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COGNITIVE BEHAVIORAL THERAPY WITH CHILDREN

Abstract: *The main goal of this paper is to present cognitive behavioral therapy as one of the treatment choices for working with children who experience disturbances in the developmental, social and emotional sphere, as well as with children who want to improve the quality of life without symptomology. The first part of the paper will present the concept of cognitive behavioral therapy, its emergence and development path in order to familiarize readers with the principles and method of work on which it rests. Further, there will be presented areas of application of cognitive behavioral therapy with children, disorders in which KBT gave the best results, as well as a description of the process of the therapy itself, by focusing on the most important steps and problems that can arise during the work. Also, we will look at some of the techniques in cognitive behavioral therapy that are most commonly used in work with children, but also on contraindicated disorders and conditions for therapeutic work. Given the fact that the paper deals with the therapeutic process with children, data will be provided on whether, how and in which way, the participation of parents or persons taking care of the child in the therapeutic process is important. Cognitive behavioral therapy is a relatively young therapeutic modality that still experiences its expansion, and we will eventually turn to the current areas as well as to the future directions of this therapy in work with children.*

Key words: cognition, behavior, emotions, children, CBT.

INTRODUCTION

The disadvantages and problems are a part of adults' everyday life. Parents, friends, school, work; virtually everything can be a source of trouble. Fortunately, we are pretty good at solving many of these problems, but there are some that may seem huge and difficult. They happen quite often, we find them persistent, too complicated to solve and they affect everything we do.

Even though childhood and adolescence are sometimes considered to be periods of careless enjoyment, as many as 20 % of children and adolescents have one or more psychological disorders that can be

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diagnosed. Children are not spared from any day-to-day problems that adults struggle with, although this may seem different to us, because there are difficulties in recognizing, processing and verbalizing those problems due to various factors, including the development stage in which children are.

Many of the psychological disorders are pervasive, consuming and challenging children in all areas: cognitive, emotional and behavioral. On a personal level, in both children and their parents, there is a chronic feeling of helplessness and suffering in dealing with some of these disorders and problems. Depending on the structure and complexity of the problem, not only parents or guardians but also other significant figures (psychiatrist, psychotherapist, social worker, teacher ...) should be engaged in finding a proper strategy that will help the child. Applying the appropriate procedures is of great importance, as it can prevent the development of mental illness. One of them is going through the process of psychotherapy.

What is Cognitive Behavioral Therapy?

"It's not what happens to you, but how you react to it that matters." — Epictetus

The precursors of the basic aspects of Cognitive Behavioral Therapy (hereinafter CBT) have been identified in various ancient philosophical traditions, especially in stoicism (Robertson, 2010). The stoics, especially Epictetus, believed that by logical thinking we can identify and remove the wrong beliefs that lead to destructive emotions, which had an impact on modern cognitive behavioral therapists and their attempts to identify cognitive distortions that contribute to the development of depression and anxiety (Mathews, 2015). The modern roots of CBT can be traced in the development of behavioral therapy in the early 20th century, the development of cognitive therapy in the 1960s and the subsequent merger of these two therapies. The revolutionary work of behaviorism began with John B. Watson and the studies on the conditioning of Rosalie Rayner in 1920 (Trull, 2007). Behavioral therapy approaches have appeared in 1924 (Rachman, 1997) with the work of Mary Cover Jones, on detecting fears in children (Jones, 1924). The roots of cognitive therapy reach back to Alfred Adler and his notion that a basic error in thought contributes to the creation of unhealthy and useless behavioral and life goals (Mosak and Maniacci, 2008). Adler's work influenced the work of Albert Elis who developed the earliest cognitive psychotherapy, now known as rational emotional

behavioral therapy, or REBT (Ellis, 2008). The basic assumptions of Elise's theoretical model, in literature known as the ABC model of emotions and behaviors (Marić, 2000), could be presented as follows: at the moment of the activating event (A), a person experiences emotions and behaves in a certain way (C) depending on their belief system (B) and not as a direct consequence of an activating event, as is commonly thought.

While Albert Elise's rational emotional behavioral therapy was being developed, Aaron Beck held sessions in his psychoanalytic practice. During these sessions, Beck noticed that the thoughts are not as unconscious as Freud previously explained in his theory and that certain patterns of thinking may be the culprits that cause emotional distress (Oatley et al., 2004). This prompted Beck to develop cognitive therapy and call such thoughts "automatic thoughts".

Although behavioral approaches were successful in treating most neurotic disorders, they had little success in treating depression (Thorpe and Olson, 1997). Behaviorism has also lost popularity due to the so-called "cognitive revolution" that occurred at that time. The therapeutic approaches of Elise and Beck have gained popularity among behaviorally oriented therapists, despite early behavioral rejection of mentalist concepts, such as thought and cognition (Trull, 2007). During the 1980s and 1990s, cognitive and behavioral techniques were merged into a single, cognitive behavioral therapy.

CBT is based on a cognitive model of mental illness, which was initially developed by Beck. In the simplest form, the cognitive model assumes that human emotions and behaviors are influenced by their perception of events.

The foundation of the cognitive model is the way in which cognition (the way of thinking about the things and the content of these thoughts) is conceptualized. Beck (1976) highlighted three levels of cognition:

1. Basic beliefs
2. Dysfunctional assumptions
3. Negative automatic thoughts

The focus of CBT is problem-oriented, with an emphasis on the present. Unlike some other treatments, it focuses on problems and difficulties "here and now". Instead of focusing on the causes of disturbances or symptoms in the past, it looks for ways to improve the patient's current state. CBT requires goals that are mutually agreed upon (the client and therapist set the goals of the therapy together). The objectives should be "SMART", i.e. specific, measurable, achievable,

realistic and time-limited). For example, the goal for a patient with an obsessive compulsive disorder may be to reduce the time spent on washing hands, from 5 hours a day to 1 hour a day until the end of the 3-week therapy. The therapist helps the patient prioritize goals by breaking the problem down and creating a hierarchy of smaller goals that are to be achieved. CBT sessions are structured to enhance the effectiveness of treatment, improve learning, and direct therapeutic efforts to specific problems and potential solutions. A Session begins with establishing the agenda, a process in which the therapist helps the patient select items that can lead to productive therapeutic work in that particular session. Additionally, homework assignments are used to extend patient's efforts beyond the boundaries of treatment and to enhance the learning of the CBT concept. CBT is a structured and time-limited treatment. In case of a non-comorbid anxiety or depression, the CBT course usually lasts 5-20 sessions. If there is comorbidity with other disorders, it's necessary to expand the treatment due to the pervading nature of these disorders and a slower change observed in CBT (Kendall, 1991).

Areas of CBT application in working with children

It's not unusual for children with learning and attention problems to struggle with anxiety or depression at some point. Challenges they face can bring about a huge decline in their self-esteem. CBT is helpful in solving these problems particularly. CBT is also used to treat diarrhea, substance abuse and sleep disorders. But its benefits are not limited to mental health issues. CBT can also help children who just want to learn better ways to manage stress.

In numerous studies CBT has been confirmed as a therapy of choice for children with anxiety and depression disorders (Compton et al., 2004; Butler et al., 2006). Numerous randomized controlled studies in both children and adults confirm the ability of CBT to reduce the emotional symptoms and related diagnosis, especially anxiety and depression, in relation to noninterference or (in some studies) alternative interventions (Compton et al., 2004).

Anxiety disorders are the most common form of psychopathology in children and adolescents, although there are large variations in the actual condition rates. Pine and Klein (2008) report that 5 - 15 % of children show symptoms of anxiety disorders at some point of their development, while Verhulst (1997) finds that 23 % of the examined adolescents show such a disorder. These differences may reflect

variations in the definition of "disorders" by different authors, but they may also be related to certain time baseline values for the determination of anxiety disorders.

CBT has proven to be an effective treatment for many psychiatric conditions. In a meta-analysis of controlled studies, Lynch (Lynch et al. 2010) finds CBT an effective method of treating severe depression. Buttler (Buttler et al., 2006) conducted a comprehensive review of 16 meta-analysis comparing CBT with absence of treatment, people on the waiting list and those on placebo. The authors found that CBT is an effective treatment for adults and adolescents with bipolar disorder, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, post-traumatic stress disorder and children's depression and anxiety disorders.

There are few scientific studies on the treating anxiety in young children. Even though many evidence point to the efficacy of CBT in children older than 8 (Kendall et al., 2004), there is currently only one empirically validated study of psychosocial treatment outcomes in anxious pre-school and young primary school children (Monga et al., 2009).

The interest in child-centered cognitive behavioral therapy is on the rise, resulting in a series of available materials and structured manuals that are helpful in children's CBT. They include special handbooks such as the "Coping Cat" program for children with anxiety (Kendall, 1990), "Stop and Think" workbook for impulsive children (Kendall, 1992), "Keeping your Cool," an operating manual for anger control (Nelson and Finch, 1996), "Freedom from Obsessions and Compulsions Using Special Tools (FOCUS)" (Barrett et al., 2004). In addition to these, there are also materials that help children with social skills issues (Nelson, 1995), chronic fatigue syndrome (Chalder and Hussain, 2002), as well as programs for the prevention of anxiety and depression, such as "FRIENDS" (Barrett et al., 2000).

Can CBT be used for preschoolers and younger children?

Children under seven apparently don't have mature cognitive skills for causal thinking, perspectives, self-reflection, verbal expression, or autobiographical memory to make CBT work smoothly. Young children may also have problems with distinguishing emotional states (Piacentini and Bergman, 2001); the ability of metacognition develops during childhood and may be underdeveloped in younger age (Durlak et al., 2001); children may find it difficult to attribute emotions and

behaviors to internal cognitive processes instead of external events (Shirk, 2001); children tend to use problem-oriented strategies to deal with difficulties rather than engaging in a more common process of cognitive restructuring (Shirk, 2001). At Tulane University, a CBT treatment for pre-school children (3-6 years) in particular, has been developed and tested. Test results were published in the manual (Scheeringa et al, 2011). While two previous studies have already shown the efficacy of CBT for young sexual abuse victims (Cohen and Mannarino, 1996; Deblinger et al., 2001), this study has proven CBT effective for a wide range of trauma including accidental injuries, domestic violence, and disasters. The study also documented the feasibility of specific CBT techniques in this age group, for the first time. The total percentage of children who completed 60 CBT tasks during 12 sessions was 83.5 %. These estimates were done by therapists. Several tasks were easier for 5-6 year old children in comparison with 3-4 year olds, such as the ability to identify feelings, presentations of autobiographical stories and discussion of future events (Scheeringa et al, 2011).

How to apply cognitive behavioral therapy in working with children?

CBT helps children learn how to interpret their environment differently. Compared to other therapeutic approaches, CBT is short-term. Sometimes it takes only a few sessions. It is also very focused on problems, which means it deals with problems in the present.

This type of therapy can provide benefits such as:improve communication with others, reduce fears and phobias;interrupt thoughts that lead to addiction or other self-destructive behaviors, improve self-confidence, identify positive responses to stress, change negative mental patterns (Flink et al., 2016).

As a therapy CBT urges children to rethink their thoughts, feelings and behaviors. It shows them how to replace negative thoughts with a more realistic and more positive one. For example, If a child thinks: "I'm stupid and I cannot learn this," the therapist will help him reconsider this idea and replace it with: "I'm good at lots of things. My dyslexia can make learning harder, but I have other qualities that help me. I am as smart as other children. "In some other types of therapy, a therapist is considered an expert who is an authority. In CBT, the therapist and child work together to set goals, identify problems, and check progress. Children often get tasks that should be done in between sessions, in order to strengthen the skills taught in therapy. Instead of

focusing on the past, CBT helps children focus on the present and the future and realize that they have control over their behavior.

In CBT, children see a therapist who can be a psychologist, psychiatrist or a social worker. They can meet individually, in a group with other children or with family members. The therapist first tries to find out what a child wants to achieve. It could be anything - from not being bullied at school any more, to feeling safer.

At the very beginning, the most important thing is to establish a relationship with a child. Child's involvement and willingness to actively cooperate and stay in therapy are major issues to be addressed. Graham and Reynolds (2013) emphasize that it is necessary for a child to accept that: there is a problem; the existing problem can be changed; the offered form of assistance can lead to this change; a therapist can help the child in developing the skills needed to achieve this change.

The process of engaging a child is particularly complex. There are certain barriers that must be overcome before the child is ready to cooperate, which therefore must be taken into account. These are the following:

- Children very rarely ask for help. They are usually referred by others, so initially their insights into the problem or motivation to engage in any form of therapy may be limited.
- Children may not share the opinion and concern of those who referred them. An example could be skipping classes in school.
- Children may feel that someone else is responsible for their problem.
- Children may not be able to see how the current situation might be different. A comment "It's always been this way" is a perfect example.
- Earlier experiences with adults may lead children to take a passive role, while in CBT the child is expected to be actively involved in the process of change (Stallard, 2005).

In the initial part, a useful framework for evaluating the child's readiness for active co-operation in therapy is offered through the model "Stages of Change in Behavior" (Prochaska et al., 1992). The framework conceptualizes the individual in motion: from the lack of will and motivation to change, towards the consideration of possible goals, to making the decision and preparing for a slight change at the end. In the starting stages, the therapist may be more focused on securing and increasing the child's readiness to change by using motivational interview techniques ("the patient-oriented style of counseling to detect behavior change by helping a patient to investigate and resolve ambivalence" (Rollnick and Miller, 1995).

CBT is appropriate only in later stages, after the child has determined what change he would like to make. Phases of lack of intent and forming a purpose are followed by the phase of preparing for the change, in which a therapist continues to work on increasing the child's motivation and confidence, in order to maximize the chance of success. This includes referring to child's previous experiences and directing his attention to some of the skills, thoughts and behaviors that have been important and useful in the past. The first steps in the process of change are particularly important, so that a child could experience some form of early success. Therefore, the first steps must be small and achievable in order to take advantage of the positive effect. Setting goals that are too big and ambitious increases the likelihood of a child's failure. Early failure could confirm the child's belief in helplessness and lack of control and discourage his further attempts to change. At the action stage, the child is fully prepared to engage and participate in therapy, and this is the moment when the CBT is implemented and a significant change is achieved. The goals and the process of ensuring change must be explicit and require regular auditing with a child's active participation. During the result maintenance stage, a child is encouraged to generalize his/her new skills to different situations, to follow them and think about their implementation. The goal is to integrate newly acquired skills into the everyday life of a child. This helps the child to consider and expect difficulties in the future and to develop skills for solving problems, which can also be used to plan and face a possible recurrence in the future.

In the final "Stage of Change of Behavior" phase, the goal is to prepare a child to face possible problems and set-backs in the future, as well as situations in which his old patterns of behavior and difficulties will return. The child will then doubt the utility and efficiency of his new skills. The therapist then works to maintain the child's confidence and encourages him to think about how he coped with the situation in the past, what helped him. It is also important to eliminate potential beliefs that the difficulties are of a lasting nature and to point out that the child has managed to make a positive change in the past and is very likely to succeed again.

Contraindications of cognitive behavioral therapy in children

In addition to assessing the child's motivation and readiness for change, the therapist should also determine whether it's appropriate to use CBT or not. There are several situations in which CBT may not be

the best intervention. This can be related to: the nature of the problem; characteristics of the problem; dealing with multiple problems; the systematic context in which the problem is expressed; child's linguistic and cognitive development.

There is strong and growing evidence that CBT is the best therapy for a number of internalizing disorders, including generalized anxiety, depression, obsessive-compulsive disorder and post-traumatic stress disorder (PTSD). However, evidence of CBT efficacy in treating children for externalizing disorders, such as attention deficit/hyperactive disorder, aggression or behavioral disorders, is weaker (Henggeler et al., 2002). Therapists need to recognize the strong sides of child-focused CBT as well as its' limitations.

If other problems, besides the main one, are identified, they are put on hold and when the basic problem is solved, the most urgent one on the waiting list is selected and dealt with. As a therapy which seeks orientation, CBT is very successful in doing so. The trouble begins when there are multiple problems that require cooperation with other professionals and services, in establishing the support system, which will meet the numerous needs of the family. Some of the needs are education problems, the need for practical assistance, providing support for parents with their own mental health issues... It is important to create a framework that will support the family's multiple needs. When this is done, CBT with a child can be more easily implemented.

Children's problems may be the manifestation of inappropriate parent patterns within the family or may reflect inappropriate processes within a wider system (e.g. the problem with respecting the boundaries).

A child's behavior can become a center of interest that unites and draws the attention of parents from more important problems, such as, for example, their own relations. In such situations, the environmental impacts must be solved and it must be checked whether the family system is dysfunctional. In order to solve this kind of problems, instead of CBT, a more polyvalent approach is implemented.

In working with children, the therapist must be creative and flexible in presenting the ideas and strategies of the CBT, in order to be consistent with a child's speech and cognitive development. Different non-verbal methods and materials should be used. In all cases, the therapist should aim for child-centered CBT to be adjusted to the degree of psychophysical development of a child. Most clinicians agree that children under the age of seven will find it difficult to participate in the CBT (Stallard, 2005).

Participation of parents in cognitive-behavioral therapy directed at the child

The theoretical model by which CBT is conducted must consider and include the child's inner and outer environment (Krain and Kendall, 1999). When it comes to external influences, there are a lot of potentially important: the school the child is attending, the children's peers, the family, the social and cultural context... A prominent example of multi-component therapy, which works with all the listed domains, is multisystem therapy. Evidence of its effectiveness is in solving each of these factors, which ultimately contributed to long-term results in severe antisocial disorder in adolescents (Henggeler et al., 2002). Each of these factors will have more or less impact depending on the age of the child. Social factors will have more impact in adolescence, while in younger children family factors play more important role. Nevertheless, one of the most important influences that should be given the most attention in CBT with children is the influence of parents. Both Kendall and Panichéli-Mindel (Kendall and Panichelli-Mindel, 1995) speak of parents' psychopathology, upbringing styles, and parental skills for the development and maintenance of many disorders in children.

Child-centered CBT should take into account the wider systemic context, and in particular the potential role of parents and those who care for the child in the origin, maintenance and resolution of their child's problems. During the assessment, the clinician should understand important family beliefs, the structure of the system, and the context in which problems arise, as well as the behavior of parents that can encourage and uphold the child's difficulties.

Although there are variations in the way parents are involved in child-centered CBT, Ginsburg and Schlossberg (Ginsburg and Schlossberg, 2002) emphasize that interventions for parents with children with emotional problems focus on several basic skills:psychoeducation, managing an unpredictable, reducing parental anxiety, cognitive restructuring, improving parent-child relation, relapse prevention.

Regardless of the fact that clinicians have recognized the need to involve parents in CBT with children, little attention has been paid to the exact role of parents in therapy (Barrett, 2000).

However, parents are often involved in therapy, either as participants in treatment, either as part of a therapeutic team (Braswell, 1991). Parents are involved as helpers, co-therapists and as clients themselves. The

focus and emphasis of intervention had a range from direct work on the child's problem to separate sessions for parents.

Currently available data from individual studies do not provide strong support to a widely accepted clinical view that parental involvement improves CBT with children (Clarke et al., 1999; King et al., 2000, Nauta et al., 2003). Some of the studies dealt with the discovery of the reasons why parental involvement in the therapy of children does not give consistent results (Breinholst et al., 2012; Creswell and Cartwright-Hatton, 2007).

CONCLUSION AND FUTURE DIRECTIONS OF CBT IN WORK WITH CHILDREN

Research on CBT treatment for childhood disorders has been significant over the last three decades. As a result, some general, albeittentative, conclusions are beginning to emerge.. Firstly, for internalizing disorders such as anxiety and depression, the CBT approach is quite promising, with a series of successful clinical studies that provide a solid foundation for future research. For externalizing disorders, such as ADHD, CBT is less promising as the only treatment that can help, but it is very effective as one of the multimodal approaches (eg. in combination with parent training, medical treatment...). The integration of CBT with other approaches is predicted to be very fruitful area in future. Also, consideration of some possibleavenues for expanding CBT, including the use ofbehavior analytic methods, the integration ofacceptance-based interventions, and a consideration of the implications for the treatment ofchildhood disorders of research on emotional processes.It is important to note that the fieldremains quite 'young' insofar as there are onlya handful of rigorous studies investigating CBTapproaches and the journey ahead is still long.

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KOGNITIVNO BIHEJVIORALNA TERAPIJA U RADU SA DECOM

Rezime: *Osnovni cilj ovog rada je da se predstavi kognitivno bihejvioralna terapija kao jedna od terapija izbora za rad sa decom koja ispoljavaju smetnje u razvojnoj, socijalnoj i emocionalnoj sferi, kao i sa decom koja žele da poboljšaju kvalitet života, bez naznačene simptomatologije. Iako se ponekad smatra kako su detinjstvo i adolescencija razdoblje bezbrižnog uživanja, čak 20% dece i adolescenata ima jedan ili više psihičkih poremećaja koji se mogu dijagnostifikovati.U prvom delu rada će biti predstavljen koncept kognitivno bihejvioralne terapije, njen nastanak i razvojni put kako bi se čitaoci upoznali sa principima i načinom rada na kome ona počiva. U nastavku će biti izložena područja primene kognitivno bihejvioralne terapije u radu sa decom, poremećaji kod kojih je KBT u radu sa decom dala najbolje rezultate kao i opis procesa same terapije sa stavljanjem fokusa na najbitnije korake i probleme koji se mogu javiti tokom rada. U radu će se osvetliti i to koji je najpovoljniji uzrast na kome bi deca mogla da učestvuju jednoj terapiji kakva je kognitivno bihejvioralna terapija. Takođe, osvrnućemo se i na neke od tehnika u kognitivno bihejvioralnoj terapiji koje se najčešće primenjuju u radu sa decom, ali i na kontraindikovane poremećaje i stanja za terapijski rad. S obzirom na to da je u radu reč o terapijskom procesu sa decom, biće izneti podaci o tome da li je i koliko bitno, i na koji način, učestvovanje roditelja ili osoba koje se brinu o detetu u sam terapijski proces. Pored osvrta na značaj roditelja ili staratelja za sam terapijski proces, biće reči i o samoj prirodi odnosa terapeut – dete i važnosti dobrog odnosa za ishod terapije. Kognitivno bihejvioralna terapija je relativno mlad terapijski modalitet koji još uvek doživljava svoju ekspanziju, pa ćemo se na samom kraju osvrnuti na aktuelne oblasti kao i buduće direkcije ove terapije u radu sa decom.*

Ključne reči: *kognicija, ponašanje, emocije, deca, KBT.*