SECOND EDITION

CHILD AND ADOLESCENT THERAPY

SCIENCE AND ART

Jeremy P. Shapiro

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Child and Adolescent Therapy

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Preface

The Therapist's Challenge

The purpose of this book is to equip readers with the knowledge and skills they need to provide effective psychotherapy to children and adolescents. I aim to provide an understanding of the major theoretical approaches, knowledge about the findings of outcome research, training in a variety of therapeutic techniques, and lots of good words to say to young people and their parents. This is an academic text and a how-to book in which intellectual rigor and practical application are viewed as equally important and complementary objectives. The goal is to articulate the knowledge base and thought processes of skilled therapists making scientifically and clinically well-informed decisions about what to do when. Thus, the book is about theory, etiology, change agents, technique, meta-analysis—and what to say to the kid.

Weisz (2004, p. 5) defined psychotherapy as "an array of nonmedical interventions designed to relieve psychological distress, reduce maladaptive behavior, or enhance adaptive functioning through counseling, structured or unstructured interactions, training programs, or specific environmental changes." The common element linking these activities is this: Psychotherapy relies on *talking* as a method of resolving problems. Therapy is not alone in its purposeful use of conversation, and people have sought help by talking to trusted relatives, friends, and clergy for far longer than counseling has existed. But therapy is also a professional service and, to justify the remuneration we receive, counselors should be able to provide forms of help that laypeople cannot reliably offer. There needs to be something different about our talk.

Psychotherapy fulfills a distinctive and rather remarkable function in our society. When something goes wrong with our cars, we go to automobile mechanics to fix them. When something goes wrong with our bodies, we go to physicians for treatment. When something goes wrong with our emotions or behavior, society recognizes psychotherapists as the people to call for help with these central aspects of self.

Given the deeply personal nature of the problems for which therapy is sought, clients and parents are in a position involving considerable vulnerability and trust. They are generally willing, just moments after meeting a stranger, to describe important, painful, and, perhaps, embarrassing aspects of their lives. Therapy is about issues that people do not usually discuss with full openness, such as love, rejection, anger, sex, hopes, fears, despair, guilt, and so forth. Clients and parents are often willing to disclose information and feelings they have never told anyone before, just because the stranger sitting in front of them has a license indicating her commitment and ability to respond helpfully to this type of disclosure.

The trust that parents demonstrate by bringing their children to therapists imposes an important responsibility on us. It is an honor and a privilege to work with people on the deepest, most personal aspects of their lives, and, in order to be worthy of this trust, we must do our best not to let our clients down.

Language is the main tool of the therapy trade. Although play and artistic activities sometimes supplement verbal communication with children, and our talk often refers to actions, for the most part the work of therapy consists of a search for good words. Physicians have their laboratory tests, radiological devices, medicines, and surgical instruments—we have our words. At first, this might be an intimidating thought, because we are up against a lot. The causes of mental health problems include genetic abnormalities, poverty, family dysfunction, child maltreatment, trauma, irrational thoughts, maladaptive learning histories, and so forth. By the time a child becomes a therapy client, factors like these may have operated in his life day after day, month after month, for years. Confronted with forces like these, words might not seem like much.

When I was a graduate student in my first clinical placement, a client with severe problems resisted my invitation to therapy on the grounds that "I don't see how talking about it will help." I did not have an adequate response. In fact, I was frightened that the young man might be right, and talking about his unhappy life would do nothing to make it better.

I panicked prematurely. As discussed in the outcome research sections of the chapters to follow, psychotherapy is generally an effective means of treating emotional and behavioral problems. During the past 100 years or so, clinicians and researchers have developed a number of methods that, for most clients, are at least moderately helpful. In a sense, this book represents a long, detailed response to the fear that therapy (i.e., mere talk) might be overmatched by the causes of mental health problems and might lack the power to create significant changes in damaged, troubled lives. The therapist's challenge is a daunting one, but most of the time it can be met. Talking about problems—in certain, specific ways—really can help.

The chapters that follow describe these ways. Part I presents the major theoretical orientations and the therapeutic techniques associated with them. These theoretically based approaches are the tools of the therapist's trade, the primary colors of our palette, and the main options from which clinicians select the strategies they will use with each client. Part II, which is organized by categories of diagnoses, applies these strategies to the mental health problems that are common in children and adolescents.

The website associated with this book includes a number of forms and handouts that therapists can use with clients. The forms can be printed out as they are, or you can modify the documents to customize them for particular clients. The web address is http://www.wiley.com/college/shapiro.

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PART I

THE TOOLS OF THE THERAPIST

1

Therapy Fundamentals

OBJECTIVES

This chapter explains:

- *The orientation toward clients at the foundation of therapy.*
- *Therapeutic language, including some specific words and phrases to use with young people.*
- *What to do in the first meeting with children and parents.*
- *What can and cannot be kept confidential from the youth's parents.*
- *Reflection of feeling and reflection of meaning.*
- *Therapy goals that motivate and organize clients' efforts for improvement.*
- *How to use play and art in child therapy.*
- *Motivational interviewing, a strategy for overcoming resistance.*
- *Simple, directive therapeutic interventions.*
- *Therapy termination.*

Case Study

Simplicity

Brent, a 5-year-old African American boy, was having trouble in kindergarten. The teacher reported that his academic skills and peer relationships were age-appropriate, but there had been repeated incidents of disobedience toward the teacher, accompanied by tantrums. Brent was not physically aggressive, but he screamed and cried, and it sometimes took 10 to 15 minutes to bring him under control. His behavior was generally pleasant and appropriate in between these outbursts, which had occurred two or three times per week during the several months since school began.

Brent lived with his mother, an older sister, and his maternal grandparents, who provided much day-to-day childcare. The caregivers reported that Brent saw his father once a month or so and seemed sad at the end of the visits. The caregivers said there were no problems with Brent's behavior at home, and they described him as a happy, energetic, cooperative child.

The therapist's impression of Brent was consistent with his caregivers' description. In both play and conversation, his behavior was organized and compliant. His play with puppets depicted exciting activities and interactions, with no unusual themes of distress or defiance. Because Brent had exhibited no problems prior to starting school, the counselor made a diagnosis of Adjustment Disorder with Mixed Disturbance of Emotions and Conduct.

While most of the chapters in this book are organized around specific theories of psychotherapy or categories of disturbance, in this chapter we begin with basic therapeutic principles and procedures that crosscut theoretical orientations and apply to most diagnoses. Research has produced a great deal of evidence that such shared or common factors of therapy are central to its effectiveness (Baskin, Tierney, Minami, & Wampold, 2003; Imel & Wampold, 2008; Wampold, 2010).

The Therapeutic Orientation Toward Clients

While the activity of psychotherapy is based largely on theory and technique, there is a certain attitude that lies at the foundation of our endeavor. This attitude orients us to our job, organizes our efforts, and governs the interpersonal tone of our behavior with children and families. The idea behind the therapeutic orientation is so simple that it might sound like a cliché, but its ramifications are important to consider. The moment-to-moment behavior of therapists should convey that they are there to help the client with her problems and her life. This is the role of therapists as established by professional ethics and licensing regulations.

Although this point seems obvious, it is worth making because parents and children sometimes fear their therapists are *not* there to help. Youth sometimes think that being brought to counseling is a serious form of getting in trouble (an impression that is not always inaccurate). Children and parents sometimes think that therapists are there to evaluate and judge them—to identify and point out their failures and inadequacies. This fear seems particularly common in low-income and ethnic minority families who feel intimidated by encounters with "the system" (Sue & Sue, 2013). Therapists should be alert to the possibility of these concerns in clients so they can counteract them either with explicit explanations of their role or by making sure to convey a help-focused agenda in their way of interacting with families. If families seem more concerned about your approval or disapproval than about benefiting from counseling, it may be useful to say something like, "Remember—you don't work for me, I work for you."

When the therapeutic attitude is translated into behavior, the therapist models an attitude toward life that is adaptive and constructive. She does not hesitate to discuss any issue or experience, no matter how awkward or upsetting. The counselor's stance toward the client does not change whether the child reveals things about himself he considers wonderful or things he considers shameful; the therapist's unvarying desire is to understand and help.

The issue of counselors making judgments about clients has two aspects. The therapeutic attitude is based on unconditional acceptance, respect, and caring about the client *as a person*. However, this attitude does not include unconditional approval of all client

behaviors. On the contrary, in many cases our efforts to assist clients necessarily involve helping them change maladaptive behaviors. This two-part attitude can be explained to children using words like the following:

> "I like *you*; I just don't like what you did. In fact, I like you too much to want you to go on doing what you did."

The idea of unconditional respect for clients generally makes sense to therapists when they read about it in a book, but in the midst of real clinical work with difficult clients, maintaining this attitude is not always easy. Our commitment to a humanistic, forgiving view of people is sometimes tested by contact with child and parent behaviors that are obnoxious, mean-spirited, and cruel. No one knows how to increase the resilience of the therapeutic attitude, but I will try to provide some guidance by offering personal, experience-based reflections.

The therapeutic attitude seems based on an awareness of certain fundamental truths about human life. People, especially children, usually do not choose the situations in which they find themselves. They do not choose the family environments, neighborhoods, and schools that influence their development. People also do not choose the genetic endowments, physical constitutions, and neurophysiologically based temperaments that, operating from within, strongly influence their experience and behavior. Within these constraints, people try to do the best they can for themselves, seeking happiness where opportunities present themselves and avoiding pain when dangers occur. People become therapy clients when their efforts to adapt are disrupted by neurophysiological dysregulation, environments that are harmful or poorly matched to their needs, unrealistic thinking, and painful emotions. As a result, clients often stumble, grope, and flail in their efforts to be happy, sometimes leaving painful experiences for other people in their wake. But clients do not wake up in the morning and decide to spend the day making themselves and others miserable—these are unchosen outcomes. Even when people do poorly, they are generally doing the best they can in a world perceived as confusing and painful.

Therapists' initial, natural response to obnoxious or purposely hurtful behavior is often emotional distancing, perhaps even revulsion. However, I have found that the most effective response to this therapeutic challenge is not distancing but attending *more* closely to the parent or child, because increased awareness of the other person's experience usually counteracts anger and disrespect. Looking closely into a person's face, feeling the rhythm of her speech and movements, and sensing the emotions behind her behavior strengthen our appreciation of that person's humanity. When your therapeutic attitude toward a client is threatened, I would suggest trying to imagine what his life feels like to him, moment to moment, as he wakes up in the morning, goes about his day, and encounters you in this strange context called therapy. If you do this, I predict your respect and concern will be rescued, not by abstract humanistic principles, but by the little things people do and say that express something intimately human and reveal their struggle and suffering.

The Therapist's Interpersonal Style

The theoretical orientations described in the chapters to follow differ somewhat in their recommendations for the counselor's style of interacting with clients. Nonetheless, there are some basic principles that crosscut the different therapeutic approaches, and we will begin with these.

One of the most robust findings in psychotherapy research is that the quality of the therapist-client alliance predicts continuation in therapy (versus dropout) and improvement in client functioning (Horvath, Del Re, Fluckiger, & Symonds, 2011; Marcus, Kashy, & Baldwin, 2009; Norcross, 2010; and see McLeod, 2011 for a meta-analytic review focusing on child and adolescent therapy). This association, which is generally of modest but significant strength, has been found across a variety of theoretical orientations and diagnostic groups.

Research indicates that therapists should try to combine the behavioral qualities of professional expertise and empathic warmth—science and heart—in their interpersonal style with clients.

The next question is: What can therapists do to engender positive relationships with clients? Therapist *empathy* seems to be the single most important factor in the development of the treatment alliance (Bohart, Elliott, Greenberg, & Watson, 2002). Most clients respond best to counselors who come across as friendly, kind, and warm (Najavits & Strupp, 1994). A review of studies by Orlinksy, Grave, and Parks (1994) identified client perceptions of therapist credibility and professional skill as important to the therapeutic relationship. Thus, research indicates that therapists should try to combine the qualities of professional expertise and empathic warmth—science and heart—in their interpersonal style with clients.

Social psychology research has found that people like others more when the person mirrors their nonverbal behavior and interacts with a similar tone of voice, energy level, and rhythm (Chartrand & van Baaren, 2009). When two people interact in an engaged, harmonious way, their styles tend to converge and become more similar over time. This phenomenon occurs in psychotherapy: Therapists whose moment-to-moment fluctuations in physiological arousal mirror those of their clients are rated as more empathic by those clients (Marci, Ham, Moran, & Orr, 2007). We can capitalize on this phenomenon by tuning into our clients' styles and allowing ourselves to fall into their rhythms. We cannot be chameleons—and it is counterproductive to try, because imitating others in a contrived way backfires and reduces liking (Chartrand & van Baaren, 2009)—but we can adjust our style to somewhere in between our baseline and the client's style, which enables us to connect while remaining anchored in our usual way of interacting. This would mean being soft and gentle with a shy, anxious child and being rougher, jauntier, and more casual with a rebellious adolescent.

Although the early influence of psychoanalysis once popularized a neutral, observant style for therapists, research indicates that most clients do not connect well with reserved, distant counselors. Instead, treatment alliances are strongest when the client perceives the therapist as a real person who is fully engaged, present, and authentic in the relationship (Geller, Greenberg, & Watson, 2011; Klein, Golden, Michels, & Chisholm-Stockard, 2002), and when the client believes the therapist likes and cares about him (Farber & Lane, 2002). I have heard young clients complain about past therapists who "sat there and waited for me to say something," and who "stared at me and didn't talk." Counselors seem to be most effective when they allow themselves to be natural and emotionally present in the context of a professional but genuine person-to-person relationship.

The traditional, analytic style excluded therapist self-disclosure, but there are problems with this exclusion. Clients sometimes ask us questions. Himelstein (2013) noted that many youth are put off by the analytic response of asking why the client desires this information; this type of answer might seem evasive. In my experience, it is better to answer the questions I feel comfortable answering (most of them) and to respond to questions that

seem too personal by saying I do not want to answer for this reason. If the question seems to have emotional meaning to the client, it is more effective to inquire about this *after* giving an answer.

As an empirical matter, research generally supports the value of therapist self-disclosure. In studies of adults, counselor self-disclosure is associated with positive client outcomes (Barrett & Berman, 2001; Hill & Knox, 2002). Self-disclosure can help clients feel comfortable by showing that therapists have feelings too and are not ashamed to share their emotions, which can strengthen the therapeutic relationship by adding an element of mutuality (Tsai et al., 2009). Modeling emotional self-expression provides a direct form of training in talking about feelings (Goldfried, Burckell, & Eubanks-Carter, 2003). Of course, therapists should self-disclose only to achieve some therapeutic benefit for the client, not to fulfill any personal need of their own (Hill & Knox, 2002).

The therapist-client alliance seems to develop best when a certain balance is achieved, and the therapist's manner is warm and caring but without an emotional intensity that would change the relationship from a professional to a personal one. Therapists should be cheerleaders for their clients, rooting for them to make progress against their problems. Our faces should light up when we hear reports of progress and should express concern when setbacks occur. However, there should be boundaries on our expression of reactions, which should never be so intense that clients come to worry about upsetting us or letting us down.

Empathy is much more important than sympathy in psychotherapy, but when people express genuine suffering, there is a place for both. If these words convey your feelings, there is no reason not to say, "I am so sorry that happened to you," or "I am sorry you are hurting so badly."

Therapy Language

Therapists' talk should consist of ordinary language and speaking styles. I would caution against adopting a stereotypically therapeutic manner because this might come across as inauthentic and affected to clients. Counselors should avoid technical jargon, intellectualized language, and an overtly "touchy-feely" style. Youth generally like therapists who talk like regular people, not "shrinks."

The phrases "It sounds like …" and "It seems like …" are convenient and useful as long as they are not overused. Statements beginning with the pronoun "I"—such as "I think that …," and "I wonder if …"—have a straightforward quality—for example:

- "I think you would like to do well in school, but you don't know how to go about doing that."
- "I can see you're mad at yourself for losing your temper with him."

Much therapy talk involves words for feelings. Most preschool children know basic emotion words like "sad," "mad," "scared," "fun," and "happy." The word "yucky" describes a certain type of discomfort or disgust. Most elementary school children can verbally label more complicated emotions like "nervous," "disappointed," "excited," frustrated, "upset," and "bored." Adolescents can usually talk about still subtler varieties of emotion.

Discussion of emotional issues need not consist entirely of words for feelings. Talking about motives, goals, meanings, and reactions also builds self-awareness and clarifies issues.

Clinicians talk about what clients want and do not want, what they hope for and fear, and what they like, love, dislike, and hate. As other examples:

- "You love the teddy bear your aunt brought you, and it was horrible when Debbie spilled grape juice on it."
- "You really had your hopes up, and it was awful when she said no."

Ambivalence can be described as "mixed feelings" or "having two different feelings about the same thing at the same time." Motivational conflict can be discussed by referring to "parts of you" that want different things. Counselors can also portray the co-occurrence of conflicting emotions by using the word "and" and connecting the two feelings with a tone of voice implying that their co-occurrence is perfectly plausible—for instance:

- "You're scared to go, and you're excited to go."
- "You want to tell me what happened, and you don't want to tell me what happened."

Several words and expressions come in handy for conveying certain important concepts to clients. The word "work" is a good description of therapy-related efforts (e.g., "I'm glad you're ready to start working on your behavior"). The best single term to describe your job with clients is "help." Because children think in terms of "good" and "bad," it is usually unnecessary to replace these words with the fancier alternatives of "positive" and "negative." The word "choice" is useful when discussing client actions because it highlights their capacity for control and responsibility. Thus, it is often useful to talk about good choices and bad choices. The word "mistake" is a useful term for maladaptive behavior. Therapists sometimes distinguish between the persona the client presents to the world and what goes on inside.

When working with children, therapists face the challenge of discussing complex issues in language that young people can understand. Finding words to use with children requires us to leave behind the familiar complexities of technical terminology and distill our messages into stark, basic terms. Albert Einstein said that if you really understand something, you can explain it to a 5-year-old. I have no idea how this applies to the theory of relativity, but it does apply to the issues of concern in therapy—for example:

- "You want to be good, but sometimes it's fun to be bad."
- "You feel like it's wrong to be mad at someone you love."
- "You think the bad things that happened to you must mean you're a bad person."

Getting Started

Most child clinicians begin treatment by meeting with the parent(s) alone for one session to obtain a description of the youngster's problems and the parent's goals for therapy. This practice is consistent with the legal structure of child treatment, which occurs at the behest of parents or guardians and is directed largely by their agenda (Weisz, Ng, Rutt, Lau, & Masland, 2013). Therapists usually meet the youngster at the second session.

Meeting the Parents

The purpose of the first meeting is to establish a treatment contract with the parents. This "contract" is not a written, legalistic document but a shared understanding of the goals and nature of what will occur.

First sessions consist mostly of clinician questions and parent answers about the child's presenting problems, development, general functioning, and history. It is usually best to start off with a simple, open-ended question, such as, "What brings you to our clinic?" or "What are your concerns about your son?" Specific questions depart from the parent's answer to this first question.

After the therapist has inquired about the child and family, he should invite the parents to ask any questions they have about him, particularly his credentials, education, experience, and methods of working with children. This part of the meeting is like a job interview for the therapist in the sense that the parents, as consumers, are entitled to inquire about the services they are thinking about purchasing. In my experience, however, while parents appreciate the invitation to inquire, they rarely have any questions about professional qualifications. Most of what they need to know they have already learned in the process of talking to the counselor—namely, whether he seems like a nice person who knows what he is doing and is genuinely concerned about their child.

First meetings should produce a decision about whether the therapist is the right person for the job of treating the child. The clinician is responsible for being ethical about her part of the decision, which depends on the fit between her areas of expertise and the child's problems. If the clinician's self-assessment suggests she does not have expertise in the child's specific difficulties, she should make an appropriate referral.

Parents generally want to know whether therapy is likely to help their child. I would suggest addressing this question with a combination of scientific information and human response. As is generally indicated by the outcome research sections of the chapters to follow, psychotherapy typically produces improvement in approximately 70%–85% of clients, with some variation as a function of diagnosis and history. However, this type of information is the beginning, not the end, of what parents want to know. Guarantees should never be given, but most parents appreciate sincere statements of determination and realistic optimism about the new endeavor they are embarking upon. Probabilistic statements based on research with large samples of clients are usually less meaningful to parents than statements like the following:

- "I believe I can help your son."
- "Therapy can certainly help children with problems like Lloyd's."
- "I'm going to do my best to help Alison. I see what caring parents you are, and your description shows that Alison brings important strengths to therapy. We've got a lot going for us here, and if we work as a team, I think things are going to get a lot better for your daughter."

Parents sometimes ask how long therapy will take. Although this is a reasonable question, the state of our science is such that we cannot give precise answers with confidence. Successful therapy typically involves about 5 to12 sessions, but there are lots of exceptions on both ends of this range. Clients whose general development is proceeding well and who have mild, circumscribed problems tend to need less therapy than clients with serious,

pervasive dysfunction. Brent was an example of the first type of client, so his clinician predicted that therapy would be brief.

First meetings usually conclude with talk about scheduling. Child therapy typically occurs on a weekly or biweekly basis. Weekly sessions seem to work best at the beginning, so children can establish a sense of continuity and interventions can get underway. After this launching phase, biweekly sessions might be more efficient because they provide time between sessions to assess the effects of interventions. The family's practical needs and preferences are also important considerations in scheduling.

Meeting the Child

At the next session, the child will be there, waiting to meet his new therapist. Except with some older adolescents, I generally begin by inviting the child and parent into my office together. This gives the child some time to transition from being with the parent to being with me, and it allows the three of us to make sure we are on the same page concerning the purpose of therapy. I ask the child what the parent has explained and proceed from there.

Providing children with an explanation of therapy might seem like a daunting task, but usually it is not. For some reason, most children seem to have an intuitive grasp of therapy, so a few sentences of explanation are all they need. When Freud first proposed that talking about emotional problems could lead to their resolution, the scientific establishment of his time rejected this proposal as ridiculous, but the idea seems to make sense to children.

With young children, you can start off by saying:

> "I'm a therapist. Do you know what a therapist is?"

Clinicians with doctoral degrees have access to a word that is handy for explaining therapy, because children understand that doctors help people with physical problems. The terms "talking doctor" and "feelings doctor," along with a statement that, "I don't give shots," convey the idea of counseling. Regardless of the clinician's degree, words like the following can be used to explain therapy:

> "Therapists help kids with problems. These problems have to do with feelings, behavior, and getting along with people. Like, if a kid was real sad, or mad, or she got in a lot of trouble at school, a therapist could help with that. In therapy, we talk about what's wrong, and we find ways to make things better."

With older children and adolescents, it is useful to ask, "Have you ever done anything like this before?" Even if you know the answer from the parent, asking this question often sets the stage for useful conversation. If the youth has had therapy before, it is important to learn about his experience. If the experience was negative, you can find out why and say you will try hard to do better than the previous therapist. If the youth has not had counseling before, you can empathize with the unfamiliarity of the experience and ask whether she has an impression of therapy from movies or TV. Most young people do. After asking about these impressions, you can say something like, "Well, by the time we're done today, you'll know whether TV and movies get it right, because you'll find out what therapy is actually like."

After a general introduction, discussion should move to the specifics of the youth's situation—for instance:

> "Your mom and dad thought it would be a good idea for us to talk because you seem sad a lot of the time. They said you don't go out and have fun the way you used to, and when things go wrong, like with homework, you get upset, put yourself down, and say you can't do it. Your parents don't think this is okay because they want you to be happy, so they brought you to see me because this is the kind of thing I help kids with."

If the youth understands the reasons for therapy but seems unhappy or ashamed about needing help, you could say something like:

> "Look, people are sometimes unhappy about starting therapy because it means there are problems in their life. Still, if you give it a chance, I think you'll find it's interesting, and good things can come from therapy. There's nothing like it."

The comfort level of young children is less a function of their abstract understanding of therapy than their visceral sense of what it is like to be with the therapist as a person. Counselors should not only be friendly and warm but should also allow shy children some space and time to warm up. Inviting children to explore our offices and toys provides a way to be together without the pressure of structured conversation.

Questions about favorite things help us enter the child's world, and giving our own answers helps clients get to know us. It may be pleasant and useful to talk about favorite foods, colors, animals, games, sports, books, TV programs, music, websites, and so forth. We need not be all business, and there is value in talking about interests, hobbies, and activities.

Research on the placebo effect indicates that, whether the target of intervention is physical or psychological, expectations of improvement tend to be self-fulfilling, so that optimism promotes healing (Duncan & Miller, 2000; Snyder, Michael, & Cheavens, 1999). Clients who expect therapy to work achieve better outcomes, compared to clients with less optimistic expectations (Joyce & Piper, 1998). Therefore, it is therapeutically useful for clients to depart from their first session with feelings of hope. Counselor statements about the likelihood of change will not be credible if they are unrealistic, but counselors can acknowledge difficulties while expressing determination and realistic optimism.

Research on the placebo effect indicates that expectations of improvement tend to be self-fulfilling, so that optimism promotes healing.

> "Next week, when you come back, we'll roll up our sleeves and get started. We'll put our heads together and think of different strategies. If one thing doesn't work, we'll try something else, and we won't stop until things get better for you."

One good line with which to conclude is, "I'm glad you came to see me." If said with the right tone of voice, this statement refers both to the seriousness of the problems and to the therapist's optimism about helping, while also communicating warmth and a sense of enjoyment about the process.

Confidentiality

The ethical and clinical issues involved in confidentiality for child clients are potentially complex, and laws vary slightly from state to state. This chapter does not address these complexities but offers guidelines that should suffice in the vast majority of cases. If needed, therapists can do additional reading (e.g., Ascherman & Rubin, 2008; Koocher, 2003) and/or consult with colleagues. If a difficult question arises, it is useful to request guidance from one's state professional board because, in the event of an allegation of misconduct, compliance with these authoritative opinions provides an effective defense.

In work with adults, therapists cannot divulge any information about the client without consent unless there is a danger of harm to self or others or a court order. The situation for children is different. Clients under age 18 have no legal right to confidentiality or privacy from their guardians. In fact, parents have a legal right to all information about their child's therapy—if they insist on it.

This description of the law might make it sound as though therapy must involve difficult conflicts between children's needs for privacy and parents' right to information. Fortunately, in practice, things usually work out quite easily. Most parents understand that, if therapy is to be effective, clients need some privacy in which to speak openly. Clinicians should present both sides of this issue to parents so they understand both their legal right to information and the clinical value of privacy for the child.

There are two types of information that parents should always receive even if they are willing to honor their child's desire for privacy. First, clinicians must inform parents about any danger of harm to the client or another person. Therapists must tell parents about client statements related to abuse, neglect, and violations of the law. Information about abuse and neglect must also be reported immediately to the state child protection agency. Client disclosures about nondangerous sexual behavior and circumventions of family rules are in a gray area; decisions about sharing this type of information should depend on possibilities of harm and the overall therapeutic situation. The second form of information parents should always receive is a general description of the overall direction of their child's treatment. This means describing what the child is working on, the treatment strategies being used, and the child's progress or lack thereof.

Therapist decisions about whether to report details of the client's thoughts, feelings, opinions, and experiences should usually depend on what the youngster wants. If the client wants this material held in confidence, the therapist should honor the request as long as this is acceptable to the parents. Often, however, youth *want* therapy material conveyed to their caregivers, either to help the parents understand them or for use in problem solving.

Children's desire for privacy from their parents generally increases with age. Adolescents usually need substantial privacy to feel comfortable in therapy.

Therapists should be honest with clients about limits to confidentiality. At the beginning of therapy, counselors should tell clients what can and cannot be kept private, so there will be no surprises.

When sensitive material must be disclosed to parents, counselors should approach this as a therapeutic opportunity, not a matter of the youth being "busted." Counselors can invite clients to participate in these meetings, so they know exactly what is said. If the youth is willing, it might be useful for her to report the information, with the therapist in a position to ensure that nothing important is left out (Santisteban, Muir, Mena, & Mitrani, 2003). This procedure allows the youth to preserve some control over the disclosure of sensitive material.

Basic Child Therapy Skills

The chapters that follow present detailed recommendations based on theoretical orientation and diagnostic category. This chapter offers some general guidelines that apply across theories and diagnoses.

Assessment

Although research has produced a number of structured interview protocols that produce detailed diagnostic information, the old-fashioned clinical interview and behavioral observation are the main methods of assessing clients and planning therapy in most clinical settings. Freedheim and Shapiro (1999) present guidelines for general assessments of child functioning; Form 1.1 on the website for this book presents their list of diagnostic interview questions.

Regardless of the therapist's theoretical orientation and the client's diagnosis, assessment should address the concrete specifics of the presenting problems, when they get better and when they get worse, the history of the problem's origination, variables associated with fluctuations in problem severity, the parent's and child's thoughts about causes of the problems, past efforts to address them, and the results of those efforts. Assessment research demonstrates that different informants often report different perceptions of the same child, making it important to obtain information from more than one perspective (De Los Reyes & Kazdin, 2005).

To be useful clinically, assessments should aim not simply to assign a diagnosis but also to illuminate the **etiology** of the client's problems. This word was originally defined as the cause of a disease (e.g., a pathogenic virus). In this book, the word "etiology" is used in a broad sense to include all the factors that cause, maintain, or contribute to a client's mental health problem (e.g., poverty, trauma, family dysfunction, irrational beliefs). This word originated in medicine, but my use of it is not meant to invoke the medical model of mental health problems.

Questions for the child should focus on the thoughts, feelings, and behaviors associated with the difficulties. This aspect of the assessment aims to achieve an empathic understanding of what the disturbance feels like to the client. Simple, basic questions are important here, with mainstays including, "How did you feel when _____?," "What was that like for you?," and "How did that feel to you?"

"Why questions"—questions about causality—are often more difficult for children, and they might not be able to answer them. Identifying the causes of difficulties is more the therapist's job than the child's, but it is often informative to ask for her thoughts about reasons for the problems.

Questions for clients are usually most effective when framed from their perspective, which means inquiring about what the behavior feels like to the child, not what it looks like to adults. For example, instead of asking, "Do you stay in your seat in school?" one could ask, "Do you ever get bored and antsy in school, so you feel like you have to get up and move around?" Therapists can encourage open, informative responses by acknowledging the pressures underlying negative behaviors, because this enables clients to disclose their difficulties without portraying themselves as bad kids.

One of the nitty-gritty problems in child therapy is that some youngsters do not talk much, especially about emotional issues, not because they are resistant but because they are unaccustomed to this type of conversation and are not skilled at translating

experiences into words. This obstacle to communication occurs more frequently in males (Jansz, 2000; Kring & Gordon, 1998). Counselors can help by doing some of the work of verbalization for the client, but without making undue assumptions. One technique for doing this is the multiple-choice question. Generally, counselors should begin with open-ended questions, but if the client does not respond with informative answers, providing some plausible options gives him a way to convey information without floundering in words. Perhaps the most common example is when the client says he feels "bad" about something; the follow-up question could ask whether he feels mad, sad, or scared. Here is a more complicated example of a multiple-choice question from therapy with a child who worried when her father, recently divorced from her mother, travelled out of town:

> "Are you worried about him flying in an airplane, or are you scared something bad might happen to him while he's away, or is it more that you think he might decide not to come home and then you won't see him anymore?"

One formula for framing empathic questions makes use of the words "easy" and "hard" to provide options from which the client can choose. These questions acknowledge the possibility of an unchosen quality in the problems—for instance:

- "Is it easy for you to pay attention in school, or is it hard?"
- "Is it easy to feel cheerful most of the time, or does life sometimes seem crummy, so you can't help feeling depressed?"

Questions that use the words "trouble" or "problems" to refer to negative behaviors also provide a palatable way to admit difficulties—for example:

- "Do you sometimes have trouble following your parents' rules?"
- "Do you have any problems with fighting?"

Assessment does not cease after the first session but is an ongoing element of therapy. Counselors monitor the child's presentation on multiple channels by attending to their words, physical behavior, tones of voice, facial expressions, and body language. They appraise, conceptualize, and integrate different forms of information, including the client's in-session functioning, reports from parents and teachers, and the child's history.

In the process of assessment, one useful question to ask ourselves is, "Why *would* a youngster feel and behave this way?"—for example:

- "Why would a child be so afraid of a father who seems so nice?"
- "Why would a 10-year-old spend so much time alone in her room?"
- "Why would an adolescent run away from home?"

Clinicians tend to focus on problems, because this is why clients come to see us, but assessment should also include attention to positive aspects of the child's life. Focusing exclusively on problems produces an incomplete, distorted picture of the youngster.

Treatment should make use of the client's strengths, and this cannot be done unless the therapist knows what these resources are. Important examples of client strengths include awareness of the problems, ability to form relationships, openness, determination in pursuit of goals, artistic talents, sense of humor, and so forth.

The most important part of Brent's assessment was the clinician's phone conversation with his teacher, who noticed a simple pattern: In practically all the incidents of concern, Brent had been enthusiastically focused on some toy or play activity when the teacher interrupted him with a directive to move on to something else. He was apparently unable to accept this external direction and shift his attention away from the activity in which he was immersed, and the teacher's efforts to get him to do so resulted in tantrums.

Session Structure and Activities

With children, early adolescents, and older adolescents in therapy for disruptive behavior problems, work with the parents is an essential part of treatment that should be part of practically every session. This is less so with older adolescents whose problems are primarily emotional, not behavioral. It is not generally necessary to speak with their parents at every session, and these clients can attend some sessions alone if they have their own transportation.

When parents are an integral part of the process, it is usually advisable to spend the first 10–15 minutes talking alone with them. This is the time to ask about recent life events, changes in the client's functioning, responses to therapy, and interventions conducted by the parent at home. Then, when the parent leaves and the child comes in, the clinician has an external view of the behaviors in question, and she needs to hear the child's view—for example:

Therapist: How have things been going?

Client: Pretty good.

Therapist: That's not what your mom said.

Much child treatment involves going back and forth between the parent and client while trying to integrate their two perspectives in a way that does justice to both—for instance:

- "Your mom said you were really mad the other night. What was going on?"
- "Your dad told me about the soccer game. What happened?"

In work with youth, conversation does not stay focused on therapy issues all the time, and there is also some talk about other topics, including the client's interests and activities. This is especially true with young children, who often spend some session time on play activities with no obvious connection to their treatment goals. Therapists need to find a balance in which there is a focus on therapeutic work but the client also has some freedom to pursue topics and activities of his own choosing. One way to strike this balance is to follow the child's lead while being alert for signs of his issues in play or conversation. When these signs appear, we can respond by addressing the issues in a context that is meaningful to the child. As examples, therapists could respond to talk about peers in school by teaching

a social skill, and clinicians could respond to self-denigrating talk during play by addressing self-evaluation and self-esteem issues.

Therapists who follow the child's lead will sometimes find themselves playing ball, watching dramas enacted by puppets, and talking about TV programs, hobbies, parties, and so forth. One technique for building rapport is to ask clients to bring in and share favorite things from their everyday life, such as toys, hobby materials, photographs of friends, favorite music, or their prom dress. Video games are so important to some clients that spending time watching them show us how these games are played is a worthwhile investment in relationship building. Clinicians with a strong work ethic might feel uncomfortable having fun with clients, and there might be thoughts like, "Uh oh—am I working? Is this therapy?"

The answer to both questions is probably yes, because the therapist-client relationship is the launching pad of counseling—you won't get far without it. Therapists join with young people on their terms by sampling their interests and experiencing what they enjoy. Spending some time following the client's lead establishes a connection that makes it more likely she will be willing to follow yours. It is like click-and-drag: First we go to clients and then, hopefully, they will come with us.

When therapy produces important insights, ideas, and plans, we want these advances to take root in clients' minds, so they do not slip away. Counselors can galvanize the memory process by being emphatic and earnest in stating important points. Therapists should not be afraid of sounding simplistic or corny, because children need simple, strong messages to hold onto. Counselors can facilitate the client's comprehension and memory of therapeutic material by providing occasional reviews and by asking the client to summarize what he has learned in therapy—for example:

Therapist: What should you do if you get mad?

Client: Take a deep breath and use my words instead of my fists.

Putting ideas and strategies in writing is an effective way to summarize and preserve therapeutic insights and plans, so the client can take therapy home.

One common problem is that clients sometimes understand and affirm positive plans in sessions but then forget or lose touch with these plans when they need them in the everyday environment. Putting ideas and strategies in writing is an important way to summarize and preserve therapeutic insights and plans, so the client can take therapy home (J. S. Beck, 2011). The activity of completing worksheets, lists, and diagrams provides structure for conversation, facilitates comprehension, and provides documents that support the child's memory. Pictures can serve the same function for children who do not read. Older clients can keep notebooks in which they record material learned in sessions, homework assignments, and their thoughts about therapy-related issues.

When counselors and clients put insights and plans into writing, a ritual can evolve in which, at the end of the meeting, they take the paper to the office copy machine and reproduce it, so there is one for the client and one for the chart. In addition to being an efficient means of documenting interventions, this is a nice way to end sessions, because many children enjoy operating grownup machines and because the child creates a physical object that transports therapy to her everyday environment. Thus, when things go well, the child leaves with a written plan for handling the problem that the parent described at the beginning of the session. It is our version of a prescription.

Table 1.1 Eric's Therapy Prescription

Why is it bad to yell at Mom?

1. It hurts the relationship.
2. It makes Mom feel bad and sad.
3. It is disrespectful.

The solution is for me to be in control of my emotions.
How can I be in control of my emotions?

1. Think before I act.
2. Take deep, slow breaths.
3. Remember my values: Nothing is as important as my family.

(End with the therapist's and client's signatures, with dates.)

(See Table 1.1 for an example.) Clients should review the written material at home until they remember it well.

Maintaining Discipline

The issue of discipline during sessions rarely comes up in child therapy. Even youth who are defiant or aggressive in everyday life usually behave appropriately in the controlled environment of counseling sessions. Clients seem to view therapy offices as our turf, where they are visitors and we are in charge.

On the rare occasions when disruptive or aggressive behavior occurs, therapists must respond. The priorities, in descending order, are protection of people and property, the maintenance of order, and the provision of therapeutic experiences. In practice, there are no significant conflicts between these priorities. I describe a progression of therapist responses to child misbehaviors ahead.

The first response should usually be a brief, simple statement of the expectation for the child, such as "Please don't do that," "I want you to sit down now," or, "Felicia, give that to me." If the child persists in a minor negative behavior, the best response is usually to ignore him and, when he stops, to reinforce the change of behavior. (See Chapter 10 on disruptive behavior.) Occasionally it is necessary to wait for a while, in which case I do paperwork, partly to make efficient use of the time and mostly because this makes my ignoring more convincing to the client.

If the misbehavior involves physical aggression, counselors should make assertive statements that portray the therapy setting as a safe place where rules have been established to ensure appropriate behavior—for instance:

- "Don't throw that toy. There's a rule here against breaking things."
- "There's no hitting here. I don't hit you and you don't hit me."

If the misbehavior continues or escalates, the next step is to state a negative consequence that will occur if the child does not comply. These consequences could include time-out or the loss of toys or activities. The next response could be to get the parent from the waiting room and obtain her assistance. Finally, there is the option of ejecting the client from the session. This action might be combined with a request that the parent impose an additional consequence at home.

Empathic Reflection

Research by Greenberg and colleagues (2002; Greenberg & Pascual-Leone, 2006; Greenberg & Malcolm, 2002) has shown that adult clients who express emotions openly and extensively in therapy usually achieve more progress than those who do not. Neuroscience research indicates that emotional expression, in and of itself, can help people feel better. Specifically, the act of naming feelings as they are experienced reduces activity in the amygdala, a brain structure centrally involved in fear and anger (Hariri, Bookheimer, & Mazziotta, 2000). Also, the process of translating emotions into words seems to increase clients' ability to think about, understand, and gain control over their feelings.

The fundamental skills for encouraging expression and elaboration of feelings were first described by Carl Rogers (1951, 1957) and applied to children by Virginia Axline (1947). These methods were originally identified with **client-centered therapy**, but the techniques have spread far beyond the theoretical orientation in which they originated and are now part of the general therapeutic repertoire (Gaylin, 1999).

According to client-centered theory, counselors can engender self-expression, self-awareness, and growth by conveying **empathy** to clients (Cooper, O'Hara, Schmid, & Bohard, 2013; Prouty, 1994). Empathy means that the counselor adopts the client's perspective, views situations through her eyes, and vicariously experiences the client's emotions. Empathy has a neurological basis in mirror neurons, with which we can partially reproduce other people's patterns of neural activity in our own brains (Cozolino, 2006; Iacoboni, 2009). Empathy demonstrates to clients that another person can register and comprehend their experiences. Interpersonally, empathy provides a sense of being heard, understood, and accepted—a good feeling.

Empathy is an act of guided imagination. The way to empathize with someone is to listen closely to his words and tone of voice, observe his facial expressions and body language, use your preexisting knowledge of the person to provide context, consider how the events and situations he encounters would feel to you, and weave this information together to imagine what he is experiencing.

Empathy is therapeutic only if it is communicated to clients. The technique for doing so is called **reflection**. In this technique, the therapist distills the essence of what the client has said and echoes it back to her—for example:

> **Client:** My mom and dad have been arguing a lot. They keep yelling at each other, and sometimes my dad says, "I've *had* it."
>
> **Therapist:** Their yelling upsets you, especially that thing your dad says.

Sometimes, reflections simply rephrase or summarize what the client has said. In more complex versions of the technique, the therapist clarifies and amplifies what the client has only implied. By drawing out feelings and thoughts that had been expressed only vaguely or partially, therapists articulate clients' experiences more fully than the clients did themselves. By making connections that clients implied but did not state, counselors help youth

face and make sense of their experiences. It is a matter of reading between the lines—for instance:

Client: My mom and dad have been arguing a lot. They keep yelling at each other, and sometimes my dad says, "I've *had* it."

Therapist: You're scared they might get divorced.

Therapists sometimes reflect the meanings contained in client statements without using emotion words. Here is an example of a **reflection of meaning**, as opposed to a **reflection of feeling**:

Client: Katie and Jessica were playing Barbies by the swings, and I went over and said, "Hey, can I play?" but they said they didn't have enough dolls for three people.

Therapist: But maybe it seemed like, if they wanted to be friends, there would have been enough Barbies.

Especially early in therapy, when clients begin describing a new issue, they sometimes feel intimidated by the communication challenge, and they say things like, "I can't explain it." At these times, the clinician's task is to create a sense of confidence about the shared endeavor by conveying that he is there to supply whatever is needed for the client to get his message across.

Therapist: Are you afraid you won't be able to think of the right words?

Client: Yeah.

Therapist: Oh, you don't have to worry about that, because in therapy kids don't have to use the right words; I'll work with you to figure out what you mean. Just say whatever words you think of, and we'll go back and forth until you feel I've got it.

Sometimes clients are hesitant to speak, not because of a word-finding problem, but because they feel guilty or ashamed about what they have to say. This is an important therapeutic opportunity. The key is to respond, not from an external, judgmental perspective, but from an empathic sense of the client's experience. The first emotions to address are the guilt or shame themselves:

- "I can see you feel really bad about doing that."
- "Feeling ashamed hurts. Ouch."
- "Feeling guilty is painful."
- "Embarrassment is such an uncomfortable feeling."

Some reflections provide clients with feedback about emotions they have not verbalized at all. For instance, if a child stalked into the therapist's office with a scowl on her face,

sat down without saying a word, and began scribbling hard with a crayon, the counselor might say, "You seem mad at me today." Counselors identify and verbalize clients' feelings to teach them how to do so themselves.

Reflections of feeling can usually be reduced to the formula, "It sounds like you're (e.g., upset)." However, I would caution against overusing this phrase, because doing so makes us sound like stereotypical shrinks. In videotapes of Carl Rogers doing client-centered therapy, he almost never says, "It sounds like you're …"

Reflections can be put in the form of questions as well as statements—for example, by asking, "Are you angry about this?" It makes sense to phrase reflections as questions when you are unsure of their accuracy. Similarly, you can check out the accuracy of your impressions by summarizing what the client has said and then asking, "Have I got that right?" This type of question sends the respectful message that clients are the experts on their own experiences.

Clinicians can fall back on the reliable technique of empathic reflection at difficult times in therapy when they are confused by what the client presents and are not sure what to do next. Empathic reflection is usually the best thing to do when clients are highly upset. Empathy is also an effective response to clients who do not want to be in therapy and are required to attend by their parents (e.g., "You hate being forced to come here"). When in doubt, empathize.

Goal Setting and Self-Monitoring

In a variety of contexts, including athletic training and dieting as well as therapy, it has been found that merely setting a goal and monitoring progress toward it, by themselves, often produces gains (Latham & Locke, 2002; Locke & Latham, 2006). Goal setting and self-monitoring seem to focus attention and galvanize effort. Therapy clients who monitor their problem behaviors often show improvement before any other technique is applied (Pope & Jones, 1996).

Clients often begin therapy with an array of vague desires and dissatisfactions, and therapists can help by organizing these feelings into clear goals.

Clients often begin therapy with an array of vague complaints and dissatisfactions. Therapists can help by organizing these feelings into clear goals. Youth can then measure their progress and root for the numbers to go in the desired direction, which gives therapy a game-like quality of striving for victory.

In several ways, effective goals strike a balance between opposite qualities (Burton & Naylor, 2002; Burton & Weiss, 2008; Weinberg, 2014). Goals should be moderately ambitious—neither so high that they cannot be achieved nor so low that they elicit little effort and leave serious problems intact. Specific goals are more motivating than general good intentions, but when goals are defined too narrowly, important sources of value might be missed. Short-term goals are more motivating than long-term goals, but the most effective goal orientation links a coordinated set of short-term objectives to a long-term purpose.

Goals are different from wishes. The difference is a matter of controllability. Counselors should help clients distill feasible, specific goals from their wishes so they can focus their efforts in a constructive manner.

Usually, psychotherapy can help only with the psychological aspect of achieving goals. We can do nothing about a mean teacher; all we can do is coach the client in dealing with

her as effectively as possible. We cannot bring a deceased loved one back to life; all we can do is help with grief-work. As other examples:

- "You have to go to school; there's no way out. But I think we could change the way you *feel* about school, so you don't hate it so much. Do you want to make that a goal for therapy?"
- "I know your dad's girlfriend rubs you the wrong way, but I still think things would improve if you figured out a better way to deal with her. Do you want to work on that?"

Table 1.2 presents additional examples of goals for therapy.

Research on goal striving has found that stated goals and actual behavior show surprisingly weak relationships, with verbal statements typically accounting for only 20%–30% of the variance in behavior (Latham & Locke, 2002; Locke & Latham, 2006). People frequently verbalize good intentions but fail to act on them. Gollwitzer (1999; Gollwitzer & Brandstaetter, 1997) discovered a self-regulatory strategy that helps people translate their intentions into behavior with more consistency. **Implementation intentions** are if-then statements that operationally define goals in terms of where, when, and how their constituent behaviors will be performed. While goal intentions are abstract and general, implementation intentions are concrete and procedural, and they specify the situations or cues that will prompt the desired behavior. When people carefully compose and rehearse implementation intentions, the planned stimulus-response sequence becomes a solid mental representation that, when activated by a cue, produces the planned behavior with little thought or effort. In this proactive strategy, people make plans when they are calm and thinking clearly; then, in stressful situations, they only need to implement their plan. For example, in work on aggression, a general intention not to fight is less effective than clear specification of the client's anger triggers and a written plan for what to do in response to each one. Therapists should help clients make plans that are concrete and situation-specific, and they should review these plans until the client knows them by heart.

Envisioning is a technique that takes implementation intentions one step further. In addition to clear if-then statements, the client envisions the desired behaviors in a detailed, sensory way. Sports psychologists make extensive use of this technique with athletes (Gould, Voelker, Damarjian, & Greenleaf, 2014; Martin, Moritz, & Hall, 1999). Just as a baseball pitcher might repeatedly imagine the precise muscle movements

Table 1.2 Examples of Therapy Goals

- Feel okay, not sad, most of the time.
- Follow school rules almost all the time.
- Have a friend over, or go to their house, at least once a week.
- Talk respectfully to my father even when I'm mad at him.
- Manage my anxiety about talking in class enough to do it at least twice a day.
- Don't let my brother get me to hit him.
- Defend my happiness against mean people, so they can't ruin my life.

involved in throwing a curveball over the lower right corner of the plate, a client could picture himself complying with a directive he dislikes, resisting the temptation to bite his nails by performing an alternative behavior, or flirting with an attractive peer despite feeling anxious.

Envisioning works best when it is practiced in situations that are similar to those in which the new behaviors will be performed (Smith, Wright, Allsopp, & Westhead, 2007). At minimum, this means the client should picture the locations, individuals, events, and emotions that have been problematic in the past and then imagine performing the goal behaviors in these contexts. Optimally, the client would practice her imagery under these actual conditions. For example, a girl who has been physically aggressive with her brother could sit next to him while imagining both his provocations and her successful self-control.

Envisioning is a learning strategy that works in basically the same way for sensory-motor skills and psychosocial skills. In both cases, repetition is key, and clients should practice their step-by-step procedures between sessions.

In therapy, Brent learned to close his eyes and imagine, in a moment-to-moment way, the action of relinquishing an enjoyable activity in order to listen to the teacher's voice and follow her directions. The counselor asked his mother to prompt this envisioning several times per day at home.

Using Play in Therapy

Because play involves physical as well as verbal means of expression, and it draws on imagination as well as reason, play engages processes that are well-developed in young children, making it a developmentally appropriate window into their internal lives (Erickson, 1963; Gardner, 1993; Russ, 2004). Young children have limited language abilities, but they are remarkably able to express emotions, act out concerns, and work through problems using the metaphors of play. Once children reach the age of 6 or so, they become progressively more able to sit and talk, but until this occurs, unstructured play is an important means of conducting therapy with children.

Child therapy offices should be stocked with human and animal figures, blocks, and drawing materials. I get a remarkable amount of use from soft foam balls that are safe for indoor use and versatile, lending themselves to all sorts of games, including ones in which the balls are bounced off walls. Many clients find this type of play remarkably enjoyable.

In imaginative play, children act out wishes, fears, and beliefs, and their inner life is translated into a public form that counselors can see.

Structured games, such as checkers and card games, reveal how the child thinks strategically, competes, and responds to success and failure. However, these activities usually provide less fertile ground for the exploration of emotional issues than does **pretend play**, which involves human or animal figures, imagination, and stories with themes and meanings (Russ, Fiorelli, & Spannagel, 2011). Children realize the dolls and puppets are just toys but, at the same time, they experience them as animated by human emotions, needs, and goals. In imaginative play, children act out wishes, fears, and beliefs, and their inner life is translated into a form that counselors can see (Chethik, 2000; Landreth, 2012).

Therapists ask clients questions about their symbolic play. Children typically answer as if the play figures have a life of their own, which the child observes rather than controls

(e.g., "What are the monkeys having for dinner?" "Pizza."). Here are some examples of questions that bring out themes in play:

- "Where are they going? Who are they looking for? Why are they in such a hurry? What happens next?"
- "Why did the father doll leave? Is he going to come back? Did he get into an argument with the mother doll? Do the children miss him? Do they wish there was something they could do to bring him back?"

The technique of reflection is just as applicable to play as to talk (Axline, 1947)—for instance:

- "You're setting up the doll house slowly and carefully."
- "Look at those bears fight! They sure seem mad at each other."
- "The little dinosaur is looking everywhere for his mother; he must be scared he won't find her."

This combination of talk and play creates a connection between the imaginative, magical experiences of young children and the controlled, logical thought processes of adults. The therapist is the bridge between the two. To perform this function, let yourself be drawn into the child's world of play, vicariously experience what it is like to be there, and then cross the bridge back by asking yourself what the play themes might indicate about your client's real life.

Interpreting pretend play is difficult because imaginative dramas and logical analyses can be related in a number of different ways. Sometimes play figures represent different aspects of the child's self (e.g., her scared and confident sides). Sometimes play figures represent other people in the child's life. An angry monster might depict the client's aggression, or it might represent her fear of powerful, scary adults. Therapists must make educated guesses about which play figures represent aspects of self and which represent other people. Children often identify with the small, child-like figures in their dramas, and the large figures often represent adults or older children, but this is not a rule.

Another source of interpretive ambiguity is that imaginative play can reflect different types of mental processes. Children's play depicts experiences that they: (a) *expect to* happen, (b) *fear might* happen, (c) *wish would* happen, and (d) *have* actually *had*. For example, the departure of a mother figure might reflect a real experience, a fear, or a wish that Dad would get rid of his new wife. The emotions accompanying play often illuminate its meanings, but sometimes these emotions are transformed or disguised. Because of these interpretive ambiguities, therapists should not draw conclusions from small units of play but should gradually build an understanding of the child by noting patterns that emerge over time and integrating these observations with other information about the child.

Children's symbolic play depicts their problems and also their strivings for resolution and gratification. Play is an opportunity to try out and practice a variety of verbal, emotional, and behavioral options. Children often set up the situations that distress them in an (unconscious) attempt to master these situations by experimenting with different responses until they find something that, on a symbolic level, works for them

(Erikson, 1963; Gardner, 1993). Sometimes children are able to translate these symbolic discoveries into behavior in real life (Harris, 2000).

However, the play of children with mental health problems often has a quality of being "stuck"—the children portray the same distressing themes over and over, but they do not find solutions to the problems depicted in the play. This is where the counselor comes in. Research on play training has found that when adults facilitate children's play by providing reflections, questions, modeling, and praise, the play becomes more imaginative and emotionally rich, which may lead to improved coping (Lang et al., 2009; Moore & Russ, 2008).

By translating the actions of play into words, therapists help clients cognitively process and organize the emotional issues they express, so these issues seem more finite and manageable. By summarizing play themes and sequences with coherent narratives that identify cause and effect, therapists help clients transform confused, swirling feelings into an understanding of important issues (Russ, 2004). These understandings can then provide a basis for problem solving.

In psychodynamic work, therapists use play to learn about the child's unconscious conflicts and help her work out resolutions of these conflicts (Chethik, 2000; Winnicott, 1971). Clinicians can enter the game to enact a symbolic solution that helps the child resolve the problem depicted in the play. If the proposed resolution clicks for the child on a symbolic level, it might produce change in the everyday environment—for instance:

> "Every time the big bear builds something with the blocks, the little bear sneaks up and knocks it down. Maybe she feels jealous that she can't build things as well as the big bear. I wonder what would happen if the little bear asked to help. Maybe then they could build something together and the little bear would learn how."

Cognitive-behavioral therapists make use of the "fantasy rehearsal" function of play: The clinician uses toys and pretend activities to model adaptive thoughts and behaviors, and the client practices these skills in the context of play (Knell, 1993; Knell & Meena, 2011; Strayhorn, 2002). Brent's therapist used dolls and puppets to enact school scenes and teach him the skills he needed to learn. Knell recommends using role reversals to create a variety of modeling and practice opportunities. Accordingly, Brent sometimes played the teacher while the therapist operated the student-puppet and modeled the skill by thinking out loud (e.g., "This game is *fun*—but the teacher is talking now, so I'd better stop and listen to what she says"). Sometimes Brent operated the student-puppet and practiced this skill while the therapist played the teacher, and sometimes Brent took the role of a peer who coached a distressed student-puppet in self-control.

Using Art in Therapy

Art is related to play: Both are imagination-based activities that lend themselves to nonverbal expression of feelings and meanings and to experimentation with possibilities (Graves-Alcorn & Green, 2013; Lombardi, 2013). Art is frequently a useful medium of communication in therapy with children, and some adolescents are comfortable expressing themselves in art.

Artistic activities sometimes get the therapy process going with clients who have trouble expressing themselves in words. Clients' pictures of themselves may provide information

about self-concept. Drawings of the client's family may reveal information about these relationships. Purely spontaneous drawings are often useful, too. Books by Case and Dalley (2014), Malchiodi (2006, 2011), and Buchalter (2009) provide a wide variety of art therapy activities and techniques.

Questions about the client's pictures bring out the meanings they express. Counselors might ask why a person who looks angry is mad, or what happened to a tree that looks broken, or why no one wants to play with the little boy shown alone on a playground.

Therapists can ask clients to draw a picture of their problem. These drawings may provide either concrete or abstract depictions of the issues. Concrete depictions sometimes produce information of practical value. For instance, when a boy experiencing academic problems drew a picture of himself in school, he drew the student sitting next to him as a bully who harassed him while he tried to work. Abstract depictions of problems illuminate the client's internal, subjective experience of the difficulties. For example, anxious clients might depict their fears as terrible, vicious monsters, and depressed children might draw their sadness as a dark, dreary landscape.

Clients can also draw solutions to their problems. An example of a concrete depiction of a solution would be a socially isolated child drawing herself initiating a conversation with a peer. Abstract or metaphoric solutions might include an anxious client drawing a picture of a kitten making friends with the monster she had feared, or a depressed child drawing sunbeams and fruit trees into his landscape. Such drawings might not lead directly to real-world solutions, but this artistic type of envisioning often galvanizes the process of change.

Overcoming Obstacles to Client Engagement

Ordinary Hesitancy

At the beginning of therapy, it is common for children to be hesitant about engaging in the process. Counseling might seem like an intimidating, uncomfortable activity in which they will be alone with a stranger who will inquire about their problems and inadequacies. Some youth are afraid they will not understand what is expected of them and will not know what to do and say.

Sometimes children feel awkward because they are unfamiliar with conversations about emotions and behavior, and they do not understand what the clinician is trying to accomplish with his questions. Phrases that convey our agenda include "Help me understand," "Take me into your mind," and "Explain what it's like for you."

If the client seems worried about performing adequately in therapy, the counselor should reassure her that therapy is not a performance situation. For example, if the client seems embarrassed about responding to a question with, "I don't know," the therapist could say:

- "That's a good, honest answer—much better than making something up. I just want to know how things look to you as we start our therapy together."
- "It seems like you're confused about this. Well, confusion is a useful feeling, because it means you know there's something you don't understand. We can work on that."

Guardedness is not an unreasonable reaction to a first encounter with a stranger in an unusual situation. Clinicians can empathize with a wary, cautious reaction by saying something like:

> "This is a new situation for you. You don't know me, and maybe you don't see why you should trust me—so it makes sense that you're not ready to talk openly about things."

Reinforcing clients for producing therapeutically useful material makes it more likely that they will do so again in the future. To let the client know exactly what she did that you found useful, say something like:

> "Ah, now I get it: (summarize what the client said). Good, that helps me understand."

Positive reinforcement is especially important when clients disclose material that is difficult, embarrassing, or painful for them. Useful comments for this type of situation include:

- "I'm glad you brought that up, because it's important for us to talk about. You really get the idea of what's good to work on in therapy."
- "I can see that was hard to get out, and I really respect the courage it took for you to tell me that."

Addressing Reasons for Resistance

If the client remains highly guarded, it is time to inquire about reasons for resistance beyond ordinary caution and shyness. Clinicians can inquire about these reasons by asking the client why he believes he has been brought for therapy, whether he agrees or disagrees, what he thinks counseling involves, whom he believes it is for, what he thinks might be bad about therapy, what he thinks might be good, and whether there is something the therapist does not know but needs to understand about how he feels about coming to counseling.

Sometimes clients do not understand why counselors want to talk about negative experiences and painful emotions, particularly when the immediate effect is to make them feel worse. Therapists should offer clients a reasonable answer to the reasonable question of why we want to talk about bad things—for example:

> "I know it hurts to talk about this stuff, and I don't want to bring you down. But there are reasons why people talk about painful things in therapy. Sometimes it helps to get things off your chest and share them with another person. Sometimes we can figure things out, so you understand your situation and your feelings better. Sometimes we can think of strategies, ways for you to do better or feel better. But we can't do any of these things without talking about what's wrong."

Therapists can gently ease clients toward discussion of sensitive issues by talking about these problems in regard to *other* people, rather than the client herself. This is an occasion for using your general knowledge about the issue the client is dealing with (e.g., depression,

puberty, bullying). Intellectually inclined clients are often interested in research about the issues they face. Placing problems in a general context normalizes them, provides some distance, makes it easy to offer relevant information, and often makes problems easier to discuss. The implication is that the youth's struggles are shared by many people. Portraying the human condition as fraught with difficulties reduces clients' sense of deviancy and reassures them that, even when they struggle with problems, they remain part of the human community (Medini & Rosenberg, 1976).

When the focus turns to the client personally, movement can still be gradual. It is sometimes effective to begin by discussing concrete, surface manifestations of difficult issues and then move gradually toward more abstract, emotional aspects of the problem. For example, discussion of a client's adjustment to his new blended family might begin by focusing on practical concerns, such as changed routines and sharing his room. This conversation might lead to more emotional issues, such as the client's feeling that his original family relationships have been disrupted.

Resistance in Externalizing Clients

Factor analytic studies have revealed two large, basic categories of psychopathology (Achenbach & Rescorla, 2000, 2001). **Internalizing** dysfunction involves symptoms of emotional distress, such as depression, anxiety, low self-esteem, somatization, and withdrawal. **Externalizing** dysfunction consists of overt, disruptive behavior problems, such as noncompliance, aggression, and delinquency. In internalizing, the problem is with how the youngster *feels*. In externalizing, the problem is with what the child *does*. Many youth have both forms of dysfunction, but there is a tendency for one or the other to predominate (Angold, Costello, & Erkanli, 1999). These two types of disturbance are often associated with different attitudes toward therapy. Because internalizing dysfunction involves distress, these children are usually willing to participate in counseling once they become acclimated, and they typically share their parents' goals for treatment.

Externalizing clients often resist therapy for reasons extending much beyond initial shyness (Clarkin & Levy, 2004). Typically, these youth see nothing wrong with their behavior and blame their problems on other people. Given this view, there is no reason why the client *would* want to participate in therapy. For example, if her definition of the problem is, "My parents are always nagging me about school," and she believes homework is for nerds, her goal would be for her parents to accept her underachievement, not for her to improve her performance.

Therapists need to work hard to achieve buy-in from externalizing clients, and they need to realize that a little bit of buy-in is better than none at all. The task is to think of changes in the youth's life that would be desirable, or at least acceptable, to both him and his parents. One strategy for accomplishing this is to portray the parents' expectations as unalterable facts and then invite the youth to join you in a search for ways to improve his life *within* this constraint. Looking at the problem from the client's perspective sometimes makes it possible to reframe therapy in a way the youth finds acceptable—for example:

- "We need to find a way to get your parents off your back. But I'm talking about something that will work, not just wishing they'll let you flunk out of school."
- "Your parents aren't going to stop having rules. Given that fact, how can I be helpful to you? How could we make things more livable in your family?"

Because internalizing and externalizing are correlated (Achenbach & Rescorla, 2000, 2001; Angold et al., 1999), externalizing youth are not usually happy, and therapists can sometimes channel this unhappiness into the development of treatment motivation. Although externalizing clients are not usually brought to treatment for this reason, including their dysphoric emotions in the targets of therapy sends the message that counseling could accomplish changes desired by the youth as well as the parents.

One key to overcoming resistance is inducing clients to verbalize the reasons why they do not want to participate in therapy. Salespeople encourage potential customers to express all their objections to buying the product because objections cannot be overcome unless they are put on the table. Similarly, therapists marketing their services to resistant youth need to convey that they genuinely want to know what the client distrusts or dislikes about the idea of counseling so they can address those concerns in an effective fashion. Sometimes this inquiry reveals objections that are not based on fact, such as that counselors function purely as agents of the parents, with no interest in the youth's point of view. This objection can be overcome by basic information.

Therapists need to form alliances with both parties. It is difficult but not impossible for the counselor to position himself between the client and parents in such a way that both perceive him as an ally. As one important example, counselors can convey both commitment to the parent's standards for appropriate behavior *and* keen interest in the youth's perspective on the situation, including possible complaints about the parents, insights into the causes of problems, and ideas for improving life in the family.

One useful technique is to use the word "we" to convey that you share the client's and parent's goals—for example:

- (To adolescent) "If we can figure out a way to get your grades up, I'll be able to help on the clothes problem with your parents. If we work together on this, I think we'll get somewhere."
- (To parent) "We've got to stop her from hanging out with kids who use drugs after school. Nothing much can be accomplished if she's high half the time."

Despite the therapist's best efforts, young clients are sometimes involuntary participants in therapy. This is undesirable but not the end of the world. Parents sometimes ask whether there is any point in forcing youth to receive counseling against their will. Generally, the answer is yes. Externalizing clients *usually* begin therapy involuntarily, but the outcome research reviewed in Chapters 10–12 indicates that positive outcomes are possible, nevertheless. If the parent is unsure whether she can get the youth to the first appointment, one strategy is to offer a trial period of three sessions, after which the youth can decide whether to continue. Usually they end up saying yes. However, parents should offer this choice only if they can accept either decision the youth might make.

Motivational Interviewing

Motivational interviewing (MI; Miller & Rollnick, 2012; Miller & Rose, 2009; Rosengren, 2009) is a counseling method with one main purpose: engendering client motivation to change maladaptive behaviors. It is most relevant to clients who are not motivated to change and who, therefore, resist engaging in therapy. Typically, clients are most resistant when their problem behaviors are pleasurable or reinforcing for them (e.g., substance

use, truancy), and/or when achieving treatment goals requires effortful, uncomfortable self-control (e.g., inhibiting impulses to overeat or explode aggressively). MI is more relevant to youth with externalizing than internalizing dysfunction.

Theory. MI is closely associated with the transtheoretical model of stages of change (Prochaska, DiClemente, & Norcross, 1992; Prochaska, & Norcross, 2010). This model describes stages of readiness for change and emphasizes the importance of therapeutic conversations being congruent with the client's current stage. In MI, therapists do not attempt to achieve quick changes by debating, urging, or imploring clients to stop their maladaptive behaviors. Instead, they create conversations that nurture an evolution of the client's own thinking and motivation in the direction of positive change.

These conversations typically occur in a certain sequence, although some back-and-forth movement is common. Here is the typical sequence:

1. The client verbalizes attraction to the problem behavior and resistance to treatment goals. The therapist responds with *reflective listening* to convey interest in the client's thinking and empathy with her experiences.
2. The counselor attempts to *develop discrepancy* between the client's attachment to the target behavior and her other goals and values. However, when clients express opposition to recommended changes, counselors "roll with the resistance," rather than arguing.
3. When clients begin to explore the possibility of change, therapists *support self-efficacy*, perhaps by teaching techniques or suggesting resources, so clients believe they have the ability to achieve treatment goals, if they decide to pursue them.

MI is nonjudgmental, nonconfrontational, and nonadversarial. This does not mean the therapist has no opinion about whether the client should choose harmful behaviors; it is a matter of therapeutic technique. MI is based on the idea that it is more effective to pursue change through reflective listening and skillful discussion than through authoritative provision of information, reasoning, or debate. Clients generally assume their therapists do not support maladaptive behaviors, and MI counselors do not contradict this assumption, but they keep their opinions to themselves except at certain points in the process.

MI is based on the idea that it is more effective to pursue change through reflective listening and skillful discussion than through authoritative provision of information, reasoning, or debate.

MI seeks to nurture whatever motivation to change the client has at the beginning of therapy. There is an assumption that most clients feel at least some ambivalence about their behavior, with some desire for change coexisting with attachment to the status quo. MI aims to explore both sides of the conflict, to nurture ambivalence, and eventually to resolve it by embracing positive change. The expectation is that the client's own thought process, supported and facilitated by conversation with the therapist, will eventually reveal disadvantages of the problem behavior and benefits that could be achieved by changing.

Therapists use several techniques to develop clients' sense of discrepancy between the target behavior and other of their desires and goals. Counselors ask clients to articulate their values, and they bring clients' attention to conflicts between these values and maladaptive choices (Hanson & Gutheil, 2004). Therapists ask clients to envision a better future and to think of realistic steps they could take to move toward that future; then they

point out ways in which the problem behavior would interfere with successful completion of the steps.

Outcome Research. The Society of Clinical Psychology of the American Psychological Association (APA) conducts systematic reviews of outcome research on an ongoing basis. These reviews evaluate the empirical support for interventions based on well-defined criteria. Their website (http://www.div12.org/PsychologicalTreatments/treatments.html) maintains current summaries of these reviews. APA rates MI for alcoholism and substance abuse in adults as having *Strong Research Support*, their highest designation. There is also extensive evidence for MI as a means of increasing health-promoting behaviors and adherence to medical regimens in adults (Lundahl et al., 2013).

In research with young people, MI has produced positive results in a number of studies with adolescents who abuse substances (e.g., Barnett, Sussman, Smith, Rohrbach, & Spruijt-Metz, 2012; Jensen et al., 2011), and who have difficulties with medical compliance and dietary control (Erickson, Gerstle, & Feldstein, 2005). MI is more effective with adolescents than younger children, probably because it requires abstract thinking (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Strait, McQuillin, Smith, & Englund, 2012).

Outcome studies of MI have typically obtained effects that are statistically significant but small in magnitude. This might be because MI interventions are brief, usually involving one to four sessions. MI can be a stand-alone therapy, but it is more often used as an adjunctive or preparatory intervention that motivates clients to engage in more extensive therapeutic work using other strategies that address the client's particular problem behaviors.

Techniques. MI is built on a foundation of client-centered therapy (Rogers, 1951, 1957). This means the typical therapist action is a reflection of feeling or meaning. Because the focus is on motivation, many of these reflections refer to what the client wants and does not want, likes and dislikes, hopes and fears.

MI adds some techniques to its client-centered therapy base. Many of these techniques consist of questions, not statements. Here are some basic MI questions:

- "Are you completely satisfied with the way you're doing things now, so there's nothing you want to change, or might you be interested in doing some things differently?"
- "Are you completely satisfied with your life right now, or could your life be better in some ways?" "How would you like things to be different?"
- "Do you have any goals for the next month? For the next year? What do you want to do to move toward those goals?
- "What are your values?" "What do you think is most important in life?" "What kinds of people do you respect the most?" "What kind of person do you want to be?"
- "How does _____ (the problem behavior) get in the way of achieving your goals or doing the things you want to do?" "How does it interfere with putting your values into action?"
- "If you could change _____ (the problem behavior) without it being too hard, how would that change your life?"

The transtheoretical model (Prochaska et al., 1992; Prochaska & Norcross, 2010) posits a normative sequence of stages through which people progress on their way toward change.

In MI, clinicians connect with clients at the stage where they are in the present, rather than urging them to move on to the next stage. Here are examples of therapist statements appropriate to each of the model's stages of change:

1. *Precontemplation*: "You are not ready to change this behavior now—you haven't really thought about it, but when you do, all you can think of is reasons not to change. You believe that what you're doing now is fine, and you don't see what would be gained by changing."
2. *Contemplation*: "You are thinking about whether you want to change _____ (the problem behavior). It seems like there's a part of you that would like to change this behavior, but another part is like, 'Whoa, I'm not sure—there could be big disadvantages to changing.'"
3. *Preparation*: "It seems like you are getting ready to change. You're not happy with the way things are, and you want to make them better. You're getting psyched up, you've told some people about the changes you want to make, and you've done some things to prepare."
4. *Action*: "It's on. You have started to make some of the changes you planned, which is exciting, but it's hard, too, which is no surprise. Now is a time to be determined and tough, because it's easy to slip back into the old way of doing things. It's also important to be smart, so let's take a look at how you're going about this."
5. *Maintenance*: "You have succeeded at changing the behavior you wanted to change. That's a big accomplishment, and I hope you feel really good about this. To make sure you keep it going, it's important to stay careful and keep an eye out for situations that have messed you up in the past, so you can handle them more effectively this time."

When clients argue against change, MI calls upon therapists to inhibit argumentative responses and to "roll with the resistance." This means exploring the client's reasons for holding onto the behavior, discussing what he feels he gains from it, and learning why he feels he cannot or should not give up the behavior. The therapist conveys that she wants to examine the target behavior from the client's point of view. As the client describes its perceived benefits, the clinician responds not with refutations but with reflections and empathy.

Order matters. Once the perceived benefits of the target behavior have been described, it is time to consider the costs. One technique for working with ambivalence is the **double-sided reflection**, which articulates both sides of an issue in a single statement—for example:

- "You really like that feeling of being high—all your troubles melt away, and the laughing is so much fun—but it's nerve-wracking to think about the trouble you could get into, and you don't like the way your grades go downhill when you smoke a lot of weed."
- "Sitting there doing homework gets really boring, and it's frustrating to think about the fun you could be having, but you also care about your future—homework affects grades, and grades affect college. The future versus the present—that's the dilemma."

Another strategy for organizing, processing, and resolving ambivalence is to guide the client through a systematic weighing of the pros and cons of two alternative courses of action (Fishbein & Izjen, 2009)—in this case, continuing the problem behavior versus

working on change. To do this in writing, divide a page down the middle and then divide the two halves down their middles, so the costs and benefits of the status quo versus change can be clearly seen. For a simpler version, divide the page in half and combine the advantages of the target behavior with the disadvantages of change in one column, and combine the advantages of change with the disadvantages of the status quo in the other column.

MI makes much use of scales from 0 to 10. By answering questions with a quantitative rating rather than a simple yes or no, clients become more aware of the two-sided nature of the issues they face.

Therapists ask clients: (a) how certain they are that they want to continue the target behavior, and (b) how extensively they want to engage in this behavior in the future. Clients usually do not give a rating of 10 to both questions, and it is significant when they do not. Any response below 10 indicates the presence of some ambivalence, and the distance from 10 indicates its degree. The next questions for the client are why they are not certain they want to continue the target behavior and why they do not want to engage in it to the maximum extent possible. Answering these questions requires clients to articulate the costs of the problem behavior and the potential benefits of change. In this way, the client's own responses fuel his treatment motivation.

If the client cites no disadvantages of the problem behavior, MI is not so accommodating that it lets the conversation end there. Still, MI requires us to tread lightly. Before giving input, ask the client whether she would like to know more about the issue, say you have some important information or thoughts about it, and ask whether she would like to hear this. If she says no, move on; perhaps her curiosity will be stimulated, and she will ask for your input at another time. If she says yes, offer your information, concerns, and reasoning. Then, ask the client what she thinks about what you have said. I often close not by asking whether she agrees with my points or will follow my recommendations but whether she is willing to give what I said some thought.

MI addresses clients' self-perceived ability to make changes, or **self-efficacy**, which often affects their willingness to try. Therapists ask clients to rate how confident they are that they *could* achieve treatment goals, if they were to attempt them. If the response is greater than zero, the counselor notes that the client has some belief in his ability to change. If the client gives a low or moderate number, the therapist asks what would need to happen to move the number up. This question can elicit useful information about perceived obstacles to change and what the client believes he needs in order to overcome these obstacles.

MI encourages clients to verbalize their resistance, but sometimes this does not happen. Some clients say the right things in therapy but come back week after week without making the efforts they said they would. Their resistance is real, but unexpressed resistance cannot be engaged therapeutically. Therefore, the objective is to get the client to verbalize her resistance.

Clinicians can broach this issue by noting that "Your words say you want to _____ (e.g., look for a job), but your actions say you don't." If the client does not respond in a substantive way, we can dig a little harder:

> "Listen, you don't seem like a kid who does things for no reason, so I know that if you're not _____, there are reasons; you must see problems or disadvantages with _____. I'd like to know what those disadvantages are, because maybe I'm not getting something about this."

Sometimes clients are not able to disclose their reasons for resistance, either because they cannot put their reasons into words or because they are not consciously aware of them. If so, therapists can help clients identify and communicate their objections to change by offering educated guesses in a multiple choice format. It is important to present the options in a face-saving way, as understandable responses to her situation (e.g., "dieting is *hard*, because sometimes you're just dying for something sweet").

Finally, I would offer a cautionary note. MI involves an unusually egalitarian way for adults to talk to young people about harmful behaviors, in that it requires us to nod with interest as clients describe the appeal of, for example, gang involvement and noncompliance with medical directives. The positive outcomes achieved by MI certainly attest to the value of this type of conversation, but this value might have limits, and other types of conversations might have different forms of value. One important proviso is that MI is less effective with younger children than adolescents (Lundahl et al., 2010; Strait et al., 2012). One reason for this difference might be that children are more amenable to influence by straightforward, authoritative reasoning and values statements from adults, since these are basic means of socialization in the natural environment. Therapists who are flexible in their use of MI can combine it with other ways of nurturing treatment motivation.

Simple Therapeutic Interventions

Therapy is generally quite complicated, as the next 14 chapters will make clear. However, sometimes there are simple things therapists can do that are quite helpful to clients, and we should not look past these in our search for more sophisticated interventions.

Making Sense of Problems

One of the first services therapists can provide is helping parents and children make sense of their difficulties. Explanations of problems span a wide range of complexity and depth. At the beginning of therapy, clinicians can offer families a basic sense of understanding by positing a few factors that help to explain the problems. For example, a therapist might attribute a child's aggression partly to witnessing domestic violence, or she might explain a client's anxiety as resulting partly from unrealistically fearful thoughts. Even simpler formulations that merely name, describe, and organize the problematic experiences can provide the beginning of a sense of coherence. Here is an example for parents:

> "It seems like life is just too much for Aaron right now. The challenges of school and peers feel overwhelming because, even though you might know he can do it, he doesn't. He's scared, so he's retreated into a shell."

Here is an example for clients:

> "Sometimes life seems so crummy it's like a sad feeling in your heart that takes over your whole body. That feeling is called depression."

These statements are not real explanations, but they organize distress and confusion in a coherent way that makes problems seem finite and manageable. Clear descriptions of the client's situation articulate the obvious in a useful fashion, cutting through the flux and

murk of moment-to-moment experience to identify the basic outlines of problems—for instance:

> "Sometimes things happen that you don't like. Then the question is, what should you do? Having tantrums doesn't help. Would you like to talk about other possibilities?"

Sometimes a description of a dilemma, with balanced attention to both sides, clarifies the challenge facing the client:

> "You want to have fun with your friends when they stay out late, but you also want to get along with your parents. I guess the dilemma is that, so far, you haven't found a way to do both things at the same time."

Planning Simple Solutions to Problems

In this section, I describe very simple, brief therapeutic interventions. This type of strategy is not a comprehensive treatment but may be helpful for some clients and for a few provides all the help that is needed. Rudimentary flaws in simple psychological processes sometimes cause serious trouble for children, in which case therapists who discern the obvious can often help in a quick, efficient way. Simple problems can sometimes be solved by simple strategies, without ever addressing complicated, deep-seated issues.

Perhaps the simplest therapeutic intervention is providing some factual information that the child does not have but needs. Children sometimes lack very basic information about how the world works, and the misunderstandings that result can be upsetting. For instance, in the aftermath of 9/11, when videotapes of planes crashing into buildings were shown repeatedly on television, some children did not realize these were replays of the same events, and they thought planes were continuing to destroy buildings and kill people in great numbers. Another example of this type of etiology is self-blame based on immature, egocentric thinking, which is sometimes compounded by misinformation from caregivers. For instance, children sometimes believe they caused their parents' divorce, their own abuse or foster placement, or other misfortunes they could not possibly have caused. In another type of misunderstanding, children sometimes fear that contact with a loved one who is ill might cause them to catch a disease that is not contagious, such as cancer.

In this type of situation, the key skill for therapists is an assessment one: identifying the misunderstanding responsible for the client's distress. Usually, the challenge is not that the missing information is complicated but that it is so obvious it is difficult to see.

In somewhat more complicated work, the counselor and child sit down with a piece of paper and make a plan to solve a problem. At the top of the paper, the therapist writes a title describing their shared mission—for example:

- How to Cope With Stress
- What to Do if My Brother Teases Me
- What to Do if I Have a Scary Thought

Then, the therapist and client discuss the problems that have occurred and brainstorm ways to prevent or manage them in the future. Counselors can ask themselves two questions to organize their thinking about these plans. The first one is: What is the psychological

process or function that the client needs to perform in order to master the problematic situation? In other words, what does the child need to do that she is not doing now? The second question is: How can that function be distilled into a simple formula that the child can understand, remember, and use when needed?

Being directive in this way is not a matter of "telling the client what to do." I usually conclude my recommendations by asking, "Are you willing to give this a try?" If the answer is no, more work is needed.

For example, one boy got into trouble because he responded to situations too quickly, without taking a moment to think about what to do. The therapist and child drew several red stop signs, which the boy placed in his school desk, book bag, and several rooms at home. The client learned to catch himself at the beginning of his reactions; then he took out a stop sign and asked himself the question written underneath it: "What should I do?" That was it—and most of the time it worked. Simple strategies like this are effective when they bring the right plan to the right situation at the right time. Table 1.3 presents another example.

The activity of list making sometimes helps clients organize their resources. For example, therapy for low self-esteem might include making a list of "Good Things About Me," or "Reasons Why I Am Not a Failure." Therapy for antisocial behavior might include making a list of the disadvantages of lying or stealing. Children who feel their lives will be turned upside down by an imminent change, such as a geographical relocation, might benefit from listing aspects of their lives that will remain the same after the change occurs.

As another example, one child's anxiety symptoms turned out to be the result of rumination about his family's financial situation. The therapist figured out that he misinterpreted his mother's ordinary complaining about bills as an indication that the family was running out of money. The clinician relayed this information to the mother, who provided her son with an age-appropriate, realistic account of the family's finances that laid his fears to rest.

How is it possible that something so simple could work? The reason is that children sometimes develop upsetting misunderstandings that could easily be reassured except that they keep their fears to themselves. Children sometimes tell their counselors worries that they withhold from their parents, sometimes because they do not want to upset their mother or father, and sometimes just because they do not know how to verbalize their fear without prompting. In these situations, therapists can help by reassuring the child about the parent's ability to handle his concern and assisting him in articulating the worry.

Much therapy seems to involve the following sequence of events, which is summarized in Figure 1.1. First, there is an airing of the child's problems, and the client comes to believe

Table 1.3 A Simple Therapeutic Plan

How to Get Rid of Tantrums

Mom or Dad can:

1. Give me some food.
2. Give me a hug.

I can:

1. Pet my dog.
2. Go away from the problem and think about something good.

No more tantrums. Do what needs to be done and *be happy*!

(End with signatures of client, mother (or father), and therapist.)

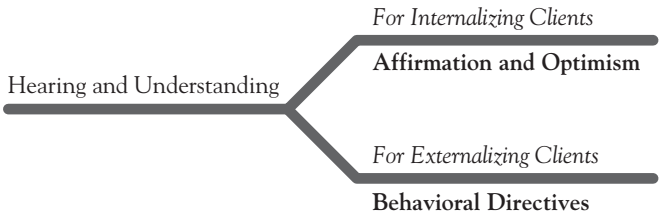

Figure 1.1 Common therapeutic sequences.

that the therapist understands him, as a result of which the therapist attains *credibility*. Then, there is a fork in the road corresponding to the two basic types of child psychopathology. Internalizing clients make progress when they believe their therapist understands the upsetting, disappointing, or shameful things they have disclosed but thinks well of them anyway. Externalizing clients make progress when they believe their counselor understands why they misbehave, including the appeal of misbehavior, but continues to state that they can and should change their behavior nevertheless.

Some simple therapeutic directives include no information or reasoning but simply *depict* an adaptive behavior that the client could try. These therapist statements do not address reasons for the problem, and they do not offer justifications for the option being recommended. The power of these statements lies simply in the compelling way they portray the path they recommend; the appeal of the option is either self-evident or not there at all—for example:

- "When you lose a game, the thing to do is be a *good sport*. Do you know what that is? Here is what a good sport does when she loses …"
- "When Mom tells you to do something that you don't want to do, you can argue back and make yourself and her miserable, or you can just do it and get it over with. Maybe that's the answer: Just do it."
- "I know it doesn't sound like fun, but why don't you give it a chance?"

Therapist actions like these are not a matter of technique but of sincere statements in the context of a relationship. The only technique is to say it like you mean it. Many children are open to taking advice from adults they like and trust.

Brent's tantrums in kindergarten did not seem to be the result of complex factors, so there was little to analyze or plan. The first couple sessions combined talk about pleasant topics, brief discussions of the problem with reflective listening (e.g., "It's *fun* to play with dinosaurs, so you don't want to stop for the teacher"), and an active game somewhat related to baseball, which resulted in lots of laughter and the development of a positive relationship. Then, the therapist looked Brent in the eye and said something like this:

"To do well in school, you have to listen to the teacher. You might be having fun with something else, but when the teacher starts talking, you need to have a little bell go off in your mind and then a voice that says, 'Hey! It's time to listen to the teacher!' If you hear what the teacher has to say, and you do what she says, you won't get in trouble, and you'll do fine in school."

Then, the counselor and Brent drew a series of cartoon-like pictures depicting a five-part sequence of events: (1) Brent was playing a fun game. (2) The teacher began talking to the class. (3) A bell rang in Brent's mind. (4) Words (drawn as little lines) travelled from the teacher's mouth into Brent's ears. (5) Brent left his activity and walked toward the teacher. This series of pictures helped Brent envision the behavioral sequence he needed to perform in school.

Therapeutic Collaborations

Young people's lives are nested in social environments and are greatly affected by the individuals and organizations constituting these environments. As a result, collaboration with parents and child-serving systems offers therapists important opportunities to channel assistance into the client's environment.

Work With Parents

Child treatment should always include work with parents or guardians. Parents are generally the most important people in their children's lives and the core of the formative environments that shape children's development. If the parents' everyday practices, behaviors, or messages are harmful to the client, hour-long therapy sessions have limited capability to undo the negative effects. More commonly, work with parents provides an efficient way to bring large quantities of therapeutic benefit to the client in small amounts of session time. Therapists can spend 15 minutes giving a suggestion or teaching a child management technique that will then be there to help the client every day for the foreseeable future. This is the way to plant a source of help for the child in her home environment.

Parents usually understand their importance in child treatment, but sometimes they do not. Parenting a child with behavioral or emotional problems can be exhausting, and parents sometimes wish they could give responsibility for solving the child's problems to the clinician. However, child therapy will generally not be effective if the parent drops the client off at the office and returns an hour later to pick him up.

One source of parental resistance to therapy participation is anxiety about being blamed for the child's difficulties (Barkley, 2013). This fear seems based on an old, obsolete view that children's mental health problems are always the result of deficient parenting. However, research in developmental psychopathology indicates that child mental health is a complex outcome influenced by genetic factors, neurophysiology, socioeconomic variables, life events, peer influences, and parent-child fit, as well as parenting effectiveness (Cicchetti & Walker, 2003; Harris, 2009; Pinker, 2002). Therapists should explain that children are not simply products of the upbringing they receive; they are separate individuals who bring their own temperaments and qualities into families. As a result, many loving and competent parents have children with mental health problems. (See Chapter 8 for guidance in discussing genetic factors with parents.) Counselors can usually recruit parents' active involvement by explaining that their participation is important not because they caused the problems but because they can contribute to solutions. The message is, "I need your help to help your child."

There are five main categories of work with parents. These treatment activities are described in detail in the chapters to follow, and brief descriptions are presented in Table 1.4.

Table 1.4 Types of Work With Parents

1. *Assessment and monitoring of change:* The clinician utilizes the parent's observations of the child for the initial assessment and for monitoring change over time.
2. *Helping parents understand their child:* The therapist identifies reasons for the child's feelings and behavior and then conveys this understanding to the parents.
3. *Parent training:* The counselor teaches the caregiver skills and techniques for managing the child's behavior and addressing the child's problems.
4. *Parent guidance:* The therapist offers suggestions and recommendations that are smaller and more specific than what is involved in skills training (e.g., reducing screen time, finding a quiet place for homework).
5. *Parent counseling:* The therapist works with the caregiver on her feelings and beliefs about the child and any personal issues that affect her functioning as a parent.

Basic Parenting Principles

One principle of effective child management is to replace negative statements about the child as a person with more specific criticisms of the child's behavior.

The distinction between criticism of behavior and criticism of personal characteristics, discussed earlier in this chapter, is just as important for parents as therapists. One principle of effective child management is to replace negative statements about the child as a person (e.g., "You're so stubborn") with more specific criticisms of the child's behavior (e.g., "I don't like it when you disobey me"). Criticisms of personality are counterproductive because they insult the child and do not provide clear information about what he should do differently the next time. Criticisms of behavior have a legitimate role in both therapy and child management. Thus, parental anger does not need to be eliminated but to be directed against the child's negative behavior.

Many parents worry that their child's mental health problem has dire implications for the future. Therapists can help restore optimism by saying that, whatever the reasons for the problem's origination, parents can guide children onto positive developmental tracks by responding effectively to problems in the present. This view enables parents to view difficult incidents as opportunities to provide the child with the learning experiences he needs—for instance:

> "Children are not born knowing how to behave; they learn this, gradually, as their parents teach them how. And one of the most important opportunities is when kids misbehave. When Celia acts up, I'd like you to ask yourself what you want to teach her by your response to her misbehavior."

For parents, thinking about child development within a long time frame may help to maintain a calm, constructive attitude. Parents all face upsetting moments in the course of their child's growing up; there are times when the child seems terribly distressed, irrational, or dysfunctional in some way. If parents extrapolate from such moments, they may panic at their vision of the future, but linear extrapolation is not realistic because, given time and effective help, most youth with problems traverse the twists and turns of development and emerge, eventually, as successful adults. Counselors can say:

"Kids make thousands of mistakes as they grow up; in a way, that's their job. The parent's job is to respond to those mistakes in a helpful, corrective way—day after day, for about 18 years. When the whole thing is over, you'll have a competent adult. So take a breath, because there's plenty of time to work on this."

Brent's therapist asked his mother and grandparents to give him opportunities to practice activity switching at home. The procedure was to interrupt his play, give him a directive, coach him in making the transition, praise his success, and remind him that this was the skill he needed to use in school.

Collaborating With Other Child-Serving Systems

Children with relatively mild, circumscribed problems usually do not need services beyond psychotherapy. Clients with more complicated problems may also need services from the special education, medical, child welfare, and juvenile justice systems. Therapists should collaborate with the professionals in these systems who work with their clients (Henggeler, Cunningham, et al., 2009; Stroul, Blau, Broderick, & Lourie, 2008).

When clinicians have a narrow definition of their work that is bounded by the 1-hour session, their ability to help clients is reduced. There is a practical factor contributing to this limited job definition: Insurance companies typically are willing to pay only for direct contact with clients, so the consultative work needed for intersystem collaboration usually cannot be billed. Nonetheless, if we understand our job as doing whatever we can to help clients with their mental health problems, we will do this work.

In effective intersystem collaboration, information flows in all directions, and the collaborating organizations enhance each other's work. Teachers, caseworkers, youth workers, and probation officers often have knowledge that therapists need about their clients' functioning in settings outside the office. Therapists' understanding of their clients and their general knowledge about mental health enables them to offer insights and recommendations to other professionals for implementation in other systems. For example, therapy might provide information about why a foster child is exhibiting behavior problems in his placement and how the child would be likely to respond to reunification with his biological parent. As another example, a therapist might tell a teacher about an anger management technique the client has learned so the teacher can coach her in use of the technique when she becomes angry in class. This type of work can be highly efficient in that one phone call might result in major benefit to the client.

In effective intersystem collaboration, information flows in all directions, and the collaborating organizations enhance each other's work.

Termination

One aspect of treatment planning is determining when therapy is finished. In general, there are two types of situations that make termination appropriate. Sometimes therapy does not seem to be helping the child. When this occurs, therapists and parents should consider a change of plan, whether use of a new treatment strategy by the same counselor or referral to a new service provider. More frequently, termination becomes appropriate when the client's functioning has shown sufficient improvement. Termination is sometimes justified

by a combination of these two situations: The client has shown some improvement, with significant problems remaining, but progress has stopped, and the client seems to be on a plateau in which additional work is not producing much benefit.

For treatment goals to be realistic, therapists and parents need to think about the problem levels that typify real children. All youngsters sometimes feel depressed, behave disobediently, and so forth. Termination should occur when the child's difficulties no longer constitute a mental health problem but are a matter of the imperfect nature of the human condition; counseling is not a cure for life. Therapy should end when the parent and client have the skills necessary to cope with remaining difficulties on their own.

In practice, parents play a more important role than therapists in decision making about termination; we provide recommendations, but parents decide what to do. Termination is considered "premature" and is construed as "dropout"—from the perspective of the clinician—in about 50% of child therapy cases (Harpaz-Rotem, Leslie, & Rosenheck, 2004; Nock & Ferriter, 2005; Shuman & Shapiro, 2002). However, in many of these cases, the parents probably believed enough therapy had been provided.

There is a classic view of termination in which therapy should be needed only once because the client's problems should be permanently resolved. The hope is that no "relapse" will occur, so the client will never need counseling again. This type of termination involves a final good-bye for the therapist and client. Terminations sometimes occur this way.

In practice, however, termination is usually less dramatic. Unless the counselor retires or relocates, it is common for parents and children to return to therapy at intervals through the years, when they believe the clinician could help with a problem that has arisen. Many parents and children appreciate having a relationship with someone they can call if a mental health problem occurs, just as they call their pediatrician if a medical need arises. I usually say that I am not going anywhere and will be available any time I am needed, whether this is the day after our supposedly last appointment or in ensuing years. One of the rewards of practicing in the same community for a long time is working with children at different stages in their development and watching them grow up.

When therapists think the time for termination is approaching, they should discuss the issue with the parent and child. If there are no objections, a plan should be designed to make the ending comfortable and therapeutic for the client. The usual procedure is to wind down by increasing the time interval between sessions, so the client can prepare and process the transition with the counselor. If the treatment episode was brief, this might require only one or two sessions. For long-term therapy, there should be a more gradual winding down.

The possibility of return notwithstanding, termination is an ending. Clients who have achieved a positive outcome generally experience a combination of positive and negative feelings, because they are happy about reaching their goals but sad about losing a good relationship. Therapists should help clients understand and work through this combination of feelings—for example:

> "Your mom brought you here to see me because you were having trouble doing what she said. Now that you have gotten good at listening, we have reached our goal, and you don't need therapy anymore. That is something to be happy about because your mom and I are really proud of you, we hope you are proud of yourself, and things are happier in your house. At the same time, you might feel sad about finishing therapy, because we had a good time together, and it's sad to say good-bye to someone you like."

One purpose of termination sessions is **relapse prevention**—that is, maintenance of the gains that have been achieved. There should be a review of past learning to prepare for the future. There are two main questions for the client:

- "What did you learn in counseling?"
- "How will you use what you learned in the future?"

Summary

This chapter describes basic features of child and adolescent therapy that characterize most theoretical orientations and apply to most client problems. Generally, therapists can build strong treatment alliances with children and parents by conveying warmth, empathy, expertise, and a commitment to help. Counselors can most effectively engage clients by means of a professional but natural interpersonal style and clear, age-appropriate language.

In their first meeting with parents, counselors should obtain a description of the child's difficulties and encourage realistic hopes for a positive therapeutic outcome. In their first meeting with children, therapists should provide honest, age-appropriate explanations of the nature of therapy and the parent's purpose in obtaining this service for the child. When youth resist participating in therapy, counselors can encourage buy-in by asking the client about aspects of his life he would like to improve and by identifying ways that therapy could help with this.

Reflections of feeling and reflections of meaning convey empathy and facilitate self-expression by bringing out the implications of the client's statements. Clarifying the nature of problems, setting clear and attainable objectives, monitoring progress toward the objectives, and envisioning desired outcomes all help the client organize her efforts toward therapeutic goals.

Motivational interviewing is a package of techniques designed to nurture the development of motivation to change in clients. The strategy is not to debate or oppose the resistance but to facilitate its full expression while also eliciting the expression of values and goals whose pursuit is blocked by the problem behaviors. The therapist then tactfully offers input to help clients resolve their ambivalence by embracing positive change.

Although problem etiologies and therapeutic strategies are often complex, simple interventions sometimes help clients in direct, immediate ways. Some therapy sessions involve a sequence in which, first, the parent identifies a problem to the counselor and, then, the counselor and youth develop a plan to resolve the problem. When practical, a summary of these problem-solving efforts should be preserved in writing to support the client's memory of the plan.

Sometimes a more indirect approach is needed to uncover and address the emotions and misunderstandings responsible for the client's disturbance. Especially with young children, play and art may supplement language as a medium of thought, communication, processing emotions, and solving problems.

Child therapy generally involves work with parents, and counselors also collaborate with other professionals to coordinate care for clients involved in multiple systems. If they share insights and strategies, professionals in the mental health, medical, education, child protection, and juvenile justice systems can enhance each other's work.

Therapy should be terminated when the goals have been basically achieved or progress is no longer being made. Traditionally, termination has been viewed as a final conclusion,

but many parents and children value having a familiar resource to whom they can turn when emotional or behavioral problems occur. Termination should include work on relapse prevention, but therapists can also leave the door open for any additional help the parent and child might desire in the future.

Case Study

The simple, directive intervention provided by Brent's therapist proved to be what this child needed to solve his problem. The episodes of noncompliance and tantrums in school came to an end.

Brent sometimes expressed sadness and confusion about his infrequent contact with his father. However, because this concern did not seem to affect his overall functioning, it did not seem necessary to make a therapeutic issue of it.

As a result of his previous misbehavior, Brent had to contend with some teasing from classmates who predicted that he would get in trouble just as he had in the past. The teacher once overheard his retort: "Dr. Shapiro said if I listen to the teacher I'll do *fine* in school."

2

Behavior Therapy

OBJECTIVES

This chapter explains:

- *How behavior therapy developed from experimental research on learning.*
- *How parents sometimes unintentionally reinforce maladaptive child behaviors.*
- *Behavior therapy's view of personality-related behaviors as learnable skills.*
- *Behavior assessment's focus on the antecedents and consequences of behaviors.*
- *The technique of exposure, which desensitizes clients to previously anxiety-producing stimuli.*
- *Contingency contracting, which uses operant conditioning to treat behavior problems.*
- *Relaxation training based on deep breathing and progressive muscle relaxation.*
- *Social skills training, which teaches children how to make and keep friends.*

Case Example

Attention

Barry, a 6-year-old European American boy, was brought to therapy by his mother because of his noncompliance and annoying, pestering behavior, constant seeking of attention, and difficulty playing independently. The mother complained that Barry was constantly getting into things and making a mess. She said that if she took her eyes off him for more than 10 minutes, there was liable to be trouble. She reported a number of everyday tasks that elicited defiance in Barry, including getting dressed in the morning, performing age-appropriate chores like putting toys away, and ending play activities when told to do so. The mother also described Barry as an imaginative, fun-loving child who behaved well as long as he was provided with entertaining activities and demands were not placed on him. The therapist made a diagnosis of oppositional-defiant disorder.

Barry was the youngest of three children. His mother said he usually got along well with his siblings, although they sometimes complained about him pestering them. The client's parents had been divorced for 2 years. Barry spent every other weekend and some holidays with his father. His mother noted bitterly that her ex-husband

claimed to have no problems managing his son's behavior, but she attributed this to the father making few demands and providing Barry with lots of toys and activities: "He's a typical Disneyland Dad."

Barry was in first grade in school. His report card indicated satisfactory academic functioning and a level of self-control and compliance that seemed below average but not clinically significant. His behavior was better controlled in school than at home.

Learning Theory

Unlike most other therapeutic approaches, behavior therapy originated in the research laboratory, not the mental health clinic. Behavioral treatment was developed by applying scientific knowledge to the design of interventions for mental health problems. Just as biochemistry research has led to the development of medicines, basic research on the psychology of learning has led to the design of therapeutic techniques.

This scientific tradition has implications for behavior therapy as an approach to clinical work. Counselors can be confident that the psychological processes utilized by behavioral techniques do exist and do operate in the ways presumed by the techniques. Also, research has produced a more definitive understanding of learning principles than, for example, the workings of the unconscious. Behavioral techniques are generally subjected to rigorous outcome research as soon as they are developed, and they are discarded, modified, or retained on the basis of the results they produce with clients.

Behavior therapists emphasize careful **operational definitions**; they describe behavior in objective, observable, measurable terms. When behaviorists criticize the more abstract therapeutic approaches (e.g., psychoanalysis), they say things like: "What does *superego* actually mean? What do people *do* when they have a harsh superego?"

Learning is defined as any lasting change in behavior that results from experience.

Behavior therapy is based on the area of psychological research called **learning theory**. The technical definition of learning is quite broad: Learning is defined as any lasting change in behavior that results from experience. Learning occurs whenever a person has an experience that changes his future behavior.

The Core Idea: Both Adaptive and Maladaptive Behaviors Are Learned

The central idea in behavior therapy is that problems are learned and, therefore, they can be unlearned (Follete & Darrow, 2014; Guinther & Dougher, 2013; Skinner, 1953; Spiegler, 2013). Learning processes are equally capable of producing adaptive or maladaptive behavior, depending on the environmental stimuli and consequences experienced by the learner. As a result, when maladaptive behaviors are acquired, therapists can use the same learning mechanisms that were responsible for problem etiology to treat the difficulties, so problems leave by the same door they entered.

Behavior theory also acknowledges genetic influences on behavior and behavior problems. But even when the root causes of dysfunction include genetic factors, learning processes generally maintain the specific, behavioral manifestations of the dysfunction, and this means that therapeutically engineered learning experiences can make a positive difference (Kazdin, 2012; Spiegler & Guevremont, 2010).

Behavior therapy is based on three types of learning: **classical conditioning**, **operant conditioning**, and **observational learning**. Although other, more complex forms of learning also exist, there is no doubt that these three types of learning are fundamental processes by which human beings change as a result of their experiences. Behavior therapy may miss out on some of the mysterious, esoteric features of human life, but it focuses effectively on core, basic processes.

Classical Conditioning

In classical conditioning, people learn *associations between stimuli* (Gottlieb & Begej, 2014; Lattal, 2013; Pavlov, 1927; Watson, 1924). This type of learning is about which stimuli occur in association with, or predict the occurrence of, which other stimuli. Classical conditioning does not involve learning new behaviors; it involves learning new stimuli for old behaviors. In other words, following classical conditioning, the learner does not do any behaviors she did not do before, but she does these behaviors at different times—she produces behaviors in response to stimuli that did not formerly elicit them.

Ivan Pavlov (1927) discovered classical conditioning in his famous experiments with dogs. Pavlov repeatedly paired food with a light or tone. In time, the dogs learned to salivate in response to the signal, before the food was given. Dogs do not naturally salivate in response to a light or a tone but, through classical conditioning, they learned to do so. Thus, the dogs learned to do an old behavior (salivation) in response to a new stimulus (a light or tone).

Classical conditioning explains how neutral stimuli can come to elicit emotional, even physiological responses: What is necessary is a repeated *pairing* of the neutral or **conditioned stimulus** with an **unconditioned stimulus** that, prior to learning, elicits an innate response. Pairing produces learning most efficiently if the conditioned stimulus slightly precedes the unconditioned stimulus in time.

Once learning has occurred, the conditioned stimulus activates a memory trace representing the unconditioned stimulus (e.g., food or pain), and this activated memory then produces the conditioned response (Gottlieb & Begej, 2014; Jacobs & Blackburn, 1995; Lattal, 2013). The conditioned and unconditioned stimuli are different from and possibly not even related to each other. The conditioned and unconditioned responses, as behaviors, are similar to each other, but they occur in response to different stimuli.

In the 1920s, John Watson (1924) demonstrated classical conditioning of emotion in an early application of learning research to a clinical issue—namely, the development of phobia. In a single subject experiment that could not be performed today for ethical reasons, Watson presented a 10-month-old infant ("Little Albert") with a white bunny. At first, Little Albert played happily with the rabbit. Then, Watson paired presentation of the rabbit with a loud, unpleasant noise, which elicited crying from the child. After a few pairings of bunny and noise, Little Albert cried at the appearance of the white rabbit, even when no noise followed. He had learned to transfer his noise reaction to the bunny; he reacted to the rabbit *as if* it were the noise, because he had learned this association.

In addition, this Pavlovian learning **generalized** to other stimuli that were similar in some way to the rabbit but that had never before been associated with an aversive stimulus in Little Albert's experience. The child not only developed a phobia of white rabbits but also cried in response to anything white and fluffy, such as a ball of cotton and a man with a white beard. He had learned that white, fluffy stimuli signal or predict the arrival of painful stimuli.

What do these laboratory experiments have to do with the development of emotional problems in the real world? A great deal. The classical conditioning paradigm explains how people learn new reactions to stimuli. These learned associations can be pleasant and positive: A child whose father cuddles her while reading bedtime stories may develop warm, happy associations with books—and with men. Classically conditioned associations can also be painful and maladaptive: A child who is sometimes nurtured and sometimes abused by her father may learn to associate closeness to men with both gratification and pain, and these conflicting associations may distort her future relationships.

Classical conditioning is of particular importance to our understanding of post-traumatic stress disorder (PTSD; De Young, Kenardy, & van Eys, 2014; Ford & Cloitre, 2009). Trauma victims sometimes experience surges of anxiety in response to stimuli that just happened to be present when they were hurt, even if those stimuli had no causal relationship to what happened. For instance, sexual abuse victims sometimes re-experience their trauma in response to a smell that happened to be in the room during their molestation.

Classical conditioning is an emotional and experiential process, not a rational one, occurring primarily in subcortical, primitive areas of the brain (Damasio, 1994; LeDoux, 1998). As a result, conscious, reality-oriented thinking usually does not undo the raw, gut feelings that are conditioned into memory by the Pavlovian mechanism.

Classical conditioning is a mechanism of treatment as well as etiology, because Pavlovian learning also runs in reverse, and acquired associations can be unlearned or, at least, suppressed and negated (Pavlov, 1927; Jacobs & Blackburn, 1995; Vurbic & Bouton, 2014). In the process called **extinction**, stimuli that had been associated are repeatedly *un*paired—that is, the conditioned stimulus is presented but is not followed by the unconditioned stimulus. For Pavlov's dogs, there was a light or tone but then no food. For the abuse victims mentioned earlier, there would be the smells but then no molestation. When this unpairing occurs, the learned response is suppressed, so it weakens and eventually disappears. The learning mechanism of extinction is the basis of the therapeutic technique of exposure.

Operant Conditioning

In operant learning, there are four ways that consequences influence behavior—in other words, there are four contingent relationships between behavior and consequences (Grace & Hucks, 2013; Miltenberger, 2015; Skinner, 1938), as presented in Table 2.1. A **contingency** is a causal relationship between two events: If Event A (a behavior) occurs, then Event B (a consequence) follows. In operant conditioning, organisms learn to do the behaviors that lead to pleasant consequences and avoid the responses that lead to painful consequences. Operant learning is the process by which organisms learn what works and what does not.

There is a 2 × 2 organizational structure to these four types of consequences: There are two types of stimuli (pleasant and unpleasant), and each can be either presented or removed. People sometimes confuse negative reinforcement and punishment, perhaps because both involve unpleasant stimuli. The key to the distinction is that reinforcement, by definition, always increases the frequency of behavior; if it does so by presenting something pleasant, it is called reward, and if it does so by removing something painful, it is called negative reinforcement.

Table 2.1 Mechanisms Through Which Consequences Influence Behavior

1. In **positive reinforcement** or **reward**, the behavior is followed by something pleasant and, therefore, its frequency increases (e.g., praising a child for cleaning up).
2. In **negative reinforcement**, the behavior is followed by the removal of something unpleasant, and the frequency of the behavior, therefore, increases (e.g., a child stays in his room to avoid being teased by his sister).
3. In **punishment**, the behavior is followed by something unpleasant, and the frequency of the behavior decreases (e.g., scolding a child for aggressive behavior).
4. In **response cost**, the behavior is followed by the removal of something pleasant, and the frequency of the behavior decreases (e.g., taking away an adolescent's driving privileges because she stayed out after her curfew).

Operant **extinction** occurs when the contingency between a behavior and consequence ceases, and there is no longer a connection between the response and consequence (Grace & Hucks, 2013; Skinner, 1938; Vurbic & Bouton, 2014). Extinction means that nothing contingent happens. The result is an unlearning of connections between behaviors and consequences. For example, when therapists believe that disruptive child behaviors have been reinforced by parental attention, they may suggest that the parent ignore the misbehavior, in order to extinguish its contingent relationship with attention.

Operant conditioning can lead to the acquisition of new behaviors through a process called **shaping** or **successive approximation** (Follette & Darrow, 2014; Murphy & Lupfer, 2014; Skinner, 1938, 1953). For example, rats do not naturally press levers. If experimenters try to train rats to press levers simply by rewarding them when they do so, the experimenters will end up waiting a long time, because behaviors cannot be reinforced unless they occur. The strategy that works is to begin by rewarding the rat for any behavior that moves toward lever-pressing in some way—for instance, walking toward the lever, pressing on something else, sniffing the lever, and so forth. Soon, the rat is spending most of its time in the vicinity of the lever and, once this occurs, an actual lever press will eventually take place. Animal trainers use successive approximation all the time, and if you have ever taught a dog to perform a trick like shaking hands (paws), you are familiar with the procedure. **Chaining** is a related technique that teaches a sequence of behaviors by separately rewarding each individual step and then training the learner to put these steps together in the correct sequence.

The type of reinforcement schedule that is best for the *acquisition* of new behaviors is opposite to the type of schedule best for the long-term *maintenance* of behaviors (DeLeon, Bullock, & Catania, 2013; Miltenberger, 2015; Skinner, 1938; Spiegler & Guevremont, 2010). New behaviors are learned most quickly when reinforcement occurs immediately, frequently, and consistently. In contrast, behaviors resist extinction and persist for the longest time when reinforcement is **intermittent**—that is, when reinforcement occurs some but not all of the time. If a child expects to be rewarded every time he does a behavior, and reinforcement does not occur, the child will quickly recognize that the contingency has changed, and the behavior will extinguish. But if the child has learned that reward occurs only a fraction of the times he does the behavior, the nonoccurrence of reinforcement does not signal that the contingency has changed, and the child will continue the behavior in the expectation of eventual reinforcement. One classic example

of an intermittent reinforcement schedule is gambling; some individuals persist in this costly behavior, without receiving much reward, because reinforcement occurs just often enough to keep the behavior going.

The gap between the continuous schedule of reinforcement best for response acquisition and the intermittent schedule best for response maintenance can be bridged by the technique called **fading** (Kazdin, 2012; Martin & Pear, 2014). Fading is gradual reduction in the frequency of reinforcement.

In summary, operant conditioning produces and maintains new behaviors most effectively when a three-phase sequence of reinforcement scheduling is used. The optimal order is: (1) continuous reinforcement, (2) fading, and (3) intermittent reinforcement.

Reinforcement contingencies are situation-specific; the same behavior that elicits reward in one situation might elicit punishment in another. (As examples, think of the behaviors appropriate to sporting events and religious services.) Some children's behavior problems are less a matter of doing the wrong thing than of doing the right thing at the wrong time. Competence requires the ability to read the situational cues or **discriminative stimuli** that signal which reinforcement contingency is in effect (McIlvane, 2013; Skinner, 1938, 1953). Traffic lights are discriminative stimuli that tell drivers whether they will be reinforced for stopping or going forward. Discrimination learning enables people to behave in situationally appropriate ways. Note that the word *discrimination* here does not imply prejudice but has the positive connotation of *telling the difference* between situations.

Operant conditioning is the basis of a number of therapeutic techniques, including token economies, contingency contracting, and any systematic use of reinforcement. Also, principles of operant conditioning are key to assessing the effects of intended and unintended consequences of rewards and punishments on children's behavior.

Observational Learning

Social learning theory (Bandura, 1977, 1986) originated in the recognition that people often learn and change their behavior without directly experiencing any stimuli, by means of observational learning. For instance, a child who sees his sister burn her hand on a hot stove might learn to avoid this consequence without ever experiencing it. Social learning theory forms a bridge between behavioral and cognitive theory.

Observational learning greatly expands people's ability to acquire new behaviors. In operant and classical conditioning, the only information available to the learner is the data of her own direct experience. Observational learning makes the data of *other people's* experiences available to the learner. Observing is a more efficient way to learn than trying different behaviors to see what is reinforced.

Modeling is a direct way of providing an observational learning opportunity: The model does what the learner wants to do. Children's natural tendency to imitate the behavior they see enables them to learn readily from models. In behavior therapy, counselors often model the behaviors their clients are trying to learn.

Observational learning can utilize symbolic models as well as live ones (Friedberg & McClure, 2002, 2014). The printed word makes possible a quantum leap in the possibilities for observational learning, enabling readers to learn from the stimuli, responses, and consequences experienced by people living long ago and far away. Multimedia and computer programs mix different media to further expand possibilities for observational learning.

What Causes Mental Health Problems?

There is an element of paradox in learning-based explanations of psychopathology: Learning is an adaptive, reality-oriented process, and yet it sometimes results in disturbed behavior and emotion. All three types of learning involve some form of information-based adaptation to the environment. How could such learning produce maladaptive functioning?

This question has two main answers. First, learning can produce dysfunctional behavior when the formative environment's stimulus associations, reinforcement contingencies, and modeled behaviors differ from those typical of the rest of the world. When this is the case, information acquired in the formative environment is a misleading guide for behavior in other settings. If a child's family operates by different rules than most people do, the behaviors needed to adapt to this family will be out of kilter and maladaptive in most other settings. By learning to adapt to her family, the child develops behaviors that do *not* work in the rest of the world. For instance, in some families, aggressive behavior is operantly reinforced with respect and access to tangible rewards. Children who adapt to such reinforcement contingencies get in trouble when they go to school, where aggressive behavior is generally punished.

Similarly, classical conditioning of stimulus associations that are uncommon outside the learning setting results in reactions that are inappropriate in most environments. For example, children abused by a man might learn to experience anxiety in response to all adult males, even though this association was realistic with only one, unrepresentative person.

There seems to be no etiology of mental health problems more fundamental than overgeneralization of learning. Although behavior theory has focused more systematically on this mechanism than have other therapeutic approaches, it is transtheoretical in its implications and is also emphasized, albeit with different terminology, by cognitive theory (Chapter 3) and psychodynamic, especially object relations, theory (Chapter 5). In overgeneralization, learning that was valid and adaptive in one setting is transferred to other settings where it is not valid and does not apply. Conveying both halves of this understanding to clients acknowledges the validity of what they learned from their experiences and identifies the boundaries to valid application of these lessons. In such cases, therapeutic intervention should involve discrimination learning, with the objective of helping the client *sequester* or limit the application of his learning to situations in which these lessons genuinely apply (Dollard & Miller, 1950; Wachtel, 1977). This is the process by which the future can be unchained from the past.

In overgeneralization, learning that was valid and adaptive in one setting is transferred to other settings where it is not valid and does not apply.

The second reason why learning sometimes produces maladaptive behavior is that, because of the subtlety and complexity of the processes involved, learners sometimes extract inaccurate information from their experiences. In classical conditioning, stimulus generalization causes people to feel afraid of stimuli that have never hurt them, as Little Albert did with balls of cotton and white beards. In operant conditioning, parents sometimes administer consequences, such as negative attention, that they think are punishments but are actually experienced as rewards by the child. Failures of discrimination learning cause people to engage in behaviors that worked in one situation but do not work in others. Intermittent reinforcement results in the maintenance of behaviors that are ineffective most of the time but persist because they are occasionally followed by a reward.

One common mistake made by parents of children with behavior problems is failing to reward the minor examples of improved behavior that occur, at times, in all children (Barkley, 2013; Kazdin, 2005; McMahon & Forehand, 2005; Patterson, 1982). The caregiver's reason for not rewarding these behaviors is generally that they are not considered good enough—the behaviors do not meet the parent's standards of acceptable child functioning. Although this stance is not illogical, it will not work, because the parent's criterion for reward is so far above the child's current level of behavior that she will never receive reinforcement—and learning depends on reinforcement.

Reinforcement is a function of the experiences of the learner, not the intentions of the trainer.

There is a paradox at the heart of behavioral parent training: Why would parents need therapists to help them reinforce the behaviors they desire in their children when, presumably, parents would naturally do so on their own? The answer seems to be that, because of the subtle complexities of operant conditioning, translating *intended* reinforcement contingencies into *actual* contingencies is no easy task. Reinforcement is a function of the experiences of the learner, not the intentions of the trainer. When the consequences intended by parents differ from the consequences experienced by the child, parents reinforce behaviors they do not want. Behavioral assessments sometimes reveal this irony, resulting in an "Aha experience" for the parent. This occurred for Barry's mother when she realized that she generally ignored Barry's quiet, appropriate play but gave him lots of attention when she heard a crash in the living room.

Reinforcement is not a mechanical process but a subjective, individual one. An experience that would be a reward for one person might be a punishment for another. Reinforcement is also a comparative phenomenon, in that people seek out the most positive experiences available to them, in comparison to the alternatives.

The subjective, comparative nature of reinforcement explains why **negative attention** is rewarding for some children. Almost all children have a profound need for adult attention. When this need is satisfied by pleasant interactions, the child has no need for negative attention, and reprimands are experienced as punishments, just as the adults intend. However, when children do not receive enough pleasant interaction from adults to satisfy their need for attention, reprimands may help to meet this need (Barkley, 2013; Kazdin, 2005; McMahon & Forehand, 2005; Patterson, 1982). Under these conditions, being yelled at may be (subtly) reinforcing. Poor-quality food that disgusts well-fed people will be eaten eagerly by people who are starving, and the same holds true for human interactions. This formulation is captured by the saying, "Beggars can't be choosers." This etiological process is discussed further in Chapter 10, on disruptive behavior.

Assessment and Case Formulation

Kazdin (2012), Spiegler and Guevrement (2010), Follette and Darrow (2014), and Antony and Roemer (2011) provide detailed explanations of behavioral assessment procedures. Clinical interview and behavioral observation are the most important methods of conducting these evaluations. Because behavior theory emphasizes the situation-specificity of children's responses, these clinicians try to obtain information about the client's functioning in multiple settings, perhaps by interviewing teachers as well as parents.

Standardized, validated instruments also provide valuable information. The most widely used set of instruments for measuring the spectrum of child problems was developed by