CHAPTER 2

Locating the Treatment Target

Ready . . . Aim . . . Target!

What Is This Chapter About?

We include this chapter in *CBT Express* for an important reason. Even though this book is designed to provide you with innumerable clinical strategies, a critical first step is correctly identifying a treatment target. The procedures will fall flat if they are aimed at an incorrect mark. For instance, if you attempt to change an emotionally sanitized cognition with a handy and quick cognitive restructuring technique, young patients' mental sets are likely to stay the same and they may even complain they already understand their thinking is off, but the intervention does not help them to feel better.

Chapters 3 through 8 include sections that offer you a very basic conceptual framework for many *CBT Express* procedures. Functional analysis (FA) provides a context for the behavioral and cognitive procedures. Measurement-based care (MBC) is central to both good clinical care and future financial reimbursement. Incorporating MBC principles into your practice gives you feedback on how well treatment is going and is a form of continuous quality improvement (CQI). Moreover, it is extremely likely that most third-party payers will require measurement-based feedback to ensure their dollars are buying value-based services.

In sum, this chapter serves a threefold purpose. First, the material provides necessary conceptual roots for the *Express* procedures. Second, the chapter emphasizes the importance of identifying treatment targets and measuring progress toward goals. Third, readers are alerted to the likely necessity of practicing MBC in the context of behavioral health care reform.

Functional Analysis: Theoretical and Empirical Background

FA has a long tradition in developing an understanding of behavioral actions in cognitive-behavioral-spectrum approaches (Cone, 1997; Haynes, O'Brien, & Kaholokula, 2011; Kazdin,

2001; McLeod, Jensen-Doss, & Ollendick, 2013). FA's roots lie in operant and classical learning paradigms. Functional behavior simply means that the action is purposeful and goal oriented. Our behaviors and actions are directed toward increasing the likelihood of positive consequences or escaping adverse outcomes. Kazdin (2001) cogently explained, "the goal of functional analysis is to identify the conditions that control the occurrence and maintenance of behavior" (p. 103).

The use of FA provides several advantages for clinicians (Kazdin, 2001). First, when you specify the cues and consequences of the problem behavior, the parameters surrounding the difficulty become more apparent. Second, actions are better understood by viewing them within the context in which they took place. Third, children's self-control is optimized. More specifically, when triggers and contingent outcomes are identified, young people can be taught skills to cope with stressors and seek productive actions.

In sum, FA maps out the behavior. Completing an FA helps you quickly identify the dynamic context in which actions exist and the factors that influence their frequency, intensity, and duration.

Alphabet City: The ABC's of Functional Analysis

FA takes shape through the ABC model. "A" refers to *antecedents,* which are cues that provoke the behavior. A's could be stimuli that directly lead to the behavior such as being bullied, taking a test, or the breakup of a relationship. Additionally, surrounding or background conditions that set the stage for the behavior are also A's. Examples include the presence of certain people, the time of day, or the noise level in the room. Finally, internal stimuli can prompt children's actions. These internal cues could be increased heart rate, muscle tension, and negative affective experiences.

B's refer to target *behaviors,* or what we like to call "the usual suspects." These behaviors are the problem behaviors or actions that clinicians seek to change. It is very important to be as precise as possible when identifying B's. Targeting vague B's can cause therapeutic interventions to misfire. Considerable effort is required to pin down these usual suspects. Caregivers, teachers, and young patients themselves often describe the usual suspects in broad strokes. For example, adults may complain about young people having bad attitudes or not listening, or patients may describe feeling "weird," which requires the therapist to concretize the problem in specific terms.

HQ Card 2.1 (p. 15) guides you in pinning down the "usual behavioral suspect" shrouded in the child's or caregiver's description of the general complaint. In the left-hand column, labeled "the usual suspect," the child's presenting problem is shown as a vaguely constructed issue (e.g., school is boring). On the right side, simple queries are suggested to help you operationally define treatment targets.

C's are *consequences* that make the B's more or less likely to recur. In general, C's are classified as reinforcers or punishers. Reinforcers may either be positive or negative. Many practitioners get unnecessarily confused about negative reinforcement. Just keep in mind a few simple points. Both positive reinforcement and negative reinforcement serve to *increase* the function of the behavior. However, positive reinforcement involves adding (+) something

pleasant (+) to increase the behavior. On the other hand, negative reinforcement is subtracting or removing (–) something negative (–) to increase behavior.

Rewards earn their value through the eye of the beholder. Remember, rewards carry power only if children prize them. Therefore, you will need to work to find the reinforcement value of different rewards. HQ Card 2.2 (p. 16) gives you some questions to ask caregivers and children to find the desired rewards.

The most typical consequences that decrease frequency of behavior are response cost and punishment procedures. Time-out and removal of rewards and privileges are typical response cost procedures.

HQ Card 2.3 (p. 17) serves as a handy reminder about positive reinforcement, negative reinforcement, and response cost.

The ABC rubric forms the architecture of FA. Precisely locating the A's and C's yields a clinical road map. HQ Card 2.4 (p. 18) gives you specific questions to find the A's and C's as you navigate through Alphabet City. To find the correct place on A Street, check out the left column of the card. Questions on the right side track down the correct spot on C Street.

After you and your patients specify the A and C routes to children's behaviors (B), you are ready design a personalized map to Alphabet City for your patient. Figures 2.1 and 2.2 show you the way.

In Figure 2.1, Jody's compliant behavior (B) is cued by an effective command (A) (e.g., "Jody, please come down to dinner."). In turn, Jody's compliant behavior is followed by contingent positive reinforcement (e.g., "Because you did what I said, you may choose dessert tonight."). Compliance is established by clear commands and positive reinforcement.

Figure 2.2 maps out Andre's avoidant behavior. Andre experiences antecedent triggers (A) (e.g., seeing announcement, feeling anxious). He then avoids the team meeting and makes a catastrophic prediction (e.g., "Everyone will think I am a wannabe."). His escape behavior is negatively reinforced by relief from his anxiety. His avoidance is maintained through the temporary relief of his anxiety.

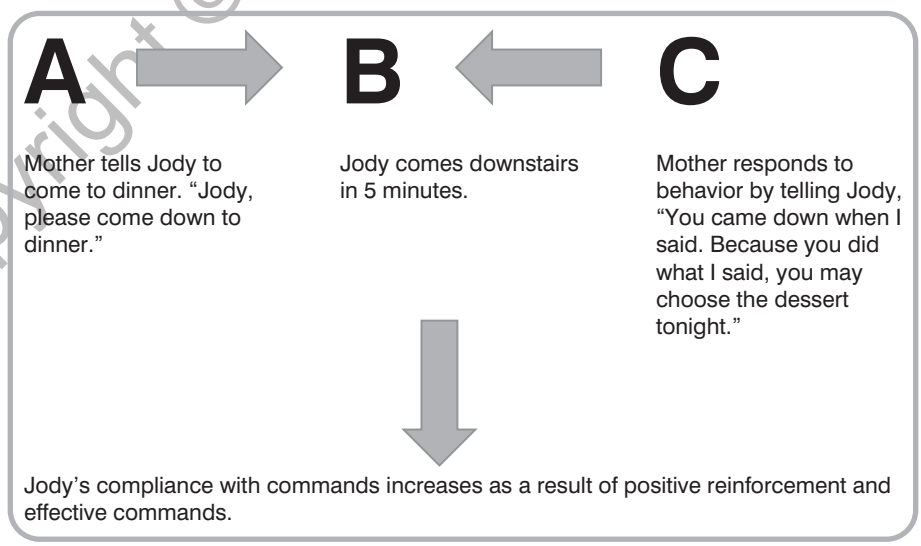

FIGURE 2.1. Sample map for Jody's Alphabet City.

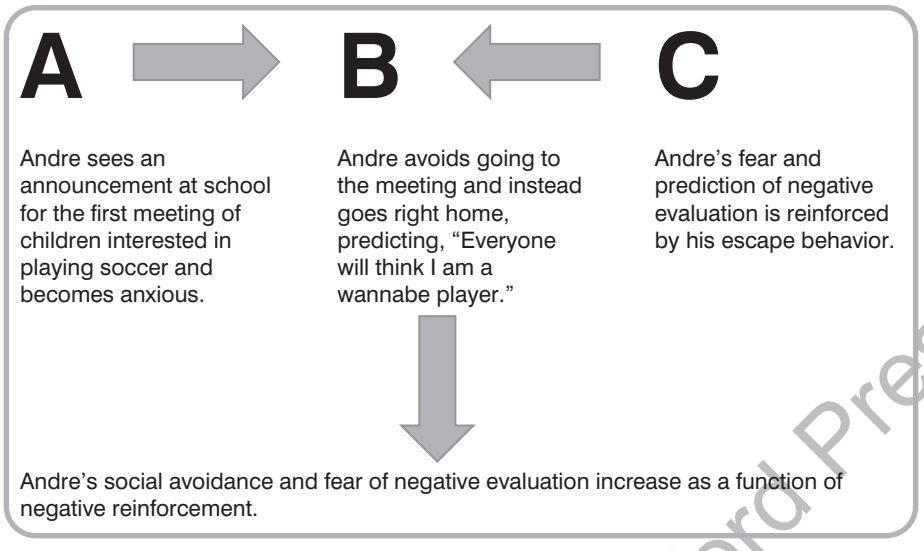

FIGURE 2.2. Sample Map for Andre's Alphabet City.

Common Interventions Based on Functional Analysis

Giving good commands or instructions, doling out praise and rewards, removing privileges and rewards, and conducting effective time-outs are common procedures born out of functional analyses. You can find specific applications of these interventions in Chapter 3 (on noncompliance). In this section, we provide you with some basic broad-spectrum rubrics.

Giving Good Commands

Giving good commands is a first step toward teaching children to behave according to reasonable expectations. In order to help children learn to comply, you will need to coach parents, teachers, and other caregivers about how to give effective requests. FA shows you the way!

We refer to making commands as "calling signals." The tips in HQ Card 2.5 (p. 19) are based on fundamental concepts in FA. First, you must ensure the caregiver captures the child's attention (e.g., makes eye contact). Second, caregivers should make clear, polite, and calm commands. Third, requests should not include "let's" (e.g., "Let's clean up the dishes"), "we" (e.g., "We need to get our shoes on"), or "why" (e.g., "Why don't you get started on your chores") statements. Rather, the calling signals are specific and direct ("I need you to put the dishes in the dishwasher before going outside"; "Put your shoes on now, please"; "It is time to pick up your dirty clothes."). Finally, good signal callers do not flood children with multiple and/or unnecessary commands. Caregivers need to be picky about the battles they elect to fight.

Delivering Praise and Rewards

Positive reinforcement is the best way to build productive behavior. However, delivering praise and rewards is not as easy as it may appear. Based on extensive research on learning theory, several authors (Chorpita & Weisz, 2009; Nangle, Hansen, Grover, Kingery, & Suveg, 2016) have identified the nuggets of effective praise and reinforcement.

HQ Card 2.6 (p. 20), an aid for parents and clinicians, lists basic strategies for effective praise statements. First, good praise is specific (e.g., "You got all your homework done tonight!") rather than vague (e.g., "Good going"). The second point to communicate to parents is that they do not have to praise every behavior. Praise should be heaped upon behaviors that reflect new learning. Parents and caregivers need to spot behaviors they want to increase that are occurring at a low frequency or are just beginning to emerge. Those behaviors should be the targets of praise and rewards.

Immediate rewards are preferred over delayed consequences. This is especially true for impulsive children and those young people who find it difficult to delay gratification. Praise and rewards should be linked to the behavior you are seeking to increase. Caregivers' reward cupboards should be fully stocked with a variety of positive reinforcers that range in magnitude. Finally, the type and magnitude of the reward should match children's behavioral achievements (e.g., small accomplishment = small reward; big accomplishment = big reward).

Removing Rewards and Privileges

Removing rewards and privileges is a response cost procedure. When a child misbehaves, he or she has to pay a cost. Typically, the penalty involves taking away a valued reward or privilege. Various sources offer fundamentals for removing rewards and privileges (Chorpita & Weisz, 2009; Kazdin, 2008).

HQ Card 2.7 (p. 21) gives parents helpful reminders about removing rewards and privileges. First, like presenting rewards and privileges, withdrawing them needs to be explicitly linked to children's behaviors (e.g. "Because you hit your sister when you were both playing with the iPad, you may not play with it tonight."). Second, the type of reward or privilege removed and the length it is withdrawn should match the child's misbehavior. Regardless of the child's impropriety, rewards and privileges should not be removed for long periods of time. If children are forced to live without something for even a week, they will learn to live without it, making the behavioral management strategy less effective. Finally, Kazdin (2008) recommends a minimum ratio of five reinforcing statements/rewards to any one response cost procedure.

Conducting Effective Time-Outs

Time-out is another response cost procedure. Simply, time-out refers to removing the child from a reinforcing situation as a penalty for misbehavior. As with other procedures, readers are referred to sources that more fully describe these behavior management strategies (Chorpita & Daleiden, 2009; Drayton et al., 2012; Kazdin, 2008).

HQ Card 2.8 (p. 22) offers pointers for implementing time-out. First, time-out should be done immediately following the undesirable behavior. Experts agree that the commands to go to time-out should be brief and to the point. Chorpita and Weisz (2009) suggest a handy rudiment ("10 for 10") where the command is given in 10 seconds with 10 words. Time-out begins when the child is sitting down and quiet. Short time-outs are preferable to long ones. Many parenting professionals agree that time-outs should be no more than 1 minute per age of the child (e.g., 4-year-old child = 4-minute time-out), although this is not a rigid rule. For many children who are on the older end of the 2–11 range, a shorter time-out is both effective and more manageable for caregivers. Finally, after time-out ends, parents and caretakers need to look for opportunities to praise the child for desirable alternate behaviors.

Hey, UMP!: Unique Mental Parcels

As cognitive-behavioral therapists readily recognize, automatic thoughts (ATs) drive most children's experiences. However, not all thoughts are created equal. Some thoughts are benign and not emotionally painful. Other beliefs carry an emotional wallop. As a clinician working on the *CBT Express,* you will want to quickly and efficiently identify the AT with the highest affective payload. In order to do this, you will need to identify the unique mental parcels (UMPs). This section helps you recognize which thoughts go with different distressing feelings.

Theoretical and Empirical Background

The content-specificity hypothesis (CSH) is supported by much bench or laboratory science investigating cognitive products accompanying particular emotional states (Cho & Telch, 2005; Ghahramanlou-Holloway, Wenzel, Lou, & Beck, 2007; Lamberton & Oei, 2008; Schniering & Rapee, 2002). Interested readers are referred to Beck (1976) as well as Friedberg and McClure (2015) for greater coverage on this topic.

The CSH allows clinicians to identify emotionally charged thoughts. Additionally, the CSH is a useful way to separate multiple thoughts and feelings. For example, in clinical practice, children and adolescents often experience multiple feelings and thoughts regarding the same situation. Knowing what thoughts go with which emotions allows clinicians to sort out the specific connections.

According to the CSH, depression is characterized by themes of loss, deprivation, and defeat. Depression is accompanied by a negative view of the self (e.g., "I'm a loser"), negative view of others and one's experiences (e.g., "Others are out to get me"), and negative view of the future (e.g., "Things will never get better"). Anxiety's core theme is danger or threat. When children experience danger, they overestimate the probability and magnitude of the danger, neglect rescue factors, and often ignore coping resources. As an alert reader, you may recognize overestimation of the magnitude of danger as catastrophizing. Social anxiety carries catastrophic content that emphasizes the fear of negative evaluation. Panic involves the catastrophic misinterpretation of normal bodily sensations.

When children experience anger, they focus critical attention on others rather than themselves. The specific content centers on making hostile attributions about other people's behaviors, which includes labeling the other person, believing someone has ruptured one's own privately held rules, and inaccurately perceiving unwanted outcomes as unfair. HQ Card 2.9 (p. 23) presents a clinician's pocket guide to the CSH.

HQ Card 2.10 (p. 24) is a practitioner's guide to identifying meaningful cognitions. "I Spy" questions are provided to help you precisely isolate the unique cognitive content associated with different moods. The "I Spy" queries are an illustrative but not exhaustive list. So feel free to modify them as long as you stay true to the goal of digging for the various themes (e.g., danger, loss, violation).

Measurement-Based Care

In the new era of behavioral health care reform, quality counts (Friedberg & Rozbruch, 2016). When writing about reimbursement issues for psychotherapy many years ago, Barker

(1983) stated, "No one will be willing to continually pay large sums of money for anything unless they are sure of its worth" (p. 76). This prophetic statement remains quite true more than 30 years later. Value for the behavioral health care dollar is the new watchword. Providers who bring good outcomes to patients' problems will receive payment premiums (Bickman, 2008; Kirch & Ast, 2017; Unutzer et al., 2012).

Clinicians and patients profit from ongoing feedback about treatment progress (Scott & Lewis, 2015). When patients do better during and after the course of treatment, patients and providers benefit. In a broader sense, better service provision raises public confidence in child psychotherapy. Consequently, more referrals are generated and reimbursement rates are likely to increase. Finally, greater provision of quality care crowds "lemons" out of the behavioral health care marketplace.

Friedberg (2015) discussed the problem of "lemons" in psychotherapy. A lemon is a poor product or service that is dissatisfying to consumers (Akerof, 1970). Naturally, people do not pay premium prices for bad services. When lemons abound in a market, poor-quality services and product persist, and overall value for similar services declines. Friedberg (2015) noted that in these circumstances, "everything has equal value and is valued at the lowest price" (p. 339). Therefore, MBC is a way to monitor quality and demonstrate that your services are peaches rather than lemons.

MBC has gained a great deal of appeal in helping to improve clinical work with children and adolescents. Simply put, MBC refers to the process of regularly and repeatedly collecting patient outcomes over time to assess progress (Bickman, 2008; Bickman, Kelley, Breda, de Andrade, & Riemer, 2011). MBC is related to increased treatment progress (Lambert et al., 2002). Moreover, in young patients, MBC was associated with a quicker rate of improvement (Bickman et al., 2011). In their review, Scott and Lewis (2015) summarized the findings of multiple studies showing that MBC resulted in better decision making and judgments by clinicians.

MBC allows for both clinicians and patients to evaluate the return on their investment. Simply, these metrics shed light on what is working in treatment. Regular treatment monitoring facilitates necessary adjustments during the treatment process. It informs practitioners on when to stay the treatment course and when to make corrections. Further, MBC lets clinicians know what type of corrections could be made if they are indicated.

Tracking Numbers

If you have ever ordered something online or used a parcel delivery service, you know about tracking numbers. A tracking number serves to monitor the process from shipment to receipt. In this way, if the shipment gets derailed or lost, there is a way to identify or correct it. This is exactly what we as CBT therapists do to monitor treatment progress. In order to effectively and efficiently deliver a proper dose of *CBT Express,* therapists need to employ meaningful metrics to evaluate progress toward goals.

There are numerous ways for you to assess treatment outcome. These methods could reflect functional improvements, symptom reductions, and/or user experiences (Scott & Lewis, 2015). Additionally, depending on the circumstances of your practice, these methods could be standardized measures or individually constructed. Regardless of what type of measure you elect to employ, these tools should be simple, quick, and relevant to clinical concerns. Simply, value is multiply determined by a combination of measurement-based instruments.

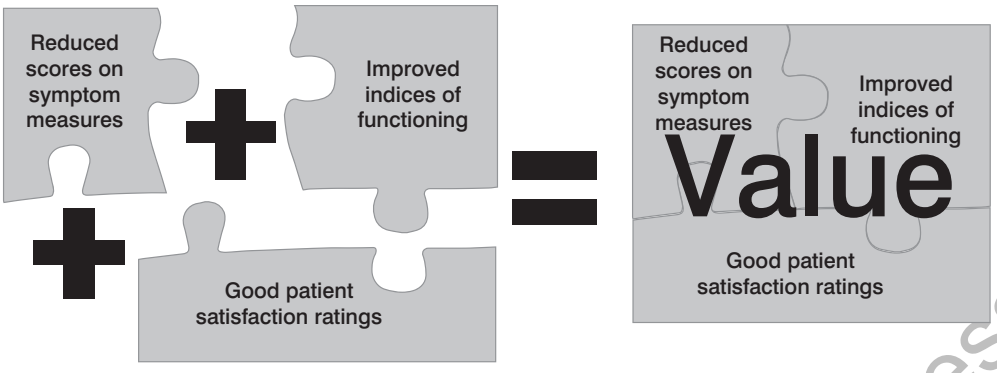

FIGURE 2.3. Assessing treatment outcomes.

Figure 2.3 illustrates the point. Accordingly, we recommend that clinicians employ diverse ways to demonstrate the value-added benefits of the services they provide.

Measures of functional improvement are personalized metrics designed to track improvement in individual patients' functioning. These functional indices might involve recording number of missed school days, visits to the school nurse, lowered medication dosages, and so on. HQ Card 2.11 (p. 25) lists several handy examples of functional improvement metrics. It should be noted that functional improvements are quite compelling to payers and patients alike. However, changes in functional outcomes can be hard to come by. Perhaps this is the reason they are so compelling.

Reductions on objective symptom measures are commonly used to track progress. There are many choices for objective symptom inventories. Friedberg et al. (2009) listed frequently selected scales that are both copyrighted and in the public domain. In a very comprehensive review, Beidas et al. (2015) outlined free, low-cost, valid, and reliable measures that are especially attractive to agencies, clinics, and practitioners with lean budgets.

User Experience

In addition to tracking numbers, user experience measures are helpful for evaluating care. User experience instruments tap patients' and families' perception of treatment and satisfaction with their services. Scott and Lewis (2015) noted that treatment alliance measures are essentially user experience measures. Finally, Miller (2015) argued that third-party payers pay special attention to patient satisfaction ratings.

Conclusion

Armed with an understanding of FA, the CSF, and MBC, you are ready to continue on the *CBT Express*. The following chapters will build upon these principles and offer specific applications of effective CBT interventions for express implementation in a variety of settings. HQ Cards (Handy and Quick worksheets and handouts) found at the ends of the chapters will serve as cues and reminders for families and clinicians when implementing the interventions at home, at school, or in a clinic or hospital setting.