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Processes for Systemic Cognitive-Behavioural Therapy with Children, Young People and Families

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Abstract. In cognitive-behavioural therapy with children, young people and families, formulation-based practice ensures that interventions are based on underlying causative and maintaining processes. Importantly, however, developmental, attachment, family, systemic and other perspectives must be incorporated into therapy. This paper describes a template for systemic cognitive-behavioural formulation that facilitates incorporation of the necessary range of perspectives including processes more traditionally expressed through other psychotherapeutic modes of working. Case formulation based on this template is sufficiently comprehensive, yet simple enough to derive collaboratively and leads to a distinct clinical process for working with individuals, families and wider support systems. This generic formulation process is appropriate for use across the range of presentations encountered in child and adolescent mental health practice and provides a structure for therapist training. It requires formal evaluation and has implications for future research.

Keywords: Cognitive-behavioural therapy, systemic, case formulation, children, young people, family.

Introduction

Formulation-based practice of CBT involves an empirical process of self-discovery that ensures that interventions are based on underlying causative and maintaining processes (Persons, 1989). Despite the lack of theoretical models explaining the development of pathological cognitions in children (highlighted by Stallard, 2002), this is also the case working with children, young people and families. In the past, failure to appreciate the need for formulation has led to a wide variety of interventions (often purely behavioural or manual-based) being labelled "cognitive behavioural therapy for children" (Graham, 1998) and leading the BABCP Child Special Interest Branch (2002) to re-emphasize that therapy should be based on a collaboratively derived case formulation.

For many years, a key problem in application of CBT with children, young people and families has been the lack of a pragmatic and user-friendly generic formulation process to integrate other important (particularly interpersonal) perspectives such as attachment, family, wider systems, cultural, developmental factors, intrinsic difficulties and biological factors into therapy. There is an extensive evidence base (reviewed in Joughin and Shaw, 2000;

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Fonagy, Target, Cottrell, Phillips and Kurtz, 2002) for the efficacy of child and adolescent mental health interventions addressing systemic factors in general and particularly for the efficacy of systemic interventions in augmenting benefits of individual CBT in this age range (Barrett, Duffy, Dadds and Rapee, 2001; Mendlowitz et al., 1999; Toren et al., 2000). Models incorporating systemic factors into CBT have been proposed in the past for one or two specific childhood and young adulthood presentations, for example eating disorders (Fairburn, Shafran and Cooper, 1999), but not for more universal use with a wide range of presenting conditions. A number of early attempts at predominantly cognitively-based generic family formulation models (Schwebel and Fine, 1992; Smith and Schwebel, 1995) helpfully focused on underlying family-related schemas held by family members. They did not, however, incorporate all of the other (affective, physiological and behavioural) components that are fundamental to cognitive-behavioural formulation.

This paper describes a systemic cognitive-behavioural formulation template and process that aims to accommodate the necessary range of perspectives, yet be simple enough for everyday collaborative working with individuals, parents and carers, families and supporting networks. These templates have evolved from the authors' clinical experience over many years. The process of development has involved the employment and empirical evaluation of formulation processes on a case by case basis, directly with individuals and families, in communication with other agencies (the "wider system") and in supervision and training of therapists. The templates are designed to be applicable across a wide range of clinical situations, so as to be suitable for generic use throughout Child and Adolescent Mental Health Services (CAMHS). Clinical experience and feedback from young people, families, colleagues and trainees suggest that this formulation process opens up new ways of working and allows the therapist and client(s) together to tailor interventions to suit the child or young person in their family and wider system context.

The systemic cognitive-behavioural formulation template

The structure (Dummett, 2003) for the systemic cognitive-behavioural formulation template (Figure 1) is theoretically derived. It is based on the Beckian Cognitive Model (Beck, Rush, Shaw and Emery, 1979) and the traditional "four systems" (cognitive, affective, behavioural and physiological) of response (Rachman, 1978) within a context that identifies systemic (family and wider interpersonal, social and cultural) factors. This is in line with the "five areas" approach described by Williams (2001), which also incorporates relationship and environmental factors and has been demonstrated to be acceptable to a wide range of practitioners (Williams and Whitfield, 2001). The systemic context (see Figure 1) is represented around the child or young person's central individual formulation by the genogram (representing family members). Ideas of proximity are incorporated by asking the child/young person and/or family to "sculpt", or decide the positioning of key relationships and individuals. Cultural influences (e.g. culturally condoned emotions or behaviours or cultural values, illness models or expectations) are listed in the formulation, in the surrounding environment or as cognitions of key individuals (if articulated as an account of their own thinking). Major life events for the central child or young person are listed chronologically on a time-line (from bottom upwards). Life events are subdivided into: early events (0–5 years and any key antenatal issues), later events (over 5 years), recent events (since onset of symptoms or distress) and present situational triggers (including practical problems and present stresses within the

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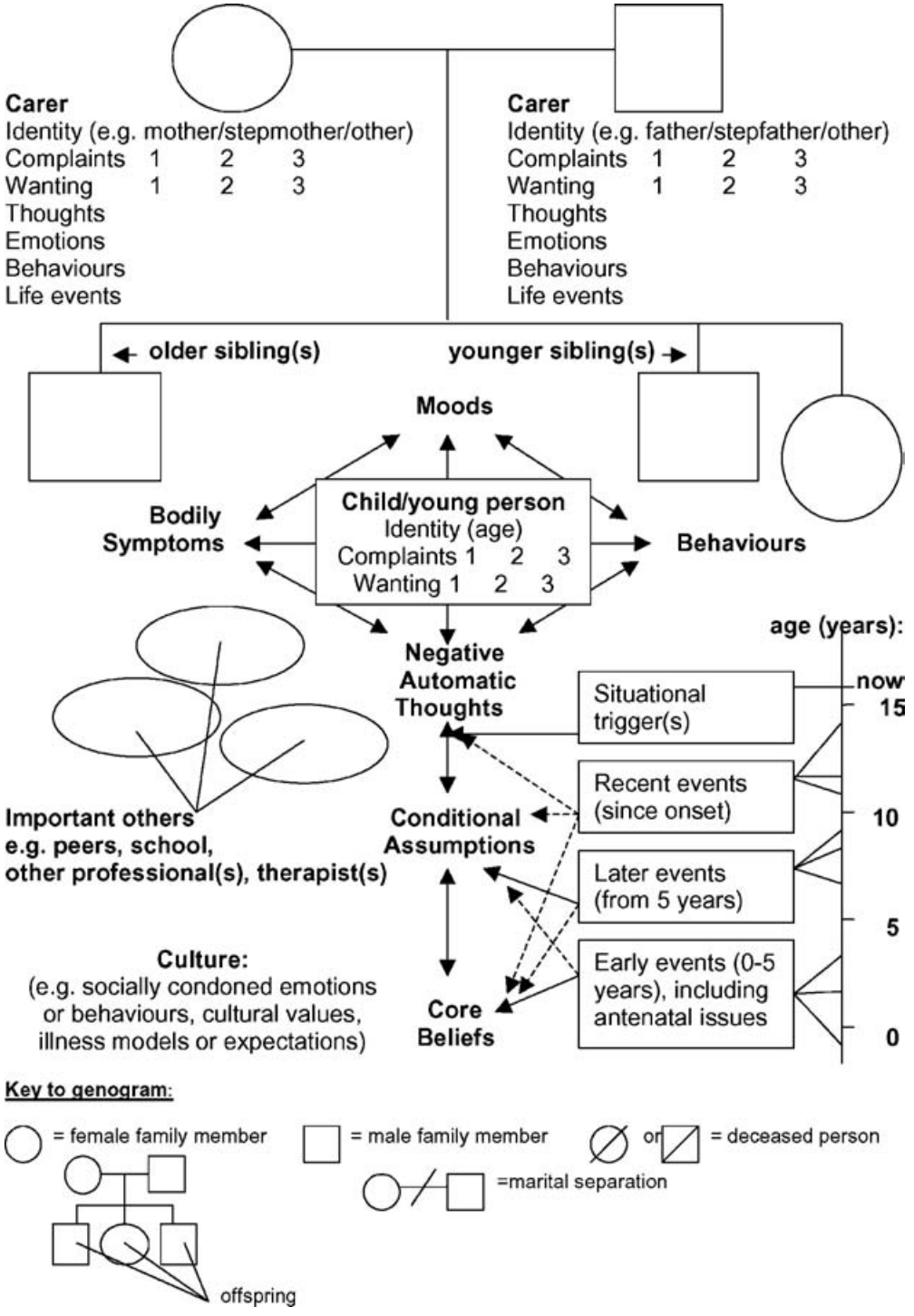


Figure 1. Systemic cognitive-behavioural formulation template

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family). Prioritized complaints and lists of aims for all key individuals are noted within the formulation from early in therapy to make explicit any differences in problem perceptions and wider motivational issues.

Clinical experience has shown that it is necessary to incorporate as many as possible of the people (for example, family, peers, school and other helping agencies including ourselves) who may be involved in problem precipitation and maintenance or in support of the child or young person. However, in the interest of simplicity, and ease of clinical use, only key factors are included in the formulation. These may include: maintaining or triggering thoughts; consequent emotions and behaviours in immediate response to the child's or young person's difficulties; and major life events. These are noted primarily for the individuals who are most closely involved in problem maintenance or support of the child, rather than representing each individual's formulation in its entirety.

If clinically appropriate, the four systems of response in the central individual formulation can be replaced by the specific formulation for a presenting complaint, for example, panic (Clark, 1986), OCD (Salkovskis, 1999) or social phobia (Clark and Wells, 1995). With a young child, the most salient elements of the four systems of response may be represented by just a simple self-statement, for example, "I shout when I am scared".

Incorporating attachment-related phenomena

Attachment patterns can be highlighted in the formulation by helping the family to observe sequences of child and adult attachment behaviours and affects from recent problem situations. It is important to identify mediating cognitions and enter them into the formulation (together with formative major losses and rejections for key players). For example, in the vignette example of Figure 2, Thomas's distress and proximity seeking evokes inconsistent parental (and other adult) responses leading to, amongst other consequences, reinforcement of his enduring anxiogenic relationship-focused schema. These core beliefs are also giving rise to expectations, affects and behaviours at the four systems of response level in the acute problem situation. This is consistent with the work of Stark, Sander, Yancy, Bronik and Hoke (2000) who have highlighted the role of attachment upon the development of core schema of the self, world and others. They suggest that these schemata then provide the basis for expectations that guide interactions with others. Similarly, pragmatic factors such as deficits in a carer's nurturing behaviours may be recorded.

Incorporating developmental and biological factors

Developmental and biological influences can be represented in the formulation on a case-by-case basis, by starting with the "primary" clinically observed functional abnormality or deficit in a system of response or level of cognition. For example, a primary abnormality might be evident as: a generalized or specific deficit in cognitive functioning in learning difficulties (for example, dyslexia, Figure 2); a behavioural tendency (impulsivity) and/or cognitive deficit (lack of preplanning and/or consequential thinking) in ADHD; absent or inaccurate motor responses in dyspraxia, or cognitive tendency of responsibility in obsessive-compulsive disorder. By working through the formulation with the young person and/or family, the consequences (for example, poor self-esteem or peer rejection) of the primary problem can be identified. Additionally, the relieving, maintaining or exacerbating responses of other

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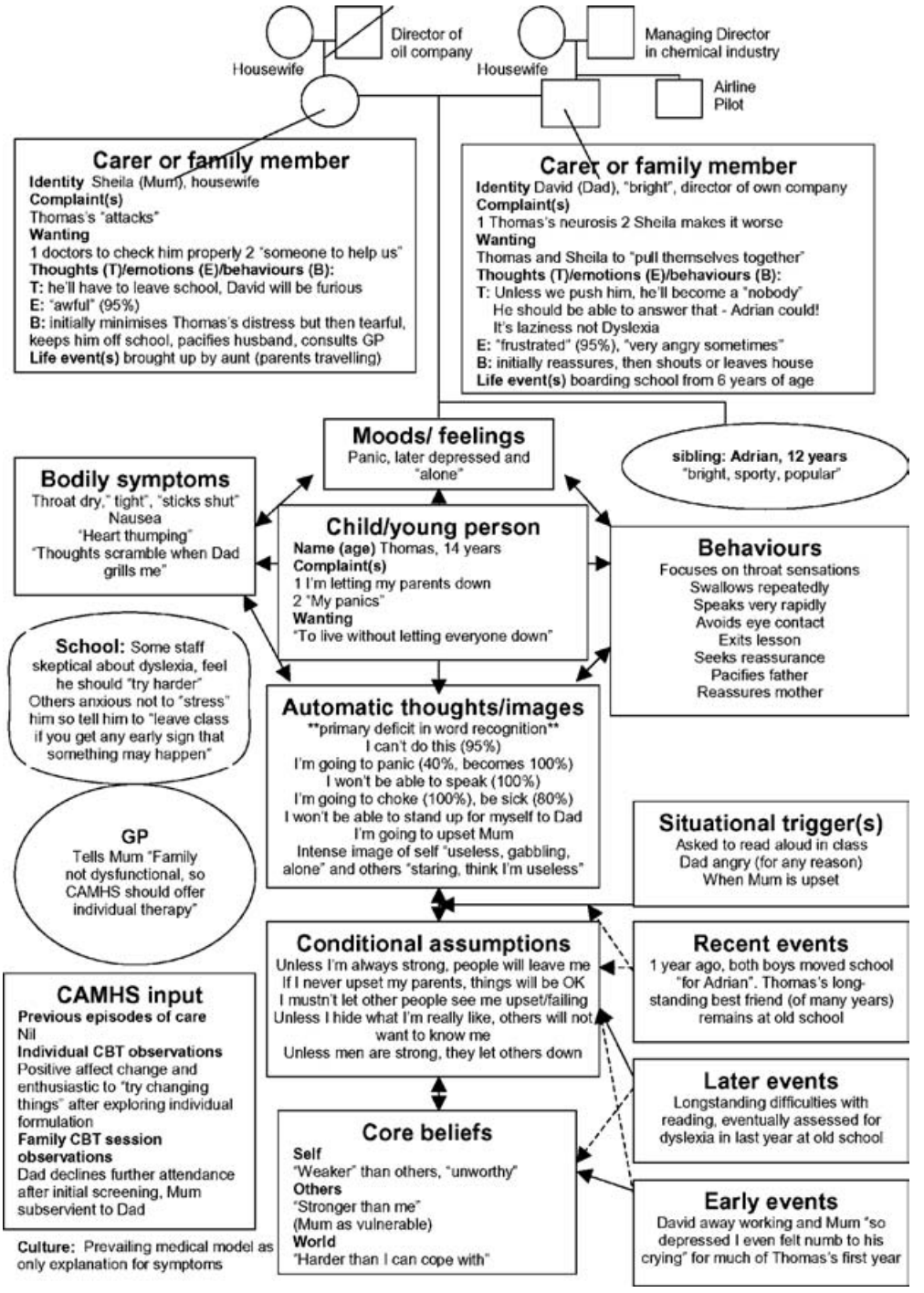


Figure 2. Thomas, referred with panic attacks on background of recent diagnosis of dyslexia

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people (carer over-control or over-anticipation of maladaptive behaviour) can be shown to clients. It is particularly important to record the expectations (appropriate or otherwise) that other people have about the young person's abilities. It may be helpful to note (in parentheses), under the appropriate system of response, what the age-appropriate normative ability would be. Where developmentally-inappropriate expectations about a child/young person are themselves the "primary problem", the systemic formulation process can be used to explore genesis, maintenance and consequences of these beliefs.

Incorporating key elements of other psychotherapeutic modalities

The formulation template can act as a framework within which to accommodate and represent, in cognitive-behavioural terms, processes of cause and effect more traditionally associated with other psychotherapeutic modalities. For example, projective processes can be illustrated by identifying particular cognitions as they occur in the problem situation, e.g. "you're criticizing me" (negative automatic thought) or "people always criticize me" (core belief). Repression of unacceptable memories can be recorded in the form of specific images and cognitions. It is also possible to focus explicitly, and in cognitive-behavioural terms, on the therapeutic relationship and on related cognitions, behaviour and even intense emotions experienced during the session. Transference and counter-transference processes can be made explicit in four systems terms. Similarly, cognitive distortions and the other components of highly dysphoric states can be re-explored and included in the formulation.

The systemic cognitive-behavioural therapy process

Systemic CBT is distinguished from other systemic therapies in being explicitly based on a systemic cognitive-behavioural formulation and in using core cognitive-behavioural processes of empirical self-reflection and guided discovery (Dummett, 2004). In common with other systemic therapies, however, the emphasis is on how the family and wider system is functioning. There is an assumption that the family and wider system may need to change, rather than just one individual.

The full systemic formulation template is never simply presented as a finished article to clients. Rather, a case formulation is always derived collaboratively using Socratic dialogue. This can be carried out with a young person (and on occasion a child) on an individual basis, in parent-child sessions, with parents or carers alone, with all the family together or with the wider system (e.g. professionals). Empirical building of a formulation can start with a blank piece of paper, an initial family sculpt or a simple self-statement. Thus whilst the template provides a complete structure for case formulation, the principle of sufficiency applies and therapist and client(s) need complete only as much as is needed for positive change to occur. This need will be determined by the most clinically significant maintaining processes and by pragmatic considerations such as developmental level and emotional state of those in the session. Thus, with a young child, their part of the formulation may be restricted to just a simple statement such as "I shout when I'm scared and Dad shouts when I shout", whereas comprehensive exploration of systemic factors can be carried out in parallel with parents/carers or in family sessions, as clinically indicated.

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Use of systemic CBT formulation in treatment planning

Use of the systemic formulation template is helpful in planning treatment, as key maintaining processes are often evident from the template even at the information gathering stage. Suitability for systemic cognitive-behavioural therapy is considered in terms of whether maintaining processes are explorable in cognitive behavioural terms using the formulation template, and whether the persons most involved are sufficiently able, motivated and amenable to the model to engage with the process. Representing the most significant processes on one sheet of paper, using the systemic formulation template, creates an "at a glance" overview of quite complex interactions, and is particularly helpful in evaluating the relative contributions of major maintaining processes. This enables the young person, family or wider system, and the therapist, to: consider treatment options; estimate likely timescales for change; predict difficulties in treatment; and, when necessary, to refocus therapy. In cases where individual (intra-psychic) maintaining factors predominate, individual therapy will be the treatment of choice. However, in the vast majority of cases, wider system CBT will be offered alone or in conjunction with individual therapy. Developmental factors always have to be considered in selecting the style of delivery (e.g. language used, use of symbols or imagery) and techniques used in therapy.

Systemic CBT process in individual sessions

Much exploration of systemic factors can be done on an individual basis, for example, by looking at evidence for and against perceptions and predictions of other family members. Many young people come to therapy with a very internal focus and benefit from taking an outwards look around themselves, for example, at the helpfulness or otherwise of other people's responses. Many of our young clients have been enthusiastic about using their individual formulation as a basis for family sessions. This process acts as a means of communication with the wider family, and also as an opportunity for the young person to explore, with their family, how responses of others link with their problem. As when working with the wider family and system, however, emphasis is kept on how the young person and those involved may be able to change things together.

Systemic CBT process in adult-child work

In parent-child sessions, sequences of interpersonal interactions taken from recent problem episodes can be explored using the systemic template, in order to highlight mediating cognitions and affects. Standard techniques can then be applied, to examine the accuracy and relevance of key attributions and predictions about each other's behaviours.

Systemic CBT process in family work

In family work, a systemic formulation of presenting difficulties is explored with the family as early as possible, using Socratic dialogue. The process usually starts with a large blank sheet of paper, on which each family member's proximity to the young person is agreed. Subsequent Socratic exploration of problem episodes can include reenactment of problem situations, to enable the family to observe how their family system is functioning, and without

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undue emphasis on any one individual. The inherently non-judgemental nature of the Socratic Questioning process is helpful, as is emphasizing why people's responses seemed reasonable at the time, given their experiences. Alternatively, the family can be asked to simply note their responses for themselves, whilst speculating on how people in general might respond, and considering the advantages and disadvantages of such responses. Occasionally, the presenting young person is enthusiastic to share their individual formulation and this can be used as a starting point. Circular questioning (getting family members to speculate on each others' responses) can be very helpful in highlighting mismatches between peoples' perceptions of each other's motivation and reality.

Family CBT sessions work best with at least one therapist experienced in family CBT and one other additional therapist, usually the child's individual cognitive-behavioural therapist, who is there as an advocate for the child and to level any perceived power differential in the setting. Family narratives or "myths" often function at conditional assumption or core belief level and so family sessions are usually offered every 3 to 4 weeks over a period of months, much as with more traditional forms of family therapy, to match the likely timescale for change in core belief level cognitions.

Parallel parent or carer sessions

Parents or carers often reveal highly idiosyncratic and powerful cognitions that are active in the acute problem situation. Where this occurs, the intervention of choice will often be to offer parallel parent/carer sessions, situated between family sessions. In these sessions, cognitions elicited in family sessions are linked with past life experiences, and their present functionality and accuracy are considered through the use of standard cognitive therapy techniques.

Systemic CBT process in working with wider professional systems and supporting networks

Much generic CAMHS work involves enabling sister agencies to take a wider-system perspective on cases, in order that tailored multi-agency packages of support may be provided. The systemic formulation process has been a useful means of communication here. Drawing the formulation out on a white board or flip chart during group discussion enables Socratic exploration with the professional group concerned. All agencies are located on the formulation, and all players encouraged, through Socratic dialogue, to identify cause and effect links in the formulation. The formulation structure is helpful in ensuring that the young person is considered in the context not only of their family or care arrangements, but also in the context of (often very complex) professional networks. Emphasis is kept on the primacy of their need for basic nurturance and physical and emotional security over higher order interventions such as therapy. The time-line representation of life events can highlight proximity of events and the, often large number, of changes of placement experienced by young people in care, together with how this might have impacted on their attachment-related cognitions. Less detail is provided about the central young person's formulation although any impact of professionals' behaviour on the young person's key cognitions may be highlighted. In this way, both immediate and longer-term advantages and disadvantages of agencies' responses can be made explicit.

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Table 1. Mean and median ratings with full range of responses (from 0 = not at all to 5 = extremely) given by 20 CAMHS professionals for utility of the systemic CBT template for a range of processes

Process considered	Median rating	Range
CBT with children, young people and families	5	1–5
CAMHS work more widely	4	1–5
Being clear/simple to use	4	2–5
Integration into CBT of other psychotherapeutic models	4	2–5
Integration into CBT of influences external to the child	4	2–5

Implications for training and research

From a training perspective, there is much active National debate about the core competencies required to practise cognitive-behavioural therapy with children, young people and families. One key competency is to be able to integrate wider-system and developmental influences into clinical working. This formulation template provides a conceptual framework for therapist training that explicitly develops this competency. In a recent (2004) survey (Table 1) of CBT-trained CAMHS professionals, respondents (20 out of 23 surveyed, response rate 87%) reported that they found the systemic template clear and simple to use and to be helpful not only in CBT with children, young people and families, but also in integrating other psychotherapeutic models into CBT.

The value of this systemic cognitive-behavioural therapy template and process is yet to be formally evaluated, but feedback from young people and families has been positive, with many anecdotal reports that systemic formulation opens up new insights and solutions. Large-scale randomized comparison trials will be needed in order to examine the benefits of this therapy over other forms.

Conclusions

In summary, there is a need for CBT that is based on a formulation process that incorporates systemic and developmental factors, yet is simple enough for use with young people and families. The template for systemic CBT formulation presented here appears to offer this. It can also accommodate perspectives from other psychotherapeutic modalities and is reported to be clinically useful. It is structured for generic use with the full range of difficulties presenting to CAMHS, leads to a distinct systemic therapy process usable on an individual, parent-child, family or wider group basis, and provides a structure for therapist training.

A limitation of this paper is that this approach is yet to undergo formal evaluation. In the meantime, this paper aims to provide colleagues with sufficient information to consider the approach for themselves.

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