Introduction

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The first edition of this book was published in 1998. It arose from a realisation that, despite the gradually increasing use of cognitive behaviour therapy (CBT) by child psychologists and psychiatrists, there was no systematic account of its use with children and families. The second edition appeared in 2005 at a time when it was becoming clear that the use of CBT with the young was unlikely to be a passing fashion but was here to stay (Graham, 2005). This third edition marks the establishment of CBT as the mode of therapy indisputably the best supported by scientific evidence for the majority of the conditions with which children and adolescents present to mental health services. The official national curriculum for the major British government NHS initiative ‘Children and Young People’s Improving Access to Psychological Therapies’ (Department of Health, 2011) prescribes the use of CBT for anxiety and depressive states and encourages interventions with a CBT rationale for both conduct disorders and parent education. Further, as the international representation of the contributors to this book illustrates, CBT is flourishing worldwide, at least in the developed world. Strong innovative clinical and research activities in the field have come over recent years from the USA and Australasia as well as from many continental European countries.

The development of the CBT field over the past 15 years has drawn both on previously established traditions in psychology and psychiatry and on new trends in academic studies and clinical work. The need for a ‘therapeutic alliance’ in successfully engaging with children and their families, described by Boege and Ougrin in Chapter 5, resonates strongly with much earlier psychoanalytic ideas. When these authors refer to the ‘relational bond between the therapist and the young person which binds the therapist and the young person together against the pain and vicissitudes of therapy’, one is inevitably reminded of the concept of transference though of course there are significant differences. In contrast, the approaches to the treatment of anxiety and phobic states described in Chapters 15 and 17 still retain a distinct element of behaviourism in their emphasis on desensitisation. Response prevention in the treatment of obsessive-compulsive disorders as described by Clark and Reynolds in Chapter 18 is similarly derived from behaviourist principles. Drawing again on earlier clinical approaches, the introduction of systemic ideas into a CBT formulation of clinical problems, as described by Dummett in Chapter 6, resonates with the family therapy tradition established in the 1970s. In all these cases, as the chapter authors describe, a cognitive component has been incorporated into the pre-existing approach to achieve greater effectiveness.
But there is another tradition in psychology to which CBT has remained faithful in more than one way. Those engaged in the evaluation of therapy are still guided by the principle that it is through the falsification of hypotheses that knowledge advances (Popper, 1959). The randomised controlled trial (RCT) approach (described by Wolpert, Fugard and Deighton in Chapter 4) to evaluating a new intervention aims to disprove that it is superior to existing methods. If there is a failure to disprove this hypothesis then evidence exists that the new method offers a promising way forward. But this can only be a temporary advance in knowledge until the findings from another study show that even this newly gained knowledge needs to be revised or modified. Further, falsificationism permeates many CBT techniques. Socratic questioning, for example, requires clients to think critically of the beliefs they hold that may be maintaining their symptoms. Such questioning encouraging scepticism in the client is central to the CBT approach to delusions in schizophrenia as well as to the cognitive elements engaged in subverting the irrational elements of anxiety, depressive and eating disorders. Karl Popper’s continuing influence in clinical child psychology and psychiatry has indeed been under-estimated (Graham, 2013).

Moving forward from traditional psychological theories, researchers have, over recent years, begun to investigate the neuroscientific and genetic basis for the changes brought about by CBT. For example, preliminary studies with adults have suggested that, when adults with obsessive-compulsive disorder were compared with controls, significant therapy-specific changes in normalised regional glucose metabolism were seen after brief, intensive CBT (Saxena et al., 2009). Porto et al. (2009) have shown, again in adult patients with anxiety disorders, that CBT modified the neural circuits involved in the regulation of negative emotions. Neuroimaging studies have thus revealed that CBT can indeed change dysfunctions of the nervous system. Very little neuroscientific work of this nature has been carried out in children and adolescents. However in Chapter 15, Newall and her colleagues describe how, by examining the association between treatment response and the serotonin transporter gene promoter region (5HTTLPR), it may become possible to use genetic information regarding the allele configuration of anxious children as a tool to inform treatment choices. In a similar vein, in Chapter 2, Lau, Hilbert and Gregory describe how associations between the serotonin transporter gene variant and increased neural responses to the appraisal of fear in anxious and depressed adolescent patients have been identified. As they say, these findings will need to stand the test of replication in larger samples before they can be regarded as established, but the approach appears promising.

In more adventurous fashion, CBT researchers have been breaking hitherto untouched ground in applying new approaches and new technologies to the treatment of mental health problems in children and adolescents. These are outlined in Section 7 of this book. In Chapter 22, Turner and Krebs describe how more economic use of precious therapist time can be made by the use of ‘low-intensity’ methods of implementing CBT such as supervised self-help, running groups rather than relying on individual treatment, and delivering therapy by phone rather than face to face. In Chapter 23, Donovan, Spence and March describe how computer-based delivery of CBT has been applied in a variety of disorders, and in some cases shown to be of equal or superior efficacy than face to face methods. Given the increasing ease with which children and adolescents are outpacing their elders in the use of such technology, it is likely that such approaches will, in the future, have greater application in the young than in older clients.

The plethora of so-called third-wave CBT approaches is encroaching strongly on the adult field. These approaches consist of a loose affiliation of various CBT therapies
including: acceptance and commitment therapy (ACT), mindfulness-based cognitive therapy (MBCT) and dialectical behaviour therapy (DBT). In Chapter 24, Bögels, de Bruin and van der Oord describe preliminary work using mindfulness training applied, for example, to parents of children with autistic spectrum disorder and to adolescents with anxiety states. The cognitive limitations of younger children described by Stallard in Chapter 3 would suggest that these methods might have less applicability in the younger age groups. Even with this age group however, the evidence for the effectiveness of trauma-focused CBT as described by Trickey in Chapter 16, while requiring considerable competence in what might well be regarded as introspective mindfulness, is reasonably strong. The flexibility of CBT, even with young people who lack theory of mind (or mindfulness), is illustrated by the successful use of CBT with children who have autistic spectrum disorders as described by Wood and Schwartzman in Chapter 13. Much of this flexibility involves the use of parents in therapy with their child and, in Chapter 7, Creswell, Cartright-Hatton and Rodriguez describe a range of methods and techniques for delivering CBT to children through, and in collaboration with, their parents.

Now that CBT has acquired a dominant position among the so-called 'talking therapies' it has inevitably become a target for criticism. The label of 'reductionist' has been attached to it in hostile fashion. In fact, all constructions of the human mind inevitably and indeed appropriately reduce the complexity that governs our behaviour. The important principle was formulated by Einstein when he wrote 'everything should be as simple as it is, but not simpler'. The need to avoid over-simplicity is particularly important in relation to the use of questionnaires which, while having their uses for screening purposes, are no substitute for dialogue in assessment and therapy. It would indeed be regrettable if CBT formed part of the tick-box culture that pervades so much of our lives.

Interestingly, perhaps because of its dominant position in psychology, CBT has become a target attacked by novelists, psychologists' main competitors in the understanding of the vagaries of human behaviour. In 1923, D. H. Lawrence wrote that psychoanalysis was in danger of becoming a 'public danger'. James Joyce referred mockingly to Freud and Jung as the 'Viennese Tweedledee and the Swiss Tweedledum' (Gilbert, 1957). In 2011, no less a novelist than Ali Smith in her novel There But For The ... depicts Jen, the most unsympathetic character in her book, shouting at another woman in tears at a dinner party that six sessions of CBT would 'sort her out' (p. 156). Jen 'shouts it like a mad person, and she shouts it over and over, until she has said it about six times'. In a laudatory review of a book by a contemporary psychoanalyst, Jacqueline Rose refers derisively to CBT. She praises Smith for having conveyed in her novel that 'there is something mad about a form of therapy whose vocabulary – get a grip, get CBT – possesses such frantic conviction' (Rose, 2011).

It would indeed be madness for CBT therapists to regard their approach as a panacea for all mental health problems. It is, at the moment, the intervention for mental health problems most strongly supported by the evidence. Further, in some forms of disorder, especially anxiety states and obsessive-compulsive disorder, the failure to use it might be regarded as a valid reason to sue for negligence. But the findings from the controlled trials make it clear that in most situations, while producing improvement, it by no means provides a cure, if indeed cure is an appropriate concept to use in relation to mental disorders. Further, some of the improvement obtained with the use of CBT is probably attributable to the non-specific effects of the therapy, especially of the therapist–client relationship (McQueen & Smith, 2012). It is for this reason that it is so important that
research activity, especially in the refinement of clinical methods and in scientific evaluation, is increased in future years. In the final chapter in this book we point to what seem to us to be the most promising directions such research might take.

References


