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Children—Behavior Therapy

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Keywords: behavior therapy, children and adolescents, cognitive behavior therapy, developmental issues, evidence-based practice

The roots of cognitive behavior therapy (CBT) for children are inextricably intertwined with the roots of CBT more broadly. Like CBT with adults, CBT for children grew out of two schools of thought—both embedded in experimental psychology; namely, learning theory and cognitive psychology.

First proposed by John Watson in the 1920s, the focus of learning theory and early behaviorism was on overt or observable behaviors rather than inferred processes thought to regulate those behaviors (e.g., ego defenses) that had been the focus of treatments for children in vogue at that time. Although Watson is considered the father of behaviorism, it was one of his students, Mary Cover Jones, who was among the first to apply behavioral principles to the treatment of children. Specifically, Cover Jones used modeling and exposure procedures to treat a child's fear of rabbits. Early behavioral applications for children were later expanded to treatments for disorders such as enuresis, stuttering, and other habit problems.

Behavioral therapies for youth are based on the premise that children learn maladaptive behaviors in the same way they learn adaptive behaviors. More specifically, learning occurs because behavior results in a reward or punishment (operant or instrumental conditioning) or because of associations between stimuli (classical conditioning). Whereas behavioral theory was considered quite controversial at first, growing discontent with psychoanalysis and humanistic or Rogerian therapy, the prevailing therapies, led

to some degree of acceptance by the early 1960s and certainly in the 1970s. However, around this time, behavioral theory itself underwent change in that cognition and its role in both producing and maintaining behaviors was recognized. This evolution occurred for several reasons. First, Albert Bandura developed a social learning theory, an expansion of behavioral theory that suggested that people could learn behavior through indirect experiences (vicarious conditioning) as well as direct ones (direct conditioning). In other words, a child could learn a new behavior or might be more or less likely to exhibit a behavior after observing someone else (i.e., a model) exhibit the behavior and witness the consequences of that behavior. Bandura's social learning theory integrated cognitive constructs, such as expectations and intentions, with behavioral theory and observable behaviors. Additionally, around this same time, Aaron "Tim" Beck and Albert Ellis began developing cognitive therapies that focused not on external stimuli but on the individual's perceptions, thoughts, and beliefs about those stimuli. Although somewhat controversial even to this day, these therapies were soon integrated with behavioral therapies to form cognitive-behavior therapy. Several early studies documented the utility of these principles with children and Donald Meichenbaum was among the first to incorporate them in his pioneering book published in 1977, *Cognitive-Behavior Modification*. Subsequently, Thomas Ollendick and Jerome Cerny explicated these principles more broadly in their book, *Clinical Behavior Therapy with Children*, published in 1981 and, more recently, Philip Kendall has expanded and promulgated these principles, particularly so in his edited book, *Child and Adolescent Therapy*, published in 2000.

BASIC TENETS AND PHILOSOPHY

The major factors distinguishing CBT for children from other psychosocial interventions for youth are their focus on maladaptive learning histories and erroneous or overly rigid thought patterns as the cause for the development and maintenance of psychological symptoms and disorders. However, several other central tenets differentiate CBT from other treatments for children.

Not surprisingly, given CBT's foundations in experimental psychology, CBT has at its core a commitment to the scientific process. In practical terms this implies that testable hypotheses derived from cognitive-behavioral theory are subjected to rigorous study. This is most amply demonstrated today by the endorsement of many cognitive-behavioral psychologists for the empirically supported treatments movement. Undoubtedly, the scientific standards applied in the development of CBTs for children contribute

to the overwhelming representation of CBTs for children on the list of empirically supported treatments (see below).

Additionally, CBT for children is focused on the here and now rather than oriented toward uncovering historical antecedents of maladaptive behavior or thought patterns. Treatment goals are often operationalized and parents and youth seeking treatment are asked to consider the types of changes they are hoping to see result from treatment. Progress is monitored throughout treatment using objective indicators of change, such as monitoring forms and rating devices.

CBT for children emphasizes a skills building approach; as a result, it is often action-oriented, directive, and frequently educative in nature. Also for this reason, CBT typically includes a homework component in which the skills learned in treatment are practiced outside the therapy room. Moreover, given the focus of behavioral theory on the context of the behavior, treatments for children often incorporate skills components for parents, teachers, and sometimes even siblings or peers. Because the focus is on teaching the child and his or her family and teachers the skills necessary to effectively cope with or eliminate the child's symptoms, the child and significant others become direct agents of change. In effect, they function as "co-therapists." Therefore, CBT is designed to be time-limited and relatively short term, rarely extending beyond 6 months of active treatment. More recently, however, some CBTs for children have started to incorporate spaced-out "booster sessions" that extend over a longer period of time to ensure maintenance and durability of change.

EMPIRICAL SUPPORT FOR CBTs FOR CHILDREN

Relative to other treatment approaches, CBT for children has received strong empirical support. Today CBTs are applied to a wide range of childhood problems and disorders including anxiety and phobic disorders, depressive disorders, aggressive and disruptive behavior problems, substance abuse and eating disorders, as well as pediatric or medical concerns (e.g., coping with painful medical procedures, enuresis, and irritable bowel syndrome). Although reviews clearly highlight the need to develop more and better empirically supported treatments for youth, CBTs for children and adolescents stand out in that they have led the way in doing so. For example, a recent review of the empirically supported treatment literature finds support for CBTs in the treatment of anxiety disorders and phobic disorders, conduct disorder/oppositional defiant disorder, chronic pain, depression, distress due to medical procedures, and recurrent abdominal pain (Chambless & Ollendick, 2001). In addition, behavior therapy or components of behavior

therapy were found to be effective in the treatment of attention-deficit/hyperactivity disorder, encopresis, enuresis, obesity, obsessive-compulsive disorder, recurrent headache, and the undesirable behaviors (e.g., self-injury) associated with pervasive developmental disorders. A growing body of research is addressing the mechanisms of change in these therapies as well as questions about the applicability of these treatments to a variety of clinical settings and populations (i.e., the moderators of change).

ISSUES SPECIFIC TO CBT WITH CHILDREN

As noted above, CBT requires that participants are active both in session and outside of session. Among the activities typically required is the completion of between-session homework assignments. Oftentimes homework assignments require the child and/or parent to engage in or focus on some unpleasant activities or thoughts. For example, a child who is afraid of dogs might be required to practice approaching a small dog or he/she might be asked to monitor the thoughts he/she has when seeing a dog during the walk to school. Although active engagement in the therapy process and particularly completion of homework assignments may also be an issue for adults, it can be especially problematic for children. Because children are typically referred to treatment by parents, teachers, or physicians and are rarely self-referred, motivation for treatment may be an issue that needs to be addressed early in treatment. Developmental issues may also become important in increasing motivation and compliance in that young children may find the link between CBT and symptom improvement difficult to understand or the cognitive tasks required in some treatments may be difficult for a young child to undertake. For this reason, CBT for children and adolescents is often slightly different, in terms of both the specific tasks and rationale given.

The degree of parental participation in CBT may also vary as a function of the child's developmental level. Although parental participation is typically involved in CBT for younger children, less parental participation is routinely solicited with adolescents. Of course, parental involvement may also vary as a result of the specific disorder or problem behavior being treated. For example, although parents often play an adjunctive or "assistive" role in treatments for internalizing disorders, most research suggests that parent training, rather than individual treatment focused on work with the child, is the most effective treatment for some externalizing disorders. The role of the parents in CBT for children is different from that expected in more traditional

therapies for children and, as such, parents may come to CBT expecting to have little or no involvement with the treatment process. Since it is rarely the case that parents are not involved at all in their child's treatment, orientation to this aspect of the CBT treatment model is very important to ensure that all involved parties are working collaboratively.

To a certain degree these statements can also be applied to the involvement of other significant people and systems in the child's life—such as teachers and other school personnel, siblings, peers, and, in the case of interventions for medically related disorders, medical personnel. In fact, some CBTs may focus almost exclusively on changing the child's environment, requiring significant behavioral changes on the part of the individuals who interact with the child on a daily basis. Therefore, CBT therapists often function as consultant to the individuals within the systems targeted for change. Similarly, CBT is increasingly being applied in community-type interventions for children (e.g., school interventions to decrease violence).

DIRECTIONS FOR THE FUTURE OF CBT WITH CHILDREN

Although some CBTs are already modified depending on the developmental level of the child being treated, one challenge currently facing CBT practitioners and researchers is how to more fully integrate developmental theory with cognitive-behavioral theory. Similarly, it remains to be seen to what extent individual and family characteristics such as race, ethnicity, socioeconomic status, and religion demand modification in CBTs for children. As research continues to establish the effectiveness of a growing number of CBTs for children, additional efficacy studies as well as studies examining moderators of effectiveness will need to be conducted.

Understanding why CBT for children works and whether the mechanisms are the same for adults and children will also be an important challenge to meet with studies testing mediational models as well as studies that break down current CBT treatment packages to isolate the necessary and sufficient components. Lastly, as we find more effective treatments, we must focus our energies on whether these same types of interventions or modified forms of CBT can be effective in preventing as well as ameliorating psychological disorders and symptoms in youth.

See also: Aggressive and antisocial behavior in youth, Anxiety—children, Play therapy, Social cognition in children and youth, Suicide—child and adolescent, Treatment of children

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Chronic Pain

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Keywords: pain, chronic pain

Everyone has been in pain at some point in his or her life. However, unrelieved chronic pain is perhaps one of the most challenging problems faced by health care consumers as well as practitioners and providers. It is estimated that 75–80 million people in the United States suffer from some sort of chronic pain, at an annual cost of \$65–70 billion (Tollison, 1993). There are a number of personal, social, and environmental consequences of having unrelieved, chronic pain (see Gatchel & Turk, 1999) that may be very difficult for clients to deal with including physical suffering, emotional distress, negative thoughts, behavioral problems (e.g., inactivity, seeking attention), and psychosocial stress (e.g., life role changes, relationship issues, legal problems). Given these experiences, psychological interventions are important for clients who have chronic pain.

TREATING PAIN: MOVEMENT FROM BEHAVIORAL TO COGNITIVE-BEHAVIORAL THERAPY TREATMENT

Behavioral therapy approaches with the chronic pain population were introduced in the late 1960s and early 1970s. Fordyce (1976) was one of the pioneers who applied operant conditioning with chronic pain clients and their families.

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Many behavioral therapy programs for pain management combine behavioral techniques in treating pain, for example, classical and operant conditioning, relaxation training, biofeedback, communication training, and problem solving.

Cognitive-behavioral approaches with chronic pain clients were introduced in the 1980s, with continued refinements over the past two decades. Turner (1982) and Turk, Meichenbaum, and Genest (1983) were among the first pain researchers to apply cognitive-behavioral principles with the chronic pain population. More recently, Beck's cognitive therapy approach with chronic pain clients has been presented (Winterowd, Beck, & Gruener, 2003).

Beliefs and attitudes are very important in managing physical illnesses and conditions such as chronic pain. Chronic pain clients tend to have specific thoughts and beliefs about their pain as well as the impact of pain on their lives. For example, they might be distressed about their ability to be engaged in activities, their relationships with others, their work and family roles, and their sense of identity, given their chronic pain condition. It is not uncommon for these thoughts and beliefs to have negative, unrealistic, and potentially catastrophic qualities. For example, a chronic pain client might think, "The pain has taken my life. I can't get beyond this pain. God must be punishing me for my sins." Catastrophizing thoughts about pain have been associated with pain, psychological distress, and perceived disability (see reviews by Boothby, Thorn, Stroud, & Jensen, 1999; Sullivan et al., 2001).

How people act or behave can also influence their physical health. Chronic pain clients may behave or act in specific ways when they are in pain, for example, wincing, lying down, complaining, and taking pain medication, otherwise known as "pain behaviors" (Fordyce, 1976). Chronic pain and the physical limitations related to it can lead to a number of potentially troublesome behaviors, including inactivity, social withdrawal and isolation, overeating, complaining, and frequent office visits to physicians.

Cognitive-behavioral therapy (CBT) addresses these aspects of pain management: the importance of realistic, healthy beliefs, attitudes, and behaviors in reducing the emotional and physical suffering associated with pain. Clients learn to view pain as a dynamic, multifaceted experience involving sensory perceptions, thinking patterns, affective responses, and behaviors, given their environmental contexts (e.g., level of support and cultural/societal attitudes toward pain).

Therapy is geared toward identifying any emotional, cognitive, behavioral, physiological, and/or environmental (e.g., family, social, cultural, and societal) difficulties that might be influencing clients' experience of pain. Although it is rare for clients to become pain free, CBT teaches clients how to cope with their pain and enhance their functioning in