Hellenic Journal of Psychology, Vol. 3 (2006), pp. 1-22

COGNITIVE BEHAVIOR THERAPY WITH CHILDREN: SKILLS-DIRECTED THERAPY

Tammie Ronen
Tel Aviv University, Israel

Abstract: This paper proposes that, in the past, the difficulties in applying cognitive behavior therapy (CBT) with children derived from the lack of an integral theoretical framework. Such a theoretical framework should integrate several features: developmental considerations, social and emotional development, and the nature of child information processing. Whereas the main components in adult CBT comprise the understanding of links between thoughts, emotions, and behavior and the understanding of one's ability to create change, the main component in child CBT constitutes skill acquisition. That is, in order to achieve change, children must undergo training and practice in the application of appropriate skills. This paper ties these key components together in a cognitive intervention with children who evidence aggressive behavior.

Key words: Children, Cognitive behavior therapy, Skills acquisition.

Cognitive theory pertaining to adults focuses primarily on cognitive factors in psychopathology and psychotherapy, deriving from the nature of adults' information processing as a key feature for understanding maladaptive behavior and positive therapeutic processes (Alford & Beck, 1997). The underlying theoretical rationale upholds that an individual's affect and behavior are largely determined by the way in which humans construct the world (Alford & Beck, 1997; Beck, 1963; Beck, Emery, & Greenberg, 1985). A person's cognitions (verbal or pictorial 'events' in the stream of consciousness) are based on attitudes or assumptions (schemata) developed from previous experiences (Beck, Freeman, et al.,

Note: The author would like to express her gratitude to Dee B. Ankonina for her assistance with the preparation of the manuscript.
Address: Tammie Ronen, The Bob Shapell School of Social Work, Tel Aviv University, Tel Aviv, Israel. Fax: +972-3-6409182. Email: tamie@post.tau.ac.il

1990). Cognitions are considered the most important links in the chain of events leading to disordered behavior and psychological dysfunctions (Powell & Oei, 1991).

Although consensus exists that cognitive therapy with adults provides an integrative theory and an effective, scientific intervention method, arguments continue to abound concerning the efficacy of cognitive behavior therapy (CBT) with children. The present paper proposes that the difficulties in applying CBT with children, in the past, derived from the lack of an integral theoretical framework. Such a framework for children should integrate several features: developmental considerations, social and emotional development, and the nature of child information processing. Whereas the main components in adult CBT comprise the understanding of links between thoughts, emotions, and behavior and the understanding of one's ability to create change, the main component in child CBT constitutes skill acquisition. That is, in order to achieve change, children must undergo training and practice in the application of appropriate skills. This paper will first review the historical and recent developments in child CBT. Then it will attempt to unite the key child-relevant and CBT components within an integral theoretical framework that can serve as the basis for cognitive child interventions such as the suggested intervention for children who evidence aggressive behavior.

Early applications of CBT with children

The basic assumption underlying CBT posits that cognitive mediational processes are involved in human learning. The cognitive processes comprise activities such as expectations, self-statements, and attributions. These play an important role in understanding and predicting psychopathology and psychotherapeutic change (Beck et al., 1985; Ronen, 2001a,b, 2003).

The basic tenet of the behavioral component in CBT is the scientific approach relying on empirical studies of human behavior. Human behavior is seen as undergoing a constant process of change subject to learning principles. The same rule explaining normal human behavior can explain deviations; persons who learn to be deviant can also learn to behave acceptably. An important feature of CBT comprises the relation existing between behavior and the environment (Powell & Oei, 1991).

Over the years, behavior theorists have shifted toward cognitive theory

and, more recently, toward constructivist theory. Constructivism emphasizes people's own responsibility for creating their own realities through the way in which they reconstruct and construe life events and attribute meaning to personal experiences (Mahoney, 1991, 1995). Therefore, thoughts, feelings, and behaviors are causally interrelated and – together – are responsible for human functioning. Thought is responsible for processing the information, and information influences one's emotions, behavior, and physiology in reliable, predictable ways.

An overview of CBT applications with children over the 1980s and part of the 1990s reveals a broad collection of techniques and strategies rather than a solid, data based, grounded theory. During this period, cognitive behavioral therapy with children constituted an umbrella term, encompassing different treatment techniques that were offered in many different sequences and permutations, precluding comprehensive meta-analysis. Reviews of the research literature emphasized the variety of interventions, definitions, assessments, and outcomes (Durlak, Fuhrman, & Lampman, 1991; Whalen, Henker, & Hinshaw, 1985). Most cognitive therapeutic work conducted with children either addressed one specific problem or made use of one specific technique, with a multitude of methods and strategies deriving both from behavioral therapy with children and from cognitive therapy with adults. Kazdin's (1988, 1994) meta-analysis of research conducted with children reported the application of more than 230 techniques to children, most of which were never studied or found effective. Kazdin (1998) emphasized the need to link assessment to theory and intervention, calling for the application of treatments shown to be effective.

Deficiency in application of CBT with children is also related to the inconsistent application of therapy. Kendall and Braswell (1993) stated that CBT with children is not restricted to one theoretical tenet or single-minded applied technique, but it rather consists of a set of interrelated strategies for providing new learning experiences. Nevertheless, at that time, only little work focused on developing broad-based assessment or treatment methods such as those existing for adults (Rossman, 1992). Indeed, this lack of a comprehensive theoretical model such as that existing for adult therapy continues to constitute the main deficiency of child CBT (Rossman, 1992). What is missing is a broad, general, integral theoretical model to assess and address childhood disorders as well as to provide a framework for evaluating the proposed techniques (Ronen, 1997).

New developments in CBT with children

Over the last decade, impressive progress has occurred in the application of CBT with children with the addition of developmental and cognitive information processing issues to child therapy (Crick & Dodge, 1994; Dodge & Pettit, 2003; Kazdin, 1998; Ronen, 1997, 2003). I believe this progress has resulted from several trends:

- The wish to provide a new theoretical framework for working with children.
- The notion of linking cognitive, emotional, social, and developmental components with information processing models and the basics of CBT with adults.
- The maturity of the theory, which is no longer afraid of being 'accused' of applying components similar to those typifying psychodynamic therapy (for example, talking about the role of emotions, the role of therapeutic relationships, and so on).

To emphasize the importance of the above features, each of them will be described and their contribution to CBT with children will be highlighted.

THE ROLE OF DEVELOPMENT IN CHILD THERAPY

Cognitive developmental features in child CBT

In the past, several authors stated that cognitive development is crucial for child therapy (Crick & Dodge, 1994; Kazdin, 1988). Childhood implies rapidly changing cognitive processes during development, which influence the child's understanding, actions, and responses toward himself or herself and toward the environment. These dynamic processes also influence the kinds of maladjusted behavior that children will develop as they grow up. Cognitive developmental components play an integral role in decision making about children's therapy throughout the entire course of intervention (Mash & Barkley, 1996; Mash & Dozois, 1996). At different ages and periods, the child holds a unique cognitive level of comprehension, which affects the way he or she construes a view of the self and of the world.

For example, cognitive development significantly impacts the child's ability to process information. As children grow, they improve in their acquisition of cognitive skills, experiential knowledge, attentional abilities,

and speed of processing (Crick & Dodge, 1994). Awareness about the child's cognitive level and its inherent strengths and limitations enables the therapist to design the treatment process and the techniques in a way that will appropriately meet the child's developmental needs (Knell, 1993; Ronen, 1997). For example, younger children exhibit a limited appreciation of time; therefore, distant goals and long-term benefits will seem incomprehensible, whereas short-term gratification and displeasure will be vivid in comparison, shaping the design of treatment objectives. Skills training with children also strongly depends on their cognitive developmental stage (Piaget, 1924; Ronen, 1997, 2001a,b). Older children in the early adolescent period (11-13 years) can learn to change automatic thoughts into mediated ones and to practice this skill, whereas young children (up to age 11) necessitate other communication modes to acquire skills. For instance, the therapist can talk about a commander and soldiers to help a young child understand the concept of changing the brain's command or can use a metaphor of bicycle riding or ladder climbing for improvement.

Piaget's (1924) classification of children's cognitive development into four stages can serve as a general guideline for therapeutic planning. In the sensory-motor stage (birth to 2 years), CBT is necessarily directed toward the child's environment. In the pre-operational stage (3 to 5 years), the child can benefit from individual therapy as long as the therapist uses symbolic language and concrete concepts and appeals to the child's nonlogical, subjective way of thinking. 'Experiential' therapy using drawing, painting, music, dancing, and so on could best suit the child's ability to learn. In the concrete operational stage (6 to 11 years), verbal therapy can now be applied, if based on the child's day-to-day life and experiences, not on universal concepts, notions, and rational arguments. In the abstract or formal operational stage (from age 12), verbal therapy can be seen as an interesting challenge; nonverbal therapy may even be insulting to the young person who wishes to be treated like an adult (Ronen, 1992, 1993a,b).

Furthermore, to optimally treat the child, the therapist should consider more than just the child's developmental ability to comprehend the disorder, its antecedents and consequences, the needed change, the techniques offered in treatment, etc. The therapist should also become sensitive to other developmental features such as the particular meaning of the disorder at that developmental stage and the most advantageous approach to the specific change needed in terms of the child's age

(especially when differing from the cognitive developmental norms), gender, and environmental variables. The following example illustrates these variables: A 7-year-old boy was sent to the principal's office after hitting another child who took his playing cards. When the teacher intervened and said "He didn't mean to do it," the hitting child shouted at her: "That's a lie." Developmentally-appropriate perceptions seemed to affect this boy's thoughts and behaviors. At the age of 7, children generally hold a rigid, extreme view of moral issues such as 'good' versus 'bad' or 'right' versus 'wrong.' For the hitting child, his own behavior was 'right' because his friend stole something from him, and thus the friend was the one being 'bad.' Environmental variables came into play because this child's family highly upheld values such as justice, truth telling, and honesty. Thus, the boy's construction of the event as a 'crime of theft' led to his conclusion that 'the thief should be punished,' and his strong reaction to the teacher's comment –"She's lying when she says he didn't mean it"– may have related to the family's emphasis on honesty.

The role of emotional stage

Almost a decade ago, Crick and Dodge (1994) referred to the role of emotions as another neglected aspect of therapy with children. Whereas some researchers view emotion as distinct from cognition (Gottman, 1986; Zajonc, 1980), others have argued that an integration of affect and cognition exists and that separation of affect from cognition actually signifies psychopathology (Greenberg & Safran, 1987). Nevertheless, both of these views emphasize the role of emotion, and, especially, of emotional development, as crucial for child cognitive behavioral therapy.

Today it is unimaginable to treat children without relating to their emotional stage as well as to their emotional needs. At different ages, children are capable of verbally expressing different kinds of emotions (Ronen, 2003). A young child aged 5 or 6 years can talk about being sad, happy, or angry, whereas older children aged 11 or 12 can already relate to feeling stressed, anxious, or worried.

Emotions are elicited through the development of attachment to significant figures, starting from the first few months of age, through the second year of life. Only after becoming attached to significant others can children develop a fear of strangers and separation protests (Schaffer, 1996; Vasta, Haith, & Miller, 1995). In the course of development,

children gradually learn to name emotions verbally and to identify various emotions. Later on, they can accept their own emotions and those of others. By the age of 11 years and up, children are already more likely to attribute emotional arousal to internal causes than to external events (Shirk & Russell, 1996; Thompson, 1989).

Determination of the child's affective stage of development (Davies, 1999; Schaffer, 1996) constitutes a prerequisite for any efficient treatment (Ronen, 1997; Shirk & Russell, 1996). The child may be at an early developmental stage, when support and clarification of emotions are most important, or the child may already understand complex emotions such as stress, anxiety, and ambivalence, thereby indicating a readiness to accept and live with constructive criticism.

The importance of observing and considering the child's emotional state relates to both the assessment and the treatment aspects of therapy. First, for assessment, the therapist should determine the child's capabilities for expressing, identifying, accepting, understanding, and controlling emotions. This information will help assess how a certain event (trauma, for example) may affect the child, what kind of response the child might exhibit, and what could signify the child's specific state of mind in this specific situation. Second, knowledge about the child's emotional development plays a vital role in applying therapy with the child. The child's emotional stage crucially shapes decision making about the kind of therapy that the child needs and about the most favorable means to achieve the therapeutic goals.

As an illustration, let us look at children of different ages who exhibit aggressive behavior. In treating a 4-year-old boy, the therapist's awareness of this age group's common problems and limited range of emotions may lead to a decision that the boy's aggression mainly reflects his attempt to manipulate the environment and obtain what he wishes. Therapy, therefore, would focus on supervising parents and teachers on how to control the child, using mainly behavioral techniques. At the age of 8, such a boy could already be expressing anger toward an older brother or parents. In this case, the therapist might relate the anger to the boy's angry feelings, which probably continue to be linked to what he wants and gets, and not to complex emotion-evoking conditions such as stress, sensitivity to rejection, and frustration. Therapy, therefore, should involve the child as well as the parents. It could focus on contracts and negotiations between the parents and their son, but should also focus on teaching him techniques for controlling himself, and for changing his angry behaviors

and feelings (for example, self-control techniques using self-talk for overcoming his wish to explode and delaying the temptation to hit). On the other hand, assessment of the emotions of a 15-year-old adolescent with aggressive behavior can pinpoint a high degree of hostile and negative feelings. The therapist may decide that this youngster's aggression relates to his negative thoughts toward the world and toward himself. Treatment, therefore, should focus directly on the youngster, using cognitive therapy to help him identify his automatic thoughts, become aware of internal cues and sensations, look at alternatives, change his automatic interpretations to mediated ones, and reduce his angry feelings and aggressive behaviors.

As can be seen, cognitive and emotional stages change the way therapists conceptualize a client as well as the way they treat a specific client. Emotion, therefore, can serve as a means for assessing what kind of disorders the child might develop, how severely a child might react to a specific event, what kind of therapy we need to apply, and what range of emotions, as well as the choice of techniques and methods for intervention we should consider (Ronen, 2001a,b).

An example can be drawn from our clinical research center for aggressive children, *Empowering Children and Adolescents*, affiliated with Tel Aviv University and founded by the author with the support of the Jewish Distribution Federation (JDC) community and the Pratt Foundation. Children were asked to draw their 'circle of emotions' and then draw the guard who decides which emotion should be let out and which should stay in. Most of the children painted a circle divided into several parts and called them love, anger, happiness, sadness. However, one child drew a grave where he buried himself, stating that his emotions were buried deep inside him. He also erected a tomb over the grave and wrote the date of his death. This severe and unusual reaction for a 10-year-old child helped us in assessing his particular emotional distress and in giving his emotions unique attention during intervention.

The role of social development

It is difficult to relate to child social maladjustment and socially problematic relationships without first focusing on children's normal social development. Social experiences and social interactions crucially influence the child's ability to become an integral part of society and to develop self-concept, self-identity, and self-control (Harter, 1983; Ronen, 2003). The

way the child behaves with peers, the way peers respond to the child, and what the child thinks about those responses all constitute central factors in determining the child's social self-perception. As they develop, children grow in their capacity to differentiate between self and others, not only as separate entities but also as having different subjective ways of coping and feeling. Both of these evolving processes are necessary in order to establish and conduct meaningful relationships (Schaffer, 1990, 1996).

The preschool years constitute a key period in children's social development. This period serves as a bridge between the egocentric toddler and the more socially adept and aware child of middle childhood (Davies, 1999). Social development is an outcome of the child's learning how to be social, how to take others' perspectives into account, and how to acquire social skills and prosocial behaviors and values. Experiencing peer relationships, attempting to become part of society, and needing to interact with others (through skills such as negotiation, situation analysis, and social skills) all constitute a significant part of this process. New circumstances and developmental change contribute to the need to develop social abilities (Davies, 1999). Schaffer (1996) claimed that children do not only learn from adults or obey adults' wishes. Children also make sense of what adults want from them and the requirements they are supposed to meet. The first sense a child makes of society derives from his or her own family. Some time over the second year of life, children begin to show interest in their social environment, demonstrating awareness of standards, violations of standards, and their own failures in meeting adults' expectation (Schaffer, 1996). Children's social development relates directly to their ability to develop acceptance and understanding of emotions, relationships with their own family, attachments, and language skill growth. Children learn about sharing, comforting, helping, controlling aggression, being empathetic, giving in, and negotiating first from their parents and later on from interacting with others.

Across the preschool years, children progress in their strategies for attaining goals in social situations. Young preschoolers may try to obtain what they want in ways similar to those toddlers employ. The development of new communication skills and new abilities for emotional understanding and social understanding allow for improvements in the development of prosocial goal setting, behavior, and skills (Davies, 1999).

As seen in the above discussion about preschoolers, identification of the child's social roles and social developmental stage can help the

therapist understand the child's needs. Forehand and Weirson (1993) suggested that children encounter different developmental tasks and develop different behaviors in each childhood period, requiring a specific treatment plan best suited to facilitating the new tasks and behaviors. The main developmental task of *infancy* comprises the shift from total dependence on the mother figure to a first step toward independence. It also comprises the first step in learning the society's role in life. Thus, problems in gaining initial achievements in autonomy during this period should be met with therapy in the form of parental counseling. The main developmental task of *early childhood* consists of developing skills in the academic and social domains; therefore, therapy should involve parents, teachers, and friends and should be directed toward educational-therapeutic assignments. Also, therapists of children in this period should start considering the role of society and peer relationships and should supervise the child in developing these basic social skills (Ronen, 2001a,b). The main developmental tasks to be mastered in *middle childhood to adolescence* entail self-identification and self-control, indicating that therapy during these periods should be directed toward the child himself or herself through individual treatment. In this period, social environment is very important for the child's development of prosocial thinking, and attributions are crucial for the child's behavior.

In both the assessment and the treatment of children, the understanding of social tasks and social developmental periods is crucial. For example, a worried mother's referral of her 3-year-old daughter because the preschooler has not yet developed social interactions with peers must be handled in light of social developmental norms. Children at age 3 may be interested in being among other children, but have not yet developed the ability to interact with peers, and often play near them and not with them. Thus, the reason for this referral does not justify treatment. The therapist, therefore, should supervise the mother, helping her to relax and develop realistic social expectations for her child. On the other hand, a similar referral by a mother of a 7-year-old child should stimulate questions about why the child is alone and why the child does not play with peers. It is important to know whether the child fails to employ basic skills because they were never learned, or whether the child's social difficulties stem from the childrearing practices of his/her social environment. For example, a family who traveled and moved the child to a new city each year may have thus prevented adequate opportunities for the child to apply such skills.

Therapy will vary in line with the child's social developmental period and current social skills. In the case of referral to therapy of a child who habitually employs undesirable social behaviors such as taking whatever he wants whenever he wants it without considering others' wishes, the therapist may attribute this behavior to the child's long-term experiences with aggressive peers or with rejection. Thus, the therapist may suggest the need to train the parents and to concurrently involve the child in a training program to reduce aggression. Different treatments would suit the child who is afraid of social situations, including exposure therapy to gradually accustom the child to being among peers.

At the age of 15, social isolation may already constitute a lifelong problem. In the future, as an adult, this individual may suffer from sensitivity to rejection, hostility, and antisocial behavior. Individual therapy should therefore focus on changing thoughts, emotions, and behaviors, while underscoring social values and training the child to participate actively in social life. As seen in these three case examples, assessment and treatment must consider the role of the family and aspects of cognitive, emotional, and social development.

An examination of the social aspect of children who evidence aggression reveals that it is almost impossible to separate these children's aggressive behavior from their social understanding and experience. For example, Dodge and Pettit (2003) found that exposure to aggressive peers at young ages could predict the child's later aggressive behavior. Also, children who had been rejected by peers over a period of 2 years were found to show aggressiveness (Dodge & Pettit, 2003; Laird, Jordan, Dodge, Pettit, & Bates, 2001).

Just as for cognitive development and emotional development, social development is directly linked to the way children develop their ability to process information. Children who show aggressiveness, for example, tend to be very selective and hostile in relating to their peers' cues. They attune to hostile cues, attribute hostile meaning to others' responses, and possess attribution biases that influence their information processing models (Crick & Dodge, 1994; Dodge & Pettit, 2003). Thus, cognitive, emotional, and social developments all directly influence information processing.

Information processing models

Over the last decade, burgeoning research and knowledge have emerged on information processing models with children. This knowledge elicits

the ability to understand children's normal behavior as well as maladjustment.

Kendall and Braswell's (1993) presentation of the basics of CBT emphasized the learning process and the influences of contingencies and environment. Kendall and Braswell (1993) underscored the centrality of cognitive mediational processes in children's learning. They stated that «the human organism responds primarily to cognitive representations of the environment rather than to the environment per se» (p. 2) and that these representations develop as children gain experience with various settings.

Dodge presented a model for understanding social information processing (Crick & Dodge, 1994; Dodge, 1986; Dodge & Pettit, 2003). According to this model, children go through four main steps before enacting competent social behavior. The first two steps comprise encoding of situational cues, and representation and interpretation of these cues. During these steps, children focus on and encode particular cues in the situation and, later on, based on these cues, they construct an interpretation of the situation. The next two steps are a mental search for possible responses to the situation, and selection of a response (Crick & Dodge, 1994). During these steps, children access possible responses to the situation from long-term memory, evaluate these responses, and then select the most pertinent one for enactment. The four-step model assumes that children possess limited capabilities and past experiences when facing a social situation (Crick & Dodge, 1994). Dodge's model successfully predicted children's social adjustment, and can be applied as a gradual model taught to children (Dodge, 1986). Bandura emphasized that the behavioral response is an outcome not only of the four steps but also of expectations and self-efficacy (Bandura, 1997).

This model contributes considerably to the treatment of children with aggressive behavior. For example, accessing of an aggressive response to provocation might occur not as a single function of the degree of peer hostility inferred by the child, but as a multivariate, contingent, and nonlinear aggregation of numerous factors (Crick & Dodge, 1994) including self-concept (Harter, 1983), expectation and self-efficacy (Bandura, 1997), some basic schemata (Alford & Beck, 1997), and various skills the child possesses (Ronen, 2003).

The role of family environment

CBT has always focused on treating the child within the natural environment. However, new trends in CBT (Ronen, 2003) focus not only

on parents as agents of change for the child, but also on parents as one of the most important features (together with the cognitive, emotional, and social components) responsible for the child's learning and normal development, as well as for the child's ability for change. We cannot refer to all of the aforementioned features for child intervention without discussing parents. Parents comprise the child's chief environment, role models, and direct trainers. Research points to the link between parents' problems and those of their children. This link can be seen, not only in terms of the history of problems and frequency of disorders, but also in terms of belief systems and behavioral development (Perris, Arrindell, & Eismann, 1994). Research outcomes, for example, have presented a link between parents' self-control and children's self-control and have also linked lack of self-control among parents to a high frequency of disorders among children (Ronen, 2001b, 2003).

In the past, most therapeutic techniques involving parents focused either on parents' supervision and guidance (Patterson, 1975, 1982; Webster-Stratton, 1982, 1993, 1994), or on family therapy (Foster & Robin, 1988). Nowadays, in applying CBT, I tend to treat the child in the presence of his or her parents, wishing parents to be part even of the child's individual therapy. The aim is for parents to learn from observing the way the therapist talks with the child, to learn the proper concepts and language and issues to be related to in day-to-day life, and to participate in discussion and negotiation with the child (Ronen, 1997, 2001b, 2003).

Up to now several major issues related to developmental considerations have been highlighted: cognitive development, emotional development, social development, information processing, and family environment. Linking all of these issues together enables us to devise a new broad theoretical and applicable model for the effective treatment of children.

Skills-directed therapy

The above description focused on the need for skills training to be applied to children, as well as on the view that therapy is a process of integrating all the above features.

Cognitive behavioral therapy with children should be a structured, time limited, and problem oriented intervention. Therapy aims at modifying faulty information, identifying distorted cognitions, identifying maladaptive assumptions, and increasing awareness of internal stimuli. These aims

target one or more goals of referral: decreasing a behavior, increasing a behavior, removing anxiety, and/or facilitating developmental processes.

Cognitive behavioral therapy combines seven features (Rosenbaum & Ronen, 1998):

1. *Meaning making processes.* Problems are partly determined by the way people construe their experiences (Kelly, 1955). Individuals assign various positive and negative meanings to their experiences according to their basic schemata and their belief systems. The meaning making process is influenced by continuous interactions between behaviors, emotions, and cognitions.

2. *Systematic and goal-directed therapy.* The most distinguishing feature of CBT is its systematic and goal-directed approach to therapy (Beck, 1963). The systematic approach is expressed in how the treatment is planned as well as in how the therapeutic hour is structured (Kanfer & Schefft, 1988).

3. *Practicing and experiencing.* CBT is not just 'talking therapy'. Its accent lies on practicing new behaviors and on experiencing new experiences as part of the change process.

4. *Collaborative effort.* Because the CBT client must perform a multitude of behavioral tasks inside and outside the therapeutic session, genuine therapist-client collaboration is imperative for a successful outcome (Beck, 1963). Therapist and client are expected to join forces in defining the goals of therapy, selecting the strategies and techniques to reach these goals, and assessing and evaluating progress.

5. *Client-focused therapy.* CBT opposed the traditional "medical model", with its emphasis on treating "diagnoses" rather than people, because each person has his or her unique enormous history of reinforcement.

6. *Focus on the role of therapist as a facilitator of the change process.* The planned and goal-directed character of CBT induces the therapist to assume greater influence over the detailed conduct of the treatment sessions and more responsibilities for the outcome of treatment than in more psychodynamically oriented therapies.

7. *Empowerment and resourcefulness.* In CBT, a main goal is empowering clients with the resources and the skills to change themselves, and this is emphasized throughout the whole process of therapy.

Six basic thinking rules characterize the skills treatment to be applied to children (Kanfer & Schefft, 1988):

1. *Think behavior* – instead of thinking about diagnosis, pathology, or interpretations.

2. *Think solution* – and focus on the way to solve problems rather on the way to just interpret them.

3. *Think positive* – and highlight one's resources and skills.

4. *Think in small steps* – not only on the one, large, final goal (small steps are easier to achieve).

5. *Think flexible* – and try to apply the best technique for each disorder.

6. *Think future* – and focus on what you wish to change rather than on the past and what was wrong then.

Skills-directed therapy focuses on asking ourselves: What skills is the child lacking? What skills should the child apply in order to help overcome the specific disorder? What is the best way to provide the needed skills to the child?

We studied and applied this skills-directed therapy model in our research clinic for aggressive children and their families, within the ongoing *Empowering Children and Adolescents* project that started 3 years ago. This project, which operates in the Bob Shapell School of Social Work at Tel Aviv University, Israel, was founded to establish a clinical research center for studying and treating children with aggressive behavior and for training professionals in this area. Its major aims include the following: (a) Designing and producing a cognitive-constructivist manual-based intervention for aggressive behavior. (b) Applying evidence-based intervention for children to reduce their aggressive behavior and increase their self-control skills. (c) Evaluating the effectiveness of involving third-year bachelor students of social work (BSW) in the project.

As part of the project, the BSW students received theoretical courses in their regular academic curriculum relating to child therapy, treating aggression, and group therapy. Also, they participated in training to treat children who exhibit aggressive behavior. Students' training emphasized the need to systematically assess children's progress and employ goal directed elements as integral components of ongoing group intervention processes, following the self-control model that was developed by the author. The students conducted a group intervention for such children as part of their regular fieldwork. Students worked with a structured manual, but they were involved in updating it, adding exercises they found to be effective and changing material that they thought was ineffective in their groups. In line with their training, the students also employed various techniques to assess children's progress in the groups. In addition, they participated in the process of evaluating the children and their parents and

teachers, and of evaluating the intervention outcomes. Overall, the training aimed at helping students appreciate the importance of using evidence-based intervention in social work.

The empowering children intervention model incorporated all of the aforementioned components considered necessary for an integrative therapeutic approach to children:

The *cognitive* developmental model influenced our design of the intervention as a learning course for the children. It also influenced the inclusion in our manuals of methods based on imagery, metaphors, exercises, drawing and sculpturing, which all served to adapt the intervention to children's ability to understand the treatment concepts (e.g., self-control).

The role of *emotion* was emphasized in our interventions with aggressive children by pinpointing the children's ability to express, identify, accept, understand, and control emotions. We worked directly toward those goals, teaching children and training them in the needed emotions and practicing the skills in the group interventions.

The *social* development model influenced our decision, first of all, to work with children in groups and to target the social interaction in vivo, and secondly, to introduce features of social values, prosocial values, and social skills training into our training programs.

The *information processing* model is reflected in our training program by our work targeting the child's ability to look at an event, interpret and encode it, search for alternatives, and try to apply the learning process.

We emphasized the role of parents by designing parent supervision groups. Parents of each of the involved children participated in a parent group and underwent a similar program, referring first of all to themselves and how they can acquire skills and then to their children and how to educate their children using appropriate skills. The self-control model that will be presented next is one example of skills-directed therapy. We also applied other skills-directed therapeutic models such as social skills training and emotional skills training.

Self-control intervention model (SCIM)

In one of his latest studies, Bandura (Bandura, Caprara, Barbaranelli, & Pastorelli, 2001) suggested that self-efficacy and self-control skills comprise the most important factors predicting adjustment in children. Relating to aggressiveness, Bandura and his colleagues proposed that

three areas of necessary self-control and self-efficacy skills can prevent the child from becoming transgressive: involvement in school, involvement in social relationships, and development of personal skills. Ronen and Rosenbaum (2001) recently developed the self-control intervention model (SCIM), which applies the self-control intervention developed by Ronen to treat various children's disorders (Ronen, 1993a,b, 1997, 2003). The model aims at imparting children with both self-control skills and also self-help methods to facilitate their future independent functioning. Enhancing children's self-help skills enables them to maintain treatment outcomes, continue treating themselves in daily life after successfully being treated by the therapist, generalize and transfer their basic learning, and facilitate self-change. The SCIM contains four modules:

1. Cognitive restructuring. This module aims at teaching the child that a certain behavior can be changed and that, like many other kinds of behavior, this change depends on the child (Beck, 1963; Beck et al., 1985, 1990). The therapist elicits cognitive restructuring by increasing children's self-efficacy about their ability to achieve change (Bandura, 1997), as well as by utilizing redefinition, changing attributional styles, and reframing the child's present functioning (Beck et al., 1985; Kanfer & Schefft, 1988; Meichenbaum, 1979). The techniques used include Socratic questions and paradoxical examples.

2. Problem analysis. This module trains the child to observe the link between brain, body, and final problematic behaviors. The therapist teaches the child to notice the links between thoughts, emotions, and behaviors and to learn the link between cause and effect (Beck et al., 1985; Ronen, 1997). The therapist uses rational analysis of these processes, employs written materials and anatomical illustrations of the human body, and helps the child accept responsibility for behaviors by learning to change the commands of the brain. The child practices identifying automatic thoughts and using self-talk and self-recording to change unmediated thoughts into mediated ones.

3. Attention focus. This module aims to increase the child's awareness of behavior and internal stimuli, raise sensitivity to the body, and particularly help in learning to identify internal cues related to the specific problem (Bandura, 1997; Mahoney, 1991, 1995). The therapist uses relaxation, concentration, and self-monitoring to promote achievement of these targets.

4. Self-control practice. This module trains the child in self-control techniques such as self-talk, self-evaluation, self-monitoring, thinking aloud, and problem solving skills (Barrios & Hartman, 1988; Brigham,

Hopper, Shaw, & Emery, 1979; Ronen, 1997). In the first stage of general skills training, the therapist assigns various kinds of practicing. Practice includes using self-instruction, both in the sessions and in homework assignments, to overcome disappointments. Through practice, the child learns that as confidence grows, the chances for success also increase (Bandura, 1997). The self-control techniques taught via this module for changing automatic behaviors to mediated ones include physical as well as emotional exercises such as resisting temptation, self-talk, self-reward, problem solving, and the use of imagery exercises (Meichenbaum, 1979; Ronen, 1997).

We apply the model both as individual therapy and as small group courses in our empowerment project conducted at the university by social work students. The children's groups participate in a 12-session course containing children who are homogenous in terms of age and problems. Each 75-minute session presents new knowledge and combines demonstrations, practice, discussion, and homework assignments. During this course, children learn what a behavior is, how to look at their aggression as a behavior, how their behavior is connected to their thoughts and emotions, what kinds of techniques can help them change their behavior, and so on. They learn to assess, evaluate, and plan the change process; they establish criteria and expectations for change; they learn to observe, evaluate, and reinforce themselves; finally, they learn to identify their internal cues and to replace automatic thoughts with mediated ones.

Preliminary outcomes from the first two years of conducting the treatment course in small children's groups reveal a very high percentage of change. That is, children attending these groups significantly improved their self-control skills and significantly reduced their aggressive behavior according to children's, parents', and teachers' assessments. The treatment showed a very low dropout rate and a very high rate of maintaining treatment outcomes at the 1-year follow up. There are good reasons to believe that this success can be attributed to our integration of the following components:

1. A *developmental approach* blending cognitive, emotional, and social developmental issues with children's information processing models.
2. A *family approach* that emphasized relationships between the child and the family and designed contracts about the involvement of each.
3. A *theoretical grounding* that integrated the basics of cognitive therapy with information processing models and self-control interventions.
4. *Cognitive constructivist techniques* both for verbal and nonverbal intervention modes.

Thus, learning was pre-designed and gradual, including training and applications, and integrated into one systematic self-control intervention.

SUMMARY

This paper presented the main components of CBT with children, integrating cognitive, emotional, and social developmental elements. CBT constitutes an educational therapeutic intervention that is characterized by a nonstop process of making decisions about the optimal treatment for the specific client, with the specific problem, during the specific period of development, in the specific environmental context.

The difficulties in applying CBT lie in the fact that the treatment necessitates the client's active participation. It is very difficult to treat someone who is not interested in learning or changing. Such clients necessitate significantly more effort to develop and maintain motivation. Kanfer and Schefft (1988) stated that everyone is motivated, and that it is our responsibility as therapists to find out what they are motivated toward, and to develop and work toward increasing that motivation.

The advantages of CBT lie in its ability to relate to all areas of human functioning –human thoughts, emotions, and behaviors. It enables adaptation and adjustment of the treatment to the individual client, couple, family, or group. Another advantage of the model lies in its aim to empower clients and develop self-control and self-help. CBT looks for and increases clients' support systems, strengths, and resources and helps them to help themselves.

REFERENCES

Alford, B. A., & Beck, A. T. (1997). *The integrative power of cognitive therapy*. New York: Guilford.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.

Bandura, A., Caprara, G. V., Barbaranelli, C., & Pastorelli, C. (2001). Sociocognitive self-regulatory mechanisms governing transgressive behavior. *Journal of Personality and Social Behavior, 80*, 125-135.

Barrios, B. A., & Hartman, D. P. (1988). Fears and anxieties. In E. J. Mash & L. G. Terdal (Eds.), *Behavioral assessment of childhood disorders* (2nd ed., pp. 196-262). New York: Guilford.

Brigham, T. A., Hopper, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Beck, A. T. (1963). Thinking and depression. *Archives of General Psychiatry, 9*, 324-333.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias*. New York: Basic Books.

Beck, A. T., Freeman, A., & associates. (1990). *Cognitive therapy of personality disorders*. New York: Guilford.

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

Davies, D. (1999). *Child development: A practitioner's guide*. New York: Guilford.

Dodge, K. A. (1986). A social information processing model of social competence in children. In M. Perlmutter (Ed.), *The Minnesota symposium on child psychology* (Vol. 18, pp. 77-125). Hillsdale, NJ: Erlbaum.

Dodge, K. A., & Pettit, G. (2003). A biopsychosocial model of the development of chronic conduct problems in adolescence. *Developmental Psychology, 39*, 1-41.

Durlak, J. A., Fuhrman, T., & Lampman, C. (1991). Effectiveness of cognitive-behavior therapy for maladaptive children: A meta-analysis. *Psychological Bulletin, 110*, 204-214.

Forehand, R., & Weirson, M. (1993). The role of developmental factors in planning behavioral intervention for children: Disruptive behavior as an example. *Behavior Therapy, 24*, 117-141.

Foster, S. L., & Robin, A. L. (1988). Family conflict and communication in adolescence. In E. J. Mash & L. G. Terdal (Eds.), *Behavioral assessment of childhood disorders* (pp. 717-775). New York: Guilford.

Gottman, J. M. (1986). Merging social cognition and behavior. *Monographs of the Society for Research in Child Development, 51*(2, serial no 213).

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy*. New York: Guilford.

Harter, S. (1983). Developmental perspectives on the self-system. In P. H. Mussen (Series Ed.) & E. M. Hetherington (Vol. Ed.), *Handbook of child psychology: Vol. 4. Socialization, personality, and social development* (pp. 275-386). New York: Wiley.

Kanfer, F. H., & Schefft, B. K. (1988). *Guiding the process of therapeutic change*. Champaign, IL: Research Press.

Kazdin, A. E. (1988). *Child psychotherapy: Development and identifying effective treatments*. New York: Pergamon.

Kazdin, A. E. (1994). Methodology, design, and evaluation in psychotherapy research. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 19-71). New York: Wiley.

Kazdin, A. E. (1998). Psychosocial treatments for conduct disorder in children. In D. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 65-89). New York: Oxford University Press.

Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.

Kendall, P. C., & Braswell, L. (1993). *Cognitive behavioral therapy for impulsive children* (2nd ed.). New York: Guilford.

Knell, S. M. (1993). *Cognitive behavioral play therapy*. Northvale, NJ: Jason Aronson.

Laird, R. D., Jordan, K., Dodge, K. A., Pettit, G. S., & Bates, J. E. (2001). Peer rejection in childhood, involvement with antisocial peers in early adolescence, and the development of externalizing problems. *Development and Psychopathology, 13*, 337-354.

Mahoney, M. J. (1991). *Human change processes*. New York: Basic Books.

Mahoney, M. J. (1995). Continuing evolution of the cognitive sciences and psychotherapies. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 39-67). Washington, DC: American Psychological Association.

Mash, E. J., & Barkley, R. A. (Eds.). (1996). *Child psychopathology*. New York: Guilford.

Mash, E. J., & Dozois, D. J. A. (1996). Child psychopathology: A developmental-systems perspective. In E. J. Mash & R. A. Barkley (Eds.), *Child psychopathology* (pp. 3-60). New York: Guilford.

Meichenbaum, D. H. (1979). Teaching children self-control. In B. Lahey & A. Kazdin (Eds.), *Advances in clinical child psychology* (Vol. 2, pp. 1-30). New York: Plenum.

Patterson, G. R. (1975). *Families: Applications of social learning to family life*. Champaign, IL: Research Press.

Patterson, G. R. (1982). *Coercive family process: A social learning approach*. Eugene, OR: Castalia.

Piaget, J. (1924). *The language and thought of the child*. London: Routledge & Kegan Paul.

Perris, C., Arrindell, W. A., & Eisemann, M. (1994). *Parenting and psychopathology*. Chichester, UK: Wiley.

Powell, M. B., & Oei, T. P. S. (1991). Cognitive processes underlying the behavior change in cognitive behavior therapy with childhood disorders: A review of experimental evidence. *Behavioural Psychotherapy, 19*, 247-265.

Ronen, T. (1992). Cognitive therapy with young children. *Child Psychiatry and Human Development, 23*, 19-30.

Ronen, T. (1993a). Adapting treatment techniques to children's needs. *The British Journal of Social Work, 23*, 581-596.

Ronen, T. (1993b). Decision making about children's therapy. *Child Psychiatry and Human Development, 23*, 259-272.

Ronen, T. (1997). *Cognitive developmental therapy with children*. Chichester, UK: Wiley.

Ronen, T. (2001a). Cognitive-behavioural therapy. In M. Davies (Ed.), *The Blackwell companion to social work* (2nd ed., pp. 165-174). Oxford, UK: Blackwell.

Ronen, T. (2001b). Collaboration on critical questions in child psychotherapy: A model linking referral, assessment, intervention, and evaluation. *Journal of Social Work Education, 1*, 1-20.

Ronen, T. (2003). *Cognitive constructivist psychotherapy with children and adolescents*. New York: Kluwer/Plenum.

Ronen, T., & Rosenbaum, M. (2001). Helping children to help themselves: A case study of enuresis and nail biting. *Research in Social Work Practice, 11*, 338-356.

Rosenbaum, M., & Ronen, T. (1998). Clinical supervision from the standpoint of cognitive-behavioral therapy. *Psychotherapy, 35*, 220-229.

Rossman, B. B. R. (1992). School-age children's perceptions of coping with distress: Strategies for emotion regulation and moderation of adjustment. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 33*, 1373-1397.

Schaffer, H. R. (1990). *Making decisions about children: Psychology questions and answers*. Oxford, UK: Blackwell.

Schaffer, H. R. (1996). *Social development*. Oxford, UK: Blackwell.

Shirk, S. R., & Russell, R. L. (1996). *Change process in child psychotherapy*. New York: Guilford.

Thompson, R. A. (1989). Causal attributions and children's emotional understanding. In C. Saarni & P. L. Harris (Eds.), *Children's understanding of emotion* (pp. 117-150). New York: Cambridge University Press.

Vasta, R., Haith, M. M., & Miller, S. A. (1995). *Child development: The modern science* (2nd ed). New York: Wiley.

Webster-Stratton, C. (1982). Teaching mothers through videotape modeling to change their children's behavior. *Journal of Pediatric Psychology, 13*, 702-714.

Webster-Stratton, C. (1993). Strategies for helping early school-aged children with oppositional defiant and conduct disorders: The importance of home-school partnerships. *School Psychology Review, 22*, 437-457.

Webster-Stratton, C. (1994). *Trouble families – problem children. Working with parents: A collaborative process*. Chicester, UK: Wiley.

Whalen, C. K., Henker, B., & Hinshaw, S. P. (1985). Cognitive-behavioral therapies for hyperactive children: Premises, problems, and prospects. *Journal of Abnormal Child Psychology, 13*, 319-410.

Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist, 35*, 151-175.