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CBASP Adapted to Child Play Therapy Structure to Prevent Early-Onset Persistent Depressive Disorder

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Abstract

The current paper is a *theoretical proposal* that interfaces the Cognitive Behavioral Analysis System of Psychotherapy (CBASP) and its emphasis on interpersonal consequences with the structured order of a Play Therapy Model for troubled 3 - 8-year-old children. This proposal is not a research paper or a review of literature; instead, it is a treatment proposal that is novel and untested. CBASP psychotherapy, an empirically validated treatment, was developed originally to treat the persistently depressed adult. CBASP's major focus of interpersonal consequation will be interfaced with a Play Therapy structured model to rectify the maladaptive preoperational functioning of five interpersonal types of problem-children. The types are classified interpersonally using D.J. Kiesler's Interpersonal Message Inventory (IMI). Kiesler's IMI is employed in this proposal as an ongoing assessment modality, a source of information to make treatment strategy consequation decisions, and thirdly as an evaluative outcome variable. The troubled child types described herein frequently become candidates for early-onset Persistent Depressive Disorder (PDD) unless rescued by successful treatment. The origins of early-onset PDD arise in dysfunctional households where toxic interpersonal relationships predominate: where "survival from abuse," not growth, describes the child's modal developmental experiences. These children are often exposed to either *serious traumas* (e.g., sexual abuse, loss of a parent, physical abuse, physical or emotional neglect) or *psychological insults* (e.g., continuous, and chronic verbal and nonverbal abuse). The result, in the most serious cases, is a maturational stunting at the preoperational stage of development which, as noted above, if not successfully resolved, thrusts the child into early-onset PDD.

1. The Need for CBASP-Play Therapy

Healthy, nurturing relationships within the family unit are the most effective means to prevent mental disorders and decrease suicidal rates. Suicide is the second leading cause of death for people aged 10 - 34 [1]. Suicide rates beginning as early as ten, more often than not, reflect a dysfunctional interpersonal environment within the family system. The early-onset Persistent Depressive Disorder (PDD) [2] child, often coexisting with suicidality issues, is related to an unresolvable interpersonal dilemma confronting the person. In order to inhibit the development of PDD in children, it is imperative to diagnose and then to remediate the dysfunctional familial interpersonal relationships. The task of CBASP-Play Therapy is to create and establish a safe and facilitative relationship between the child and caregiver; thus salubriously healing the developmental dilemma confronting the youth.

A child comes into the world seeking someone "looking for them" and, in finding that person, becomes aware that they are loved [3]. Such caregivers are attuned to the child's needs and initiate the developmental-rhythmic dance of secure attachment. A strong emotional bond between a baby and an adult provides a secure attachment and an adult who will be consistently present in the child's life. Such relationships denote occasions where older persons assume responsibility for the well-being of the young [3].

Unfortunately, secure attachment is not always the case. Most parents repeat with their children the ways in which their parents behaved toward them. Daniel Siegel writes, "If you had a difficult childhood but have come to make sense of those experiences, you are not bound to re-create the same negative interactions with your own children. Without such self-understanding, however, research has shown that history will likely repeat itself, as negative patterns of family interactions are passed down through the generations." [4]. Many parents have experienced neglect and a lack of nurture during their own critical, developmental years. As a result, their attachments to their own children will be insecure and their "road map" for raising children will necessarily repeat earlier toxic experiences. These households often produce maladaptive children.

When adults reach maturity with an insecure attachment history, they begin the parenting cycle with relational and physiological deficits. We know now that early maladaptive experiences leave physiological residue. "Advances in neuroscience have discovered that the physical growth and development of the human brain is dependent on the quality of the relationships and life experiences in the early years of life" [5]. Purvis shows that early trauma has devastating effects

impacting the brain, and she writes: "It's as if the prior trauma has left its fingerprints in these children's brains. The resulting neurotransmitter imbalances make it physically difficult for formerly harmed children to maintain a relaxed and happy mood and cause them to get easily excited and distressed" [5]. Children who do not receive consistent and loving care are left void of the basic building blocks for later, facilitative interpersonal functioning.

Consistently responding positively to the early needs of a child not only provides insight about how relationships should work, but also provides the foundations for later mental health, self-regulation and optimal brain development. Schore & Schore [6] underscore the importance of these early developmental interactions, "At the most fundamental level, attachment represents the evolutionary mechanism by which we are sociophysiologically connected to others and reveals how nonconscious implicit interactive regulation is the central strategy that underlies all essential survival functions of the human self-system" [6].

Summarily, early secure attachment provides a foundation of health for a child to build upon physiologically and interpersonally. In instances where secure attachments are not achieved but where maltreatment conditions predominate, the child is faced with an unresolvable dilemma that poses psychological dangers. Child "survival" styles emerge that place the individual in danger of developing early-onset PDD. The CBASP-Play Therapy theoretical proposal described below offers a means to address and rectify these developmental dangers and thus inhibit the progression into early-onset PDD.

2. Effects of Interpersonal Trauma among Early-Onset PDD Children/Adolescents

2.1. The DSM-5 Diagnostic Task

The Diagnostic and Statistical Manual of Mental Disorders-5th Edition [2] divides PDD onset into early- and late-onset categories. Early-onset diagnoses implicate individuals who report mood disorder beginnings during childhood or adolescence while late-onset patients report onset at ≥21 years. Onset may also take the disorder forms of Major Depression (MD) or Dysthymia (DD) and, in the early-onset instance, require a duration of only one year for a PDD diagnosis.

The *DSM*-5 symptom checklist for the diagnosis of PDD requires that two symptoms from the following checklist be present more days than not for the previous year: poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions; increased irritability and/or feelings of hopelessness.

If the diagnosis of early-onset chronic depression (PDD) is made for a child applying for Play Therapy treatment, a diagnostic determination of the present disorder is required; that is, is the individual currently reporting a DD- or an MD-level disorder?

2.2. Etiological Description of Early-Onset PDD

Etiological events in the history of PDD children and adolescents suggest famili-

al social-emotional conditions that may entrap the child/adolescent in a preoperational stage of development—a developmental stage occurring between the ages of 4 - 8 [7] [8]. The following clinical researchers (e.g., [9]-[16]) opine that maturational arrest in the interpersonal-social domains may result from excessive and chronic emotionality or "paroxysms" in the home [10] or adverse familial circumstances that disrupt normal cognitive-emotional maturational and physical development. Said another way, a child's early-developmental environment, when it becomes an obstacle-course to growth with no resolution, may inhibit normal maturational psychological and physical development.

Under such circumstances, surviving the "hell of the family," not normal growth-directed development, becomes the child's only existential goal [17]. The hallmark emotions of chronic depression—helplessness and hopelessness—are appropriate and valid symptoms associated with a familial world that offers "no exit" [17].

The categories of maltreatment that are often reported are emotional mistreatment, parental loss, physical abuse, sexual abuse, and physical neglect [18] [19]. McCullough [8] has also written that *chronic psychological insults* such as demeaning and threatening verbal and nonverbal behavior continually experienced over time may also function as sources of developmental arrest. Frequently, early-onset PDD children/adolescents bring the "results" of a catastrophic developmental history into treatment and present difficult challenges to psychotherapists. Their extreme interpersonal detachment and withdrawal and their pervasive avoidance living styles seriously challenge the best practitioners.

We turn now to a brief review of the CBASP Psychotherapy Model [7] [8] [20] [21] that has been adapted to treat preoperational children with CBASP-Play Therapy.

3. The Adapted CBASP Therapy Model

Primary Goals of CBASP

The CBASP Model is characterized by two major goals [8]. The first goal is (1) to extinguish the fear-avoidant behaviors and emotions of the patient. This is accomplished through a CBASP-like clinical role where the play therapist choreographs contingent reinforcement into the session to modify maladaptive behavior. This means that she will focus the child's attention on the interpersonal effects the child has just had on the therapist, particularly during stressful dyadic moments. In the beginning of treatment, children emit behaviors that are problematical and that create interpersonal conflict; they also behave with learned expectancies that therapists will react as their caregivers at home have reacted—that is, with screaming or yelling, physical punishment, verbal chastisement, with exclamations of disappointment or frustration, or with being left alone and ignored during periods of parental emotional withdrawal. The therapist, in a compare and contrast fashion, focuses the patient's attention on how the therapist just reacted to the child and on the observed differences from previous Significant Other reactions in the home. This strategy may include some or all of

the following maneuvers:

- Saying, "This is the effect you had on me when you behaved this way."
- Asking, "Did you see what you did to me? What did you see?"
- Asking, "Try doing what you just did another way, and I'll show you how."
- Therapist behavior is modeled for the child—"Now you try doing it—just like I did."
- Asking, "Did you see my reaction when you behaved differently?"
- Asking, "What did you just notice?"
- Asking, "What was different about what I did and what reactions you get at home?"

These maneuvers denote a CBASP *discrimination step* making explicit the impacts the child had on the practitioner and then comparing and contrasting the play-room behavior of the clinician with the behavior of the child's Significant Others. Over time, and it will take time, the patient will gradually become aware that the practitioner is NOT behaving or reacting like mommy, daddy, or their siblings. Importantly, we have found that unless the interpersonal discrimination between the therapist and Significant Others is made explicit, children will rarely generate these critical distinctions.

The second major goal in CBASP-Play Therapy is (2) to make a perceived connection between the child's behavior and the interpersonal consequences the child receives in the playroom. The perceptual connection between behavior and consequences has been inhibited from emerging within a maladaptive family environment which has pushed the child into an isolated psychological state of survival. From a CBASP perspective, the interpersonal disconnection between behavior and consequences nudges children into a solitary trajectory where the world of others no longer has the power to inform the child's behavior; said another way, this isolated intra-personal orbit is the serious maturational break-point that inhibits growth and fuels a preoperational cognitive-emotional stunting that may lead to PDD. In effect, the child's reply to their abusive world is the following: "*You can't hurt me anymore, because I've tuned you out!*"

To counter this isolated orbital disconnection, the CBASP-Play Therapist explicitly communicates the following through contingent interpersonal behavior: "*When you behave in your usual manner, the outcomes/consequences with your Significant Others are not pleasant or fun; but, when you behave in ways you've learned with ME, the outcomes/consequences are frequently pleasant and fun.*" In summary, the intra-personal disconnection and isolation are resolved by repeatedly administering interpersonal consequation strategies that make child-patients aware of the impacts their malevolent behavior has on the therapist; next, the patient is taught alternative strategies that produce more salubrious and facilitative dyadic outcomes.

4. CBASP-Play Therapy Familial Reparations for a Potential Preoperational Train Wreck

CBASP-Play Therapy addresses the individual, relational needs of the child

while simultaneously teaching parents how to create a secure attachment with their child. Helping parents learn salubrious, nurturing, and trust-building parenting skills inhibits the pathological interpersonal processes that have occurred in the home and reduces additional interpersonal hurt and traumas; these toxic conditions, as mentioned above, have resulted in survival, not growth-oriented patterns in their child.

Children who are introduced to CBASP-Play Therapy range in age from 3 - 8 years. These ages overlap the second stage in Piaget's [22] Theory of Cognitive Development, the *Preoperational Stage.* Preoperational children engage in symbolic play or use toys or other objects to symbolize the actions of people (e.g., a 5-year-old might use a plastic dinosaur to knock down other animals symbolically acting out the aggressive behavior they witness at home). Preoperational functioning is also the stage where Santa Claus, the Easter Bunny, Superhero figures and other fantasy personages predominate and where an extremely egotistical, self-centered orientation is normal. Because the child does not have the cognitive-emotive capacity to discriminate fact from fantasy, their generalized belief system is highly ego-centric. Another example of preoperational thinking is as follows: "*My worldview is the way it is because I believe it.*" The cognitive skill of hypothesis-testing has not yet developed and doesn't influence the child's thinking or behavior. At the outset of CBASP-Play Therapy, pre-operational children have little to no awareness of how their behavior affects others.

5. CBASP-Play Therapy Overview and Goals

CBASP-Play Therapy focuses on the holistic family system during treatment process. The therapy endeavor involves four different components: the therapist, the child, the parents/caregiver(s), and the consequation-teaching strategies of the clinician. Each component plays a critical role in the teaching process of learning how to implement and maintain safe and secure familial relationships. Within the CBASP-Play Therapy structure, the child is seen individually for treatment; concomitantly, the parent(s) receive "coaching" in parenting skill-training and participate in a Parenting Psychoeducation Group led by the Play Therapist. More specifically, parents learn consequation teaching strategies to strengthen adaptive behaviors in the child; they also receive strong positive reinforcement from the therapist whenever they emit positive teaching reactions and inhibit negative parenting behaviors. During Stage Two of the parents' training, to be discussed later, the caregivers and child will participate together in the play-room practicing what they have learned. Fourthly, a Graduation Ceremony is conducted for the family during Stage Three.

In summary the overall goal of CBASP-Play therapy is to teach salubrious interpersonal skills to both the patient and parents, to help the child perceive their worth by receiving affirmations from both the clinician and parents, and to teach the patient that their opinions matter by first experiencing a listening comrade on the therapist's part and then experiencing a listening and attentive

ear from their parents (who have been taught how to listen). If these goals are achieved, we hypothesize that the Persistent Depressive Disorder with its corollary, preoperational maturational stunting, will be successfully inhibited.

6. CBASP-Play Therapy Play-Room Stages of Treatment

The structural process of CBASP-Play Therapy consists of two stages: 1) Stage One occurs in sessions 1 - 3 and consists of two parts: a) creating a safe dyadic relationship with heavy weighting placed on the therapist's reactions to the patient (CBASP therapist's Goal 1 is to communicate: "*I will not hurt you.*"); and b) assessing the patient's interpersonal style and constructing a remedial interpersonal strategy to resolve the stylistic problems [i.e. determining through play if the child is controlling-dominant, hostile-sarcastic, generally distant, fearful-withdrawn, or passive-compliant]; 2) In Stage Two (sessions 4-on) the therapist administers a remedial interpersonal strategy to resolve the stylistic problems and then shapes in more appropriate interpersonal behaviors. This is done in two ways: first, by making the patient's behavioral impacts explicit and secondly by using interpersonal consequation strategies to modify behavior (CBASP-Play Therapy Goal 2: "*I want you to learn how your behavior affects me! Then, I want to show you how to behave differently.*"). The uniqueness of this model is found in the way the therapist will use D. J. Kiesler's Interpersonal Theory [23] [24] [25] and his Impact Message Inventory (IMI) [26] to assess the child's maladaptive interpersonal style and to construct a strategy of change to counter-condition the patient's dysfunctional behavior.

6.1. Stage One

Trust between the child and therapist begins by the therapist *tracking* (*i.e.* carefully observing) the child's play and empathically disclosing to them what they appear to be doing. When therapists *track* play, they strive to convey that the actions and words of the child are understood and meaningful. Simply put, the practitioner communicates, "*I see you and what you do matters to me.*"

A secondary goal during Stage One is to assess the child's interpersonal style by observing how the individual interacts with the clinician (as well as to the caregivers). Does the child take charge and tell the clinician what they will and will not do? Do they make sarcastic comments about the playroom or the therapist herself? Do they make it obvious they do not want to interact with the clinician? Do they retreat to a neutral corner in the room and remain alone? Or is the child timid, refusing to make eye contact or asking what they should play with? These interactive patterns provide an interpersonal window into the child's interpersonal functioning style and reveal how they view themselves as well as how they perceive the clinician. The therapist completes Kiesler's Impact Message Inventory [26] on the patient after session three. This instrument describes the interpersonal impacts and pulls the child exerts on the clinician and should validate the practitioner's experiences in the sessions. These experiential impacts and

pulls for reactions on the part of the therapist are labeled *complementarity impacts* by Kiesler [23] [25] and direct the essential interactional method used throughout. We will briefly describe the eight octants included in Kiesler's [26] IMI to make the ongoing complementarity assessment process more understandable to the reader.

6.2. Octants on the Interpersonal Circle

The eight octants of the IMI [26] or Kiesler's Interpersonal Circle [24] include the following labels, listed in counter-clockwise order: Dominant, Hostile-dominant, Hostile, Hostile-submissive, Submissive, Friendly-submissive, Friendly, and Friendly-dominant. Dysfunctional children who come to CBASP-Play Therapy will frequently peak on five of the eight octants and obtain pathological peak scores on these domains. We focus on five pathological child-types and discuss them. Our five child-types will produce high peak scores on the Dominant, Hostile-dominant, Hostile, Hostile-submissive, and Submissive octants.

Before describing these octants as well as the children who peak on them, we illustrate how Kiesler uses the IMI to formulate a treatment strategy designed to modify behavior. First, the play therapist introspectively assesses and pinpoints the interpersonal impact or pulls she experiences when with the child patient. In Kieslerian terms, this means that therapists must introspect to determine the *complementarity pulls* the individual evokes in them. Kiesler defines *complementarity* as an interpersonal (mostly inadvertent) action that invites, pulls, elicits, draws, entices or evokes restricted classes of reactions from the clinician. This is the *natural interpersonal reaction* the therapist experiences when being in the presence of the child—a natural reaction that experientially describes how the therapist feels like responding to the child. It is not the actual reaction that is emitted, only the *experienced pull or push* produced by the child's behavior.

Working our way around the Interpersonal Circle [23] [24] and looking at the several complementary pulls that play therapists encounter, we can identify the specific complementary pulls/pushes for reaction that play therapists confront with the five problem-octants: 1) Dominance (D) or take-charge behavior on the part of the child pulls for Submission (S) or passivity from the therapist; 2) Hostile-dominant (H-D) behavior which might involve verbal outbursts or aggressive language evokes Hostile-submissive behavior (H-S) often pulling for clinician withdrawal or detachment; 3) Hostile (H) responses such as refusals to play, demeaning comments to the therapist or refusals to make eye contact all communicate, "*Stay away from me!*" "*I don't like you!*" In the face of such hostility, counter-hostile (H) reactions from therapists are often elicited and must be inhibited; 4) Hostile-submissive (H-S) patterns often characterize the behavior of many children who enter the play-room. Interpersonal detachment and withdrawal describe the behavior of the H-S child, and therapists often become frustrated and feel pulled, in a complementarity manner, to react in Hos-

tile-dominant ways (e.g., "*You are being ugly to me*!" "*Why are you behaving in a mean and belligerent way?*"); and finally; 5) Submissive (S) behavior, the fifth problem child-octant, may be expressed with indecisive behavior or stated helplessness; this style easily elicits Dominant (D) reactions from the adult like preaching, telling, criticizing, or taking charge of the play activity.

Clinicians use these introspective experiences or pull to action to identify the complementarity impacts of these five-octant problem-type children. Using the felt complementary impacts as guidelines, therapists then construct healthy counter-strategies to address the maladaptive pulls/pushes. The crucial point being made here is that the inner-experience of interpersonal complementarity, when identified, offers an effective assessment tool that becomes part of an effective treatment plan.

6.3. Effective Treatment Strategies Using the IMI

Effective treatment planning denotes that instead of Submission complementarity reactions for the Dominant (D) child, a controlled task-focused Friendly-dominant strategy is enacted; instead of reacting with withdrawal and detachment for the Hostile-dominant (H-D) child, task-focused Friendly-dominant (F) behavior is required; Hostility (H) must be countered with a task-focused Friendly-dominant reaction; Hostile-submissive (H-S) patterns are again met with task-focused Friendly-dominant reactions as are the styles of Submissive (S) children. Friendly-submissive strategy (not dominant strategy) is used sparingly when interacting with all five types to help build trust and to model power-sharing within the dyadic relationships. See Figure 1 for an illustration of where the five problem-peak octant areas lie for children on Kiesler's Interpersonal Circle (illustrated in red) and where play therapists must position themselves on the Circle (illustrated in green) to counter and modify these extreme behaviors. Avoiding reactions that fall on the hostile side of the Circle (e.g., "*Why are you so angry with me today?*") and inhibiting behaviors that are too dominant or excessively passive ("*Let's don't play with that toy, let's play with this one.*" or, "*We can do whatever you want.*") require mature personal involvement and wise clinical judgment on the clinician's part.

The task-focused *Friendly-dominant* & *Friendly-submissive interpersonal therapist styles* shown in green in Figure 1 is recommended to treat the five-problem peak-octant children. The word "task-focused" denotes a carefully monitored *friendly interpersonal style* characterized by a gentle (not too dominant) and friendly (not too friendly) and at times submissive (not too submissive) presence coupled with direct eye-contact. The therapist's position on Kiesler's Circle reveals that the clinician will work flexibly in the mild-range on the Friendly-dominant and Friendly-submissive octants—she can become more dominant or more submissive as the situation requires (see Figure 1). Her disciplined interpersonal behavior will stand in stark contrast to the behavior employed by the patients' Significant Others who have used overpowering strategies
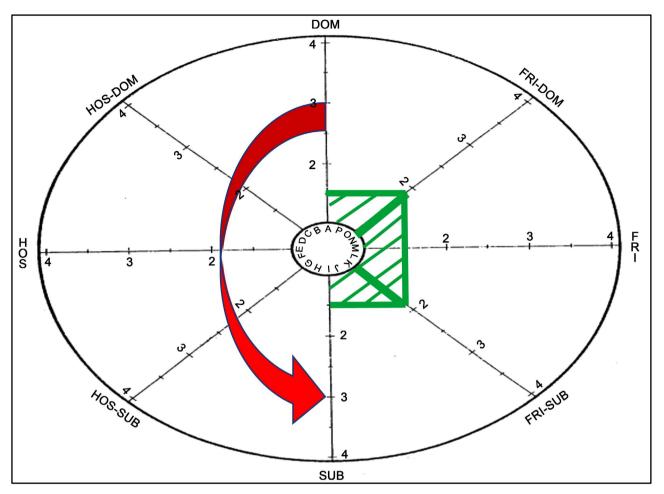
Figure 1. The red arrow illustrates where the peak octants fall on the hostile side of D. J. Kiesler's Interpersonal Circle for the five problem-octant children. The green octant lines illustrate the mild "task-focused" interpersonal position on the friendly side of the interpersonal circle that must be taken by the Friendly-dominant/friendly-submissive CBASP-Play therapist.

like extreme dominance (e.g., punishing, commanding, punitive taking-charge [grabbing or yanking]), or extreme submission (e.g., emotional and/or physical withdrawal).

7. Implementing IMI CBASP-Play Therapy Strategies in the Playroom for the Five Problem-Octant Children

We turn now to a brief description of the above pathological octants that the CBASP-Play Therapist encounters to illustrate how the practitioner modifies insalubrious behavior. First, we describe the behavioral characteristics of each octant; next, the recommended IMI strategies are delineated; and thirdly, several interpersonal patient goals for each pathological octant pattern are described.

7.1. The Dominant (D) Child

The Dominant Child is one who behaves in a "take-charge" manner by telling the therapist unequivocally what they want and don't want. They are disinclined to cooperatively participate in play, particularly if the therapist initiates the ac-

tivity. In this instance, the child may ignore the therapist's initiative or continue doing what they are doing which may or may not include the therapist.

- IMI therapist impacts from the dominant-type child elicit pulls for strong reactions. For example, the D child interpersonally pulls/pushes, in a complementarity way, for the play therapist to become submissive and non-assertive (see Figure 1). These children may also exacerbate feelings of inadequacy in the clinician due to the patient's obvious inability to participate cooperatively. The clinician may also experience strong feelings of being left out as well as experience emotions of helplessness.

- Therapy Tactics for the D Child: One IMI strategy for the peak octant D child involves not providing a Submissive response coupled with presenting a task-focused friendly-dominant stance. Providing choices for the individual in a gentle manner keeps the clinician on the Friendly side of the Interpersonal Circle but also includes administering an anti-complementarity strategy [25]—Dominant behavior met with Friendly-dominant behavior will likely be a novel experience for the D child not likely encountering interpersonal friendliness before and in such a direct way. This strategy establishes the structure of how the session will be organized. For example, saying to the patient: "*I want you to make some choices with me. We are going to do an art activity today. Would you like to use paint or markers? When we're finished, you can choose the next activity.*" When moments of irritability arise as control is removed from the patient, the play therapist may disclose how the patient's irritability reaction affects her and question how her reactions in these moments differ when compared to conflict moments with Significant Others. The clinical role becomes that of an "active participant" who provides observations from time to time about what the child is doing (with the toys) and asking questions if the patient's behavior raises concerns that the clinician does not understand. The therapist also provides empathic-interpersonal feedback concerning how the child's play behavior impacts her, or she may make suggestions about how a different play-approach might open new possibilities for the child. As the child progressively tolerates increasing degrees of feedback and participatory behavior from the clinician, she may become more active in the play process. Impact feedback, making explicit the therapist's interpersonal style of disclosure particularly when it is compared to that of Significant Others, and providing opportunities for participatory play while continuously reinforcing adaptive behavior will lead to significant interpersonal modifications.

- Treatment Success for the D Child: Success is indicated when the clinician is able to make a statement like this: "*I like it when we both get to choose an activity to do. Let's divide our session in half. Would you like to do your activity for the first 25' or the last 25'?*" and then the event occurs: the child then makes a deliberate choice. When the child's decision is accepted, it demonstrates an increase in shared-reciprocal power and awareness of another's de-

sires. The worldview of the patient has expanded and now includes the play therapist.

7.2. The Hostile-Dominant (H-D) Child

This young patient is overtly bossy, interpersonally demanding, quick to react with displeasure and frustration. The patient attempts to control the therapist's behavior employing dominant reactions that quickly turn into hostility. The child maintains a stance and attitude of, "*it's my way or the highway.*" The patient may also become aggressive by throwing toys, stomping around the room, or raising their voice to tell the therapist what they want and don't want and what they will and will not play with.

- The IMI Impacts from H-D children come as strong pulls/pushes to retreat, withdraw or behave in a submissive manner. The explicit verbal and nonverbal messages are the following: "*Let me do what I want*!" Again, these experiential pulls/pushes are used to assess where the child's behavior falls on Kiesler's Circle (see **Figure 1**). Recognizing the H-D profile, wise clinicians begin to conceptualize treatment strategies that will counter the child's push-away behaviors.

- Therapist Tactics for the H-D Child: This child puts significant pressure on the play therapist to be submissive and to follow their lead. Therapists may also experience strong feelings of hostility and counter-aggression that are not always easy to control—but they must be. Kiesler [23] argued that interpersonal hostility, in whatever form it is expressed, is usually an attempt to overtly withdraw, to distance oneself from another in some way, or to actively push others away. It is helpful to remember that the hostile reactions of this patient stem from the individual's efforts to remain interpersonally distant and to keep the clinician at a distance; thus, the patient uses anger, his major interpersonal strategy, to keep others at a distance. The effective counter strategy is to remain on the friendly side of the interpersonal circle, maintain eye-contact, and disclose the patient's impacts in a gentle but direct manner such as the following: "*When you behave so strongly, you push me away and make me feel uncomfortable*" (see **Figure 1**). With another hostile child when he slapped the practitioner's hand, the clinician replied while maintaining eye-contact: "*When you slapped me, you hurt my hand* (*while exhibiting a mild-painful nonverbal gesture*). *There is a better way to let me know what you don't want. Let's go through this again without hitting. Just tell me what you want.*" This is an example of a task-focused Friendly-dominant response. A key component of this Friendly-dominant response is repeating some components of the situation, anger and hurt, but remaining on the friendly side of the Circle and disclosing feedback of the behavioral effects. The therapist leads the child in the desired response and then celebrates the child's participation and salubrious interaction. Such repetitions result in new interpersonal learning.

- Treatment Success for the H-D Child: Success is realized when, over time, the child's hostile behavior softens, and the angry outbursts decrease in frequency. Verbal and nonverbal acknowledgment and praise must be administered by the practitioner when these changes occur. For example, "*I like it when you ask me to do something in a kind way*," or "*Saying to me what you want lets me know your feelings about playing with a toy. I like that!*" Compared to the patient's behavior at the beginning of treatment, the H-D individual has learned to share control and to acknowledge the therapist's views and perspectives. The CBASP influence is realized in the acquisition learning approach to modifying the behavior of the H-D- child: learning through repetitive-practice and disclosed consequation strategy.

7.3. The Hostile (H) Child

The child who is generally angry and stand-offish may emit both angry and withdrawal behavior. The salient impact of this young individual the moment they enter the playroom communicates: "*Stay away from me*," "*Leave me alone*," or, "*I don't like you.*" These children are loners and are unable to achieve any type of interpersonal relationship. As noted above, hostile interpersonal impacts for Kiesler [23] always communicate, "*Back off!*" The usual complementary reaction from others is "*I don't like you either.*"

- Therapist Tactics for the H Child: This child pulls strongly for the therapist to keep their distance and stay out of the way. Clinicians should honor the push-away impacts in the beginning of treatment, realizing this behavior is all the child knows how to emit in order to survive. Gradually, the play therapist begins to disclose the interpersonal consequences concerning their behavior or try to initiate some brief conversations with a minimum of eye-contact. Early comments might be the following: "*I surely am feeling all alone in this room. I'd like to get to know you.*" "*Do you have any ideas of what we could do together?*" *or* "*What do you see me doing right now with you?*" *etc.* Progress will predictably be minimal and slow. "Patience, patience, patience" should be the clinician's mantra when faced with the H patient's inability to engage in dyadic encounter. The therapist may also have feelings of discouragement as she fails at achieving her goal of helping the individual move toward more interpersonal cooperation. Focusing on building an atmosphere of trust must dominate the early sessions. Any signals, verbal or nonverbal, the child sends must be responded to gently but firmly; for example, "*You looked at me for a moment, I like that. Made me feel I'm with you in the room.*" Going no further, the play therapist waits until the next signal comes. When it occurs, the clinician might say: "*Tell me what happens to you when you get angry at home. How do your parents react?*" If the child offers some explanation, the clinician must respond with a compare and contrast question calling attention to what's been happening in the play-room. If the patient says something like: "*Everyone leaves me alone at home, or they yell*

at me." The practitioner might inquire: "*What's it like here when I don't yell at you or leave you alone? What's different about that?*" The H child has been hurt by insensitive caregivers and pervasively avoids interpersonal encounter – fending off others with anger. It will take time and gradual interpersonal impact disclosures coupled with specific discriminations between therapist and caregivers to shape in discriminations between the play-room and the home environment. Patience, patience, and more patience with the therapist remaining in a task-focused friendly-dominant stance are required before breaks in the wall of hostility open. When the child finally can converse with the clinician, the accomplishment is a beautiful accomplishment: "*Safe, Safe at last!*" Shaping in felt dyadic safety is probably the most difficult task in play therapy—it occurs over time and only in incremental steps.

Helping the H-child feel safe in the room with the play therapist will take time. Gentle disclosures of what hostility does to the clinician and giving the patient practice at saying what toys one wants to play with or what activities one wants to engage in must be repeated frequently. If the child plays with people or animal toys in a rough manner, the therapist begins to encourage the patient to describe how rough play must be experienced by the toy people or animals. This child has never learned to talk about the effects rough behavior has had on them nor been taught to observe the effects their behavior has on toy animals or play people. The therapy play-room offers an opportunity for the child to learn how he affects the toys and the clinician and how the clinician's behavior affects him. All interpersonal effects are made explicit in CBASP-Play Therapy. For example, the play therapist might say: "*Describe my reactions when you told me which toys you wanted to play with.*"

- Treatment Success for the H Child: Successful treatment is realized when the child-patient is able to verbalize what they want to play with and what activities they would like to engage in; finally, they are able to allow the therapist to have minimal participation with them in the play-room.

7.4. The Hostile-Submissive (H-S) Child

The H-S child is noticeably inhibited and shy in the playroom. The general impact play therapists experience is that they must work hard to inject themselves into the child's solitary bubble—that is, to prompt the individual to identify what they want to do. The patient emits minimal information about themselves at first. In the beginning of treatment, it's up to the clinician to find it out. For example, the H-S patient may have a desire to play with certain toys, but they are reticent to express their wants. Verbalizing their wants and needs is fearful. Instead, they often wait for the therapist to tell them what to play with or to suggest activities they might engage in. Sometimes, anger is expressed in subtle ways when what the child's wants does not materialize. In such moments, the patient might say, "*I don't want to do this*," or "*This is not going to be any fun*," and sits quietly on the floor. Clinicians can sit on the floor with the child and comment: "*I like it when you tell me what you want to do.*" Interpersonal withdrawal and

detachment are the hallmark characteristics of the patient and their trump cards of isolation are acted out in the therapy room.

- Therapeutic Tactics for the H-S Child: The pulls the play therapist experiences are to assume a dominant stance and take the lead; however, some therapist initiative is required at first to begin play activities. The patient's inhibited style pulls for therapists to keep suggesting toys to play with and initiating activities to engage in. Over time, however, practitioners may become frustrated and even angry over the patient's detached passivity. Remaining in a task-focused mild-Friendly-submissive (not dominant) mode on the Circle is the most facilitative interpersonal position (see Figure 1). It is a very difficult position to assume and difficult to maintain. In working with the H-S child, we have found one useful rule: *Do nothing in the playroom that the child can do for herself.* For example, if the child suggests playing with clay, the therapist does not open the clay box unless the child asks for help. Clinicians should carefully follow the child's lead and position themselves in the room-area where the child moves to (this is submissive behavior). Any initiative the child takes must be praised and reinforced. For example, "*You don't like to choose what we do, but I know you have good ideas. Say, do you have any ideas of how we can make a big mess*?" Child points to the paint. "*Great idea, what did you have in mind?* Child shrugs. "*Which do you think would be more fun: painting with your hands or splatter painting*?" Then the therapist praises the child for deciding, participating and showing any effort. For example, "*I like how you decided to use your whole hand while painting.*" The process is slow and arduous. Again, patience is necessary and remaining on the friendly side of the Circle in a mild-submissive position is a personal involvement requisite. The consequation strategies of CBASP are utilized to shape in any verbalized patient initiatives. Disclosing pleasure at these novel initiatives, whenever they are emitted, is a major task-focused tool used by the clinician.

- Treatment Success for the H-S Child: Success comes when the young H-S patient initiates new activities or suggests toys to play with and indicates a desire to include the therapist. With initiative instances, the therapist must provide explicit feedback concerning how the patient's behavior impacts them: "*I like it!*" Then, she inquires how this reaction contrasts to those encountered in the family. Spontaneity in the playroom is usually accompanied by utterances of having fun playing with the therapist: "*I like coming to see you!*" Verbal spontaneity and expressed verbal and nonverbal pleasure are the key indices of behavior change with this child. The H-S child who is no longer reticent or inhibited and the treating clinician who has ceased to feel she must work so hard to make interpersonal contact and who can now relax with the child, taken together, both have produced a successful outcome.

7.5. The Submissive (S) Child

The interpersonal behavior of Submissive children is not directed toward them-

selves but toward others; they strive to please, do for others or please therapists. When entering the play-room, the S patient will ask clinicians what they prefer to do, what toys that wish to play with, or what activities they want to engage in. Such individuals often clean up after themselves and leave the play-room neat and tidy. The child's modal approach to the world of others is the following: "*Tell me what to do and take care of me.*"

- Therapist tactics for the S Child: This child pulls heavily for therapist dominance. With the S child, the message to clinicians is to take charge and run the show. This is the only interpersonal safety the child knows. Play Therapists must not be seduced by the "happy participating" S child who seeks to do what they want. In the beginning of treatment, it is suggested that therapists take the lead that will build a "familiar bridge" to interaction with the patient; but S children must be weaned from their passive-dependent style. These children, unlike the other problem-patients we have discussed, are easy to get along with. If therapists aren't acutely aware of these pulls for dominance and counter by shaping in and instituting a task-focused mild Friendly-submissive style, they will not wean these patients from their passive stance and will inadvertently reinforce continued dependence. One skilled CBASP play therapist remarked during an early session: "*You have been very concerned about what I want to do. This time, I want you to stop and look around the room. After a few minutes, think about what you want to do or play with and tell me one thing you want to do.*" If the child completes this request, in part or in toto, and subsequently states or points to a preference, expressed praise and pleasure from the clinician must be verbally and nonverbally forthcoming. A task-focused strategy to thrust the child further into the driver's seat is to say something like this: "*How would you like me to participate with you in the activity you selected?*" These requests and calm waiting maneuvers must dominate the remainder of the play sessions. This strategy will teach the child that the therapist will wait on them to make decisions then, follow them to the designated play or activity area and participate with them as instructed. Practice, practice, practice until this session-ritual becomes easy and natural for the child to accomplish. Play therapists must become "participant followers" for the S child.

- Success for the S Child: Gradually, the patient becomes more self-focused and tells the therapist what she wants, which toys she wants to play with, and how she wants the clinician to participate. Trying to please the therapist or wait for the adult to take the lead will be extinguished through the behavioral counters of practitioners who shift the attentional focus of the patient from themselves to the child. In doing so, they teach the child how to take the lead in the session.

In summary, being cognizant of where the child's interpersonal behavior falls on the Interpersonal Circle (see Figure 1) is essential for constructing an effective treatment plan—a program for teaching patients more adaptive ways of in-

terpersonal functioning. Once therapists understand the major impact style of the patient, practitioners use the task-focused *Friendly-Dominant/Submissive Style* to counter-condition children toward more salubrious interpersonal goals. From an interpersonal viewpoint, the desired outcome for CBASP-Play Therapy is for patients to move from a hostile problem-octant position (*see* Figure 1: *hostility is usually consistent with an interpersonal avoidant style*) to a position on the friendly side of the Circle (*usually more compatible with interpersonal approach behavior*). As stated above, this will be accomplished by therapists assuming a task-focused *Friendly-Dominant/Submissive position* on the Circle coupled with teaching patients how to behave more adaptively.

8. The Structure of Stage One Parent/Caregiver Training

During the period the child participates in individual play therapy, the caregivers participate in parent-training activities: 1) the first activity is observing the therapist work with their child during every other session through a one-way mirror wired for audio sound. Following the session, parents and therapist discuss what happened in the play-room; through these discussions, parents learn how interpersonal consequation feedback coupled with a task-focused Friendly-dominant/submissive style on the part of the clinician modify behavior. The therapist also answers all of the caregivers' questions in these sessions; 2) in addition, the parents participate in Parent Psychoeducational Sessions run by the play therapist and given training in general foundational parenting skills. During these sessions, they are taught emotional regulation skills to use with their child's behavioral problems, they are exposed to interpersonal theory, and they learn how to use Kiesler's Impact Message Inventory. They are taught where their child falls on the Interpersonal Circle and how to navigate the complementarity pulls/pushes that have caused them so much trouble; finally, 3) they receive specific guidance concerning what to do and what not to do when interacting with their child. These didactic sessions are designed to provide personalized training tailored to the unique problems of parenting the young child. The overriding aim is to help parents learn to create a healthy family system and avoid the interpersonal crises which have caused the familial dysfunction.

Enlisting the parents' full cooperation is paramount in CBASP-Play Therapy! Prior to the beginning of the play therapy sessions, the caregivers are told of the seriousness of the maturational dilemma their child faces. Frank discussions are held stating that if both the parents and patient do not modify their behavior in the home, their child faces of lifetime of destructive misery. Negative parental attitudes such as the following, *I don't want to get involved in this therapy*; *I never got such attention when I was a child*, or *No child should need all this*, when present, are directly challenged in a Friendly-dominant manner. Examples of physical diseases such as "cancer" may be used, which if not treated effectively, may physiologically and psychologically impair the youngster irreparably. Research data with problem-child patients may also be quoted to illustrate that individuals who are not treated to remission with the help of parents and who go

on to develop early-onset Persistent Depressive Disorder, will not spontaneously improve over time.

9. The Structure of Stage Two Parent/Caregiver Training
Stage Two: Parent and Child Combination Sessions

During Stage Two, the parent and child work together in the play-room to practice the skills both have learned separately. In these combination sessions, the CBASP-play therapist takes a "back seat" and the adults are encouraged to lead the therapy session. During the session, both the parents and child engage in play activities. Meanwhile, the parent, behaving similarly to the therapist, will give feedback to the child on the positive or negative interpersonal impacts the child produces on them and actually teach their child more adaptive skills. Play-room activities may include:

- Creating a scrapbook/picture book of the "story" of the child in the family.
- Playing with play-dough together to make objects (use one bowl and get their hands messy).
- Tracing one another's body on "butcher paper" and filling in various characteristics they observe in one another.
- Playing catch with a ball and while doing so, the parents make loving and affirming comments referring to specific "character qualities" (e.g., "You are kind, caring, creative." "You keep going when things are hard." etc.) each time they toss the ball to each other.
- Telling a story together by only using "stickers."

At the end of several intensive-work combination sessions, the therapist uses the last 10 - 15 minutes to highlight the effective interpersonal strategies observed, correct mistakes, and to celebrate the growth that is observed. This time is also used to talk together about what needs to be worked on at home to facilitate continued growth.

10. The Structure of Stage Three Parents/Caregiver Training
Stage Three: Adult(s) and Child Graduation!

The child-patient and parents are ready to graduate from CBASP-Play Therapy following the combination sessions period when the caregivers demonstrate mastery of the new interpersonal strategies. Both parties must demonstrate that they are able to engage successfully in a connected-facilitative manner, the adults show they are able to provide facilitative feedback concerning their child's interpersonal impacts, and the child now responds to the caregivers with friendly-approach behaviors. The final goal is realized when both parent and child provide specific examples about the home and report how they are implementing the above strategies.

11. Conclusion

The CBASP-Play Therapy Model has been described as a *theoretical proposal* to

treat 5 types of severely disturbed children. The child patients would be classified and treated using Kiesler's Impact Message Inventory [26]. The IMI would be used as a guide for assessment, for treatment strategizing and for outcome assessment. The CBASP-Play Therapy Model lends itself to empirical testing. It is the sincere hope of the authors that the model will be tested for efficacy in future intensive single-case and randomized clinical trials.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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