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EDITOR'S NOTE FOR VOLUME 7, MODULE 3: Paul Clement has conducted an active private psychotherapy practice since 1966, seeing a total of 1,656 clients in completed therapy as of mid June, 2011. Throughout this time, he has employed an innovative, integrative theoretical model which is inspired primarily by cognitive-behavioral, person-centered, and positive psychology concepts, and which is pragmatically rooted in his private practice experience. What makes Clement's practice particularly distinctive has been his ongoing commitment to developing and implementing methodologies for the systematic, quantitative evaluation of all his clients, using a treatment effect size (ES) statistic, paralleling the one employed in meta-analyses of group studies. Clement has shown how individual practitioners can be accountable within the context of research-based benchmarks of outcome in the field, thus providing a crucial bridge in psychotherapy between traditional practice, on the one hand, and effectiveness-based and efficacy-based group research studies, on the other.

In October of 2007, *PCSP* published an adult case of Clement's, "Story of 'Hope': Successful Treatment of Obsessive Compulsive Disorder," with commentaries by Alan Kazdin (2007) and David Barlow (2007). The present case of "Rafael" provides an example of Clement's child and adolescent case practice. It involves themes of conduct problems, on the one hand, and resilience, on the other. As the reader can see from the cases of Hope and Rafael, Clement has an overall theoretical guiding conception to his work and a common accountability system, but he adapts it to the developmental age of his clients.

A Strengths-Based, Skill-Building, Integrative Approach to Treating Conduct Problems in a 12-Year-Old Boy: Rafael's Story

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ABSTRACT

School administrators suspended Rafael, an adopted, 12-year-old boy being raised by a single mother, following an episode of vandalism. They demanded that he enter psychotherapy in order to return to school. Raphael had a history of acting out, aggressive behavior, angry outbursts, disruptive classroom behavior, destruction of property, fighting, lying, stealing, and being teased by peers about his serious birth defects. The initial task facing the clinician was to make a differential diagnosis including to determine what developmental trajectory the youth was following. The first course of treatment covered 29 sessions. Goal setting, assertiveness training, and training in conflict resolution were the major components of treatment. Based on his mother's ratings, Rafael was clearly improved by the 17th session and greatly improved by termination. Eight months later he returned to treatment because of an episode of stealing. The second course of treatment was for 20 sessions. Rafael and his mother evaluated Rafael at intake and at termination during this second course. Based on their input his treatment outcome was extremely positive, with an effect size of 3.02. The article concludes by describing Rafael's

major accomplishments during the eight years since treatment ended as well as his plans for a career.

Key words: adolescent psychotherapy; birth defects; child psychotherapy; developmental assets; developmental trajectory; evidence-based practice; positive psychology; resilience; stealing; vandalism; clinical case studies; case studies

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1. CASE CONTEXT AND METHOD

Statistical Profile of My Practice

Over the past 44 years of private practice, I have assessed and treated a total of 2,240 clients, with close to half (43%) involving children and adolescents.[1] Specifically, I have seen 948 children from age 6 months through age 17 years. The median age has been 11 years. A majority (72.51%) has been male. Among the most frequent diagnoses given to these children and youth (in increasing order of frequency) have been:

- Conduct Disorder (CD),
- Generalized Anxiety Disorder
- Adjustment Disorders
- Attention-Deficit/Hyperactivity Disorder (A-D/HD): Predominantly Inattentive,
- Dysthymic Disorder,
- Oppositional Defiant Disorder (ODD), and
- A-D/HD: Combined or Predominantly Hyperactive/Impulsive.

Based on calculating the year-by-year rates of improvement for all cases treated during a given year, the mean percent improved per year has been 74.38 (95% CI: 69.97-78.79; standard deviation of 14.16); the median was 76; and the range was from 50 to 100. For the 248 cases for whom adequate data were available to calculate a treatment effect size (ES), the mean was 1.70 (95% CI: 1.54-1.87; standard deviation of 1.35); the median was 1.50; and the range was –1.56 to 7.43. Only 3.56% of the ESs were negative. (For the procedures used in calculating an effect size within an individual case, see Clement, 2007.)

As will become clear from the presentation that follows, my initial evaluation of the present case, Rafael, posed the challenge of deciding whether the child best fit the criteria for

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[1] This includes 1,656 clients who have completed therapy. The larger number (2,240) is for all intakes in my private practice career, including people who came for assessment only, consultation only without any intervention, and ones who dropped out before there had been any intervention.

Conduct Disorder (CD), an Adjustment Disorder, or Oppositional Defiant Disorder ODD). For each of these diagnoses my treatment outcomes have been as follows:

- for CD, 48.72% improved, with a mean ES = 1.39 (95% CI: 0.83-1.95; standard deviation of 1.01),
- for Adjustment Disorders 70.00% improved and mean ES = 1.72 (95% CI: 0.70-2.74; standard deviation of 1.92), and
- for ODD 63.22% improved and mean ES = 1.74 (95% CI: 1.38-2.10; standard deviation of 1.59).

The mean number of sessions per treated child/adolescent case has been 16.16 (standard deviation of 20.73); the median has been 10 sessions; and the range has been 1 - 257. There has been a positive relationship between the number of treatment sessions and treatment outcome ($r = 0.65$, $p = 0.0082$, for the relationship between median number of sessions taken at 50 cases per block versus percentage of cases improved within each block).

The Rationale for Selecting This Particular Client for Study

I chose the case of Rafael described below because, as a 12-year old male with conduct problems, he was in many ways typical of children and youth treated by me. The outcome from his first course of treatment at the mid-point of treatment was very typical for my practice, although his outcome at termination was exceptionally good. The fact that we had a second course of treatment was not characteristic.

I also selected this particular boy because his story illustrates the importance of interpreting referral problems in terms of the child's maturational stage, his total social milieu, and his apparent developmental trajectory.

Finally, this case study is distinctive in illustrating resilience in a youth with significant physical impairments and in providing long-term follow-up data.

The Methodological Strategies Employed for Enhancing the Rigor of the Study

This was a routine treatment case. I did not employ any special methodological strategies to enhance the rigor of the study. For children 12 and younger I normally ask the parent(s) to identify areas of concern on the Childhood Problems Checklist (Clement, 1999), presented in Appendix 1. and to rate the severity of each problem. As shown in Appendix 1, on this instrument the parent is presented with a list of items and asked to indicate the degree of concern (if any) that he/she has about the item, from "1-a persistent danger to self or others," to "8-slight concern." Below are the eight items on which she indicate a rating of 1-6. I subsequently ask the parent(s) to re-evaluate their child during the course of treatment and at termination. Following each re-evaluation I calculate an ES using the formula that I employ with all cases for which I have adequate data (Clement, 1996, 1999). This formula uses the scores obtained at intake as the baseline data and the point of comparison for all subsequent re-evaluations. This approach adapts

the logic of meta-analysis as introduced by Smith and Glass (1977) and Smith, Glass, and Miller (1980) to outcomes for individual patients or sets of patients. Rather than comparing mean scores of treated and control/contrast groups, the present approach makes comparisons across multiple measures within an individual, with each patient serving as his/her own control. Across all of my child and adolescent cases the mean number of problems scored at intake has been 16.99 (95% CI: 14.69-19.28; standard deviation of 9.64).

The Clinical Setting in Which the Case Took Place

All sessions occurred in my private office. It was in a suite of four offices on the second floor of an office building. The location was just a few blocks from the patient's school.

Sources of Data Available Concerning the Client

The mother was the sole source of information used to evaluate treatment outcome during the first course of treatment; however, three teachers rated the boy's behavior at intake. I also reviewed progress reports and report cards from school, but these data were not included in the quantitative evaluation of outcome. I provide more information about these instruments below under "Presenting Problems."

Confidentiality

Names, nationality, and other specific identifiers have been changed in the following presentation in order to protect the identity of the patient. Prior to submitting this case study for publication, I asked Rafael and his mother to read it for accuracy and for adequate protection of their identities.

2A. THE CLIENT

At the time of intake Rafael was 12 years 9 months old. He was born in another country and had serious birth defects. He had no hands, no right forearm, and his feet were deformed requiring special shoes. His birth parents kept him for three months and then gave him to an orphanage. When he was 13 months old an American woman adopted him and brought him to the United States. She had two older children: a son who was 11 years older than Rafael and a daughter who was 3 years older. She was divorced prior to adopting her daughter and Rafael; hence, she raised all three children as a single parent. She was a doctoral-level healthcare provider. He had a history of periodic anger and aggression, and had been specifically referred to therapy by his school for minor vandalism.

2B. THE THERAPIST

I am an American-born male of western European descent. I grew up on a small farm in Washington State and acquired a pragmatic approach to life. My undergraduate education in psychology took place in a large, public university. In 1965 I earned my doctoral degree from an APA-approved program in clinical psychology in another public university. I became licensed in

mid-1966 and immediately began a part-time private practice. In 1970 I became a Diplomate in clinical psychology of the American Board of Professional Psychology. Over the years four divisions of APA elected me a Fellow: 12 (clinical psychology), 36 (psychology of religion), 37 (child & family policy and practice, and 53 (clinical child and adolescent psychology). Following 22 years of part-time private practice and 23 years of full-time work as a graduate school professor, I entered full-time private practice in late 1988.

In the context of my lifespan private practice, the present article deals with one of my child/adolescent cases. As part of my academic work, I conducted research on child psychotherapy. My research, writing, and teaching mostly focused on child therapy.

I have not been aligned with any particular school or theoretical system of psychotherapy, but have always favored diagnostic and treatment approaches that have sound foundations in empirical evidence, particularly including cognitive-behavior therapy, positive psychology, and empirically supported strategies for developing and maintaining positive therapeutic relationships (Norcross, 2001). During the decades of my career I have sought out what have become known as *empirically supported treatments* (ESTs) or *evidence-based treatments* (EBTs) and incorporated them into my therapeutic repertoire. What has become known in recent years as *evidence-based practice in psychology* (EBPP) (APA Presidential Task Force, 2006) probably represents my orientation the best.

3. GUIDING CONCEPTION WITH SUPPORT FROM RESEARCH AND CLINICAL EXPERIENCE

Trajectories of Problem Development versus Resilience

In recent decades many researchers have focused on the development of problem behaviors from infancy through adolescence. Perhaps the best known of these is Gerald R. Patterson and his colleagues at the Oregon Social Learning Center. In particular, they have focused on the trajectory followed in the development of aggressive, antisocial, and violent behaviors as well as conduct problems (e.g., Granic, I. & Patterson, G.R., 2006; Patterson, 2008; Snyder, J., Cramer, A., Afrank, J., & Patterson, G.R., 2005). Coercive behaviors are the key factor in the development and stabilizing of aggression over time (Patterson, 1982; Patterson, Reid, Dishion, 1992; Reid, Patterson, & Snyder, 2002). Initially coercive behaviors develop within the family and are based on hostile exchanges between parent and child. As a youth moves from childhood toward and into adolescence there is much evidence of a connection between hanging out with deviant peers and increasing antisocial behaviors (e.g., Gold, 1970; Hawkins, Catalano, & Miller, 1992; Patterson, 1993). Deviant peers reinforce each other for talking about topics, such as breaking rules or the law, stealing, lying, fighting, or taking drugs. Other contributors to the development of antisocial behavior are rejection by most peers, academic failure, depression, and unstable parenting that swings between being permissive and being hostile/harsh/authoritarian (Granic & Patterson, 2006).

There is evidence that other kinds of child/adolescent psychopathologies follow developmental trajectories (e.g., Forehand, 2010), but that literature is not as directly related to

the present case as the work cited in the preceding paragraph. In contrast, the research on resilience and protective factors is relevant.

Resilient is the term applied to children, adolescents, or adults who have flourished in spite of growing up facing significant adversities (Garmezy, 1974; Masten & Coatsworth, 1998; Rutter, 1979; Werner & Smith, 1982). Individuals who later are identified as resilient are persons who developed a repertoire of competencies during childhood and adolescence. According to Masten and Coatsworth (1998) mastery of various developmental tasks is the basis of resilience. During infancy through the preschool years the tasks include attachment to parents and other caregivers, oral language , differentiation of self from the environment, self-control, and compliance with directions from significant adults. During middle childhood the major developmental tasks include school attendance, appropriate behavior at school, academic achievement (reading, writing, and arithmetic), being accepted by peers, making friends, and following the rules at school, at home, and in the community. During adolescence the challenges include making a successful transition to high school, academic achievement that prepares the student for higher education or a job, participating in extracurricular activities, forming close friendships with both boys and girls, and developing a clear self-identity.

Masten and Coatsworth (1998) identified common characteristics found in resilient children and adolescents. In terms of personal characteristics they listed good intelligence, sociable behavior, a positive self-concept, talents, and faith. Family variables included having a close relationship to a caring parent, authoritative parenting (e.g., the parent is/was warm, structured, and had positive expectations for the offspring), socioeconomic advantages, and connections to a supportive family network. Extrafamilial contributors to resilience involved ties to prosocial adults (e.g., teachers, coaches, and mentors), involvement in prosocial organizations, and going to effective schools.

In light of the preceding brief review, when a child psychotherapist evaluates a new case in which some of the referral problems involve antisocial behavior, that clinician will want to identify what trajectory the youth seems to be following. Is antisocial and aggressive behavior increasing or decreasing across the years? Similarly, what competencies does the child manifest and what factors that protect against a worsening trajectory are present in the child's life?

Teasing, Bullying, Fighting, and Birth Defects

Keltner, Capps, Kring, Young, and Heerey (2001) defined teasing as "an intentional provocation accompanied by playful markers that together comment on something of relevance to the target of the tease" (p.229). In their extensive review of research on teasing, they confess that teasing can have a positive social impact on the target or it can trigger a hostile response. Whitney and Smith (1993) claimed, "It is also bullying when a child or young person is teased repeatedly in a nasty way" (p. 7). In their study of middle school students from three states Horowitz, Vessey, Carlson, Bradley, Montoya, McCullough, and David (2004) found that up to 15 percent of children experienced chronic teasing and bullying. Being different in any way greatly increased the probability that a student would be the target of teasing or bullying. Children with visible birth defects have noticeable differences from their peers and are in danger

of being teased or taunted about their physical appearance (Keltner et al., 2001). Such teasing is a form of bullying. When boys get bullied, they are most likely to retaliate physically by pushing or hitting their tormentor (Croog, 2007).

Although children with birth defects are at risk for being teased for something over which they have no control, there is hope for a positive, long-term trajectory in their development. For example, in their extensive review Frieidman, Holmbeck, DeLucia, Jandasek, and Zebracki (2009) concluded, "Overall, children with spina bifida show considerable developmental resiliency" (p. 16). Similarly, Szienberg-Arazi, Heim, and Steinbach (1991) reported that peers of children with congenital limb absence said that their classmates with birth defects were as popular and had the same social status as those without birth defects. For at least 40 years there has been evidence that mothers of children with birth defects can promote positive adjustment in their offspring by accepting the reality of the child's defect, communicating openly with the child about the birth defect and its implications, manifesting liking and respect for the child, maintaining a positive outlook toward the child's future, and encouraging the child to achieve and to be independent (Fishman & Fishman, 1971a, 1971b).

A Challenge to Child Psychotherapists

In 1952 the English psychologist, Eysenck, published an article based on his review of 19 studies of adult psychotherapy outcomes covering more than 7,000 cases. The analysis included both psychoanalytic and eclectic types of treatment. He concluded that there was no evidence that psychotherapy had facilitated improvement. Five years later an American psychologist, Levitt, (1957) reviewed studies of psychotherapy outcomes obtained with children. He came to the same conclusion. These conclusions of Eysenck and Levitt provoked both psychotherapy researchers and practitioners around the world. Many articles challenged the conclusions of Eysenck and Levitt, but both of these writers held to their positions. In 1963 Levitt updated his earlier review and concluded, "[T]here is no sound basis for the hypothesis that psychotherapy facilitates recovery from emotional illness in children" (p. 45). Three years later Eysenck (1966) expanded his review and covered studies for both children and adults. The result was the same as in 1952: "When untreated neurotic control groups are compared with experimental groups of neurotic patients treated by means of psychotherapy, both groups recover to approximately the same extent" (p. 39).

In addition to theoretical and methodological criticisms of the reviews by Eysenck and Levitt, many investigators conducted experiments to identify the value of psychological treatments for a wide variety of clinical problems. Then in 1970 Meltzoff and Kornreich provided a comprehensive review of research on the processes and outcomes of psychotherapy. They identified 35 adequately controlled outcome studies with positive results, 18 adequately controlled studies with minor benefits, 10 questionably controlled studies with positive outcomes, and 26 questionably controlled studies with minor benefits. Overall they reported that the evidence was very clear; psychotherapy was beneficial. In addition, they encouraged researchers of psychotherapy to focus on the patient's goals when measuring treatment outcomes. Doing so is a central aspect of the approach described in the present paper.

Seven years after Meltzoff and Kornreich's book appeared, Smith and Glass (1977) used meta-analysis to evaluate psychotherapy outcome studies quantitatively. Three years later they expanded their meta-analysis into a book (Smith, Glass, & Miller, 1980). Both quantitative reviews concluded that there was substantial evidence that psychotherapy was beneficial; however, their review did not cover psychotherapy with children and adolescents.

Meta-analyses of research on child and adolescent psychotherapy eventually appeared. The reviewers concluded that child and adolescent psychotherapies were also beneficial (Bratton, Ray, Rhine, & Jones, 2005; Casey & Berman, 1985; Erion, 2006; Fossum, Handegard, Matinussen & Morch, 2008; Maughan, Christiansen, Jenson, Olympia, & Clark; 2005; Kazdin, Bass, Ayers, & Rodgers, 1990; Lewinson & Clarke, 1999; McLeod & Weisz, 2004; Michael & Crowley, 2002; Reinecke, Ryan, & DuBois, 1998a, 1998b; Stage & Quiroz, 1997; Weisz, McCarty, & Valerie, 2006; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). Averaging across all the ESs in these reviews produced the following results: a mean ES of 0.71 (95% CI 0.56-0.85; standard deviation of 0.27).

Although Smith and Glass (1977) and Smith et al. (1980) used meta-analysis to determine outcomes from randomized controlled trials (RCTs) or their equivalent, more than 30 years ago I began adapting their methodology to sets of single-subject experiments (e.g., Clement, Anderson, Arnold, Butman, Fantuzzo, & Mays, 1978) and to individual cases in my private practice.

"Readiness" for Treatment and "Stages of Change"

Children virtually never ask to see a psychotherapist, and adolescents rarely do so. Child and adolescent psychotherapy is usually someone else's idea. In the present case the principal and vice-principal demanded that the boy enter treatment in order to be readmitted to school. Such circumstances pose a challenge to the therapist in forming a working alliance with the young patient. Although the parent(s) may be highly motivated to get help for their child, the youth is unlikely to show interest in self-discovery and personal change. At the beginning of treatment the child is at what Prochaska, DiClemente, and Norcross (1992) called the *pre-contemplation* stage of change (i.e., there is no intention to change and no personal recognition that a problem exists).

The therapist is likely to face major challenges in helping the young patient to move through the remaining stages of change (Prochaska et al., 1992): (a) *Contemplation* is the stage in which personal awareness of the problems exists, the person thinks about overcoming the problem, but there is no commitment to action. (b) *Preparation* covers the phase in which the person decides to take action toward change within the next month. (c) *Action* is when the person modifies his/her thoughts, feelings, actions, or environment in order to solve their problems. (d) *Maintenance* includes when the gains achieved in the action stage are consolidated and strategies to prevent relapse are used. When Rafael first came to see me, he was in the pre-contemplation stage.

Empirically Supported Treatments, Common Factors, and Evidence-Based Practice

Fifteen years ago a task force of the American Psychological Association's Division of Clinical Psychology (Division 12) published criteria for defining and identifying "empirically validated treatments" and listed nine "well-established treatments" and seven "probably efficacious treatments" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Only one of these treatments was specific to child psychotherapy: parent training programs for children with oppositional behavior. Over the years since then, however, researchers have identified many additional empirically supported treatments for children and adolescents. There are many journal articles and books that list and describe them or that provide treatment manuals to guide clinicians in employing a given approach (e.g., Corcoran, 2011; Christophersen & Mortweet, 2001; Hibbs & Jensen, 2005; Silverman & Hinshaw, 2008; Spirito & Kazak, 2006; Steele, Elkin, & Roberts, 2008; Weisz & Kazdin, 2010).

This move to identify empirically validated or empirically supported treatments stood in contrast to a long-standing emphasis on common factors that are present in most or all approaches to psychotherapy. About 75 years ago Rosenzweig (1936) identified such common factors, for example, social reconditioning, catharsis, the therapist's personality, and the provision of a conceptual scheme for the patient to make sense out of their problems.

About 20 years later Rogers (1957) published his famous paper identifying the necessary and sufficient conditions to produce therapeutic change: (1) The therapist and patient had to have contact. (2) The one seeking help had to be in some kind of distress. (3) The therapist had to be authentic or genuine. (4) The therapist had to manifest acceptance of the patient. (5) The therapist had to manifest empathic understanding of the patient. (6) The therapist had to communicate his/her empathy and acceptance to the patient. Rogers claimed that doing these six things would produce gains for the patient. Clearly his list was an example of what has come to be known as "common factors" of psychotherapy.

Throughout my career I have tried to identify empirically supported treatments (e.g., Barlow, 1993; Klerman, Weissman, Rounsaville, & Chevron, 1994; Mash & Barkley, 1989) and empirically supported therapy relationships (e.g., Norcross, 2001). In spite of debates between supporters of these two emphases during the past 15 years or more, I have always tried to integrate specific techniques or treatment packages with therapist variables, with client variables, and with client-therapist variables.

For about the past 15 years there have been many debates about how much of change that occurs during a course of psychotherapy is due to specific treatment procedures, how much is due to characteristics of the therapist, and how much is due to characteristics of the patient or of the patient's environment. Barlow (2007) claimed that the answers vary considerably depending on the particular disorder and treatment. He said that specific techniques could account for as little as 10% of the variance in treatment outcome to as much as 60%. Patient, therapist, environmental, and unexplained sources would account for the rest of the variance. The adoption of a conceptual model that accommodates all sources of variance in treatment outcome has released much of the energy driving these debates.

This newer model is known as evidence-based practice (EBP) in psychology (APA Presidential Task Force on Evidence-Based Practice, 2006). This paradigm values *research evidence* (including clinical observation, qualitative research, systematic case studies, single-case experimental designs, public health and ethnographic research, process-outcome studies, studies of interventions in the natural environment, randomized controlled trials, and meta-analysis), *clinical expertise* (including assessment, diagnostic judgment, systematic case formulation, and treatment planning; clinical decision making, treatment implementation, and monitoring of patient progress; interpersonal expertise; continual self-reflection and acquisition of skills; evaluation and use of research evidence; understanding the influence of individual, cultural, and contextual differences on treatment; seeking available resources as needed, such as, consultation adjunctive or alternative services; a cogent rationale for clinical strategies), and *patient characteristics, culture, and preferences*. The present case study illustrates EBP.

Parallels between the Therapist Role and Being a Swimming Instructor or Lifeguard

Years before deciding to major in psychology I began teaching swimming. Eventually I also became a lifeguard and coach of a swimming team. The American Red Cross taught me as a swimming instructor to (a) assess a child's emotional state and level of water safety skills at the beginning of the first lesson, (b) match the lesson to the child's level of confidence and competence, (c) model and describe each action that I wanted the student to perform, (d) ask the child to do what I had just demonstrated, (e) invite the child to repeat the task until s/he was fully relaxed, (f) increase very gradually the difficulty or challenge of each successive task, and (g) celebrate (i.e., socially reinforce) each success.

My years as a lifeguard also instructed my later practice of psychotherapy. I learned that the best swimming rescue is one that the victim makes for him/herself under the guidance of the lifeguard. The rescuer swims close to the victim without making physical contact. Then s/he talks to the victim offering reassurance, assessing the victim's ability to follow directions, telling the victim what to do, and then swimming near the victim as they move toward shore and safety. Similarly as a therapist I have believed that the best treatment is one that the patient executes on him/herself (cf. Chapter 11 in Walker, Hedberg, Clement, & Wright, 1981).

During 3 of the 11 summers that I worked on the water I was the coach of a swimming team that consisted of about 75 children and youth from age 5 through 17. My experiences as a coach also informed my later work as a psychotherapist. The swimming coach diagnoses each swimmer's strengths and weaknesses. Then the coach determines how to tap into existing assets and how to replace weaknesses with new competencies. The swimmer, not the coach, will practice the new competencies in the pool. Also the swimmer, not the coach, will compete in eventual races; but the coach will be at each practice and each competition rooting for the competitor.

One summer 10-year-old Harry came to the pool and asked to join my team. He was a dwarf. His body, arms, hands, fingers, legs, feet, and toes were much shorter than those of other children his age. Unfortunately, the rules of competitive swimming required a child to swim against swimmers of the same age group or against swimmers of an older group. They did not

allow one to compete against swimmers in a younger age group. Once he joined the team Harry never missed a practice, but he always came in a distant last place during intra-team races or time trials. In swimming meets competing against other teams, the result was always the same. But at the end of a practice race or the "real thing," Harry would look up and excitedly ask, "What was my time?" He was practicing a powerful strategy of resilience. He was comparing today's performance with his past performances. He was focused on his personal improvement. He was not comparing himself to other swimmers his age. He was a powerful model of something I have tried to help many of my patients of all ages to see. As will be demonstrated below, he and Rafael had this *something* in common.

The Use of Reinforcers

I did my undergraduate work in psychology at the University of Washington from 1958-1960. Donald Baer taught two of my courses. He was the first professor to introduce me to the strategy of applying B.F. Skinner's methods of laboratory research to real-world problems (e.g., Baer, 1960, 1961). Unfortunately, the rest of my undergraduate and graduate courses mostly neglected the work of Skinner and his followers.

Self-Regulation and the Development of 39 Treatment Interventions

In 1953 Skinner published his book *Science and Human Behavior*. The book contained a chapter in which Skinner asserted that individuals control their own behavior the same way that one individual influences the behavior of another. This claim first led to a series of laboratory studies testing the proposition and second to a long string of experiments in applied settings.

In 1969 I treated a nine-year-old foster child who was presenting with severe behavior problems at school. I set up a simple self-monitoring plan for her. She followed the plan, and her behavior improved greatly (Clement, 1974, pp. 93-95). Based on this case I decided to develop a research program on self-control, self-regulation, or self-management in children. From 1971 through 1989 many of my doctoral students and I carried out investigations of self-administered treatments by children.

Writing treatment plans for children to modify their own behavior was challenging. The task required great clarity and specificity. In order to meet this challenge I developed a system for describing any intervention (Clement, 1980). The system includes 39 generic interventions nested under four broad categories: (a) *Setting events* are variables that affect the general state of the individual. (b) *Cues* and *prods* are signals for particular actions and triggers for particular emotions or other reflexes. (c) *Primary behaviors* are actions that the individual may choose to practice. (d) *Consequences* and *feedback* are what normally follow an action thereby affecting the probability of the action occurring in the future.

Positive Psychology

Children come to therapy because of problem behaviors, but an implicit goal of treatment is to replace each problem behavior with a positive one. This emphasis on developing or

strengthening positive behaviors has a very long history. For example, over 70 years ago Guthrie (1938) articulated the basic formula for behavior change:

> To break a habit it is first necessary to know the stimuli responsible for its release. It is then necessary to use whatever arts one has to cause the person to do something else in this situation. This is the full recipe. The situation will now itself lead to the substituted act. (pp. 386-387).

Almost 40 years later Azrin and Nunn (1977) provided step-by-step instructions for how to replace bad habits with positive behaviors in just one day. They reviewed much research that supported Guthrie's hypothesis. In the present case the basic strategy was to identify the circumstances under which problems occurred and to replace them with adaptive, resilient, or positive behaviors.

This strategy of creating and focusing on positive goals matches well the emphasis of *positive psychology* (e.g., Seligman, 2002a, 2002b; Seligman & Csikszentmihalyi, 2000). *Resilience* is an important topic of positive psychology (Reivich & Shatte, 2002), and *optimism* is another (Seligman, Reivich, Jaycox, & Gillham, 1995). The treatment plans that appear below were based on positive psychology.

A Pragmatic, Problem-Solving Focus

Growing up on a small farm also influenced my approach to clinical psychology. I acquired a bias toward discovering practical solutions to problems in life. In contrast I was surprised by the emphasis on theories and theoretical debates permeating psychology in the late 1950s and in much of the 1960s. As a student, I was interested in learning *how* to help. And once I had completed my graduate education and training I maintained the same interest. Having a conceptual scheme (i.e., a theory) for one's professional practice is important, but the ultimate test of treatment outcomes is not theoretical arguments, it is empirical results. I want every therapist (including myself) to *show me the evidence* that what you or I have done has made a difference.

A word of warning: A case study such as the present one is incapable of identifying how much of the total gains achieved during treatment is due to specific interventions, to characteristics of the patient, to the patient's environment, to qualities of the therapist, to the therapeutic alliance, etc. (cf., Barlow, 2007). We can, however, measure total gains from all sources that occur from intake to termination.

Child and adolescent psychotherapists have not done a very good job of providing such evidence. For example, Weisz, Jensen-Doss, and Hawley (2006) performed a meta-analysis of published and unpublished studies that directly compared evidence-based treatments (EBTs) with usual care (UC) in the community, but their "UC" did not include private practice. In their introduction they reported, "[T]he average effect in … comparisons [of UC and control groups] has hovered near zero, suggesting no benefit of UC, on average. By contrast, the mean ES in hundreds of studies of structured, mostly manual-guided treatments for youth tested in randomized trials … have hovered within the range of 0.50 to 0.80" (p. 672). They reported a

mean ES of 0.30 across 32 studies that had compared EBTs with UC at the end of treatment and a mean ES of 0.38 across 16 studies that had compared EBTs with UC at follow-up. Unfortunately, these findings do not reveal anything about treatment outcomes for children and adolescents seen in private practice.

There is another problem with existing research. Randomized controlled trials (RCTs) compare treatment with contrast or control conditions, and a majority of published ESs are based on such comparisons. Although researchers could report ESs expressing the magnitude of change within subjects *from pre-treatment to post-treatment* or follow-up, they usually fail to do so. When they do, the ESs are substantially larger than the more common ones. In a review of relevant meta-analyses of child and adolescent psychotherapy research (Kazdin & Whitley, 2006; Maughan et al., 2005; Michael & Crowley, 2002) the mean ES for pre-treatment to post-treatment was 1.13 (95% CI 0.77-1.48) (0.38). A one-way ANOVA comparing these results with those reported above on page 7 for the more common meta-analyses of RCTs produced the following results: F (1 & 21) = 9.11, p = 0.0065. ESs based on pre-treatment versus post-treatment measures are substantially larger than those based on a comparison of treated and control cases. The present case study employs pre-treatment versus post-treatment measures.

4. ASSESSMENT OF THE CLIENT'S PRESENTING PROBLEMS, HISTORY, GOALS, AND STRENGTHS: FIRST COURSE OF TREATMENT

History

Here's a reminder of the capsule description of Rafael provided earlier:

> At the time of intake Rafael was 12 years 9 months old. He was born in another country and had serious birth defects. He had no hands, no right forearm, and his feet were deformed requiring special shoes. His birth parents kept him for three months and then gave him to an orphanage. When he was 13 months old an American woman adopted him and brought him to the United States. She had two older children: a son who was 11 years older than Rafael and a daughter who was 3 years older. She was divorced prior to adopting her daughter and Rafael; hence, she raised all three children as a single parent. She was a doctoral-level healthcare provider. He had had been specifically referred to therapy by his school for minor vandalism.

His adoptive mother reported that Rafael had always had difficulty expressing his feelings orally. He had manifested temper outbursts since he was of preschool age. When I first met him, he was in the seventh grade in a private school that he had been attending since kindergarten. Over the years students at his school had teased him regarding his birth defects. He tended to respond to such taunting with anger and aggression. On one occasion the school suspended him for ½ day for such reactions and for a full day following another episode.

He was physically healthy. His only medical problems were allergies and acne. He took Flonase for his allergies and tetracycline and an over-the-counter topical medicine for acne.

Rafael had no history of seizures and had never seen a mental health professional prior to his coming to me; however, four days prior to the intake interview, his principal and vice-principal had suspended him. They demanded that he enter psychotherapy as a prerequisite for returning to school. The reason for this requirement was that one night he had gone to the home of a teacher's aide to one of his classes, let the air out of one of the tires of her car, broke two raw eggs on her porch and one on her driveway. This minor vandalism occurred on a day that the teacher had been absent. The class allegedly went out of control. Rafael took offense to the way the teacher's aide handled the class. Although he had a long history of talking out in class, this was the first known occurrence of vandalism.

In addition to physical education at school his major forms of exercise were running, playing soccer on a team, and participating in intramural basketball. His main hobby was listening to a police scanner.

His relationship with his mother and siblings seemed to be good. In contrast to acting out behavior at school, when he was mad at his mother, he tended to retreat and clam up. In spite of the history of peers taunting him about his birth defects, he identified a set of friends at school and seemed motivated to connect with other students. His methods for dealing with being teased seemed to have prevented him from being bullied.

Given the history of aggressive behavior and vandalism, I wondered what a thorough evaluation would reveal: conduct disorder, oppositional defiant disorder, an adjustment disorder, or something else.

At the time of the intake interview Rafael was on the third suspension from school in his life. He could not return to school until he started seeing a therapist. His contact with me was the first of his life with a mental health professional. He had been growing up in the same private school. He was functioning at or above grade level. He was passing all of his subjects. He attended school and all of his classes regularly. He identified at least two good friends. He appeared to have a good relationship with his mother and two older siblings. In spite of his physical limitations he was active in sports. Although he was physically aggressive on occasion, such behavior seemed to be a reaction to being teased or taunted. In addition, his self-control when angry had been improving across the years.

Mother's Treatment Goals

At intake Rafael's mother filled out the Childhood Symptom Inventory-4 Parent Checklist (Gadow & Sprafkin, 1997), and three teachers independently completed the Childhood Symptom Inventory-4 Teacher Checklist (Gadow & Sprafkin, 1997). Table 1 summarizes the results from the four informants. There was substantial disagreement among these four adults. The only category on which all four agreed was "conduct disorder," but with the exception of Teacher C all T scores fell below 70, a score this is usually considered as clinically significant.

On the Childhood Problems Checklist (see Appendix 1) Rafael's mother identified the following as areas of concern: acts without thinking (hyperactive or impulsive), aggressive

behavior, anger, classroom behavior, destruction of property, fighting, impact of child's problems on the mother, lying, sleep schedule, stealing, and teased by peers.

At intake, Rafael's mother was also given the Childhood Problems Checklist. As shown in Appendix 1, on this instrument the parent is presented with a list of items and asked to indicate the degree of concern (if any) that he/she has about the item, from "1-a persistent danger to self or others," to "8-slight concern." Below are the 11 items on which she indicated a rating of 7 or less, which are also listed in the first column of the Scale of Functioning (SOF) in Table 4.

Acts Without Thinking (Hyperactive or Impulsive)	"7-Some Problem"
Aggressive Behavior	"7-Some Problem"
Anger	"6-Moderate Problem"
Classroom Behavior	"7-Some Problem"
Destruction of Property	"7-Some Problem"
Fighting	"7-Some Problem"
Impact of Child's Problems on the Mother	"7-Some Problem"
Lying	"7-Some Problem"
Sleep Schedule	"7-Some Problem"
Stealing	"7-Some Problem"
Teased By Peers	"7-Some Problem"

Raphael's Treatment Goals

Given that coming to therapy was not Rafael's idea, he had no goals for therapy. Although his mother's only articulated goal was "Determine whether there are issues causing Rafael's problems that need to be worked out," there were many implied goals related to her list of his problems. The tacit goals were as follows: (1) become more thoughtful in his actions when provoked, (2) become more friendly or assertive when angry, (3) improve his classroom behavior, (4) be more respectful toward the property of other people, (5) be more truthful, (6) develop better habits around sleeping, and (7) become more socially skillful in responding to being teased or taunted.

In his book for parents on how to deal with their defiant child, Kazdin (2008) described a hypothetical situation with many similarities to what Rafael's mother faced when she brought him in to see me:

> Your thirteen-year-old gives you nothing but attitude. On a couple of occasions, he has stolen something or committed an act of vandalism, the most worrisome pieces of a larger pattern of defying authority. You tell yourself that he's going through a phase, that he's just a normal preadolescent, but you fear that he may be heading toward serious trouble. You have tried to talk to him in every way you can think of—punishing, explaining, begging, crying—but nothing works. Your spouse says you are exaggerating, but you feel it's time to face the seriousness of what's happening to your family. Your child has a good heart, but that doesn't keep you from feeling always a little on edge, not knowing when the next crisis will develop (p. 2).

Diagnosis

Based on all of the information that I gathered during the intake process, I concluded that Rafael did not meet the criteria for ODD or for CD. In addition, I didn't think that he was on a trajectory that would ultimately lead to his meeting the criteria for either of these diagnoses. Specifically arguing against a diagnosis of ODD or CD were the following.

- Rafael and his mother were not engaging in hostile exchanges.
- He did not manifest a general pattern of oppositional behavior at home or school.
- He was not hanging out with deviant peers.
- His antisocial behaviors were not increasing across time.
- His peers did not reject him.
- He was successful academically.
- His mother manifested stable, authoritative parenting.
- There seemed to be a good attachment to his mother and siblings.
- He was involved in extra-curricular activities.
- He was not depressed.
- Although he had a history of breaking some school rules, the occasions seemed infrequent.
- His occasional aggressive behavior toward peers appeared to be a form of self-defense against being teased and taunted.
- Although coming to see a therapist wasn't his idea, he did not deny to me what he had done and made no attempt to defend his actions when we discussed the critical incident that caused his suspension and compulsory psychotherapy. This

lack of denial and defensiveness would not be typical of children presenting with ODD or CD.

Based on the above, I concluded that overall, Rafael seemed to be on a positive developmental trajectory marred by occasional misconduct, and that this pattern was captured by the following diagnosis:

Axis I: 309.3 Adjustment Disorder with Disturbance of Conduct

Axis II: V71.09 no diagnosis

Axis III: acne, allergies, and significant birth defects

Axis IV: long-term teasing and taunting by peers

Axis Va: Current GAF = 66

Axis Vb: Highest GAF in past year = 80

Strengths

Rafael had many personal assets. Among them were good intelligence, a desire to do well academically and athletically, a positive self-concept, involvement in organized sports, and engagement in his church. He served on his school's academic decathlon team. He had played soccer in an American Youth Soccer Organization (AYSO) league in the fall for the past six years. He was on his school's track team. His mother was warm, provided structure, and had positive expectations for him. She was able to provide him with socioeconomic advantages including attendance at a private school. He seemed to be part of a supportive family network that included an older brother and sister to whom he seemed bonded. His friends seemed to manifest pro-social values. Although he had experienced teasing and taunting for his birth defects throughout his lifetime, he actively stood up for himself.

5. FORMULATION AND TREATMENT PLAN: FIRST COURSE OF TREATMENT

Case Formulation

As indicated earlier, there was some information in his history and in his presenting problems that was consistent with a diagnosis of ODD or of CD, but the frequency and intensity of his aggressive behaviors, vandalism, and rule violations did not reach the level required for either of these diagnoses. I concluded that the diagnosis that fit his clinical facts the best was Adjustment Disorder with Disturbance of Conduct.

Because of his many strengths and the fact that he would soon become a teenager, I decided to see him in individual therapy. If he had presented with many problems at home, I may have used conjoint family therapy that included training his mother in behavior management strategies. In his case, however, the complaints were coming from school.

Treatment Plan

Table 2 summarizes the treatment plan. In addition to what is listed in the table, I wanted to form a working alliance with Rafael. In the initial sessions I wanted to establish rapport with him and to focus on ways to help him get what he wanted both at home and at school. During the intake process I learned nothing that suggested Rafael saw any potential benefits to him from being in therapy. His school administrators were demanding that he be in treatment in order to be allowed to come to school. Most of our sessions occurred on a weekday at 8:00 AM. At the end of each session I gave him a brief note on my letterhead saying, "Please excuse Rafael's late arrival to school this morning. He and I had an appointment that lasted almost until 9:00 AM." Given that he wanted to attend school, these notes served as a kind of token reinforcer for his having attended the therapy session.

6A. FIRST COURSE OF THERAPY [2]

This first course of treatment ran for 29 sessions from mid March of the seventh grade through late November of the eighth grade, with Rafael being in summer school between grades. Session 1, 16, and 29 were conjoint with Rafael and his mother, and the others were just with Rafael. His school was on a trimester system. During the time that I was seeing him he received a final report card for the last trimester of the seventh grade, for summer school, and for the first trimester of the eighth grade. Also his mother left me messages periodically. Rafael regularly provided reports of major events in his life during our weekly sessions. Finally, his mother re-evaluated him on the Childhood Problems Checklist following the 16th session and at the 29th and final session.

My Overall View of my Role as Therapist

Given that Rafael had been growing up without a father, some male therapists may have perceived themselves as a father figure in Rafael's life. That is not how I viewed my role. During my many years teaching swimming often times I was working with a child who had not chosen to take swimming lessons. The parents had sent the child to learn how to swim. My approach to teaching such children how to swim was very similar to my subsequent approach to doing psychotherapy with children whose parents have brought them for treatment. Addressing the child's emotions is very important. Forming a working relationship and building trust in me is also important. Ultimately I want to add to the child's repertoire of skills and competencies.

Sessions 1-3: Establishing a Relationship and Initial Conflict-Resolution Training

Following the initial intake interview with Rafael and his mother, I had telephone conversations with his principal and school counselor. Rafael and then I spent our second session

[2] Note that I do not audio- or video-record my sessions, and my treatment notes do not normally contain direct quotations of what I have said or what the patient has said to me. This means that the following session-by-session descriptions will not include direct quotes from the sessions.

debriefing the critical incident that got him suspended. (As described in Section 2 above, four days prior to the intake interview, Raphael's principal and vice-principal had suspended him and demanded that he enter psychotherapy as a prerequisite for returning to school. The reason for this requirement was that one night he had gone to the home of a teacher's aide to one of his classes, let the air out of one of the tires of her car, broke two raw eggs on her porch and one on her driveway.)

In addition, we explored alternative ways for Rafael to express negative emotions and complaints that would not get him into trouble. As indicated earlier Rafael was not defensive and he did not deny his actions. In order to increase the odds of a cooperative process I proposed that he and I perform a "psychological autopsy." We would examine the critical incident like pathologists examine a dead body to determine the cause of death. We would figure out what happened and then identify what alternative actions he could take in the future that would produce a positive outcome for him. He cooperated with this process.

In our third visit we discussed the value of rules for any social setting including schools. He identified one of his two best friends as being very socially skilled; therefore, I asked him to observe that friend as a social model for dealing with interpersonal conflicts. Rafael did carry out his assignment, but his friend had been sick for part of the week. In addition, Rafael did not observe his friend encounter any socially challenging incidents.

Sessions 4-9: Cognitive Restructuring Using Foster & Robin's 24 "Contrasts" in Framing Interpersonal Conflict

During the week between sessions #3 and #4 his class visited a court room and observed a mock trial. We spent part of the fourth session debriefing what he had observed. He had noticed how the two opposing attorneys had presented their cases while treating each other with respect, a good model of appropriate assertiveness.

For the next six appointments we worked through a set of 24 contrasts for dealing with interpersonal conflicts based on a program developed by Foster and Robin (1989). Each contrast identified a problematic way of dealing with a conflict and then a more positive alternative method. In session #4, after discussing the mock trial, we covered the following four contrasts: (1) talking through a third person (triangles) versus talking directly to the other person; (2) accusing, blaming, or criticizing versus using "I"-statements (complaints); (3) defending oneself versus actively listening to the criticism; (4) rejecting praise versus accepting praise.

My general approach to working through each contrast started with first giving examples of the contrast, and the having Rafael identify what examples from his life experiences would align with a given contrast. I viewed this part of his treatment as a form of cognitive restructuring. I wasn't asking him to do anything at this point in time other than to reflect on each contrast.

He had taken a preliminary SAT test at a local university between our visits, so at the beginning of session #5 we discussed his experience with the test. He also described in more detail what he had done in vandalizing the teacher aide's property than he had done when we

performed the initial psychological autopsy. Finally, we examined the next contrast: (5) putting down, zapping, or shaming versus accepting responsibility or making "I"-statements.

Part of my approach to Rafael in each of our sessions was to connect with something that was important to him or happening in any part of his life. Doing so is an important part of building rapport.

Two days following our fifth session, Rafael's school counselor telephoned me. She reported that he engaged in all of the playground activities. She described him as "brilliant." In spite of his physical limitations she said that he writes quite well and draws well. She described one incident in which he jumped on a kid and hit him in response to the other boy calling him names related to his birth defects.

In session #6 I told Rafael what the counselor told me. It was spring time, and he volunteered what was happening on the track team. He said that he usually ran the 220 and did the long jump. He, his mother, and his sister were leaving later in the day of our meeting, so he told me about the plans for their trip to the Grand Canyon. We completed the hour by addressing the following contrasts: (6) asking questions during a conflict versus making statements; (7) arguing about past facts versus making statements based on the present or future; (8) interrupting versus listening without interrupting or waiting one's turn or making brief statements; (9) over generalizing, catastrophizing, or making extreme/rigid statements versus making tentative or qualified statements.

During the early part of session #7 Rafael reviewed what happened on his family trip in the preceding week. Then we discussed what his life had been like growing up without a father. He had no complaints and spoke in positive terms about the family he did have—his mother, brother, and sister. Then I asked him to describe what happened during a typical lunch time at school and to tell me about his social life outside school. We ended the session by examining the following contrasts: (10) lecturing, preaching, or moralizing versus making brief, explicit problem statements or requests; (11) talking in a sarcastic tone of voice versus talking in a neutral or business-like tone; (12) avoiding eye contact versus looking at the person with whom one is talking; (13) fidgeting, moving restlessly, gesturing, making faces, or rolling one's eyes while being spoken to versus sitting in a relaxed fashion; (14) mind reading versus reflecting, paraphrasing, and validating what the other person says.

At the start of session #8 he told me about his performance in last week's track meet. He ran both the 100 and 220. He felt pretty good about how well he had done. There were no surprises. Next he talked about his involvement on his school's academic decathlon team. Then he described taking a fall during a "sparring match" with his religion teacher. He was looking forward to competing in a track meet scheduled for the coming weekend. Then he told me about his recent progress report on which he got all "Good" marks except for one that marked between "Good" and "Outstanding." I asked whether he had encountered any conflicts that we might debrief, but he couldn't think of any. He did have a grammar test scheduled for later in the day. He related to me in a relaxed and friendly way and seemed to enjoy sharing the preceding information with me. Toward the end of the session we discussed just one contrast: (15) getting

off the topic versus catching oneself and returning to the problem at hand and putting other problems on a future agenda.

Rafael commenced session #9 by describing what happened at his track meet. He did the long jump and ran the 440. His brother had visited for three days and was on his way to Europe to begin graduate school. Rafael had enjoyed getting to spend time with his brother. Then we shifted to a discussion of the functions of our emotions. Much of the sessions focused on the remaining contrasts: (16) commanding or ordering versus suggesting alternative solutions; (17) dwelling on the past versus sticking to the present and future; (18) monopolizing the conversation versus taking turns making brief statements; (19) threatening versus suggesting alternative solutions; (20) humoring or discounting versus reflecting or validating the other person; (21) words say one thing but body language says another versus matching words and feelings or being direct about one's feelings; (22) "psychologizing" versus inquiring about situations that provoke the behavior and about the consequences of the behavior; (23) yelling versus talking in a conversational tone; and (24) remaining silent or not responding to what the other person says versus reflecting, validating, expressing one's own emotions.

As mentioned above, throughout the preceding sessions 4-9 that addressed the 24 contrasts, I gave concrete examples of each one. I encouraged Rafael to identify examples from his own life, but I did not require him to do so. The spirit in which I presented the contrasts was as food for thought and as ways to increase or improve our skills in dealing with conflicts. The emotional tone of these discussions was relaxed and friendly.

Sessions 10 – 15, Homework Assignments

During our tenth session I gave Rafael two tasks for homework in the form of written "Action Requests." The first involved completing a Feeling Talk Self-Evaluation Chart (see Table 3) with the following written instructions:

> At the top of each column write the name of one person with whom you relate on a regular basis or the category of that person (e.g., salesperson, policeman, teacher, etc.). For each of the cells in the Chart choose a number that best indicates how likely you would say the feeling to the person in question IF your were having the feeling toward that person or if you were having the feeling not toward the person but in their presence" [see the scale just below Table 3].

As homework, in addition to the Chart, I gave Rafael a written Action Request that said, "Fill in the Feeling Chart at home this week and bring it to our next session." He complied and we calculated the mean rating for each row and column. Those results appear in Table 3

We spent most of our time in session 10 going over the blank Feeling Talk Self-Evaluation Chart and the instructions for completing it.

The second Action Request I gave to Rafael as homework was to: "Ask your mother what she wanted him you to do when you get into a conflict with someone."

Normally when I give a child or adolescent a therapy homework assignment, my intent is to encourage actions that I believe will make the young person's life better. I am not delivering commands. The spirit of the assignments is something like, "Try this out and see how it works for you." This was the spirit in which I gave the assignments to Rafael.

When he came to session #11, Rafael had filled in the Chart, as shown in table 3, but he had not asked his mother how she would like him to deal with conflicts. We spent this whole session discussing his Chart ratings and computing the means of each column and row (see Table 3). I also inquired about important events in his life during the past week. At the end of the session I asked him again to ask his mother how she would like him to deal with conflicts.

In session #12 he reported that he had talked to his mother about how she would like him to deal with conflicts. He did not identify specific suggestions. His understanding was that she simply wanted him to deal with conflicts without getting into trouble. We debriefed his weekend. I gave several examples of "I" statements and contrasted them with less helpful communications. Then I inquired about any situations involving conflicts with anyone during the past week. His explanation of his sleeping problems was that he often stayed up too late at night, but he didn't have any difficulty sleeping. He also described his plans to attend summer school. I did not assign any specific therapy homework during this session.

His behavior during session #13 was different than in any previous one. He avoided eye contact. His responses were minimal. He rubbed his eyes frequently. He did describe a conversation with his mother during the past week. I wasn't confident that he had understood what she was trying to communicate, so I asked him to tell her what he had understood her to mean. I hypothesized that she would be pleased if he had understood her. And if he had missed anything important in her message, she would appreciate the opportunity to clarify here meaning.

By session #14 he was back to his normal self. He carried out his last assignment and had understood his mother accurately. We discussed historical heroes, but he claimed that he didn't have any. I invited him to tell me any reactions he had to the saying, "The pen is mightier than the sword." Then we compared power tactics with methods of persuasion. For his homework assignment I asked him to identify what he wanted his mother to know.

Although he had not identified anything that he wanted his mother to know, he was the most relaxed and talkative in session #15 than he had ever been. He had just completed the academic year and was on a one-week break from school. He had made the honor roll with a 3.40 GPA. He had received all "Good" marks for behavior. He described his plans for his week off including cleaning up his room and reading for the following year's academic decathlon. A big task for the summer was to read 1000 pages and then to write a summary report on what he read. He would turn in that report in September. I asked him to bring his mother to our next visit.

Session 16, Conjoint Session with Rafael ad His mother

In this session, Rafael's mother expressed pleasure in his deportment grades on his recent report card; they were the best he had ever received. His coach also gave him an award for being the most improved member of the track team.

In contrast with this good news she said that Rafael was not being successful in discussing anything with her when they disagreed. He had been seeing me through a managed care company, and we had authorization for a maximum of 20 sessions. His mother asked me to ask the insurance company for an additional block of sessions. She also expressed concern that he was spending an excessive amount of time on-line. At the end of the session I gave her a photocopy of the Childhood Problems Checklist (Appendix 1) with the ratings she had made at intake. I asked her to take the checklist home and to provide her ratings of him in the present. The results appear in Table 4.

Sessions 17 – 28: Addressing Conflicts with his Mother and Reviewing His Daily Life

By session #17 he was in summer school taking a course on multi-media presentations using Microsoft PowerPoint. He explained what he would be learning. Then he talked about visiting the campus of a private school that he was considering for his high school years. He felt good about how people at that school received him. As we talked I filled out part of the paper work to request additional sessions from the managed care company. His homework assignment was to identify one or more things each day that he wanted to happen.

We began session #18 by following up on his assignment. The thing he was most looking forward to this day was a meeting of his academic decathlon team from 2:00—4:00 PM followed by a party from 4:00—6:00. The team consisted of about 25 students. The two coaches of the team were parents. We spent most of the session exploring ways to deal with disagreements with his mother. These included staying in the situation and talking rather than walking away or clamming up; identifying what he and his mother wants; seeking win-win solutions for conflicts; brain storming as many options as possible before choosing a solution; identifying pros and cons for each option; then choosing a mutually acceptable option. His therapy assignment was to apply these strategies during the coming week.

He reported on the academic decathlon team's meeting and party during the early part of session #19. Then he talked about a critical incident that had happened at summer school. The event did not involved Rafael directly. He observed a conflict between another student and that student's mother. He told me what he was thinking during the time that he observed the conflict. He thought of doing what we had discussed the prior week had he been in the shoes of the other student. Then he wanted to show me on my computer what he was learning to do with PowerPoint. I did not give him a homework assignment at the end of this session.

The next day his mother telephoned me. She had received a bill from AOL for on-line services. When she showed the bill to Rafael, initially he denied knowing anything about it. Eventually he admitted that he had called AOL about three months earlier and signed up for two months of free service. He had forgotten that bills would start arriving with the third month of service unless he cancelled. From his mother's perspective he had gone behind her back and had initially lied to her when she confronted him with the bill.

During the past week he had recorded some internet addresses for me to download PowerPoint backgrounds for my own presentations. He gave them to me at the beginning of session #20. He described the vacation he was going on in a little more than two weeks. His

brother would be visiting from Europe and would join Rafael, his sister, and mother. In addition, an aunt, uncle, and cousin would be with them. Clearly he was looking forward to the vacation with the extended family.

Next we performed a psychological autopsy on the AOL bill and how he handled his mother's confronting him. Then he described his PowerPoint presentation on the ocean in summer school. He also told me about his preparation of an additional presentation he would make the following week; it would be about Pearl Harbor. Finally, he confessed getting mad at his sister yesterday; we performed a psychological autopsy on that conflict.

The managed care company approved additional sessions, so we were able to continue treatment. In session #21 he told me that he received an A in his summer school class. He also said that things were fine between his sister and him. He showed me notes that he had taken throughout his summer school class. This session was in early August. We agreed to wait a full month before meeting again shortly after his school began in September. I asked about the final outcome from the AOL matter with his mother. She had removed all internet privileges from him, and they had not yet agreed on how he could regain access to the internet. He described his goals for the new school year. They included being on the honor roll all year and playing AYSO soccer for the seventh year in a row.

Session #22 fell on Tuesday, September 11, 2001. As was true for most of our meetings, we started at 8:00 AM. He would then leave our session and go straight to school. We spent the early part of this session discussing his reactions to what he had seen on TV regarding the attacks on the World Trade Center and the Pentagon. He talked about his first AYSO game on the previous Saturday. He said that he had new teachers for home room, English, religion, literature, social studies, and PE. His teachers for math, music, and Spanish were ones he had previously had. As his therapy homework I asked him to identify the advantages of strengthening his negotiation skills.

Because he had been sick, two weeks passed before we met for session #23. We reviewed the past 14 days. His school had closed for a few days following the terrorist attacks. He seemed interested in exploring possible motivation for terrorism and possible antidotes. When I probed his thoughts about negotiating with his mother, however, he had difficulty identifying how to negotiate and for what. Presently his mother was not allowing him to watch TV (with a few exceptions) or to use the internet. I asked him to continue reflecting on negotiating.

Rafael did not recall any occasions in which he practiced negotiation skills since our last time together. I did probe for any occasions when he had become angry. In this session I gave him a written list of the behaviors that teachers like to see in their students. His response to this handout was similar to the way he responded to any input from me. He maintained a respectful demeanor and accepted what I gave him without committing himself to act on the recommendations. His mother had complained that he was fairly unexpressive when greeting her or when saying goodbye, so we did some role playing. I played the role of his mother. Then he talked about his impressions of his teachers. His assignment was to practice saying hello and goodbye to his mother in a more chipper manner during the coming week.

Our next meeting (session #25) was two weeks later. We reviewed that period of time and I followed-up on his assignment. He talked about asking his principal for permission to wear a certain vest to school. We did some role playing of his making his request to the principal. He described a field trip his class made to a Buddhist temple during the preceding week. He had also received a progress report. He had "Good" or "Outstanding" in all of his classes except Spanish where the mark was between "Good" and "Needs Improvement." The progress report contained no letter grades for the academic subjects. He was pleased to report that he was on the "A" team for the academic decathlon, and he was specializing in science. I probed for any critical incidents that triggered his anger; there hadn't been any. His assignments were to talk to his principal about acceptable clothing at school and to his mother about how to schedule our remaining authorized sessions.

In session #26 I learned that he had not carried out either of his assignments. He reported that he had received an A- in a social studies test and that Spanish was going well. We explored what he thinks about in a typical day. He told me that he wants to get into as many honors and advanced placement classes as possible in high school. He thought that he would try out for track and soccer in high school. He described his being an alter server at his church. He did so about every three or four weeks. In addition, when the alter server crew was missing a member, he volunteered to fill in. He also said that he would be starting confirmation classes during his freshman year. Currently science was his most interesting subject. Given that he had not carried out his assignments from our previous meeting, I gave them in writing today.

At our next meeting (session #27) he said that he had decided not to talk to his principal about the school's dress code. He reported that his mother would be calling me about our remaining sessions, but she was leaving the final decision up to him. We reviewed the past week and what was happening for him in soccer. I probed for frustrating or angering situations. I asked him to bring his mother to our next meeting.

I learned in session #28 that he had not told his mother until Friday night that I wanted her to join us. Given that we met on Tuesday mornings, she did not have enough time to change her schedule. She said that she would come to our next session. His major focus in this session was how to get back his internet privileges. He identified four problems: (1) accessing sites his mother would not approve, (2) making unauthorized purchases on-line, (3) tying up the phone line, and (4) spending too much time on-line. I recommended that he identify a solution for each of these problems. We identified some potential solutions and went on-line to determine how to produce a log of all time spent on-line. I suggested that if we take the other person's concerns seriously, they are more likely to take us seriously. His assignment was to prepare a written proposal for his mother regarding using the internet.

Session 29: Termination

His mother joined us for the final session, number 29. Rafael had not prepared a written proposal for his mother. We reviewed his report card. He was on a trimester system and had just completed the first trimester. This was his best report card ever. He got all As with the exception of a B in religion. In contrast to his past report card, this one had no negative comments. We explored options for his social involvement with other kids. His mother re-evaluated how he was

doing by scoring him on the Childhood Problems Checklist. The results appear in the right-hand column of Table 4. Given how well he was doing in most areas of his life, we agreed to terminate.

In the months that we had worked together he had often shared information about his life that I perceived was important to him, but he was never effusive. When reporting an accomplishment about which he was obviously pleased, he always did so in a low-key manner. Although he seemed to have a solid, positive attachment to his mother, brother, and sister, he did not express appreciation for their support. As we terminated, I viewed Rafael's case to have ended up with a very positive outcome. I didn't expect to be seeing him again.

Quantitative Outcome Evaluation

Table 4 summarizes the major treatment outcome data for Rafael based on his mother's ratings. The Treatment Effect Size (ES) at roughly the mid-point of treatment was 1.80, approximately average for all of my child and adolescent cases as of termination. The ES at the end of treatment, 7.43, set an all-time record for my practice.

6B. SECOND COURSE OF THERAPY

When Rafael returned to see me for a second course of treatment, I did not have him and his mother fill out the Youth's Inventory-4 Self-Report and the Adolescent Symptom Inventory–4 (Gadow & Sprafkin, 1997). Had I been seeing them for the first time, I would have done so. In fact, he returned about eight months following our terminating from the first course of treatment. I just had the two of them jointly identify the reasons for returning to treatment. Then I asked them to rate the severity of each problem using the 10-level SOF scale. .

Presenting Problems

Not quite eight months following termination of our first course of treatment Rafael's mother called early one morning saying that she was having a crisis with him. I was able to see them later the same day. It was a Tuesday. On the preceding Saturday he had been visiting a relative. During the visit he had stolen the relative's cell phone and charger. Although no other stealing had occurred during the eight months since we terminated his initial treatment, his mother was concerned about his stealing again, his lying again, his secretly using the Internet, and his failure to express remorse. Clearly his mother was afraid that the recent episode of stealing might be a sign that he had started on a downward trajectory.

On the positive side during the final two trimesters of the eighth grade he had received all As and had graduated in the preceding month. The high school he most wanted to attend had admitted him, and he was taking two summer courses at this school.

Although he was very quiet, subdued, and generally non responsive in this first session back in my office, he did engage in problem solving. He volunteered that the best consequence for what he had done would be to return the cell phone personally. In fact, he did so on the

following Saturday, one week after he had taken the phone. He expressed his regrets for what he had done to the owner. He seemed genuinely to regret what he had done.

Objective Assessment

When Rafael returned to see me for a second course of treatment, I did not have him and his mother fill out the Youth's Inventory-4 Self-Report and the Adolescent Symptom Inventory–4 (Gadow & Sprafkin, 1997). Had I been seeing them for the first time, I would have done so. In fact, he returned about eight months following our terminating from the first course of treatment.

Treatment Goals

What I did do during the second session was to have Rafael and his mother to jointly identify the reasons for returning to treatment. Then I asked each of them to rate the severity of each problem using the 10-level SOF. The results were as follows (see also table 5):

Problem	Rafael's Rating	Mother's Rating
Lying (pervasive, on-going)	"7-Some Problem	"7-Some Problem"
Stealing (several occasions)	"6-Moderate Problem"	"5-Serious Problem"
Secretly using the Internet	"7-Some Problem"	"5-Serious Problem"
Does not express remorse	"6- Moderate Problem"	"5-Serious Problem"

I then asked them to convert these problems to goals, and they framed the following as goals for Rafael: (1) to respect other people's property, (2) to be more open and honest, (3) to develop a contract for internet use, and (4) to become better at expressing remorse to and empathy for his mother.

Diagnosis

Based on all of the information that I gathered during this second intake process, I still concluded that Rafael did not meet the criteria for ODD or for CD. In addition, I didn't think that he was on a trajectory that would ultimately lead him to meet the criteria for either of these diagnoses. Instead, I came to the following diagnostic conclusions:

Axis I: 309.3 Adjustment Disorder with Disturbance of Conduct

Axis II: V71.09 no diagnosis

Axis III: acne, allergies, and significant birth defects

Axis IV: none

Axis Va: Current GAF = 51

Axis Vb: Highest GAF in past year = 90

Strengths

In addition to the strengths that have already been mentioned, in session 17 I asked Rafael and his mother independently to complete the Developmental Assets Checklist for Adolescents (DACA) (Watson-Adams, 2006). There are 40 items in the DACA. The level of agreement between their responses was very great ($r = 0.70$, $p < 0.0001$). They both agreed that each of the following was true for him:

- His family provides high levels of love and support.
- There is positive communication between his mother and him, and he is willing to seek advice and counsel from his mother.
- His neighbors are caring.
- His school provides a caring, encouraging environment.
- His mother actively helps him succeed in school.
- He believes that adults in the community value him.
- He has roles to serve in his community.
- He feels safe at home, school, and in his neighborhood.
- His family has clear rules and consequences and monitors his whereabouts.
- He believes that his school provides clear rules and consequences.
- His mother and other adults model positive, responsible behavior.
- His best friend models responsible behavior.
- Both his mother and teachers encourage him to do well.
- He spends one or more hours per week in activities or services in a religious institution.
- He is out with friends "with nothing special to do" two or fewer nights per week.
- He is motivated to do well in school.
- He is actively engaged in learning.
- He does at least one hour of homework every school day.
- He cares about his school.

- He places high value on helping other people.
- He acts on his convictions and stands up for his beliefs.
- He believes that it is important not to be sexually active or use alcohol or other drugs.
- He knows how to plan ahead and make choices.
- He has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
- He can resist negative peer pressure and dangerous situations.
- He perceives that he has control over "things that happen to him."
- He has high self-esteem.
- He believes that his life has a purpose.
- He is optimistic about his personal future.

Case Formulation

Given the preceding long list of assets in his life plus his substantial successes during the last two trimesters of the eighth grade, I did not amend my basic clinical impression of Rafael. I thought that the episode of stealing that triggered his return to me was a relatively isolated incident. His mother's reference to *recurring* stealing was applied to stealing *prior to* eight months ago. The lying seemed to refer to his initial denial of knowing anything about the cell phone. Apparently he had not verbalized any sense of remorse to his mother, but in our initial session following the cell phone incident, he seemed unhappy with himself for what he had done. It is also true that he did not directly articulate regret, sorrow, or remorse for his actions. He did seem contrite, however, and proposed how to correct his misdeed. He would return the cell phone in a face-to-face meeting with the owner. In our first session upon his return to my office he made no attempt to deny or to defend what he had done.

I did not think that his long-term trajectory had changed. At the same time I understood that his mother was concerned about his having stolen again~~a few things in recent years.~~ She worried that he might be on a downward path. In spite of the circumstances of Rafael's return to my office, my impression was that he and I were picking our relationship where we had left off eight months earlier.

Treatment Plan

The first session focused on debriefing the critical incident that motivated his return to therapy and developing a plan of action for him. The basic treatment plan for our remaining

sessions was to address the goals that Rafael and his mother set during the second session. The major methods of treatment included

- active listening,
- acceptance of Rafael as he presented himself,
- genuineness, social modeling,
- clarification of goals and goal setting,
- assertiveness training,
- assignment of therapy homework, and
- conjoint sessions that included his mother.

Therapy Process: Overview

I chose to use our sessions as a "practice field" on which to strengthen and to refine the social skills that would serve him at school, at home, and in the community. At the beginning of most sessions I invited him to choose what we would discuss, but he tended not to suggest anything; however, he was engaged in the material that I did introduce. We had a total of 20 sessions. His mother joined us in five of these: the 1st, 2nd, 13th, 19th, and 20th.

The overall goals in the 20 individual sessions were to identify problems, set goals, explore alternatives for problem-solving, and to evaluate functioning at intake and at termination. The basic thrust of the individual sessions was to strengthen and expand on gains made during the first course of treatment and to address any issues that seemed important to Rafael. The conjoint sessions also focused on managing conflicts between Rafael and his mother.

Therapy Process: Specifics for Sessions 1-20

For most of the first session in early July Rafael and I met alone. He told me that he had received all As in January and June and had just graduated from the eighth grade. The high school he most wanted to attend had accepted him, and he was taking math and reading in summer school there. He confessed having taken a cell phone and charger from a relative on the preceding Saturday. He proposed that the best single consequence would be for him to personally return the cell phone and apologize for taking it. The victim was his brother's step-grandmother. On a different matter his top goal was to graduate from his new high school and to try out for the soccer team there. His mother met alone with me for the final five minutes of the session and told me what had happened on the preceding weekend.

Rafael and his mother met with me for most of the time in session #2. She had taken him to his brother's step-grandmother's home. He met with her alone, returned the items, and said that he was sorry. His mother was not in the room to observe, but the step-grandmother described

to his mother what Rafael had said to her. During this session he and his mother identified the four problems that appear in the first column of Table 5, they agreed on a goal corresponding to each problem (second column of Table 5), and each independently rated his level of functioning as recorded in the third and fourth columns of Table 5. His mother and I met for the last 10 minutes of the session without Rafael. During that time I recommended that in the future she require him to return anything for which he did not have a receipt.

A week later he and I met alone for session #3. He said that he and his mother were talking again, and he was no longer grounded except for using the computer. He talked about his plans for soccer in the fall. We explored the goal of becoming more open and honest with his mother. We talked about the proposition that most people view their thoughts, perceptions, and emotions (feelings) as constituting the essential them. Given that nobody is a mind-reader, the only way another person can get to know the essential us is by our verbalizing our thoughts, perceptions, and feelings. I reviewed the nature of confidentiality regarding our sessions as well as its limits. I hypothesized that his mother would probably be less upset by learning that he had kept a secret from her than learning that he had lied to her. His homework assignment was to check out this hypothesis with his mother.

As of session #4 he had not checked out my hypothesis with his mother. He had received As in both of his summer classes. He described orientation events for the start of his freshman year, the location of his new school, and the plans for car-pooling. He told me the advantages to him of attending his high school. Then I probed his resistance to putting his feelings into words—particularly when talking to his mother. We also discussed his relationship with his sister. He indicated that they tended not to talk about personal matters. His therapy assignments were (1) to do last week's assignment and (2) to identify some issue that he would like us to discuss in our next visit.

At the beginning of session #5 he told me that he did check out my hypothesis with his mother. She confirmed it. Then he talked about a recent meeting with a blood cousin and an uncle by marriage. The uncle was married to a blood aunt. This family lived in northern California. From time to time Rafael's birth parents sent gifts to him via this aunt and uncle. The cousin was just six months older than Rafael. These gifts from his parents and contacts from blood relatives seemed to be positive events in his life. In addition, he explained that his adoptive mother had two brothers, but these uncles lived on the other side of the country. He had only met one of them. When he talked about them, his descriptions were the same as when talking about his blood relatives. He said that his mother had been an "Army brat" and moved around much as she was growing up. Once again we discussed the possible effects of his growing up without a father, but he had no complaints. I encouraged him to know and be known by as many teachers in high school as possible. We talked about the advantages of doing so. He was looking forward to having more male than female teachers in high school. His assignment for the coming week was to find out what people have served as mentors in his mother's life and what were their impacts on her.

He did talk to his mother about mentors in her life, but he did not do so until she was driving him to my office for session #6. Given that they only lived about a five-minute drive to

my office, he had not learned very much. I invited him to choose what we would talk about. He indicated that he would be most comfortable talking about the kind of topics that he discussed with his friends, for example, school issues and sports. This session was in the middle of August. Orientation would be at the end of the month, and school would begin on September 5. Meanwhile, his mother, sister, and he planned to vacation in the San Diego area and then near Santa Barbara. I probed for any worries or anxieties he had regarding starting high school. His only concern was about how hard Latin would be. His assignment was to gather more information about his mother's mentors and about her biography.

In our next session he started out by describing what happened in the orientation week. We met at the beginning of the second week of school. He said that his teachers had assigned much work, and the assignments were difficult. He was taking Latin, global studies, algebra, global science, English, and scripture. His mother was driving every other day as part of the car pool. At his new school he knew seven students from his previous school plus a few others from AYSO soccer and from the recent summer school. We explored his desire for privacy. Since he had not carried out his assignment from our previous session, I repeated it.

During our first course of treatment we met in the morning at the beginning of the day. During this second course we usually met at 6:00 in the evening. At the beginning of session #8 he said that he had had a test this day in global studies (i.e., world history) and had scored 100%. He had decided to play AYSO soccer again this year but had signed up late. He was waiting to learn his assignment to a team. He also intended to try out for his school's soccer team in the following month. He indicated that there would be an activities fair at school the following week. He planned to attend and to join one or more clubs. He reported that he had not interviewed his mother, so I offered to use our time to practice. He was hesitant. I asked him to watch Larry King on CNN one or more times to observe how he interviews people.

In session #9 he claimed that his heavy load of homework prevented him from watching Larry King. He had received his assignment to an AYSO team and was going to his first practice following our visit. He had gone to a school dance the preceding Saturday night and had a good time. Unfortunately, his friends did not enjoy the dance. He saw himself as more outgoing that some of his friends. The activities fair got postponed to today, but not all clubs showed up. He had not joined any club yet, but he and some of his friends were talking about forming a new club to play a particular video game. He had two quizzes today. He got a C+ in Latin and a C in scripture. I did not give him an assignment.

I continued to encourage him to take more of a lead in our times together. He had a soccer game the day before session #10. He said that his team had a bad game, and he didn't get to play very much. He had gone to a church dance with a friend who had invited him. The dance used a DJ from a local radio station. Rafael danced but not as much as he did at the first dance put on by his high school. He had not learned anything new about his mother. He felt reasonably satisfied with his social life in this first month of his high school years.

At the beginning of session #11 I noticed that he was wearing a silver cross and chain that I had not noticed before. When I inquired about these items, he explained that his birth

parents had sent them to him. They usually sent him a present for his birthday or for Christmas. Next he talked about his freshman class retreat on the preceding weekend. He talked about what he learned on the retreat. Then I asked about his earliest memory in life. Although he did not give an early memory, he told me that he lived with his birth parents for his first three months of life. Then he was in an orphanage for the next 10 months. When he was 13 months old his mother adopted him and brought him to this country. I inquired about conversations with his mother in the past week and what progress he was making in raising his mother's trust toward him.

At the start of session #12 he said that progress reports were mailed out today. He was predicting As and Bs for himself. His soccer team had won their game the day before. There had been a fight on his campus today. The consequence of fighting at his high school was suspension or expulsion. We debriefed the possible meaning of fighting among high school students. Based on what he said, I reflected, "It seems like you are feeling mellow at your high school and not feeling like fighting." He agreed. Then we discussed how to use our remaining sessions. His managed care company had authorized 20. We discussed including his mother in some of them. As a way of modeling personal openness I read him part of an autobiographical piece about my childhood and adolescence and invited his comments. At the end of the session I asked him to bring his progress report next time and to invite his mother to join us.

Rafael and his mother attended session #13. His progress report showed five As and one B-. The lower grade was in his scripture class. We celebrated his academic success, but he said very little in this session. His mother was very pleased with how his freshman year of high school was starting out. At the end of the session I asked his mother to tell him stories from her growing years that were important to her.

He reported that his mother was worn out from work today and did not feel up to coming to today's session (#14). He told me that she had told him and his sister that they didn't seem interested in her personal history. He confessed that there was some truth to her perception of him. He said that her stories tended to be sad or serious. In contrast, he told me that he did care about how she feels. He had started confirmation classes at his church. He had attended a festival at his former school during the past weekend. He had also wanted to attend a dance at his new school, but his mother declined to drive him. He also mentioned that his brother's grandfather (married to his brother's step-grandmother from whom Rafael had stolen the cell phone) had died recently. At the end of the session I asked him to tell his mother that he does care about her feelings.

At the start of session #15 he confessed that he did not do his homework as assigned, but he did ask his mother how her day went. This behavior represented a turn toward her in a more personal way. He spent most of the session talking about his confirmation class. He told me that they would be talking about human sexuality at the next meeting. We spent much of our time discussing this topic. He revealed that his sister had told him that she was sexually active. I gave him two assignments at the end of the hour: (1) tell your mother that you do care about how she feels and (2) invite your sister to tell you her reasons for having intercourse with boys at this

stage of her life. I thought that both assignments would move him toward relating more personally to his mother and sister.

As of session #16 he had not carried out the two assignments. He talked about participating in the try-outs for his school's soccer team. He had survived the first two cuts. The final cut was scheduled for the end of the week. Official soccer practices were to begin in two weeks. He reported on his scores from his mid-term exams. He scored 85% on the global studies exam; this corresponded to a B+. Latin was 91%. Math was 97%. He didn't have his score yet for science. I gave him the DACA documents mentioned above for him and his mother to complete.

He returned the first set of DACA documents in session #17. He sadly reported that he did not make the soccer team at school, but he would continue playing AYSO soccer. We processed his disappointment. His GPA as of mid terms was 3.67, and his grades had improved since the first grading period. He said that his mother was very pleased. He and two friends had started a new club at school for playing a particular video game. In addition he had joined the martial arts club. He told me about the community service that he would be doing this year. His school required students to do a certain amount of community service each year. He had already completed the requirement for this year by volunteering in a retirement home. I again gave him the DACA documents for him and his mother to complete a second time to help determine the test-retest reliability of the instrument.

At the beginning of session #18 he returned the second set of DACA documents. We spent the session reviewing and discussing his answers. I emphasized that he and his mother had indicated that most of the possible assets were present in his life. At the end of the hour I asked him to talk to his mother about whether to terminate treatment or to continue.

His mother joined us for session #19. We spent most of the time comparing their answers. I pointed out that they had a very significant level of agreement in the ratings that they had made independently. Then we discussed the advantages to any of us for improving our listening/empathy skills. Finally we talked about reasons to develop a good relationship with one's mother.

Both of them came to session #20. They announced that they had decided to terminate Rafael's treatment. I asked them to re-rate Rafael on each of the four problems and goals that they identified at intake for this second course of therapy. The results appear in the last two columns of Table 5. As can be seen, they showed a very high degree of inter-judge agreement. Given how well he was doing, ending treatment made sense to all three of us.

Summary of Therapy Process

As was true during the first course of treatment, this second round of treatment was not something that Rafael had requested for himself. At the same time he did not resist coming. My impression was that he was accepting psychotherapy as a natural consequence for his mistakes, - but he did not seem to perceive that he needed treatment or that time with me was going to benefit him other than to meet the demands of his school or mother. On the other hand, as I

indicated in presenting the first course of treatment, he did not engage in denial or defensiveness as we began this second course of treatment. He openly admitted what he had done. Perhaps even more impressive was the fact that he proposed returning the stolen items in a face-to-face meeting with the victim. These positive behaviors would be extraordinary in a youth presenting with Oppositional Defiant Disorder or Conduct Disorder.

I don't know whether he ever perceived me as his ally, but that is how I saw myself. As his therapist I viewed myself as like a lifeguard performing a swimming rescue. I would swim beside him, coach him in what to do, and guide him safely to shore, but he would do his own swimming. I wanted to encourage him to take advantage of his personal strengths and of the many assets available to him through his family, school, church, and community. I also wanted to expose him to new strategies and skills for dealing with conflicts and to practice and interalize these. Given what he did during the two courses of treatment as well as what he has accomplished during the eight years since our final termination, he ultimately has done what I hoped would happen.

Quantitative Outcome Evaluation

Table 5 reveals that both Rafael and his mother agreed that he had improved in all four areas. No problem was significant enough to require additional treatment. The magnitude of his change (ES = 3.02) was very large. He seemed to be leaving therapy in excellent shape. Would the gains last?

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

Throughout both courses of therapy, I monitored Rafael's behavior and performance outside the therapy via reports from the school and his mother In addition, during the first course of therapy, I monitored Rafael's improvement via Scale of Functioning ratings at the midpoint of therapy (see the Session 17 ratings in Table 5). I monitored Rafael's response to the therapy itself by being sensitive and to his reactions to the therapy tasks I structured and by being flexible in adapting to these reactions.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

The Two Courses of Therapy Tables 4 and 5 indicate that both courses of therapy were successful, with ESs of 7.43 and of 3.02, respectively. Also, the fact that Rafael's mother did not initiate a third course of therapy suggests tat she was satisfied with the ongoing results after the second course.

Eight-Year Follow-Up

The summer that Rafael graduated from high school his mother sent me a note saying how well he had done. Four years later she sent another note informing me that he had graduated from college and was headed toward graduate school. These notes were important reminders of

our therapeutic work together and provided an impetus for my contacting him and her eight years following our final termination. I solicited their authorization for me to write the present account and asked them to meet with me to provide details about the important events in his life since termination of treatment.

We met in their home for about 1 ½ hours at the end of November during his first semester in graduate school. During our time together he reviewed some of the major events in his life during the past eight years. He also admitted that he remembered very little about our two courses of treatment other than we met early in the morning (during our first course of treatment) and the two problems that motivated his mother to bring him to see me. He was cordial and provided a number of details about his life in the past eight years. Given the amount of time that had passed, given that he had not decided to enter therapy, given that he had not chosen me as his therapist, and given my 45 years of experience doing therapy with children and adolescents, I was not surprised or concerned that he didn't remember many details from our time together. I was grateful that his mother had kept in touch. I was grateful that he agreed to meet with me. I was grateful that he agreed to permit me to write the story of our therapeutic work together. I was grateful that he had followed the developmental trajectory that I perceived when assessing him at both intakes.

During high school he took many Advanced Placement (AP) classes. He particularly enjoyed his AP class in psychology during his senior year. He played AYSO soccer through his junior year. Also he was on his high school's track team for three years, and his coach gave him an award in his junior year as the "most inspirational" member of the team. He was in the same car pool for all four years of high school, and he mostly hung out with students he knew before entering the ninth grade. His school required all students to do community service every year, and in the twelfth grade this was the "Senior Project" consisting of at least 82 hours. He did his Senior Project at a food bank near his home. He particularly enjoyed going to an annual "Latin" conference each year.

Upon graduating from high school he got a job as a "bag boy" in a local super market. After working there for just three weeks, the store manager promoted Rafael to be a cashier. He filled that position through the summer and fall. He spent that fall semester in the local community college and entered a major university for the spring semester of his freshman year. During that spring semester he lived in an apartment with just a few other students who were upper classmen. His social life was limited that semester, but he made many new friends during the next three years in university. He was very involved in political activism and became secretary and eventually vice president of a campus organization, Students Taking Action Now: Darfur (STAND).

Since the end of high school he has almost always worked at least part-time. During his years in university he has held various paid positions on campus. These have included working with youth from poverty and encouraging them to obtain a college education, doing accounting, and tutoring athletes to help them to maintain their academic eligibility to compete. Currently he attends classes all day and tutors in the later afternoon and early evening.

He spent the spring semester of his junior year at a European university. During that time he went backpacking alone for six weeks, providing a stunning example of his survival skills. When he returned to his home institution, he completed his senior year and received a B.A. degree in one of the social sciences. During that same year he decided to pursue graduate studies that will lead to a B.S. and then an M.A. degree in a health field. His ultimate goal is to obtain a doctoral degree and to serve military personnel who have lost limbs or suffered other physical disabilities in combat situations. Clearly he intends to take advantage of the many obstacles that he has overcome and to use himself as a model of how others who have experienced major losses may build a new life.

Final Observation

As indicated as "a word of warning" above in section 3 above, "Guiding Conception," a case study such as the present one is incapable of identifying how much of the total gains achieved during treatment or follow-up is due to each of the various, possible sources of change. Figure 1 presents my very tentative, clinical guess about the sources of improvement in Rafael. It shows about two thirds coming from the clients characteristics and background, and the rest roughly equally divided among the therapist's characteristics, the therapeutic alliance, and specific interventions. My main point here is to emphasize that while specific interventions are important for improvement, they are only one piece of a larger set of dynamic factors accounting for outcome. In any event, regardless of how much of his improvement and success came from each source, I continue to celebrate the way that Rafael's life has been unfolding.

9. REFERENCES

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*, 271-285. doi: 10.1037/0003-066X.61.4.271

Azrin, N.H., & Nunn, R.G. (1977). *Habit control in a day*. New York: Simon & Schuster.

Baer, D.M. (1960). Escape and avoidance response of pre-school children to two schedules of reinforcement withdrawal. *Journal of the Experimental Analysis of Behavior, 3*, 155-159. doi: 10.1901/jeab.1960.3-155

Baer, D.M. (1961). Effect of withdrawal of positive reinforcement on an extinguishing response in young children. *Child Development, 32*, 67-74.

Barlow, D.H. (1993). *Clinical handbook of psychological disorders: A step-by-step treatment manual (*2nd ed). New York: The Guilford Press.

Barlow, D.H. (2007). The case of Hope: "Evidence-based practice" (EBT) in action. *Pragmatic Case Studies in Psychotherapy [Online], Vol. 3*(4), Article 3, 50-62. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Bratton, S.C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research & Practice, 36*, 376-390. doi: 10.1037/0735-7028.36.4.376

Casey, R.J., & Berman, J.S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98*, 388-400. doi: 10.1037/0033-2909.98.2.388

Christophersen, E., & Mortweek, S.L. (2001). *Treatments that work with children: Empirically supported strategies for managing childhood problems.* Washington, DC: American Psychological Association.

Clement, P.W. (1974). Parents, peers, and child patients make the best therapists. In G.J. Williams & S. Gordon (Eds.). (1974). *Clinical child psychology: Current practices and future perspectives.* New York: Behavioral Publications (pp. 81-97).

Clement, P.W. (1980). *A system for describing therapeutic interventions.* Pasadena, CA: Graduate School of Psychology, Fuller Theological Seminary. (ERIC Document Reproduction Service No. ED 013 371).

Clement, P.W. (1996). Evaluation in private practice. *Clinical Psychology: Science and Practice, 3*, 146-159.

Clement, P.W. (1999). *Outcomes & incomes: How to evaluate, improve, and market your psychotherapy practice by measuring outcomes.* New York: The Guilford Press.

Clement, P.W. (2007). Story of "Hope:" Successful treatment of obsessive-compulsive disorder. *Pragmatic Case Studies in Psychotherapy [Online], Vol. 3*(4), Article 1, 1-36. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Clement, P.W., Anderson, E., Arnold, J., Butman, R., Fantuzzo, J. & Mays, R. (1978). Self-observation and self-reinforcement as sources of self-control in children. *Biofeedback and Self-Regulation, 3*, 247-267.

Cordoran, J. (2011). *Mental health treatment for children and adolescents: Evidence-based practices.* New York: Oxford University Press.

Croog, D. (2007). Bullying in middle schools. *Primary Psychiatry, 14(7),* 17-18.

Erion, J. (2006). Parent tutoring: A meta-analysis. *Education & Treatment of Children, 29,* 79-106.Eysenck, H.J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16,* 319-324. doi: 10.1037/h0063633

Ensenck, H.J. (1966). *The effects of psychotherapy.* New York: The International Science Press.

Fishman, C.A., & Fishman, D.B. (1971a). Emotional, cognitive, and interpersonal confrontation among children with birth defects. *Child Psychiatry and Human Development, 2,* 92-101. doi: 10.1007/BF01434642

Fishman, C.A., & Fishman, D.B. (1971b). Maternal correlates of self-esteem and overall adjustment in children with birth defects. *Child Psychiatry and Human Development, 2,* 255-265. doi: 10.1007/BF01441088

Forehand, R.L. (2010, August). *Advances in the understanding and treatment of child psychopathology: A conceptual framework and overview for teachers of psychology*. Invited address: G. Stanley Hall Lecture at the annual meeting of the American Psychological Association, San Diego.

Fossum, S., Handegard, B.H., Matinussen, M., & Morch, W.T. (2008). Psychosocial interventions for disruptive and aggressive behavior in children and adolescents: A meta-analysis. *European Child & Adolescent Psychiatry, 17,* 438-451. doi: 10.1007/BF01441088

Foster, S.L., & Robin, A.L. (1989). Parent-adolescent conflict. In E.J. Mash & R.A. Barkley (Eds.), *Treatment of childhood disorders* (pp. 493-528). New York: The Guilford Press.

Friedman, D., Holmbeck, G.N., DeLucia, C., Jandasek, B., & Zebracki, K. (2009). Trajectories of autonomy development across the adolescent transition in children with spina bifida. *Rehabilitation Psychology, 54,* 16-27. doi: 10.1037/a0014279

Gadow, K.D., & Sprafkin, J. (1997). *Child Symptom Inventory 4 norms manual.* Stony Brook, NY: Checkmate Plus.

Garmezy, N. (1974). The study of competence in children at risk for severe psychopathology. In E.J. Anthony & C. Koupernik (Eds.), *The child in his family: Vol. 3. Children at psychiatric risk* (pp. 77-97). New York: Wiley.

Gold, M. (1970). *Delinquent behavior in an American city.* San Francisco: Brooks and Coleman.

Granic, I. & Patterson, G.R. (2006). Toward a comprehensive model of antisocial development: A dynamic systems approach. *Psychological Review, 113,* 101-131. doi: 10.1037/0033-295X.113.1.101

Guthrie, E. R. (1938). *The psychology of human conflict: The clash of motives within the individual.* New York: Harper & Brothers.

Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112,* 64-105. doi: 10.1037/0033-2909.112.1.64

Hibbs, E.D., & Jensen, P.S. (Eds.). (2005). *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (2nd ed.). Washington, DC: American Psychological Association.

Horowitz, J.A., Vessey, J.A., Carlson, K.L., Bradley, J.F., Montoya, C., McCullough, B., & David, J. (2004). *Journal of the American Psychiatric Nurses Association, 10,* 165-172. doi: 10.1177/1078390304267862

Kazdin, A.E. (2007). Systematic evaluation to improve the quality of patient care: From hope to hopeful. *Pragmatic Case Studies in Psychotherapy [Online], Vol. 3*(4), Article 2, 37-49. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Kazdin, A.E. (2008). *The Kazdin Method for parenting the defiant child: With no pills, no therapy, no contest of wills.* Boston: Houghton Mifflin Co.

Kazdin, A.E., Bass, D., Ayers, W.A., & Rodgers, A. (1990). Empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting & Clinical Psychology, 58,* 729-740. doi: 10.1037/0022-006X.58.6.729

Kazdin, A.E., & Whitley, M.K. (2006). Comorbidity, case complexity, and effects of evidence-based treatment for children referred for disruptive behavior. *Journal of Consulting & Clinical Psychology, 74,* 455-467. doi: 10.1037/0022-006X.74.3.455

Keltner, D., Capps, L., Kring, A.M., Young, R.C., & Heerey, E.A. (2001). Just teasing: A conceptual analysis and empirical review. *Psychological Bulletin, 127,* 229-248. doi: 10.1037/0033-2909.127.2.229

Klerman, G.L., Weissman, M.M., Rounsaville, B.J., & Chevron, E.S. (1994). *Interpersonal psychotherapy of depression.* Northvale, NJ: Jason Aronson.

Levitt, E.E. (1957). The results of psychotherapy with children: An evaluation. *Journal of Consulting Psychology, 21,* 189-196. doi: 10.1037/h0039957

Levitt, E.E. (1963). Psychotherapy with children: A further evaluation. *Behaviour Research and Therapy, 1,* 45-51. doi: 10.1016/0005-7967(63)90007-X

Lewinson, P.M., & Clarke, G.N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Review, 19,* 329-342.

Mash, E.J., & Barkley, R.A. (1989). *Treatment of childhood disorders.* New York: The Guilford Press.

Masten, A.S., & Coatsworth, J.D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist, 53,* 205-220. doi: 10.1037/0003-066X.53.2.205

Maughan, D.R., Christiansen, E., Jenson, W.R., Olympia, D. & Clark, E. (2005). Behavioral parent training as a treatment for externalizing behaviors and disruptive behavior disorders: A meta-analysis. *School Psychology Review, 34,* 267-286.

McLeod, B.D., & Weisz, J.R. (2004). Using dissertations to examine potential bias in child and adolescent clinical trials. *Journal of Consulting & Clinical Psychology, 72,* 235-251. doi: 10.1037/0022-006X.72.2.235

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy.* New York: Atherton Press.

Michael, K.D., & Crowley, S.L. (2002). How effective are treatments for child and adolescent depression? A meta-analytic review. *Clinical Psychology Review, 22,* 247-269. doi: 10.1016/S0272-7358(01)00089-7

Norcross, J.C. (2001). Purposes, processes and products of the task force on empirically supported therapy relationships. *Psychotherapy: Theory, Research, Practice, Training, 38,* 345-356. doi: 10.1037/0033-3204.38.4.345

Patterson, G.R. (1982). *Coercive family processes*. Eugene, OR: Castalia.

Patterson, G.R. (1993). Orderly change in a stable world: The antisocial trait as a chimera. *Journal of Consulting & Clinical Psychology, 61,* 911-919. doi: 10.1037/0022-006X.61.6.911

Patterson, G.R. (2008). A comparison of models for interstate wars and for individual violence. *Perspectives on Psychological Science, 3,* 203-223. doi: 10.1111/j.1745-6924.2008.00075.x

Patterson, G.R., Reid, J.B., & Dishion, T. (1992). *Antisocial boys*. Eugene, OR: Castalia.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47,* 1102-1114. doi: 10.1037/0003-066X.47.9.1102

Reid, J.B., Patterson, G.R., & Snyder, J. (2002). *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention.* Washington, DC: American Psychological Association.

Reinecke, M.A., Ryan, N.E., & DuBois, D.L. (1998a). Cognitive-behavioral therapy for depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry, 37,* 26-34. doi: 10.1097/00004583-199801000-00012

Reinecke, M.A., Ryan, N.E., & DuBois, D.L. (1998b). Meta-analysis of CBT for depression in adolescents: Dr. Rienecke et al. reply. *Journal of the American Academy of Child & Adolescent Psychiatry, 37,* 1006-1007. doi: 10.1097/00004583-199810000-00005

Reivich, K., & Shatte, A. (2002). *The resilience factor: 7 essential skills for overcoming life's inevitable obstacles.* New York: Broadway Books.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103. doi: 10.1037/h0045357

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6,* 412-415 [reproduced in *Journal of Psychotherapy Integration,* 2002, *12,* 5-9].

Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M.W. Kent & J.E. Rolf (Eds.), *Primary prevention of psychopathology: Vol 3. Social competence in children* (pp. 49-74). Hanover, NH: University Press of New England.

Seligman, M.E.P. (2002a). *Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment.* New York: Free Press.

Seligman, M.E.P. (2002b). Positive psychology, positive prevention, and positive therapy. In C.R. Snyder & S.J. Lopez (Eds.), *Handbook of positive psychology* (pp. 3-9). New York: Oxford University Press.

Seligman, M.E.P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55,* 5-14. doi: 10.1037/0003-066X.55.1.5

Seligman, M.E.P., Reivich, K., Jaycox, L., & Gillham, J. (1995). *The optimistic child.* New York: Houghton Mifflin.

Silverman, W.K., & Hinshaw, S.P. (2008). The second special issue on evidence-based psychosocial treatments for children and adolescents: A 10-year update. *Journal of Clinical Child and Adolescent Psychology, 37,* 1-7. doi: 10.1080/15374410701817725

Skinner, B.F. (1953). *Science and human behavior.* Oxford, England: Macmillan.

Smith, M.L., & Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32,* 752-760. doi: 10.1037/0003-066X.32.9.752

Smith, M.L., Glass, G.V., & Miller, T.I. (1980). *The benefits of psychotherapy.* Baltimore: The Johns Hopkins University Press.

Spirito, A., & Kazak, A.E. (2006). *Effective and emerging treatments in pediatric psychology.* New York: Oxford University Press.

Stage, S.A., & Quiroz, D.R. (1997). A meta-analysis of interventions to decrease disruptive classroom behavior in public education settings. *School Psychology Review, 26,* 333-368.

Steele, R.G., Elkin, T.D., Roberts, M.C. (Eds.). (2008). *Handbook of evidence-based therapies for children and adolescents: Bridging science and practice, issues in clinical child psychology.* New York: Springer Science.

Szienberg-Arazi, D., Heim, M., & Steinbach, T. (1991). An evaluation of social integration by peers and teachers of pre-adolescent children with a congenital limb absence. *International Journal of Adolescent Medicine and Health, 5,* 141-147.

Snyder, J., Cramer, A., Afrank, J., & Patterson, G.R. (2005). The contributions of ineffective discipline and parental hostile attributions of child misbehavior to the development of conduct problems at home and school. *Developmental Psychology, 41,* 30-41. doi: 10.1037/0012-1649.41.1.30

Task Force on Pomotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically-validated psychological treatments: Report and recommendations. *The Clinical Psychologist, 48,* 3-23.

Walker, C.E., Hedberg, A., Clement, P.W., & Wright, L. (1981). *Clinical procedures for behavior therapy.* Englewood Cliffs, NJ: Prentice-Hall.

Watson-Adams, A. (2006). *Checklist for assessing adolescent developmental assets.* (Unpublished doctoral dissertation). Graduate School of Psychology, Fuller Theological Seminary, Pasadena, CA.

Weisz, J.R., Jensen-Doss, A., & Hawley, K.M. (2006). Evidence-based youth psychotherapies versus usual clinical care: A meta-analysis of direct comparisons. *American Psychologist, 61,* 671-689. doi: 10.1037/0003-066X.61.7.671

Weisz, J.R., & Kazdin, A.E. (Eds.). (2010). *Evidence-based psychotherapies for children and adolescents* (2nd ed.). New York: Guilford Press.

Weisz, J.R., McCarty, C.A.,& Valerie, S.M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin, 132,* 132-149. doi: 10.1037/0033-2909.132.1.132

Weisz, J.R., Weiss, B., Alicke, M.D., & Klotz, M.L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting & Clinical Psychology, 55,* 542-549. doi: 10.1037/0022-006X.55.4.542

Weisz, J.R., Weiss, B., Han, S.S., Granger, D.A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. *Psychological Bulletin, 117,* 450-468. doi: 10.1037/0022-006X.55.4.542

Werner, E.E., & Smith, R.S. (1982). *Vulnerable but invincible: A study of resilient children.* Ithaca, NY: Cornell University Press.

Whitney, I., & Smith, P.K. (1993). A survey of the nature and extent of bullying in junior/middle and secondary schools. *Educational Research, 35,* 3-25.

Table 1: T Scores on the Childhood Symptom Inventory-4
When the Score Was Higher Than 50

Scale	Mother	Teacher A	Teacher B	Teacher C
ADHD, Combined			62	56
ADHD, Hyper-Impulsive		54	76	68
Oppositional		58	62	66
Conduct Disorder	60	66	60	70
General Anxiety Disorder				54
Schizophrenia		60		72
Dysthymic Disorder		64		64
Major Depressive . Disorder				58
Asperger's Disorder				60
Autistic Disorder				60

Table 2: Summary of the Treatment Plan for Rafael

Goal	Method(s) for Pursuing Goal
Increase self-control when provoked	Assertiveness training
Increase assertiveness	Assertiveness training
Improve classroom behavior	Goal setting
Increase respect for others' property	Conflict resolution training
Increase truthfulness	Conflict resolution training
Improve sleeping habits	(not addressed directly)

Table 3: Feeling Talk Self-Evaluation Chart

Emotion	Mom	Teachers	Friend A	Friend B	Sister	Mean
Anger	4	4	5	4	5	4.4
Anxiety	3	2	4	3	4	3.2
Compassion	6	3	3	2	3	3.4
Disgust	6	4	5	5	4	4.8
Envy	3	3	3	4	3	3.2
Fright	5	3	4	3	4	3.8
Gratitude	4	4	5	4	5	4.4
Guilt	4.5	3	4	3	3	3.5
Happiness	6	5	5	4	5	5.0
Hope	4	4	4	4	4	4.0
Jealousy	3	3	3	3	3	3.0
Love	6	4	3	2	5	4.0
Pride	6	4	3	3	4	4.0
Relief	7	5	6	6	6	6.0
Sadness	5	4	4	4	5	4.4
Shame	3	3	3	3	3	3.0
Mean =	4.72	3.62	4.00	3.56	4.12	

Rafael used the following scale to make his estimates:

1 = I would **never** say the feeling when I was having it

2 = I would **rarely** say the feeling when I was having it

3 = I would **sometimes** say the feeling when I was having it

4 = I would say the feeling about **half of the time** that I was having it

5 = I would **often** say the feeling when I was having it

6 = I would **usually** say the feeling when I was having it

7 = I would **always** say the feeling when I had it

Table 4: Rafael's Treatment Outcomes During the First Course of Treatment Based on Mother's Ratings

Problem	SOF[a] at Intake	SOF[a] at Session 17	SOF[a] at Session 29
Act without Thinking (Hyperactive or Impulsive)	7	7	8.5
Aggressive Behavior	7	7	9
Anger	6	6	9
Classroom Behavior	7	8	10
Destruction of Property	7	8	10
Fighting	7	8	10
Impact of Child's Problems on Parent	7	7	9
Lying	7	8	8
Sleeping	7	7	9
Stealing	7	8	9
Teased or Victimized by Peers	7	8	9
Mean SOF Score =	6.91	7.45	9.14
Standard Deviation of SOF Scores =	0.30	0.69	0.64
Treatment Effect Size (ES)[b] =		**1.80**	**7.43**

[a]Scale of Functioning (SOF) Rating, on the following scale:
10 = Excellent Functioning
9 = Good Functioning
8 = Slight Problem
7 = Some Problem
6 = Moderate Problem
5 = Serious Problem
4 = Major Problem
3 = Unable to Function
2 = In Some Danger of Hurting Self or Others
1 = In Persistent Danger of Hurting Self or Others

[b]ES = [(Mean of Session *x*) – (Mean of Intake)]/Standard Deviation at Intake

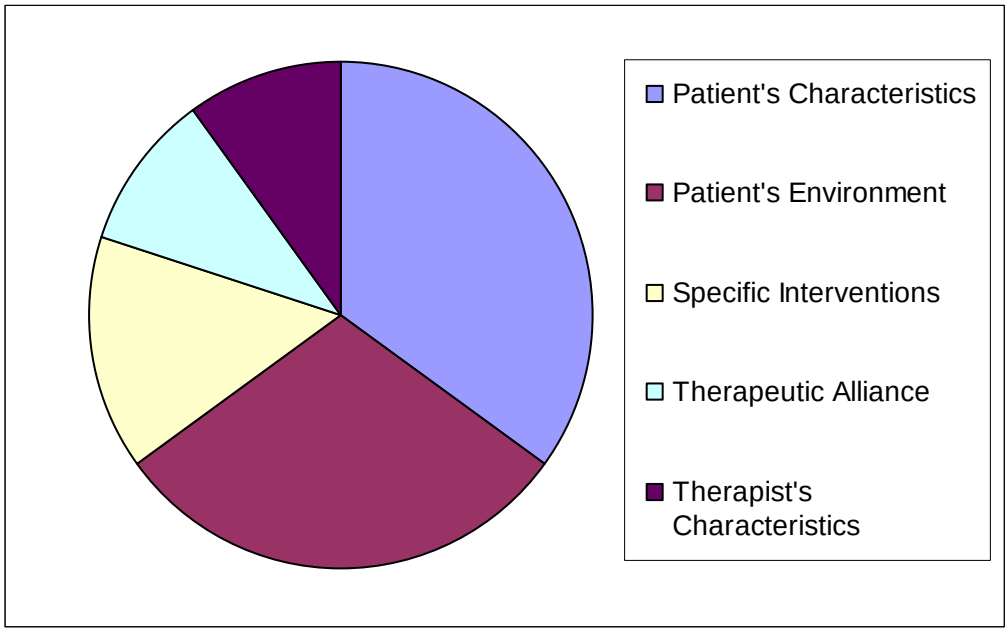
Table 5: Rafael's Treatment Outcomes During the Second Course of Treatment

Problem	Jointly Determined Goals	Rafael's Self-Assessed SOF[a] at Intake	Mother's SOF[a] at Intake	Rafael's Self-Assessed SOF[a] at Session 20	Mother's SOF[a] at Session 20
Lying (pervasive, on-going)	Be more open and honest	7	7	9	9
Stealing (several occasions)	Respect other people's property	6	5	9	9
Secretly using the Internet	Develop a contract for internet use	7	5	9	9
Does not express remorse	Become better at expressing remorse and empathy for Mom	6	5	8	8.5
Mean SOF Score =		6.00		8.81	
Standard Deviation of SOF Scores =		0.93		0.37	
Treatment Effect Size (ES)[b] =				3.02	

[a]Scale of Functioning (SOF) Rating, on the following scale:
10 = Excellent Functioning
9 = Good Functioning
8 = Slight Problem
7 = Some Problem
6 = Moderate Problem
5 = Serious Problem
4 = Major Problem
3 = Unable to Function
2 = In Some Danger of Hurting Self or Others
1 = In Persistent Danger of Hurting Self or Others

[b]ES = [(Mean of Session *x*) – (Mean of Intake)]/Standard Deviation at Intake

Figure 1. Estimated sources of change in Rafael.



Appendix 1: Childhood Problems Checklist (Clement, 1999)

Child's Name: _____ **Date:** _____

Person completing this form: _____

Please identify your concerns about this child by placing a number beside a problem, using the choices below. Only rate items when you have a concern. Do not place numbers next to problems about which you have no concerns.

8 = Slight concern but I have *not* thought about getting help for this problem
7 = Some concern *or* I have thought about getting help for this problem
6 = Moderate concern *or* someone has encouraged me to get help for this problem
5 = Serious concern *or* a few people have encouraged me to get help for this problem
4 = Major concern *or* many people have pressured me to get help for this problem
3 = Unable to function *or* the child is totally unable to do what is age-appropriate in this area
2 = A danger to self or others some of the time
1 = A persistent danger to self or others

_____ Abuse or Neglect of Child
_____ Acts without Thinking (Hyperactive or Impulsive)
_____ Aggressive Behavior
_____ Anger
_____ Anxious, Tense, Worried
_____ Arguing with Adults
_____ Arguing with Other Children
_____ Arithmetic
_____ Articulation, Spoken Language
_____ Bad Dreams or Nightmares
_____ Bedwetting
_____ Bothered by Recurring Thoughts
_____ Bothered by Some Trauma
_____ Bullying or Threatening Others
_____ Classroom Behavior
_____ Complains about Not Feeling Well
_____ Coordination
_____ Critical of Self
_____ Daydreaming
_____ Defiant, Oppositional, Noncompliant
_____ Destruction of Property
_____ Divorce of Parents
_____ Eating
_____ Fears or Phobias
_____ Fidgeting, Squirming, "Hyper"
_____ Fighting
_____ Fire Setting
_____ Grief or Bereavement
_____ Health Problems
_____ Homework
_____ Impact of Child's Problems on Parents
_____ Impact of Child's Problems on Siblings
_____ Irritable
_____ Lying
_____ Makes Strange Vocal Sounds
_____ Makes Strange, Jerking Movements
_____ Making or Keeping Friends
_____ Parent–Child Relationship
_____ Paying Attention
_____ Performing Unusual Habits or Rituals
_____ Playground Behavior
_____ Playing or Relating with Other Children
_____ Reading
_____ Refusing to Speak
_____ Relationship with Sibling(s)
_____ Sadness/Depression
_____ School Attendance
_____ School Grades
_____ Self-Injurious Behavior
_____ Sexual Behavior
_____ Shy
_____ Sleeping
_____ Social Skills and Problem Solving
_____ Soiling Underwear
_____ Stealing
_____ Strange, Weird, or Peculiar Behavior
_____ Tantrums
_____ Teased or Victimized by Peers
_____ Weight
_____ Worrying about Being Separated from a Parent
_____ Writing
_____ Other: _____
_____ Other: _____
_____ Other: _____