SECTION ONE

Preparation

CHAPTER 1

Psychodynamic and Social Learning Concepts and Techniques for Working with Children and Families

Le coeur a ses raisons que la raison ne connaît point. [The heart has its reasons of which reason knows nothing.]

—Blaise Pascal (1623–1662)

In the course of a day, I may see a 5-year-old boy who refuses to use the toilet, insisting instead on wearing a diaper prior to having a bowel movement; a 21-year-old young man with Asperger's syndrome; a 7-year-old girl who is having difficulties adjusting to her school situation; a college student with a history of depression and a current substance abuse problem; a 12-year-old boy with social skills problems and significant parent-child conflict; a selectively mute 9-year-old girl; and a married couple in conflict about how best to help their anxious child with obsessive-compulsive tendencies or their child with pervasive developmental disorder (PDD). This sort of range of presenting problems and family issues is typical for a clinician with a practice in child and family therapy, and it calls for a different kind of model from that which suffices for colleagues whose practices are restricted to adults or even to adults and couples.

There are many competing models available, and many have at least one appealing feature, interesting strategy, or useful technique. How is a savvy clinician to formulate a model that gives him or her the freedom to incorporate these characteristics without ending up with a smorgasbord of unrelated techniques? This is the problem that has preoccupied me since my first days as a grad student. It is the problem that led me to learn to use psychodynamic, behavioral, and family therapy concepts and techniques. And it is the problem that led to the integrated model I present here.

Range of Convenience

The integrated model for therapy with children and families is a model with a clearly defined range of convenience. It provides a framework, with related strategies and techniques, that will be helpful to clinicians and others who work with children,

adolescents, and their families. Although other kinds of professional activities, such as couples therapy, consultation to family businesses, and long-term intensive individual psychotherapy, have much in common with treating children and families at the highest levels of abstraction, they call for different sets of strategies and techniques, and so for different intervention models. Some readers may find it interesting to extrapolate from what is offered here to these other kinds of professional activities, but this is not my intent. As an aside, I believe that one potential pitfall for any model of psychological intervention occurs when its adherents try to apply it far more widely than was originally intended, rather like trying to use a socket wrench as a hammer. It's possible, but it will take far longer than it should, and the chances of banging your thumb are higher, as are the chances of bending the nail and denting the picture frame, windowsill, or cabinet top.

The Model

The integrated model is three models in one: an overall general and moderately abstract model; a more specific set of strategies and techniques for addressing externalizing problems, especially among younger children; and a parallel set of strategies and techniques for addressing internalizing problems at all ages. The overall model is composed of assumptions, values, and guidelines and offers a general approach to problems and a general therapeutic stance. Each of these features is discussed in detail, some in this chapter and some in the next.

Assumptions

I offer these assumptions largely without empirical justification and with the expectation that they are sufficiently familiar and sufficiently widely shared as to be relatively noncontroversial:

- The therapist-patient relationship is, if not the entire therapy, at least its most crucial component.
- Historical factors are important. Whether the case concerns a 2½-year-old whose parents are concerned about speech development, the oppositional 8-year-old with a single mother, or a depressed 15-year-old, we have to learn as much as we can about the child's history and the family history. Part of the reason for this is that family history figures significantly in our current understanding of a number of disorders, including obsessive-compulsive disorder, eating disorders, mood disorders, and substance abuse disorders. A second reason is that early experiences, among them traumatic experiences, figure prominently among the factors that are involved in the development of a sense of self. A third reason for being aware of family history is that it profoundly affects the capacity of parents to change how they see themselves and their children and their capacity to bring true caring, sensitivity, and consideration to the very challenging task of parenting. And the fourth reason, one about which I'll have much more to say later, is that knowledge of history is crucial to applying the useful contextual therapy concepts of *constructive* versus *destructive entitlement.*
- The patient is more important than the theory. The integrated model always takes second place to what the patient presents, what the patient needs, and what will help the patient. The guidelines I offer are just that: guidelines, not rules. They are meant to be modified as needed and replaced as needed. A therapist who strives to be consistent to the model, or to work "purely" within the model (whatever that means), is unlikely to be doing good therapy.
- Issues typically thought of as "purely physical" are important. The integrated model is not reductionistic: It does not try to reduce psychological phenomena to biological

phenomena, biological phenomena to biochemical phenomena, and biochemical phenomena to phenomena responding only to something that can be dispensed by a pharmacist. It does, however, recognize the importance of nutrition, exercise, and rest, not only to physical health but to psychological health as well.

- Developmental issues are important. Developmental issues are front and center when we see children with learning problems and mental retardation. In other cases, the developmental issues are more subtle and involve social learning, fears of independence, and issues of identity. For many clinicians, the adjustment of manner and style to accommodate the needs and capacities of children from 2 to 16 are automatic and intuitive.
- Individual differences matter. Until fairly recently, this assumption was so widely accepted that stating it would have been superfluous. All personality theorists started with this as the most basic of assumptions. Psychological tests, whether of intelligence, other cognitive skills, or personality, are designed to be measures of individual differences. Among family systems therapists, some of this has, I fear, been forgotten. Interest in and, to a certain extent, concern for individual differences has been supplanted by interest in and concern for systemic differences. Family typologies have supplanted individual typologies. This is not altogether a good thing. Some psychodynamic approaches may have erred by going too far in the direction of purely intrapsychic therapies and by promoting approaches that seemed to be based on the notion that everything important occurs between one's ears. The first generation of family therapy researchers and theorists (e.g., Bowen, Haley, Minuchin, Bateson) may have felt that they needed to make a clean break from the psychoanalytic tradition in which most of them were trained if they were to draw clinicians' attention to their new models of

family interaction and family communication. Much was lost, though: the appreciation of individual differences in intelligence, personality style, and personal history, in goals, in values, and, of course, in emotional difficulties.

- It's always worth trying the simplest and quickest interventions first, especially if the patient is very young and if there is a clear target problem on which one can bring a straightforward intervention to bear. I've always liked the metaphor of Occam's razor and see this model as incorporating an analogous perspective on therapy: The simplest intervention that works, not merely the simplest intervention, is the *best* intervention.

Integrating Three Models of Therapy

There is considerable variation in the way the term *integrative therapy* is used (e.g., Garfield, 1994; Goldfried, 1980, 1982; Norcross & Goldfried, 1992). Perhaps the clearest is that used by Stricker (1994), who defines *theoretical integration* as "an attempt to understand the patient by developing a super ordinate theoretical framework that draws from a variety of different frameworks" (p. 5). This book represents my attempt to achieve this goal by bringing together three seemingly disparate streams of thought about children, adolescents, and parents; their relationships; the behavioral, emotional, and interpersonal problems that occur in families; and how psychotherapists can most helpfully intervene. The three streams of thought on which I base this model are the psychoanalytic theory and practice developed by Freud and generations of his colleagues and students, social learning theory as formulated by Julian B. Rotter and his colleagues, and the contextual model of Ivan Boszormenyi-Nagy and his colleagues.

My solution to the problem of how to help children and families presenting a diverse set of problems rests on a primary assumption: Solving problems of childhood and adolescence is best done when one is equally comfortable with cognitive, behavioral, family systems, and psychoanalytic approaches. This assumption has a corollary: Clinicians who can integrate these approaches will function more effectively. This is what I set out to do here: to integrate psychodynamic, behavioral, cognitive, and family systems concepts in a way that is most useful to clinicians working with children, adolescents, and their families. To do this, I draw on a flexible behavioral model, Rotter's (1954) social learning theory; a flexible family systems model, Boszormenyi-Nagy's (1987) contextual theory; and Freud's psychoanalytic theory. I draw from these three approaches in different ways. Rotter's social learning theory explains the cognitive and behavioral mechanisms that lead children, adolescents, and their parents to make choices. Boszormenyi-Nagy's model provides a framework for considering four sources of information about those things that affect children, adolescents, and their families. It also draws our attention to the broader ethical nature of clinical work. The explicit goal of contextual therapy is to help people be more balanced in their relationships with those closest to them, give more spontaneously and freely of themselves to those in their families, and to state their own needs and wishes in a spirit of open dialogue. The role of psychoanalytic theory and psychoanalytic psychotherapy in my model is to provide a counterbalance to the behavioral and cognitive approaches of Rotter and Boszormenyi-Nagy. I draw on psychoanalytic ideas that speak to the child's developing sense of an autonomous self, psychological development more generally, the importance of unconscious motivation, the value of helping patients of all ages gain awareness of their emotional lives, the importance of the therapeutic relationship, and the importance of therapists' intuitive understanding of their patients. I incorporate Anna Freud's (1946/1964) insights regarding child

treatment, especially her recommendations on engaging young children in treatment.

Therapists who work with the full range of issues and problems that confront children, adolescents, and their families need a model that addresses cognitive, behavioral, and emotional issues and can be applied to narrow behavioral issues (toilet training, sleep problems, tantrums); to emotional issues related to school achievement, adolescent identity, and social concerns; to parent-child conflicts, school achievement issues, and family relationship issues. Helping families also means being able to address the concerns of cooperative parenting as well as parents' individual issues that affect and are affected by their children. Any therapeutic model has to have a way of helping patients of all ages know what they are feeling, tolerate what they are feeling, and make informed decisions about what to do with those feelings. A useful model will have something to say about the therapist-patient relationship, including issues related to both transference and countertransference. A useful model will also address a problem that plagues those who treat more than one person in a family at a time: considering the impact of their interventions on each of these people, even when the people are temporarily at war. These three models complement each other to form an integrated and practical model that makes this possible.

In this chapter and the next, I offer brief synopses of the two sources that are likely to be less familiar to readers (social learning theory and contextual therapy) and, based on my belief that all readers will have some familiarity with Freud's work, an even more brief synopsis of some aspects of psychoanalytic theory and practice.

Integrated therapy for children and families is a model designed to help clinicians conceptualize and select interventions from whichever of the three component models fits the child, family, and situation best. The interventions themselves vary considerably depending on the kind of problem the child presents,

the child's age and developmental level, and the ability of the child's parents to engage in treatment and to help their child.

Of the many ways to categorize children's problems, one of the simplest and most useful is to consider whether the child's presenting problems are primarily externalizing (tantrums, oppositional behavior, aggression, noncompliance, rule violations, etc.) or internalizing (anxious or depressed mood, social anxieties, chronic worry, sleeplessness, etc.). Some concepts are useful in treating all of these problems and situations, but in different ways depending on the particulars. One example of a concept that is useful in all treatment cases is the contextual principle of *multidirected partiality,* choosing interventions with awareness of their impact on each person they may touch.

The technique of multidirected partiality has to be used in one way with a shy, self-doubting, and somewhat dysthymic 7th-grade girl and in a very different way with an aggressive, oppositional, and defiant 7th-grade boy. Successful treatment of both children requires the development of a strong therapeutic alliance and a trustworthy relationship. In both cases, the therapist should strive to be as multidirected as possible. In both cases, it will be helpful to think about the extent to which the child and parents are relying on destructive entitlement. When we leave the level of these abstract treatment principles, things begin to diverge. The treatment of the internalizing girl will exemplify the adage "the relationship is the therapy" to a much greater extent than will the boy's treatment. It will be far less directive, more interpretative, and more exploratory. Depending on how verbal she is, significant amounts of time may be spent in individual sessions, with her parents' involvement being adjunctive. A classically trained psychoanalytic psychotherapist would be comfortable observing these sessions.

In contrast, the boy's treatment, in addition to attention to emotional and interpersonal factors, will involve some sort of direct behavioral intervention, probably including teaching his parents how to more effectively use reinforcement contingen-

cies to manage his behavior. He will rarely be seen individually. Rather, the therapist will see him with his parents and may see them without him to provide further coaching. This treatment will be highly directive. Parents will receive instruction on how to use what contingencies they have available to regain some control over his behavior. Efforts at understanding the root of his challenging behavior will depend as much on learning about its antecedents and consequences as on uncovering his thoughts and feelings. If he were 5 or 7, even more attention would be paid to parenting techniques.

Integrated therapy offers a general set of principles and more specific sets of guidelines, one for internalizing problems and one for externalizing problems. This chapter provides a preview of these guidelines, and later chapters fill in the details. Included in the externalizing category are various behavior problems (challenging behaviors, toileting problems, enuresis, encopresis, tantrums, bedtime problems, so-called compliance issues, preschoolers with challenging temperaments, etc.). Some of these problems are more characteristic of younger children, usually preschoolers through 10-year-olds, and others occur more frequently among slightly older children. The treatment of moderate to severe Conduct Disorder often requires more structure than outpatient therapy can provide and is outside the range of convenience of this model, although support for parents dealing with this issue is not. Among internalizing problems are specific fears, general anxieties, relationship concerns, self-worth issues, identity issues, adolescent adjustment issues, and mood problems.

Because nothing can be that simple, a third option exists. Not infrequently, externalizers have internalizing problems, too. When the externalizing problems are mild or sporadic, it may make sense to focus on the internal conflicts that precipitate the behavioral outburst, school refusal, or noncompliance. When the behavioral problems are persistent, frequent, or more intense, this approach is not likely to succeed. This is what can seduce

well-meaning but naïve therapists into believing that given enough empathic understanding and time, insight will obviate the undesirable behaviors. As Ann Richards said in her keynote address at the 1988 Democratic National Convention, "That old dog won't hunt." It makes more sense to work with behavioral contingencies and situational variables (e.g., school setting) to gain control over the unacceptable behaviors, and then to help the child come to grips with his or her inner turmoil. The way I expressed it to a boy I had been seeing weekly for over a year and with whom I had a strong relationship was something like this: "I know you're in pain and have been badly hurt, and I want to help you with that, but I can't when there are these constant crises of you screaming at your mom and threatening her."

Having roughly categorized problems as either primarily externalizing or primarily internalizing, the next consideration is the child's age. Externalizing problems of very early childhood almost invariably respond well, and often very quickly, when parents are provided with more effective parenting techniques. My belief is that we are obligated to resolve children's problems as quickly as we can. A particular therapist may be fascinated by the nuances of child development or bored with them. Either way, he or she ought to be trying to resolve the problem with sleep, tantrums, or toileting as quickly as possible. Patients are not research subjects. The goal is not to learn about child development from them, but to help them as quickly as possible, without resorting to depth psychology, if possible. Typically, this means relying on reassurance, education, coaching, and behavioral techniques—all of this guided by the general principles set out in the overall model. Very young children may be passive recipients of their parents' new skills, or they may be directly involved in therapy.

The treatment of internalizing problems, and problems characterized by both internalizing and externalizing components, has to be adjusted similarly in accordance with a child's age and developmental level. Dennis, whose case I discuss in Chapter 2, was an 11-year-old with the verbal abilities of a 5-year-old. His

disruptive behaviors were the direct result of his frustration in trying to communicate and his parents' lack of appreciation for how significant was his delay. In treating him, I addressed his emotional upset and wishes by using language that he could understand and asking only for very simple responses.

A Few Words about the Language of Psychoanalysis

Some of the language of psychoanalysis suffers in translation. Many people have found it confusing and difficult to decipher into plain English. I rely on three sources to effect a translation: John Dollard and Neal Miller, Anna Freud, and Erik Erikson. Dollard and Miller (1950) wrote a landmark book that provides tremendous help to clinicians who want to learn from what psychoanalytic thought has to offer while maintaining a commitment to clear expression. Their work is important to all clinicians, whether their focus is the treatment of adults (as was theirs) or children, adolescents, and families (as is my interest). Unfortunately, their book is little read today; it is deserving of more attention. In brief, their goal was to frame psychoanalytic hypotheses about human behavior, as well as psychoanalytic techniques, in a more readable, and potentially researchable, language. Quoting from the introductory chapter: "We have attempted to give a systematic analysis of neurosis and psychotherapy in terms of the psychological principles and social conditions of learning" (p. 9). In this process, they note that "the concept of 'pleasure' has proved a difficult and slippery notion in the history of psychology" (p. 9). For this reason, they replace "pleasure principle" with "reinforcement." They go on to note, "The same is true of the idea that the behavior that occurs is 'adaptive,' because it is awkward to have to explain maladaptive behavior on the basis of a principle of adaptiveness" (p. 9). In the remainder of their introductory section, Dollard and Miller

sketch out the way they will be recasting the concepts of ego strength, repression, transference, and conflict behavior into a clearer language, one that is more apparently tied to what was known about learning and cognitive processes.

In this spirit, and with appropriate credit to Anna Freud and Erik Erikson, I offer the following perspective on *psychosexual development.* For the casual and even not so casual reader, the idea of infantile sexuality may be either shocking or simply ungrounded in reality. If one reads this differently, it begins to make sense. Here is what I believe Freud, at least Anna Freud, is saying. As a child develops, the way he or she experiences and relates to the world and the people in it changes. These changes are not only cognitive (as discussed by Piaget, his students, and their students); the changes are also profoundly emotional and physical. The youngest—infants and very young children—experience the world and relate to their mother and other nurturers through their mouths. They must take food in through their mouths or starve. The mouth is the route to emotional connection as well: Food is love. As children grow, they begin to develop a sense of individuation from their mothers and to simultaneously develop the capacity to use their mouths in another way: to bite. Traditionally, when babies begin to bite the breast, mothers begin to think about weaning them: It is a sign that the baby is becoming, in a small way, independent and that he or she is ready for a tiny bit of distance. Psychoanalysts give this stage in every child's development a name, *the oral stage,* which they then subdivide into two aspects: *oral incorporative* (i.e., eating) and *oral aggressive* (i.e., biting). In psychoanalysis, these names for early childhood stages are used in speaking about later personality, emotional, and behavioral issues. Erikson refers to this as the stage in which the psychosocial crisis of basic trust versus basic mistrust first arises. So, when a 14-year-old girl fluctuates between being dependent, insecure, and clingy, constantly seeking reassurance and nurturance; and being sarcastic, verbally offensive, verbally aggressive, and mov-

ing away, one may speak of the adolescent as moving between oral incorporative and oral aggressive ways of relating to her parents. One may also speculate that this young person continues to be conflicted about aspects of her relationship with her parents that first occurred when she was nursing and that we are seeing her struggle to remain close and yet to move away into more independence at the same time.

During the second or third year, children begin to have some bowel control; in psychoanalytic terms, this is referred to as *the anal stage.* The newfound power enables them to choose to please their parents by having a bowel movement, to disappoint them by refusing to have a bowel movement, or perhaps to anger them by having a bowel movement at an inconvenient time or in an inconvenient place. The psychoanalytic literature writes about these alternatives as *anal-retentive* and *anal-eliminative* tendencies, emphasizing their biological and physical aspects. Psychoanalytic literature uses these terms to characterize emotional and behavioral realities as well as personality patterns. Erikson recasts the issue in psychosocial terms as one of a stage in which the important crisis is that of autonomy versus shame and doubt. For Erikson, the issue is whether children begin to take pride in their productions and gain a sense of being in control of their body or whether they begin to be preoccupied by a sense of having committed some infraction. So, children or adolescents who choose not to do their homework or chores may be spoken of as anal-retentive, and those who are very messy in their habits or in their room as anal-expulsive.

The next stage in development is referred to in classical psychoanalytic literature as *the phallic stage* and by Erikson as the stage centered on resolving the crisis of initiative versus guilt. This is followed by the stage of *latency* (in psychoanalysis), or industry versus inferiority in Erikson's psychosocial scheme. In Erikson's theory, the central psychosocial crisis of adolescence is that of identity versus identity confusion.

Psychodynamic Psychotherapy

Psychoanalysis as originally described by Sigmund Freud consists of three elements: a body of clinical lore, a theory of personality development, and a model of treatment. Anna Freud's (1946/1964) little book has much to offer any therapist who works with children. I write about her techniques for engaging children in treatment in Chapter 8.

The influence of psychoanalytic thought is so pervasive as to defy summary. Suffice it to say that all forms of therapy that have emerged since Freud have been either developments of psychoanalytic thought or reactions to it. In my work and in this model, a model that seeks to integrate diverse strands into one cable, the two most visible contributions of psychoanalytic literature are the theory of psychosexual development as formulated by Freud and expanded on by Erikson, and the psychoanalytic attitude toward individual human beings and toward the work of psychotherapy. Of those who have written about this, I have been most influenced by Anna Freud's book, by Guntrip's (1971, pp. 175–196) discussion of psychoanalysis and psychotherapy and Schaeffer's (1983) writings on the analytic attitude, and by a recent and very readable book by psychoanalyst Elio Fratarroli (2002). With the exception of Anna Freud, these writers do not concern themselves explicitly with the issues that confront the child therapist, and yet their ideas about the therapist (they would say the analyst) and the patient are relevant to the model I'm presenting here. This is true in part because my model is very much concerned with parents as active participants in the treatment of children, in part because the treatment of adolescents has much in common with the treatment of adults, and in part because these psychoanalytic writers speak to the uniqueness of each human being in a way that others, even those who agree with the position, do not.

The writings of psychoanalysts draw our attention to a number of important issues: what a therapeutic relationship is, how therapists can manage their own feelings, the role of personal therapy, how to use our own reactions to understand what is going on with patients, and how to help people get deeper into their emotions. All this is essential for working with parents and adolescents, and also with young children, although in a different way, as it helps us rely on intuition and connecting with children. Social learning theory provides an interesting framework for understanding how people make choices and is especially useful when trying to understand how adolescents make choices that may seem not to be logical.

Behaviorism and Social Learning Theory

Behavior therapist or not, one must recognize that behavioral principles, both classical and operant, explain much behavior. Pavlov described experiments in which dogs, after being exposed to a previously neutral stimulus (a bell) that was paired with a conditioned stimulus (food powder) a sufficient number of times, began to emit the conditioned response (salivation) to the neutral stimulus (the ringing bell) alone. Thus, the previously neutral stimulus becomes conditioned and is referred to as the conditioned stimulus. This is, of course, why it is called conditioned learning or classical conditioning. This was a powerful discovery.

Thorndike's (1911) law of effect states that behaviors that are followed by a reinforcing event will tend to occur more often in similar situations, eventually taking on the characteristics of a habit. Although Thorndike was not interested in what internal experiences might go along with this, even therapists who are very interested in internal events should remember this law, especially when working with young children and challenging

behaviors. This single idea helps explain why young children engage in some of the behaviors that distress their parents so. The practical effect of this is that the behavior at hand becomes much more likely in the presence of the stimulus that signals a reinforcer in the offing than otherwise.

B. F. Skinner expanded on Thorndike's work when he developed his model of operant conditioning, a model of understanding and modifying behavior that has an important place today in the treatment of mentally retarded children and developmentally delayed adults in the form of applied behavior analysis. Skinner was opposed to theorizing and to postulating any cognitive activities that might mediate an organism's choices. As Rotter (1982) puts it, a theory of cognitive motivation does little to explain the behavior of rats, or of pigeons for that matter. It is essential, however, if we are to understand the behavior of people.

Rotter (1954) is not a behaviorist per se, but a research-oriented personality theorist who built on the work of Hull in developing a general theory of personality that predicts how people will make choices based on what they expect will be the result of those choices, on how much they value a particular possible outcome relative to other outcomes, and on how likely they believe that desired outcome is. Rotter puts this into a general equation: NP = f (FM + NV), where f is function, NP refers to the need potential, FM is freedom of movement, and NV is need value. This equation may be off-putting to some readers, but before you flip the page, take a minute to consider what Rotter is saying: If we want to know if a child will be likely to follow his mother's instructions (what the child's need potential is for instruction-following behavior), say, following his mother's instruction to wash his face, brush his teeth, and get ready for bed, we will stand a better chance of knowing whether or not he will do this if we know what he expects will happen (his freedom of movement) if he follows the instructions and how important that thing he expects to happen (the need value) is to him. So, if

he expects that quickly brushing his teeth will mean that his mother will read him his favorite story, and if he loves being read to, the odds are better that he will brush his teeth than if he expects that brushing his teeth quickly will mean only that he has to go to bed sooner, something he would rather avoid. That is all that Rotter is saying, and it's hard to argue with. Rotter is not saying that these factors (expectancy, reinforcement, and reinforcement value) are the only ones involved. He is saying, rather, that the child's behavior is a function of these factors and one other: *the psychological situation.*

The concept of the psychological situation is an important contribution to Rotter's model because it draws our attention to two issues that are easy to overlook. If we are to understand how reinforcement really works for a child, we need to understand what events and objects are reinforcing to the particular child, and to what extent they are reinforcing. We need to know the unique way that our particular patient responds to potential reinforcements. We need to know how likely this particular child believes it is that he or she will receive the desired reinforcement in response to particular behaviors and in a particular psychological situation. The adjective is important. It is not enough to take a situation into account (e.g., preschool, home, playground). We need to know something about the psychology of the situation for that child (e.g., a situation involving unstructured activity with peers, a situation involving the need to follow instructions from an adult, a situation involving competing for parental attention with a sibling). The emphasis on understanding the child's subjective experience of situations, of reinforcers, and of the relative value of potential reinforcers provides a framework for constructively and creatively using more narrowly behavioral interventions. The emphasis on the child's subjective experience and how he or she subjectively values reinforcers can, in conjunction with contextual and psychodynamic considerations, also help to explain seemingly inexplicable behaviors. Chapter 11 applies this concept, in conjunction

with contextual and psychodynamic considerations, in the clinical vignette of a 4-year-old boy who was so enraged by the favoritism his parents seemed to bestow on his older brother that he intentionally soiled himself and played with and smeared his feces, all the while pretending to enjoy it. The distress this activity caused his parents, and the attention that resulted from it, made it worthwhile—made it reinforcing.

Of course, the formula says nothing about how a therapist may help parents and children. Rotter's theoretical writings do not provide specific guidance for therapists; instead, Rotter focuses on concepts that have implications that creative clinicians can use to develop helpful interventions. For example, Rotter defines a *minimal goal level* as the goal above which a person subjectively feels successful and below which he or she feels unsuccessful. His theory goes on to say that people who set their minimal goal levels too high will expereince (subjective) failure repeatedly. The result will be that their expectancies for (subjective) success will drop markedly, and so will their interest in trying those activities in the future. It is not too much of a stretch to see how this applies to many situations in which we would like to help parents help their children take on a challenge, whether that challenge is academic, social, or athletic. It also has clear implications for working with an underachieving high school student who believes that if she can't be sure of getting an A-plus, there is no point in trying, as anything less will feel like a failure to her.

Social learning theory has implications for guiding parents in their choice of behavioral techniques to use in parenting, in bringing disruptive behaviors under control, in toilet training, in encouraging a selectively mute child to begin to speak in public, and in addressing many other problems examined in Section 2 of this book. Most important, it puts behavioral considerations into a social and subjective context, one that explicitly draws our attention to understanding how children experience events and situations before we try to intervene behaviorally.

In the next chapter, our attention will turn to Boszormenyi-Nagy's contextual therapy and to the contextual concepts that will be most useful in working with children and families.

Anticipating Chapter 2

Although the integrative approach includes a family therapy approach, it emphasizes the thoughts and, above all, the emotional lives of individuals, in contrast to the emphasis on the family as a system. Thinking of families as systems can be very useful. It is important to remember, however, that these systems are made up of people who have thoughts, feelings, and complex inner lives. Individuals are systems, too, not just cogs in a systemic wheel.

Failing to see each individual's personal concerns, feelings, thoughts, wishes, hopes, past hurts, and disappointments can lead one to make major errors when conducting family therapy sessions as much as they can when working with an individual. Children, as well as adults, differ from each other in important ways. Some of these differences, such as ego strengths and weaknesses, character structure, ego defenses, and coping style, are emphasized by the psychodynamic tradition. Other important individual differences reflect difficulties in life that are experienced by people as individuals. Even in an approach that tries hard to focus on resources rather than on pathology, it must be recognized that some people with whom we work have very significant individual emotional and psychological difficulties; when a child has diabetes, cystic fibrosis, or cerebral palsy, or when a parent has lupus or has suffered a stroke, this condition needs to be recognized, acknowledged, and addressed.