Chapter 9
Introduction to Functional-Analytic Psychotherapy with Children

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Behavior therapy changed its focus significantly after some therapist-researchers took the risk of applying the Skinnerian model to the clinical context. Although Skinner was not a therapist and was not specifically concerned with clinical problems, the theoretical and philosophical assumptions that he introduced within the scope of scientific behavior analysis led behavioral therapists to a new understanding and intervention with their clients. Several aspects of the Skinnerian approach, for example, the recognition of the value of self-observation, the analysis of private events, and the proposition of a functional analysis of verbal behavior and its influence on other behaviors, contributed to the overcoming of mentalistic proposals and to the construction of a truly behaviorist identity for behavioral therapy.

In the 1980s, two different groups of researchers led by Hayes (1987) and Kohlenberg and Tsai (1987) developed models of clinical intervention with adults from the perspective indicated by Skinner's radical behaviorism, which took shape in the 2000s (Hayes, 2004; Kohlenberg & Tsai, 1991). These models, in general, have been applied to clinical problems by providing a language and a conceptualization concerning human nature and the interaction between an individual's behavior and the natural environment. Although they follow different paths in strategic terms, both have congruent therapeutic goals. Hayes adopts an approach that aims to intervene on the control of behavior as a way to obtain the alteration of the client's specific problem. Kohlenberg takes the problem behavior itself as the unit and starting point for a comprehensive and broad functional analysis. Since the behavior

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occurs in the clinical context, the therapeutic relationship is seen as the appropriate instance to bring about the desired changes.

Functional-analytic psychotherapy (FAP), proposed by Kohlenberg and Tsai (1987, 1991), is part of what has been called third wave or third-generation therapies (Hayes, 2004; Pérez Álvarez, 2006). And, as such, it shares with other therapies of this generation the applications of advances in the study of behavior: the equivalence relations between stimuli, the behavior governed by rules, the functional analysis of verbal behavior, and its impact on understanding cognition and emotions (Fernández Parra & Ferro García, 2006).

According to Hayes (2004), what characterizes the third wave therapies is the greater attention to the context and functions of psychological phenomena and not only to their form. Therefore, they tend to propose contextual and experiential change strategies in addition to classical didactic strategies. These are treatments that seek, together with the client, to build a broad, flexible, assertive, and effective behavioral repertoire rather than a specific approach to narrowly defined problems. In short, third wave therapies focus on the way language affects experience, the therapeutic relationship, the concept of mindfulness, the self as context, and acceptance.

Although it was not designed for clinical practice with children, the FAP proposal seems to be well suited to the context of child psychotherapy (Moura & Conte, 1997). In the rest of this chapter, I analyzed how, from a certain point of view, the proposal of Kohlenberg and Tsai (1991) can be used in clinical practice with children and, in this way, also legitimize a radical behaviorist action of the child behavioral therapist. Although we consider the action of the child therapist with parents or carers fundamental, we will purposely exclude the discussion in this sense, since the purpose of this chapter is to specifically approach the FAP with children.

The FAP Model Extended to Therapy with Children

The FAP approach is based largely on a proposal to apply procedures based on the principles of behavior analysis within the limits of the typical clinical treatment context. One of these limits is established by the fact that the therapist-client contact is generally restricted to the moment of therapy, and it is difficult or almost impossible for the therapist to observe and interact with the client outside the session.

However, what is configured as a limit can also be an opportunity for significant changes from the intimate and intense relationship established between therapist and client, which offers the client a live learning setting, helping him to deal with the problem in the here and now and, thus, acquire skills to overcome his problems in daily life.

These conditions also apply to the context of child psychotherapy, because we hardly have access to the child outside the clinical context for some kind of intervention and, because he/she is a child, the relationship with him/her is also hardly distant or impersonal. Thus, given that the child audience “fits” the FAP proposal,

mainly because children's therapy works a lot with direct modeling, it becomes relevant to consider how the central characteristics of the approach of Kohlenberg and Tsai (1991) can be applied to work with them in order to intensify the possible results of the psychotherapeutic process.

The Use of Reinforcement

Reinforcement in the clinical context plays an important role in the FAP model, since the main aspect of behavioral-analytic treatment is direct modeling through differential reinforcement of required repertoires during therapy sessions. A well-known aspect of reinforcement is that the closer in time and space the behavior is in relation to its consequences, the greater the control exerted by them. This concept is fundamental to the work of the child behavior therapist, because in the session, as the interaction with the therapist takes place, based on the planned intervention, the therapist can model and strengthen the child's behaviors, desirable for overcoming his problems. When the same behaviors occur at home or at school, far from the therapist's direct observation, modeling becomes the responsibility of parents or teachers, not always sufficiently prepared for the task.

With the identification of the probable contingencies present in the natural environment, from the child's report or representation (drawings, stories, games, make-believe games), the therapist can act in an alternative way, confronting the child with a new way of understanding or dealing with the situation, thus weakening possible distorted perceptions and fanciful relations between events, giving the child the opportunity to experience new interactions that produce behavioral changes and emotional growth.

The child psychotherapist may have many artificial resources for reinforcement, such as rewarding the achievement of a certain behavioral criterion in the session, with colored stickers or access to a "secret," such as learning a magic trick, for example. Kohlenberg and Tsai (1991), however, point out that natural reinforcers, that is, spontaneous actions and reactions between client and therapist, are usually potentially more powerful in generating significant change. In the natural environment, the spontaneous expressions of people involved in an interaction are reinforced by the reciprocal positive responsiveness between them. Thus, for example, if the child's expression of affection is a target behavior and the therapist also has a spontaneously affectionate reaction when she emits it, the reinforcement will most likely be natural, which favors behavioral generalization in this direction.

Arbitrary reinforcement, however, can be useful as a transitional procedure in child therapy. It can increase sensitivity to environmental stimuli more quickly and make it easier for the therapist to conduct more concrete analyses of the child's own behavior. On the other hand, arbitrary reinforcement can also replace or interfere with the possibility that natural reinforcers gain control over behavior (Ferster, 1979). For this reason, they should be used sparingly, although experience shows

that, in general, children "dismiss" arbitrary stimuli, as if they no longer made sense when compared to naturally reinforcing consequences inherent to the behavior.

Clinically Relevant Behaviors (CRBs) and the Clinical Environment as an Agent of Change

Kohlenberg and Tsai's (1991) model is also characterized by its attention to the specification of behaviors of interest. The term "clinically relevant behavior" (CRB) includes both problem behavior and target behavior. Thus, the child psychotherapist needs to be a skilled observer, because careful clinical observations are the basis for defining CRBs. Obviously, the child's problem behavior cannot be directly observed unless it happens in the therapist's presence, even if the therapist can obtain a good description through the parents' or other observers' report or can watch it through a videotape recording. Thus, the therapeutic environment will be considered adequate for promoting direct changes if the problem behaviors presented by the child are of such a nature that they can also occur during the session. Based on this criterion, the functional-analytic approach focuses on problems of the outside world that also occur during the session, which does not mean that it is not also possible to deal with those that do not occur, such as enuresis, for example.

The applicability of this aspect to child behavior therapy needs to be well understood, because the problems that children present may occur in the session, both directly, in the therapist-child relationship, and indirectly, in the way they behave during the proposed playful situations. Thus, a child with complaints of aggressiveness, for example, does not necessarily need to attack the therapist in order for him to deal with the problem (in fact, it is more comfortable if this does not occur, although it may eventually happen) but may demonstrate this pattern of conduct through story characters or a toy situation.

The play or story may show the therapist the contingencies that established the child's aggressive behavior and provide a good opportunity to investigate its current function. During this analysis, the therapist may also discuss with the child the alternatives for more socially appropriate behavior of the character, request the emission of more cooperative behavior in the game, or discuss the similarities between the behavior of the character in the story and his own or between the behavior emitted in the game and the behavior with friends at school (Conte & Regra, 2000; Moura & Conte, 1997). This information will also serve as important subsidies for guidance to parents and other adults of interest.

The selection and discriminability of CRBs by the child therapist will be facilitated if he/she has developed, in his/her personal repertoire, the target behaviors he/she wants to achieve with the child. This seems obvious because the therapist is an adult and the client is a child, but in practice it is not. It means having developed in yourself skills considered appropriate and been able to observe similar reactions in the child, such as remaining relaxed, knowing how to play and have fun, knowing

how to deal with frustration and defeat, and dealing with demands and pressure. They also need to have the ability to do things that children like, be flexible and creative, and not be anxious about obtaining immediate positive results (Conte, 1993). These characteristics of the therapist will help the child to adapt more easily and quickly to the clinical environment and to present his most typical and "natural" reactions. Importantly, when observing and assessing the appropriateness of the child's behavior, the therapist should be sensitive to the child's level of development and to the characteristics of the current context and social environment in which the child lives.

According to Kohlenberg and Tsai (1991), a factor that restricts the range of target behaviors selected in a traditional therapy is the requirement that these refer only to the observable. They state that, in practice, it is almost impossible to achieve such objectivity when faced with applied problems, that inferences are not only necessary but useful. In many moments, the therapist needs to use his own "personal impressions" to raise hypotheses and verify the functionality of certain behaviors. This applies to the child therapist as well. The FAP therapist intervenes by testing his hypotheses: if they are confirmed, his acting strategies can be maintained; otherwise, others should be implemented. The important thing is that the professional is guided and reinforced by the client's improvements and progress, also outside the clinical environment.

Traditionally, the best way to create conditions for the generalization of the progress obtained by the client would be to conduct therapy in the same environment where the problem occurs. In Kohlenberg and Tsai's (1991) view, this is not necessary, as there is a functional similarity between the therapeutic context and the client's daily environment and clinically relevant behaviors tend to occur in both. This concept radically changes the child behavior therapist's practice, as he can, through his relationship with the child, directly evaluate the occurrence of both problems and improvements and thus favor the generalization of progress.

In summary, the most important characteristic of a problem that makes it suitable for child FAP is the possibility of its occurrence during the therapy session. This conclusion is based on the following assumptions: (1) the specific effects of therapy result from events that happen during the session, and the only controlling events that can happen at that time are discriminative – therapist can function as a discriminative stimulus for a situation in which certain client behaviors are more likely to occur; eliciters – therapist can evoke client emotional responses, sensations, images, or thoughts; or reinforcers – therapist reacts in ways that increase the occurrence of certain client behaviors; (2) occurring within the session, these events will have greater effects on behavior occurring in the same environment, so improvements may be naturally reinforced by contingencies provided by the therapist or conditions arranged in therapy.

The CRBs of Children in the Process of Therapy

Live learning opportunities emerge in the therapeutic relationship when the client emits clinically relevant behaviors in relation to the therapist's person. These are moments when behavior can be modeled directly from the effects on the relationship. Kohlenberg and Tsai (1991) describe three types of client behavior that may occur during the session, of particular relevance to the therapeutic process. In this sense, although the whole description refers to the clinical context with adults, children seem to demonstrate more clearly during sessions the clinically relevant behaviors with which you can work.

CRB1 refers to instances of behavior that happen during the therapy session that are occurrences of the clinical problem. These behaviors should decrease in frequency during the course of therapy. CRB1s usually consist of avoidance behaviors that, in the client's daily life, are under the control of aversive stimuli, which are often accompanied by negative emotional states. A child's rude behavior in answering her questions may be both proximity avoidance, due to negative experiences with attachment figures, and a resistance to yielding to her control, due to a history of "being obeyed" by the adults in her environment.

Children may come to therapy with low self-esteem and a low sense of competence, showing dislike for themselves, not feeling able to achieve or recognize success and social approval in their accomplishments. Or they may arrive with apparently "high" self-esteem, also hiding a sense of social or academic incompetence. In any case, they will relate to the therapist in the way they relate to other people and will provide samples of the problems to be worked on.

Here are some examples of behaviors to be observed: does the child look at you, greet you, and smile? Does he/she enter without the mother, or does he/she enter with the mother and accepts to stay without her? Does the child follow your instructions or ignore your commands? Does the child look around and pick up objects or walk around the room? Does he/she talk like a baby? Does he/she make a point of cooperating or contradicting? Is he pushy, agitated, difficult to remain seated? Stubborn, knocks things over? Concerned with organization or cleanliness? Impatient, irritable, short tempered? Does he/she bite fingernails? Keeps hand or fingers in mouth? Refuses to try a game/activity that he/she does not know or chosen by you? Is shy, timid, soft-spoken, monosyllabic?

Children often use indirect communication through play, drawings, and stories to demonstrate their feelings and other related behaviors, such as their perception of the environment. These are rich opportunities for observation and identification of CRBs1. They may frown after losing a single game, draw tiny pictures in a corner of the paper, tear up their drawing and throw it in the trash (or tear up their drawing!), model a family of snakes with play dough, or model a cage with the whole family inside.

When the therapist participates in the fantasy and, through it, provides opportunities for children to experience new experiences indirectly, they tend to gradually acquire greater self-control and begin to communicate more directly. By acting this

way, the therapist provides the child with the feeling of being understood and supported and thus creates a less aversive context for the development of the child's ability to recognize, analyze, and change problematic behaviors and feelings, paving the way for more adapted behavioral solutions, which, according to FAP, constitute the CRB2s.

CRB2 refers to those repertoires whose absence or low strength are directly related to the present problem. These behaviors must increase in strength during the course of treatment to indicate progress or improvement. During the early stages of treatment, these repertoires are usually not observed, probably due to the lack of experiences in their natural environment that could have favored the development of these types of behavior. Possible CRB2s include assertive behavioral repertoires, positive emotional expressiveness, appropriate problem-solving, higher self-esteem, and a greater sense of competence, among others.

Let us return to the hypothetical situation of the child who presented a rude response to the therapist's questions and proposals for activities, as a proximity dodge. Now she responds without rudeness, draws a picture to give to the therapist, hugs him on the way out, and spontaneously tells facts about her week. Or, for example, the child who was always obeyed accepts to play "follow the boss," asks (not tells!) to do some specific activity, accepts to wait when the therapist tells him they will do it the following week. These are small changes in the desired direction, modeled very probably by the reinforcing characteristics of interaction with the therapist, who reciprocally responds to pro-social behavior and affective interaction. Another example is the child who "doesn't remember" what happened when the therapist approaches him about occurrences of the problem behavior during the week. When he realizes that he will not be punished in this environment, he begins to "remember," reports such occurrences more spontaneously, and accepts your suggestions for alternative solutions.

Progressively, the child begins to use more direct verbal communication in therapy, using more of the "I" and less of the "fantasy character." At this point, more directive interventions and strategies can gradually be introduced. When the child becomes more aware of his open and covert behavioral patterns, he will be able to produce changes in his environment, collaborating with the efforts of the responsible adults. Experience has shown that modeling and reinforcing the CRB2s during the session favors the generalization of therapeutic gains to situations outside the clinic, by the same principle of functional similarity.

As a result of the previous step, CRB3 is constituted by children's verbalizations about the correspondence between CRBs 1 and 2 and their controlling variables. It refers to children talking about their own behavior and what seems to cause it. More specifically, this involves the observation of the behavior itself and the associated reinforcing, discriminative, and eliciting stimuli. This description of functional relationships can help the child make generalization of their progress and obtain reinforcement in daily life. According to Kohlenberg and Tsai (1991), CRB3 repertoires also include descriptions of functional equivalences that indicate similarities between the situation-stimulus present during the session and those occurring outside the treatment.

According to this definition, developing CRB3 seems a big, or even impossible, task for children. Experience has shown that, on the contrary, respected the limits of their development, children discover this reasoning and use it in a special and useful way. For example, one of the author's patients, 8 years old, practically "fought" with her because of an attentional training with the use of Sudoku on the cell phone. As he presented some difficulty, he refused and wanted to give up in the middle. In one of the sessions when he was close to finishing and the therapist held him in the activity for him to finish it, he left angry saying "I hate you and your Chinese puzzle!" But the next session, surprisingly, he asked to do it again and did much better. The therapist celebrated the effort and praised the initiative, as well as the result, and ended by saying "we even fought about it last week, remember? It was ugly what I did, do you forgive me? You were just teaching me something that I have to do at school too, wasn't it? Now I've learned that I can do it".

It is not always possible, however, for therapists to observe the achievement of this stage, not because the children are not capable but because, when progress starts to occur, many parents interrupt the therapy, for feeling satisfied with the partial results obtained or bothered with the increase in the child's autonomy, expressiveness, and assertiveness (Moura & Conte, 1997). However, the achievement of such goal may figure as a discharge criterion in child therapy, since it impacts the child's global development.

The Skills of the Functional-Analytic Child Psychotherapist

The assessment procedures in FAP to generate clinical hypotheses and monitor the client's progress are the same used by other child therapists: interviews, self-reports, questionnaires, records, drawings, stories, and games. Throughout the treatment, however, he interacts honestly with the child, expressing his feelings to her and her behaviors in order to intensify the therapeutic relationship and make the therapeutic setting a place of genuine learning.

Given that psychotherapy is a complex interactional process involving multidetermined behaviors, Kohlenberg and Tsai (1991) suggest some rules for the therapist's behavior, which, according to them, if followed, result in reinforcing effects. The first rule prescribes the development of a good observation repertoire, as a prerequisite for the therapist to identify possible instances of CRBs occurring during the session and, thus, to react appropriately and consistently to them. Observation can increase the likelihood that progress will be reinforced and inappropriate behaviors extinguished or punished.

The second rule is widely used by child psychotherapists: building a therapeutic environment favorable to the evocation of CRBs. With children, it is not possible to work only at the verbal level, and it becomes necessary to use the playful language, proper of children. According to Conte (1993), when attending children, the therapist should explore the behavior of playing through strategies that interest them, such as drawings, comics, storybooks, painting, music, and other playful resources,

as a form of metaphorical expression of the child about his relations with the world and his public and private reactions. Play helps to make explicit to the child the antecedent and consequent situations of their responses and to identify the occurrence of similar behaviors inside and outside the session, as well as to raise with the child more adaptive alternatives to the problem they face and to train new skills.

The third rule calls the therapist's attention to the value of immediate positive reinforcement of CRB2s. If problem behaviors can be detected and worked on within the clinical situation itself, it is assumed that improvements can and should also take place within the session and thus be valued and strengthened by the therapist. For reinforcement to occur appropriately, the therapist must be clear which incompatible behavior should be reinforced so that he/she can then be sensitive to small behavioral changes towards the desired improvement. When the child begins to abandon his inadequate behavior patterns; to present a more positive interaction with the therapist, significant others, and his environment; and to develop more appropriate problem-solving alternatives, it is time to value such progress and feel reinforced by it.

Being able to naturally reinforce the client's improvements by feeling reinforced by them is an important therapeutic skill, and, to help therapists acquire it, Kohlenberg and Tsai (1991) proposed a fourth rule: it is important that the therapist develop a repertoire of observation of the potentially reinforcing properties of his or her behavior, contingent on the occurrences of the client's clinically relevant behavior. This rule, basically, prescribes a good repertoire of self-awareness and self-observation for the therapist, so that he/she can discriminate during the therapeutic process which of his/her reactions evoke the child's problem behavior and which reinforce the development of the target behaviors.

Thus, during the consultations, I adopted the practice of playing, saying that I will "faint with emotion" when they achieve something difficult. Depending on the child's reaction to the first use of the joke, we can tell if it will have a reinforcing effect or not: some children look at me with a face of "that's not funny," and others burst out laughing and ask to see another fainting spell. The fourth rule increases the therapist's discrimination regarding the therapeutic function of his personal resources, always keeping in mind that a reinforcing relationship with his client is fundamental to the process.

The fifth rule emphasizes the development of a repertoire of description of functional relations between the controlling variables and the child's behavior, a priority for good therapeutic performance, because it would be incongruous to intervene and try to help the other to develop self-awareness when one does not understand the interrelations and determinations of the behavior in focus. For the 8-year-old Sudoku fighting client reported earlier, my response was: "Wow, you achieved two difficult things: doing Sudoku in record time and finding out why we are training to do difficult things!"

This is a simplified response to the child. Behind the scenes, the therapist needs to understand the more complex relationships established between the child and his/her family, school members, friends, and agents of other social institutions. In this case, why does a child cry and stop trying to complete his activities at school at the

slightest sign of difficulty? How did the family install this behavior protecting the child from bigger problems? And how did what seemed an adequate protective attitude turn into a problem, with daily crying and a drop in school performance? A comprehensive analysis makes it easier to plan a focused intervention, but one that produces equally comprehensive results in the shortest time possible.

General Aspects of Child Therapy and Final Considerations

With regard to its structuring, starting from what happens in the therapeutic session, the application of FAP in children does not differ significantly from its application in the adult population, as already described above. The difference is in the fact that the goals need to adjust not only to the child's behavior but to what is feasible for him/her according to his/her age and developmental level (Cattivelli et al., 2012), in addition to considering how parents can (and if they can) contribute, both to solving the child's problem and to minimizing the impact that family problems may be having on the child. Another point of consideration is the knowledge of what certain circumstances or adverse conditions usually generate in children. There are situations in which knowledge of certain behavioral patterns, based on scientific evidence, leads the therapist to formulate more appropriate hypotheses and thus better plan his interventions.

The great contribution of FAP lies in the precise description of what therapists should do and how to do it. However, little is still known about the important variables that direct therapeutic decisions, although research is being conducted in this direction (Romero-Porras et al., 2018). What leads a therapist to choose one direction or another within the therapeutic interaction has been a topic of study and discussion for some time now (Moura & Venturelli, 2004). Intervention with children based on FAP principles allows child therapists to apply scientific principles and work consistently within behavior analysis.

In fact, much of what Kohlenberg and Tsai (1991) managed to systematize and conceptualize in relation to clinical practice in behavior therapy has already been used for some time, in another way and under other theoretical bases, by psychotherapists of various approaches. For example, Oaklander (1978), working within the Gestalt approach, describes in his book a psychotherapeutic work with children, based mainly on the experiences that occur during the session and in his relationship with them. His approach could well be considered a practical and very functional way of applying the strategies arising from the FAP in children's clinical practice. Although technically useful, such a work does not have the purpose and, therefore, does not contain the conceptual basis that subsidizes the proposal of Kohlenberg and Tsai (1991). This is the great gain for behavioral therapists, who can increasingly expand and intensify their intervention in a consistent and scientific manner and create stronger links between clinical practice and behavior analysis.

Finally, a word about the therapist. To be ready for this type of work implies the development of his self-knowledge and a constant self-evaluation and support, if

possible through personal psychotherapy or therapeutic supervisions. Without this, the analysis of the therapeutic relationship can be something complex, costly, and risky, even in work with children. For this is the proposal of FAP: that the special and unique relationship between client and therapist is the main vehicle for change.

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