Chapter 5
Clinical Assessment in Clinical Behavior Analysis for Children and Definition of Therapeutic Goals

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As described in previous chapters of this book, child intervention from an behavior analysis' perspective is composed of different stages, including the initial assessment, which aims to collect data through interviews with parents and professionals involved, as well as through assessment sessions of the child's behavior. This evaluation seeks to gather the largest amount of information in order to help the therapist in the formulation of the case and intervention. Thus, the more information collected at this stage of clinical care, the broader the understanding of the case and the greater the chance of formulating complete functional analyses.

The conduct of the initial assessment may take several paths, to be chosen by the clinical behavior analyst. The literature in the area presents different positions on what the initial assessment (or diagnostic assessment) encompasses. After a non-systematic bibliographic survey, no consolidated model was found to perform this relevant stage of child care. Among the models in the literature, for example, Silvares (2000) proposes that the diagnostic assessment comprises four phases, namely, (1) identification of problems, concluding their nature and possibility of treatment, (2) functional analysis, (3) treatment selection, and (4) treatment evaluation. In turn, for Kanfer and Saslow (1976), the assessment comprises seven steps: (1) initial assessment of the problem situation, (2) clarification of the problem situation, (3) motivational analysis, (4) developmental analysis, (5) self-control

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analysis, (6) analysis of social relationships, and (7) analysis of the socio-physical-cultural environment.

Regra (2012) describes in detail each step of the initial assessment and makes the following division: (1) data survey with description of the undesirable behaviors; (2) survey of hypotheses that may be favoring the occurrence of the target behaviors; (3) survey of the most likely hypotheses about the variables that may be hindering the occurrence of the desirable behaviors; (4) presentation of the work proposal; (5) initial guidance of selected simple situations, to expedite the process of change; and (6) closing of the therapeutic contract.

In Naves and Ávila's (2018) text on case formulation, the behavioral assessment requires the therapist to consider behavioral patterns and functional relationships established in the child's current and past history. Investigations regarding client data; child development; life, family, academic, medical, and psychological histories; as well as therapeutic routine and goals are the main steps that make up the assessment in case formulation.

From theory to practice, there seem to be different positions on the form of assessment to be developed in the clinic by the child behavior analyst. Del Prette et al. (2005) assessed 20 Brazilian studies of clinical behavior analysis for children and concluded that, in general, initial assessments with parents and child, as well as interviews with parents during therapy, predominate. As for the method of data collection, the main one is the observation in session, before, during, and after the interventions (without reference to systematic record). In addition, in less than half of the cases, there was reapplication of instruments initially applied or of assessment at the end.

Still referring to the way the initial assessment is conducted, some authors highlight the relevance of using different playful strategies (e.g., drawings and make-believe games) that facilitate the therapist's access to relevant information. This is because, in general, children are not always able to accurately report daily events. Thus, in addition to accessing information by observing the child's behavioral patterns while playing, the clinician can also collect data on the daily life through questions during play (Del Prette & Meyer, 2012; Del Rey, 2012).

The difference between the stages of assessment and intervention is not a consensus in the area. Bertolla and Brandão (2017), for example, argue that assessment and intervention are not formally differentiated in the literature and, in practice, both take place simultaneously throughout the therapeutic process. Thus, there is not a set number of sessions for this initial period of information collection. In all stages of the progress of the case, the therapist gathers information that may be relevant to the functional analysis.

Converging with the abovementioned authors, Conte and Regra (2012) state that, from the initial contact with the family, data are collected and interventions possibly leading to changes are implemented. Thus, it is not characterized a moment of assessment and another of intervention throughout the child care. For them, these moments happen intertwined during the sessions.

The authors who advocate the non-differentiation between assessment and intervention explain that waiting for the completion of an assessment to then start the

intervention becomes unfeasible, given the urgency required by many cases. There are also situations in which a complete assessment is not always necessary for the intervention to take place (Conte & Regra, 2012). In these situations, intervention and assessment go hand in hand.

Despite the distinct positions between the moments of assessment and intervention, it is understood that the structuring of the stages of an initial therapeutic assessment, with defined phases and specific objectives, can be of great use for the therapist and for the family who seeks therapy. For the therapist, a good clinical practice requires the ability to gather data to build consistent functional analyses and to define therapeutic objectives. For the family, this structuring facilitates the understanding that there is an outline to be followed during the work, also combating possible myths that the therapeutic process would be unstructured.

Finally, it is clear that there are several difficulties faced in the evaluation process and, more specifically, in the delimitation of an initial evaluation moment, given the breadth of possibilities. In order to systematize and contribute to the construction of the evaluation process in the clinical behavior analysis for children, a material prepared by the authors of this chapter will be presented, consisting of different elements that are described in the literature of the area.

Proposal for Evaluation

Based on some needs observed by the authors during the initial assessment process, a critical analysis of the literature already produced so far was conducted, leading to the proposition of an initial assessment framework.

As a fruit of this work, the proposed initial evaluation framework lasts 5 to 7 weeks and consists of the following steps:

1. Initial interview and therapeutic contract.
2. Application of complementary instruments.
3. Child observation.
4. Assessment of child-caregiver interaction.
5. Contact with school and other professionals.
6. Feedback to parents.

Below is a brief description of each of the steps that make up this process.

Initial Interview and Therapeutic Contract

The initial interview is conducted with parents (or caregivers) and lasts from one to two sessions. In line with the model proposed by Regra (2012), the initial interview with parents can be divided into a unstructured interview – when parents freely report their concerns – and, subsequently, a structured interview, in which

the therapist asks questions to guide the parents' discourse, thus helping professionals build a functional analysis.

The questions asked by the therapist aim to investigate aspects related to the main complaint and the contexts in which it manifests itself, i.e., possible antecedent and consequent variables that may be contributing to the maintenance of the problem behavior (Vermes, 2012). It also seeks to investigate aspects of the child's environment, such as the educational practices adopted by parents, family structure and dynamics, relationships with peers, educational performance, etc. At this time, possible reinforcing stimuli for the child are also investigated to assist in planning the initial sessions with the child.

It is essential that the therapist considers that the reports brought depend on the parents' capacity of observation and description and are often a cutout of the behavior. Thus, environmental variables that may be contributing to the maintenance of the problem are not always described. Thus, it is up to the therapist to select relevant information from the report in order to build functional analyses.

After gathering this data, a summary is made for the parents of the main points that were discussed, and, whenever possible, initial orientations are also offered in relation to some of the problems presented. Such orientations, although certainly not covering all the possible solutions to the complaints presented, may offer relief to the most immediate difficulties. In addition to having the purpose of producing small changes in the environment, they may contribute to the engagement of parents in the therapeutic process. Next, the theoretical approach from which the therapeutic process will be conducted is presented, as well as the structure of the assessment to be performed with the child and parents.

It is worth remembering that, still in the initial session, it is verified if the parents have already discussed with the child the beginning of the therapeutic work. If this has not yet occurred, guidance is offered on ways to do so. For example, the parents may tell the child that he will start seeing a psychologist, who is someone who studies feelings and behavior, and that this professional will help him better understand what he feels, as well as receive help to better deal with what is happening. Then, with the psychologist, he will talk, play, draw, and do various activities (Vermes, 2012). Alternatively, it is possible to suggest that parents make a parallel between the therapist and another professional by whom the child has already been seen (e.g., psychiatrist or pediatrician), relating the psychologist to someone who works together with the professional with whom they already have some kind of bond established. In this same context, Bertolla and Brandão (2017) suggest telling the child that he/she will meet a friend of the psychiatrist, doctor, or other professional who made the referral. It is worth pointing out that each therapist will gradually find his own way of presenting his work to the child and may, of course, present himself in different ways, considering the particularities of each case.

Finally, it is important that the therapeutic contract is established, covering issues related to the format of the work. At this moment, therefore, agreements are made about the duration and frequency of sessions, absences, delays, joint and individual sessions, how the contact by phone is made, payment, vacations, orientation session and parent training, and family session, among others (cf. Regra, 2012).

Application of Complementary Instruments

The initial interview is a moment when parents usually feel distressed about the difficulties they are experiencing and are sometimes anxious to meet the professional who will conduct the work. In this stage of the process, the therapist, in addition to listening and welcoming the parents, also has a series of other objectives, such as those discussed in step 1. In practical terms, these are objectives that require considerable time, and, in this context, it is very useful to use other means to complement the investigation.

Data collection can also occur through the completion of supplementary materials, questionnaires, or inventories delivered to parents as a way to investigate important information. Such documents can be filled out by parents in between sessions and aim to investigate areas related to the child's behavior, parenting practices, and the main caregiver's mood, for example.

Evidently, it is up to the therapist to evaluate which material or instrument best suits the case and the data they seek to know. However, for the investigation of data on clinical history, psychosocial and health aspects, school life, routine, and family, among others, the delivery of the Initial Assessment form (Annex I) is suggested. In addition, some other questionnaires and materials related to areas of investigation recurrently present in the child's clinic are recommended, which can be useful for the collection of complementary data.

Registration form – particular to each professional.
Routine description – material for filling in the activities of the child's routine.
Inventory or questionnaire screening for child problem behaviors. Example: Child Behavior Checklist (CBCL) (Achenbach, 1991; Bordin et al., 1995).
Frequency map of problem behaviors (Regra, 2012) – document for recording situations referring to the complaint and the times when they occur.
Questionnaire/assessment developed by the therapist to investigate autonomy in relation to activities of daily living – when pertinent.
Questionnaire for the investigation of the main caregivers' mood. Example: Beck Depression Inventory (BDI-II) (Gorenstein et al., 2011).
Questionnaire for research on parenting practices.
Questionnaire for collecting data on the child's behavior at school.

Observation of the Child

For this stage, two sessions with the child are planned, which have, as one of their main objectives, the beginning of the establishment of the therapeutic bond (Regra, 2012). Other objectives include building, together with the child, an understanding of what the therapeutic process is and how it takes place, presenting confidentiality as an element of the therapeutic relationship, establishing agreements in relation to

the sessions' structures, and conducting observation, which will allow for the identification of target behaviors for intervention and the child's general repertoire (Vermes, 2012).

To identify target behaviors, playful activities and games appropriate to the client's age are used. Through these resources, we seek to produce antecedent stimuli that evoke responses from the child associated with the clinically relevants behaviors. It is understood that the emission of clinically relevant behaviors during the session allows the therapist to observe responses that will potentially be targets of intervention, as well as important data for the construction of the functional analysis and the establishment of a baseline for the intervention.

During the initial sessions with the child, aspects related to compliance with rules and sociability with the interlocutor, among other skills, are also observed, with the objective of evaluating the child's total repertoire. We seek to identify behavioral deficits and excesses, as well as desirable responses already installed, which may become important resources in the development of alternative responses to problem situations or even serve as intermediate responses to be reinforced in a modeling process.

In this stage of the evaluation, the "Support material for the child therapist" (Annex II) is suggested as support material for the therapist, which offers a description of items to be evaluated during contact with the child. This material guides the therapist's observation, directing the recording of several classes of responses that, in general, are important in a child's repertoire. It becomes an antecedent stimulus for the therapist to reflect on the stage of development of various abilities of the child.

Through this material, the following items are investigated: identification of possible reinforcers, rule-following, self-knowledge, frustration, self-control and emotional expressiveness, civility, empathy, assertiveness, problem-solving, and academic skills. This material also includes the record therapist's mediation for the items in which the child does not demonstrate autonomy of execution. Thus, it is evaluated and recorded whether, with a certain level of help, the child would be able to perform the investigated behavior.

Thus, based on the child's observation sessions, the therapist will build a kind of panorama regarding the child's current difficulties and potential, which will serve as a baseline for the target behaviors. This baseline will be followed throughout the therapeutic process in order to assess the impact of the intervention and possible progress in the child's behavior.

Assessment of Child-Caregiver Interaction

At this moment of the assessment, activities are proposed with the objective of evaluating the dynamics of interaction of the child with the primary caregiver. Since the individual's behavior varies according to the context and the reinforcement scheme in place, it is relevant to observe how the child behaves in the presence of his parents. As part of the variables that will determine the emission and

maintenance of certain behaviors, it is especially important to observe how parents react to some behaviors. That is, through child-parent interactions, one seeks information on how parents deal with the child's difficulties, that is, whether they exercise some form of punishment or help the child to develop the repertoire for the emission of an appropriate response. With the same degree of relevance, the parents' reaction to the child's appropriate behaviors is observed, that is, if they offer some form of description and appreciation or if they present some consequence in order to increase the probability of future occurrence of such classes of responses.

The second part of the "Supporting material for the child therapist" (Annex II) is proposed to be used to record the data obtained in relation to the parents, which can also contribute to the collection of relevant data for the formulation of the case. The data can be obtained (1) through the parents' report and observation of the child, (2) through observation during the child's session with the parents, and (3) through contacts with the parents in the waiting room and scheduling situations. The items of this support material are related to the following aspects: parenting practices, parents' social skills, family, parental motivation, and concerns.

Contact with School and Other Professionals

After the previous steps, it is suggested to establish contact with the school and other professionals who accompany the child. In the contact with the school, general perceptions of the teachers and coordinators regarding the child are investigated, both in relation to the concerns brought by the parents and to general aspects of the child's behavior, including student attitude, academic performance, and socialization. Also in the "Support material for the child therapist" (Annex II), there is a specific section about expected behaviors in the classroom context and in the relationship with peers and teachers, which can serve as guidance for the therapist. More specifically regarding problem behaviors, it is important to ask how these responses occur in the school context, investigating antecedent and consequent stimuli that may be contributing to their maintenance.

Sometimes the school's report on the child's problem-behavior may be different from the family's report. This difference, among other factors, may be related to behavioral changes that may occur according to variations in the environments in which the child is inserted. This is important data for the therapist to evaluate environmental specificities favorable to the appearance of the complaint. When pertinent, it is possible to offer guidance to professionals who work with the child at school, in order to favor the initial management of the problem issues.

In addition, it is valid to establish what will be the best channel of communication between professionals (e.g., email and/or telephone), so that the exchange of information and guidance can occur continuously, as needed. In addition, the need for contact with other professionals who accompany the child, such as learning specialist, speech therapist, occupational therapist, psychiatrist, and neuropediatrician, among others, is reinforced. Such contact can help the professional to gather

important data on the history and also allows an aligned performance among professionals, offering an interdisciplinary approach.

Feedback to Parents

With all the data collected in the previous steps and through the analysis of the complementary instruments, the therapist should develop the case formulation. This process includes functionally analyzing the complaint-behavior, establishing the target behavior(s) of the intervention, and defining the form of action (cf. Eells, 2007).

For the feedback session, only the presence of the caregivers is required. Feedback is given on the clinical observations, the initial hypotheses, the initial intervention plan, and the structure of the work to be performed. Next, the aspects that the therapist believes should also be the target of the intervention should be presented. It is worth noting that not always what is put forward by the parents as a complaint covers what the therapist observed as clinical demand during the evaluation process. Thus, it is recommended that in the feedback session the therapeutic objectives be aligned with those of the parents so that they can adjust their expectations in relation to the therapeutic work. In this way, parents can also actively participate in the intervention, increasing engagement and therefore the possibility of successful therapy. Objectives are usually related to aspects that should be managed throughout the therapeutic process, both in relation to the child's repertoire and to the manipulation of environmental variables. Such objectives must obey a priority criterion, since covering all issues at the same time may cause the intervention to lack the solidity required for change. Therefore, the relevance of a given objective should be verified at each moment of the progress of the case, as well as the possibility of reaching the goal and the intermediate steps necessary for the long-term objectives to be achieved (Eells, 2007).

Regarding the structure of the work to be done, each case has its own particularities. In some cases, the intervention occurs more directly with the child. For example, one may aim to develop repertoires of naming feelings and ability to tolerate discomfort, which will allow the child to be more successful in dealing with the challenges posed by the environment. In other cases, a more intense parental participation may be crucial for the clinical intervention to allow the rearrangement of environmental contingencies through parental guidance and/or training or family sessions. Many times, the active participation of school professionals is also requested, as they constitute an important part of the child's environment.

The request for parents' participation, either more distantly or more closely, often faces some barriers. Some parents are unwilling to engage directly in the therapeutic process, justified by lack of time, low motivation to review their parenting practices, or by the expectation that the issue will be solved without the family's involvement. When these and other difficulties are observed, it is important that the parental motivation to participate in therapy is investigated and that the need for the parents' active partnership is clarified for the development of the work.

In addition to the points raised, the need for periodic monitoring of therapeutic objectives both for verification of the effectiveness of the process and for the establishment of the following objectives is also emphasized. That is, despite the information obtained and the objectives outlined in the initial assessment, it is understood that the assessment process needs to be maintained throughout the psychotherapeutic care. Additionally, it is understood that the verification of the effectiveness of the process should be composed by the report of the parents, the child, and other people of the acquaintanceship, as well as by the clinical observation of the therapist in session.

Conclusion

This chapter aimed to present a proposal for an initial structured assessment that includes an interview with the parents, observation of the child and of parental practices, and contact with the school and other professionals involved in the case. A proper delineation of the case may contribute to more targeted and effective interventions, increasing the likelihood of success in therapeutic intervention. Finally, it is worth pointing out that this is a specific proposal for a comprehensive topic, which is not restricted to a single model. Thus, it is expected that a continuous improvement of this model will occur.

Annex-I

INITIAL ASSESSMENT FORM

IDENTIFICATION

Date:

Patient's name:

Age: Date of birth:

Questionnaire completed by:

Address:

Neighborhood: City: ZIP CODE:

Home phone:

With whom does the patient reside?

Mother's name:

Training:	Occupation:

Mother's contact phone number:

Father's name:

Training:	Occupation:

Father's contact phone number:

Name and age of siblings:

School name:

Coordinator:	Professor:
Year:	Class:

Other professionals accompanying the case (name, profession and contact telephone number):

ISSUE

Reason for seeking therapy (describe):

ANALYSIS

How and how long ago did the problem appear?

....

....

....

....

....

Cite which contexts increase the problem:

....

....

....

....

Name the contexts in which the problem does not appear or appears less frequently:

....

....

....

....

....

How does the family currently deal with the child at times when the problem manifests itself?

....

....

....

....

....

....

CLINICAL HISTORY

PREGNANCY

Planned pregnancy: ( ) yes ( ) no

Complications (in pregnancy or delivery): ( ) yes ( ) no

....

Id:

....

....

....

....

Use of substance: ( ) yes ( ) no

....

Specify which and the frequency of use:

....

....

....

....

Any change in health: ( ) yes ( ) no ( ) do not know

Id:

Any developmental delay? ( ) yes ( ) no ( ) I do not know

Id:

HEALTH CHANGES

Hospitalization for diseases or accidents?
( ) yes ( ) no ( ) I do not know

What happened and when it happened:

Have you ever had neuropsychological evaluation? ( ) yes ( ) no

When:

NEUROPSYCHOMOTOR DEVELOPMENT

Age when he walked without support:

Age when he spoke his first words:

Age of defrosting:

-Daytime:

-Evening:

PSYCHOSOCIAL AND HEALTH ASPECTS

Stressful events prior to the current symptoms: ( ) yes ( ) no

Id:

Important changes in life: ( ) yes ( ) no

Id:

How was the family's life at the time of the onset of the difficulties?

Changes:

Financial situation:

Marital difficulties:

Difficulties with other children or family members:

PSYCHOSOCIAL AND HEALTH CONDITIONS

Diseases:

Diagnoses and comorbidities: ( ) yes ( ) no

Identify (note age at onset):

Use of regular medications? ( ) yes ( ) no

Name, dosage and time of administration:

Follow-up with other health professionals: ( ) yes ( ) no

Specify:

Cognitive development (compared to peers):

( ) equivalent ( ) above ( ) below

Specify:

Emotional development (purchased in pairs):

( ) equivalent ( ) above ( ) below

Specify:

When faced with new or stressful situations, he tends to have a posture: ( ) withdrawn ( ) exploratory

Self-regulation in the face of stressful situations (from preschool to the present):

Perceived skills, abilities and potentials (list and describe):

Relationship with peers (from preschool to the present):

Acceptance among peers: ( )high ( )medium ( )low

Specify:

PEER RELATIONSHIPS

Make friends easily? ( ) yes ( ) no

What are the name of his closest friends?

Have you ever been a victim of *bullying*, including *cyberbullying*: ( ) yes ( ) no

What happened:

SCHOOL LIFE

Age of school entry:

Adjustment to school start (describe):

SCHOOL LIFE

Which schools has he studied?

Name of the school	*Period*

Reason for exchange(s):

Child's current school experience:

- School schedule:

- Period:

- Academic performance (compared to peers): ( )equivalent ( )above ( )below

Specify:

- School support - Does the school support and collaborate with family positions and requests? ( ) yes ( )no

Describe:

Extracurricular activities: ( ) yes ( ) no

Identify (note frequency and when they occur):

Participation of the child in other out-of-school groups: ( ) yes ( ) no

Id:

ROUTINE

What is the child's study routine like at home?

Does the child do his homework on his own or with others?

STUDY ROUTINE	....
	Does the child have free time to play? At what times? ....
	Does the child help with household chores? Which ones? ....
FOOD ROUTINE	Eating routine (describe time and what is consumed): ....
	The times of meals are regular? ( ) yes ( ) no
	Does he accept well a variety of foods or are there any restrictions? Explain: ....
	Are meals taken at the table? ( ) yes ( ) no If yes, does the child remain at the table until the end of the meal? ( ) yes ( ) no
	Are meals taken separately or together with others? ( ) separate ( ) joint
	Does the child use any device (mobile phone, TV, tablet) during the meal? ( ) yes ( ) no Which ones: ....
SLEEP ROUTINE	- Usual bedtime:
	- Usual time to wake up:
	- Does the child take naps during the day? How many and at what time? ....
	- Does the child have pre-sleep routine? ( ) yes ( )no
EXERCISE ROUTINE	- Type and frequency of exercise: ....

FAMILY	
MEMBERS	Siblings: ( ) yes ( ) no Name and age:
FAMILY HISTORY	History of mental illness in the family: ( ) yes ( ) no Which (note the relationship):
RELATIONSHIPS	Long-lasting separations from those responsible: ( ) yes ( ) no Running time: Relationship between mother and child: ( ) assertive ( ) passive ( ) aggressive Describe: Relationship between parent and child: ( ) assertive ( ) passive ( ) aggressive Describe: Relationship between siblings and child:( ) assertive ( ) passive ( ) aggressive Describe: Handling done in situations of conflict with siblings (describe): Other family conflicts (list the main ones): Do you carry out activities together? Which ones?

CULTURAL/RELIGIOUS ASPECTS	Family identification with some cultural or religious tradition: ( ) yes ( ) no
	Specify:
	Cultural/religious practices: ( ) yes ( ) no Which ones:
FINAL ASSESSMENT	
FINAL ASSESSMENT	How do you understand/explain the difficulties that the child currently presents?
	Describe:
	Is the child aware of his/her own difficulty?
	Describe:

Annex-II

Support material for the child therapist					
Items to direct observation in session with the child		**Does**	**Does with mediation**	**Does not**	**OBS**
Survey of reinforceers	Appropriately describes preferred activities				
	Describes preferred foods				
	Names friends, family activities, tv shows, games, preferred sports				
Following rules	Accepts to interrupt ongoing activities during the waiting time at the reception				
	Respects the proposed session format				
	Follows the rules of activities and games				
	Accepts when prompted about session termination				
	In fantasy activities, demonstrates knowledge of social rules				
Self-knowledge	Appropriately speaks of lived experiences (those heard, felt, seen, and thought about)				
	Describes your behavior patterns				
	Orally describes contingencies related to the complaint				
	Describes contingencies of your life through playful resources				
	Describes characteristics that you consider qualities				
	Describes characteristics that you consider difficulties/defects				
	Describes characteristics that you consider important to develop/work				
	Can understand the relationship between experienced events and their emotions				
Frustration	Accepts when you are denied something you ask/would like to do				
	Asks for help/persists when he/she perceives difficulty in performing some activity				
	When he loses, he seeks alternative answers to achieve the proposed goal (asks for rematch, tries in other ways, etc.)				
	Shows proper competitiveness during the game				
	Has a regulated emotional response when losing in the game				

Support material for the child therapist					
Self-control and emotional expressivity	Knows how to name their own emotions and those of others				
	Can you describe your feelings in situations experienced				
	Tolerates frustrations				
	Demonstrates appropriate anger management				
	Demonstrates proper voice modulation				
	Expresses other emotions (e.g., fear/joy/sadness) appropriately				
Civility	Greets and says goodbye properly				
	Uses expressions of gratitude				
	Waits for your turn to speak				
	Asks and answers questions				
	Gives and accepts compliments				
	Respects hierarchy				
	Calls the interlocutor by name or nickname (e.g., aunt)				
Empathy	Shows interest in others				
	Observes				
	Pays attention to each other				
	Demonstrates listening to the other, responding to requests				
	Shows interest in others				
	Infers feelings from the interlocutor and demonstrates putting himself in their place				
	Expresses understanding of the other's feelings				
	Shows respect for differences				
	Offers help				
	Shares something you have				
Assertivity	Expresses negative feelings				
	Talks about strengths and weaknesses (of the other and of oneself)				
	Can maintain a dialogue initiated by the interlocutor				
	Agrees and disagrees opinions				
	Makes and declines orders				
	Deals with criticism and mockery				
	Asks for behavior change				
	Negotiates conflicting interests				
	Defends your own rights				
	Resists peer pressure				

Support material for the child therapist					
Problem-solving	Remains calm in the face of a problem situation				
	Recognizes and names different types of problems				
	Thinks before making decisions				
	Identifies and evaluates possible solution alternatives, chooses				
	Chooses, implements, and evaluates an alternative				
	Evaluates the decision-making process				
Academic skills	Follows rules or oral instructions				
	Observes and pays attention to what is said				
	Ignores peer interruptions				
	Imitates socially competent behaviors				
	Waits for your turn to speak				
	Asks and answers questions				
	Offers, requests, and appreciates help				
	Seeks approval for performance performed				
	Praises and appreciates compliments				
	Recognizes the quality of the other's performance				
	Fulfills orders				
	Cooperates and participates in discussions				

Items to direct observation of the environments in which the child is part		**Observed data**
Parenting practices	What disciplinary techniques do or do not work well?	
	Parents converge in parenting opinions and practices	
	What is the child's reaction to the parents' practices?	
	Quality of the commands (topography and what is produced with the commands)***	
	Parents are effective in describing and valuing desirable behaviors	
	Physical abuse	
	Inconsistent punishment (parents punish or reinforce the child's behaviors non-contingently)	
	Relaxed discipline (non-compliance with rules set by parents)	
	Negative monitoring (excessive supervision / large number of repetitive instructions)	
	Neglect (not attentive to the needs of their children)	
	Positive monitoring (parents' attention and knowledge about where their child is and the activities carried out)	
	Moral behavior (transmit values)	
	Parents demonstrate self-knowledge about the parenting practices used	
Social skills of parents	Follow parents' rules	
	Reaction to frustration (in the relationship with the child)	
	Self-control and emotional expressiveness	
	Civility	
	Show empathy with the child	
	Assertiveness when expressing yourself	

Items to direct observation of the environments in which the child is part		**Observed data**
Family	Relationship with siblings	
	Mediation made by parents in the relationship between children	
	Relationship with mother	
	Relationship with father	
	Relationship between parents	
	Relationship with another caregiver	
	Family dynamics	
	Parents' report on compliance with ADLs	
	Does it help with household chores?	
	Who gives more attention to the child? Why?	
	Do you spend a lot of time away from your parents?	
	Who in the family group does the child most identify with? Why? What are the identification points?	
Parental motivation	Parents understand that solving the problem will also depend on changes in their own behavior.	
	Parents are available to attend treatment	
	Parents are available to be involved in treatment (albeit remotely)	
	Parents are willing to learn and apply the guidelines given in the session at home	
	Parents are willing to review their parenting practices to help their child	
Complaint	What are the attempts made by the parents to resolve the complaint and what are the results obtained?	
	How did the complaint evolve, was there a change in frequency and intensity?	
	What are people's current reactions to complaint behaviors and why?	
	Does the child agree or disagree with the parent's complaint?	
School	Academic achievement	
	Relationship with peers	
	Is the school aware of the complaint?	
	Child self-regulation at school	
	Any school adaptation for the child?	
	Child's relationship with teachers	

Items to direct observation of the environments in which the child is part		**Observed data**
Friends	Do you make friends easily?	
	Who are the child's friends?	
	Is it very requested by the group of friends?	
	How are the relationships with colleagues, neighbors, etc.?	
Relevant data from the questionnaire		

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