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Guiding Theory for Therapy with Children and Adolescents

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Specifiable theory can guide the design, implementation, and evaluation of treatments, and treatment programs for children and adolescents are no exception. Theory provides proper initial guidance for clinical endeavors.

Even basic descriptions of any one of the various psychological therapies are related to some form of a guiding theory. For some therapies, the theory is an extrapolation from clinical experience; for others, the applied theory is an adaptation of a complementary theory from a more basic area of psychology, and in still others, the theory is built upon and extended from empirical research. Theory guides us in clinical work and in empirical evaluation, and the resulting data guide further theoretical development and related applications. Theories of stable traits are interesting and important, but the most direct and useful theories for clinical work are those that help to explain the processes of change.

Given our focus on children and adolescents (i.e., youth), we can benefit greatly from consideration of theories that deal with psychological change in youth, and that address aspects of human development that unfold during youth. What may be alarming, especially to those well versed either in theories of behavior change or of human development, is that until recently there has been precious little connection in applied work between these two areas. As will be evident in the chapters in this volume, cognitive-behavioral approaches to treating behavioral and emotional problems in youth have paid attention to and been guided by such theory. And, importantly, as will be evident in the chapters that follow, the cognitive-behavioral approaches described herein have also been evaluated with rigorous methodologies.

In this chapter, along with consideration of other related themes, I outline a cognitive-behavioral theory in which behavioral events, associated anticipatory expectations and postevent attributions, and ongoing cognitive information processing and emotional states

combine to influence behavior and behavior change. Relatedly, the theory adapts to the different challenges facing different levels of development. The theory is problem solving in its orientation, deals directly with the cognitive forces that impact social information processing, incorporates emotional and social domains, addresses matters associated with parenting and families, and emphasizes performance-based interventions. The applications of the guiding theory employ structured and manual-based procedures. A closer look at each of these features is informative.

Without exception, humans routinely experience problems that require solutions. Quite simply, problems occur! The ability to recognize a problem and address it (problem solving) is an essential ingredient to adequate adjustment in childhood, adolescence, and across one's life span. Youth face different developmental challenges as they move through childhood and adolescence, and these youth differ in their ability to recognize a problem, to manage their emotional arousal, and to generate and consider possible solutions. Importantly, their ability to generate alternative solutions and evaluate each option competently will form an important basis for the quality of their psychological health. A problem-solving orientation is seen in many of the empirically supported psychological treatments (see Silverman & Hinshaw, 2008) for disorders of youth (Hibbs & Jensen, 2005; Weisz & Kazdin, 2010; Ollendick & King, Chapter 17, this volume).

As we all know from our own lives, problems of all sorts can occur, without provocation or effort. Optimal solutions to problems, in contrast, do not materialize from thin air, nor are they handed to someone carte blanche. And, in instances when solutions appear to jump out or to be provided by someone else, they are not always the optimal solutions. A child who has someone else solve his or her problems is not him- or herself benefiting. Rather, successful solutions often require some time and effort, then emerge from an individual's active use of thinking—or, as we call it, involvement with cognitive strategies.

Cognitive problem-solving strategies are not transmitted magically from parents to children, but they are acquired through experience, observation, and interaction with others. As is evident in the chapters in this book, the use of cognitive strategies can be maximized through intentional and planned intervention activities. Varying styles of information processing have profound effects on how one makes sense of the world and one's experiences in it, and dysfunctional information processing requires attention and modification (e.g., Ingram, Miranda, & Segal, 1998). Correcting faulty information processing (i.e., changing distorted thinking) and/or teaching strategies to overcome a deficiency in information processing (i.e., overcoming deficiencies in thinking) (Kendall, 1993) are both valuable steps in the treatment of psychological disorders of youth.

Is cognitive-behavioral therapy concerned with emotions? Yes. Our emotional states, both positive (Diener & Lucas, 1999) and negative, influence our cognitive and behavioral abilities. Indeed, an induced positive emotion influences the threat bias seen in anxious youth (Hughes & Kendall, 2008). The absence of positive emotions can have unwanted effects, and a sensitivity to dwelling on negative emotions can be distressing as well. What is especially interesting is that positive and negative emotions are not opposite ends of a single continuum; rather, each is a continuum of its own. Learning about the nature and regulation of emotions (e.g., emotion management skills) can provide a solid building block for advancing one's well-being (see other chapters in this volume). It simply is not enough to know how to think through problems; conditions of persistent emotional arousal, as well as transient but impactful emotions, can interfere with efforts to think reasonably! Effective cognitive problem solving requires an understanding of the experience and modification of emotions (Suveg, Sood, Comer, & Kendall, 2009), and effective interventions require recognition, consideration of, and therapeutic attention to emotional states (see Suveg, Southam-Gerow, Goodman, & Kendall, 2007).

Are social and interpersonal domains important? The psychological problems in need of solutions are not *im*personal problems (e.g., how to distribute weight when loading a trailer) but are *inter*personal (social) ones (e.g., how to adjust to maturing physiology and changing family roles). Mental health professionals are interested in effective adaptation and adjustment (coping) in social situations. Note that developmental theory has uniformly underscored the importance of social relationships (peers [see Hartup, 1984] and family) to psychologically healthy adjustment. Therapy is an interpersonal process, and the child's involvement in therapeutic interactions is associated with favorable outcomes (Chu & Kendall, 2004). Social/interpersonal domains are of special importance in clinical interventions.

Not surprisingly, theory must address matters associated with parenting and families. Indeed, it is common lore, and partially supported empirical practice, that the inclusion of parents in the treatment of youth with behavioral and emotional problems adds to the benefits gained by treatment. What may be surprising, however, is that the nature of this involvement varies across child problems and with development. Consider parental monitoring. Parents of youth will conduct disorders will likely be shaped by treatment to increase monitoring of their children's activities, whereas parents of anxious youth would likely be less vigilant in overseeing their children (e.g., Barmish & Kendall, 2005). Improvements in children's adjustment may be better when parents are included in sessions—or better when parents are intentionally separated from their children. Younger children, such as a separation-anxious child, may benefit more when parents are included from the start, whereas an adolescent with depression may want to be separate and may benefit more when the parent is not included in treatment sessions. Parents play a crucial role, but cognitive-behavioral interventions vary the role to be in concert with the empirical evidence on parental inclusion, and with the variations needed given different disorders and different levels of development.

Cognitive-behavioral procedures for children and adolescents typically follow a manual-based or structured approach to treatment. Is this a good idea? Manual-based interventions have generated lively discussion (see *Clinical Psychology: Science and Practice*, Vol. 5, 1998) and prompted efforts to "breathe life into a manual" (e.g., Kendall, Chu, Gifford, Hayes, & Nauta, 1998). Like theory, structure provides an organization and guides the treatment: an understanding of the target problem and the nature of its experience for the youth, as well as an arranged set of progressive experiences that build on what we know about the disorder—its cognitive, emotional, behavioral, social, and familial features. Having these empirical bases folded into the content of the treatment manuals optimizes the beneficial gains we can expect the youth to attain. In addition, a manual-based approach helps keep the therapists focus on explicit goals, offers a suggested pace, and provides sequenced steps for movement toward the goals.

It is important to recognize that manual-based treatments are *not* inflexible or rigid cookbooks—they are intended to be applied with "flexibility" (Kendall & Beidas, 2007). Indeed, our suggested catchphrase is "flexibility within fidelity" (Kendall & Beidas, 2007; Kendall, Gosch, Furr, & Sood, 2008)—meant to communicate that one can adhere to general treatment strategies while simultaneously making adjustments to personalize the treatment; that is, a manual-based intervention provides the guidance to apply strategies in order and with focus, but there can be and are adaptations that, remaining consistent with the cognitive-behavioral strategies, provide flexibility to adapt to individual youth. Likewise, workbooks for the child-client to use in treatment provide opportunities to learn new skills and allow for structured practice. For example, the *Taking ACTION Workbook* (see Stark, Streusand, Arora, & Patel, Chapter 6, this volume) provides training materials for use of cognitive-behavioral strategies to overcome depressed mood, whereas the *Coping Cat Workbook* and the *C.A.T. Project* workbook (see Kendall, Chapter 5, this volume) provide sequenced tasks for the management of unwanted and disturbing anxious arousal. Com-

puter-assisted applications are also available (Kendall & Khanna, 2008; Khanna & Kendall, 2010), and other examples of sequenced interventions exist throughout this book (see also *www.workbookpublishing.com*). Workbooks are consistent with the mode of learning that is common for school-age youth. Manuals and workbooks provide organization and structure to guide treatment; they are not inflexible boundaries.

Why should a guiding theory place an emphasis on performance-based interventions? Some interventions, often targeting adults, and often those of more historical interest, may be geared toward helping the client gain insight or understanding. In contrast, cognitive-behavioral interventions focused on youth typically intend to remediate skills deficits or correct distortions in thinking, emotions, or action, and it is through performance-based procedures (and practice) that such goals are best accomplished. Practice, with encouragement and feedback, leads to further use and refinement of social and cognitive skills. Involvement in these performance-based activities is encouraged and shaped to firm up intrinsic interest or to promote motivation in otherwise disinterested participants. For youth, it simply is not enough to try to talk about what changes may be needed; their level of cognitive development may not be sufficient, and their skills, without opportunities to practice, will not be honed. Not unlike schoolwork, sports, or musical expression, practice is a crucial part of the optimal intervention.

In this the fourth edition of *Child and Adolescent Therapy* expert authors have provided the details of refined and advanced treatments developed and evaluated for specific youth problems. Importantly, the evaluations have resulted in favorable outcomes, often leading to the treatments being described as "empirically supported." Interestingly, the approaches hold together very well in terms of the dimensions discussed thus far; that is, as will become even more evident throughout the book, the guiding cognitive-behavioral theory has more than one facet and is appropriate in multiple applications. The theory places greatest emphasis on a therapist helping youth to advance his or her cognitive information processing in social contexts by using structured, a behaviorally oriented practice, while concurrently paying attention to the participant youth's emotional state and involvement in the tasks of the treatment. As needed, members of social groups (e.g., peers, parents) are included. As central as a guiding theory is to the provision of interventions, it is nevertheless crucial that the intervention be examined and evaluated for efficacy and effectiveness (see Chambless & Hollon, 1998; Ollendick & King, Chapter 17, this volume). A guiding theory is necessary but not sufficient. Empirical support for an intervention is a priceless key to the choice of one intervention over another, and to the assignment of the label "best practice" or "empirically supported" (see Kendall, 1998). Interested readers can search the Web and locate independent resources (e.g., the Association for Behavioral and Cognitive Therapies (ABCT) Web page on empirically supported treatment for children and adolescents; the Substance Abuse and Mental Health Services Administration (SAMHSA) review) that have examined and reviewed the available literature and identified those treatments that can be deemed "empirically supported." It is pleasing to note that works within this volume are among the works identified. In an effort to permit you, the reader, to reach your own conclusions, the chapters in this book mention the empirical evaluations that guided the content of the treatments, as well as those that examined the outcomes associated with treatment implementation.

Toward a Working Definition of "Cognitive-Behavioral"

The child and adolescent therapies described in this volume fall under the umbrella label "cognitive-behavioral." How is cognitive-behavioral therapy (CBT) defined?

There are numerous psychosocial interventions designed to facilitate child and adolescent adjustment and to remediate psychological distress, but they overlap to various degrees

and are not independent of one another. It is easy to speculate about the similarities and differences that actually exist among the different treatment philosophies (for an interesting and informed look inside four different child therapies, see Fishman, 1995). In an effort to provide a working definition of CBT for youth, consider the following: CBT is a rational amalgam, a purposeful attempt to preserve the demonstrated positive effects of behavioral procedures within a less doctrinaire context, and to incorporate the cognitive activities and emotional experiences of the client into the process of therapeutic change (Kendall & Hollon, 1979). Accordingly, CBT uses enactive, performance-based procedures and structured sessions (e.g., it is manual-based and uses workbooks), as well as strategies designed to produce changes in thinking, feeling, and behavior.

The cognitive-behavioral perspective on child and adolescent disorders, and related treatment-produced gains, includes consideration of the youth's internal and external environment. CBT places greatest emphasis on the learning process and the influence of the models in the social environment, while underscoring the centrality of the individual's mediating/information-processing style and emotional experiencing. The hyphenated term "cognitive-behavioral" is not intended as a direct insult to the role of emotions or the impact of the social context. Rather, it is a hybrid representing an integration of cognitive, behavioral, emotion-focused, and social strategies for change. Abandoning an adherence to any singular model, the cognitive-behavioral model recognizes and embraces the relationships of cognition and behavior to the emotional state and to the overall functioning of the organism in a larger social context.

"Emotions" have been assigned to both primary and ancillary roles in childhood psychopathology and therapy. I argue that cognition, emotion, and behavior are interrelated, that the variance in the etiology and treatment of some disorders may be best accounted for by a cognitive analysis, that whereas other disorders may be best understood in terms of a more direct focus an emotion, still other disorders may be best viewed as largely behavioral, but they are all interrelated. For example, anxious children behave in frightened ways (they avoid distressing situations), and they not only misperceive threat and danger in an otherwise routine environment but also fail to recognize and understand the modifiability of their own emotions (Southam-Gerow & Kendall, 2000); often anxious youth have parents who create an environment that permits avoidance. It is not that any one domain always primary or uniformly accounts for the most variance. Rather, cognition, emotion, action, and social environment are all involved but may vary in their potency across the different types of psychological difficulties and disorders (for a discussion of the role of emotion regulation in childhood psychopathology, see Suveg et al., 2007).

Because behavioral patterns in the external world and cognitive interpretations in the internal world pertain to social/interpersonal contexts (peers and family), CBT addresses the social context. For instance, social/interpersonal factors play a crucial role in the design of strategies for treatment. For children and adolescents, the centrality of the social context must be underscored. Indeed, a satisfactory relationship with peers is a crucial component of a child's successful adjustment, and an understanding of peer and social relationships (even if appearing evanescent to the therapist) is required for a meaningful assessment of a child's needs and for accomplishing an effective intervention. Similarly, the role of the family cannot be neglected, for this social microcosm sets many of the rules and roles for later social interaction.

Parents: Consultants, Collaborators, or Co-Clients?

Acknowledgments of peer and family contributions to child and adolescent psychopathology, however, far outweigh the research database that is currently available, and the need for

further inquiry in these areas cannot be overemphasized. This statement is especially true with regard to treatment (e.g., Barmish & Kendall, 2005): Parents are regularly involved in many of the programs designed for their children in spite of the fact that there is a tremendous need for a larger empirical database on the optimal nature of their involvement. Yes, CBT does recommend that treatment involve parents, but how best to do so? What is the optimal role for parents? Parents can serve as *consultants* when they provide input into the determination of the nature of the problem. When parents are seen as contributing to or maintaining some aspect of the child's problem, they may become *co-clients* in the treatment itself. Parents may also be involved as *collaborators* in their child's treatment when they assist in the implementation of program requirements. Cognitive-behavioral interventions assess, consider, and incorporate social/interpersonal matters into their programs. Involvement of parents and changing the family system should be used in conjunction with the nature of the treatment and the needs of the child. Further research is needed (e.g., studying parents as consultants, co-clients, or collaborators) to inform the ideal involvement of parents and to examine the different parent roles relative to factors such as the child's age and the principal disorder.

Therapist as Coach: The Posture of the Therapist

"Basketball as Life" is the hypothetical title of my unwritten book. If written, I would highlight how aspects of what children learn through rule-governed activities (e.g., sport, social services, acting, computers) provide valuable life lessons that have broader application. For the past 25 years, I have struggled when searching for words to try to describe the mental attitude that is recommended for therapeutic work with youth. Using the term "posture" to refer to one's mental attitude, although not exact or ideal, can help to describe a therapist working with youth. The word "coach," too, carries useful connotations. A coach is there because of prior experience to enhance the participant's abilities, to guide development, to further a common goal, and to have fun in the process. By the way, I recognize that not all coaches conform to this ideal.

I choose to describe three characteristics of the posture of the "therapist as coach," using the terms "consultant/collaborator," "diagnostician," and "educator," all within the umbrella of a supportive yet exacting coach who can bring out the best in someone with opportunity and feedback. After years of using the terms in a certain way, I am now very comfortable with the therapist as "coach." Indeed, within a most recent computer-based CBT for youth, the therapist is called the "coach" (see Kendall & Khanna, 2008; Khanna & Kendall, 2010). By referring to the therapist as a consultant/collaborator, I am referring to the therapist as a person who does *not* have all the answers, but one who has some ideas worthy of trying out and some ways to examine whether the ideas have value for the individual. Telling a child and/or adolescent exactly what to do is *not* the idea; giving the client an opportunity to try something and helping him or her to make sense of the experience is the idea. The therapist as consultant collaborates with the client. The therapist as consultant strives to develop skills in the client that include thinking on his or her own and moving toward independent, mature problem solving. The consultant (therapist) is a problem-solving model working with the client. When the client asks, "Well, what am I supposed to do?", the therapist might reply, "Let's see, what do you want to accomplish here?", then, "What are your options?" or "What's another way we could look at this problem?" The exchange is geared toward facilitating the process of problem solving, but without forcing a specific solution. The youngster and therapist interact in a collaborative problem-solving manner. Insession activities are practice; life outside a

session is the game, and coaches provide practice opportunities for the very skills needed in the real arena.

Notions of a diagnostic system are typical when the word "diagnostician" is mentioned. Diagnostics, after all, refer to the process of labeling within a diagnostic system (e.g., fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV], tenth edition of the *International Classification of Diseases* [ICD-10]). Although this process is not here criticized, it is not the thrust of the meaning of the term used here to describe the therapist's mental posture. The mental attitude associated with "diagnostician" is one of being confident to go beyond the verbal report of the client and his or her significant others. A diagnostician is one who integrates data and, judging against a background of knowledge of psychopathology, normal development, and psychologically healthy environments, makes meaningful decisions. This aspect of the term "diagnostician" is that which I underscore. Consider the following example. Suppose that you win a brand new Jaguar automobile. You drive it around for 2 days, and you notice a "clug-clug" sound in the front end when you make a right-hand turn. There is no noise when you go straight or when you turn left. The noise has you perplexed, so you contact a mechanic and tell him that the front tie-rod ends need repair. You leave the car for repair and pick it up at the end of the day. Your tie-rod ends have been replaced. Would you be satisfied? My answer is a definite "no." Why should I be satisfied when the mechanic relied on me as the diagnostician? What do I know about tie-rod ends? I just won the car—I am not a mechanic, and I should not be diagnosing the problem. The auto mechanic is the expert who should be making the determination. He should ask for a description of the problem and look under the hood! The mechanic should not fix what I say is wrong, because I am not the Jaguar expert. He can use my descriptions of the problem and consider my ideas as helpful information, but he should nevertheless make his own determination.

We, as mental health professionals, cannot let others be solely responsible for noting what is wrong and what needs to be fixed—especially when we are working with children and adolescents. That a parent says an adolescent has a depressive disorder is not, alone, sufficient reason to undertake an depression treatment program. That a parent or teacher says a child is hyperactive is not sufficient reason to initiate a medication regimen and/or therapy. The fact that a parent or teacher suspects or suggests hyperactivity in a child is valuable information, but several rival hypotheses must be considered. For example, the child's behavior may be within normal limits but appear as troubled when judged against inappropriate parental expectations about child behavior. When the parent expects too much "adult-like behavior" from a child, the essential problem does not lie within the child. There is also the possibility of alternative disorders: "Hyperactivity" may be the term used by the referring parent, but aggressive noncompliance may be a better description in terms of mental health professionals' communications and targets for treatment. Also, the child's identified problem may be a reflection of a dysfunctional family interaction pattern, with the parenting styles needing the greatest attention, not the child per se. In a nutshell, the cognitive-behavioral therapist serves as a diagnostician by taking into account the various, multiple sources of information and, judging against a background of knowledge, determines the nature of the problem and the optimal strategy for its treatment.

The therapeutic posture of a cognitive-behavioral therapist entails being an educator. The use of "educator" here is intended to communicate that I am talking about interventions for learning cognitive skills and emotional development, and about optimal ways to communicate to help someone to learn. A good educator stimulates the students to think for themselves. An active and involved coach is a good educator. Let us consider the following sports story. You are off to a weeklong golf camp for adults. You arrive and learn that for your $2,600 fee, you will lie on the couch and tell your instructor how you feel about

golf, about the clubs, hitting the ball, and your early experiences with golf. How would you respond? Your answer might be, "Excuse me, but I'd like to improve my golf game. My short irons are weak, and my driving is terrible."

The instructor might then reply, "What is it about driving that you don't like? Does it make you feel uneasy to be the driving force?"

"No—no," you reply. "My drive is weak—I think my backswing is too quick."

"Aha," he mumbles, "backswing. Is there any meaning to that? Are you nervous about your back, or backside perhaps?"

An interpretive approach is not seen as optimal instruction toward an improved game of golf. Some observation and comment about what needs to be changed (the role of a diagnostician) is needed, but the week will prove more successful following opportunities for practice with feedback.

In contrast to the scenario just described, what would a good educator (coach) do? He or she would first get you out on the links and watch you play, not taking your self-report as perfect truth, but instead observing how you hit the ball and determining for him- or herself (diagnostician) whether your backswing is or is not too quick. The observations would take place on different occasions, using different clubs, and approaching long and short holes. Then, there would be some feedback about strengths and weaknesses, and some discussion of alternatives and options (acting as a consultant). For example, the educator might inform you that your drives are inconsistent because your waist is shifting when it should not—and it may be that you need to practice with a pole in the ground at your side to get feedback about when your waist is moving. Videotaping, along with modeling by the expert, and group lessons might be integrated as well—before you play the course and keep score. Importantly, a good educator/coach does not make all players play the game the same way! A good coach observes how each student is playing and helps to maximize strengths while reducing hindrances. If a player uses a cross-finger grip for driving but a noncrossed grip for putting, there is no reason to force the player always to cross fingers—if the putting is effective, there is no need to force conformity. Individualized educational attention means that individuals can and should do things a bit differently.

A good educator/coach also pays attention to what the learner is saying to him- or herself, because this internal dialogue may be interfering with performance. Walking up to address the ball and thinking, "I can't hit this low iron—the ball's going to go into the rough," is not a preferred internal dialogue. An effective therapist, just like an effective teacher/coach, is involved in the cognitive and behavioral process. More on this later in this chapter.

The posture, or mental attitude, of the cognitive-behavioral therapist working with children and adolescents is one that has a collaborative quality (therapist as consultant), that integrates and decodes social information (therapist as diagnostician), and that teaches through experiences with involvement (therapist as educator). A quality coach has many of these characteristics, and it is not difficult to suggest that the therapist may view him- or herself somewhat as a mental health coach. A high-quality intervention, be it provided by a psychologist, psychiatrist, school counselor, special educator, classroom teacher, or parent, is one that alters how the client makes sense of experiences and the way he or she will behave, think, and feel in the future. Such coaching and correction in thought and action places the client on track toward improved adjustment.

Cognitive Functioning and Adjustment in Youth

Although it is not uncommon for some to infer that cognitive functioning has to do with intellectual skills and related assessments, such is not the theme of this discussion. Rather,

cognitive functioning within psychopathology and psychological therapy has to do with social information processing. As the term is used here, "cognition" refers to a complex system, but one that can nevertheless be subdivided for increased understanding. For instance, it has been suggested (Kendall & Ingram, 1989) that cognitive content (events), cognitive processes, cognitive products, and cognitive structures can be meaningfully distinguished. Considering these various facets of cognitive functioning permits a more detailed examination of the nature of change sought through treatment.

Cognitive structures can be viewed as memory, and the manner in which information is internally represented in memory. "Cognitive content" refers to the information that is actually represented or stored: the contents of the cognitive structures. "Cognitive processes" are the procedures by which the cognitive system operates: how we go about perceiving and interpreting experiences. "Cognitive products" (e.g., attributions) are the resulting cognitions that emerge from the interaction of information, cognitive structures, content, and processes. Psychopathology may be related to problems in any or all of these areas, and effective therapy includes consideration of each of these factors as relevant for and related to each individual client. Although these concepts are complex, a simple, though not everyday, example can help to illustrate their meaningful interrelationships.

Consider the experience of stepping in something a dog left on the lawn. Have you ever had such an experience? If this were to happen to you now, what would you say to yourself? The typical first reaction ("Oh, sh:#!") is a self-statement that reflects dismay. This self-statement, which may be made by most of the people having just made such a misstep, reflects an initial cognitive content. But these same people then proceed to *process* the experience quite differently, and it is important to understand how these individuals process the same experience differently. For example, some people might process the event by beginning to think about the potential for social embarrassment ("Did anyone see me?"); others might become self-denigrating ("I can't even walk"); still others might be inattentive to the processing of environmental cues and simply keep walking! The manner of processing the event contributes meaningfully to the behavioral and emotional consequences for the individual.

After the unwanted experience (i.e., stepping in it) and a processing of the event, conclusions are reached regarding the causes of the misstep—cognitive products, such as causal attributions, which also vary across individuals. Some may attribute the misstep to their inability to do anything right: Such a global internal and stable attribution often characterizes depression (Stark et al., Chapter 6, this volume), and there are related implications for suicidality (see Spirito, Chapter 7, this volume). An angry individual, in contrast, might see the experience as the result of someone else's provocation ("Whose dog left this here?—I bet the guy knew someone would step in it!"); attributing the mess to someone else's intentional provocation is linked to aggressive retaliatory behavior (see Lochman, Powell, Whidby, & Fitzgerald, Chapter 2, and Nelson, Finch, & Ghee, Chapter 4, this volume). Cognitive content, processes, and products are involved in each individual's making sense of environmental events.

"Cognitive structures," or templates, are an accumulation of experiences in memory that serve to filter or screen new experiences. The anxious child, for instance, brings a history to upcoming events: the memory of the past. Also referred to as a "cognitive schema," a theme of this structure for anxious children/adolescents is threat—threat of loss, threat of anticipated criticism, or threat of physical harm (see Kendall, Chapter 5, and Piacentini, Peris, March, & Franklin, Chapter 8, this volume). An individual who brings an anxiety-prone "structure" to the misstep experience noted earlier would see the threat of embarrassment and the risk of germs, and process the experience accordingly. Anxious cognitive processing of the misstep experience might include self-talk such as "What if somebody notices the bad smell; they'll think I'm dirty" or "What if germs get into my shoes and then to my

Artist: Peter J. Mikulka, PhD

socks, and my feet? Should I throw these shoes away?" Anxiety, as seen in this example of cognitive processing of an event, is laced with perceptions of threat and social evaluation.

Cognitive structures can serve to trigger automatic cognitive content and information processing about behavioral events; that is, after several real or imagined experiences, the person can come to have a characteristic way of making sense of events. Attributions (cognitive products) about the event and its outcomes reflect the influence of the preexisting structure. Therapeutically, through cognitive-behavioral interventions the therapist seeks to provide meaningful and real experiences, while intentionally attending to the youth's cognitive content, process, and product (paying attention to the child's self-talk, processing style, and attributional preferences), so that the child/adolescent can be helped to build a cognitive structure that will have a beneficial influence on future experiences.

Does this cognitive analysis make too much of too little? After all, stepping in a dog mess is not psychopathology. True, but the example illustrates cognitive processing variations that are linked to maladaptive emotional adjustment. Indeed, the same experience may be linked to reasonable adjustment. What is a healthy way to think about and deal with having just made such a misstep? It would certainly be detrimental if one were to think "It's good luck to step in sh$%!", because that might lead one to seek out and intentionally step in it more frequently. Good luck is not likely to accrue, and this would not be healthy thinking. To think (say to oneself) "Good thing I had my shoes on" might be reasonable, because it reflects the absence of self-punitiveness and has an accepting quality. Likewise, "Good thing it was a small dog" reflects self-talk that is not overly harsh. The person might then process the experience by thinking/accepting that cleaning is necessary, that some time will be needed to do an adequate job, and that, next time, one might be more careful and look where one is walking. With regard to an attribution, a person might conclude: "I made a mistake—maybe rushing too much" or "I haven't stepped in it for over a year. Maybe I can go for over 2 years before the next misstep." Such an attribution reflects acceptance of a minor error and hints that increasing the time between mistakes (as opposed to never doing it again) is a reasonable goal.

Cognitive-behavioral interventions provide an organized set of treatment activities that challenges the youth's existing way of thinking, acting, and feeling. Knowing that we all, figuratively, step in it at times, what is needed is a structure for coping with these unwanted events when they occur. Insession role-playing experiences are ideal opportunities for learning, as are out-of-session activities, and with the focus on cognition and emotion during the experience, the experiences make an impression on the client's current and future information processing.

Recall that a goal of treatment is to alter the cognitive structure of the child/adolescent such that he or she will think, feel, and behave differently in the future. Might I be so bold as to now suggest that I have altered your cognitive structure for the rest of your life! Indeed, I am confident that I have done so.

When you next step in, or barely miss, a dog mess, you will think of me (this chapter). You will step in it and have a self-statement that reminds you of this passage. Even if I would like for you not to think of me, I probably cannot stop it. I cannot chemically or surgically remove the memory, and I cannot, effectively, ask you not to think of me. I am, as a result of your reading this passage, inextricably linked to dog mess. Paul Salkovskis, himself a cognitive therapist in London, has himself been impacted by my earlier telling of this example—so much so that he has adopted it in his own lectures. The story of your misstep has altered your cognitive structure in such a way that you will think differently the next time you step in it. So, too, the therapeutic activities in the CBT interventions described in this book, when accompanied by careful attention to the child's thinking, result in a major alteration in the child's view of future events and experiences.

Distortions and Deficiencies

Dysfunctional cognition is maladaptive, but not all dysfunctional cognition is the same. Understanding the nature of the cognitive dysfunction has important implications for the optimal design of treatment. One central issue for children and adolescents concerns cognitive processing and the differentiation between "cognitive deficiency" and "cognitive distortion" in processing. Processing deficiencies refer to an absence of thinking (lacking careful information processing where it would be beneficial), whereas distortions refer to dysfunctional thinking processes.

This processing distinction can be furthered when other childhood and adolescent disorders are considered. Anxiety and depression, for example, are typically linked to misconstruals or misperceptions of the social/interpersonal environment. There is active information processing, but it is distorted (e.g., illogical, irrational, crooked). In a series of studies of depressed children, for example, depressed youngsters reported viewing themselves as less capable than did nondepressed children, when, in fact, their teachers (objective outsiders' judgments) saw the depressed and nondepressed groups of children as nondistinct on the very dimensions in which depressed youth saw themselves as lacking (Kendall, Stark, & Adam, 1990). In the teachers' eyes, the depressed children were not less competent across social, academic, and athletic dimensions. It was the depressed children who evidenced distortion through their misperception (underestimation) of their competencies.

Impulsive children, in contrast to anxious and/or depressed youngsters, are often found to act without thinking (Kendall & Braswell, 1993) and perform poorly due to the lack of forethought and an absence of planning (see Miller & Hinshaw, Chapter 3, this volume). The same can be said for children with attention-deficit/hyperactivity disorder (ADHD). Here, cognitive deficiencies are implicated. These children are not engaging in careful information processing, and their performance suffers as a result. Consider, for example, a small

group of youngsters playing soccer. Twelve players are on the soccer field; some are kicking at the ball, others are looking around and talking, and still others are standing around. A nonparticipating child sits on the sidelines and, when asked why he is not playing, replies, "I can't play. I'm not good at soccer." In reality, the child can stand, talk, kick at a ball, and so on, and could easily participate in this game being played at a modest skills level. The child's comment reflects mistaken perceptions of the demands in the situation and suggests that he thinks he cannot play as well as the others—that they are good players, but he is not. This perception is distorted, and such thinking is tied to feelings of inadequacy, isolation, and withdrawal. Contrast this overly self-critical and isolating style of the withdrawn and depressive child to the impulsive child who, when seeing the soccer game, runs directly onto the soccer field and starts chasing after the ball. He is kicking and running but does not yet know what team he is on, who is on his team with him, or which goal he is going to use. His difficulties emerge more from failing to stop and think (cognitive deficiency) than from active but distorted processing of information.

The terms "deficiency" and "distortion" have been used in the extant literature to describe features of cognitive dysfunction (Kendall, 2000). In the many instances in which the terms have been employed, their use has been, even if unwittingly, consistent with my distinction. Spivack and Shure (1982) contend that deficits in interpersonal cognitive problem-solving skills carry etiological clout, and Barkley (1997) has described impulsivity as a disorder resulting from mediational deficits.

To further illustrate the differences between distortions and deficiencies, consider the role of cognition in overcontrolled and undercontrolled (Achenbach, 1966) childhood disorders. Anorexia, most often observed in adolescent females, is related to setting perfectionist goals and demands, carrying an inaccurate view of the self (e.g., self-perception of body), and being "too good" behaviorally. These features of an *overcontrolled* problem reflect cognitive distortions. Anxiety and depression are also considered internalizing problems, and they, too, evidence cognitive distortions that are dysfunctional—misperceptions of demands in the environment, misperceptions of threat and danger, attributional errors (e.g., depression: Hammen & Zupan, 1984; Prieto, Cole, & Tageson, 1992; anxiety: Daleiden, Vasey, & Williams, 1996; see also Kendall, Chapter 5, and Stark et al., Chapter 6, this volume). In contrast, impulsive acting-out and aggressive behavior, often more characteristic of young boys, is in part related to a lack of self-control, limited mediational skills, and a lack of social perspective taking. The child with the *undercontrolled* problem seems to evidence a deficiency in activating and following careful and planful cognitive processing. In aggression, there is evidence of both cognitive deficiency and cognitive distortion (see Lochman et al., Chapter 2, this volume). Data suggest that aggressive youth have deficiencies in interpersonal problem solving and document that they also show distortions in their processing of information (e.g., Edens, Cavell, & Hughes, 1999; Lochman & Dodge, 1998; see also Lochman et al., Chapter 2, and Nelson et al., Chapter 4, this volume). Limited ability to generate alternative, nonaggressive solutions to interpersonal problems is an example of their deficiencies, while misattribution of the intentionality of others' behavior (Dodge, 1985) demonstrates a tendency toward distorted processing.

Emerging from, and consistent with, the empirical literature is the position that (1) undercontrol versus overcontrol is an important behavioral differentiation; (2) distortions versus deficiencies is an important cognitive differentiation; and (3) meaningful relationships between the two exist (see Kendall & MacDonald, 1993). Internalized problems are linked more to maladaptive, distorted processing, whereas externalizing problems reflect, in part, deficiencies in processing. Moreover, recognition of this distinction and use of interventions that direct themselves appropriately to the needed area have benefits for participating youth.

A Temporal Model: Developing Coping Over Time

Both empirical research and clinical theory continue to document and emphasize the role of cognitive concepts such as expectations, attributions, self-talk, beliefs, distortions and deficiencies, and schemas in the development of both adaptive and maladaptive behavioral and emotional patterns. Interestingly, these same concepts play important roles in the process of behavioral change. However, the interrelationships of these and other cognitive factors themselves have yet to be fully clarified. How are the functional effects of self-talk similar to or different from those of attributions? How does an individual's maladaptive cognitive structure relate to his or her level of irrational beliefs? Do inconsistent or anxious self-statements reduce interpersonal cognitive processing and problem solving? Quite simply, we know only a modest amount about the organization and interrelations of the cognitive concepts receiving theoretical, research, and clinical attention.

A model with some potential utility is one built on development and organized by time. The developmental model must take into account and be able to reflect the role of cognition associated with behavior across time (e.g., the cognition that occurs before, during, and after events). Because events do not occur in a vacuum (they are typically social and have associated emotional components), and because behavior is determined by multiple causes, the model must allow for the feedback that results from multiple sequential behavioral events and the associated cognitive processing and emotional reactions. Again, this involves development over time; that is, a person's cognitive processing before an event varies, depending on the outcomes (behavioral and emotional) of previous events. The model must allow for fluctuations in preevent cognition associated with the different outcomes (e.g., successful, unsuccessful) of prior events. Moreover, because repetitions of cognitive event sequences eventually result in some consistency in cognitive processing, the model highlights the eventual development of more regularized cognitive processing (e.g., cognitive structures, cognitive styles).

Figure 1.1 offers an illustration of the model. The figure depicts the flow of cognition across multiple behavioral events (BEs) that vary in their emotional intensity. The starting point is a hypothetical initial BE, and the model moves from the initial BE point at the left in Figure 1.1 to the cognitive consistency that results (at the right).

How do children disambiguate the causes of their behavior after it has taken place? Stated differently, of all the possible explanations for behavior, how do youth explain their own and others' behavior to themselves? Attributions are temporally short-lived in that their occurrence is at the termination of an event. Nevertheless, their effects can be long-lasting. One could assess an attribution long after an event, although numerous factors (e.g., recall from memory) may interfere with accurate recall. Typically, attributions are preferably assessed immediately after the behavioral event has taken place.

Repetition of behavioral events (multiple BEs in Figure 1.1), especially those with heightened emotional impact, and repetition of the related cognitive processing result in some degree of consistency. Figure 1.1 illustrates that cognitive consistency (i.e., a cognitive structure, beliefs, an attributional style) results after multiple events. These cognitive variables (consistencies over time) are more stable than a single attribution. More stable cognitive style variables may be more predictive in a general sense but are less predictive in specific situations than the actual cognition at the time of the specific behavioral event. Upon the accumulation of a history of behavioral events and event outcomes, the child or adolescent entertains more precise anticipatory cognition (i.e., expectancies).

Expectancies have been described, for example, as outcome expectancies and self-efficacy expectancies (Bandura, 1977). Other anticipatory cognition includes intentions, plans, and commitments. These latter variables may be more stable and consistent over time than

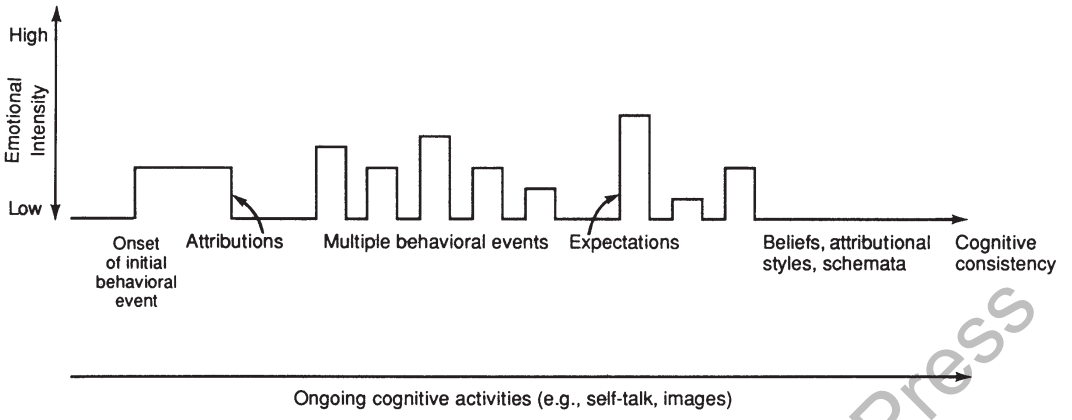

FIGURE 1.1. A temporal model of the flow of cognition across behavioral events of different emotional intensity. Self-statements and images occur at any point and can be studied at various points in the temporal flow. Problem-solving processes also occur at various points, especially where conflicts arise.

situationally specific expectancies. A generalized expectancy (e.g., locus of control), by its very general transsituational nature, can also be seen as an attributional style. For instance, the generalized expectancy of an external locus of control may be present both before (expectancy) and after (attribution) an event. Before the event, the person's externality leads to an anticipation of having a minimal effect: "Why bother to speak up? No one listens to me." After the event, when a decision has been reached without the individual's input, the event is attributed to powerful others: "See, the big mouths always get their way."

In addition to the cognitive factors mentioned thus far, other cognitive variables have been demonstrated to be important in a cognitive-behavioral analysis—variables such as imagery, self-statements, and cognitive problem-solving skills. These factors occur at all points along the temporal flow depicted in Figure 1.1, and assessments of these factors (e.g., self-talk) can prove valuable in understanding and treating children and adolescents.

Emotional forces are crucial in the design and conduct of interventions, and in the eventual permanence of effective outcomes. The intensity of emotion is represented vertically in Figure 1.1. The higher the bar, the higher the emotion: A high bar indicates a behavioral event that is more emotionally intense. Emotional intensity contributes, because the more intense the experience, the greater the impact on the development of a cognitive structure (schema). Accordingly, minor events, in terms of emotional involvement, may have a limited influence on attributions, future expectations, and behavior, whereas an emotionally significant event has greater impact on the development of a cognitive structure and on future thinking and action. One strives to design and implement therapy as an emotionally positive and involving experience, leading to coping and adaptive cognitive processing. As will be discussed in more detail later in this chapter and others throughout this book, therapy can help to reduce the client's support for dysfunctional thinking/schemas, and it can help to construct a new schema through which the client can identify and solve problems—movement toward coping.

With specific reference to therapy for children and adolescents, an effective program is one that intentionally plans and capitalizes on creating behavioral experiences with intense positive emotional involvement, while paying attention to the anticipatory and after-the-fact cognitive activities of the participants. The therapist guides both the youngster's attributions

about prior behavior and emotions, and his or her expectations for future behavior and emotions. Thus, the youngster can acquire a cognitive structure for future events (a coping template) that includes the adaptive skills and accurate cognition associated with adaptive functioning.

Reasonable Aspirations

What goals are set before us as worthy of conscientious effort? To what end does the cognitive-behavioral therapist aspire? Do we expect to correct all problems for each child client? To answer these questions, let us consider (1) the trajectory of normal development, (2) rational therapist expectations about change, and (3) theoretical models that detail the nature of our goals.

Normal Developmental Trajectory

The human organism is on a course of development that, in general, strives to move toward the acquisition of skills, self-direction, autonomy, and happiness in life; that is, when developmental trajectories are not deflected, an organism moves toward a satisfying, self-determined role. Assuming such a trajectory, what place do cognitive-behavioral interventions serve?

Interventions for children and adolescents can be therapeutic, preventive, or enhancement-focused. Ameliorative interventions (therapy) are designed to help youth overcome problems that already exist, whereas prevention attempts to forestall problems before they emerge. Enhancements are aimed at the improvement of the quality of life for individuals not currently in distress (not meeting diagnostic criteria). The clear majority of cognitive-behavioral interventions are therapeutic, with a substantial number being currently or potentially preventive and fewer still serving to enhance an adequate adjustment. Some, such as those intended for victims of disaster (see La Greca & Silverman, Chapter 10, this volume), are designed for otherwise adapting individuals who are victims of natural and other crises. It is considered advantageous to work both to serve currently suffering individuals and to prevent future suffering by intervention to help build self-determined persons.

Children and adolescents, as clients, require that the therapist give special consideration to treatment goals. To what extent does the therapist want to help the client make a better adjustment to the present life situation? To what extent does the therapist want to help the client to alter his or her life situation? When family members, school personnel, and other adult authorities are involved, the matter becomes even more complicated. Adjusting to a life situation that is psychologically unhealthy may not be advised (see Deblinger, Behl, & Glickman, Chapter 11, this volume), yet one cannot always alter a life situation as dramatically as might be construed when thinking of optimal adjustment for the client. The resolution offered by the cognitive-behavioral approach is one that focuses on individual problem solving. The client is given skills that can be used to make self-determinations—skills that are in natural agreement with the developmental move toward autonomy.

Problem-solving skills allow for individual choices, unique to the client, that are optimal for the individual at the time. A child or adolescent client is supported through the thinking processes, encouraged to consider alternative solutions, rewarded and encouraged for effort, and helped to practice the skills needed for future challenges to adjustment. In this manner, the child or adolescent is guided through the process of becoming an active participant in a problem-solving process that, while not dictating which answers to choose, does allow for some choice and self-determination. Adolescence may be an especially opportune

time for applications of problem-solving (see Holmbeck, Devine, Wasserman, Schellinger, & Tuminello, Chapter 15, this volume). Helping to identify, think through in a careful manner, and guide the testing and evaluation of options is a goal of CBT.

To return to the notion of a natural developmental trajectory, psychologically healthy adjustment, as it unfolds in nature, builds on resolutions to prior challenges. No one passes directly through. Managing frustration contributes to competence. When one is on a fault-free course of adjustment, interventions may appear to be unnecessary. However, when challenges do not present themselves, or when prior challenges have not been met successfully, new skills are needed and, to the extent possible, the acquisition of those general skills that can be applied to a multitude of new challenges is most promising. By demonstrating, teaching, and honing problem-solving skills, the cognitive-behavioral therapist's efforts coincide with changes to adjustment. The goal is a better prepared individual—prepared for the inevitable difficulties of life with a set of skills that can facilitate problem resolution.

Rational Therapist Expectations

The best hitter in major league baseball hits approximately .340, professional bowlers do not bowl 300 routinely, and not every play in football leads to a touchdown or even a first down. Perhaps even more striking, Michael Jordan—consensually the best basketball player ever—has a lifetime shooting percentage of approximately 49%. Yet we, as mental health professionals, often carry expectations that we (and our therapies by implication) are expected to help all, or almost all, of our clients. To expect such a success rate is irrational, maladaptive, and likely to be associated with other distressing problems.

Rational therapist expectations include the belief that interventions will be helpful in the movement toward successful adjustment, and that individuals who acquire the skills communicated in therapy will at some time experience the benefit of those skills. What is irrational is to expect that any child, with any problem, can be "fixed" using psychological therapy—cognitive-behavioral or otherwise. The notion that therapy provides a "cure" is a troublesome and misleading belief (see Kendall, 1989).

Children and adolescents do not, automatically, evidence benefit from psychological forms of therapy or health-enhancing programs. And even in cases where some success is obvious, the chance of relapse remains ever present. If relapse does occur, was the therapy ineffective? Should therapy be expected to prevent all relapses as a part of the "cure" of psychopathology? A reasonable and rational expectation for therapists to hold is that therapy does not cure psychopathology. Therapy does provide help, but the help is more in the form of a strategy for the *management* of psychopathology. The adolescent with an anxiety disorder, for example, does not receive treatment that totally removes all perceptions of situations as anxiety-provoking or totally eliminates self-evaluative concerns, but the treated youth will be able to employ newly acquired strategies in the management of anxious arousal when it does occur. The angry–aggressive child may not erase all impulses for immediate retaliatory action, but he or she will have available skills that can be implemented when more cautious, thoughtful action and emotion management are needed. To expect cures is irrational; to expect to impart the wisdom that, through experience, will facilitate adjustment is sage.

Not all participant youth experience ideal outcomes. The idea behind empirically supported treatment is that, for the most part, and to a degree that is better than chance, the treatment has been found to be effective. Consider the treatment of anxiety in youth, and the six-site study of 488 youth with anxiety disorders (Walkup et al., 2008) and other comorbid conditions (Kendall et al., 2010). Sixty percent of CBT-treated youth were found to have "very much improved" or "much improved" outcomes following treatment. Though such a response rate was comparable to that produced by medications and significantly better than

a pill placebo, not all youth outcomes were of such a favorable magnitude, and not all positive responders went forward without other difficulties. The empirical support documented that the treatment was effective, but other matters remain and often need added attention.

Dealing with relapse, or relapse temptations, is part of life, as is evident in efforts to maintain healthy eating habits (see Wilfley, Kass, Kolko, & Stein, Chapter 13, this volume). Even our most successful clients are challenged by the many opportunities for decisions that are less than optimal. Our goal is not to "have all go well forever," but to improve upon the trajectory that was evident before treatment began. To alter a nonadaptive trajectory is to produce therapeutic gains, and such an expectation is rational.

Social anxiety and depressive symptomatology are common emotional difficulties. Many therapists working with children and adolescents deal with problems of detrimental anxiety and unwanted depression. Youth with these emotional problems, as part of their distress, process their world in a maladaptive way that requires intervention. As is true with adult clients suffering from these same disorders, cognitive-behavioral interventions strive to rectify the distorted information processing linked to the emotional distress. Unfortunately, the popular press has overpromoted an idea that has been labeled the "power of positive thinking." Do we want our clients to become big-time positive thinkers? Is such a goal a rational and desired outcome of treatment? As it turns out, theory suggests, and research evidence supports, the notion that it is *not* so much the power of positive thinking related to emotional adjustment or improvement in treatment as it is the reduction in negative thinking. I have elsewhere referred to this as "the power of non-negative thinking" (Kendall, 1984). As we achieve reductions in overly negative and harsh cognitive processing, we reduce negative thinking and associated psychological distress (Kendall & Treadwell, 2007; Treadwell & Kendall, 1996).

Would you want to be someone who always thinks positively? Individuals who think or talk to themselves in only positive terms are not psychologically healthy. Rather, we all experience life events that have negative features, and a rational individual accepts these inevitabilities. One would not want to be thinking only positive thoughts when in a difficult situation. For example, imagine that you are on an intercontinental airplane trip. During excessive air turbulence, you find yourself sitting next to someone who sees everything positively. The turbulence causes the plane's door to open, and the person next to you says, "Ah, fresh air!" Not exactly a rational response! There are times when a negative thought or two is quite reasonable. Purely positive information processing is, when judged against reality, somewhat distorted. If purely positive thinking is not the goal, and adjustment is related to a reduction in negative thinking, what then should therapists hold as a rational expectation for the outcome of interventions?

Should treatments be designed to reduce the negative, self-critical thinking styles of the anxious and depressed youth? An answer lies in the ratio of positive to negative thinking. The ratio of positive to negative thinking found to be associated with adjustment is 0.62:0.38 (see Kendall, Howard, & Hays, 1989). These findings are reported for older adolescents, but the concept holds true for younger persons as well. Generally speaking, this 2:1 ratio suggests that positive thinking occupies two-thirds of the thinking, whereas negative thinking occupies one-third of the thinking in individuals who are not maladjusted. Depressed persons, identified psychometrically and clinically, show a 1:1 ratio: The 50–50 split reflects an equal frequency of positive and negative thinking—an internal dialogue that evidences conflict between the positive and the negative. Let me suggest that knowing an optimal ratio of positive to negative thinking is 2:1 serves as a guide for the therapist. Overly optimistic thinking is not necessarily healthy, and shifting too much toward a 1:1 ratio is unhealthy as well. It is healthy to acknowledge certain unwanted situations, accept a negative thought or two, then proceed to counter the negative aspects with some positive

thinking. Positive thinking helps overrule negative thinking, but negative thinking should not be totally eliminated.

Although we all have our share of successful child clients, is it the case that children and adolescents typically strive to (1) display their newly acquired skills and (2) thank the therapist for the help? Sometimes, as the many fortunate therapists can attest, children and/or their parents do offer a warm and genuine "thanks." We have received postcards and e-mail attesting to solid gains, but one does not expect such correspondence. Nevertheless, it is also quite possible (likely) that children and adolescents learn from their therapeutic interactions but, for a variety of reasons, do not want to let us know. They sometimes act as if they were right all along and did not need or benefit from therapy. It is irrational for therapists to expect that all clients will, at posttreatment, demonstrate that they have benefited from our interventions.

It is possible that there will be beneficial effects, but that these effects will not immediately be evident at the end of treatment. I refer to this, admittedly optimistically, as "sleeper effects." Beneficial learning took place, but the evidence of the learning does not appear until a later point in development, or until a different situation emerges. For example, completion of a therapy that provides an opportunity for learning social problem-solving skills might not produce immediate use of these skills. It may be that after the passage of time, the percolation of the ideas at various times, and the successful use of parts of the problem-solving process, the child/adolescent client comes to employ and recognize the benefits of a problem-solving approach. It has been my experience, for instance, that interpersonal skills learned by a child during early childhood take a temporary backseat to the social pressure of peers. After further developmental changes, the skills acquired earlier can emerge without conflict and better serve the individual's current adjustment.

Continuing an optimistic line of thought, it is also possible for spillover effects to occur. The term "spillover effects" refers to beneficial gains associated with a child's treatment that may be evident in the parents, siblings, or other nontarget participants in the treatment. For example, a child participates in and successfully completes cognitive-behavioral treatment for depression (see Stark et al., Chapter 6, this volume). At the end of treatment he or she is more participatory in the activities of his or her peers. As a result, the child spends less emotionally draining time with the parents and is less demanding and troublesome to them. The tension between the parents, which in part had been linked to the child's depressed mood, diminishes in conjunction with the child's gains. The effects of the treatment spill over onto other, nontarget areas. In this example, although such effects may occur, they will be more likely and more pronounced with increased involvement of the child's parents. Some optimism is justified given the frequency with which CBT appears on the list of empirically supported treatments. However, there are challenges remaining (Kendall & Choudhury, 2003; Kendall & Ollendick, 2004), and the authors contributing to this volume add to our knowledge of not only what to do and how to do it but also what remains to be done.

Conceptualization of Change

Children and adolescents with behavioral and emotional difficulties have associated maladaptive qualities in their social information processing. For both the depressed adolescent who is misattributing negative outcomes to internal–global–stable features and the impulsive/hyperactive child who is active in behavior but deficient in planful forethought, modifications of cognitive processing are in order. Theoretically speaking, how might we conceptualize the needed changes? How best do we describe the nature of the cognitive changes that are a part of the goals of treatment?

Some cognitive distortions, as noted in earlier discussion, require modification. New

experiences, with guided processing both before and after the experiences, help to straighten out crooked thinking. What I am suggesting is not that the existing cognitive structure be erased, but that new skills and means of construing the world be built, and that these new constructions may come to serve as new templates for making sense of future experiences. Therapy does not provide a surgical removal of unwanted cognitive structures or emotional histories, but it helps to build new schemas and employ new strategies in place of the earlier dysfunctional ones.

Therapy offers exposure to multiple behavioral events with concurrent cognitive and emotional processing, such that new cognitive structures can be built over time (recall the discussion tied to Figure 1.1). Positive emotional tones can increase the potency of the experience and add to its impact on the youth's developing new views. As these new perceptions are incorporated into the child's more overarching view of the world and his or her place in it, future experiences are construed differently (less maladaptively). Using these "revised views" (newly acquired skills and constructed schemas), the individual moves forward to face and to confront new challenges in ways that manage former maladaptive tendencies.

Closing

Children and adolescents typically do not call therapists or refer themselves for mental health services. Quite the contrary, individuals other than the child or adolescent, such as parents, teachers, or guardians, are often the initiators of psychological services. The receipt of mental health services as a youth is special: Seeking help for oneself is very different than being sent for services by someone else! Adults who themselves have personal suffering seek their own mental health services.

The fact that children are sent for treatment, whereas adults often seek it, is an important distinction that has clinical implications. Children and adolescents must, on their own, enjoy the experience, want to be there, and even come to see the potential benefits of therapy. Accordingly, efforts to create a pleasant affective environment and a motivation for further participation are essential. As we like to say when working with anxious children (see Kendall, Chapter 5, this volume), the goal of Session 1 is to have the child return for Session 2!

One of the main challenges facing the developing organism is movement toward autonomy and independence. Central to this movement are the family members (specifically, the parents) and their supportive or constraining styles. Child and adolescent clients are not fully capable, as yet, of being entirely independent, and family, school, and other contextual influences must be considered. Indeed, although the thrust of the present theory is on individual change, multiple influences have been considered and incorporated.

In the analysis thus far, little discussion has been devoted to factors such as trust, respect, and the child–therapist relationship as part of the therapeutic process. It is not because these matters are unimportant, but because they are *essential* to all forms of therapeutic interventions. The relationship, for example, is a common factor across treatment approaches that can contribute to favorable outcomes (see Shirk, Jungbluth, & Karver, Chapter 16, this volume). Factors that contribute to a strong relationship, such as "collaboration" (Creed & Kendall, 2005), are to be encouraged, as are behavioral and emotional patterns that clearly communicate mutual respect and trust. As an illustration, independent raters' judgments about the therapist's degree of "collaboration" have been found to be predictive of the child's assigning a favorable rating to the therapeutic relationship (Creed & Kendall, 2005). It is my position that optimal treatment outcomes are linked to the implementation of empirically supported procedures in a manner that evidences "flexibility within fidelity" and in a context that is based on a supportive environment.

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