PRACTICING COGNITIVE BEHAVIORAL THERAPY

With

Children and Adolescents
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A Guide for Students and Early Career Professionals

David J. Palmiter, Jr., PhD, ABPP
This book is dedicated to my supervisees, past, present, and future. To me, as you bumble and tumble and strive and screech and find the art and healer within you, you are beauteous beauties who gift me more than I gift you. Thank you for allowing me to travel with you for a brief time and for helping me to find the art and teacher within me.
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FOREWORD

One of the best students I ever taught (I will call her Robyn) went on to a doctoral training program in clinical psychology a number of years ago. This student was very smart in both academic and practical intelligence, showed great self-awareness of her own strengths and weaknesses, had a strong ethical compass, and was very dedicated to developing her professional abilities. A year after she started her doctoral program, I was happy that she agreed to come back to my class and talk about life in her doctoral program and about her experience in treating her first client. This first client had many social anxieties and some depressive symptoms; Robyn described what seemed like very appropriate cognitive behavioral strategies with this client that were delivered in the context of a positive humanistic relationship. The client got much better during therapy, which was a very encouraging experience for Robyn. However, Robyn ended her presentation to my class on a less upbeat note as she told the class that she didn’t know what it was she had done that was helpful for the client and she was worried because she wasn’t sure if her next client would replicate her initial client success or turn out to be a horrible failure and prove that Robyn had chosen the wrong career. I believe that I now have a solution for her!

David J. Palmiter’s book, *Practicing Cognitive Behavioral Therapy With Children and Adolescents: A Guide for Students and Early Career Professionals*, will not eliminate the universal experience of new therapists feeling like imposters, but it will go a long way toward providing a conceptual and practical framework that the therapist in training and early career mental health professional can use to anchor the early stages of learning how to work with children and adolescents. Although this book is focused on students in practicum training and those new to child and adolescent clinical work, I believe it will also be a great resource for many practicing child clinical psychologists. Palmiter has clearly put in his 10,000 hours of preparation in coming to write this book and has accumulated a wonderful mix of clinical acumen that he combines with a careful and deep awareness of evidence-based practice issues. Dr. Palmiter’s clinical work with children and adolescents puts him in the category of what Skovholt and Jennings (2004) called “Master Therapists.” As mental health clinicians we often hear of each other’s work, and some individual clinicians “rise to the top” in terms of their work, achieving exceptional successes with their clients. Over the years I have heard many stories of Dr. Palmiter’s work that describe children being brought back to a successful life path after having suffered from seemingly impossible mental health problems. Palmiter’s book illustrates one of the characteristics of “Master Therapists” in the depth and passion of his seeking and integrating sources of knowledge to offer help to his clients. His book integrates the core of the
cognitive behavioral model with insights derived from psychodynamic, positive psychology; philosophical writings; and spiritual writings. In this book, Reik’s (1948) “listening with the third ear” meets B. F. Skinner’s token economy (Skinner, Jordan, Wagner, & Hall, 1972).

This book is simultaneously both very conceptual and very practical. I have taught graduate-level cognitive behavioral therapy (CBT) courses for more decades than I choose to recall, and Palmiter’s book includes the entire pantheon of evidence-based CBT treatments (e.g., relaxation training, cognitive reframing, exposure therapy, mindfulness, token economies, and behavioral contracting). He also integrates cutting-edge work in positive psychology into the conceptual model for this work (e.g., gratitude lists and visits, identification of and building on character strengths). This wide-ranging conceptual work is matched, point by point, with practical examples and narratives that vivify how therapists can enact these interventions in work with a wide variety of child and adolescent presenting symptoms. It is these practical elements that will be of most help (and perhaps will be the most challenging as well, as they model a very high standard of care) to clinicians in training. This book will not replace a good introductory course in CBT. However, students with a strong introductory knowledge of CBT will find this book to be a great complement to such an introduction as the trainee learns to implement these evidence-based therapies in practicum experiences with clients.

An essential starting point in the Palmiter approach is illustrated in the carpenter’s axiom: “Measure Twice: Cut Once.” So much in the world of psychotherapy, at least as practiced in public mental health programs and in settings that are constricted by insurance policies that limit the quality of care, involves a “fly by the seat of your pants” approach. Clients are screened, determined to be eligible for care, and then the therapy begins. In contrast, Palmiter’s work involves a careful case formulation that is based on an in-depth analysis of the child or adolescent client, his or her family, and school settings (and other relevant settings) in which the client lives. School records are accumulated, previous mental health treatments and diagnoses of both the child and her or his parents are examined, medical issues are considered, rating scales describing the behavior of the child client are completed, and diagnostic interviews and at least screening-level mental health assessments are completed by the parents. Out of this extensive set of client and family information comes a diagnostic case formulation, an individualized understanding of the sources of the client’s problems and strengths, and the development of treatment plans and goals that will guide at least the initial stages of the treatment (subject to revision, depending on how well the treatment progresses based on these initial formulations). Palmiter’s work here is consistent with best practices in medicine where many elaborate tests might be ordered to correctly diagnosis a patient’s cancer before determining appropriate surgery, chemotherapy, and/or radiation therapy. Much of the magic in the outcomes Palmiter and his student therapists achieve follows from the careful diagnostic and case formulation work that is the focus of the first few weeks of the therapy.

This work is presented in a very human and personal manner. Palmiter shows how CBT always relies on the development of a thoughtful, positive, empathic, and genuine relationship with clients. Some who are not well trained in CBT caricature
this approach as a collection of therapeutic interventions applied in an impersonal or mechanical manner. Anyone well trained in CBT knows that from the outset people like Aaron Beck insisted that relationship issues (in the form of the Rogerian triad, for example) are a crucial part of cognitive therapy (e.g., Beck, Rush, Shaw, & Emery, 1979). In addition, those with experience in CBT know that there is nothing so important in building a positive relationship with clients as when the therapist presents specific strategies that begin to help them overcome the problems that brought them into treatment.

Palmiter’s approach is in keeping with the most current best practices in CBT in that it is module focused rather than manual focused (e.g., Barlow et al., 2011). Fifteen years ago, evidence-based therapy in CBT was somewhat equated with manual-focused therapy. Many dozens of treatment manuals (hundreds of which exist today) were developed for disorder after disorder on the assumption that most clients come into therapy with either anxiety or depression. Clinicians often complained that these manuals made little sense, as it was much more common for clients to be polysymptomatic when they entered treatment—more likely to be suffering from both anxiety and depression (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001). Barlow and Palmiter have taken the point of view that the clinician can achieve the best outcomes by flexibly applying a set of modules that have been shown to be effective for the particular symptoms being uniquely experienced by each client (e.g., behavioral activation for depression, exposure for anxiety). I can’t think of an evidence-based therapy approach that has been widely validated in the past 30 years that is not integrated into Palmiter’s book.

An important feature in this book is that each treatment module comes with tailored self-monitoring forms that provide a way to promote change and continuously evaluate progress. It is up to the clinician to link the treatment modules to a conceptualization of the client’s underlying problems and determine how and when these modules should be deployed. For example, Palmiter describes the value of deploying behavior therapy techniques early in therapy to decrease acting-out problems and then later deploying more cognitive strategies to deal with the client’s depression. Perhaps if the initial behavioral interventions are successful in reducing acting-out behavior, the depressive symptoms may also go away, or at least be decreased (there is nothing more depressing than the “attention” that acting-out teenagers get from “the system”).

Some clinicians in training (and clinical trainers) may question the specificity of Palmiter’s intervention examples. However, these examples are presented in a very creative and clear manner, with the intervention wording presented in verbatim detail and then clearly annotated as to the rationale for each element of the intervention. I generally agree with the rationale for this training approach where clinicians should first overlearn basic skills of client engagement, reframing, problem solving, and so forth, and then later on evolve their own individualized intervention styles. Overlearning these basic skills as a core of one’s practice (when these skills are based on a strong evidence-based foundation) will serve the student well when facing new and unexpected challenges or during times of high levels of work stress. The child clinical psychologist who masters the methods in this book will be well
served in dealing with a very wide variety of clinical problems, particularly those involving internalizing disorders such as anxiety and depression. This book is also clear in describing the limits of the methods presented (e.g., “simple” posttraumatic stress can be treated with these methods, “complex trauma” symptoms require additional work that is beyond the scope of this book).

This book is based on an in-depth understanding of our current thinking about taking an evidence-based practice approach. Evidence-based practice is an oft-repeated mantra in today’s world of training and practice in clinical psychology, and yet I often find that students and professionals in the field have no in-depth understanding of what actually constitutes such practice. I once was part of a clinical qualifying exam where a student explained that his interpersonal approach to a client’s problem was evidence based because he found a case study article where someone had once used this approach with a client carrying the same diagnosis as the student’s client (ignoring meta-analyses of the many dozens of successful clinical trial outcome studies using a CBT approach with the same client problems). The American Psychological Association has evolved, along with the field of medicine more generally, in understanding the complexities of what defines evidence-based practice (or what we used to call empirically validated therapies; APA Presidential Task Force on Evidence-Based Practice, 2006). Palmiter’s approach is consistent with the best current thinking about evidence-based treatment. Where the evidence is overwhelming (e.g., utilizing exposure treatments for most anxiety symptoms, cognitive reframing for emotional disorders more generally), it would be rather poor practice to not at least consider employing modules derived from this clinical “toolbox.” And yet, the complexity of the clients we treat requires a great deal of flexibility in determining which of these tools best fit our idiographic case formulation of the individual client. An evidence-based outlook also informs us that we can sometimes do the best for our clients by recognizing that they are low on a scale of readiness for change. Rather than burning ourselves out as we attempt to achieve treatment goals that the client is not ready to work on, Palmiter wisely follows the clinical maxim that in successful therapy the therapist should not be working harder than the client.

Not only does this book mirror and expand upon the best CBT writings, but Palmiter’s writing brings in a considerable amount of evidence-based material from the best empirically supported work in the broader field of psychotherapy, as described in books such as Bergin and Garfield’s Handbook of Psychotherapy and Behavior Change (Lambert, 2013). Palmiter has read widely in the psychotherapy literature and integrates many insights into this book from diverse points of view such as humanistic, psychodynamic, and interpersonal approaches.

This is a magical book (not only in its liberal citation of magic tricks that Dr. Palmiter uses to help engage even the most resistant child and adolescent clients). It is full of humor, appropriate self-disclosure (and a discussion of guidelines to define what is appropriate vs. inappropriate self-disclosure), and humanity. For example, Palmiter describes himself as a “parent-lunatic” filled with all the worries that parenting brings in today’s overscheduled and complicated world of online social networking and cyberbullying. Awareness of his own issues as a parent helps him normalize the intense anxieties that parents bring into therapy for their children.
In addition to clearly presenting a cornucopia of clinical skills, this book provides a glimpse into the intense dedication and humane concern for client well-being that is the core of the best clinical work.

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REFERENCES


Were I to use one word to describe why I wrote this book, I would use “frustrations.” You kindly and whimsically ask, “Why Dr. Palmiter, of what frustrations do you speak?” I reply that they number thusly:

1. Despite completing bountiful doses of relevant coursework before seeing real child or teen clients for the first time, most therapist-trainees have zero clue what to actually say or do when offering evaluations and treatment to children, teens, and parents. This creates terrible anxiety. And it has been this way ever since Freud started analyzing Anna’s dreams! It’s like some sort of cruel hazing that all psychotherapy trainees are made to endure. It really doesn’t have to be this way. And as I can’t find a single book that addresses this concern by offering step-by-step instructions, I’ve written this one.

2. Despite wonderful and flourishing developments in the field of positive psychology, and bountiful evidence having been generated regarding what promotes resilience and happiness in children, teens, and families, there doesn’t appear to be a single book available that helps clinicians to offer positive psychology interventions to children and teens. There are plenty of parenting books that help parents to promote happiness and resilience in their kids; I know, I’ve written one. But there are no volumes that I can find that help therapist-trainees integrate positive psychology into cognitive behavioral therapy. So, imagine a parent said this to a therapist: “I really appreciate that you’ve done this cognitive behavioral therapy with my kid to heal his depression. It’s been wonderful! Thank you! Now, because you rock so much, I need to ask, do you have any therapy you can offer to him to promote his happiness?” If that trainee looked on her bookshelf or on Amazon for help, she’d end up sucking air.

3. Despite earning graduate degrees in how to do psychotherapy, and despite years of doing clinical work with youth, the number 1 (with a bullet) question that clinicians ask me at workshops regarding child and adolescent clinical work is (paraphrasing), “What can I do about these pain-in-the-ass parents?” The number 1a question is, “How can I help, and not strangle, resistant kids?” Think about the unique problem we have as mental health professionals (MHPs) serving youth and their parents. If a mom takes her kid to a pediatrician for a wellness check, she is unlikely to say, “Ah, you can examine her, but
not with a stethoscope!” Or, if a dad needs to have his son’s cavity treated, it’s unlikely he’ll say to his dentist, “Nah, you can’t use a drill, but you can use a flower. I’m really looking for a dentist who does flower drilling with kids.” Is there another class of clinicians who deals with as much resistance as MHPs? And my experience at workshops suggests that many experienced MHPs, never mind trainees, are left wondering how to respond effectively. Try searching for a book that offers help. It’s like looking for a unicorn that speaks Greek.

4. One of the earlier subtitles for this book was “OMG, What Would I Do if My Client____?!” That title didn’t get past my sage acquisitions editor at Springer Publishing Company, Nancy S. Hale. But that wording addresses another common source of freaking out among trainees: how to respond when parents or kids do surprising things, as they so often do, beguiling and mysterious beings that they are. I can’t find any texts that cover this topic. So, I wanted to address that because I’m really not into the whole hazing/rite-of-passage/sadomasochistic/let’s-let-them-freak-out-so-we-can-be-their-rescuer-and-show-how-wise-we-are supervision model.

5. I’ve been doing clinical supervision for more years than I care to admit. (This is probably the same reason I can’t yet allow myself to put the AARP magazines that are delivered to me in my waiting room. Notice, I say “delivered to me” and not “my” magazines.) Grizzled vet that I am, there are two frustrations that I commonly experience when doing supervision that I’m hoping this book will alleviate for me and others of my kind. First, I feel bad as students struggle to write down example phrasing I offer to them regarding what they can say to parents, children, and teens. If you’re a supervisor, or your first supervision experiences are now in your rearview mirror, you know what I mean. It seems necessary but not right. So, I just want to provide specific language that folks can adopt or adapt and by doing so (hopefully) reduce the amount of panicky transcription that goes on in supervision meetings. Second, I want to spend time in supervision going over case material. That’s where the big-time learning takes place. With this book available, students can read the relevant didactic material between supervisions and (hopefully) create more time for specific case reviews.

6. The evidence suggests that most kids experience some kind of a mental health problem by the time they reach adulthood. However, only about a quarter to a third of them get any professional help for it. And among those that get help, most suffer for years first; when they finally go for help, they often don’t get the kind of care that a steely-eyed behavioral scientist would consider to be state of the art. While there are plenty of books and treatment manuals that cover evidence-based interventions for youth, I’ve found none that are as specifically prescriptive as I think is most helpful to those MHPs who want to improve their evidence-based game.
Frustrations aside, I’m writing this book for two other reasons, the second of which is my top motivation.

1. I wish to contribute to the small but growing evidence base indicating that using magic in clinical work with youth can be a wonderful way to facilitate an alliance, respond to resistance, and make clinical teaching points more approachable. In using magic when doing clinical work with youth, I feel like someone panning for gold who has found a mostly undiscovered and bountiful stream. I just keep finding more and more uses for it. So I’d like to share some of these insights.

2. I’m a meaning junkie. And I take great meaning from helping MHPs in their missions to understand, heal, and advance the mental health of children, teens, and their families. Such MHPs do the work of angels, and I so very much enjoy being a support. Most contemporary authors don’t make much money. But if we’re lucky and have well understood our readers’ needs, we make lots of meaning.

So, ready to go? Okay, let’s get after it!
CHAPTER 1

Introduction

This chapter is the most eclectic in this volume. Here I (a) make some opening remarks for mental health professionals (MHPs) and trainees who are new to doing cognitive behavioral therapy (CBT) and positive psychology (PP) treatments with kids suffering from an internalizing disorder, (b) describe a few conventions in this volume, (c) review a concept I call “parental lunacy,” and (d) make some overview comments regarding positive ethics and multiculturalism.

REMARKS FOR TRAINEES AND EARLY CAREER MHPs

Even a thief takes 10 years to learn his trade.
—Japanese proverb

This book is designed to be helpful to anyone who endeavors to apply CBT and PP interventions with kids, no matter the clinician’s or the trainee’s level of experience. These interventions are very effective in treating internalizing disorders. In this volume, I take you to the point of first contact through termination and booster sessions, offering specific steps and language to use all along the way. I also cover the common challenges that come up when doing this sort of clinical work as well as what MHPs can do to proactively reduce the odds that those challenges occur.

However, before I get to all that I want to address trainees, and those who are still finding their clinical legs, and talk about a common phenomenology among those new to working clinically with kids: self-doubt and insecurity.

I have an acute memory of three points in my training: my first class, my first practicum client, and the first time I did on-call work by myself. These memories are acute because, in each instance, I was terrified.

My first class was within the PhD program in clinical psychology at George Washington University (GWU). The faculty there, throughout the interview process, noted that they tended to get over 300 applications for eight openings each year. I don’t know if they said this to comfort us (i.e., “If you’re one of the more than 292
yuck-a-bucks we reject, don’t take it personally”), to imply that what they were offering was special (“People really, really like us”), or just because they had to say something as we were nervously eating our doughnuts. But they said it a lot, or so it seemed at the time. So, when I got in, and later sat there waiting for my first class to begin, several thoughts went through my mind: “I’ve perpetrated a massive fraud.” “These other seven people are a lot smarter than you, so watch what you say.” “What would the faculty think if they found out that this was the only doctoral program I got into?” “What happens if I can’t cut it?” Any of this sound familiar?

My first client was at the counseling center at GWU, at the start of my second year in the program. Of course, completing four undergraduate years of psychology and one year of graduate training left me with exactly NONE of the information I needed to be a therapist, or at least that’s how it felt at the time. Sure, I had survived a year of graduate-level classes, but now my fraudulent status would surely become impossible to hide. I so well remember my first-ever supervision session, which occurred before my first-ever intake. I went in prepared to take copious notes on what I should say or do with my first-ever client. However, and despite my pleas, my supervisor kept repeating various versions of “Just go do the interview and then we’ll talk about it later.” I flashed to the image of a sadistic father throwing his child into the middle of a cold lake and maniacally laughing as he trumpeted, “Swim, you little s**t!” What I didn’t say—for fear of having her realize how incompetent I was—was “I HAVE NO CLUE HOW TO DO THE INTERVIEW!” But, she was insistent. So I left the supervision anxiously resolved to do my best. However, my anxiety reached a completely new (and previously unknown to me) height when I saw the S-word on the form. That’s right: “suicidal.” “OMG,” I thought, “now I’m actually going to end up killing somebody!” I then proceeded to break the world’s record for “most-amount-of-research-done-on-how-to-conduct-a-suicide-evaluation-within-a-24-hour-period.” I put the key points of my learning on yellow sticky pads that I positioned around the office in places I could see but the client could not (again trying to avoid being found out to be a fraud).

I did my first on-call work during my postdoctoral year. (How completely foreign it felt to not have any more hoops to jump through. I remember thinking, “Who am I if not a circus pony jumping through the next hoop for his masters in order to earn my feed bag for the day?”) I was working full-time in a community mental health center in Norwich, New York, and I had to take my share of on-call. You would think that my 4 years of practicum, across six to eight sites, and my full-time year of internship would leave me relaxed about such a duty. It didn’t. Again, I had imposter thoughts and fears about killing someone.

Why do I share these vignettes with you? Because I bet you can relate. This isn’t because I imagine that you and I are uniquely neurotic. This is because my 20-plus years of training others have taught me that these kinds of thoughts and fears are normative among trainees. They just aren’t always openly acknowledged and discussed. So I’ve written this book to help you along in your desire to work effectively and meaningfully with children, teens, and their families. I’m going to provide you with very specific instructions on how to do what when, as well as how to think
about, and respond to, situations when the fecal matter hits the fan. I will also explain the underlying principles for the specific steps as I go.

I'd like to make one other point about the efficacy of this work. When I attended GWU in the late 1980s, the training was exclusively psychodynamic. I don't know how much the doubt we trainees were experiencing about the efficacy of the therapeutic enterprise was secondary to GWU's training model (i.e., the benefit typically takes more time to accrue in insight-oriented treatments), or perhaps just about all trainees wonder about this, but we all were very fretful about this question: “Does this s**t really work?” Of course, we all were too chicken to ask our supervisors, probably for fear of exposing our imposter status. However, I find contemporary trainees wonder the same thing about efficacy. Yes, everyone is exposed to the treatment outcome literature in lecture courses, and the accounts there are impressive, and you can find such references in the References and Bibliography section at the end of this chapter. But the question lingers. So, let me address that before we start: This s**t not only works, it usually works amazingly well! As a man, I’ll never give birth to a child, but I’ve given rebirth to more people than I can begin to remember. I’ll give you a quick example.

I was at a large Super Bowl party last year that probably had 200 adults and kids in attendance. As I was walking to the food table, a man and a woman stopped me. The woman said something like, “Dr. Palmiter, we wanted to just stop you and thank you for all you did for our son. He is so different now. The transformation is amazing”—the mom started to choke up—“He’s just the boy we always knew he could be and we are just so grateful.” The dad was misty-eyed and just nodded. She added, “So, thank you.” I told them how touched I was, hugged them, and went on my way. But what was notable about that moment is that I didn’t remember who they were. I didn’t even recognize their faces. This isn’t because I’m brain-damaged, despite what my teen children sometimes assert. My unfamiliarity with them occurred because outcomes like theirs happen so often that it’s impossible to keep track of them all. People say things like, “Thank you for giving us our child back,” and “Why isn’t this stuff taught on maternity units in hospitals?” Just last week, a parent texted me, “You saved my daughter’s life. I’m forever in your debt.” The problem is not, “Does this stuff work?” The problem is, sometimes, “How do I process the large abundance of back-to-back, day-in-and-day-out meaning?”

In my informal surveys of kid MHPs, this is a common experience. There’s nothing special about me. I’m the guy who got into only one doctoral program (and one doctoral internship). But I do have a God-given aptitude for this work, and I work very hard at learning and refining my craft. So, if you likewise have an aptitude for clinical work, and you likewise are willing to get after it, you’ll also get to the highly rewarding place of wondering how to handle all of the meaning that comes your way. In this volume, it is my plan to give you many of the specific tools and techniques you’ll need to get there.

By the way, for me, it took 2 years after I was licensed to feel like I had found my stride. If you count my undergraduate years, that’s 12 years total. This brings to mind the proverb I used to open this chapter. So, if you’re in doubt about your adequacy, and if you’re in doubt about the efficacy of the kid clinical enterprise, and if
1: Introduction

you're frustrated by how slow your practical skill set seems to grow, and if you feel like academic classes aren't leaving you prepared to meet with other humans to do clinical work, JOIN THE CLUB . . . but, I'm here to tell you that it's glorious on the other side and worth every little bit of sacrifice and suffering you are now engaging in.

CONVENTIONS IN THIS VOLUME

Creativity is allowing yourself to make mistakes. Art is knowing which ones to keep.
—Scott Adams

The primary sections in this book are (a) laying the foundation for the interventions, (b) the clinical interventions for kids and parents, and (c) how to think about and respond to surprising events. The first section is all about establishing a good foundation for doing interventions, something that is too often missing in clinical work with youth. The second section regards the nuts-and-bolts of delivering healing. The third section covers evidence-based strategies for facilitating adherence and responding to resistance and surprising events. There are also a number of unique features of this volume:

► This volume integrates interventions from the PP literature with traditional CBT. Traditional clinical psychology asks the question: “How do we reduce or eliminate this pain?” PP asks the question: “How do we promote joy and meaning?” In my read of the extant literature regarding kids, the same factors that promote resilience in kids are the same ones that promote happiness and meaning. Actually, I wrote a book for parents on how to promote resilience in kids, deploying what I believe to be the top 10 strategies suggested by the extant science (i.e., Working Parents, Thriving Families: 10 Strategies That Make a Difference). In this book, I’m reviewing what MHPs can do to promote the same.

We MHPs need to know how to heal pain as well as how to promote joy and meaning in kids, teens, and their families. Certainly, our clients who are in pain want both. However, the CBT literature is far more developed than the PP literature, across the age spectrum; fortunately, the resilience literature on kids allows for sage clinical extrapolations. Regardless of the state of the science, in the References and Bibliography section at the end of each chapter you will find the references that support the recommendations for each chapter.

► Beginning with Chapter 2, you will find specific wording on how to proceed clinically. I offer these scripts only because I have found that having samples of specific words to use comforts trainees. With each script I will include the rationale for why I say what I say. Please understand that I’m not looking to train a small army of MHPs to say things the same way I do; that would be weird and unproductive. Moreover, I fully expect that even those who quote
these scripts verbatim will morph them into words that fit their own styles over time. These scripts simply offer a place to start.

- Whenever I use the words “kid,” “kids,” or “youth” I mean both children and teens. When I mean to speak about one of those subgroups I’ll indicate such.

- Many of the interventions in this volume could be easily adapted for group treatments, both with kid groups and with parent groups.

- I’m going to vary chapters regarding whether the kid client is a male or a female. Aiden is the male and his parents are Tanisha and Bill. Monica is the female and her parents are Paula and Roberto. This is merely a writing convention.

- All volumes have important material that goes uncovered. For example, in the evaluation chapters I won’t be presenting material on how to reach diagnostic closure (e.g., here’s how the data look when rendering a diagnosis of generalized anxiety disorder) or how to do a lethality evaluation. Moreover, I will discuss multicultural issues only a little bit beyond this first chapter. There are only so many pages available, unfortunately.

I number among a small group of MHPs that are learning that magic can be a wonderful tool to use in kid clinical work. Hence, each chapter, starting with the next one, will include a sidebar instruction on how to use a magic trick with a kid client. I use magic for the following purposes:

- To enhance the alliance with kids. As I’ll review in the evaluation chapter, most kids are either neutral or opposed to seeing an MHP. I’ve seen so many instances when sharing a few moments of magic causes a kid to relax and enjoy being in the consulting room. Moreover, I’ll sometimes say to a kid as he’s leaving, “Remind me next time and I’ll show you my magic water bottle that won’t pour water out unless I want it to.”

- To weaken resistance-facilitating moods. Magic helps anxious kids to relax, angry kids to be amused, and depressed kids to smile. Magic is magical in this way.

- To teach kids a new prosocial skill. As I cover in Chapter 12, becoming good at something that others enjoy is a major resilience-promoting factor. As most kids enjoy a good magic trick, teaching a kid to do magic can promote self-esteem. Moreover, to be successful, magic tricks call for effective patter, which requires interpersonal engagement. It may be tough to incentivize a kid to learn things like nonverbal social skills when that kid has little or no interest in such. But, if that kid gets interested in magic and sees that such behaviors are essential to success in that hobby, such a kid can become motivated to do things like make eye contact. For example, an MHP can
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first arrange for a kid to do a magic trick for his mom on his own and then do it again, after he has been coached on how to deploy effective patter; the mom’s feedback, and the kid’s experience, both reinforce the value of the prosocial verbal and nonverbal cuing.

• To help to teach a kid a CBT principle, such as the value of shifting one’s focus to positive memories (e.g., see Sidebar 8.1 in Chapter 8).

I continue to be delighted by the ways that other MHPs use magic in their practices, as can be witnessed by reviewing the references in the References and Bibliography section at the end of this chapter. For these reasons, each chapter has at least one sidebar at the end where I will teach you a magic trick that you can try with your kid clients.

Try some of these magic tricks with kids and I think you’ll like what happens. And you might even decide to teach a supervisor, if she treats you well, a trick or two!

PARENT-LUNATICS

"When I was a kid my parents moved a lot, but I always found them."
—Rodney Dangerfield

This is an excerpt from my aforementioned parenting book that reviews what I mean when I refer to parents as lunatics.

I worked with parents and their children in a clinical setting for about 10 years before I had my first of 3.0 children (were I to count our Portuguese Water Dog I’d say 3.5 . . . though my wife says 4.0 as she counts both me and the dog). Until I had my first child, it seemed to me that the parents with whom I was working would, from time to time, temporarily lose their minds. This temporary insanity would occur in the context of us having established a good working relationship. The parents seemed to realize that I cared about them and their child. They also seemed to view me as competent and appeared invested in our shared goals for healing their child. Yet, despite all of this, they would occasionally distort something I said and become angry or hurt. They recovered quickly enough, usually by the next session, but this temporary “insanity” confused and troubled me. I usually didn’t see it coming and had no clue what was causing it. Then I became a father and it became instantly clear: The average parent loves his child so much it makes him crazy.

My wife and I suffered from infertility for 3 years before our first child, a girl, was conceived. When she was born it was like crawling out of hell and into Eden; we were instantly healed and indescribably elated. During the 9 months of pregnancy, my wife and I were obsessive in how much we studied, prepared, hoped, and worried; during the latter part of the pregnancy I would calm myself, and imagine what she would be like, by listening to the Elton John song “Blessed.”
My eldest ended up being delivered by emergency C-section, which was maddening in itself. After she was delivered, I accompanied her and the nurse to the neonatal unit. As the nurse was prepping, I was allowed a few moments alone with my new baby. I offered her my little finger, which she began to suck on as the song “Blessed” played over the intercom (a gift from the Master Lover). In that moment I felt so much love that it hurt, and I found it difficult to breathe. While I had had experiences of intense love before, I had never experienced anything like this. Other loves in my life felt like some combination of exciting, gentle, and soothing waves I could either float or swim in as I chose. This love felt too powerful and big for me physically and mentally, like a huge and powerful wave that knocked me knees-over-elbows and carried me where it would. I still cannot describe or write about this experience without tears.

Later in the week, when my wife and I were readying for the discharge, we were filled with peace and patience. We also realized, and understood, that the discharge nurse had to review a number of things with us that were obvious: “Yes, when our daughter is crying we should consider feeding her, as that may mean she is hungry. Good health tip. Thank you.”

“Make sure to change her diaper routinely.”

“Yes, a good hygiene strategy. We appreciate that.” And it went on like that for about 20 to 30 minutes. No problem because, as I said, we were in Eden.

Then, in the evening of our first night home, we found blood discharge in our baby’s diaper. The madness that descended upon us was intense. Here we were, 3 years trying to have a baby, and there was something seriously wrong with her. It took me about 45 minutes to get the on-call pediatrician on the phone—45 minutes that felt like 2 days. After hearing the problem, the pediatrician immediately tried to be reassuring. He adopted a soft tone and said exactly this: “Dave, your daughter has just been born. She is still going through a lot of hormonal changes. Blood discharge from the vagina is common and not to be worried about.”

My first-ever bout of parental lunacy—and I’ve since had hundreds of them—was to respond: “Well, if it’s so blankety-blank common, how come that blankety-blank nurse at that blankety-blank hospital didn’t mention this on that long list of blankety-blank obvious blankety-blank guidelines that she gave us!” Except I wasn’t saying “blankety-blank.”

Sensing that the real emergency was a psychiatric one, he tried to calm me with a joke: “Dave; relax, man. Just think of it as her first period.” At that point I lost consciousness.

Three years later, while driving to the hospital to deliver our third child, my wife brought up the pediatrician’s comment and I got red hot about it all over again. Yes siree. Becoming a dad helped me to understand why my parent-clients sometimes act like lunatics; and, should I forget, I need only monitor myself for a week or two.
When working with parents, we MHPs would all do well to remember this lunacy. This is part of the reason why kindness, empathy, and an artful delivery of science-based evaluation and intervention procedures are essential skills for any effective kid MHP.

POSITIVE ETHICS

A quiet conscience makes one strong!
—Anne Frank

This volume approaches kid clinical work from the vantage point of positive ethics. Knapp and VandeCreek have represented this perspective: “Ethics could also be viewed as a way to help psychologists fulfill their highest potential as psychologists. It could mean relying on an underlying philosophical system to help psychologists think through complex ethical dilemmas. Ethics should focus not only on how a few psychologists harm patients but also on how all psychologists can do better at helping them. This view of ethics is called positive or active ethics” (2006, p. 10). Thus, positive ethics is less about avoiding screwups and more about maximizing missions. Kid clinicians operating predominantly from a perspective of not stepping on land mines can be filled with anxiety, stress, and self-doubt. Kid clinicians operating predominantly from a perspective of maximizing understanding, healing, and happiness can be filled with a sense of purpose, flow, and self-efficacy. Both perspectives are important. It’s just a question of which one is the engine and which one is the caboose.

The ethical principles that are the foundation of positive ethics are those listed in the American Psychological Association Ethical Principles of Psychologists and Code of Conduct: beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people’s rights and dignity (American Psychological Association, 2002). If you think about it for a moment, these principles are pretty inspirational. Put in lay terms, we kid clinicians want (a) to do clinical work that promotes healing and happiness and avoids causing or accentuating pain and suffering; (b) to promote and deserve trusting relationships with families and the villages that surround them; (c) to passionately and steadfastly pursue the truth, as that is what best promotes understanding and excellence in service delivery; (d) to be fair and honest with ourselves and the families and systems with which we work; and (e) to respect that every kid and family is on their own unique path; hence, our job is not to try to get kids and families to switch to our path but to understand their path so that we can tailor our science and art in a way that maximizes their good outcomes. In this volume it is my aspiration to offer organizing schemas and methodologies that adhere closely to these ethical principles. You’ll ultimately be the judge regarding how well or how poorly I do that.
MULTICULTURALISM

*The only way to understand another culture is to assume the frame of reference of that culture.*
—Carl Rogers

Coming to understand how our differences from others affect us, and how to work effectively with that knowledge, is an essential meta-skill for MHPs. However, many multicultural trainings I’ve attended seemed to inspire defensiveness and needlessly complicate learning for people who are power up in our culture (e.g., white heterosexual Christian men). What follows are excerpts from an article I wrote for *The Pennsylvania Psychologist* during my year as that organization’s president:

In my last column I proposed this definition of positive multiculturalism (Palmiter, 2012, pp. 8–9):

> To explore and understand our cultural differences and to learn how an understanding of such can enrich our professional missions. This process endorses the concept that all humans are impacted by cultural differences in a manner that traverses a wide continuum of reactions, some of which are conscious and some of which are unconscious, some of which are adaptive and some of which are not. In considering these issues positive multiculturalism eschews the promotion of shame and embraces the promotion of enrichment.

... As someone who works regularly with youth, I note two relevant trends in the literature:

- There is a consistent trend for undertreatment of minority youth, even when controlling for the financial resources of the family (e.g., Burns, Phillips, Wagner, Barth, Kolko, Campbell, & Landsverk, 2004; Cuffe, Waller, Cucarro, Pumariega, & Garrison, 1995; Kataoka, Zhang, & Wells, 2002; Leslie, Weckerly, Landsverk, Hough, Hurlburt, & Wood, 2003; Zewelanji, Evans, & Barbour, 2005).

- Minority youth are treated differently than Caucasian youth when interacting both with traditional mental health systems (e.g., Kilgus, Pumariega, & Cuffe, 1995; Zito, Safer, dosReis, & Riddle, 1998) and systems serving youth at large (e.g., Zewelanji et al., 2005).

Similar trends exist among adult minority populations as well (e.g., Fortuna, Alegria, & Gao, 2010). Indeed, the October 2012 edition of the *American Psychologist* has a special section on “Ethnic Disparities in Mental Health Care.”
I don't believe this occurs because the mental health community is racist or evil. While I can't argue why it does happen, I believe a major contributing factor is the way we discuss, or don't discuss, race. I have five related vignettes from my own journey.

#1: My wife of 22 years, Lia, is African American and I'm an Irish guy. Early in our marriage we entered a church in the southern suburbs in Chicago (this was during a time when *National Geographic* could create a map of neighborhoods in Chicago based on ethnicity). Lia was the only person of color there. I remember a palpable and strong feeling of being unwelcome. I had never had this feeling before in my life, and I certainly wasn't expecting to feel it then. If someone had challenged, “Well, what did anyone say or do to make you feel unwelcome?” I would have had to do a “hummida, hummida, hummida,” as I couldn't say. (It harkened me back to many of the diversity trainings I had had through the years when I thought the presenter, usually a person of color, was overreacting to a concern under review.)

#2: I previously worked at a large outpatient medical facility in NW Indiana. The clientele and the clinical team were diverse. On the day that the O. J. Simpson verdict was due to be delivered, clinicians were gathered in the physicians’ lunchroom. This was the only time that the African American and Caucasian clinicians were segregated by those designations. When the verdict came in, the African American clinicians were bombastically jubilant while the Caucasian clinicians were somberly silent. Though this phenomenon was nearly as in our faces as the verdict itself, no one talked about it.

#3: A few years ago I needed to get rehab for an injury. As Lia had been to that same facility months earlier, she asked me to mention her to some of the clinicians there. The clinician who did my intake remembered Lia and was joyful in recounting their interactions. This clinician then called over a colleague and cheerfully said, “This is Lia’s husband!” The second clinician didn't know whom she was talking about. So, the first clinician started rattling off a bunch of Lia’s characteristics (but not her race), which wasn't helping the second clinician. I thought to myself, “Say she’s Black. Y’all don’t get a lot of Black folks in here and that’d do it.” I speculated that the clinician who remembered Lia was worried that bringing up race could somehow make her look racist. So, finally, I, with a neutral tone, said “Lia is Black.” This had two immediate effects: The second clinician remembered her and both clinicians became visibly uncomfortable.

#4: At a diversity training event I attended a few years ago, only a few attendees actively engaged in dialogue with the presenter, even
though the presenter was striving for an interactive training. Afterwards I was discussing this with a colleague. This psychologist is a gentle soul who doesn’t have a discernable aggressive or rude bone in her body. But she said, “I was afraid to speak some of my doubts out loud about the material out of fear that I’d unknowingly commit a microaggression.”

#5: For years I asked graduate students and workshop attendees to do a simple exercise. I asked them to take out a piece of paper and number it from one to six. I told them that I would name a variety of demographic characteristics and then have them write a “yes” if they would alter their clinical methods based upon that characteristic and a “no” if they would not. I then called out characteristics like this: 1. race, 2. sex, 3. sexual orientation, 4. age, 5. psychological mindedness, and 6. psychiatric condition. I found that about 40% or more would say that they would not alter a case approach based on the first three while 80% or more would on the final three. My speculation is that folks feared that if they said they altered how they approached clinical work based on the first three that they could be deemed as suffering from an “ism.”

I believe that the dynamics I just reviewed are facilitated by the difficulty we have thinking and talking about diversity. As I wrote in my last column, we seem slow to acknowledge how others’ differences (e.g., skin color, sex, sexual orientation, religion) impact us. We fear that this human condition (i.e., to be impacted by differences) could make us, or could be used to label us as, racist, sexist, ageist, homophobic, and so on. The harmful ripples from this paralysis in open discussion are many (e.g., the sorts of unfortunate outcomes I reviewed at the top of this article).

I would propose three immediate action steps. First, take Harvard University’s Race Implicit Association Test, which is located at implicit.harvard.edu. This is one resource to help us to consider our humanity as we interact with people who are different from us. Second, I would propose considering whether there could be value in asking clients who are different from us, or who have some salient minority status in their community, two questions. First, “(Client’s name), I’m (salient characteristic), you’re (salient characteristic). What’s that like for you?” Second, “You’re (salient minority characteristic), living in (location). What’s that like for you?” These questions communicate at least two things: We get how important these matters can be and it’s not dangerous to talk about them. Third, when we come together to share our perspectives on our differences, let’s assume that all of us are good-hearted, well-intended people who only want to discover how each other’s differences may enrich us. So, let’s be slow to use words like “racist,” “sexist,” and “micro-aggression” just like the positive ethics people ask us to be slow to use words like “unethical.” Such a kind and respectful approach can’t be the wrong thing to do. Right?
1: Introduction

We all do well to think of multicultural awareness and training as a lifelong journey that never ends. After I’ve offered an all-day workshop on this topic to engaged and interested participants, I’ve been left with the feeling that we’ve merely completed one lap on what truly is an endless course. So, in this brief segment you and I have only taken one or two steps together. But I hope that you are, or have become, interested in learning more. For those interested, I would close with two additional recommendations. First, learn more about the science behind implicit bias and how it affects us all. My favorite book on this topic is *Everyday Bias* by Howard Ross (2014). Second, embrace this calling by Dr. Martin Luther King, Jr:

> Whatever career you may choose for yourself—doctor, lawyer, teacher—let me propose an avocation to be pursued along with it. Become a dedicated fighter for civil rights. Make it a central part of your life. It will make you a better doctor, a better lawyer, a better teacher. It will enrich your spirit as nothing else possibly can. It will give you that rare sense of nobility that can only spring from love and selflessly helping your fellow man. Make a career of humanity. Commit yourself to the noble struggle for human rights. You will make a greater person of yourself, a greater nation of your country, and a finer world to live in.

—Martin Luther King, Jr., April 18, 1959

Okay, ready to get after it? Well, just turn the page and saddle up!

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