

1

Parents and Child Development

CHILDREN, THEIR PARENTS AND ATTACHMENT

What does the CBT practitioner need to know?

CBT with children and young people needs to be provided so that it is sensitive and supportive to the role of parents in caring for their children. It should aim to harness the positive resources of parent and carer relationships to support the child's progress and development. Such aspects of therapy are not always easily achieved, and the CBT therapist needs to have a working model of the way parents typically support a child's development to guide this aspect of the work.

The knowledge base

Children are cared for in families, and the vast majority of emotional and psychological help for children is primarily (and usually successfully) provided by parents. Childhood itself could be characterised as a developmental obstacle course through which the majority of children successfully navigate by being cared for by parents and receiving help from teachers, other significant adults and peers. It is only when obstacles become too difficult (or when caring systems become ineffective) that problems emerge that may require therapeutic input of some kind.

Attachment theory has provided a useful model for making sense of the variability of the quality of parent–child relationships in navigating a child's developmental journey. Early work into the study of attachment theory was initiated by John Bowlby (1988) and has been taken forward both empirically and theoretically by the work of Ainsworth (1991), Fonagy, Gergely and Target (2008) and many others. The core aspect of the theory is that attachment is a process by which a child maintains a sense of safety, initially

by maintaining proximity to the parent. As children begin to explore the world, they increasingly move away from the object of safety (the attachment figure) only to seek proximity if they experience threat, fear or need (hunger or warmth). This mechanism has obvious survival functions. With maturation, the process of seeking and maintaining proximity to the attachment figure becomes increasingly symbolic, mediated through self-regulation of responses to fear and threat and satisfaction of needs. Although proximity to parents as a method of safety diminishes with age, residual aspects of this may persist into adulthood, so that in times of personal difficulty or crisis offspring may return to parents for periods of recuperation and recovery.

From this basic framework, attachment theory has evolved a complex assessment methodology and typography for mapping out the degree to which a parent–child dyad successfully (or not) navigates this attachment process. For parent–child dyads for whom this attachment process works well, the relationship may be described as ‘secure’. Within a ‘secure’ relationship, the child will engage in exploratory behaviour in an age-appropriate way while being able to show distress and seek proximity whenever they experience threat or fear. A wide range of studies (e.g. Steele, Steele, & Fonagy, 1996) have shown that approximately 65 per cent of children fall into this attachment pattern. A second group making up approximately 25 to 30 per cent of the population have an attachment pattern which is described as ‘insecure’. Although this attachment pattern is less overtly adaptive than the secure pattern, the overall association between insecure attachment and psychological difficulties in children is not strong, and many children with insecure patterns of attachment function well and have typical normative developmental trajectories to adulthood (Goldberg, 1997). A third attachment category (formally a subtype of insecure attachment) is described as ‘disorganised’ and characterised by highly unpredictable attachment behaviour. This occurs for a small minority of children (less than 5%) and has a much higher association with child mental health difficulties in later childhood than children rated as insecure in general (Goldberg, 1997; Atkinson & Goldberg, 2004). A fuller description of both secure and insecure patterns of parent–child dyads can be found in Ainsworth (1991).

Attachment and the three case examples

Mia

Sally (Mia’s mother) described how a series of previous miscarriages had led to high levels of anxiety during her pregnancy with Mia. This worry about her daughter was exacerbated by Mia’s temperamental tendency towards shyness, and she had difficulty settling at the school nursery. Mia’s temperament and problems with early separation led Sally to be hypersensitive to anxiety in her daughter and led to her experiencing her *own* anxiety both before and during separations. She often assumed that Mia experienced the same feelings as she did. In attachment terms, the relationship between Sally and Mia could be characterised as being insecure and anxious.

Ryan

Ryan had a very difficult early life with his mother experiencing post-natal depression when he was a baby, and later in infancy he witnessed violence directed at her by his father. His relationship with his mother was characterised by a combination of anger and feeling protective towards her. His mother sometimes accused him of making her ill and depressed and he hated this. In attachment terms, his relationship with his mother could be summarised as being insecure with an avoidant style of dealing with his anxiety. His positive relationship with his stepfather mitigated his anger and resentment to a certain extent.

Rehana

Rehana had been an easy baby to care for. During the first two years of her life her mother, Sana, had enjoyed being a mother and was supported by her own mother, who shared much of Rehana's care. When Rehana was about two, her grandmother returned to her home country and Rehana missed her grandmother a lot. Rehana's distress at her grandmother's departure made Sana feel guilty, and she worried that this had caused Rehana not to be as confident as she would like. Rehana felt very distant from her father and believed that he did not really know her. In attachment terms, Rehana appeared to have been securely attached to both her mother and her grandmother and her loss of her grandmother had been very significant for her. Her relationship with her father was distant and difficult to characterise in attachment terms.

Implications for CBT practice

- 1 The immediate challenge for the CBT therapist is to ensure that the offer of professional help does not unintentionally undermine or disempower the parent's capacity to provide effective help for the presenting problem.
- 2 The value of attachment theory is that it invites curiosity in the CBT therapist about the nature of the parent-child relationship and the degree to which it is characterised by confidence, warmth and predictability or by anxiety, distance or even resentment or hostility.
- 3 For CBT with children it is not required for the therapist to assess the attachment status of the child using formal measures, but it may be very helpful to consider whether the parent-child relationship has created a degree of vulnerability to the presenting problem (e.g. anxiety or anger) or may be unintentionally supporting it.

ATTACHMENT AND SOCIAL COGNITION

What does the CBT practitioner need to know?

One of the central tenets of CBT is to understand the way a person's ideas, attitudes, beliefs and assumptions may contribute to maintaining specific difficulties which negatively impact on the person's life. With children and young people, the CBT therapist needs to have a model of how such a child's cognitions about themselves, others and the world have come about. This process is far from completely understood so that there are different perspectives on this process. However, it is essential to have a broad understanding of what is currently known about this process.

The knowledge base

The starting point of social cognition (Sharp, Fonagy, & Goodyer, 2008) is that key cognitive processes develop through a complex process of social interaction, primarily with attachment figures. Social cognition contributes to our understanding of some of the central problems for CBT, namely processes of emotional regulation (controlling one's feelings), the co-construction of cognitions (developing ideas about oneself, others and the world) and mentalisation (the capacity to make sense of one's own state of mind and others). We shall briefly look at each of these in turn.

Emotional regulation

Attachment theory suggests that early processes of seeking emotional help and relief from fear are central to early human survival, and so the early processes of emotional regulation are fundamentally social in their origin. When distressed, the child seeks comfort from their parent, and this regulates and reduces their distress. Within normal development, children learn how to understand and control feelings through their interactions with others, initially and importantly with their parents. Although this process is most apparent in younger children, the way that a parent of an older child responds to the child's feelings remains a key aspect of much therapeutic practice. If an anxious child experiences her own anxiety as making her mother feel anxious or cross, then this is likely to exacerbate her own feeling state and reduce her capacity to manage her own feelings. Similarly, such interactive patterns may apply to the relationship between the child and the therapist if the child experiences the therapist as anxious or disapproving.

Co-construction of cognitions

Attachment theory emphasises the way that core childhood cognitions about the nature of the self, others and the world are constructed in the child's mind during countless

interactions between the child and parent. These 'internal working models' (Bowlby, 1988) are not formal, logical thoughts but general expectations and assumptions about the world that are more likely to be implicit than explicit or conscious. Developing an understanding of the interpersonal process of co-construction of meaning is fundamental to CBT. A crucial component is the central interest by the therapist in the states of mind (thoughts and feelings) of the child, but also from a social cognitive perspective, how a child's cognitions about self, others and the world are constructed in partnership with others, particularly parents/carers.

This suggests that the therapist may get assistance from the parent in learning about the child's cognitions simply by listening to what the parent says to and about the child. This observation was made by Bolton (2005), who hypothesised that the future core beliefs of the child were often articulated somewhat transparently in the consulting room by the parents. Statements by parents such as 'He's a terrible child', 'It's all his fault' or 'He's just like his Dad' may well become internalised by the child as part of his implicit self-schema or internal working model. Bolton's suggestion is that the therapist may not need to go digging around for these core beliefs within the child as they are often presented to him rather more transparently by the parent.

Mentalisation

Attachment theorists have suggested that as children develop, they gain an increasing ability to make sense of the behaviour of others in terms of their intentions and internal experience, based on an understanding gained first of all through interaction with their parent(s). This human attribute has been termed mentalisation, which can be defined as the imaginative ability to understand the behaviour of oneself and others in terms of intentional mental states (Fonagy, Gergely, Target, & Jurist, 2002a). However, mentalisation theory emphasises that it only works imperfectly. A recent study of parents' capacity to mentalise the states of mind of their children showed that parents were accurate no more than about 50 per cent of the time (Sharp, Fonagy & Goodyer, 2006). No one accurately reads the mind states of themselves or others even most of the time, and much human distress and difficulty is caused by this. The crucial benefit of mentalisation is that it provides a framework for sorting out errors in constructing the intentions of oneself and others.

For a child, the experience of being able to hold in mind the belief that their parent has benign intentions towards them even when, for example, they are being told off is likely to be different to the experience of the child who assumes that her mother hates her and that this scolding merely confirms this. These contrasting experiences are determined by the capacity of the child to mentalise. There is a positive association between secure attachment and more advanced mentalising skills in young children (Steele, Steele, Croft, & Fonagy 1999) and there is some indication that children with restricted capacity to mentalise the mind states of others will experience greater levels of emotional distress and poorer social adjustment (e.g. Dunn, 2004; Charman, Carroll, & Sturge, 2001). Processes of repair may be enhanced by facilitating increased mentalisation in parent-child interaction (Hood & Eyberg, 2003; Zisser & Eyberg, 2010).

Implications for CBT practice

- 1 What differentiates CBT with children compared with work with adults is that the interactive process between a child and a parent is live and present and not something related to a previous context. The implication for the CBT therapist is that the process of understanding the child's cognitions is very likely to involve observing and exploring the feelings and cognitions that arise in the child's interactions with the parent.
- 2 CBT with children is often concerned with helping children control difficult feelings (anxiety or anger), or in understanding their cognitions about themselves or others. Social cognition suggests that the CBT therapist may be assisted in understanding these difficulties by considering the parent-child interactions that may have supported the development of such problems.
- 3 In general, improving mentalisation in parent-child interaction is likely to be a very useful component of CBT with children and their parents. Put simply, this means encouraging curiosity as to what the child thinks the parent thinks and vice versa.
- 4 For the CBT therapist there is no assumption that a child's difficulties are always due to the quality of parenting. There are clearly cases in which consideration of the parent-child relationship and interactions indicates little connection with the child's difficulty. This will be increasingly apparent in adolescents where wider world factors may be more significant.

SIBLING AND PEER RELATIONSHIPS

What does the CBT practitioner need to know?

For the CBT therapist, it is easy for other aspects of a child's life to have greater prominence so that sibling and peer relationships may not be sufficiently recognised in the formulation of the child's difficulties. This is even more pronounced with respect to adolescents where peer relationships may be the predominant focus of the young person's concerns. The purpose of this section is to remind CBT practitioners that knowledge of peer relationships may both improve understanding of the child's difficulties and also provide ideas about how peers may be helpful in the intervention plan.

The knowledge base

Positive peer relationships are protective of childhood difficulties

The quality of peer and sibling relationships is strongly associated with overall emotional well-being in childhood and adolescence so that the absence of positive friendships may increase vulnerability to psychological problems (Dunn, 2004). In younger children poorer reasoning skills about the mental states of others has been shown to be related

to behavioural difficulties (Hughes, White, Sharpen, & Dunn, 2000) and associated with family patterns of not resolving conflict (Herrera & Dunn, 1997). Not surprisingly, positive peer relationships are associated with increased resilience (Bukowski, 2003) whereas problems in peer relationships can increase an individual's vulnerability, particularly in adolescence, for example, by leading to the development of a poor self-image and a reduced sense of social acceptance (Harter & Whitesell, 1996; Shirk, Burwell, & Harter, 2003). Spence (2003) has provided convincing evidence that children experiencing social difficulties as a result of deficits in social competence are more likely to experience emotional and behavioural distress and have psychological disorders that may persist into adulthood. Her extensive research into social skills training has demonstrated how young people can be directly taught key social behaviours and interpersonal problem-solving skills to assist them to function in social situations.

Parents may not be well informed of children's friendships

Commonly, parents may be quite restricted in their knowledge and understanding of their child's network of friends and acquaintances at school. Dunn (2004) reported that 3- to 4-year-old children show greater empathy and concern for their peers when adults are not present. However, in the presence of caring adults, they appear to transfer this caring role to the adult and revert to less sympathetic forms of interaction. Such an observation highlights how adult perceptions of children's peer relationships can be potentially inaccurate.

Loneliness

Loneliness can be seen as a marker for unsatisfactory social relationships and the frequency of loneliness in children may be underestimated by teachers and parents (Asher & Gazelle, 1999). Cassidy and Asher's (1992) research indicated that primary school children generally understood the concept of loneliness, with about 10 per cent reporting feelings of loneliness. Children experiencing the greatest degree of loneliness might be shy and withdrawn, but they also could be those who were disruptive and aggressive. Loneliness is often related to peer rejection and social isolation and such difficulties are predictive of serious adjustment problems in later life, including both internalising disorders such as anxiety and depression (Crick & Ladd, 1993) and externalising problems such as aggression (Cassidy & Asher, 1992). Lonely children are also more likely to have difficulties with academic achievement (Asher, Hymel, & Renshaw, 1984).

Bullying

Bullying is an important aspect of peer relationship difficulties that should be singled out for consideration due to the great distress it can cause and because of the high rates of reported bullying by children. A report of a survey by Cawson, Wattam, Brooker and

Kelly (2000) reported that 31 per cent of children reported being bullied. For about 50 per cent of schoolchildren, bullying and the daily experience of social isolation and fearfulness is a serious concern (Oliver & Kandappa, 2003) and may have a damaging effect on a child or young person's overall development and sense of global self-worth (Cawson et al., 2000). A survey of 2,300 10- to 14-year-olds reported that 30 per cent had been bullied and not told anyone about this (Smith & Shu, 2000).

Peer relationships: the three case examples

Mia

Mia liked, and was good at, playing with other children, but only those she knew well, and she tended to have one 'best friend'. She consequently found it difficult when this friend was not there and described feeling 'lonely' at times. She got on well with her brother who tended to protect her at school. Consequently, she became more anxious when her brother moved to secondary school. One aspect of the CBT intervention was to work on Mia's social skills, so she felt more confident with her peer group.

Ryan

Ryan had unstable friendship patterns at school, so that he would play with different children from one week to the next. He tended to try to make friendships by forming alliances with children which excluded them from other friendships. He would often tell his Mum that he had lots of friends at school even though he had no stable friendships. In the family, he liked his cousin Ashley who was 12 years old. They played computer games together for many hours, and this was perhaps his most successful relationship with another child.

Rehana

From an early age, Rehana was shy of social situations. She was looked after by her older siblings and cousins in family social situations. At primary school she had friendships with two other children. Her social avoidance became more prominent at secondary school where she found the increasing social demands hard to manage. This intensified her feelings of social isolation and detachment. Her relationship with her older sister became strained because she experienced her as much more confident than herself.

Implications for CBT practice

- 1 Knowledge about a child's peer group and social functioning may provide important information for a CBT formulation and provide a guide about areas to focus on within the intervention plan.
- 2 Young people can be directly taught key social behaviours and interpersonal problem-solving skills to assist them to function in social situations.
- 3 For CBT with children, bullying is an important area of enquiry. This should be asked gently but directly, and the therapist should be aware that children may be reluctant to talk about this. Knowledge that a child perceives that they have been bullied will provide important information in understanding their difficulties, and associated cognitions that may have developed.
- 4 Bullying is a common maintaining factor of childhood distress and CBT should actively address (with the young person's consent) this issue with either the school or the family.
- 5 Identification of lonely children may contribute to a CBT formulation of their difficulties.

PLAY

What does the CBT therapist need to know?

Play is a vital part of childhood and may enable a child to experiment with new ideas or understandings. For CBT with children, play may be something which is hard to get right as the therapist may be caught between the wish to enhance engagement through play against the need to retain an explicit focus on the purpose of the therapy. For adolescents, play is more ambiguous as they move towards interacting like adults. For some adolescents, face-to-face verbal interaction with the therapist may be quite aversive and the CBT therapist may want to find more indirect and creative and perhaps playful ways of working together. Again it may be hard to find a balance between more adult and more playful styles of interaction. Overall, the challenge for the CBT therapist is to harness the potential value of play to support the goals of the intervention.

The knowledge base

Play has a central importance in child development. Apart from being a source of pleasure and fun, play provides a way for children to act out their mental representations of the world and process their experiences. Thus, play has a significant adaptive function. It provides a way for children to learn about objects, events and relationships, and to develop and refine knowledge about the world. Whether children are involved

in imaginative rehearsals of aspects of their lives as adults or are enacting their current desires, wishes and fears, play represents an important way in which a child is making sense of the world, developing control over their environment and rehearsing for change (Moore Taylor, Menarchek-Fetkovich, & Day, 2000). This function declines in intensity and pervasiveness into adulthood.

Play in children is important for the development of cognitive, social, emotional and language skills (Sawyer, 1997). As CBT goals often relate to the definition of alternative modes of conceptualisation and response, *play may be an important vehicle to try out alternative possibilities*, like a form of apprenticeship (Sheridan, 1997), providing an opportunity for children to learn new ways of thinking and behaving. In order for play to be shared, children need to orientate themselves to the other participants in the play activity and anticipate multiple levels of meaning, negotiating actions and roles (Garvey & Kramer, 1989).

Play and the three case examples

Mia

Mia's level of engagement in CBT was maintained by explicitly dividing the CBT session in two parts: things that the therapist wanted to do and things that Mia wanted to play. Initially, the CBT practitioner made available pens and paper, and toys that Mia might be interested in, including a pack of playing cards. Later in therapy, Mia brought in favourite toys from home which provided information about Mia's interests that the therapist could use when devising activities. Mia brought some miniature figures which the therapist used as puppets to represent family members in a story aimed at eliciting Mia's thoughts and feelings about her mother being absent and in modelling possible coping strategies through play.

Ryan

In the CBT session with Ryan, play was used as a reward for 5 to 10 minutes at the end of the session. The therapist ensured that time was spent playing a card, paper (hangman) or board game chosen by Ryan. He found it fun to beat his therapist at such games. The use of play was also a way of modelling the need to stick to a plan as Ryan would often ask during the session if it was time to play a game yet. In general, the style adopted by the therapist was to try to validate success in not doing things impulsively and praised Ryan for managing to defer and wait for the reward.

Rehana

For Rehana, play was an important part of engaging her in the work, although it took a different form than with younger children. Rehana liked computers, and used to enjoy board games. The therapist used this knowledge of her interests to facilitate her participation by playing the 'All About Me' board game which proved helpful in enabling Rehana to relax and talk about herself. The therapist also took an interest in the computer games and websites Rehana liked while admitting to general ignorance about the web. Rehana used to play on-line chess, so the therapist proposed ending the session each time by playing draughts. This evoked a playful competitiveness between them which increased rapport and balanced the more overt therapeutic work. It was also a useful way of helping Rehana calm down at the end of the session, particularly when it had involved discussing difficult topics.

Implications for CBT practice

- 1 Play activities can contribute to the therapy as a method of imaginative exploration of general or specific themes identified by the child. This type of interaction may be used in CBT as part of specific efforts to increase a sense of rapport with the child or because more direct efforts to establish an authentic communication have proved unsuccessful.
- 2 Some CBT manuals with children, e.g. the Coping Cat manual for anxiety (Kendall & Hedke, 2006) include a period of play between the child and the therapist at the end of the session as a 'fun time' which provides a reward for the child's efforts in the session and enables the session to finish on a positive note.
- 3 Many CBT programmes with children emphasise the need to make the therapeutic process enjoyable and engaging and frequently include games as ways of addressing aspects of the intervention plan.
- 4 A range of games may be used to address specific aspects of the case formulation such as role plays, acting games, pencil and paper games, making books, generating stories or working on the computer (Friedberg, McClure, & Garcia, 2009).
- 5 The therapist needs to keep in mind that children are the true experts on play and collaboratively devising games with the child may be equally effective as using more standard games and techniques.
- 6 Diaries, workbooks and other resources designed in consultation with the child may be more engaging than standard formats. Similarly, some therapists work with children to devise their own board or computer games designed around the child's specific formulation and problem.
- 7 The quality of playfulness, apart from the entertainment and enjoyment generated, is also likely to facilitate aspects of cognitive functioning that are relevant to therapeutic change, particularly mentalisation and problem-solving.

COGNITIVE DEVELOPMENT AND LEARNING

What does the CBT practitioner need to know?

CBT with children and young people encourages them to think about their experience, to do problem-solving and to engage in conversations with an adult about their life and problems. One of the key questions for CBT with children is the degree to which children's developing cognitive skills significantly impacts on their capacity to engage in this process. The therapist's understanding of how children at different ages think and learn is fundamental to the whole application of CBT to this client group and is likely to impact on nearly all aspects of the intervention.

The knowledge base

Aspects of cognitive functioning such as more abstract thinking may be particularly relevant to CBT (see Grave & Blissett, 2004). However, differences in capacity are not confined to thinking and reasoning but also include, for example, emotional understanding, social skills, confidence and experience. All of these will be included in this section. Because of its importance, this section will look at core theories of cognitive development such as proposed by Piaget and Vygotsky (along with recent elaborations of these models) and link these theories to central aspects of core CBT practice.

Piaget's basic theory

Piaget's theory of cognitive development has been highly influential and has subsequently been tested, elaborated and contested by successive researchers (e.g. Goswami, 1995, 2008). Piaget considered cognitive development to occur largely as a consequence of the child's own actions on the environment and described the progressive, stage-like elaboration of cognitive structures that were associated with cognitive growth. He defined the term schemata to refer to the cognitive and mental structures that enable individuals to process incoming stimuli in order to adapt to and organise the perceived environment. Schemata are constantly being created, changed and refined through process of assimilating and accommodating new experiences. Disequilibrium (or 'cognitive conflict') refers to an imbalance between assimilation and accommodation, i.e. when the child can't make sense of something with existing schemata. In order to resolve states of disequilibrium children must adopt more sophisticated modes of thought and in this way make developmental progress (Piaget, 2000; Piaget & Inhelder, 1962).

According to Piagetian theory, direct instruction is not considered necessary for cognitive structures to develop, and the role of the parent and teacher is seen in an enabling capacity rather than an instructional one. Although the environment provides opportunities for cognitive structures to develop and be tested, in general its role is

secondary to spontaneous, child-driven developmental processes. Hence children will learn through engagement with relevant experiences and will benefit less from being taught specific skills.

Piaget proposed distinct developmental stages that were qualitatively different from each other, and occur within the continuum of development. All children pass through the same stages in the same order but rates of development vary from child to child. Advances through the stages reflect children's increasingly complex ways of thinking and constructing knowledge as they interact with and attempt to represent environment-action complexes. Piaget considered that cognitive and affective factors constantly interact in learning and that affect influences the rate of progress and can speed up or slow down development (Wadsworth, 1989). He was of the view that affect develops in a similar way to cognition, that the two parallel each other and are inextricably intertwined.

Piaget described a journey of increasing cognitive sophistication so that by around 11 years of age most children are capable of holding images in mind and, through their actions, demonstrate the acquisition of some core meta-cognitive processes (thinking about thinking). In this way a child can begin to think about states of mind that are not created by immediate circumstances.

The somewhat abstract nature of this theory should not detract from its relevance to CBT therapy. Put more simply, it suggests that children may achieve new ways of thinking about things out of discovering that there is a mismatch between what they expect and what they experience. However, new thinking about such discrepancies may not occur if the child experiences high arousal and distress. For example, the exploration of the child's dilemma as to whether 'Dad does not love Mummy but does he still love me?' may benefit from a Piagetian starting point of helping the child to work out the discrepancies of his own expectations and assumptions.

What was less clear from this theory was the degree to which adults could contribute to the child's developing understanding of self, others and the world. For example, McNaughton (1995) disagreed with this aspect of Piagetian theory, arguing that it does not satisfactorily explain the influence of the context in which learning occurs and in particular the impact of social and cultural influences. This leads us to consideration of Vygotsky.

Vygotsky and the zone of proximal development

Vygotsky's (1986) theory argued that learning is socially mediated and that the support provided by adults as they guide children towards more sophisticated levels of knowledge and understanding is particularly important. Vygotsky introduced the concept of the 'zone of proximal development' which he defined as the

distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined by problem solving under adult guidance or in collaboration with more capable peers. [The concept] ... defines those functions that have not yet matured but are in the process of maturation, functions that will mature tomorrow, but are currently in an embryonic state. (Vygotsky, 1978: 86)

Hence, the more competent individual guides and extends the novice's learning by the provision of temporary and adjustable support, using interactive dialogue and models. From this perspective the child's development is critically tied into her social experiences and the role and influence of the environment is active and central. Vygotsky considered learning from a cultural perspective and argued that culture is transmitted from one generation to the next through formal and informal education. The social and cultural framework is seen, within this perspective, as having a significant influence on a child's development of cognitions. Unlike Piaget, Vygotsky did not view development as moving through a sequence of invariant stages but considered that children could acquire particular knowledge and understandings following a variety of routes.

Vygotsky disagreed with Piaget on the role of the educator (or therapist), which he saw as being more didactic and central to cognitive development, considering instruction to be important in guiding and extending children's understandings. He stated:

Instruction is one of the principal sources of the schoolchild's concepts and is also a powerful force in directing their evolution; it determines the fate of his total mental development. (Vygotsky, 1986: 157)

The concept of scaffolding

Wood, Bruner and Ross (1976) developed Vygotsky's notion of the zone of proximal development in a seminal paper that considered how maternal behaviour can support and extend learning in young children. They described how adult tutors can provide temporary and adjustable support when assisting a child with a task and refer to this process as 'scaffolding'. Adjustments to materials, presentation and linguistic support all influence the nature of the scaffold, which is progressively removed. Ultimately the young person will be able to achieve their goal independently and their performance will be self-regulated. The concept of scaffolding has been extended from the support offered by the more competent individual in one-to-one interactions to the support and structure provided in group learning situations (Beed, Hawkins, & Roller, 1991). In therapy, this scaffolding may be provided by the therapist, the parent or teacher or, ideally, by all.

There are conflicting viewpoints about the pace of development of meta-cognition in childhood. Lidz and Thomas (1987) have suggested that children are unable to think about thinking (an important aspect of CBT) until they reach school age. However, Flavell, Green and Flavell (1995) have shown that meta-cognitive skills can be taught to children by helping them to be more aware of their own thought processes. They provide experimental evidence that meta-cognitive ability changes with age, and that improved competence in reflecting on thinking is related to experience rather than age per se.

A similar process can be seen with respect to the development of reasoning. Piaget predicted that transitive thinking (if A is bigger than B, and B is bigger than C, then A is bigger than C) is usually acquired by children at the age of six to seven years. However, a classic study by Goswami (1995) showed that children of three to four years could do this task using analogical thinking using the story of the three bears. What was particularly

interesting about her findings was that 3- to 4-year-old children could do this task if they were *previously familiar* with the Goldilocks story. For the CBT therapist this finding has particular significance as it highlights the importance of using familiar stories and ideas as methods of scaffolding children's learning. Similar findings can also be shown with respect to children's learning and use of cognitive strategies.

Cognitive strategies and CBT

CBT advocates the use of cognitive strategies as a change technique. Cognitive strategies have been defined as deliberately implemented, goal directed operations used to aid task performance (Bjorklund, 1990). What do we know about the use of cognitive strategies in children in general? Younger children use strategies less frequently and less effectively than older children (Bjorklund & Douglas, 1998). For example, for memory tasks, children under the age of four rarely rehearse in order to remember something, whereas children between four and seven years begin to use rehearsal. As they get older, children start to use categorical strategies to cluster information to help them remember in addition to rehearsing, which is less efficient. There are many indications that *with adult help*, children of all ages can learn cognitive and mnemonic strategies. However, younger children have what Bjorklund and Douglas (1998) describe as a 'utilisation deficiency', i.e. they do not use strategies across contexts even when they know they work. So younger children may be able to learn new strategies under certain conditions, but they are less likely to apply them spontaneously in situations where the strategy would be useful.

For CBT practitioners, the problem of how to ensure that within-session learning is generalised to other settings is familiar. Siegler's Adaptive Strategy Choice Model (Siegler, 1996; Crowley & Siegler, 1999) showed that although children use more sophisticated strategies with increased practice and age, these do not replace simpler strategies but remain alongside new ones and older strategies may be 'selected' by the child in certain contexts, particularly when faced with new problems. This may explain why some children find it so hard to generalise strategies learnt in CBT sessions to other aspects of their lives, which may be chaotic or stressful. In practical terms, it is important for the therapist to ensure activities have sufficient scaffolding (in activity and relational terms). This scaffolding process is illustrated in the example of Sam described next.

Sam

Sam, a 5-year-old boy, had an intense fear of dogs which was having a significant impact on his life – he was becoming avoidant of visiting the homes of friends with dogs. He attended therapy with his father and was an articulate child, clearly used to talking with adults. The first session was spent talking,

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(Continued)

playing and drawing dogs (to a degree that he could tolerate). In the second session, Sam told the therapist that he was most frightened before seeing a dog and imagined being bitten by the dog **even though this had not happened**. At the end of the second session, Sam said that he was more frightened by his thoughts about dogs than by the dogs themselves. He had little difficulty in getting hold of one of the basic tenets of CBT and was able to separate thought from fact.

Many 5-year-old children would not come to understand things as quickly as Sam. In this example Sam was unable *on his own* to reach an understanding that there was a difference between thought and fact. This discovery was made through collaboration with the therapist (ably supported by his father) in which the therapist modelled alternative thoughts and activated a parallel understanding in the child. Activities were highly scaffolded and operated within his zone of proximal development. The therapist was constantly assessing and monitoring Sam's response to questions posed to ascertain that everything was within his cognitive competence. However, it was unlikely that Sam could retain this understanding on his own. In this way, the capacity to remember what Sam learnt in therapy needed to be a joint task with his father so that together they could remember and reinforce his learning at home.

The job of looking after a child's learning and insight may not be an easy one for a parent. In parent-child relationships which are strained or adversarial, it would probably be unwise for a child to trust a parent with such a valuable commodity. The potential for insights like this to become weapons against the child are all too familiar in troubled families. ('You're just making a big fuss about nothing. You told that man that it was just in your head.') In other cases a parent may be too anxious to tolerate knowing what is going on in their child's mind.

Sam had a trusting relationship with his father, so it was safe for him to collaborate in therapy and be responsible for keeping Sam's alternative thought alive and active i.e. the possibility that dogs themselves might not be so scary if he didn't make them so scary in his mind. Sam also appeared to experience some relief from expressing this idea in the session through not being judged or criticised within the process. Sam still retained a nervousness about dogs, but together he and his father were able to challenge the idea that he should avoid positive activities due to the thought that they were going to attack and bite him.

Memory and executive functioning

Sam's case example also illustrates that developmental differences with respect to memory and executive functioning may also impact on aspects of CBT. The ability to reflect on past and future events improves with age as children's memory capacity increases and

they develop more abstract and symbolic ways of psychological representation. Because of this relative immaturity, children's state of mind tends to be more obviously influenced by the 'here and now' aspects of their environment than for adults. For example, asking a 7-year-old child 'what sort of week have you had?' may be a genuinely challenging question not because they do not remember things that have happened in the preceding week, but because they do not process them in the way that adults do.

In CBT, children often find it hard to report accurately on events outside of the therapy room. For example, asking children to rate their feelings (e.g. sadness) over a particular time period (e.g. a week) may be unreliably carried out for a variety of reasons, one of which may be that the task lacks authenticity and relevance. Additionally, children's responses may be even more influenced by their immediate state of mind (i.e. how relaxed or anxious they feel) or by how much they like or dislike their therapist. For the CBT therapist the use of diaries or other prompts to memory retrieval is likely to be essential for children as a method of accessing events and experiences outside of the therapy session.

Similar difficulties should be anticipated for children's capacity for planned activity. For adults, this relies on well developed executive functioning skills which support planned activity through conscious memory prompts and a capacity for planned actions. These skills are far less developed in children where parents typically provide scaffolded planning and executive functioning on their behalf. For adolescents this is much more developed and difficulties in planned activity may be more motivational than cognitive.

Children's learning

Research into learning should inform CBT practice with children and young people. CBT involves finding ways of helping children to learn about their experience and finding new ways of coping. There is a large body of empirical research which has focused on teaching approaches associated with effective learning, summarised by Hattie (2009). Following Piaget, new information needs to link with pre-existing understandings and be organised within an accessible conceptual framework for children to grasp the ideas presented. In order to extend understanding, information needs to be presented in a variety of ways, drawing on many examples in which the same concept is central. With respect to practice, spaced or distributed practice (i.e. short, multiple practice sessions interspersed with rest or other activity) will lead to more efficient learning and consolidation of skills than massed practice, where the skill is practised for less frequent, longer periods without taking a break (Walker, Greenwood, Hart, & Carta, 1994).

There is compelling evidence about the importance of feedback in learning (Hattie, 1992). This does not refer to the feedback from adult to child, but rather *the responsiveness of the adult to feedback sought from the young person* about what they know and what they understand. Only through ensuring clarity about the child's conceptions and misconceptions can the therapist synchronise their understanding to develop an appropriately targeted and collaboratively agreed intervention.

Some children may have difficulty with the abstract nature of some aspects of CBT and coping with a level of thinking that is removed from the 'here and now'. Typically,

in schools, concrete examples are used to introduce abstract concepts. For example, children are introduced to mathematical concepts using concrete tools such as blocks. If there is a high degree of similarity between concrete and abstract domains, with sufficient practice, there is likely to be a transfer between the two (Gentner, Rattermann, & Forbus, 1993). The effectiveness of CBT may benefit from preparing concrete examples of abstract concepts.

Cognitive development and the three case examples

Mia

Without carrying out a formal assessment, Mia appeared to have age-appropriate cognitive skills for a 7-year-old child. The therapist aimed to scaffold activities carefully and to avoid abstract ideas and language as much as possible. For example, the therapist used drawing to externalise her anxious cognitions and slowly developed verbal labels for particular feeling states. This included helping her to name her own and her mother's feeling states and to amplify differences between these. The cognitive work focused on helping her to develop positive self talk and other coping strategies.

Ryan

Ryan had some residual problems of expressive language development with verbal fluency and vocabulary deficits, but his comprehension was age-appropriate. When he was in a relaxed state, he could show for brief periods (ten minutes) cognitive flexibility, was able to talk about his relationships with some insight, and reflect on feelings such as remorse and disappointment. He could rarely provide moment-to-moment accounts about his angry outbursts. His capacity to generalise the use of cognitive strategies and impulse control had to be highly scaffolded with concrete reminders and active practising.

Rehana

Rehana presented as intellectually able. The therapist ensured that they developed a shared language for Rehana's emotional states in the early parts of the therapy. Cognitive techniques were considered highly appropriate such as evaluating evidence for and against her thoughts, and working on her underlying beliefs and rules.

Implications of cognitive development for CBT with children

- 1 The task for the CBT therapist is to enable the child to work things out in a contained and safe context and allow a process of active learning about salient ideas linked to the child's difficulty.
- 2 Some cognitive change techniques, such as cognitive restructuring, require some aspects of formal operational thinking, as the young person must consider aspects of their experience in relation to a defined thought. Using Piaget's framework, children described as being in the stage of concrete operations are unlikely to carry out this type of meta-cognitive processing *on their own*.
- 3 What is less clear is the degree to which children may be able to do such cognitive tasks if this is done in collaboration with others, particularly an adult who may be able to guide a child to learn and discover things that they would be unable to do alone. This issue is directly addressed by the work of Vygotsky.
- 4 CBT can be seen as creating a zone of proximal development. With careful assistance from an attentive adult, children and young people can learn new ways of thinking, feeling and behaving. Collaborative scaffolded activity can lead to new understandings and ways of thinking.
- 5 Children's developing cognitive skills may have more impact on their capacity to generalise ideas and skills learnt in therapy sessions than in their capacity to learn new understandings in therapy. For children, addressing the problem of generalisation is likely to require input from parents or teachers to support new understandings discovered in therapy.
- 6 Children tend to operate more in the here and now than adults. Explicit methods of recalling critical events related to therapy and to supporting planned activities will be needed to assist a child who has less developed memory and executive function skills than adults.
- 7 In order to extend understanding, information needs to be presented in a variety of ways, drawing on many examples in which the same concept is central. Children may have difficulty with the abstract nature of some aspects of CBT and coping with a level of thinking that is removed from the 'here and now'. The effectiveness of CBT may benefit from preparing concrete examples of abstract concepts.
- 8 Repeated, frequently experienced tasks/activities will be learnt more effectively than when less frequent blocks of time are spent on an activity. In planning practice tasks, short bursts of practice are preferable to extended practice once or twice a week.
- 9 The responsiveness of the adult to feedback sought from the young person about what they know and what they understand is a key aspect of what supports learning. This should be at the heart of CBT.

Overall, the task for the CBT therapist is to consider the degree to which he/she may need to scaffold activities and communications in order to enable the child to participate fully and in a meaningful way in the therapy. We suggest that the challenge for CBT with children is not to try to establish competency criteria that children would need to meet 'to do CBT' but rather to develop techniques which enable the principles of CBT to be appropriately adapted to meet the specific cognitive capabilities of children.