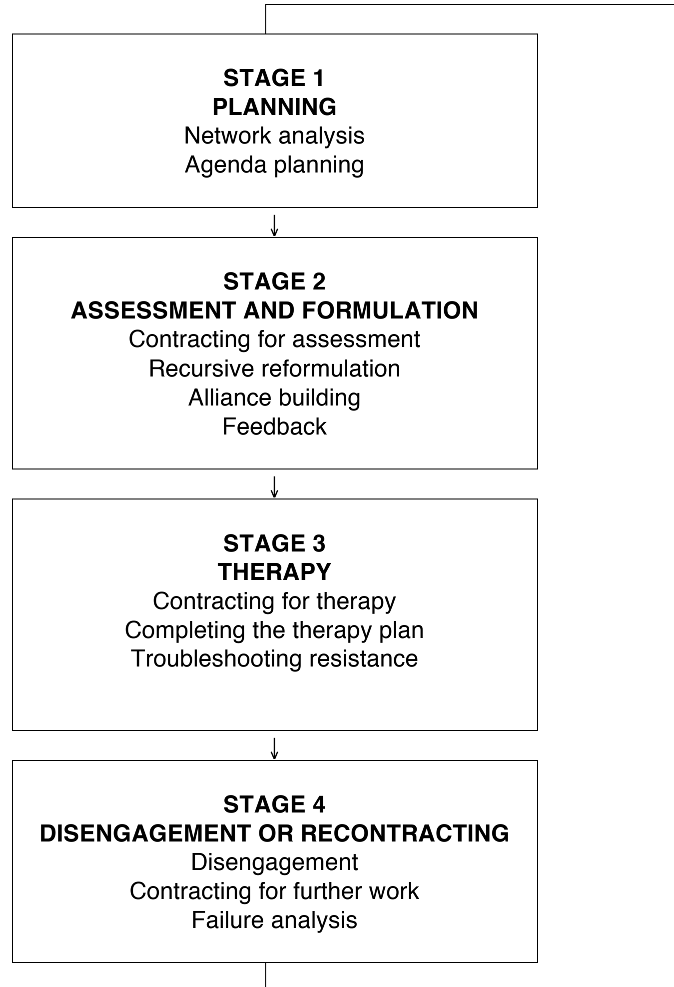

Figure 2. Chart for monitoring antecedents and consequences of positive and negative target behaviours.

TARGET BEHAVIOUR TRACKING FORM

Fill out one line of this form when you have finished dealing with a situation in which any of the following target behaviours occur

1.____
_

2. ____

3. ____

This will help you to keep track of

- the types of situations which trigger these behaviours
- the consequences of these target behaviours
- the impact of these consequences on the intensity of target behaviours
- the frequency of these target behaviours

Day and time	What happened before the target?	What was the target behaviour and its intensity 1 = low 10 = high	What happened after the target behaviour?	What was the intensity of target behaviour after this consequence? 1 = low 10 = high

Figure 3. Mood tracking form for tracking depression, anxiety, pain and other negative mood states.

MOOD TRACKING FORM

When you have finished dealing with a situation that changed you mood fill out one line of this form. This will help you to keep track of

- the types of situations in which you mood changes
- what you think about in those situations
- how these affect your mood
- how you cope with these thoughts and situations
- how your coping strategies improve your mood

Day & Time	What happened before your mood changed?	Give a rating for your mood before it changed 1=low 10=high	What negative things were you thinking as your mood changed?	Give a rating for your mood after it changed 1=low 10=high	What positive coping responses did you use? CTR Relaxation Leave situation Get support other	Give a rating for your mood after you coped 1=low 10=high

Figure 4. Guidelines for listening and communications skills

SPECIFIC GUIDELINES	GENERAL GUIDELINES
LISTENING SKILLS • Listen without interruption • Summarize key points • Check that you have understood accurately • Reply **COMMUNICATION SKILLS** • Decide on specific key points • Organize them logically • Say them clearly • Check you have been understood • Allow space for a reply	• Make a time and place for clear communication • Remove distractions and turn off the TV • Discuss one problem at a time • Try to listen with the intention of accurately remembering what was said • Try to listen without judging what is being said • Avoid negative mind-reading • State your points without attacking the other person • Avoid blaming, sulking or abusing • Avoid interruptions • Take turns fairly • Be brief • Make congruent *I statements*

Figure 5. Guidelines for problem-solving skills

SPECIFIC GUIDELINES	GENERAL GUIDELINES
• Define the problem • Brainstorm options • Explore pros and cons • Agree on a joint action plan • Implement the plan • Review progress • Revise the original plan	• Make a time and place for clear communication • Remove distractions and turn off the TV • Discuss one problem at a time • Divide one big problem into a few small problems • Tackle problems one at a time • Avoid vague problem definitions • Define problems briefly • Show that the problem (not the person) makes you feel bad • Acknowledge your share of the responsibility in causing the problem • Do not explore pros and cons until you have finished brainstorming • Celebrate success

Figure 6. Guidelines for supportive play

<table>
<tr><th>SPECIFIC GUIDELINES</th><th>GENERAL GUIDELINES</th></tr>
<tr><td>
• Set a specific time for 20 minutes supportive play per day
• Ask child to decide what he or she wants to do
• Agree on an activity
• Participate wholeheartedly
• Run a commentary on what the child is doing or saying, to show your child that you are paying attention to what they find interesting
• Make congruent I like it when you... statements, to show your child you feel good about being there
• Praise your child repeatedly
• Laugh and make physical contact through hugs or rough and tumble
• Finish the episode by summarizing what you did together and how much you enjoyed it
</td><td>
• Set out to use the episode to build a positive relationship with your child
• Try to use the episode to give your child the message that they are in control of what happens and that you like being with them
• Try to foresee rule-breaking and prevent it from happening or ignore it
• Avoid using commands, instructions or teaching
• Notice how much you enjoy being with your child
</td></tr>
</table>

Figure 7. Guidelines for reward systems

SPECIFIC GUIDELINES	GENERAL GUIDELINES
• Define the target behaviour clearly • Decide when and where the monitoring will occur • Make up a smiling-face chart or points chart • Explain to the child that they can win points or smiling faces by carrying out the target behaviour • Ask the child to list a set of prizes that they would like to be able to buy with their points or smiling faces • Agree on how many points or faces are necessary to buy each prize • Follow through on the plan and review it for effectiveness	• Present the reward system to your child as a way of helping him or her learn grown-up habits • All parental figures in the child's network should understand and agree to using the system • Use a chart that is age-appropriate. Smiling faces or stars are good for children and points may be used for adolescents • The sooner points are given after completing the target behaviour, the quicker the child will learn • Highly valued prizes lead to faster learning • Try to fine tune the system so that successes are maximized • If prizes are not being won, make the target behaviour smaller and clearer or the cost of prizes lower and make sure that all parent figures understand and are committed to using the system • If the system is not working, do not criticize the child • Always keep the number of target behaviours below 5

Figure 8. Child's star chart for child reward systems

Colour in a happy face every time you							
Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Figure 9. Points chart adolescent reward systems

For these target behaviours you can earn points	Points that can be earned
Up by 7.30 am	1
Washed, dressed and finished breakfast by 8.15	1
Made bed and standing at door with school bag ready to go by 8.30	1
Attend each class and have teacher sign school card	1 per class (max 8)
Good report for each class	1 per class (max 8)
Finish homework	1
Daily jobs (e.g. taking out dustbins or washing dishes)	1 per job (max 4)
Bed on time (9.30)	1
Responding to requests to help or criticism without moodiness or pushing limits	2
Offering to help with a job that a parent thinks deserves points	2
Going to time-out instead of becoming aggressive	2
Apologizing after rule-breaking	2
Showing consideration for parents (as judged by parents)	2
Showing consideration for siblings (as judged by parents)	2
Cash in points for privileges and accept fines without arguing	2

Figure 10. Guidelines for behaviour-control programmes

SPECIFIC GUIDELINES	GENERAL GUIDELINES
BEHAVIOUR CONTROL PROGRAMME • Agree on a few clear rules • Set clear consequences • Follow through • Reward good behaviour • Use time-out or loss of privileges for rule breaking • Monitor change visibly **TIME- OUT** • Give two warnings • Bring the child to time-out without negative emotion • After five minutes engage the child in a positive activity and praise him for temper control • If rule-breaking continues, return child to time-out until thirty seconds of quietness occurs • Engage in positive activity with child and praise for temper control	• Set out with the expectation that you can teach your child one good habit at a time • Build in episodes of unconditional special time into behavioural control programme • Frame the programme as learning self-control • Involve the child in filling in, designing and using the monitoring chart or system • Monitor increases in positive behaviour as well as decreases in negative behaviour • Do not hold grudges after episodes of • negative behaviour • Avoid negative mind reading • Avoid blaming, sulking or abusing • Ask for spouse support when you feel bad about the programme • Celebrate success

Figure 11. Time-out monitoring chart

Date	Time going in	Number of minutes in Time Out	Situation that led to time out	Pleasant activity that happened afterwards

Figure 12. Adolescent behaviour control privileges and fines chart

You can buy these privileges with points	Points	You must pay a fine for breaking these rules	Points
Can watch TV for 1 hour	10	Not up by 7.30 am	1
Can listen to music in bedroom for an hour	5	Not washed, dressed and finished breakfast by 8.15	1
Can use computer for 1 hour	5	Not made bed and standing at door with school bag ready to go by 8.30	1
Can stay up an extra 30 minutes in bedroom with light on	5	Not attend each class and not have teacher sign school card	1 per class
Can stay up an extra 30 minutes in living room	10	Bad report for each class	1 per class
Can have a snack treat after supper	20	Not finish homework within specified time	1
Can make a phone call for 5 minutes	10	Not do daily jobs (e.g. taking out dustbins or washing dishes)	1 per job
Can have a friend over for 2 hours	25	Not in bed on time (9.30)	10
Can visit a friend for 2 hours	30	Respond to requests to help or criticism with moodiness, sulking, pushing limits or arguments	5
Can go out with friend to specified destination for 1 afternoon until 6.00pm	35	Swearing, rudeness, ignoring parental requests	10 per event
Can go out with friend to specified destination for 1 evening until 11.00	40	Physical aggression to objects (banging doors, throwing things)	20 per event
Can stay over at friend house for night	60	Physical aggression to people	30-100
		Using others things without permission	30-100
		Lying or suspicion of lying (as judged by parent)	30-100
		Stealing or suspicion of stealing at home, school or community (as judged by parent)	30-100
		Missing class or not arriving home on time or being out unsupervised without permission	30-100

Figure 13. Relaxation exercises

RELAXATION EXERCISES

After a couple of weeks daily practice under your supervision, your child will have developed enough skill to use these exercises to get rid of unwanted body tension.

- Set aside 20 minutes a day to do these relaxation exercises with your child.
- Try to arrange to be on good terms with your child when you do these exercises so your child looks forward to them
- Do them at the same time and in the same place every day.
- Before you begin, remove all distractions (by turning off bright lights, the radio etc..) and ask your child to loosen any tight clothes (like belts, ties or shoes).
- Ask your child to lie on a bed or recline in a comfortable chair with the eyes lightly closed
- Before and after each exercise ask your child to breath in deeply and exhale slowly three times while saying the word relax to him or herself.
- At the end of each exercise praise your child by saying *Well done* or *You did that exercise well* or some other form of praise.
- Repeat each exercise twice
- Throughout the exercises speak in a calm relaxed quiet voice

Area	Exercise
Hands	Close your hands into fists. Then allow them to open slowly. Notice the change from tension to relaxation in your hands and allow this change to continue further and further still so the muscles of your hands become more and more relaxed.
Arms	Bend your arms at the elbow and touch your shoulders with your hands. Then allow them to return to the resting position. Notice the change from tension to relaxation in your arms and allow this change to continue further and further still so the muscles of your arms become more and more relaxed.
Shoulders	Hunch your shoulders up to your ears. Then allow them to return to the resting position. Notice the change from tension to relaxation in your shoulders and allow this change to continue further and further still so the muscles of your shoulders become more and more relaxed.
Legs	Point your toes downwards. Then allow them to return to the resting position. Notice the change from tension to relaxation in the fronts of your legs and allow this change to continue further and further still so the muscles in the fronts of your legs become more and more relaxed. Point your toes upwards. Then allow them to return to the resting position. Notice the change from tension to relaxation in the backs of your legs and allow this change to continue further and further still so the muscles in the backs of your legs become more and more relaxed.
Stomach	Take a deep breath and hold it for three seconds, tensing the muscles in your stomach as you do so. Then breath out slowly. Notice the change from tension to relaxation in your stomach muscles and allow this change to continue further and further still so your stomach muscles become more and more relaxed.
Face	Clench your teeth tightly together. Then relax. Notice the change from tension to relaxation in your jaw and allow this change to continue further and further still so the muscles in your jaw become more and more relaxed. Wrinkle your nose up. Then relax. Notice the change from tension to relaxation in the muscles around the front of your face and allow this change to continue further and further still so the muscles of your face become more and more relaxed. Shut your eyes tightly. Then relax. Notice the change from tension to relaxation in the muscles around your eyes and allow this change to continue further and further still so the muscles around your eyes become more and more relaxed.
All over	Now that you've done all your muscle exercises, check that all areas of your body are as relaxed as can be. Think of your hands and allow them to relax a little more. Think of your arms and allow them to relax a little more. Think of your shoulders s and allow them to relax a little more. Think of your legs and allow them to relax a little more. Think of your stomach and allow them to relax a little more. Think of your face and allow them to relax a little more.
Breathing	Breath in ...one...two..three....and out slowly..one..two..three..four...five...six ...and again Breath in ...one...two..three....and out slowly..one..two..three..four...five...six ...and again Breath in ...one...two..three....and out slowly..one..two..three..four...five...six

Visualizing	Imagine you are lying on beautiful sandy beach and you feel the sun warm your body. Make a picture in your mind of the golden sand and the warm sun. As the sun warms your body you feel more and more relaxed. As the sun warms your body you feel more and more relaxed. As the sun warms your body you feel more and more relaxed. The sky is a clear, clear blue. Above you, you can see a small white cloud drifting away into the distance. As it drifts away you feel more and more relaxed. It is drifting away and you feel more and more relaxed. It is drifting away and you feel more and more relaxed. As the sun warms your body you feel more and more relaxed. AS the cloud drifts away you feel more and more relaxed. (Wait for 30 seconds) When you are ready open your eyes ready to fact the rest of the day relaxed and calm.

Figure 14. Daily school report card

Name______________________________Date____________________

For his or her performance toady, please rate this child in each of the areas listed below using this 5 point scale

1 Very poor	2 Poor	3 Fair	4 Good	5 Excellent

Target behaviour	**Class 1**	**Class 2**	**Class 3**	**Class 4**	**Class 5**	**Class 6**	**Class 7**	**Class 8**
Paying attention								
Completing classwork								
Following rules								
Other								
Teacher's Initials								