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Cognitive-behavior therapy with children

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Abstract

This paper will look at the use of cognitive-behavior therapy with children. Specifically, it will focus on the areas of depression and anxiety. First, there will be a look at applying cognitive-behavior therapy to children. This includes strategies for working with children, and developmental considerations with children. Next, there will be a focus on using cognitive-behavior therapy for children with depression. This section includes an examination of depression in children, and three cognitive-behavioral treatment strategies. The strategies to be discussed include affective education, cognitive restructuring, and social skills training. Finally, there will be an exploration of the use of cognitive-behavior therapy for children with anxiety. This section includes a discussion of the nature of anxiety in children and two cognitive/ behavioral treatment strategies. The strategies to be discussed include cognitive restructuring, and relaxation training.

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Cognitive-Behavior Therapy with Children

Mental health counseling for children is an increasing need in today's society. As a result of this need, theories and techniques are being adapted to create the greatest benefit for children. One area of growth in counseling children is in the use of cognitive-behavior therapy (Kendall 1991). This growth has occurred in the following areas--treatment, theory, and empirical foundations.

Many may wonder if the use of cognitive-behavior therapy differs with adults and children. Hart and Morgan (1993) contended that there is an essential difference in cognitive-behavioral therapy between children and adults. According to Hart and Morgan, the difference lies in cognitive distortions--in adults, negative behavior and emotions result from a cognitive misrepresentation of circumstances. However, with children the focus shifts from a misrepresentation of events to a possible deficiency in the child's cognitive abilities. This important difference between children and adults demonstrates the significance of learning how cognitive-behavior therapy can be used with children.

The author of this paper will provide a look at the use of cognitive-behavior therapy with children. Specifically, the author will focus on the areas of depression and anxiety. First, there will be a look at applying cognitive-behavior therapy to children. This application includes strategies for working with children and developmental considerations with children. Next, there will be a focus on using cognitive-behavior therapy for children with depression. This section includes an examination of the

expression of depression in children and three cognitive-behavioral treatment strategies for children with depression. The treatment strategies to be discussed include affective education, cognitive restructuring, and social skills training. Next, there will be an exploration of the use of cognitive-behavior therapy for children with anxiety. This section includes a discussion of the nature of anxiety in children and two cognitive-behavioral treatment strategies for working with children with anxiety. The strategies to be discussed include cognitive restructuring and relaxation training.

Applications with Children

Children behave and think differently than adults (Hart & Morgan, 1993). They also behave and think differently than other children. According to Kimball, Nelson, and Politano (1993), children vary in important cognitive skills as a function of developmental changes. It is important for professionals who work with children to be aware of strategies which may be helpful when working with children. It is also important that these professionals be aware of developmental considerations when working with children.

Strategies for Working with Children

When working with children, as with adults, it is necessary to build rapport with the client. DiGiuseppe (1989) suggested some strategies for rapport building with children. One strategy is to not be "all business." This author suggested the counselor let the child get to know him or her through conversation or play. DiGiuseppe (1989) also insisted the counselor always be honest with the

child because children may be more cautious to trust than adults. Providing an open and honest atmosphere from the beginning may make it easier for the child to gain trust.

Next, DiGiuseppe (1989) suggested the counselor use questions carefully. This is because children may not be as open with individuals who give them the "third degree." DiGiuseppe also noted the importance of talking with the child about what the child wants to achieve from the counseling. The child may be more willing to open up when given the chance to acknowledge what he or she wants, instead of just working on the goals of the parents and teachers.

Strategies for working with children can help counselors engage the child in counseling and get him or her to open up. These strategies include interventions such as play or conversation, being honest, and being cautious with questions. Besides specific strategies, there are developmental considerations of which counselors must be aware for their work with children to be effective. These developmental considerations will be addressed in the next section.

Developmental Considerations

Many of the special considerations to be taken into account when working with children have to do with a child's developmental abilities. It has been only in recent years that professionals have come to realize the importance of developmental capabilities when working with children (Kimball et al., 1993; Vernon, 1993; Vernon & Al-Mabuk, 1995). Kazdin (1989a) contended that

behaviors which may be considered "normal" for a child at one stage of development, may be considered "abnormal" for children at another stage.

These differences are the main reason it is important for counselors to have knowledge of developmental processes (Kimball et al., 1993; Thompson & Rudolph, 1992; Vernon, 1993; Vernon & Al-Mabuk, 1995). These authors suggested counselors should be aware of developmental considerations in areas such as attention and retention, moral reasoning, and problem-solving.

As a child develops, there are changes in attention and retention. Some children have less attention and retention abilities, which may impact the effectiveness of many counseling techniques. Kimball et al. (1993) suggested that counselors should be aware of their use of techniques such as modeling. The authors suggested using less comprehensive modeling and being aware of time lags when using modeling techniques, depending on the developmental level of the client.

Children also show differences in moral reasoning. According to Piaget (1932), children before age eight or nine focus on consequences rather than intention. Kohlberg (1976) suggested six stages of moral reasoning. However, it is not yet clear whether moral development occurs in stages or a sequence (Kimball et al. 1993; Vernon, 1993).

Kimball et al. (1993) suggested that there are two strategies which can be used by teachers, counselors or parents to help advance a child's moral reasoning.

According to Sehlman and Lieberman (as cited in Kimball et al., 1993), the first strategy involves presenting children with a series of moral dilemmas. According to the authors, this series should include reasoning below, at, and above the children's level to promote their moral reasoning. The second strategy, according to Kimball et al. (1993), includes involving children in role-playing situations to advance moral reasoning. These authors suggested that there should be a discussion of the reason a behavior is good or bad, as well as the motives, consequences, and feelings about a certain behavior.

These strategies can help children to understand their actions or the actions of others. Another area of development with which counselors may be faced is problem solving. Problem solving is an important skill for children to acquire is the ability to generate alternative solutions, as well as the capacity to produce alternative consequences (DiGiuseppe, 1989; Kimball et al., 1993; Thompson & Rudolph, 1992). These authors suggested that, for young children, these skills may first take place in play. Children should then be encouraged to generate as many solutions as possible to presented situations. With older children, the emphasis should be shifted to identifying the best possible alternatives to situations relevant to the child's life. This allows the child to practice using the problem solving skills in his or her own life.

Counseling with children requires special attention to the developmental abilities of each child. Some developmental areas which may affect counseling

include attention and retention, moral reasoning, and problem solving. By being aware of the client's developmental abilities in each of these areas, the counselor can adapt techniques to make counseling more effective for the child. The counselor may also implement techniques to advance these developmental areas with the child.

Children with Depression

Many people know that there are adults who suffer from emotional disorders. What many may not know is that children also suffer from emotional disorders. Among these emotional disorders, according to Ingersoll and Goldstein (1995), depression is the most common among both children and adults. While it is now known that children suffer from depression, as Ingersoll and Goldstein pointed out, it was not until 1980 that childhood depression was officially diagnosed in the Diagnostic and Statistical Manual of Mental Disorders III (American Psychiatric Association, 1980).

Expression of Depression in Children

According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) (DSM-IV) (American Psychiatric Association, 1994), the basic symptoms for children with depression are the same as those for adults. The DSM-IV stated, however, that children may experience more physical symptoms, along with behavioral and emotional symptoms. Ingersoll and Goldstein (1995) suggested some of the physical symptoms children may experience are

stomachaches and headaches. The authors also pointed out that children may express their depression behaviorally through a decline in school performance. This decline may be due to an inability to concentrate or think quickly (Ingersoll & Goldstein, 1995). Another physical symptom is social withdrawal.

Stark (1990) described one of the emotional symptoms of depression in children. According to Stark, the main symptom of depression in children is dysphoric or sad mood. The author noted, however, that sad mood is not just related to childhood depression. Stark (1990) stated that the symptom of dysphoric mood associated with depression can be distinguished from other disorders by the severity and duration of the symptom. To further differentiate, Kazdin (1989b) suggested distinguishing "depression as a symptom from depression as a syndrome or disorder" (p. 137). Kazdin described depression as a symptom of sadness that is common in everyday life. He described depression as a disorder to include sadness combined with many other symptoms including loss of interest, feelings of worthlessness, sleep disturbances, and changes in appetite.

Depression in children may be expressed in three types of symptoms. These symptoms may be (a) emotional symptoms such as dysphoric mood; (b) physical symptoms such as stomachache and headache; or (c) behavioral, such as decreased school performance and social withdrawal. Depressed children may express any combination of these symptoms, but they are more likely to experience physical and behavioral symptoms. Once parents, teachers, and

counselors are aware of the symptoms of depression in children, treatment strategies may be explored.

Treatment Strategies

It has been established that depression among children does exist and symptoms of this depression have been discussed. Now, the author will explore treatment strategies for children with depression. Once rapport has been established with a child, the counselor can begin to move towards treatment. Stark (1990), Kaslow, Morris and Rehm (1998), Knell (1993), and Stark (1990) all suggested one basic aspect of cognitive-behavioral treatment for children with depression is teaching. This includes teaching the child skills for managing his or her depressive symptoms on his or her own.

Cognitive-behavioral theories suggest the importance of an individual's internal dialogue and his or her perception of events for emotional well-being. This concept is used with children as well as adults with some variance. The cognitive-behavioral treatment strategies that will be discussed in this section include affective education, cognitive restructuring, and cognitive modeling.

Affective education. One treatment strategy for depressed children that uses the teaching component of cognitive-behavioral therapy is affective education. Affective education can be used as a first step in treatment along with other cognitive-behavioral strategies. According to Stark (1990), the strategy of affective education is useful at the beginning of therapy because it helps the child

to become comfortable with disclosing personal information and helps in building rapport. Another reason affective education would be useful at the beginning of therapy is because it helps to teach the child about different emotions and the different intensity of emotions.

The strategy of affective education involves a "series of games which is used to teach children about their emotions" (Stark, Rousee, & Livingston, 1991, p. 183). According to Stark et al. (1991), the process involves creating cards with the names of different emotions on them. These cards are then used in a series of different games. The first game, "Emotion Vocabulary," has the child draw a card, read the emotion, and describe the emotion and what was happening the last time he or she felt that emotion (Stark, 1990). In the next game, "Emotion Vocabulary II," the child reads the emotion on the card and describes how a person feeling that emotion might be thinking or behaving.

In a third game, "Emotion Charades," the child acts out the emotion on the card, without using sound, for the counselor to guess (Stark, 1990). Emotion expression, a fourth game, is similar to emotion charades only the child makes noises relating to the emotion for the counselor to guess. Stark also suggested the games might be played in a group where the children describe and act out the emotion to other group members. A game called "Emotion Statues" can be used in a group as well (Stark, 1990). This game involves one group member "sculpting" another group member into an emotion for the others to guess.

Stark et al. (1991) pointed out that affective education could be useful for all children, not just depressed children, to help them to identify emotions and understand the relationship between thoughts, feelings, and behaviors. To help the child process the games, Stark (1990) suggested that while the child plays the game the counselor should ask him or her questions about his or her personal experiences with that emotion. He also added that the counselor should point out to the child that the different names for an emotion can stand for different intensities of emotion.

The affective education technique is a teaching technique that involves the children and helps them to open up and builds rapport. The strategy can be used with an individual child or in a group and is a technique that teaches about emotions and relates the emotions to a child's real experiences.

Cognitive restructuring. Along with identifying emotions, it is also important for children with depression to be aware of their thinking patterns. Spence (1994) stated that in cognitive restructuring, "children learn to replace unhelpful thoughts with more constructive self-talk" (p. 1203). Stark (1990) suggested that cognitive restructuring was "designed to change the way the client derives meaning from the world" (p. 115).

Cognitive restructuring models have been suggested by Ellis (1962) and Beck, Rush, Shaw, and Emery (1979). Stark (1990) suggested that Ellis' model is difficult with children because when children's thoughts are disputed, they may

see it as scolding. Instead, Stark (1990) suggested Beck's model. According to Spence (1994), Beck's model involves identifying maladaptive cognitions and cognitive structures, cognitive challenging, and finally, generating alternative cognitions.

Stark (1990) suggested some ways of identifying maladaptive thoughts for children are playing back tapes of the sessions and identify the thoughts and using self-monitoring techniques. According to Stark, the self-monitoring can include asking the child to write down his or her thoughts in regards to changing emotions. This recording can be done on a monitoring sheet or journal.

Stark (1990) then suggested the counselor needs to develop a hypothesis about the underlying theme of the child's maladaptive thoughts in order to get to the cognitive structures of those thoughts. Examples of such a hypothesis, as suggested by Spence (1994), include "I am useless" or "I am no good" (p. 1208). Once the counselor has identified a hypothesis about the child's core cognitive structure, he or she looks for cues in the child's maladaptive thoughts, behavior, and words, to confirm or refute this hypothesis.

The next step in the model, cognitive challenging, involves the counselor and the child looking at the evidence to support or refute the child's thoughts and cognitive structure (Spence, 1994). According to Spence, gathering evidence involves both the child and the counselor, but the child may be asked to look for evidence outside the sessions such as in the classroom or at home as well.

Finally, in the last step, the child is aided in finding more adaptive interpretations for events (Spence, 1994). This may be done by asking the child to identify some alternative explanations, besides the negative interpretation that the child is personalizing, to explain a situation (Stark, 1990). According to Stark (1990) "the assumption is that if a negative interpretation is replaced by a more positive and adaptive one, the child will feel better (p. 126).

Although this is a cognitive restructuring model to be used with children, Spence (1994) suggested that this technique may not be helpful for children under 10 years old. Stark (1990) suggests using this model as one aspect of a multi-treatment approach. There also seems to be a lack of research in the effectiveness of the cognitive restructuring model when used with children (Spence, 1994).

Social skills training. As was stated previously, social withdrawal may be one symptom of depression in children. Depression can result from a lack of peer relationships at a time when peers play a very important role in a young person's life (Ingersoll & Goldstein, 1995). According to Dujovne, Barnard, and Rapoff (1995), a deficiency in social skills may underlie depression by causing a decrease in social interactions and a reduction in feedback from the environment. This is why social skills training is an important aspect of working with a depressed child. The goal of social skills training, according to Dujovne et al. (1995), is to help the child obtain reinforcement from others by helping him or her to achieve more rewarding interactions.

Ingersoll and Goldstein (1995) suggested that some aspects of social skills training include, "an opportunity to learn and practice a variety of social skills, such as how to initiate social contacts, how to make new friends, and how to negotiate and problem-solve in interpersonal relationships" (p. 88). Spence (1994) recommended some methods to be used for social skills training include "instructions and discussion, role-plays, pictures and audiotapes" (p. 1205). Spence also suggested that a social skills training approach might also include empathy skills, and social-perspective-taking training.

Social skills training helps the child to improve his or her social skills, according to Dujovne et al.(1995). Social skills training might be most beneficial when used with other treatment strategies such as affective education and cognitive restructuring.

Studies on the effectiveness of cognitive-behavioral therapy with depressed children show significant reductions in depression treatment groups as compared to non treatment groups. A study by Stark et al. (1991) compared the outcome of cognitive-behavioral treatment with traditional counseling when used with depressed children. The cognitive-behavioral treatment in the study consisted of self control, social skills, and cognitive restructuring components. According to Kendall (1993), the study by Stark et al. showed "cognitive-behavior therapy produced greater improvements in depression and reductions in depressive cognitions than traditional counseling" (p. 241). Kendall pointed out,

however, that because those gains were not maintained at follow-up, the long term effect of cognitive-behavioral therapy with depressed children was not supported by the study.

Reynolds and Coats (1986, cited in Kendall, 1993) compared cognitive-behavioral therapy with relaxation training and a control group. This study showed a significant decrease in depressive symptoms for both the cognitive-behavioral and relaxation training interventions. Five week follow-up studies showed treatment results were maintained.

Depression in children is the most common emotional disorder among children and adults. This is why it is so important for those professionals who work with children to be aware of the signs of depression in children, as well as some possible strategies for working with these children. Depression in children may be expressed in physical, behavioral, and emotional symptoms. These symptoms may include stomachaches, social withdrawal, and dysphoric mood. Treatment strategies for working with children with depression include affective education, cognitive restructuring, and social skills training. Studies on the effectiveness of cognitive-behavioral treatment for children with depression show significant decreases in depressive symptoms for posttreatment groups.

Children with Anxiety

Anxiety is another disorder which can occur in children as well as adults. As was the case with depression, an understanding of anxiety in children has

evolved over the years (Laurent & Potter, 1998). According to Laurent and Potter, the symptoms of anxiety are similar in children, adolescents, and adults. These authors suggested, however, that there are variances based upon developmental differences. It is well known is that fears are common among children. The key to assessing the nature of fears and anxieties in children is to establish whether the fear is developmentally natural or unnatural. According to Kendall, Chansky, Freidman, Kim, Kortlander, Sessa, and Siqueland (1991), unnatural anxiety in children may impede development and affect growth and mastery. In order to help define anxiety in children, next the author will discuss the nature of anxiety in children and two cognitive-behavioral treatment strategies for children with anxiety.

Nature of Anxiety in Children

The DSM-IV listed such symptoms for anxiety as worry, recurrent or persistent thoughts, actual or perceived physical symptoms, and fears and/or phobias. Laurent and Potter (1998) suggested some ways in which these symptoms may appear in children. According to Laurent and Potter, children may worry about school performance or separation from someone close to them. These authors also suggested children may experience fears such as fear of dying, fear of separation, fear of being alone, or fear related to an object or situation.

Finally, Laurent and Potter (1998) contended other symptoms children with anxiety may manifest include refusal to go to school, refusal to participate in

other activities or nightmares associated with separation, and refusal to sleep away from home. Kendall et al. (1991) suggested some physical symptoms children may experience include perspiration, butterflies in the stomach, blushing, trembling, and a need to urinate.

Barrios and O'Dell (1989) stated that there are a series of three reactions to fear in children. According to Barrios and O'Dell, the first reactions are motor reactions. These authors suggest that these reactions include "avoidance, escape, and tentative approach" (p. 168). The second reaction, is "subjective reactions such as verbal reports of discomfort, distress, and terror" (p. 168). Finally, the third reaction is physiological reactions. These reactions include "heart palpitations, profuse sweating, and rapid breathing" (Barrios & O'Dell, 1989, p. 168).

Kendall et al. (1991) suggested that older children (12-19) are more likely to experience major depression and simple phobia concurrently, while younger children (5-11) are more likely to have separation anxiety or attention deficit disorder concurrently. According to Kendall et al. (1991), children report fewer fears as they get older and girls report more fears than boys. These authors pointed out, however, that sex-role expectations and other sociocultural factors may affect these reports.

Fears and anxieties are common among children and are expressed through symptoms such as avoidance, sweating, heart palpitations, and frequent

urination. The challenge for counselors is to determine whether these anxieties are developmentally appropriate or not and to select a treatment.

Treatment Strategies

Once it has been determined that a child would benefit from treatment for his or her anxiety, a treatment strategy must be selected. The two cognitive-behavioral strategies to be discussed are cognitive restructuring, and relaxation training.

Cognitive restructuring. The strategy of cognitive restructuring for children with anxiety is similar to the use of cognitive restructuring for children with depression. According to Laurent and Potter (1998), one key symptom in anxiety in children is worry. Children's worries are why it is logical that treatment for children with anxiety focus on thoughts as well as behaviors. Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, and Siqueland (1992) described a treatment approach which identifies anxious feelings and their somatic reactions, unrealistic expectations in anxiety-reducing situations, and developing a plan for coping in anxiety producing situations.

Kendall (1991) stated that children with high anxiety have negative self-evaluative thoughts. Examples of these thoughts include, "I'm going to mess up" and "I'm going to get hurt" (Kendall, 1991, p. 134). He also pointed out that children with low anxiety have a low frequency of these negative thoughts. These thoughts show that "anxious children seem preoccupied with concerns about

evaluations by self and others and the likelihood of severe negative consequences" (Kendall, 1991, p. 134).

Cognitive restructuring for children with anxiety is similar to the cognitive restructuring for children with depression described previously. When using the approach with children with anxiety, the feelings and somatic reactions associated with the anxiety are identified, and the negative thoughts or unrealistic expectations about the anxiety-producing event are identified. Finally, steps are taken to change these negative thoughts/expectations using the strategies suggested for children with depression.

Relaxation training. Another cognitive-behavioral strategy which may be beneficial for treating children with anxiety is relaxation training. Weisman, Ollendick, and Horne (as cited in Kendall, 1991) suggested that relaxation training with 6 to 7 year old children "resulted in significantly reduced muscle tension levels" (p. 141).

According to Kendall (1991), relaxation training involves a process of teaching children to progressively relax the major muscle groups of the body to release muscle tension. It is suggested that children learn no more than three muscle groups per session and practice between sessions at home. Once the child has learned about relaxing each of the muscle groups, Kendall suggested introducing cue-controlled relaxation. This process involves associating the relaxed state with a cue word such as calm or relax.

Koeppen (1974, as cited in Grace, Spirito, Finch, & Ott, 1993) suggested using fantasy in relaxation with children. Kendall (1991) also reported that relaxation training scripts are available for children as well as adults. Once the child has learned the relaxation techniques, the techniques are then paired with the anxiety provoking event (Grace et al., 1993). The focus is on identifying the physical or cognitive symptoms of anxiety. Once these symptoms are identified, the child can "become aware of these anxiety response cues and can use them to signal use of relaxation coping skills" (Grace et al., 1993, p. 267).

Studies on the use of cognitive-behavioral therapy with anxious children support the effectiveness of the therapy with this population. A study by Barrett, Dadds, and Rapee (1996) compared the use of cognitive-behavioral therapy alone and cognitive-behavioral therapy combined with family training programs for children with anxiety. The cognitive-behavioral treatment program in this study included recognizing anxious feelings and somatic reactions, cognitive restructuring, and changing self-talk. The family training portion of treatment included training parents on rewarding courageous behavior, dealing with their own emotional upsets, and communication and problem-solving skills.

The results of this study showed a significant decrease in anxiety symptoms for both the cognitive-behavioral treatment group and the cognitive-behavioral/family training group in comparison to the control group. Barrett et al. (1996) stated that 57% of those children in the cognitive-behavioral treatment

group were anxiety-free at posttreatment, and 84% of those in the cognitive-behavioral/family training group no longer met the diagnostic criteria at posttreatment. Follow-up studies by Barrett et al. showed that results were maintained by the cognitive-behavioral treatment group and improved for the cognitive-behavioral/family training treatment group.

A study by Kendall (1994) compared cognitive-behavioral treatment to a wait-list control group for children with anxiety. Kendall's study showed 64% of the cognitive-behavioral treatment cases did not qualify for a diagnosis at the end of treatment compared with one case for the wait-list control group. Follow-up for this study showed maintenance of these treatment gains after a one-year period.

Anxiety in children shares similar symptoms as it does in adults. The key to assessing anxiety in children is to establish whether the fear is developmentally natural or unnatural. Children experience three reactions to fear. These reactions include motor reactions, subjective reactions, and physiological reactions. Examples of these symptoms include avoidance, reports of discomfort or terror, and heart palpitations or sweating. Once a fear in a child has been assessed, the counselor chooses a treatment approach. Two examples of cognitive-behavioral treatments for children with anxiety include cognitive restructuring and relaxation training. Studies provide support for the effectiveness of cognitive-behavioral treatment for children with anxiety at posttreatment and follow-up.

Limitations

Although several authors (Knell, 1993; McWhirter, McWhirter, & Gat, 1996) have suggested that the cognitive-behavioral model is an effective intervention strategy for working with children little empirical research has been conducted to support this assertion, especially with minority children. In a review of the literature, the author found only one study (Trimble, 1992) on the use of cognitive behavioral approach with minority children. Many of the articles and book chapters found in the literature use descriptions of specific interventions (Grace et al., 1993; Stark, 1990) or reviews of the literature on cognitive-behavioral treatment related to children (Hart & Morgan, 1993; Kazdin, 1989a; Kendall 1993).

Research which has been conducted is limited be several methodological flaws. These flaws include the lack of follow-up studies, a limited number of subjects, and a dearth of subjects from diverse cultures.

Summary

Cognitive-behavioral therapy with adults has been widely written about and used in counseling. The area of cognitive-behavioral therapy with children has experienced recent growth. The first aspect of working with children using any theory is for the professional to be aware of developmental changes. Counselors should be aware of developmental differences in such areas as attention and retention, moral reasoning, and problem solving.

Another important aspect when working with children is building rapport. Children may be more cautious to trust than adults, therefore it is important for counselors to be aware of strategies to build rapport with children. These strategies include using conversation or play to get to know the child, using questions carefully, and talking with the child about what he or she wants from counseling. Each of these strategies can help to build trust and rapport between counselor and child.

Two disorders with which children may suffer include depression and anxiety. Depression is the most common emotional disorder in children as well as adults. Children experience three types of symptoms for depression. These symptoms include emotional, physical, and behavioral symptoms. It has been reported that children may experience more physical symptoms for depression than adults.

Three cognitive-behavioral treatment strategies for working with children with depression include affective education, cognitive restructuring, and social skills training. One important aspect of cognitive-behavioral treatments for children is teaching. In each of these treatment strategies, the counselor teaches the child about emotions, cognitions, or social interactions. These strategies may be used together in a multimodal approach to working with children with depression.

Anxiety is also common in children. This anxiety may be expressed in fears that are natural for a child's development or unnatural. Anxiety in children is expressed in motor, subjective, and physiological reactions. Examples of these symptoms include avoidance, reports of distress or terror, and rapid breathing.

Two cognitive-behavioral treatment strategies for working with children with anxiety include cognitive restructuring and relaxation training. As was the case with treatment strategies for depression, each of these strategies involves teaching. In the case of anxiety, these strategies teach cognitions, and relaxation skills.

There is an increasing need for counseling for children in today's society. As a result of this increasing need, there is a need for counseling theories to be expanded for use with children. Cognitive-behavior therapy has developed strategies for working with children in many different areas of mental health.

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