UNIVERSITY OF CALGARY

Department of Psychology
Psychology 683 (01) (H3-3) – Child Psychotherapy
Fall 2008

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Alberta Children's Hospital: Assistant Training Coordinator:
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Days and Meeting Times:

Class Time: Fridays 12:30 - 15:30 hours **Place:** A248

Practicum Organization Meeting:

Wednesday, September 3, 14:00 – 15:30 hrs (if needed); Alberta Children's Hospital; 4th Floor, Conference Room #04).

Required Readings and Texts:

(1) Mash, E. J., & Barkley, R. A. (Eds.). (2006). *Treatment of childhood disorders* (3rd ed.). New York: Guilford Press.

(2) Kazdin, A. E., & Weisz, J. R. (Eds.). (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.

(3) Specific journal articles and readings as assigned.

(R) **Recommended:**

Weisz, J. R. (2004). *Psychotherapy for children and adolescents: Evidence-based treatments and case examples*. New York: Cambridge University Press.

The books by Mash and Barkley (2006) and Kazdin and Weisz (2003) include assigned readings, and also provide background information and resource material for specific topics in this course as well as for other components of your clinical training. The volume by Weisz (2004) includes case descriptions and treatment procedures for a variety of different problems and is recommended reading. With the increasing output of recent years, the assigned readings are but a small selection from the relevant literature. It is hoped that this outline and the course itself will not only familiarize you with current issues in child psychotherapy/treatment, but that it will also guide you in your future reading and research in this area.

Child Psychotherapy: Developments and Challenges

The fool tells me his reasons, the wise man persuades me with my own.
Aristotle

"The overall philosophy of this course follows from a cognitive-behavioral systems perspective in which treatment decision-making with children and families proceeds from a consistently applied theoretical framework, well-established research findings relevant to both normal and atypical child and family functioning, evidence-based treatment procedures, and operational rules and procedures that are sensitive to the realities and changing demands of clinical practice and to the broader socio-cultural context in which treatments are carried out." [Mash, 2006, p. 5]. In this context, please consider the following views of child and family treatment:

"The type of treatment offered should not simply be the one suggested by the therapist's theoretical orientation, but one that at a given point in time is most likely to be useful based on available research findings--*if such guidelines are available*. It is necessary for the clinician to be familiar with many treatment models and methods, not just one approach dictated by past training or theoretical preference and to give adequate consideration to research findings pertinent to one's clinical activities." [Johnson, Rasbury, & Siegel, 1986, p. 105]

"Progress in the development and evaluation of psychotherapies for children has been slow relative to research that has been completed with adults. There are many different treatments-indeed over 230 for children and adolescents. The great majority of these have not been shown to be effective. Even more regrettably, most of these techniques *have never been carefully evaluated*…There is some urgency to the task of stimulating further work (in the area of child treatment research). The urgency does not derive from an imminent crisis or new psychological problem of childhood or adolescence that requires immediate attention before reaching epidemic proportions. To be sure, there are enough crises because of the tragedy of many childhood and adolescent problems that occur on any scale (e.g., suicide, depression, antisocial behavior). The urgency of further work derives from greater dangers in the field, namely inertia and tacit acceptance of the status quo, and limited avenues to progress. There is an unfelt problem vis-à-vis child treatment research. Unfelt problems are dangerous because they are likely to be neglected and ignored." [Kazdin, 1987, pp. 8-9]

"The field of psychosocial treatment research for children and adolescents is still in its early childhood. Although in the past two decades research has been burgeoning, methodologies have improved, and public awareness has been raised concerning children's mental health issues, the field is still far away from the level reached in other areas of study, such as biological, pharmacological, and treatment research, with adult populations." [Hibbs & Jensen, 1996, p. xix]

"the complexity of childhood disorders, the diversity of circumstances under which they occur and are treated, the evolving nature of cognitive-behavioral treatments, efforts to integrate different therapy orientations, the widespread use of combined and multimodal treatments, and the uncertainties regarding the clinical significance and long-term effectiveness of current treatments for children, would contraindicate a rigid adherence to *any* narrowly defined therapeutic perspective." [Mash, 2006, p. 6]

"A funny thing happened on the way to the clinic: treatments that fit very nicely in university trials have had to stretch to fit real world practice conditions…The therapists are

dedicated and hard working, but they find it challenging to fit the manualized treatments (for anxiety and depression) into their demanding workloads, and into the complex array of life circumstances their clients present. The referred youngsters they treat are often quite different from the youngsters treated in many university trials; as an example, co-morbidity is rampant in the referred cases with anxiety and depression typically mixed with serious oppositional behavior, conduct problems, or ADHD. Furthermore, the parents don't look much like the middle class volunteers who tend to sign up for laboratory trials. Financial and social stresses often limit the clinic parents' participation in their child's treatment (say, by meeting with the therapist or helping the child with therapy homework), and parents often have serious personal and family problems, and sometimes diagnosable disorders of their own. Treatment appointments are frequently missed, and termination can occur without notice. My colleagues and I were wrong, some years ago, when we wrote about differences between lab and clinic…we under-estimated the differences. [Weisz, 2000, p. 1]

"….we note several characteristics of the treatments and evidence that are particularly admirable, including breadth of coverage of important youth problems and disorders, a creative array of treatment delivery models, an increasingly rich mix of informants and measures in outcome assessment, and recently expanded attention to moderators of treatment outcome…..But we also find areas in which change is needed and topics that need attention in future research. Among these we note orphan conditions—most youth-relevant categories in DSM-IV, in fact—for which treatment development and testing are sorely needed. We also note a need to extend treatment outcome research to the treatment models, or schools of therapy, that are widely used in clinical practice but poorly represented in the research literature thus far. We note how little is currently known about the ways therapist behavior and the therapeutic relationship relate to treatment persistence and outcome, particularly in the new world of manual guided treatments. We stress the critical importance of mediation tests, to identify the mechanisms of action that explain why treatment works. And we emphasize the need to understand evidence-based treatments in relation to clinical practice, with more the research treatments carried out under conditions such as those practitioners confront. Viewed in historical perspective, the trajectory of research on child and adolescent treatment is quite remarkable, particularly in recent decades…There are laurel wreaths all around for the leaders who have brought us to this significant point in treatment research. But there is little time for resting on laurels. A great deal of work remains to be done. [Kazdin & Weisz, 2003, pp. 448-449]

General Course Description:

The overall objective of Psychology 683 is to assist you in acquiring beginning knowledge and skills relevant to theory, research, and practice in child psychotherapy, behavior change, and treatment. We will emphasize the knowledge base and issues underlying child treatment that are a necessary foundation for the ongoing development of practice and clinical research skills. Our main emphasis will be on evidence-based treatments and cognitive-behavioral theories and treatment strategies, with some attention given to other theoretical perspectives and approaches. The seminar will have a theoretical and research emphasis, but the real world of client problems and therapist challenges will be continually considered as we move back and forth between theory and data on the one hand, and clinical applications on the other. A theme of the course will be the dialectical tension between science and practice in child psychotherapy, between a commitment to data and an appreciation of the clinical realities that often require therapists to operate in ways that may be weakly supported by scientific evidence.

The course is designed to provide broad coverage of selected topics in the treatment of child and family disorders. Some of these topics are concerned with general issues in child psychotherapy (e.g., theoretical models underlying treatments, developmental considerations in

child treatment, the therapist-client relationship/alliance, treatment outcome effectiveness, special legal and ethical issues in working with children and families, gender and culture sensitive treatments, translating research-based treatments into clinical practice, and dissemination). Others will involve a more detailed examination of specific modes of treatment (e.g., behavioral parent management training, cognitive restructuring, systematic desensitization, school-based interventions) for children and adolescents with a variety of specific disorders (e.g., depression, anxiety disorders, conduct problems, attention-deficit/hyperactivity disorder, autism).

The course is intended to be part of your ongoing education and training in clinical psychology in which you are expected to play an active role. It is designed to assist you in gaining increasing levels of knowledge, competence, and confidence in the science and practice of psychotherapy, behavior change, and treatment with disturbed children and adolescents in a wide range of activities engaged in by Ph.D.-level clinical psychologists (e.g., case formulation, clinical practice, consultation, treatment design, program evaluation, research, teaching, training, and clinical supervision). Within this broad framework, a number of more specific objectives will be pursued.

Course Objectives:

(1) Acquisition of knowledge about **basic conceptual issues** in treatment including current evidence-based theoretical models for the treatment of children and their families; developmental and cultural considerations; decision-making/problem solving approaches to child and family psychotherapy.

(2) Acquisition of knowledge about **research** in child psychotherapy; evaluating therapy process; evaluating moderating and mediating variables in child psychotherapy; evaluating the efficacy and effectiveness of outcomes in child psychotherapy.

(3) Acquisition of knowledge about substantive and practical issues relevant to different child and adolescent psychotherapy **approaches and techniques**.

(4) Acquisition of knowledge about substantive and practical issues involved in the treatment of specific **populations and problems**, children of different ages, gender, family, ethnic, and cultural backgrounds.

(5) Acquisition of knowledge about substantive and practical issues involved in treatments carried out in different **settings** (e.g., pediatric practice/hospital, mental health clinic, school, home, residential treatment, and other community settings).

(6) Acquisition of knowledge about **professional issues** relevant to psychotherapy with children and families including record keeping and ethical and legal aspects of the treatment process.

(7) Exposure to and practice in beginning general **clinical skills** and specific **practice skills** in using cognitive-behavioral and other treatment strategies with children and families.

(8) Acquisition of knowledge, exposure to, and practice in, beginning skills related to the **process of treatment** with children and families in the clinical context. Such skills include: case formulation; evaluating, integrating, and interpreting assessment information; communicating such information to children and parents; formulating treatment goals and plans; designing and selecting appropriate treatment strategies; establishing therapeutic relationships with children,

parents, and teachers; motivational strategies for engaging children and families in treatment, promoting treatment adherence, and minimizing treatment drop-outs; strategies for promoting treatment generalization across behaviors, settings, and time; working collaboratively and consulting with other health professionals within multi-disciplinary settings; and, strategies for evaluating individual client's treatment progress and outcomes in the clinical context.

Overview of Topics:

Listed below is an overview and outline of topics that we will be addressing during the term.

Week	Topics
0 - September 3 -	Introduction to Practicum - 14:00-15:30 hrs (if needed) – Alberta Children's Hospital, Conference Room 04/
1 – September 12 -	Organizational Meeting/Introduction to Course Introduction to Child Psychotherapy
2 – September 19 -	Models of Child Treatment Developmental Issues, Outcome Research Clinical Demonstration I: Relaxation Training Procedures with Children
3 – September 26 -	Theoretical Approaches and Issues I
4 – October 3 -	Theoretical Approaches and Issues II
5 – October 10 -	Psychotherapeutic Strategies with Maltreated Children Ethical and Legal Issues
6 – October 17 -	Cognitive-Behavioral Approaches to Anxiety Disorders Clinical Demonstration II: Desensitization/Exposure/Cognitive Restructuring Procedures
7 – October 24 -	Cognitive-Behavioral Approaches (ADHD and Conduct Problems) Class Presentations: Specific Techniques I
8 – October 31 -	Cognitive-Behavioral Approaches (Developmental Problems) Class Presentations: Specific Techniques II
9 – November 7 -	Cognitive Behavioral Approaches III (Substance Use/Eating Problems)
10 – November 14 -	Cognitive-Behavioral Treatment of Child Depression
11 – November 21 -	Class Presentations: Clinical Processes I
12 – November 28 -	Class Presentations: Clinical Processes II
13 – December 5 -	Mental Health/Pediatric Consultation and Future Developments
14 – December 10	Final Examination

Course Requirements and Evaluation:

Grades will be assigned based on the following:

1. Readings and class participation: Completing all of the assigned readings; class comments and questions indicating that you have read, digested, and thought about the assigned readings for a particular week; active participation during class discussions and presentations.

2. Three in-class presentations as follows:

(a) A presentation focusing on the conceptualization of the problem and treatment of a child with a *specific phobia* from one of several different **theoretical perspectives.** Details for this assignment are given in the section below on details of class presentations.

(b) A presentation, selected from the topics provided below, focusing on a **specific treatment technique.** As much as possible, you should try to illustrate one or more of the procedures that you would use in implementing this form of treatment. Details are provided below.

(c) A presentation, selected from the topics provided below. focusing on a **clinical process**. As much as possible, you should try to illustrate the clinical process that is the focus of your presentation. Details are provided below.

3. Final Examination (Short answer and essay questions).

Overview of Practicum Placement:

The PSYC 683 child practicum placement will provide you with exposure to basic issues in the practice of clinical child psychology. This first supervised child psychotherapy practicum experience is designed to expose you to the practice of psychotherapy and behavior change with children and families. Through observation, discussion, and rehearsal, you will gain a beginning familiarity with a number of therapeutic procedures as they are used in a pediatric hospital setting (Alberta Children's Hospital) and other settings in the community. Within this general framework, the extent and nature of each student's involvement within the practicum setting will be individually determined at the beginning of the term on the basis of collaborative discussions and a contractual agreement between each student and their clinical supervisor.

Practicum Requirements and Evaluation:

Practicum Requirements:

1. A current resume of your relevant background in psychology, including academic, research, and applied experience, to be given to your clinical supervisor and the course instructor at our practicum orientation meeting on September 3.

2. Completion of the most current standard Practicum Agreement Form (see Graduate Student Handbook).

3. Approximately one half day per week in the practicum setting. As is the case with most clinical placements some flexibility in scheduling and times will be required to meet the needs of particular clients, the clinical setting, and your clinical supervisor's schedule.

4. Completion of a variety of activities including observation of clinical practice, verbal or written case formulation and analysis, and direct client involvement as deemed appropriate by clinical supervisor and student.

5. Completion of two practicum evaluation and feedback forms by the dates specified below. It is your responsibility to ensure that the forms used for contracts, evaluations, and feedback are the current ones contained in the Clinical Program Handbook.

   (a) Evaluation of Clinical Performance-Documentation of Clinical Hours

   (b) Clinical Practicum/Internship Evaluation Form

   Note: When completed, all practicum forms are to be submitted directly to the Clinical Psychology Program Practicum Coordinator for placement in your graduate file *and* also copied to the course instructor.

Practicum Evaluation:

A pass-fail grading scheme will be used for the practicum. A passing grade in the practicum portion of this course is a requirement to obtain credit for PSYC 683. Grade assignment by your clinical supervisor will be based on your successfully meeting professional and academic responsibilities throughout the practicum placement (i.e., completing all clinical responsibilities and assignments, reliable attendance at setting, handing in student-supervisor contract, handing in appropriate evaluation forms by the specified dates). You are expected to dress professionally, fully respect client confidentiality, and behave in a professional and ethical manner at all times with respect to your cases and other professional contacts. A breach of ethical conduct will lead to a failing grade in the course. The pass/fail grade assignment for the practicum will be based on the recommendation made by the student's clinical supervisor to the course instructor and practicum placement coordinator.

Following the initial meeting with your clinical supervisor you and your supervisor will complete a standard practicum agreement form specifying the range of activities and responsibilities that are agreed on by student and supervisor (see Program Handbook). A copy of this form is to be submitted to the clinical program practicum coordinator and copied to the course instructor **no later than September 19, 2008.**

At the end of the Fall 2008 term, your clinical supervisor will complete an evaluation form concerning your performance during the practicum placement. Areas from the standard clinical program practicum evaluation form that are relevant to your practicum experiences will be addressed, with the appropriate portions of the evaluation form completed. You are also required to complete an evaluation of your practicum placement experience and your supervisor using the clinical program standard feedback form. **You are expected to communicate and discuss expectations concerning your evaluation with your practicum supervisor at the beginning of the placement and to provide your supervisor with copies of the current appropriate practicum evaluation forms for student and supervisors, and due dates, at this time**. All practicum forms are to be submitted directly to the clinical program practicum coordinator for review and placement in the your file *and* copied to the course instructor. Not all categories on the forms may apply to this type of short-term initial child psychotherapy placement, and relevant categories may vary from student to student in relation your specific experiences.

Summary and Review of Due Dates for Practicum Assignments:

Due dates for practicum assignments are specified below and are viewed strictly, both to manage the course and to mirror some of the demands commonly present in clinical practice.

1. **September 3 (14:00-15:30)**: A current resume of your relevant background in psychology, including academic, research, and applied experience, to be given to your clinical supervisor and the course instructor at initial orientation meeting in September.

2. **September 19**: Standard practicum agreement specifying the range of activities and responsibilities that are agreed on by student and supervisor. To be submitted to the clinical program practicum coordinator and copied to the course instructor no later than September 19, 2008.

3. **December 5**: Supervisor will complete and submit an evaluation form concerning your performance during the practicum placement. Areas from the standard clinical program practicum evaluation form *that are relevant to your experiences* will be addressed, with the appropriate portions of the evaluation form completed.

4. **December 5**: Submit evaluation of your practicum placement experience and supervisor using the clinical program standard feedback form. Form should be submitted to the clinical program practicum coordinator and copied to the course instructor.

Note: In order to manage the course and the demands that typically occur in clinical practice, the due dates for practicum assignments must be met unless prior permission has been obtained from the instructor. A failure to submit any of the assignments by the prescribed date and format will result in a penalty of 5% from your final grade in the course.

Practicum Orientation Meeting

At the practicum orientation meeting at on September 3 you will meet with clinical supervisors (Depending on final practicum arrangements for the course some of you may have an alternative meeting time with your supervisor—I will let you know). At this meeting you will be asked to provide a current copy of your curriculum vitae to your clinical supervisor, a brief introduction and some background information about your clinical and research experiences and interests, as well as any personal or other information you would like to add. At this meeting you will learn about the kinds of clinical activities in which supervisors are involved, will be selecting a supervisor to work with, and you will be making arrangements for your next individual meeting with your clinical supervisor.

Assignments, Due Dates, and Percentage Values:

Percentage values and due dates for class and practicum assignments are specified below. For grading purposes, a maximum of 100% may be accumulated throughout the term, with weightings of the various assignments as specified in the following section.

	Assignments	Percentage Values
1.	Readings and Class Participation	15%

2.	Class Presentation: Theoretical Perspectives Due Date: September 26, October 3	15%
3.	Class Presentation I: Specific Techniques Due Dates: October 24, October 31, Nov 7	20%
4.	Class Presentation II: Clinical Processes Due Dates: November 21, November 28	20%
5.	Final examination Date: December 10	30%
6.	Practicum Placement (see above for requirements) Due Date: December 5 - Supervisor and student evaluation forms to instructor	Pass/Fail

Percentages below indicate the approximate standard required for each letter grade; some or all cutoffs may be lowered but will not be raised.

A+	96-100%	B+	80-84%	C+	67-71%	D+	54-58%
A	90-95%	B	76-79%	C	63-66%	D	50-53%
A-	85-89%	B-	72-75%	C-	59-62%	F	0-49%

To determine final letter grades, final percentage grades will be rounded up or down to the nearest whole percentage (i.e., 89.5% will be rounded up to 90%; 89.4% will be rounded down to 89%, etc.

NOTE: Students must achieve a passing grade on both the class and practicum components to pass this course.

IMPORTANT: A student seeking reappraisal of graded exams, assignments, etc. must discuss his/her work with the instructor within 15 days of being notified of the mark of the work having been returned to the class. In accordance with faculty regulations, the entire assignment or exam will be re-marked, and the mark may be raised, lowered, or remain the same. No reappraisal is permitted after the fifteen-day period.

Intellectual honesty is the cornerstone of the development and acquisition of knowledge and requires that the contribution of others be recognized. Consequently, plagiarism or cheating on any assignment is regarded as an extremely serious academic offense. Plagiarism involves submitting or presenting work in a course as if it were the student's own work done expressly for that particular course when, in fact, it is not. Students should examine sections of the University Calendar that present a Statement of Intellectual honesty and definitions and penalties associated with Plagiarism/Cheating/and Other Academic Misconduct.

Important Dates
The last day to drop this course and still receive a fee refund is **September 19, 2008**. The last day to withdraw from this course is **December 5, 2008**.

Class Format:

This course will be taught in a seminar format. Therefore, a heavy emphasis will be placed on class discussion of assigned readings and related issues. Readings will be assigned each week and will serve as the basis for class discussions of each topic. Class time will be used to discuss the assigned topics and readings in a seminar and discussion format, and for student presentations. Students are expected to read the assigned material prior to each class session, to prepare written thought questions to facilitate class discussion, and to participate fully in all class discussions. While I shall frequently offer opinions, tell stories, and pontificate, the success of

the course will depend in large measure on your willingness to pitch in, take a chance, and otherwise actively engage the subject matter through spirited discussion and debate.

The 15% of your grade that is associated with readings and class participation will be assigned based on: the instructor's appraisal of your mastery of the required readings; some independent reading; your course involvement and contributions as reflected in such things as class comments and thought questions indicating that you have carefully read and thought about the assigned readings for a particular week; and active participation during class presentations and discussions. The grade for readings and class participation will be assigned at mid-term and at the end of the course; however, students can and are encouraged to seek individual informal feedback at any time during the course.

Grades for the class presentations will be based on: the appropriateness and quality of your assigned reading(s) to the class; the quality of your handout and reading list; material used in your presentation; knowledge and mastery of the topic as reflected in your presentation; organization and quality of the presentation; class engagement and discussion. The official grade for the presentation will not be assigned until all presentations of a particular type are completed; however, you can and are encouraged to seek individual informal feedback at any time after your presentation.

For many of the specific technique and process presentations there may be treatment manuals that are available in the clinical program library, the university libraries (main, medical, education, nursing) at the Alberta Children's Hospital (you may wish to check with your clinical supervisor), or at other community placements (e.g. Learning Centre). When you do your background research on these topics you will identify whether treatment manuals are available and the types. Part of the handout for your presentation should include a *comprehensive* list of appropriate treatment manuals that you have identified.

Details of Presentation Assignments:

1. Class Presentation: Theoretical Perspectives

A class presentation of approximately 40 minutes in which the problem of a 6-year-old child's excessive fear of balloons (see attached handout titled "Case Material - Theoretical Perspectives") is considered from one of the following theoretical perspectives:

1. Behavioral
2. Social Learning
3. Cognitive-behavioral
4. Acceptance and Mindfulness
5. Psychodynamic
6. Attachment
7. Client-Centered
8. Family Therapy

Each of you will be responsible for presenting an overview of the key features of one of the above theoretical approaches to *this* problem with an emphasis on describing and critically evaluating the **primary theoretical propositions** underlying the recommended treatment(s). A central goal of this assignment is for each of you to gain in-depth mastery and exposure to **original sources** for at least one theoretical approach to child psychotherapy, not only for this

presentation, but also so that you can serve as an in-class resource for this approach throughout the term. As you may know, there is much diversity within each of the theoretical perspectives listed above and you may wish to highlight important similarities and differences among different perspectives within your approach while choosing to emphasize a particular perspective in your presentation. In selecting the topic for your theory presentation, you should select the approach that you know the least about, so that you can expand your knowledge base. In preparing your presentations please be sure that you have read and referenced **original** writings by a theorist(s)/clinician(s) in your particular area (e.g., B. F. Skinner, J. Wolpe, A. Bandura, P. Kendall, D. Meichenbaum, A. Beck, S. Freud, A. Freud, M. Klein, S. Minuchin, J. Haley, J. Bowlby, C. Rogers, S. Hayes).

As a guiding framework for your presentation and class handout you should provide:

a. An overview of the main theoretical constructs of the theory in conceptualizing this problem.

b. An overview of the theoretical model's view regarding possible **etiologies** for this problem. The emphasis should be on the link between the theoretical formulation of the disorder and recommended treatment strategies.

c. A clinical **case conceptualization** of the focal problem of Jenny, from the perspective of this theoretical framework.

d. An overview of your recommended **treatment strategies** for remediating this problem, along with their rationale.

e. Any research that you believe to be especially relevant in evaluating the **empirical support** for this approach in the treatment of specific phobias.

f. What you see as **key issues** related to the use of this approach for the treatment of this particular problem.

To facilitate your presentation, please provide each member of the class and the instructor with a thoughtfully crafted three-page written handout (not to exceed three single-spaced pages + references) that highlights, in summary or point form, the major elements of your particular theoretical position *vis-à-vis* the above areas. Attached to your handout should be a list of recommended readings for this theoretical approach, *not to exceed one page*. Designate **one** reading from this reference list as an assigned reading for class members. The quality, comprehensiveness, and appropriateness of the assigned reading that you select in capturing key theoretical concepts of your theory are important. Eight copies of this reading (one for each of the other students and myself) should be distributed at the end of class on September 19 or September 26, one week prior to your theoretical perspectives presentation. In preparing your presentation, keep in mind that other students will have read your assigned reading, and you theirs. You should be prepared to *debate*, from the vantage point of your theoretical perspective, the strengths and limitations of other approaches that are presented. Likewise, you should be prepared to respond to any criticisms of your approach that are raised by others.

2. <u>Class Presentation I: Specific Techniques</u>

A 50-minute individual presentation/discussion of a specific child treatment technique(s), during which you will present and illustrate selected techniques directed at a specific child or adolescent problem. You should also present a recommended and realistic strategy for evaluating the effectiveness of your treatment in the context of clinical practice. To facilitate your presentation, please provide each member of the class and the instructor with a thoughtfully crafted three-page written handout (not to exceed three pages + references) that highlights, in summary or point form, the major elements of your presentation. Part of your handout should include a section on the empirical status of the approach you are recommending based on the criteria that have been developed for assessing the efficacy and effectiveness of child-based treatments. Attached to your handout should be a comprehensive list of recommended treatment manuals for this problem as well as a brief description and key reference for each. Also attached to your handout should be a list of recommended readings for this specific technique, *not to exceed one page*. Designate **one** reading from this reference list as an assigned reading for class members. The quality, comprehensiveness, and appropriateness of the assigned reading that you select are important. Eight hard copies of this reading should be made and distributed to class members and myself at class time one week prior to your presentation. **Note**: If appropriate, your assigned reading may be an already assigned chapter(s) from Mash and Barkley or Kazdin and Weisz (in many but not all instances this will suffice) or another required reading that you deem the most relevant to the topic of your specific technique presentation. Other handouts or forms that include important information regarding details of specific techniques may also be provided, as you deem useful.

<u>Topics for Specific Techniques Presentation</u>:

Specific Techniques I (October 24)

1. Describe and demonstrate some of the evidence-based strategies that have been used to teach parents to manage young children who display oppositional and aggressive behavior.

2. Describe and demonstrate some of the evidence-based cognitive-behavioral strategies for teaching anger-management and social skills to aggressive children and adolescents.

3. Describe and demonstrate some of the evidence-based procedures that have been used with children with ADHD to increase on-task behavior and manage disruptive child behaviors in the classroom.

Specific Techniques II (October 31)

4. Describe and demonstrate the evidence-based steps and procedures that you would use in setting up a program for the treatment of nocturnal enuresis..

5. Describe and demonstrate some of the evidence-based procedures that have been used to treat children with autism.

6. Describe and demonstrate some of the evidence-based procedures that have been used to treat children with sleep disturbances.

Specific Techniques III (November 7)

7. Describe and illustrate some of the evidence-based procedures that have been used to treat adolescents with a substance use disorder).

8. Describe and illustrate some of the evidence-based procedures that have been used to treat adolescents with an eating disorder.

3. Class Presentation II: Clinical Processes

A 40-minute individual presentation of a specific clinical process, during which you will present and illustrate this process as it applies to a specific child/family problem. To facilitate your presentation, please provide each member of the group with a thoughtfully crafted three-page written handout (not to exceed three pages) that highlights, in summary or point form, the major elements of your presentation. Attached to your handout should be a list of recommended readings for this specific technique, *not to exceed one page*. Designate **one** reading from this reference list as an assigned reading for class members. The quality, comprehensiveness, and appropriateness of the assigned reading that you select are important. Eight copies of this reading should be made and distributed to class members and myself at class time one week prior to your presentation. Other handouts that include important information regarding details of clinical processes or your presentation may also be provided, as you deem useful.

Topics for Clinical Processes Presentation:

Clinical Processes I (November 21)

1. Describe and illustrate a "first-session" statement and rationale regarding your approach to issues of confidentiality and crisis intervention in child treatment.

2. Describe and illustrate your approach to establishing a therapeutic relationship in work with children and families.

3. Describe and illustrate your approach to dealing with issues related to "resistance" in work with children and families.

4. Describe and demonstrate your approach to evaluating treatment outcomes for individual clients in clinical practice with children and families.

Clinical Processes II (November 28)

1. Describe and illustrate your approach to working with minority and immigrant children and their families.

2. Describe and illustrate your approach to the assessment and management of suicide risk in children and adolescents.

3. Describe and illustrate your approach to working with adolescents in group therapy.

4. Describe and illustrate the approach you would use in recommending medication for a school-age child with ADHD,

including the rationale you would provide to both parent and child and how you would evaluate the effectiveness of the treatment.

Class Schedule, Topics, and Readings:

What follows is a more detailed schedule with specified required readings and assignments on a week-by-week basis.

Note: Additions and changes to assigned readings may be made as needed.

Week 0 – September 3

Topic: Introduction to Practicum

Assignments: Please bring a current copy of your curriculum vitae to practicum orientation meeting to give to your clinical supervisor and instructor.

Week 1 – September 12

Topic: Organizational Meeting/Introduction to Course

Required Readings:

Mash, E. J. (2006). Treatment of child and family disturbance: A cognitive-behavioral systems perspective. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 3-62). New York: Guilford Press.

Weisz, J. R., Sandler, I., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60*, 628-648.

Kazdin, A. E., & Weisz, J. E. (2003). Context and background of evidence-based psychotherapies for children and adolescents. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 3-20). New York: Guilford Press.

Chorpita, B. F., Yim, L. M., Donkervoet, J. C., Arensdorf, A., Amundsen, M. J., McGee, C., Serrano, A., Yates, A., Burns, J. A., & Morelli, P. (2002). Toward large-scale implementation of empirically supported treatments for children: A review and observations by the Hawaii empirical basis to services task force. *Clinical Psychology: Science and Practice, 9*, 165-190.

Silverman, W. K., & Hinshaw, S. P. (2008). The second special issue on evidence-based psychosocial treatments for children and adolescents: A 10-year update. *Journal of Clinical Child and Adolescent Psychology, 37*, 1-7.

Assignments: Theoretical perspectives presentation for September 26 and October 3.

Week 12 – September 19

Topic: Models of Child Treatment, Developmental Issues, Outcome Research

Required Readings:

Holmbeck, G. N., Greenley, R. N., & Franks, E. A. (2003). Developmental issues and considerations in research and practice. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 21-41). New York: Guilford.

Chorpita, B. F. (2003). The frontier of evidence-based practice. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 42-59). New York: Guilford.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research, 7*, 5-20.

Recommended:

Hoagwood, K. (2003). Ethical issues in child and adolescent treatment research. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 42-59). New York: Guilford.

Clinical Seminar: Relaxation Training Procedures with Children
Dr. Sally During

Required Reading for Clinical Demonstration on Relaxation Procedures:

Cautela, J. R., & Groden, J. (1986). *Relaxation: A comprehensive manual for adults, children, and children with special needs*. pp. xi-xii, 21-35, 64-68. (Available from instructor).

Assignments: Theoretical perspectives presentation for September 26 and October 3.

Week 3 – September 26

Topic: Theoretical Approaches and Issues

Class Presentations: Theoretical Perspectives I

Required Readings: Theoretical Approaches

Chorpita, B. F., & Southam-Gerow, M. A. (2006). Fears and anxieties. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 271-335). New York: Guilford.

One reading pertaining to each of the theoretical perspectives listed below. Readings are to be distributed to other students and instructor by 5 p.m. on Friday September 19 at the latest.

1. Behavioral
2. Social Learning
3. Cognitive-behavioral
4. Acceptance and Mindfulness

Assignments: Class Presentation I: Specific Techniques (October 24, 31, November 7).

Week 4 – October 3

Topic: Theoretical Approaches and Issues

Class Presentations: Theoretical Perspectives II

Required Readings: Theoretical Approaches

One reading pertaining to each of the theoretical perspectives listed below. Readings are to be distributed to other students and instructor by 5 p.m. on Friday September 21 at the latest.

1. Psychodynamic
2. Attachment
3. Client Centered
4. Family Therapy

Assignments: Class Presentation I: Specific Techniques (October 24, 31, November 7).

Week 5 – October 10

Topic: Psychotherapeutic Strategies with Maltreated Children

***Clinical Seminar:** John Pearce, Ph.D.
Child Abuse Program
Alberta Children's Hospital

Required Readings:

Azar, S. T., & Wolfe, D. A. (2006). Child physical abuse and neglect. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 595-646). New York: Guilford.

Wolfe, V. V. (2006). Child sexual abuse. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorder*s (3rd ed., pp. 647-727). New York: Guilford.

Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for Treatment (Revised Report: April 26, 2004*). Charleston, SC: National Crime Victims Research and Treatment Center. [Document may be downloaded electronically at: http://www.musc.edu/cvc/

Assignments: Class Presentation I: Specific Techniques (October 24, 31, November 7).

Week 6 – October 17

Topic: Cognitive-Behavioral Approaches to Anxiety Disorders

Clinical Seminar: Desensitization/Exposure/Cognitive Restructuring
Dr. Sally During

Required Readings:

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psycyhosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 37*, 105-130.

Kendall, P. C., Aschenbrand, S. G., & Hudson, J. L. (2003). Child-focused treatment of anxiety. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 81-100). New York: Guilford.

Barrett, P. M., & Shortt, A. L. (2003). Parental involvement in the treatment of anxious children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 101-119). New York: Guilford.

Cartwright-Hatton, S. Roberts, C., Prathiba Chitsabesan, P., Fothergill, C. & Harrington, R. (2004). Systematic review of the efficacy of cognitive behavior therapies for child and adolescent anxiety disorders. *British Journal of Clinical Psychology, 43*, 421-436.

Assignments: Class Presentation I: Specific Techniques (October 24, 31, November 7).

Week 7 – October 24

Topic: Cognitive-Behavioral Approaches: Externalizing Problems

Class Presentations: Specific Techniques I

Readings to be assigned by class members.

1. Describe and demonstrate some of the evidence-based strategies that have been used to teach parents to manage young children who display oppositional and aggressive behavior (Possible assigned reading).

2. Describe and demonstrate some of the evidence-based cognitive-behavioral strategies for teaching anger-management and social skills to aggressive children and adolescents (Possible assigned reading).

3. Describe and demonstrate some of the evidence-based procedures that have been used with children with ADHD to increase on-task behavior and manage disruptive child behaviors in the classroom (Possible assigned reading).

Required Readings:

Topic: Attention-deficit Hyperactivity Disorder/Conduct Problems

Required Readings:

Attention-Deficit/Hyperactivity Disorder:

Smith, B. H., Barkley, R. A., & Shapiro, C. J. (2006). Attention-deficit hyperactivity disorder. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 65-136) New York: Guilford.

Anastopoulos, A. D., & Farley, S. E. (2003). A cognitive-behavioral training program for parents of children with attention-deficit/hyperactivity disorder. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 187-203). New York: Guilford.

Conduct Disorder:

McMahon, R. J., Wells, K. C., & Kotler, J. S. (2006). Conduct problems. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 137-268). New York: Guilford Press.

Kazdin, A. E. (2003). Problem solving skills training and parent management training for conduct disorder. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 241-262). New York: Guilford.

Required Readings (possible assigned):

Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 204-223). New York: Guilford. (1)

Webster-Stratton, C., & Reid, M. J. (2003). The incredible years parents, teachers, and child training series. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 224-240). New York: Guilford. (1)

Lochman, J. E., & Barry, T. D. (2003). Anger control training for aggressive youth. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 101-119). New York: Guilford. (2)

Pfiffner, L. J., Barkley, R. A., & DuPaul, G. J. (2006). Treatment of ADHD in school settings. In R. A. Barkley, *Attention deficit hyperactivity disorder: A handbook for diagnosis and treatment* (3nd ed., pp. 458-490). New York: Guilford. (3)

Week 8 – October 31

Topic: Cognitive-Behavioral Approaches: Developmental Problems

Class Presentations: Specific Techniques II

Readings to be assigned by class members.

1. Describe and demonstrate the evidence-based steps and procedures that you would use in setting up a program for the treatment of nocturnal enuresis.

2. Describe and demonstrate some of the evidence-based procedures that have been used to treat children with autism.

3. Describe and demonstrate some of the evidence-based procedures that have been used to treat children with sleep disturbances.

Required Readings:

Newsom, C., & Hovanitz, C. (2006). Autistic disorder. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 455-511). New York: Guilford Press.

Handen, B. L., & Gilchrist, R. H. (2006). Mental retardation. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 411-454). New York: Guilford Press.

Required readings (possible assigned):

Enuresis

Houts, A. C. (2003). Behavioral treatments for enuresis. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 389-406). New York: Guilford Press. (1)

Autism

Lovaas. O. I., & Smith, T. (2003). Early and intensive behavioral intervention for autism. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 325-340). New York: Guilford Press. (2)

Koegel, R. L., Koegel, L. K., & Brookman, L. I. (2003). Empirically supported pivotal response interventions for children with autism. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 341-357). New York: Guilford Press. (2)

Week 9 – November 7

Topic: Cognitive-Behavioral Approaches: Adolescent Substance Use and Eating Problems

Class Presentations: Specific Techniques III

1. Describe and illustrate some of the evidence-based procedures that have been used to treat adolescents with a substance use disorder.

2. Describe and illustrate some of the evidence-based procedures that have been used to treat adolescents with an eating disorder.

Readings to be assigned by class members.

MacPherson, Frissell, K., Brown, S. A., & Myers, M. G. (2006). Adolescent substance use problems. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 731-777*)*. New York: Guilford Press. (1)

Henggeler, S. W., & Lee, T. (2003). Multisystemic treatment of serious clinical problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 301-322). New York: Guilford Press.

Terre, L., Poston II, W. S. C., & Foreyt, J. P. (2006). Anorexia nervosa and bulimia nervosa. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., 778-829). New York: Guilford Press. (2)

Robin, A. L. (2003). Behavioral family systems therapy for adolescents with anorexia nervosa. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 358-373). New York: Guilford.

Epstein, L. H. (2003). Development of evidence-based treatments for pediatric obesity. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 374-388). New York: Guilford.

Lyon, G. R., Fletcher, J. M., Fuchs, L. S., & Chhabra, V. (2006). Learning disabilities. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 512-591). New York: Guilford Press.

Week 10 – November 14

Topic: Cognitive-Behavioral Treatment of Depression

Clinical Seminar: Annette Vance
Mental Health Program
Alberta Children's Hospital

Required Readings:

David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychology, 37*, 62-104.

Clarke, G. N., DeBar, L. L., & Lewinsohn, P. M. (2003). Cognitive-behavioral group treatment for adolescent depression. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 120-134). New York: Guilford.

Stark, K. D., Sander, J., Hauser, M., Simpson, J., Schnoebelen, Glenn, R., & Molnar, J. (2006). Depressive disorders during childhood and adolescence. In E. J. Mash & R. A. Barkley (Eds.), *Treatment of childhood disorders* (3rd ed., pp. 336-407). New York: Guilford

Press.

Weersing, V. R., & Brent, D. A. (2003). Cognitive-behavioral therapy for adolescent depression. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 135-147). New York: Guilford.

Mufson, L., & Dorta, K. P. (2003). Interpersonal psychotherapy for depressed adolescents. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 148-164). New York: Guilford.

Weisz, J. R., Southam-Gerow, M. A., Gordis, E. B., & Connor-Smith, J. (2003). Primary and secondary control enhancement training for youth depression: Applying the deployment-focused model of treatment development and testing. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 165-183). New York: Guilford.

Recommended:

National Collaborating Center for Mental Health (2004, November). *Depression in children: Identification and management of depression in children and young people in primary community and secondary care: National Clinical Practice Guideline*. London: National Institute for Clinical Excellence.
Available online at: http://www.nice.org.uk/page.aspx?o=cg028

Week 11 – November 21

Topic: Class Presentations: Clinical Processes I

1. Describe and illustrate a "first-session" statement and rationale regarding your approach to issues of confidentiality and crisis intervention in child treatment.
   Reading to be assigned.

2. Describe and illustrate your approach to establishing a therapeutic relationship in work with children and families.
   Reading to be assigned.

3. Describe and illustrate your approach to dealing with issues related to "resistance" in work with children and families.
   Reading to be assigned.

4. Describe and demonstrate your approach to evaluating treatment outcomes for **individual** clients in clinical practice with children and families.
   Reading to be assigned.

Required Readings:

Green, J. (2006). The therapeutic alliance – A significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47*, 425-435.

Karver, M.S., Handelsman, J.B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic

relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review, 26*, 50-65.

Additional readings to be assigned by class members.

Week 12 – November 28

Topic: Class Presentations: Clinical Processes II

1. Describe and illustrate your approach to working with minority and immigrant children and their families.
   Reading to be assigned.

2. Describe and illustrate your approach to the assessment and management of suicide risk in children and adolescents.
   Reading to be assigned.

3. Describe and illustrate your approach to working with adolescents in group therapy.
   Reading to be assigned.

4. Describe and illustrate the approach you would use in recommending medication for a school-age child with ADHD, including the rationale you would provide to both parent and child, and how you would evaluate the effectiveness of the medication.
   Reading to be assigned.

Required Readings:

Goldston, D. B., Daniel, S. S., & Arnold, E. (2006). Suicidal and non-suicidal self-harm behaviors. In D. A. Wolfe & E. J. Mash (Eds.), *Behavioral and emotional problems in adolescents: Nature, assessment, and treatment* (pp. 343-380). New York: Guilford.

Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., & Hall, G. C. N. (2008). Cultural considerations in adolescent suicide: Prevention and psychosocial treatment. *American Psychologist, 63*, 14-31.

Kongnetiman, L., & Eskow, E. (2005). *Enhancing cultural competency: A resource kit for health professionals*. Calgary, AB: Calgary Health Region. (Available on class blackboard)

Robbins, M. S., Szapocznik, J., Santisteban, D. A., Hervis, O. E., Mitrani, V. B., & Schwartz, S. J. (2003). Brief strategic therapy for Hispanic youth. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 407-424). New York: Guilford.

Malgady, R. G., & Constantino, G. (2003). Narrative therapy for Hispanic children and adolescents. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 425-435). New York: Guilford.

Additional readings to be assigned by class members.

Week 13 – December 5

Topic: Mental Health/Pediatric Consultation and Future Developments

Clinical Seminar: Pediatric and Mental Health Consultation/Evaluation
Dr. Sally During

Required Readings:

Weisz, J. R., & Kazdin, A. E. (2003). Concluding thoughts: Present and future of evidence-based psychotherapies of children and adolescents. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 439-451). New York: Guilford.

Assignments: Final Exam (Wednesday, December 10, 12:30-16:00) – A248

PLEASE NOTE: Additions, deletions, adjustments, or changes in required weekly readings, topics, or assignments may be made throughout the term as required.

Recommended Reading: Journals and Books

In addition to theory and research in various journals which deal with complex behavioral and emotional problems in children and adolescents (e.g., *Journal of Abnormal Psychology, Development and Psychopathology, Journal of Abnormal Child Psychology, Journal of Consulting and Clinical Psychology, Journal of Clinical Child and Adolescent Psychology, Psychological Assessment, Clinical Psychology Review, Clinical Child and Family Psychology Review, Journal of Pediatric Psychology, Journal of the American Academy of Child and Adolescent Psychiatry,* and certain articles in *Psychological Bulletin, Current Directions in Psychological Science, and Psychological Science),* there are several journals that specialize in (cognitive) behavior therapy, among them *Journal of Behavior Therapy and Experimental Psychiatry, Child and Family Behavior Therapy, Journal of Rational-Emotive and Cognitive-Behavior Therapy, Behaviour Research and Therapy, Behavior Therapy, Behavior Modification, Journal of Applied Behavior Analysis, Cognitive Therapy and Research, Behavioral and Cognitive Practice, and International Journal of Cognitive Psychotherapy.*

Also listed below are a number of recommended books that provide several different perspectives on the treatment of children and families, mostly from a cognitive-behavioral perspective. A number of more focused books and manuals are also available in relation to each of the specific disorders we will be discussing throughout the term. The books are also intended to provide useful resource and background reading material for your class presentations.

Ammerman, R. T., Last, C. G., & Hersen, M. (1993). *Handbook of prescriptive treatments for children and adolescents*. Des Moines, IA: Allyn and Bacon.

Barrett, P. M., & Ollendick, T. H. (Eds.). (2004). *Handbook of interventions that work with children and adolescents: Prevention and treatment*. New York: Wiley.

Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change*

(4th ed). New York: Wiley.

Bongar, B., & Beutler, L. E. (Eds.). (1995*). Comprehensive textbook of psychotherapy: Theory and practice*. New York: Oxford University Press.

Brown, R. T., & Sawyer, M. G. (1998). *Medications for school-age children: Effects on learning and behavior*. New York: Guilford.

Herbert, M. (2004). *Managing children's disruptive behaviour: A guide for practitioners working with parents and foster parents*. Hoboken, NJ: John Wiley & Sons.

Hibbs, E. D., & Jensen, P. S. (Eds.). (2005). *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (2nd ed.). Washington, DC: American Psychological Association.

Kazdin, A. E. (1988). *Child psychotherapy: Developing and identifying effective treatments*. New York: Pergamon.

Kazdin, A. E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. Oxford University Press.

Kendall, P. C. (Ed.). (2000). *Child and adolescent therapy: Cognitive-behavioral procedures* (2nd ed.). New York: Guilford.

Kratchowill, T. R., & Morris, R. J. (Eds.). (1993). *Handbook of psychotherapy with children and adolescents*. Des Moines: Allyn and Bacon.

Maris, R. W., Berman, A. L., & Silverman, M. M. (Eds.). (2000). *Comprehensive textbook of suicidology*. New York: Guilford.

Meier, S. T. (2003). *Bridging case conceptualization, assessment, and intervention*. Thousand Oaks, CA: Sage Publications, Inc.

Olkin, R. (1999). *What psychotherapists should know about disability*. New York: Guilford.

Phelps, L., Brown, R. T., & Power, T. J. (2002). *Pediatric psychopharmacology: Combining medical and psychosocial interventions*. Washington, DC: American Psychological Association.

Russ, S. W., & Ollendick, T. H. (Eds.). (1999). *Handbook of psychotherapies with children and families*. New York : Kluwer Academic/Plenum Publishers.

Schroeder, C. S. (2002). Assessment and treatment of childhood problems: A clinician's guide (2nd ed). New York: Guilford.

Stoiber, K. C., & Kratochwill, T. R. (Eds.). (1998). *Handbook of group intervention for children and families*. Boston : Allyn and Bacon.

Van Hasselt, V. B., & Hersen, M. (Eds.). (1993*). Handbook of behavior therapy and pharmacotherapy for children: A comparative analysis*. Des Moines, IA: Allyn and Bacon.

Walker, C. E., & Roberts, M. C. (Eds.). (2001). *Handbook of clinical child psychology* (3rd ed.). New York: Wiley.

Associations

1. *Association for Behavioral and Cognitive Therapies* (ABCT) (formerly known as the *Association for Advancement of Behavior Therapy*)

I would encourage you to join ABCT. Despite the name of the organization, it is much more than a group of cognitive behavior therapy enthusiasts. Rather, it is an organization of empirically minded scientist-professionals who have, for over 35 years, been concerned with establishing a science-based clinical psychology (and psychiatry, social work, and counseling psychology). Furthermore, ABCT is as concerned with the scientific study of psychopathology and assessment as it is with intervention, and as will quickly become evident in our course, behavior therapy encompasses much more than classical and operant conditioning. Indeed, a broadening of theoretical perspectives has taken (cognitive) behavior therapy to some unexpected conceptual and procedural places. Information on student membership in AABT is available on the organization's website, www.abct.org.

2. *Society for a Science of Clinical Psychology (SSCP)*

I would encourage you to join SSCP. SSCP is an organization of empirically minded scientist-professionals who are concerned with establishing a science-based clinical psychology.

CASE MATERIAL - THEORETICAL PERSPECTIVES**

Background Material

Jenny is an attractive 6-year old white female from a middle-class family. At the time of the initial evaluation she had just entered the first grade. An only child, she lived with her natural parents, who were both high school graduates and were employed full-time. Although Jenny had never received an intellectual evaluation, a recent school readiness testing suggested that her abilities were average for her age.

Presenting Problems

Jenny was referred to the clinic by her mother, who voiced strong concerns about Jenny's fear of balloons. The mother noted that, when possible, Jenny avoided situations in which balloons were present. She noted also that Jenny became tearful and obviously distressed when she was unavoidably in the presence of balloons. The mother was embarrassed about bringing her daughter to the clinic for a seemingly trivial problem. However, she indicated that it posed enduring problems for her daughter and the family.

Jenny's mother cited several incidents to illustrate the seriousness of the problem. On one occasion Jenny was unwilling to enter a toy store in the local mall because there was a large balloon display located near the entrance. On another occasion Jenny had to leave an otherwise entertaining parade because of the large numbers of balloons that were present. On still another occasion Jenny refused to enter her school classroom because her classmates were involved in an artistic play using papier mache and inflated balloons. The mother related one incident that occurred just prior to seeking help, where, after a wedding ceremony, Jenny had panicked at the sight of a number of festive balloons that had been placed inside the bride and groom's car. Finally, the mother stated that Jenny had been recently having nightmares about balloons.

History

Jenny's developmental history was unremarkable. She was the product of a normal pregnancy and was said to have developed quite normally and to have met specific milestones with the normal age ranges. There was no evidence of early illness or injury, and the mother reported nothing to suggest anomalous conduct of noteworthy proportions apart from her fear of balloons. The mother did, however, describe Jenny as having been a rather sensitive girl who sometimes tended to overreact to a range of situations.

The mother reported that since the age of 2 Jenny had responded fearfully to diverse inflatable toys. Seemingly, these fears had gradually been narrowed to balloons. The mother was unable to recall any aversive encounters with balloons or with other inflatable toys. She did note that the early balloon phobia was paralleled roughly by fearfulness in response to television commercials characterized by loud music and bright lights. She did note also, that once, recently, Jenny had appeared afraid of a noisy dragon that appeared on a television game show. Finally, the mother reported that Jenny was somewhat fearful of any type of violence on television, including cartoon violence. None of these fears, however, posed adaptive hazards comparable to those imposed by her fear of balloons.

The mother reported that neither she nor her husband had gone to great lengths to avoid situations where balloons were present, although sometimes in those settings they and other

relatives and friends tended to shield Jenny from the balloons. She also reported a history of crude and traumatic parental attempts to treat the fear by direct exposure. These attempts generally ended in failure with some conflict and disagreement between parents about how far Jenny should be pushed in confronting her fear. Jenny's father generally was less concerned about the problem and thought that his wife might be overreacting to a problem that Jenny would likely outgrow.

Assessment

A parental interview suggested that Jenny's fear took the form of motoric agitation and crying in the presence of balloons, along with attempted escape behaviors. Parent reports suggested also that Jenny's fear intensity was regulated importantly by the amount of air the balloons contained and by the extent to which she controlled the inflation. Jenny was described as not fearful of deflated balloons and as very fearful of fully inflated balloons. She was described as most fearful when someone else was blowing up a balloon. The fear was reportedly unrelated to the colors, sizes, or numbers of balloons, or to the presence of others in settings where inflated balloons were confronted. The mother's responses to the Child Behavior Checklist were consistent with her report that Jenny's fear of balloons was the only problem of significance.

In order to assess Jenny's fearfulness more directly she was encouraged to enter a room which had at the far end a "bouquet" made up of 4 large round balloons and 6 long thin balloons. The 10 balloons were attached and all were fully inflated. Although hesitant, Jenny entered the room and moved slowly toward the balloons. When she was prompted to touch the balloons, she displayed motoric agitation and said she did not want to, adding that her mother did not allow her to touch balloons. When the therapist picked up the balloons and prompted Jenny to touch them, she touched one reluctantly, and said she had to return to her waiting mother, and started to leave the room. These behaviors were ignored and Jenny was prompted to handle one of the balloons. She was able to do this but when asked if she could pop a balloon she became extremely fearful, turned to leave the room and again asked to go to her mother. She said she did not want any of the balloons to pop, adding, "I might cry if they pop."

The therapist then took several uninflated balloons out of his pocket and gave one to Jenny. When prompted to blow up her balloon she put only one exhalation into it. When the therapist said he was going to blow up his balloon, Jenny became visibly agitated and said, "My brains don't want anyone to blow up balloons. My mommy won't like it if I see anyone blow balloons up." She went on to say, "My mom said that if I see someone blow it up I'll be afraid." Jenny's behavior bordered on panic when the therapist began to put more than one breath of air into his balloon. Jenny refused to put any more air in her balloon. She then asked to leave to and go back to her mother. Finally, she asked the therapist to put the uninflated balloons back into his pocket.

**Case material adapted from Johnson, J. H, & McGlynn, D. (1988). Simple phobia. In M. Hersen & C. G. Last (Eds.), *Child behavior therapy casebook* (pp. 43-53). New York: Plenum.

Psychology 683
CHILD PSYCHOTHERAPY
Fall 2008

Class Assignments and Presentation Schedule

Theoretical Perspectives I

September 26, 2008

1. Behavioral Name:_____
2. Social Learning Name:_____
3. Cognitive-Behavioral Name:_____
4. Mindfulness and Acceptance Name:_____

Theoretical Perspectives II

September October 3, 2008

5. Psychodynamic Name:_____
6. Attachment Name:_____
7. Client Centered Name:_____
8. Family Therapy Name:_____

Psychology 683
Child Psychotherapy
Fall, 2008

Class Assignments and Presentation Schedule - Specific Techniques

October 24, 2008 - Specific Techniques I

1. Describe and demonstrate some of the evidence-based strategies that have been used to teach parents to manage young children who display oppositional and aggressive behavior.
   Name: _____

2. Describe and demonstrate some of the evidence-based cognitive-behavioral strategies for teaching anger-management and social skills to aggressive children and adolescents.
   Name: _____

3. Describe and demonstrate some of the evidence-based procedures that have been used with children with ADHD to increase on-task behavior and manage disruptive child behaviors in the classroom.
   Name: _____

October 31, 2008 - Specific Techniques II

4. Describe and demonstrate the evidence-based steps and procedures that you would use in setting up a program for the treatment of nocturnal enuresis.
   Name: _____

5. Describe and demonstrate some of the evidence-based procedures that have been used to treat children with autism.
   Name: _____

6. Describe and demonstrate some of the evidence-based procedures that have been used to treat children with sleep disturbances.
   Name: _____

November 7, 2008 - Specific Techniques III

7. Describe and illustrate some of the evidence-based procedures that have been used to treat adolescents with a substance use disorder.
   Name: _____

8. Describe and illustrate some of the evidence-based procedures that have been used to treat adolescents with an eating disorder.
   Name: _____

Psychology 683
Child Psychotherapy
Fall, 2008

Class Assignments and Presentation Schedule - Clinical Processes

November 21, 2008 - Clinical Processes I

1. Describe and illustrate a "first-session" statement and rationale regarding your approach to issues of confidentiality and crisis intervention in child treatment.

   Name: _____

2. Describe and illustrate your approach to establishing a therapeutic relationship in work with children and families.

   Name: _____

3. Describe and illustrate your approach to dealing with issues related to "resistance" in work with children and families.

   Name: _____

4. Describe and demonstrate your approach to evaluating treatment outcomes for **individual** clients in clinical practice with children and families.

   Name: _____

November 28, 2008 - Clinical Processes II

3. Describe and illustrate your approach to working with minority and immigrant children and their families.

   Name: _____

4. Describe and illustrate your approach to the assessment and management of suicide risk in children and adolescents.

   Name: _____

5. Describe and illustrate your approach to working with adolescents in group therapy.

   Name: _____

6. Describe and illustrate the approach you would use in recommending medication for a school-age child with ADHD,

including the rationale you would provide to both parent and child, and how you would evaluate the effectiveness of the medication.

Name: _____