Cognitive Behavior Therapy for Children and Adolescents: Challenges and Gaps in Practice

Since its emergence in the 1960s, cognitive behavior therapy (CBT) remains one of the mainstays of psychotherapeutic intervention for different mental health conditions. It is one of the most evidenced-based psychotherapeutic interventions.[1] CBT is used for clients from diverse socioeconomic backgrounds, cultures, and ages.[2,3] Apart from hospitals and clinics, it is also used in schools, vocational programs, and rehabilitation centers among other settings. It has been found beneficial in generalized anxiety,[4] stress,[4] obsessive compulsive disorder,[5,6] phobias,[7] depression,[8] and behavioral problems.[9] Research also suggests fluid use of CBT in individual,[10] couple, and family formats.[11,12] Despite the evidence base of CBT for different mental health conditions, including for children and adolescents, the practice of CBT for the younger population may have several issues.[13] The authors list some of the issues that are encountered while delivering CBT in Indian children and adolescents. The opinion is based on clinical experiences and supported with literature as available.

1. **Limitations of the standard model:** While the core principles for CBT in children remain the same, several familial and cultural aspects risk binding the delivery of the therapy to limit it within behavioral management only, so much so that therapists hesitate in applying CBT in children even though CBT models for children and adolescents in specific disorders[14,15] are well-defined. Often, their primary approach and focus are more on neutralizing behavioral problems rather than core cognitive errors

   CBT and its variants have been found effective in several childhood and adolescent mental health conditions.[16-18] Reviews of efficacy studies[18,19] suggest that adolescents who receive CBT show benefits comparable to younger children. They also suggest that CBT protocol modifications routinely carried out by expert trial therapists may explain these findings, further adding that these protocols are needed to facilitate the transportability of efficacy research effects to usual care settings where therapists may have less opportunity for CBT training and expertise development

   On the other hand, reviews studying the relative effectiveness of psychological interventions, antidepressant medication, and a combination of these interventions did not establish the effectiveness of either of these interventions for treating depressive disorders in children and adolescents,[20,21] further warranting appropriately powered randomized control trials.
2. **The familial and cultural variables:** Certain familial and cultural influences have an impact on the overall therapeutic formulation for a case.[22] Many parents may fail to recognize the psychotherapeutic treatment need of their ward owing to their attitude and belief, and often the referral for consultation come from teachers. It could be an area of investigation to know the proportion of child and adolescent cases referred from school. Schools are, however, better equipped than earlier times, and many do have psychologists to counsel their students. While teachers may be proactive in referring students with academic and behavioral difficulties for psychological consultation, the mechanism to involve the teachers for their role in the therapeutic process may remain informal and unstructured. In a scenario where performance in the examination is often the benchmark of being a good student, those having certain psychotherapeutic needs can do better if given assurance and validation by teachers themselves

   Unlike in the case of adults, treatment planning and structuring for psychological intervention in children and adolescents require an active involvement of parents and teachers. Teachers are often the source of referral for young clients with academic difficulties. They have a big role in facilitating the therapy process, especially when academic difficulties are one of the major concerns for the young clients. Active involvement of the teachers can bring a better outcome of the therapy process

   There is a possibility of different therapeutic agendas of parents and the child pertaining to treatment, especially in adolescents. It is not uncommon to see differences in therapeutic goals of the child as conceptualized by the therapist and "priorities and expectations" of the parents. Adolescents, in particular, are more likely to have emotional conflicts with parents and could present a totally different perspective of the situation presented by the parents. For example, parents may

be focusing only on their ward's poor academic performance, while the adolescent client, though aware of his or her academic performance, may be more perturbed about the parents' attitude toward him or her. Parent–child attachment relationship, thus, is an important domain to be addressed and needs to be integrated for a better therapeutic outcome[23]

It may be opined that parents being critical of their wards and failing to validate their wards' efforts in the therapy process could be detrimental to the therapy outcome. Existing literature does suggest that maternal overinvolvement contributes to CBT failure among youth with anxiety disorders, and mothers' expressions of fear, such as being stiff, tense, and fidgety, have been identified in CBT failure.[24] In addition, fathers' reports of rejecting their child, and children rating their mothers as low in warmth, have also been shown as significant predictors of CBT failure[25]

A certain level of insight regarding the genesis of emotional and behavioral problems of their children is desired for a better therapeutic outcome. One study suggested that parents of children with autism, who attributed the condition to environmental factors, experienced emotional upset or confusion about the condition, or perceived the condition to be pervasive or burdensome were more likely to report clinically significant emotional and behavioral difficulties.[26] It was implied that parent perceptions are vital when developing interventions to assist with children's emotional and behavioral challenges

Considering the above, parental counseling becomes an essential component for the CBT process in children and adolescents.

3. **Issues of acceptance and stigma:** Awareness regarding mental health conditions and the readiness to consult a professional in the event of mental health issues have seen a sea change than yesteryears. However, the insight behind this awareness may not be that satisfactory. Despite the growing awareness regarding mental illness, a large number of parents may dwell in a denial of the mental health condition of their ward,[27] which can have an impact on therapy outcome. Parents and teachers, at times, involve in a blame game of not giving an individual attention and the requisite time to the ward. Developing a true insight in the parents and the family often becomes an integral part of the therapeutic program. Teachers too need to be more sensitive to the mental health needs of their students
4. **Issues in building therapeutic alliance:** Developing a working therapeutic alliance is essential for progress and positive outcome of any therapy. While adults reporting for psychotherapeutic treatment are generally competent of describing their problem concerns, setting the agenda, and discussing treatment goals, this may not be the same in the case of children. Children may not be florid in explaining their concerns, and often a thorough assessment is required to know about the child's emotions, important relationships, behavior patterns in school, family, and neighborhood. As discussed earlier, parents have a major role in the presentation of complaints; their focus may be biased toward behavioral difficulties and externalizing behavior than emotional distress of their ward. Adolescents may deny having any problem and can resist establishing rapport and a good therapeutic relationship
5. **Structuring sessions and planning of treatment:** Negotiating the aforementioned issues comes at the expense of two to three sessions, which is significant for clients from a middle socioeconomic background. The initial sessions are also devoted to developmental assessment and a cognitive or psychodiagnostic assessment required, if any. In several Asian countries including India, psychotherapy sessions are not covered by health insurance, making it appear a costly treatment, and that could be detrimental for continuation of the therapy. A big proportion of parents may believe in pharmacotherapy only and consult a psychologist only upon referral. In such a scenario, the parents may deem the therapy sessions as a compulsion and fret in the absence of a "quick and guaranteed" outcome. Considering the above, CBT in children and adolescents may not be a cost-effective treatment method in Indian scenario, increasing the risk of dropout. Dropout from psychotherapy with a therapist may impact the outcome of consultation with a new therapist, as the therapeutic process may appear a repetition to parents. Considering these, the therapist may need to focus more on short-term treatment goals than long-term goals.
6. **Assessment issues: Identifying and targeting dysfunctional cognitions:** The most important core component of CBT could also be the most difficult to achieve when dealing with children and adolescents. Language and communication competency of the child could be a barrier in the therapeutic process, as a minimum level of cognitive and linguistic competency as well as verbal reasoning is required for CBT. Thus, CBT has been inferred more suitable for mid-childhood or older children.[28] The therapeutic process of CBT essentially includes appropriate recognition of own emotions and discriminating thoughts, feelings, and behavior on the part of the client. Identification of automatic thoughts and distinguishing different

emotional states and linking of these emotional states with thoughts and events could be a difficult one with children. "Guided discovery" usually helps, but children and adolescents may lack the maturity and tenacity to sustain the process and become impatient. There also lies the risk of the child getting "guided" and choosing the alternative "suggested" by the therapist. While a guided approach may yield short-term gains in terms of improved insight on the part of young clients, the maintenance of these insights in future crisis situations could be questionable. This inference is supported by the clinical experience of seeing the same clients coming for consultations at multiple times whenever a crisis situation arises

7. **Comorbid conditions:** Children and adolescents brought to clinics may have high comorbidity[29,30] and externalizing behavior. These externalizing behaviors can take predominance over the emotional distress of the child, and accordingly, the planned therapy becomes more eclectic in approach. Literature does support the use of eclectic combinations of techniques drawn from multiple theoretical orientations,[31,32] though with a mention of lack of data of its efficacy. However, some studies do suggest the efficacy of the eclectic approach in treating anxiety symptoms in children.[33] While it is perfectly okay to go for an eclectic approach to address therapy needs, the theoretical basis or research evidence of the technique may be questioned[34]
8. **Facilitating behavioral and cognitive change:** Homework assignments, thought diaries, and activity scheduling are important tools in facilitating behavioral and cognitive change. They help in tracking compliance and effort on the part of the client. More importantly, it also helps in reviewing own progress by the client. For children and adolescents, complying with these needs active assistance from parents, family members, and teachers. As previously discussed, the role of teachers is important in the therapy process and outcome. It could be a difficult task to generalize research findings,[35] which suggest that teachers have a low knowledge about conditions such as attention deficit and hyperactive disorder but have a positive attitude toward these children and acknowledge the need for special teachers. Media reports on rejection and noncooperative attitude of schools toward children with mental health needs are common not only in India but also from western countries.[36-38] However, teachers need not be always blamed for not giving individual attention to the student, considering their existing responsibilities.
9. **Reinforcing compliance:** It is vital to reinforce adherence to the therapeutic process through planned review sessions. Emphasizing on positives is an easy method that is a kind of morale booster for the client by attending to their strengths and positives. While it is relatively easy than other components, it may pose difficulty in very adverse familial or school environment, thus clients need to be consistently motivated with positive feedback.

RECOMMENDATIONS

- CBT for children and adolescents integrates from different approaches, and the practice itself is very eclectic. There is a wide scope for customization of the CBT therapeutic package. However, the recipient is at a risk of too much experimentation and exposure to nonevidence-based techniques in the therapy process
- Considering the familial and cultural issues, it is imperative to include a psychoeducational program for parents within the CBT framework. Literature does suggest the efficacy of modified forms of CBT that include psychoeducation to parents in treating anxiety disorders in preschool and early school-aged children[39]
- While formulating a therapy plan for children, a thorough developmental assessment of the child is vital to see his or her adaptive capabilities for CBT. If not, it could be beneficial to focus on behavioral approach, using reinforcement techniques, to achieve the desired change in the child's behavior
- Children, and parents, may consider the problems as a temporary situation, and insights gained could be lost once the sessions are over. For an appropriate appraisal of stress situations, it is important that children are able to identify and label their emotions and thoughts appropriately. This is an important task for adult clients too, and considering the difficulty involved, more number of sessions are required for this. Studies suggest that while teaching skills that require various aspects of emotion understanding, clinicians must not presume that all older children or adolescents are competent, but rather should conduct an actual assessment[40]
- It is advised that behavioral experiments and homework assignments are planned with the active participation of family members.

It can be said that CBT can be used as an effective treatment for many of the childhood and adolescent mental health conditions as the first line of treatment, provided the familial, cultural, and compatibility perspectives are appropriately considered. Furthermore, efficacy studies using a standard model in specific populations are warranted.

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