Introduction
to Cognitive Control Therapy with Children and Adolescents

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Introduction

The method of cognitive control therapy (CCT) is designed to treat children and adolescents whose cognitive dysfunctions are a major source of school failure and maladaptive functioning and who seem not to benefit from traditional play and verbal psychotherapy. It is assumed that psychotherapy is a process of learning, and to benefit from this process, a person should have available cognitive structures necessary for efficient learning. But, children for whom CCT is intended do not have these requisite cognitive structures. They need first to learn how to learn before they are able to learn about themselves.

To illustrate this point, and to set the stage for the concepts and techniques that make up CCT, we begin by comparing children during moments of psychotherapy. In each comparison, one child shows cognitive capacities required by the process of psychodynamic verbal and play therapy, and another shows deficiencies in these requisite capacities.

THE FIRST CLINICAL COMPARISON

Case A. John, a 15-year-old, flops into the chair he usually uses. Suddenly he pops up, sits in another chair further away from the therapist and chuckles, "That (the chair he vacated) is hard on my back today." His right hand clenches his left, he glares at the therapist, looks away, and sighs, "Since

we met last . . ." He pauses, handles an ashtray on the table next to him, glares at it, and seems to be miles away. Shifting restlessly in his chair, he turns his attention to the bookshelves and wonders how many books each holds, and then recalls with pleasure a vacation the family took this time last year. The books and vacation fade away as he comments, "Yesterday I was late for school. My father blasted me and made me put tools back in the garage. I felt like s___. I can't seem to do anything right . . ." His attention shifts to a homework assignment. He ignores this thought, fingers the ashtray again, moves it toward the therapist and says with an edge of anger, "Your ashtray is cracked like my father." Then he laughs anxiously.

During these moments, John regulated his body motility (e.g., he moved further away from the therapist; he shifted about in his chair; he sat still), and he visually and tactually scanned and copied information from his external environment (e.g., books, ashtray) and from his internal environment (e.g., a happy memory of a family vacation; anxiety over a homework assignment). As he coordinated information from these two environments, he organized a theme, very likely without awareness, that contained the following ingredients: the office chair is hard on his back; an incident in which his father blasted him causing him to feel a failure and rejected; a cracked ashtray symbolizing father and therapist and associated with anger and anxiety. This theme, offered to the therapist for examination as a source for learning (he pushed the ashtray toward the therapist), resulted from cognitive structures

which (a) copy and select information from the environment and the personal world of thoughts, fantasies, and emotions; (b) coordinate and integrate these two pieces of information, transforming them into symbols that represent and express one of his conflicts, e.g., authority is on his back, is cracked (flawed), and makes him feel impotent and angry; (c) enable John, while dealing with the issue, to pretend that the therapist is father and at the same time a source of assistance. During these moments, then, John's cognition was operating efficiently and serving the process and goals of psychotherapy.

Case B. Tom, also 15 years old, sits relatively still, stares at the floor, and initiates no conversation, behaviors typical of him since the start of treatment six sessions ago. The therapist acknowledges Tom's difficulty with being in treatment and sharing his concerns. Tom continues looking at the floor, carefully adjusts the creases of his trousers with thumb and forefinger of each hand, slowly picks at a piece of lint on his jersey, and stares out the window. After a long pause, he comments that he is bored, and then directs intense annoyance and anger at the therapist. He points out that he is missing a special TV program because of this appointment. The therapist acknowledges the inconvenience, empathizes with Tom's disappointment, and notes that he is trying to help Tom learn why he is failing school and has a difficult time relating to classmates. Tom glares at the therapist, looks away, and after a long pause says, "There are just a lot of things racing through my mind." The therapist urges him to "Catch one of those things and share it." Another long

pause and Tom notes with irritation that he, " . . . can't; they just go too fast; and, if I could, why should I share it?" At this point he unties and carefully ties his shoelaces and then carefully repositions a Kleenex box on the table.

Tom's behavior suggests several cognitive dysfunctions which are viewed as a major source of his academic and social failures. He was unable or unwilling to produce information about his external environment and his personal world. He also seemed unable to balance and coordinate external and internal stimulation, at one moment withdrawn and apparently preoccupied with private thoughts, and at another bound to external, isolated stimuli (e.g., creases of his trousers, lint on his shirt). As a result, he did not transform information into symbols that express his private experiences and concerns. While behaviors such as aligning the Kleenex box symbolized his need to keep things in order, such symbolic behaviors did not serve the process of learning in therapy. Rather, they served to control and restrict any input from the relationship, the situation, as well as from his private fantasies.

THE SECOND CLINICAL COMPARISON

The following examples of younger children engaged in play therapy illustrate the same issues.

Case A. The parents of Mary, an 8-year-old, have separated and Mary and mother have moved from their home to an apartment. Moments after

entering the playroom, Mary places a girl hand-puppet on the table and then other doll figures, at first randomly, then gradually forming a ring around the girl puppet. She interrupts this activity and discusses a school concert to be given for parents by the fourth and fifth grade glee club. She returns to the table and continues carefully locating other doll figures around the girl puppet. She comments, “This is her house, and she has a lot of aunts and uncles and cousins." She interrupts this activity again now to make an “exact" drawing of her home, taking much care to locate the correct number of windows, and so on. Satisfied that she has made a good reproduction of her house, she asks the therapist to draw “a mother” in the front yard while she draws “a father," commenting, "It's really a happy place." She continues locating more doll figures on the table, saying, "All of these are her (hand-puppet) mother and father," and then with a burst of laughter, "That's impossible!"

Case B. Sally, a 10-year-old, sits passively before a game of checkers, an activity she initiated each meeting since therapy started. When she did not engage the therapist in checkers, she seemed submerged in "private play," dreamily manipulating materials and ignoring the therapist's suggestion that he be invited into the play. As with past checker games, the therapist patiently waits for Sally to initiate conversation, however banal, and hopes for conversation and play related to her occasional, unprovoked angry outbursts at home and her refusal to attend school. The therapist also makes statements

in an effort to construct a therapeutic process (e.g., "Maybe it's hard to talk about what worries you, like school, because the thoughts scare you.") and suggests they play a game with puppets. After a long silence, Sally carefully moves a checker on the board and calmly says, "Your move."

Case C. Harry, an 8-year-old, charges into the playroom and darts from toy to toy engaging each for seconds (e.g., he thrusts his hand into a puppet and waves it about vigorously; he sets a doll figure on a truck, racing it along the floor). He punctuates this frantic behavior with comments that seem to bear no relation to the activity at hand, e.g., "My father is the greatest!" (the therapist is aware that Harry's father is an alcoholic and sometimes behaves abusively); "My teacher sucks! She said I stepped on chalk and squashed it, but Johnny did." As the session progresses, Harry's behavior escalates from restless, diffuse play to impulsive, destructive actions (e.g., he nearly tips over a lamp, he tugs at the curtain, and he pulls the therapist's necktie). As with previous sessions, the therapist intervenes by attempting to channel Harry's aggression into an organized game (shooting darts at a target), bringing attention to his difficulties, "You act like this in school, and it gets you in trouble," and setting standards, "You can't hurt anything here." But, again, the therapist is forced to restrain Harry when he pounds his fist against the window, trying to lift it so he can throw out a toy.

In Case A, Mary's cognition selectively produced information from the

external and internal worlds and shifted flexibly between pretend playing (locating many relatives and then many parents around a girl doll), drawing an exact copy of her house, and remembering a real-life event (a concert for parents). As cognition coordinated information from her external and internal worlds, a theme was constructed which would serve her learning about one source of her conflicts, namely, the way in which she has construed and managed the separation of her parents and disruption of her home life (e.g., instead of being separated and lost as a couple, her parents are very available, surrounding her in multiple numbers; and, instead of losing her happy home, it is present in all its detail.)

In contrast, Sally did not or could not share observations of current events or engage in pretend play that expressed how she experienced her current situation, especially her difficulty attending school. She maintained control over the therapist and over her fantasies by limiting her interactions to repetitive checker games. Harry, although very active, capable of engaging play material and offering comments and complaints, was, nonetheless, unable to produce and coordinate information from reality and fantasy and sustain pretending in a way that enabled the therapist to help him understand and work through his aggressiveness and school difficulties.

THE APPROACH OF CCT

CCT maintains that it is not effective to engage children such as Tom, Sally, or Harry, described above, in a process which requires them to learn about themselves by scanning, selecting, and talking about private thoughts, fantasies, and emotions, either literally or symbolically, or which requires them to express themselves in pretend play, since the cognitive structures required by these processes are dysfunctional. They become stuck in therapy because their cognitive deficits remain unmodified, and therefore they perpetuate in therapy the flight and fight behaviors that cause them difficulty at home and school.

These children must first develop new, or rehabilitated, cognitive structures. To accomplish this, CCT asks a child to deal with a series of structured cognitive tasks which, in a stepwise fashion, attempt to improve the way in which a *particular* cognitive function copies information, then considers that information from different points of view, and then participates in transforming that information (i.e., pretending the information is something else).

For children whose cognition avoids fantasies (outer-oriented children), the tasks initially consist of neutral, "conflict free" information and gradually contain stimulation that arouses emotions and fantasies. For children whose cognition avoids reality in favor of fantasy (inner-oriented children), the tasks initially incorporate elements from the child's fantasies and gradually become

more neutral. For children with impulse disorders, the tasks integrate aggressive actions and fantasies within the requirements of the task, cultivating cognitive control over action.

In all cases, the tasks are designed to rehabilitate selected cognitive structures so that they become efficient in copying and coordinating the requirements of reality, fantasy, and affects and in guiding actions taken. In addition, the tasks provide an arena within which the child is trained to observe and become aware of his/her unique approaches to learning and adapting. When dealing with the tasks, the child relives and reveals the unconscious cognitive maneuvers and associated emotions of boredom, anger, anxiety, which the child uses to cope and learn. During these moments, the therapist teaches the child, bit by bit, to examine these maneuvers, to learn how they mediate between the demands of reality and fantasy and how they influence the way in which the child acts in and experiences the environment, and to use this knowledge to develop new actions that are more adaptive.

The child not only develops new cognitive structures that make available new information but is also able to use his/her thinking in a qualitatively different way, more efficiently adapting to and coordinating the requirements of reality and fantasy in the service of learning and adapting. When the child has cultivated these cognitive tools, CCT shifts from a format

of directed tasks to a format resembling traditional non-directed verbal and play therapy. In this more non-directed format CCT emphasizes a process within which the child is free to initiate, repeat, and restructure key pathological metaphors that are major sources of maladaptation and inefficient learning.

With the approach of CCT before us, emphasizing the need to rehabilitate cognitive structures that produce and coordinate information from reality and fantasy, it is necessary to consider in more detail what is meant by cognition and cognitive structures in therapy.

WHAT IS COGNITION IN THERAPY?

CCT is being presented at a time when a "cognitive revolution" is occurring within psychology, resulting in numerous cognitive treatment methods and points of views (e.g., Arnkoff & Glass, 1982; Kendall & Hollon, 1979; Mahoney, 1977). Whenever such a revolution occurs clinicians often experience confusion as they set out to decide which methods to use in certain circumstances. Therefore, I would like to address this confusion from several angles, to aid the reader in navigating through this cognitive revolution and in relating the CCT approach to others.

All cognitive approaches to therapy maintain that cognitive processes play a central role in psychological functioning and development, and

accordingly, in the formation of psychopathology and maladaptations. However, beyond this agreement, widely different behaviors are proposed as the cognitions to be treated and changed in therapy. One volume (Emery, Hollon, & Bedrosian, 1981), for example, refers to "sleeping cognitions" (p. 288); "dream content (cognition)" (p. 231); cognition as "helplessness . . . anxiety" (p. 231), as "discussing perceptions of an event" (p. 57); as "a person's tendency to drift from topic to topic" (p. 88) and as "distortions" concerning physical appearances (p. 71). Some (e.g., Cacioppo & Petty, 1981) propose a broad definition of cognitive behaviors to be addressed in therapy ("Those thoughts that pass through a person's mind," p. 310) while others (Bedrosian & Beck, 1980) propose a more circumscribed one ("dysfunctional ideation" p. 128).

While a wide variety of cognitive behaviors have been proposed as the target for therapy, Arnkoff & Glass (1982) point out in their critique that there is an "overwhelmingly narrow focus in the literature on self-statements and beliefs" (p. 9). (See also, Goldfried, 1980; Kendall & Hollon, 1979; Mahoney & Arnkoff, 1978). Belief systems (and thought patterns) are the rational and irrational rules and thoughts a person holds which influence the way he/she conducts life (e.g., I'm not very good at what I try). Self-statements refer to the thoughts a person says to herself while dealing with situations or performing a task. Other behaviors, which are dominant in current cognitive assessment and therapy methods, include: attributional

styles—the inferences a person draws across different situations to explain why a particular event occurred (e.g., John was picked for the baseball team because "taller people are better"); role-taking (or perspective-taking)—the degree to which a person assumes the point of view (thoughts, perceptions, and emotions) of another person; and cognitive problem solving—whether and how a person thinks of alternative solutions to a problem (e.g., Joe wants to play with a toy that Harry has; think of different ways he could get it).

In their critique, Arnkoff and Glass also articulate several problems that arise from the emphasis given self-statements and beliefs by many current approaches to cognitive therapy. Highlighting a few of these is another useful way to introduce the reader further to CCT within the current cognitive revolution.

1. A belief or self-statement such as, "I am a failure," may have several meanings and several different statements may convey a single meaning (e.g., "I hate life; I like the color gray."). Arnkoff and Glass suggest that what a person says may be the "tip of an iceberg," and therefore there is a need to consider "surface and deep" cognitive structures in order to learn the meaning underlying a particular verbalized statement. (See also Sollod & Wachtel, 1980.)

2. The cognitive therapy literature tends to dichotomize self-statements and beliefs as irrational versus rational, unrealistic versus realistic, and task irrelevant versus task

relevant. Not only are these bipolar distinctions used interchangeably, but according to Arnkoff and Glass, underlying these classifications is also the inherent assumption that it is better to be rational, realistic, and task relevant, than it is to be irrational, unrealistic, and task irrelevant. Because of this assumption, self-statement therapies set out to help the client identify the "bad thoughts" and replace them with "good ones." Arnkoff and Glass propose that an "irrational" thought could sometimes be adaptive, while a rational thought, maladaptive, depending upon the meaning of the thought to the individual and the function it serves.

3. Some experiences may be less amenable to self-report because of their inaccessibility to language. A belief could have been formed, Arnkoff and Glass note, prior to the full development of language.

Each of these issues should be familiar to therapists from a psychodynamic-developmental persuasion. The issue of deeper structures underlying conscious beliefs and self-statements relates to the concept of multiple determinism—that a belief may be determined by different behavioral structures which may be conscious or unconscious and expressed by alternative modes and modalities (e.g., in thought/language and fantasy, or in action). The concept that a rational thought may be maladaptive, and an irrational thought adaptive, depending upon the function each serves, is related to the notion of regression. That is, returning to a developmentally

early form of behaving, can under certain circumstances, serve successful adaptation. And, the concept that an experience may be formed prior to the full development of language, and therefore less amenable to self-statements, is a familiar one, especially to child clinicians who observe the difficulty many emotionally-disturbed children have verbalizing. Some clinicians take the position that the child's problem is not her current inability to express experiences in verbal terms. Rather, the child may need to use other behavioral modes (e.g., actions, fantasies) which were dominant when the particular experience was encoded. In a therapy process that emphasizes self-statements, the child is required to express presymbolic experiences in verbal-symbolic terms.

This sketch of the current cognitive revolution, with its emphasis on self-statements and beliefs as the cognitions to be changed, and the limitations brought by this emphasis, provides a bridge to the population of children and adolescents for whom CCT is intended.

FOR WHOM IS CCT INTENDED?
COGNITIVE DYSFUNCTIONS PRIOR TO THE FULL DEVELOPMENT OF LANGUAGE

Over the past two decades an increasing number of children and adolescents have been identified as needing assistance because they experience severe difficulty both in learning and adapting, despite their

adequate intelligence. In terms of cognitive difficulties, observations have included: short attention span, distractibility, inability to organize and stick with a task, excessive daydreaming, anxiety or depression while learning and working in the classroom, and poor retention of details. In terms of difficulty with coping at home and school, observations have included: shy, withdrawn, lost in fantasy, frequently bored or sleepy, excessive moving about, easily frustrated, low self-esteem, and outbursts of physical and verbal aggression.

Labels such as perceptual handicap, minimal brain dysfunction, hyperkinetic, developmental deviation, and tension discharge disorder have been used in the past to diagnose these children. While these labels acknowledged that neurotic conflicts are not the main source of the difficulties these children experience, they failed to be useful in guiding innovations in treatment. Psychodynamically oriented therapists tended to try to aid these children with non-directed play therapy, while behaviorally oriented clinicians used various forms of perceptual training.

Recently a new diagnostic category, "Attention Deficit Disorder," has been proposed by the American Psychiatric Association in its revision of the Diagnostic Statistical Manual (DSM III) to formulate the difficulties of these children. Attention Deficit Disorder is defined by various forms of inattentive as well as aggressive, hyperactive, and impulsive behaviors.

These behaviors are also implicated in many other clinical syndromes (e.g., conduct disorders, developmental disorders, oppositional disorders, overanxious disorders, and schizophrenia). In defining Attention Deficit Disorder, the manual states, “The essential features are signs of *developmentally* inappropriate inattention" and the *onset* is “typically by the *age of 3 years."* [italics added] In other words, the disorder begins before language is fully developed.

The significance of this new category is that, for the first time, many children who need assistance are treated by integrating, rather than by segregating, cognition and personality, by emphasizing a developmental view, and by proposing that the origin of their pathology predates the full development of verbal-symbolic functioning. The formulation of attention deficit disorder, then, challenges clinicians to make operational what is “developmentally inappropriate inattention," to determine which cognitive-personality processes become derailed by the age of three, resulting in pathological functioning, and to design treatment methods that address preverbal as well as verbal cognitive structures. The development of CCT over the past 20 years can be viewed as one response to this challenge. While intended primarily for the broad population of children noted above, the approach, with modification, is also appropriate with children who are mentally retarded, autistic, or psychotic, as well as with severe neurotic disorders within which cognitive dysfunctions dominate.

THE POINT OF VIEW OF CCT

From our sketch of issues raised by prevailing approaches to cognitive therapy and from our discussion of the method of CCT and the populations for which it is intended, we can now turn full circle and revisit the anecdotes presented at the start of this introduction. Tom, who was failing all of his subjects and incompetent at peer relations, could not verbalize in therapy and showed that he coped and learned by shifting between very active private fantasies and thoughts and concrete, isolated details in his environment (lint on his shirt), each domain of information segregated from the other. Sally, who resisted attending school and occasionally became physically and verbally aggressive, coped and learned by responding primarily to the requirements of her fantasies while tenaciously limiting interventions by playing checker games. Harry, who presented an aggressive disorder and school failure, revealed fragments of pretending from his fantasy life and produced some self-statements and beliefs, both of which failed to establish a therapeutic process within which he could learn about himself and ways of regulating the steady stream of aggression that invaded his functioning at home and school.

Each of these children suffers from attention deficit disorder. More importantly, according to CCT, the cognitive and personality difficulties these children show are two sides of the same coin. Not only do they lack the

cognitive control necessary to copy, coordinate, and integrate information from reality and fantasy, they also are unable to use this information when learning and adapting. And, their deeper nonverbal, cognitive structures are deficient as well as structures concerned with expressing beliefs and self-statements. Therefore, therapy should be directed at rehabilitating cognitive structures, within personality, at all levels. To accomplish this we need a model of cognition which consists of:

1. A developmental-interaction view of an individual as an active organism who creates his/her own knowledge (i.e., imposes symbols on things and events, giving them meaning; takes actions according to this meaning; assimilates the outcomes of these actions, which, in turn, modify the original symbols; uses the modified symbol to construe new things and events, etc.).

2. Cognition as a range of structures from surface, verbal ones to deeper, nonverbal ones; these structures are mobile so that a person may behave in logical and illogical ways from one moment to the next in the same situation or from one situation to another. The person's adaptive intention influences how cognition shifts within this range.

3. The notion that the purposes cognitive structures serve change throughout development in concert with changes in personality, while the structures remain the same.

4. The structures and functions of cognition in the first three years of

life, especially symbolizing/pretending, which are critical for future development and adaptational skill.

5. The relations between cognition, on the one hand, and affect, fantasy, reality, and action, on the other.

6. How the meanings given experiences undergo change and the purpose of these changes for successful psychological development and adaptation.

The next two chapters address these needs. Chapter 2 presents a model based on research findings of cognition in personality and adaptation. Chapter 3 translates this model into a set of principles that guide the approach and techniques of CCT detailed in Chapters 4 to 10.

To make optimal use of the techniques described in this book, the reader should have some knowledge of the theory and rationale presented. Of course, at the same time, familiarity with the techniques is necessary to make optimal use of the theory and rationale. Therefore, the reader is encouraged to review one discussion, and then another, and to return to each, recycling the total presentation in order to ascertain how theory and technique are combined in conducting CCT and whether and how CCT could serve the reader in treating children or innovating other techniques more suited for a particular child.

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