Chapter 7
Functional Play: Ways to Conduct and the Development of Skills of the Clinical Behavior Analyst for Children

Ana Beatriz Chamati and Liane Dahás

Introduction

The beginning of the work of the child behavioral psychologist raises many questions. A considerable part of psychology courses do not teach relevant guidelines for the treatment of children. One of the main differences between adult and child psychotherapy is the constant search for alternative procedures to verbal reporting to access the child's world and for information about the variables that control their behavior.

One of the prerequisites of child care is the use of play as a clinical care tool, a practice also known as play therapy. Thus, psychologists who start attending children end up identifying the importance of play, as well as its effectiveness in the psychotherapy session as one of the most explored tools in psychotherapeutic context to evoke clinically relevant behaviors (CRB1) as described by Kohlenberg and Tsai (1991). In addition, it also plays a key role in clinical intervention and management, which makes it worthy of careful analysis.

According to Rule (2000), child psychotherapy is unique because (1) the child may have difficulty talking about his or her own feelings when they are unpleasant, since his or her behavior has likely been punished, (2) the child may have been poorly taught to name his or her covert behaviors, since the verbal community itself has difficulty establishing this training, (3) the child may fear being disapproved of by the therapist when reporting certain feelings, and (4) the child may fear that what he or she says to the therapist will be reported to his or her parents.

A methodology that has been shown to be effective for children to produce reports is the use of fantasy, games, and drawings. In this way, data collection in child therapy differs greatly from that of therapy with adults, since not only

A. B. Chamati · L. Dahás (✉)
Paradigma, Center for Behavioral Sciences and Technology, São Paulo, Brazil

© The Author(s), under exclusive license to Springer Nature Switzerland AG 2022

A. S. U. Rossi et al. (eds.), *Clinical Behavior Analysis for Children*,
https://doi.org/10.1007/978-3-031-12247-7_7

drawings and games are indispensable but also reports from adults with whom the child interacts, such as parents and teachers.

According to Moura and Venturelli (2004), the use of play is also effective for the therapy and the therapist to be paired with enjoyable activities, as well as for the therapist to plan situations in which the client explains antecedents and consequences of observed behaviors. Furthermore, the use of play can be useful to therapist and child analyze together the feasibility of more adaptive behaviors, which could even give the opportunity to practice them within the session.

For gestalt psychotherapist Violet Oaklander, "How she plays tells a lot about how she is in her life" (1978, p. 160). In her book, the author describes various techniques she has used in child care, including play, drawings, storytelling, etc. The psychotherapist can, in fact, use these techniques as a way of collecting data about his client, as well as teaching and training him (behavioral rehearsal) to have more appropriate behaviors in the environment, through activities such as fantasizing that he is another person, drawing, or playing in general.

Concept of Play

If, on the one hand, this chapter presents the possibility of using play with a therapeutic purpose, the most commonly used concept in the Portuguese language for playing means precisely doing something without any practical purpose. According to the definition of Dicionário Aurélio (2018), to play is "(...) [d]ivertise. To amuse oneself with something childish. To joke; to jest. To agitate in a mechanical way. To proceed lightly. To agitate (it is said of the waves)."

We then understood that, in a certain way, using play for psychotherapeutic purposes would make it lose its most central characteristic, that of being the result of spontaneity and lack of teleological biases. This theoretical discussion loses its importance, however, when we rely on a basic premise of radical behaviorism, which is that all behavior has function, even if the person behaving does not know how to describe it (or is not aware of it). Thus, if all behavior has function and if playing is something done spontaneously, we understand the phrase "children do not play at playing, they play for real" (Quintana, 2005, p. 805).

When a child plays house freely, it does not say that she does it to learn how to behave when she is older, in her profession, or when caring for her children; however, it is known that this turns out to be an important function of "imitating adult play" (Papalia et al., 2009, p. 292). Similarly, when children play freely representing the daily activities of their own routine, they tend to reproduce what they live in everyday life. Thus, this chapter presents, explains, and defends functional play, which would be nothing more than to maintain, in psychotherapeutic context, the typical spontaneity of play that occurs outside the office, provided that the psychologist knows how to conduct and describe for himself the functions that the actions of the players are presenting and how to use them for psychotherapy purposes.

Play in Child Development

Play is believed to be a way to develop skills, or in other words, to build knowledge. In several mammalian species, play during the first years of life has survival value. The game of hide-and-seek is common in several cultures around the world (Fernald & O'Neill, 1993), for example. The adult draws the child's attention with exaggerated gestures or sounds, hides behind a cloth or hands, and then reappears emitting specific, usually high-pitched, sounds. In the first 6 months, play primarily involves the adult's attempt to draw the child's attention to the start of play, which becomes less necessary as the months pass; until by age two, the infant is able to initiate play by covering himself or herself or by covering a doll (Rome-Flanders et al., 1995).

Papalia et al. (2009) describe the changes in the hide-and-seek play over the months involving more and more anticipatory responses of the infant to what is expected from the adult, indicating that the experience taught that child to react to what we call expectation. It is also possible that this play teaches him/her skills such as alternating turns during verbal episodes, responding attentively to the action of others, regulating emotions when facing the disappearance of the adult, or even developing the ability to deal with the permanence of objects, as pointed out by the Piagetian theory.

In addition to establishing a bond, play such as "Follow the leader" allows children to learn to coordinate their actions with those of other children, a behavior that enables the development of even more complex games such as "Police and robbers" and "Pike and hide," common in the preschool years (Eckerman & Didow, 1996). Make-believe play allows children to explore different social roles, identify other children's perspectives, and sometimes get in touch with emotions considered uncomfortable.

Culture strongly influences the content and partners of play: in Eastern cultures, for example, make-believe tends to be more cooperative and frequent with caregivers, who use this moment to teach behaviors perceived as appropriate (such as cooperation), while Western children tend to do imaginative play among their peers, developing autonomy and sometimes creating conflict situations, placing less emphasis on group harmony than Eastern children (Farver et al., 1995; Haight et al., 1999).

Gender typification is also, in part, a consequence of childhood play, in which boys and girls learn how their culture expects them to behave: mothers encourage their daughters to talk to them more than their sons (stimulating socialization and the expression of feelings), while fathers play more roughly with their sons than with their daughters (stimulating competition and aggression) (Leaper et al., 1998; Leaper & Smith, 2004). Gender specificities in peer play are also common across cultures and, from an evolutionary perspective, seem to promote training for later developmental periods in which appropriate behaviors for reproduction and survival of that gender should be emitted (Papalia et al., 2009).

As the examples above illustrate, for developmental psychology, children's play leads to the acquisition of skills, from the most basic, such as sensorimotor skills

(Papalia et al., 2009), to more complex ones, which involve verbal behavior, such as predicting the future, describing past events, mathematical concepts, planning, self-control, and cooperative responses. Although permeated with mentalistic explanations, the consumption of this literature allows behavior analysts to understand the importance of play and, therefore, to assume it as a psychotherapeutic practice.

Functional Play

The use of games and toys in clinical behavior analysis for children is relatively recent. The relationship between the child and the toy in psychotherapy has evolved since the child behavior modification (Krumboltz & Krumboltz, 1977), when the child was not considered part of the psychotherapy process and only the parents' complaint was treated without direct and frequent contact with the child (Gadelha & de Menezes, 2004). The behavioral assessment materials were inventories that assessed behaviors and symptoms present in anxiety, depression, aggressiveness, and shyness (Watson & Gresham, 1998). The therapist worked with parents to identify the child's problem behaviors, and their private events were not part of the complaint analysis (Conte & Regra, 2000). Experimental practices from laboratories were also used to modify the child's problem behaviors (Conte & Regra, 2000). Since the psychologist had no contact with the child, it was not possible to assess whether the parents' verbal report about their children corresponded with what the child presented in clinical context. Thus, play was far from being a tool for behavioral assessment and intervention, since the child was not even part of the psychotherapeutic process.

In 1960, child behavior therapy became a psychotherapeutic model (Gadelha & de Menezes, 2004). The child became the protagonist in the psychotherapeutic process, and his behavior began to be analyzed functionally in relation to his environment, such as parents, school, and peers (Gadelha & de Menezes, 2004). With these changes in the configuration of child therapy, the psychologist began to have direct contact with the child, and this relationship then became the target of functional analysis (Conte & Regra, 2000).

Thus, the need arose to accurately describe the behavior of the child psychologist, who identifies antecedents, responses, and consequences that make up a class of responses through what we call play. He also identifies variables that guide decision-making about the path to be followed. It is through play that the therapist evaluates the child's behavior and intervenes to modify what is presented as a complaint.

Although the definition of play is not precise within behavior analysis, it cannot be neglected that children play (De Rose & Gil, 2003). Playing requires spontaneity and pleasure and, whether done in a planned or free manner, is part of child development, presenting itself as one of the child's ways of communicating. In play, the child expresses feelings, wishes, and desires that often are not expressed verbally (De Rose & Gil, 2003).

Exploring the possibility of understanding what play behavior is, we cannot consider only the topography of the response. To this end, behavior analysts take into account the notion of reinforcing contingencies, which allows exploring the function of playing in child development (De Rose & Gil, 2003). Our behaviors are selected by the consequences produced in the environment (Skinner, 1953). Children need to learn to play, and, to do so, a wide variety of operant behaviors are necessary (De Rose & Gil, 2003). A baby lying in the crib, when swinging his arm, hits the hanging mobile and produces the sound of a song. This sound is a reinforcing consequence for the baby's behavior, so the probability that he will again swing his arm to produce the noise may increase. We then say that the baby is playing in his crib. We call this whole contingency play.

Toys can be discriminative stimuli, models, instructions, and consequences, and with them, from the child's initial repertoire, it is possible to refine behaviors and learn new ones. Thus, we use play and toys as an evaluation and intervention method, since it is possible to evaluate problem behavior and install new behaviors, modifying the child's relationship with the environment. Therefore, once the child has acquired a minimum repertoire to participate in play, it opens wide perspectives to refine and diversify the individual's repertoire in its motor, cognitive, affective, social, and verbal aspects (De Rose & Gil, 2003).

It's common to see children spontaneously playing with something that we don't necessarily call a toy. A class of stimuli can be called a toy if, in the presence of these stimuli, the child emits a single play response. When, in front of an object, the child manipulates, touches, handles, explores, stacks, looks, and puts in the mouth, among other actions, that's when we say she is playing. Thus, a toy is an instrument of the learning process, and playing is also a possibility to learn new behaviors in the face of certain stimuli. When recording the observation of playing behavior, we should pay attention to the most accurate behavioral description possible. It is worth remembering that in trying to propose a format for using play as a working tool in child therapy, we must never forget the individual analysis of each peculiar situation involving play, because two children may present the same topography in a given play, having different functions in each case.

When playing, free from any punitive audience, the child presents a behavioral repertoire related to his life story and expresses his feelings, values, secrets, and intimacy. Playing is a class of responses subject to functional analysis and behavioral management just like any other class of responses. Through play, children develop their ability to observe and describe what happens around them, increasing their knowledge of themselves and of others. When she plays, she shows her world and the behaviors she learned to relate to others. When she plays, the child is herself.

In general, playing freely, without demand, may be easy for some. On the other hand, functional play as a resource for the behavior analyst is a more complex skill that requires learning, training, study, supervision with more experienced therapists, and exposure to the universe of children, among others. All this brings more security in clinical performance for the use of any playful tool, forming an important baggage over the years of work.

Thus, we understand that functional play in the assessment phase involves the emission of responses typical of the behavioral repertoire of the child under analysis, allowing clinical behavior analysis for children to analyze the functions of such responses, and can also be used as an aid in the installation of new repertoire during the intervention phase[1]. Let's list some functions of play for the psychotherapist: (1) to bond with the child so that he/she will want to return for future sessions; (2) bring up themes possibly paired with aversive situations and that, therefore, elicit feelings such as anger, sadness, anguish, jealousy, etc.; (3) access the child's relationship with his environment, whether private or public; (4) evaluate the complaint; (5) install a new response; and (6) teach the child to observe antecedents and consequents of his responses, to help him identify the occurrence of similar behaviors in the natural environment.

Play as a Method of Assessment and Intervention

It is common for beginning therapists to report the feeling that they are just playing, without a clear objective, and that they are not using the tool of play as a method of assessment and intervention. Therefore, one must always keep in mind the following question: why and for what purpose am I doing this now? Whenever we use functional analysis structuring sessions, in an attempt to manage the target behavior, we are directing the play with psychotherapeutic function. We should always use play as part of this logic.

We will highlight two objectives presented above: playing as an assessment method and playing as an intervention method. At the beginning of the therapeutic process with the child, after the initial interview with the parents, the behavioral assessment phase begins. It is suggested that the first sessions be almost entirely intervention-free on the part of the psychotherapist. Obviously, if a child is about to hurt himself, take a risk, or break some material in the room, one should assess how safe and necessary it is to leave the child free to explore the environment. The behavioral assessment phase is most intense in the first four or five sessions, but is present throughout the psychotherapy process, since we are always evaluating the effect of interventions and clinical management strategies, as well as the maintenance of new behaviors.

In the first sessions, we should expose the child to different materials and situations. The focus is on observing how the child relates to the treatment room and therapist, rather than manipulating variables. What are the correspondences between the behavioral repertoire presented by the child and what the parents described? What is different from what the parents described? It is necessary that the therapist has knowledge of child development to evaluate any and all behaviors that the child

[1] It is possible that understanding the concept of a higher order (or second order) class of behavior may help the clinical behavior analysis for children in training to generalize their functional play repertoire. For further exploration, we suggest reading the ninth chapter of Catania (1999).

presents and that together may indicate some alteration in the development typically observed.

Some examples of behaviors to be evaluated are eye contact with the interlocutor; greeting when arriving for the session, verbally or with hug or kiss on the cheek gestures; literality; rigidity/flexibility; ability to play individually and with others, competing or cooperating; way of organizing the room, the game, and objects; drawings; appropriation of the therapeutic space; way of sitting; verbalizations about the room; preferences for activities and games; and if he tries new games. Everything the child does should be evaluated, and everything in the room can be a discriminative stimulus that evokes and/or elicits responses relevant to the clinical context.

After the evaluation phase, the intervention phase begins. This phase is planned to structure games that allow the child to learn alternative responses to the problem behavior presented, such as hitting, swearing, yelling, crying, difficulty expressing what they are feeling, and breaking rules, among others. When playing, the child exhibits the problem behavior and, through the therapist's intervention and management, learns alternative responses more adapted to the social context. The therapist should teach the child to understand that the problem is not feeling the emotions that the context elicits but how he/she experiences and expresses these emotions in the world. Thus, learning alternative ways of expressing emotions is a key goal of the psychotherapy process.

Listed below are some variables that should be taken into consideration by the therapist when choosing the play activity to be used:

(1) Target behavior selected for intervention and (2) its possible controlling variables (identification of antecedent and consequent that control the child's behavior): the initial sessions with the parents already bring numerous hypotheses about variables that maintain the complaint to be checked in the sessions with the child. Listing these responses is the first step to thinking of games capable of evoking them. It is also important to vary the play contexts to verify in which the problem behavior is more frequent. Children who arrive with a previous psychiatric diagnosis or if it is possible to identify in the symptoms described by their parents the possibility of a psychiatric diagnosis already bring the hints about the behaviors to focus on in child therapy. For example, children diagnosed with attention deficit hyperactivity disorder (ADHD) or oppositional defiant disorder (ODD) need to have their self-control and rule-following repertoires evaluated.

In this sense, any game with rules can be very effective in establishing both natural, winning the game, and arbitrary, therapist praise for having obeyed pre-established rules, consequences of behavior. Another function of a game may be to bring the child closer to an aversive theme, for example, using a game that contains the picture of a dog to evoke behaviors of a child who the parents described as someone who is afraid of dogs.

Baking a cake at home or making Jell-O can be medium-term consequence teaching contingencies, teaching the child to wait (the consequence of trying to eat them ahead of time tends to be aversive). Another possibility is to guide parents to make allowance available, educating children to think with spending categories

such as short, medium, and long term, associating them with the child's reality spending and desires. To do so, three boxes can be built (in session or at home with the parents) to help separate spending criteria, establishing the notion of monetary values, magnitudes of reinforcing value, and importance for the delay of the consequence. In session, it is possible to have a surprise box whose contents are only revealed at the end of the session.

(3) Activity appropriate to what is previously known about the child's repertoire and developmental stage: when presenting any activity to the child, it is important to know previously if it is appropriate for his/her age. A 12-year-old child will hardly wish to play with dolls and a house in session. In the same way, a 4-year-old child will hardly sit on the couch in the treatment room and discuss with linear speech and relevant details about possible complaints for treatment during the therapeutic process. It is necessary to take into consideration what the literature describes about what is appropriate for each age.

(4) Preferences and tastes of each child: the therapist should seek to know the children's universe for each age group: characters, sticker albums, movies, toys, etc. When not aware of something brought by the client, it is expected that the clinical behavior analyst for children will show interest, seeking to understand during the session or, even outside it, the context in which the toy/personage appears in the child's imaginary, and thus be able to use it for analysis or even intervention purposes.

(5) Degree of aversiveness of the activity: it is common that some activities, although unpleasant or unwanted by the child, are important for intervention, such as the presentation of a new game or a book with longer texts. In these cases, it is suggested to establish the *fade-in* procedure of the activity, i.e., that it be suggested and inserted gradually, allowing habituation of unpleasant responders and pairing the activity with some motivational stimulation (characters, costumes, songs).

The Premack principle (Catania, 1999) can also be used: it consists of presenting to the patient the possibility of engaging in an aversive activity with the possibility of engaging in another highly reinforcing activity. One can propose a hunt for pictures previously hidden in the office, a subsequent session involving a high-magnitude reinforcer, such as one outside the office to meet the therapist's pet, or even arrange for the child to borrow a toy from the office, which generates the teaching of trust, responsibility, and care, among others.

(6) Division of session time between the moment when the therapist proposes an activity and the moment when the client can propose what will be done: this is usually done in order to establish a routine for the therapeutic environment, usually beginning with an activity proposed by the therapist with a specific objective (which may be orally explained to the child, depending on the function) and ending with something chosen by the client. It is important to remember that the need for this division (or even this order) should be related to the management/intervention in each case. In some cases, it will be necessary to develop autonomy and decision-making in some children and especially in adolescents. In this case, it would be more advisable to allow them to have a more active participation in the choice of activities. In cases where the child shows natural motivation for the activities

presented by the therapist, as well as talking about the complaints related to the problem behavior, this division is not necessary.

(7) Availability of resources (material, time, space): there are several possibilities of materials for the development of play. We can use games, dolls, and play dough, create activities applied to therapeutic objectives, adapt the material according to the client's demand, and change the rules of games for specific purposes modifying the initial proposal, such as repeated album pictures used as a memory game.

(8) Unforeseen events during the session: one of the greatest difficulties of therapists, especially the less experienced, is to deal with unforeseen events during the session. Understanding that functional analysis guides our interventions and guides our decisions may assure the beginning therapist the possibility of experimenting with creating a playful situation adequate to the new context, maintaining the initial objective of the session or even changing it to another that emerges. All this is sometimes done in the company of the child itself. If the planning to read a book that will explore social skills repertoire does not make sense because the child came to the clinic crying after learning that the dog is sick, for example, the therapist should be sensitive to the demand brought, accept the suffering, and redirect the course of the session (e.g., to tasks of expressing emotions, and problem-solving). Many times, the therapist plays with the attachment function, and, if this is clear in the functional analysis, the therapist, beginner or experienced, will feel safe.

Below are some play resources for the child therapist and their clinical management possibilities:

(a) Board and card games: allow teaching obedience to pre-established rules, modifying rules to adapt to the needs of the case, evaluating the ability to cooperate, and using parts of the game with another function, for example, making the pins into interacting characters. We should be careful with games that teach theoretically about social and socioemotional skills, because children may not be interested. We also run the risk of the child verbalizing correctly what empathy or cooperation is, but the verbal discourse does not correspond with the child's doing/living outside the clinic.

(b) Fantasy: it is one of the richest resources with infants and toddlers. An imaginary friend allows bringing direction to some problem behavior in session, explores the capacity of creativity and problem-solving, and stimulates the development of social repertoire. The "fairy door"[2], which can be made by the therapist and introduced into the treatment room, functions as a possibility to train social repertoire and to talk about feelings and problems to the therapist in an indirect manner, as the child can write and draw for the fairy. Waiting for the fairy's response, which may occur in the following week's session or 2 or

[2] The fairy door is a small wooden door (or other material, like EVA, for example) that is used by the first author to connect the real world with an imaginary world of the child, bringing several possibilities of intervention. The child can write to the fairy about something they have difficulty with, which may or may not be part of the complaint, and they can share with the fairy some situation they have experienced. The child's drawing or letter is answered by the fairy when she passes by to pick up what the children leave for her, without having a certain day or time.

3 weeks later, also allows the child to develop his/her self-control and waiting repertoire.

Cloth dolls also stimulate fantasy: through interaction between the characters, we teach children to make functional analysis of the behavior of the characters and of themselves, and we can represent roles of difficult situations for the child assessing and creating new social repertoire. Playing with dolls involves exploring the natural environment in a non-aversive way and also emotional expression, representing the child's real environment, such as two houses in the case of separated parents. Many children speak through the dolls what they cannot speak directly to the therapist. It is possible for both the therapist to visualize the way the child manipulates the dolls in order to reproduce the home environment and for the therapist to represent situations from the child's life that he/she has knowledge of in order to analyze how the child reacts. The therapist can stimulate the child's critical thinking by asking what he thinks about the way the doll acted or how he is feeling.

The activity of playing at being the "problem detective," another possibility using the resource of fantasy, stimulates problem-solving step by step and also creativity, because the child asks himself questions, as if he were a detective, and, with each answer, creates a new question in an attempt to reach the final objective. It is noteworthy that it is even possible to have a magnifying glass in the office and interpret with the child as a detective.

(c) Children's books: these are rich tools and allow countless possibilities, such as observing the child's reading of both words and images, presenting an important theme for the psychotherapeutic process, exploring the attitude of the characters, and reflecting if the child knows someone who resembles a character in the book, among others.
(d) Play dough: allows exploring basic motor skills, fantasy with the construction or creation of objects, characters, food, identification, and naming of feelings in front of the material represented by the dough.
(e) Activities with paper, crayons, and markers: the possibilities are endless. It is possible to make free drawings, family drawings, and family drawings representing an animal for each family member or a goal, based on the individual characteristics of each family member; create stories from the drawings; and build comics with the children, decreasing or increasing the response cost of the child involving the participation of the therapist.

Conclusion

The clinical behavior analyst for children in training often enters this playful universe in such a pleasurable, genuine, and spontaneous way that we sometimes hear from students who feel in doubt whether they are playing to work or working to play. At this moment, our achievement of having contributed to the training of a child therapist becomes clear, leaving us with the hope that he/she will remain in

constant search for learning and improvement of his/her abilities to play functionally.

This chapter aimed to present the countless possibilities of creativity of management and clinical intervention in the clinical behavior analysis for children. Suggestions and ideas were presented, without exhausting by any means the infinite range of creative possibilities within the universe of functional play. It is important for the psychotherapist, based on his studies, supervision, reading, and clinical experience, among others, to create his own way of working, always considering that if there is a behavioral function, within ethical limits, we can act.

References

Catania, A. C. (1999). *Aprendizagem: Comportamento, linguagem e cognição* (D. G. Souza, trad. coord.). Artes Médicas.

Conte, F. C. S., & Regra, J. A. G. (2000). A psicoterapia comportamental infantil: novos aspectos. In E. F. M. Silvares (Ed.), *Estudos de caso em psicologia clínica comportamental infantil* (pp. 79–13). Papirus.

De Rose, J. C. C., & Gil, M. S. C. A. (2003). Para uma análise do brincar e sua função educacional. In M. Z. Brandão (Ed.), *Sobre comportamento e cognição: a história e os avanços, a seleção por consequências em ação* (Vol. 11, pp. 373–382). ESETed.

Dicionário Aurélio Online. (2018). https://dicionariodoaurelio.com/brincar

Eckerman, C. O., & Didow, S. M. (1996). Nonverbal imitation and toddlers' mastery of verbal means of achieving coordinated action. *Developmental Psychology, 32*, 141–152.

Farver, J. A. M., Kim, Y. K., & Lee, Y. (1995). Cultural differences in Korean and Anglo-American preschoolers' social interaction and play behavior. *Child Development, 66*, 1088–1099.

Fernald, A., & O'Neill, D. K. (1993). Peekaboo across cultures: How mothers and infants play with voices, faces, and expectations. In K. MacDonald (Ed.), *Parent-child play*. State University of New York Press.

Gadelha, Y. A., & de Menezes, I. N. (2004). Estratégias lúdicas na relação terapêutica com crianças na terapia comportamental. *Universitas: Ciências da saúde, 2*(1), 57–68.

Haight, W. L., Wang, X. L., Fung, H. H., Williams, K., & Mintz, J. (1999). Universal, developmental, and variable aspects of young children's play: A cross-cultural comparison of pretending at home. *Children Development, 70*, 1477–1488.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy: Creating intense and curative therapeutic relationships*. Plenum Press. https://doi.org/10.1007/978-0-387-70855-3

Krumboltz, J., & Krumboltz, H. (1977). *Modificação do comportamento infantil*. Editora EPU.

Leaper, C., & Smith, T. E. (2004). A meta-analytic review of gender variations in children's language use: Talkativeness, affiliative speech, and assertive speech. *Developmental Psychology, 40*, 993–1027.

Leaper, C., Anderson, K. J., & Sanders, P. (1998). Moderators of gender effects on parents' talk to their children: A meta-analysis. *Developmental Psychology, 34*, 3–27.

Moura, C. B., & Venturelli, M. B. (2004). Direcionamento para a Condução do Processo Terapêutico Comportamental com Crianças. *Revista Brasileira de Terapia Comportamental e Cognitiva, 6*, 17–30.

Oaklander, V. (1978). *Windows to our children: A gestalt approach to children and adolescents*. The Gestalt Journal Press.

Papalia, D. E., Olds, S. W., & Feldman, R. D. (2009). *Desenvolvimento humano*. McGraw-Hill.

Quintana, M. (2005). *Poesia completa*. Organização: Tania Franco Carvalhal. Nova Aguilar.

Rome-Flanders, T., Cronk, C., & Gourde, C. (1995). Maternal scaffolding in mother-infant games and its relationship to language development: A longitudinal study. *First Language, 15*, 339–355.

Skinner, B. F. (1953). *Science and human behavior*. Free Press.

Watson, T. S., & Gresham, F. M. (1998). *Handbook of child behavior therapy*. Plenum Press.