Chapter 2
The Clinical Behavior Analyst for Children

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Reflection upon the responsabilities and duties of the child-analytic-behavioral psychotherapist brings us back to the very meaning of being a psychologist, forged in the evolution of societies, cultures and which was organized in undergraduate and graduate curricula. To some extent, the way in which this organization occurs distances this knowledge from people and from institutions, which leads them to have different impressions of our work. Within this reasoning, when asking about the purpose of the work of the psychologist, of the psychotherapist, a plausible answer might be "to solve problems." When adding to the question the terms child-analytic-behavioral, perhaps the answer does not change much: "solve behavior problems of children." Such an answer, however, seems too simple, too simplistic, and too mechanical. The idea that the only role of the psychologist is to solve behavioral problems is part of a binary logic, reductionist and hierarchical, that there is presence and absence of problems and that attending the office of a professional once or twice a week can make the problems disappear and, furthermore, that this professional, who holds a certain knowledge, will solve unknown problems that are mine that I know nothing about. None of this makes sense.

We feel called upon, for deeper reflection, to present our position on the purpose of the work of the child therapist. In reality, this is not a question that has one single answer, nor many simple answers. This is the context of this chapter that aims to discuss different characteristics of the work of the behavior analyst who works with children in the office. Since it is a little discussed theme, the content presented here will be based not only on the literature but also on our experiences as psychotherapists and supervisors of services in this approach. It is important to point out that all the proposed divisions of roles attributed to the psychotherapist are merely didactic, since these roles overlap and interchange at all times, varying from case to case and

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modifying throughout the therapeutic process. To reflect on this, stages of the therapeutic process will be described in line with what is proposed in Vermes (2012). For those who wish to have a deeper understanding of how to structure child care, we recommend reading this material.

Analyzing the therapeutic process chronologically, the beginning may be considered the moment in which one of the persons responsible for the child contacts the therapist or the psychological institution with the aim of seeking help to deal with some situation that is related to the child's behavior and that is negatively affecting the family dynamics. Reflecting on what leads parents to seek psychotherapy for their child allows us to begin to understand the multiplicity of roles that the child psychologist plays. Often, the demand for psychotherapy is raised by the school or by a doctor, who indicates that some behavior(s) of that child may be harming its development and that the support of a psychologist may be beneficial.

Other times, the family itself seeks help because it has difficulty in managing a child's behavior, or because it perceives a difficulty in the child's interaction with peers, or even because it notices a difference in the child's development in relation to other children. Each situation demands different actions from the professional, since families come to the clinic with particular understandings about what they expect from the service they are seeking. The individual histories of each parent with therapy and psychologists in general also make the family's expectations about the work differ. It is necessary at this early stage for the psychologist to clarify what their role is and what parents can expect from the therapeutic process. It is the therapist's role to explain about the functioning of the therapeutic process, which includes practical aspects of establishing a therapeutic contract, such as periodicity and fees[1] and theoretical aspects.

The role of parents in establishing and changing behaviors generates the need for their participation in the therapeutic process, when theoretical aspects will be worked with them. Theoretical contextualization of care for the family helps parents to understand the dynamics of the therapeutic process and can help increase their engagement. We are talking, here, about the need for a posture in the work of commitment and collaboration with parents, which establishes an interaction between equivalent and aligned partners in decisions, sharing goals, responsibilities, and resources. In this direction, psychotherapist and caregivers work in a horizontal, nonhierarchical relationship to design and implement actions for relevant issues, defined in agreement.

Given the multiplicity of possibilities that the family-psychotherapist encounter brings, it is safe to say that one of the roles of the child therapist is to be a good listener and observer. Listening and observation skills are the main skills of the psychologist in general; it is no different here. At the beginning or during the therapeutic process, with the child or with the parents, the professional must always be attentive to what is said and what is not said, since a careful data collection provides rich material for further functional analysis. Based on the assumption that listening

[1] For more details on establishing the therapeutic contract, we suggest reading Pergher (2011).

and observation are practical skills (learned behaviors), which are developed throughout life and improved during clinical performance, exposure is fundamental.

In this journey, theoretical knowledge is the compass that will guide the entire therapeutic process, because the professional needs to know where to focus his attention, in search of answers to the questions that will help in the development of the work. There is no useless information, so that paying attention and recording all the information that can be apprehended will allow the formulation of more hypotheses and more functional analyses, whether molar or molecular.

What about working directly with children? To do so, it is necessary to plan the activities that will be proposed throughout the sessions (including planning when the play will be guided by the child), always seeking to evoke those behaviors that one wants to observe (in this first moment of therapy and, later, intervening in a more planned manner, guided by the information collected). Here we find another of the child therapist's roles, which is to know the universe of play and to manage child behavior. Such skills are rarely developed during the psychologist's undergraduate education, and it is up to those interested in working with children to develop these repertoires individually. It is worth saying that, in this process, having the support of a supervisor is highly recommended.

In other words, if you are not comfortable or enjoying the exchange that is happening in session, there is a high possibility that the child is also perceiving the behaviors related to these feelings, and this can greatly harm the development of the therapeutic bond. Becoming familiar with children, with playing, and with talking to them in a way that respects their level of development may be good ways to develop as a child therapist.

Following chronologically the flow of care, the next important role of the child therapist is that of "functional analyst." Doing functional analysis is almost never a simple task, but it is the path to be followed by the psychotherapist who needs to understand more clearly what is happening in the different environments of the child, especially in the family sphere, which consequently will enable him to contribute to the work with the family in a more profoundly effective and more transformative way. This posture is certainly antagonistic to the focus only on the resolution of specific problems. The whole intervention proposed by the clinical behavior analyst is based on functional analyses of the complaint behaviors or relevant behaviors (initially presented by parents and children), as well as broader analyses of the functioning of the client's environment in general. It is part of this process to select which, among the data collected, are interesting for the understanding of the phenomena in question and which are missing, as well as ways to obtain them.

Completing a case formulation may help in this task and may facilitate the next step in the therapeutic process. Although conducting functional analyses is something that is studied since the early years of college, in the initial disciplines of experimental behavior analysis, the beginning clinician may realize that it is quite challenging to perform analyses in the clinical context, when the experimental control of the laboratory practically does not exist. At this time, the importance of

careful and extensive data collection is relived, since the clearer the information available, the more material one will have on which to draw in order to create functional hypotheses. With these data in hand, a good start is to create a triple contingency analysis table (antecedent stimulus-response-consequence), placing the behavior-question as the response, and try to fill in the antecedent and consequence fields with all the information obtained via report or direct observation. Supervision can be of great value to broaden and deepen the analysis and to plan the next steps more clearly.

Initial analysis carried out, the therapist should be able to transform a set of functional analysis into intervention planning, to be discussed with the child and their guardians within the principles of partnership and co-responsibility that sustain the psychotherapeutic process. Planning is a task of which little is said, but it is one of the most relevant elements in the development of psychotherapy. Planning intervention is to program in which behaviors to intervene, in what way and in what sequence, and, finally, where one wants to get with the therapy. This planning is, and should be, flexible; since therapy is like "changing the tire of the car with the car running," the child's universe does not stop changing after the analyses are done, and new elements are presented as time goes by.

Hence, one of the reasons why the evaluation process should occur throughout the therapeutic process. Despite the possibility of altering the planning throughout the work, it is important to know where to start and what one wants to achieve. The transformation of analysis into planning demands good, initially, and as the therapist becomes more experienced, excellent theoretical knowledge of behavior analysis – understanding modeling and differential reinforcement, among other concepts – and also how to use them in practice. In conducting the session, the therapist needs to be guided by theory. Once again, supervision can help a lot in this process! It is worth noting that the intervention plan in working with children may include not only the objectives of the work in relation to them but also the parents and the school, as will be explained in later chapters of the book.

What exactly does "transforming a set of functional analyses into intervention planning" mean? The following situation will seek to exemplify: suppose a child is brought to the clinic for yelling at his parents "out of the blue." The parents cannot understand what is happening, but they can no longer stand such verbal violence at home and feel that they are not managing to educate their child as they would like. The therapist talks to the parents, holds some sessions with the child, and gets a lot of information. The analyses he carries out lead him to the hypothesis that the parents tend to deny the child's requests when she asks in a polite and kind way and provide what she requests when she yells. With these analyses, it is hypothesized that the complaint behaviors here are being maintained, because shouting provides access to reinforcers, while talking does not. Only this functional understanding allows us to elaborate an intervention plan focused on replacing the complaint behaviors with others that positively alter the family dynamics and that do not bring damages, or at least minimize them, to the child, her parents, and eventually other family members.

In this case, the therapist may plan an intervention that includes, for example, guidance for parents and work with the child focused on differentially reinforcing responses to ask in a polite manner, to the detriment of aggressive responses. Such interventions and guidance should always be done taking into account specific family dynamics and also functionally analyzing the parents' behaviors to increase the likelihood that the proposed changes will be effective and long-lasting.

It is worth an addendum on the moment of intervention planning: in addition to functionally analyzing elements responsible for the maintenance of current problem behaviors, taking into account the broader objective of the therapeutic process, of human development, it is worth thinking of repertories that can be taught that are not necessarily linked to the resolution of current problem behaviors but that can be related to the prevention of future problems. Collaborating to care for the context in which the child is growing up, in the family, school, and community dimensions, for example, produces gains for the family and society. To the extent that, as therapists, we participate in the construction of nurturing environments for children and their caregivers, we are collaborating to promote health and prevent health problems.

The field of prevention studies broadly describes risk and protective factors for the development of mental health problems. That is, it describes elements related to the greater or lesser likelihood of a problem, so that it is possible to work to prevent or interrupt the escalation of problems relevant to the individual and society. Thus, it is up to the clinical psychologist who works with children to know risk factors for the development of the most prevalent psychological problems and know how to identify their presence in the child's context. With this, it is possible to arrange contingencies and teach behavioral repertoires that allow minimizing these risk factors, promoting protective factors. Thus, when planning an intervention, it is pertinent not only to evaluate the contingencies that promote current complaint behaviors but also to analyze issues that may arise in the medium term, for example, during adolescence, and plan actions that can prevent or minimize damage.

Once the intervention plan has been designed, taking into account current and future developmental needs, the time comes to talk to parents again and to discuss with them what was observed and analyzed in the first contacts with them and with the child. Here arises another role of the child therapist, the role of communicator. Technical and hermetic language does not invite parents to dialogue, to collaboration (in that sense that we approached in the opening pages). This language establishes distance and perhaps serves to prescribe rules to parents about what they should do. In this sense, it distances us from the working posture we advocate here.

It is up to the therapist to develop a way of communicating that conveys the technical information involved in his evaluation, but without neglecting to establish the necessary partnership. This – very difficult – skill is necessary from the first contact with the parents, since from the interview the therapist shares with the family information based on theories and research, generally available in dense language difficult for lay people to understand. Sharing analyses and descriptions of functional relationships is a task that can be difficult, since they may touch on sensitive issues for family members. The role of translator of "behaviorese" into Portuguese is perhaps one of the most demanding activities of the office of child therapist. Doing this

with empathy and taking into account the feelings of all involved is an eternal challenge.

This moment requires an empathic and sensitive look from the therapist, as well as didactic. It is common for parents to blame themselves for the difficulties their children face. Therefore, the clinician should avoid a blameful tone when describing the establishment of problem behaviors. The use of analogies and metaphors, as well as examples that may have happened during the sessions, can help parents visualize the functional relationships to be presented at this time, increasing their understanding and their possibility of appropriation of the process. These and other resources can be used in the construction of the therapeutic alliance with parents, since, in the work with children, in addition to the bond with the client himself, the establishment of a good bond with the family is fundamental for the progress and maintenance of the therapeutic process, since, in addition to having a significant part of the contingencies that maintain the child's repertoire, they are responsible for the decision to continue therapy. This means that the therapeutic alliance with the family is an important predictor for the success of psychotherapy. Collaborating to build an environment that favors parents' understanding and appropriation of the dynamics of the therapeutic process and the maintenance of behaviors – desirable or not – may increase engagement in the therapeutic process and facilitate the generalization of therapy gains.

With the family and therapist opting to continue the therapeutic process, a stage with a mainly interventional character begins (highlight the term "mainly," since the evaluation of behaviors continues to occur throughout the therapeutic process). During the therapeutic intervention, the role of teaching new behaviors to children through behavioral strategies to help them overcome current difficulties and act as active agents of change in the intra- and extra-consultant environment comes into play. It is important to note here that this role is very different from that proposed in the early days of behavioral therapy, in the behavior modification era. It goes beyond reducing the frequency of inappropriate responses. The application of behavioral strategies here is one part of a much more complex whole. Behavior modification only makes sense and does not produce all the complications criticized back then, as part of constant analysis, which takes into account not only the child but his environment. The behavioral strategies used will be those defined at the time of intervention planning, seeking not only the specific transformation of a given behavior but the change of a broader repertoire in a sustainable manner over time, always taking into account the child's full development and interaction with the environment.

In practice, this role includes, for example, ignoring inappropriate behaviors and reinforcing appropriate ones during play or reinforcing each target behavior in a modeling procedure. So does asking a child to help put away toys and ensuring that he does so, followed by clear expressions of approval. It's teaching the behaviors that you've concluded, after analysis, that the child needs to learn, doing so in a playful and – preferably – reinforcing manner. Paying attention to the child's behaviors can help the therapist identify if the space provided is being welcoming. Good signs are the child's cooperation, smiling, bringing up issues spontaneously, and interacting affectionately with the therapist. In the context of the session, always

taking into account the holistic repertoire of the individual, rather than "taking" responses from the repertoire, the therapist's role is to be a facilitator of the child's process. This means programming contingencies to teach new repertoires that allow the child to obtain important reinforcers, in a sustainable manner in the environment to which he or she belongs.

Taking into account the integral development of the child, as the therapist has access to the client's behaviors, he can observe aspects of that repertoire. At this moment, he may identify demands that go beyond the psychologist's scope of work, and one more of his roles comes to the fore: to be responsible for making referrals to other professionals, establishing working partnerships. This is a role of vital importance in the holistic understanding of health and development, since, in many situations, other colleagues will provide the changes that the family needs at that moment. To fulfill this role, it is necessary that the therapist knows the work of other professionals who work with children, such as psychiatrists, speech therapists, occupational therapists, and psycho-pedagogues, among others. It is also desirable that the therapist understands what behaviors suggest the need for assistance by one of these professionals. It makes sense to think of professionals who work in conjunction with the psychologist's work, since this type of partnership brings gains for the child and his family.

More than knowing the goals of the work and understanding the importance of developing these characteristics of the child, it is important to know when to refer and how to make this referral so that the family feels welcomed and cared for. The family may feel overwhelmed with the need for more therapeutic work and may also have the need to control financial costs of yet another treatment and stop seeking help. There may also be, on the part of the family, prejudice and resistance to some treatments, such as psychiatric. Referral is more than just informing that there is a need to work with another professional but a discussion of the therapeutic strategy with the family, listening to their fears and concerns and making sure that the family feels genuinely cared for and welcomed. At times when the referral is really necessary, the child is the greatest beneficiary, and the therapist should channel his efforts to support the family in the search for the requested professional. This situation signals to the therapist the need to work in a multidisciplinary team, making periodic contacts with colleagues to ensure comprehensive care to the child and family.

When a referral to other professionals is chosen, it is also important to inform and explain to the child the need for this additional work – once again making sure to treat the child as an active participant in her therapeutic process. Often, the new work will be with a professional in a specialty with whom the child has no previous experience, so that it is part of the therapist's role to explain the reasons for the referral and who the person is whom the child will meet – always taking care to use a language compatible with the child's development, so that the child understands this as additional care. It is always important to welcome any feelings that the child may express at this time – which may range from fear and opposition to excitement and curiosity – in order to facilitate the first contact with the new professional.

Expanding the understanding beyond the health x illness binarism, seeking a more comprehensive view of human development and mental health, allows looking at the role of the child therapist in a broader way. Health is more than the absence of disease, so that the child therapist can help families beyond the longing for the extirpation of a problem. In line with the premise presented, one of the important roles of this professional is to look at the child's development as a whole, seeking to understand barriers to their full development, and, from there, to draw up a plan with the family aiming at the child's full development. The end of the therapeutic process will ideally occur when therapist, parents, and child understand that the family's repertoire gains are sufficient for the child to interact with his/her environment without the need for psychotherapy support. More details about the assessment of the child's behavioral repertoire and how to work with the topic will be the subject of a later chapter.

Contrary to what a simplistic view might assume, the child therapist has functions beyond superficially resolving the complaint, generally of parents, firstly because resolving complaints by itself demands various professional skills. To do this with care, empathy, and respect for all the people involved in the therapeutic process is quite demanding, not only from the point of view of workload but also from the emotional point of view. It is difficult not to get involved with the situations and difficulties brought by families with whom you work so closely, with contact often more than once a week. It is difficult to find the line that separates the interested and available therapeutic involvement from the "over involvement," in which the therapist exceeds his personal limits to meet the demands of the case. It is important that the therapist has well established his personal values and objectives, so that it is easier to place limits on the work and avoid establishing a work marked by exhaustion, anxiety, *burnout*, and excessive questioning. This time, not only supervision may help but mainly an individual therapeutic process, which may help the professional to (re)know his/her limits and balance.

Finally, it is hoped that this chapter has broadened the reader's view of the different roles of the child behavior analytic therapist, both from the practical point of view, in the different moments of the clinical process, and from the reflective point of view. Keeping a critical eye on this complex role allows us to treat each child and family with the respect and ethics that the profession requires, without neglecting our own health. Being a child therapist demands a lot of work, even more so with the level of involvement and attention proposed in this chapter. Helping families and children to develop in a healthier and more harmonious way is, however, worth all the cost.

References

Pergher, N. K. (2011) Contrato em Terapia Analítico-comportamental. In: Carpigiani, B. (Org). *Teorias e Técnicas de Atendimento em Consultório de Psicologia*. (1st Edn., pp. 135–156). Vetor.

Vermes, J. S. (2012). Clínica analítico-comportamental infantil: a estrutura. In: Borges, N. B., & Cassas, F. A. (Org.). *Clínica analítico-comportamental: aspectos teóricos e práticos*. (1st Edn., pp.1, 214–222). Artmed.