

CHAPTER ONE

LEARNING STYLES, CHILD DEVELOPMENT, AND EXPERIENTIAL TREATMENTS

LEARNING STYLES

The use of experiential therapies with youth is an effective treatment method that enhances standard cognitive-behavioral treatment. The use of experiential exercises can facilitate treatment, add new and different insight to patient learning, and enrich the overall treatment experience. This is especially true when one takes into account that individuals have different learning styles.

The ancient Chinese proverb, “*Tell me I forget; Show me I remember; Involve me I understand*”, summarizes the value of experiential work. Not all people respond well to traditional sit-down, verbal/linguistic learning styles. Integrated (holistic) treatment seeks to bring a variety of theories and models into the treatment process to enhance a person’s potential. For example, Howard Gardner (1983), a Harvard researcher noted for his work on multiple intelligences, teaches us that children have a variety of learning styles and abilities and suggests there are seven learning styles common to children. These learning styles include Verbal/Linguistic Intelligence, Visual/Spatial Intelligence, Musical/Rhythmic Intelligence, Body/Kinesthetic Intelligence, Logical/Mathematical Intelligence, Interpersonal Intelligence, and Intrapersonal Intelligence. He notes that of the seven multiple intelligences, most people are taught using Verbal/Linguistic teaching styles. The use of experiential therapies opens avenues for patients to use all seven multiple intelligences and thus have a better opportunity to learn and grow while in treatment. The multiple intelligences are described briefly below with examples.

Verbal/Linguistic Intelligence. Verbal/Linguistic Intelligence is related to the use of words and language, both written and spoken. The use of and reliance upon this intelligence dominates most western educational systems and includes poetry, humor, story-telling, use of metaphors, grammar, symbolic thinking, abstract reasoning, and conceptual patterning, reading and writing.

This is the intelligence most treatment programs for youth rely upon, as they incorporate a variety of reading and writing assignments. Use of this intelligence is also used in sit down individual and group therapies and psycho-educational classes. For children who do not learn well with this intelligence, it is possible that the patient will not do well in treatment, may drop out of treatment, or fail in treatment. Examples of methods to develop this intelligence include:

- Vocabulary development
- Reading
- Formal speech
- Creative writing
- Humor/jokes

Experiential exercises that enhance this learning style include:

- Journal/Diary keeping
- Verbal debate
- Impromptu speaking
- Storytelling

Visual/Spatial Intelligence. Visual/Spatial Intelligence deals with such things as the visual arts (including painting, drawing, and sculpture); navigation, map-making and architecture (which involve the use of space and knowing how to get around in it); and games which require the ability to visualize objects from different perspectives and angles such as chess. The key sensory base of Visual/Spatial Intelligence is the sense of sight, and being able to form mental images/pictures in the mind and to visualize objects.

For children who do not work well with the verbal/linguistic style of learning, this intelligence can be a primary mode of learning and assimilating information. Experiential therapies are useful in working with those who use this form of intelligence. Examples of methods to develop this intelligence include:

- Color schemes
- Patterns/designs
- Pictures

Experiential exercises that enhance this learning style include:

- Guided imagery
- Art therapy
- Painting
- Drawing
- Sculpture

Musical/Rhythmic Intelligence. Musical/Rhythmic Intelligence includes such capacities as the recognition and use of rhythmic and tonal patterns, including sensitivity to various environmental sounds, the human voice, and musical instruments. Many of us learned the alphabet through this intelligence by singing the “A-B-C song”. Of all forms of intelligence, the consciousness altering effect of music and rhythm on the brain is probably the greatest. Examples of methods to develop this intelligence include:

- Rhythmic patterns
- Vocal sounds/tones
- Percussion vibration
- Humming
- Environmental sounds
- Instrumental sounds
- Singing
- Tonal patterns
- Music performance
- Music composition

Experiential exercises that enhance this learning style include:

- Combining art therapy with music
- Using music in conjunction with various experiential exercises

Body/Kinesthetic Intelligence. Body/Kinesthetic Intelligence is related to physical movement and the knowing/wisdom of the body, including the brain’s motor cortex, which controls bodily motion. This intelligence relies on the ability to use the body to express emotions (as in dance and body language), to play a game, and to create a new product. It is “learning by doing” which has long been recognized as an important part of education. Our bodies know things our minds do not know and cannot learn in any other way. For example, our bodies know how to ride a bike, roller skate, and type. Examples of methods to develop this intelligence include:

- Folk/creative dance
- Physical exercise
- Inventing
- Martial arts



Experiential exercises that enhance this learning style include:

- Exercises involving movement
- Role-playing
- Physical gesturing
- Drama therapy
- Mime

Logical/Mathematical Intelligence. Logical/Mathematical Intelligence is most often associated with scientific thinking and inductive reasoning. This intelligence involves the capacity to recognize patterns, work with abstract symbols (such as numbers and geometric shapes), and discern relationships and/or connections between separate and distinct pieces of information. Patients who suffer with developmental delays and learning disabilities may not rely upon this form of intelligence for learning. Examples of methods to develop this intelligence include:

- Outlining
- Calculation
- Number sequences
- Deciphering codes

Experiential exercises that enhance this learning style include:

- Problem solving
- Pattern games

Interpersonal Intelligence. Interpersonal Intelligence involves the ability to work cooperatively with others in a group as well as the ability to communicate, verbally and nonverbally, with other people. This intelligence builds on the capacity to notice distinctions among others; for example, contrasts in moods, temperament, motivations, and intentions. Thus, interpersonal intelligence operates primarily through person-to-person relationships and communication. In the more advanced forms of this intelligence, one can literally pass over into another's perspective and read their intentions and desires. One can have a genuine empathy for another's feelings, fears, anticipations, and beliefs.

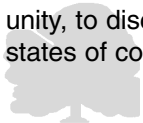
When this intelligence is used, the therapeutic relationship can be extremely powerful in teaching patients and supporting them through the treatment process. Examples of methods to develop this intelligence include:

- Intuiting others' feelings
- Person-to-person communication
- Cooperative learning strategies
- Sensing others' motives

Experiential exercises that enhance this learning style include:

- Empathy practices
- Collaboration skills
- Giving feedback
- Receiving feedback
- Group projects

Intrapersonal Intelligence. Intrapersonal Intelligence involves knowledge of the internal aspects of the self, such as knowledge of feelings, the range of emotional responses, thinking processes, self-reflection, and a sense of intuition about spiritual realities. Intrapersonal intelligence allows us to be conscious of our consciousness: that is, to step back from ourselves and watch ourselves as an outside observer. It involves our capacity to experience wholeness and unity, to discern patterns of connection with the larger order of things, and connection with people, to perceive higher states of consciousness, to experience the lure of the future, and to dream of and actualize the possible.



In working with youth with behavioral problems it is not likely that this intelligence has been developed and one facet of treatment will be to develop this intelligence in order to promote the patient's ability to develop relationships, empathy, and work with unhealthy thinking patterns. If this intelligence is not developed as a part of treatment, there is less likelihood that cognitive restructuring and emotional development will realize its fullest potential as part of the treatment process. Most certainly, the lack of developing this intelligence will effect attachment and the ability to form meaningful relationships. Examples of methods to develop this intelligence include:

Silent meditation/reflection
Focusing/concentration skills

Experiential exercises that enhance this learning style include:

Mindfulness practices
Centering practices
Thinking strategies
Emotional processing
Complex guided imagery

CHILD DEVELOPMENT

Whether you work with children who are average, above average, or children who are developmentally delayed or have learning disabilities, it is important to adjust exercises and focus on learning styles that are suited to the patient's level of understanding or ability. Age and the patient's stage of developmental are important to factor into doing this work. Understanding the work of Piaget, Erikson, and Kohlberg² can serve as a guide to understanding a patient's developmental abilities and learning styles.

PRESCHOOL-AGE CHILDREN

Physical Characteristics of the Preschool-Age Child

Preschool children (age 3-5) are very active, and enjoy running, climbing, and jumping. Frequent rest periods are required, as much energy is spent in these activities. Children at this age need to be supervised and directed in their activities so that the teacher/parent/caregiver does not lose control. Large muscles are more developed than the child's small-motor control. Large items/toys i.e., building blocks, crayons, etc. should be used so the child will be able to handle them easily. Eye-hand coordination may be less than perfect. Large print books are easier for them to read. The skull bones are still soft, and therefore, special attention is paid to activities in order to avoid possible head injuries.

Social Characteristics of the Preschool-Age Child

Preschoolers are very flexible socially. Friendships are usually within their own gender, but friends of the opposite sex are not uncommon, and playgroups will change rapidly. Quarrels are frequent, but usually resolved quickly. Different types of play are demonstrated based on social class, gender, and circumstances affecting free play (availability of toys, place to play, etc.).

Emotional Characteristics of the Preschool-Age Child

Children of this age are very emotional. Children share their emotions frequently. Jealousy is inevitable, as each child is competing for the parent's/caregiver's/teacher's attention.

² <http://tip.psychology.org/piaget.html>
<http://www.nd.edu/~rbarger/kohlberg.html>
<http://psychology.about.com/library/weekly/aa091500a.htm>



Cognitive Characteristics of the Preschool-Age Child

Preschoolers will stick to their own rules in language development, rather than accept corrections given by others. Interaction, interest, opportunities, urging, limits, admiration, and displays of affection encourage competence. Authoritative parents are most successful in fostering competent children. These parents set boundaries, but are loving and compassionate.

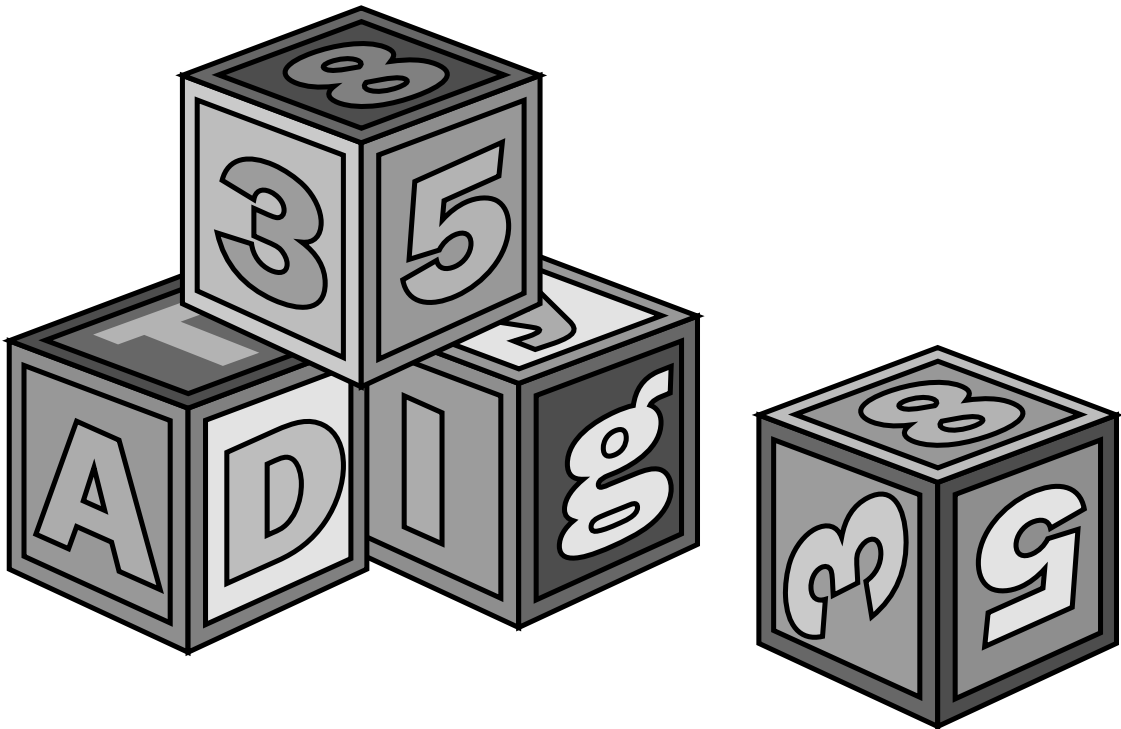


TABLE 1

COMPARISON OF ERICKSON'S, PIAGET'S, AND KOHLBERG'S VIEWS ON PRESCHOOL CHILDREN 3-5

Erikson's Views: Preschool-Age Child

Autonomy versus Shame and Doubt: Toddlers that are able to find some independence in doing what they are capable of doing and are properly supervised, form a sense of autonomy. If these explorations are suppressed however, by the parents or teachers, the child may begin to doubt their abilities or feel ashamed of their actions.

Initiative versus Guilt: An elaborate form of autonomy, initiative is the addition of planning and undertaking a task, rather than just exploring places and ideas. Exploration and experimentation should be encouraged by the teachers and parents. Guilty feelings occur when the child's activities are considered pointless or boring by the parent or teacher, or if the adult is annoyed by these actions.

Piaget's Views: Preschool-Age Child

Preoperational Stage: Gradually acquires ability to conserve and decenter but not capable of operational thinking and unable to mentally reverse actions.

Kohlberg's Views: Preschool-Age Child

Pre-moral

Stage 1: Punishment-Obedience Orientation: Physical consequences determine good and bad behavior. The authority has superior power and determines good and bad. Punishment is avoided by staying out of trouble.

Stage 2: Instrumental-Relativist Orientation: Actions are right when they are instrumental in satisfying one's own needs or involves an even exchange. Obeying rules should bring benefits in return.



PRIMARY-AGE CHILDREN

Physical Characteristics of the Primary-Age Child

The high energy of primary-age children (age 6-8), combined with the frequent classroom situations used by teachers, encourages children to form nervous habits, such as chewing on pens and pencils, fingernail biting, and fidgeting. Rest periods are still needed to balance the energetic play periods, and naps may still be required for some children. Fine-motor skills are still lacking, especially in boys. Focusing on small print may be difficult and may lead to eye fatigue. Children may put themselves into danger because of extreme physical activity. Reckless play should be discouraged because of the risk of injury, especially since bones are not yet fully developed.



Social Characteristics of the Primary-Age Child

Children of this age tend to be more selective in their friends and they usually have a best friend. Organized games are popular, but there may be controversy in setting rules or team spirit. Quarrels are still common, although they tend to be more verbal than physical. Boys in particular are prone to engage in punching and wrestling.

Emotional Characteristics of the Primary-Age Child

Children of this age are eager to please parents/caregivers/teachers. Primary-age children are sensitive to criticism and find it hard to handle failure. Frequent praise and recognition should be used by parents, caregivers, and those working with children. Children become increasingly sensitive to others' feelings as empathy develops, however, personal attacks to hurt others are common and without the child realizing the deep emotional impact on the other child.

Cognitive Characteristics of the Primary-Age Child

Primary grade children are eager to learn, and therefore, self-motivation is high. These children like to talk and their language skills are demonstrated better in their speech than in their writing. Literal interpretation of rules may inspire students to become tattletales. Therefore, acknowledge the child for reporting the wrong doing, but don't praise the child for telling on his/her classmates.



TABLE 2

COMPARISON OF ERICKSON'S, PIAGET'S, AND KOHLBERG'S VIEWS ON PRIMARY AGE CHILDREN 6-8

ERIKSON'S VIEWS: PRIMARY-AGE CHILD

Industry versus Inferiority: Intellectual curiosity prompts students of this age to be creative and industrious. Teachers and parents should encourage this creativity, as this stage is a key stage in a student's academic development. Inferiority occurs when the child is discouraged and has the feeling that their academic work is worthless. School work seems tedious and boring. These children have the belief that they will not excel in their schoolwork.

PIAGET'S VIEWS: PRIMARY-AGE CHILD

Preoperational Stage: Gradually acquires ability to conserve and decenter but not capable of operational thinking and unable to mentally reverse actions.

Concrete Operational Stage: Capable of operations, but solves problems by generalizing from concrete experiences. Manipulation of conditions is difficult unless the child has experienced such conditions.

KOHLBERG'S VIEWS PRIMARY-AGE CHILD

Stage 1: Punishment-Obedience Orientation: Physical consequences determine good and bad behavior. The authority has superior power and determines good and bad. Punishment is avoided by staying out of trouble.

Stage 2: Instrumental-Relativist Orientation: Actions are right when they are instrumental in satisfying one's own needs or involves an even exchange. Obeying rules should bring benefits in return.

ELEMENTARY-AGE CHILDREN

Physical Characteristics of the Elementary-Age Child

Elementary-age boys and girls (ages 9-10) are leaner and stronger. Girls may be slightly taller and heavier than boys. Gender confusion may result due to similarity in hairstyles and clothing. Obesity is an issue with some children, as junk food and lack of physical activity may contribute to problems with body weight/height ratios. Gender differences display themselves in athletic abilities. Boys tend to be more skilled in baseball and basketball, whereas girls are usually more skilled in gymnastics. Growth is usually predictable, although there may be some 'early bloomers' that will begin puberty during this time.

Social Characteristics of the Elementary-Age Child

The peer group is much more central in the elementary-age child's life, and it is the child's peers that determine social standards. Friendships are more selective and gender-based. This is the age when Boy Scouts, Girl Scouts, team sports, and other similar activities are popular. Avoidance of the opposite sex when possible is commonly seen.

Emotional Characteristics of the Elementary-Age Child

Self-image is developed during this stage. Self-concept entails physical, social, cognitive, and emotional characteristics, while self-esteem entails judgments that children make about their personal characteristics. Disruptive family relationships, social rejection, and school failure may lead to delinquent behavior. Delinquents often have few friends, short attention spans, and do poorly in school due to a lack of basic skills.



Cognitive Characteristics of the Elementary-Age Child

Logical thinking is constrained and inconsistent. Differences in cognitive style are apparent. The tendencies to respond to different intellectual tasks in different ways are shown by these children. Some students prefer structure, whereas some students would rather work on their own initiative. Impulsive students tend to give quick responses to questions, while reflective students think things through before they answer.



TABLE 3

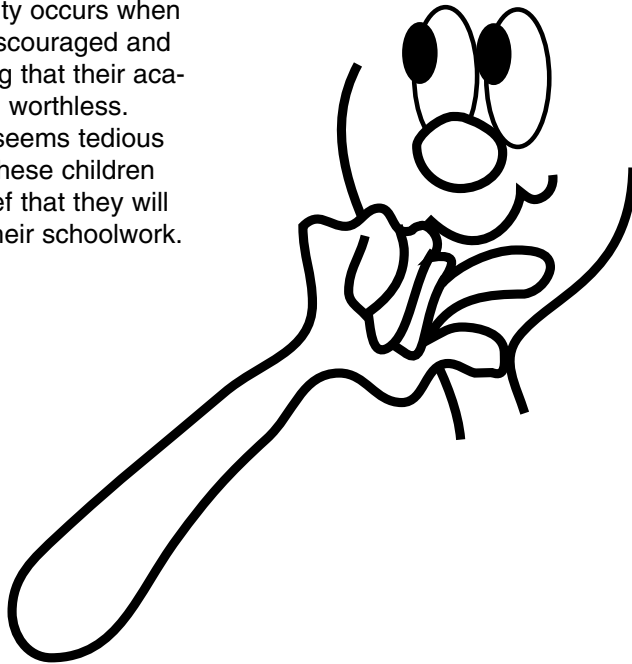
COMPARISON OF ERICKSON'S, PIAGET'S, AND KOHLBERG'S VIEWS ON ELEMENTARY AGE CHILDREN 9-10

Erikson's Views: Elementary-Age Child

Industry versus Inferiority: Intellectual curiosity prompts students of this age to be creative and industrious. Teachers and parents should encourage this creativity, as this stage is a key stage in a student's academic development. Inferiority occurs when the child is discouraged and has the feeling that their academic work is worthless. School work seems tedious and boring. These children have the belief that they will not excel in their schoolwork.

Piaget's Views: Elementary-Age Child

Concrete Operational Stage: Capable of operations, but solves problems by generalizing from concrete experiences. Manipulation of conditions is difficult unless the child has experienced such conditions.



Kohlberg's Views: Elementary-Age Child

Stage 1: Punishment-Obedience Orientation: Physical consequences determine good and bad behavior. The authority has superior power and determines good and bad. Punishment is avoided by staying out of trouble.

Stage 2: Instrumental-Relativist Orientation: Actions are right when they are instrumental in satisfying one's own needs or involves an even exchange. Obeying rules should bring benefits in return.

Stage 3: Good Boy-Nice Girl Orientation: The right actions will impress other people.

Stage 4: Law-and-Order Orientation: In order to maintain social order, rules must be established and followed. Respecting authority is critical in maintaining order.

MIDDLE SCHOOL-AGE CHILDREN

Physical Characteristics of the Middle School-Age Child

Children of the middle school-age (age 11-13) go through puberty at different rates and times. Growth spurts can be rapid and uneven. Early-maturing girls are sometimes embarrassed about their growth spurts and tend to be less confident and popular. Early-maturing boys are often very confident, high in self-esteem, and are leaders among their peers. Late-maturing girls are outgoing and tend to be more accepted by their peers. Late-maturing boys sometimes demand attention through immature behavior and they tend to feel inferior. Curiosity about sex increases in this age group, and parents and educators should address human sexuality education and health focused courses.

Social Characteristics of the Middle School-Age Child

Interpersonal reasoning, or the ability to understand relationships between motives and behaviors in groups of people, is developed in this stage. Conformity is highest among middle school students, which explains the popularity of certain items such as shoes, clothes, jewelry, or backpacks.



Emotional Characteristics of the Middle School-Age Child

This is the "Storm and Stress" period for many pre-adolescents and early adolescents. Feelings of confusion, anxiety, and depression are evident in this age group. Many children are self-conscious and self-centered, and feel that adults just don't understand what they are going through in adolescence.

Cognitive Characteristics of the Middle School-Age Child

Self-efficacy, the concept that one feels capable of doing certain things is apparent among middle school children. Gender differences are decreasing among this age group, although some studies show that girls feel inferior in certain subjects and, therefore, achieve less in these areas.

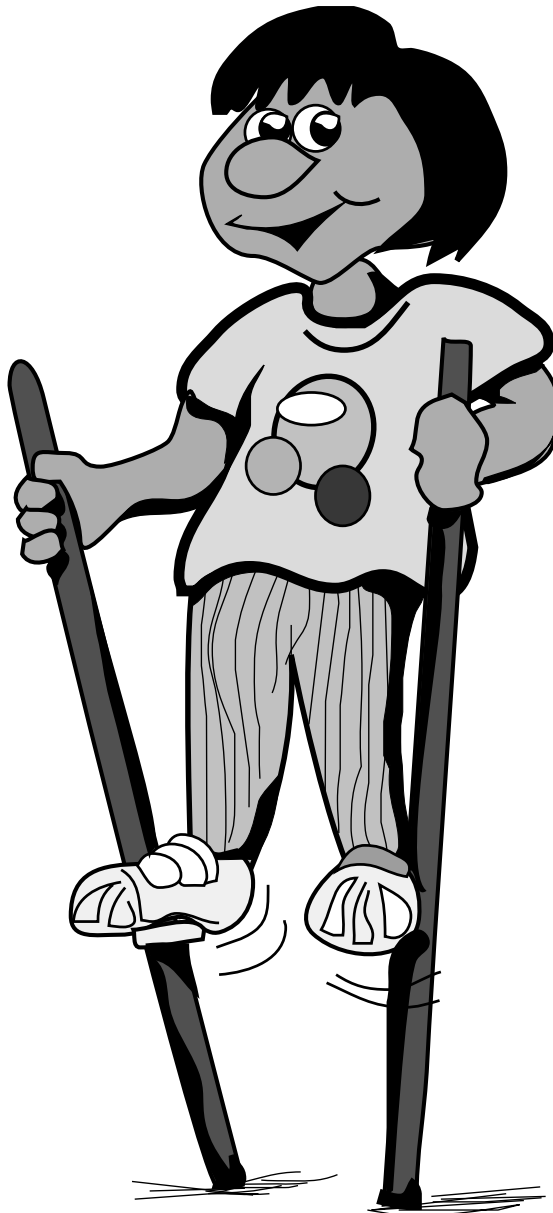


TABLE 4

COMPARISON OF ERICKSON'S, PIAGET'S, AND KOHLBERG'S VIEWS ON MIDDLE SCHOOL CHILDREN 11-13

Erikson's Views: Middle School-Age Child

Identity versus Role Confusion: The development of one's identity is critical at this stage, as children progress through adolescence and become an adult. Role confusion occurs when children are unsure about what behaviors will be reacted to favorably. Some children develop negative identity characteristics, which demonstrate themselves in the form of rebellion and attempts to display individuality.

Piaget's Views: Middle School-Age Child

Formal Operational Stage: Ability to deal with abstractions, form hypotheses, solve problems systematically, engage in mental manipulations. Logical processes are developed in this stage.

Kohlberg's Views: Middle School-Age Child

Conventional

Stage 3: Good Boy-Nice Girl Orientation: The right actions will impress other people.

Stage 4: Law-and-Order Orientation: In order to maintain social order, rules must be established and followed. Respecting authority is critical in maintaining order.

HIGH SCHOOL-AGE CHILDREN

Physical Characteristics of the High School-Age Child

Most high school-age children (age 14-18) have reached puberty, and have matured fully. However, some boys do continue to grow even after high school. Many students engage in sexual activity, but they usually do not form sexual relationships well. Sexual activity may lead to unwanted pregnancy or sexually transmitted diseases.

Social Characteristics of the High School-Age Child

Parents tend to influence long-range plans, while peers influence short-term planning and spontaneous events. Girls experience greater anxiety about friendships than boys. After-school employment is common among high-school students, as it helps students develop responsibility and gives them independence and self-confidence. However, having a job reduces available time for studying, extra-curricular activities, socialization, and sleep.

Emotional Characteristics of the High School-Age Child

Psychiatric disorders manifest themselves during high school. Eating disorders, substance abuse, schizophrenia, depression, and suicidal tendencies are demonstrated in this age group. Encouraging success in learning will help students that suffer from depression, which when severe, may lead to suicide.



Cognitive Characteristics of the High School-Age Child

Formal thought can be executed by most students, although some students choose not to. Using prior knowledge to accomplish new tasks will encourage formal thought. Political thinking becomes more abstract, liberal, and knowledgeable.

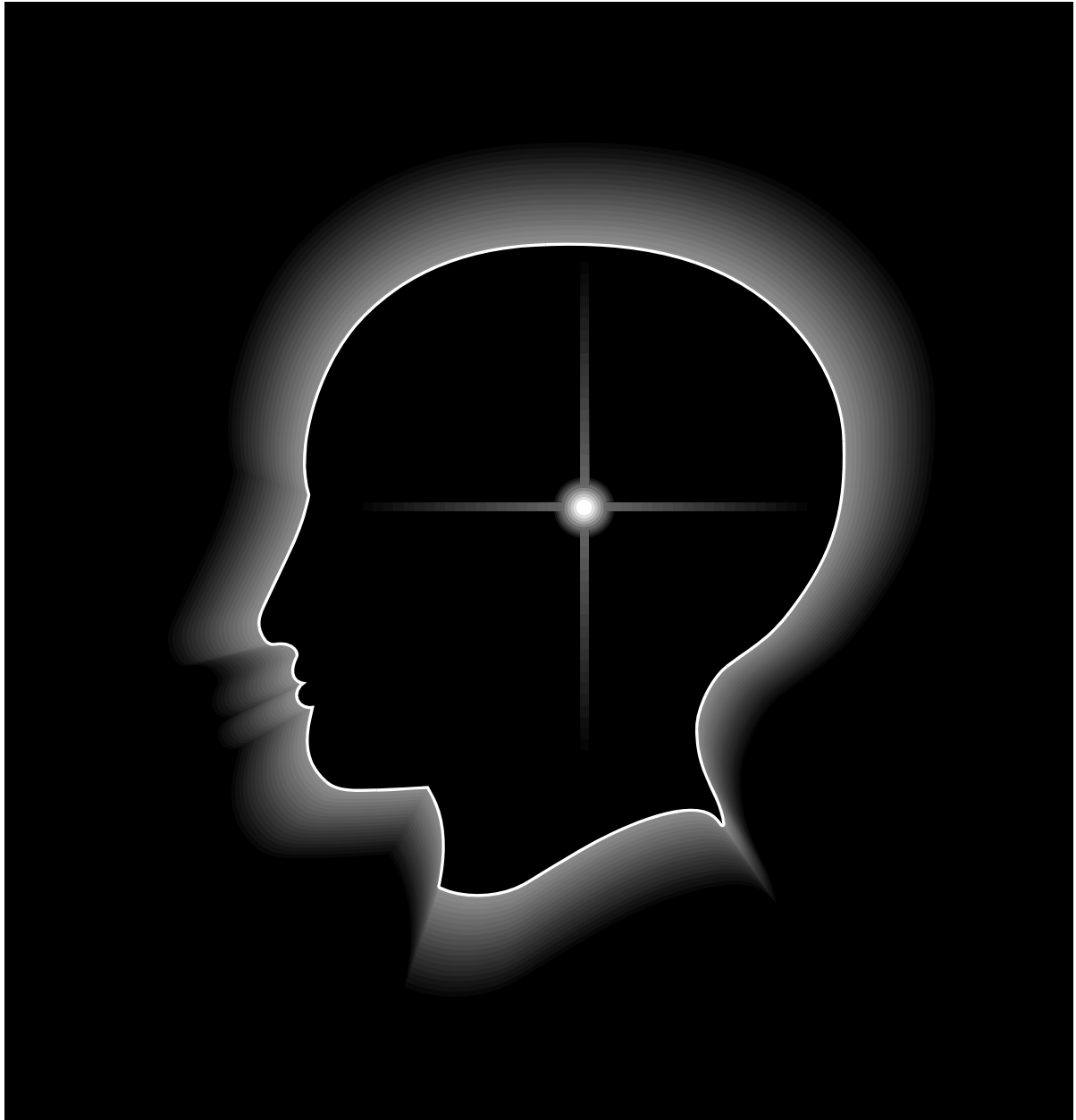


TABLE 5

COMPARISON OF ERICKSON'S, PIAGET'S, AND KOHLBERG'S VIEWS ON HIGH SCHOOL CHILDREN 14-18

**Erikson's Views:
High School-Age
Children**

Identity versus Role Confusion: The development of one's identity is critical at this stage, as the child progresses through adolescence and becomes an adult. Role confusion occurs when children are unsure about what behaviors will be reacted to favorably. Some children develop negative identity characteristics, which demonstrate themselves in the form of rebellion and attempts to display individuality.

Intimacy versus Isolation: The development of intimate relationships with other people is the central focus of this stage. Sacrifice and compromise contribute to establishing these relationships. The inability to develop relationships may result in a sense of isolation, or loneliness. This stage may not be reached by all students of high school age, rather, it may occur as late as age 25-30.

**Piaget's Views:
High School-Age
Children**

Formal Operational Stage: Ability to deal with abstractions, form hypotheses, solve problems systematically, engage in mental manipulations. Logical processes are developed in this stage.

**Kohlberg's Views:
High School-Age
Children**

Stage 3: Good Boy-Nice Girl Orientation: The right actions will impress other people.

Stage 4: Law-and-Order Orientation: In order to maintain social order, rules must be established and followed. Respecting authority is critical in maintaining order.



REACTIVE ATTACHMENT DISORDER³.

Insecure Attachment and Attachment Disorder (AD) also known as Reactive Attachment Disorder (RAD), which is a relatively new diagnosis to the DSM-IV-TR, is a disorder that is often misunderstood. Insecure attachment (which is not diagnosable) and AD which is, are conditions in which individuals have difficulty forming loving, caring, lasting, intimate, relationships. Attachment and bonding are generally used interchangeably. AD youth usually do not learn how to trust, and often fail to develop a conscience. AD youth learn that the world is not a safe place.

RAD as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)*, requires etiological factors, such as gross deprivation of care or successive multiple caregivers, for diagnosis. Attachment disordered youth may present in two ways.

In inhibited RAD, the child does not initiate or respond to social interactions in a developmentally appropriate manner. When caregivers are not reliable, consistent, or respond in an unpredictable and uncertain way, the child may not be able to establish a pattern of confident expectation. One result is insecure attachment, a less than optimal internal sense of confidence and trust in others. The child uses psychological defenses to avoid disappointments, which may contribute to a negative working model of relationships that leads to insecurity.

In disinhibited RAD, the child has diffuse attachments, indiscriminate sociability, and excessive familiarity with strangers. These children repeatedly lose attachment figures or have multiple caregivers and have never had the chance to develop a continuous and consistent attachment to at least one caregiver. The usual anxiety and concern with strangers is not present.

AD youth are masters at manipulating their environment and people in their environment. They may demonstrate learning problems in school. Lack of conscious appears to be caused by his or her lack of trust in anyone.

High risk factors for attachment disorders may include:⁴

- maternal ambivalence towards pregnancy
- unprepared mothers with poor parenting skills
- sudden separation from a primary caretaker
- child abuse/neglect
- frequent moves or placements
- traumatic prenatal experience
- inconsistent or inadequate day care

Stimulation from birth on, is especially critical during the first 2-3 years of life. The absence of appropriate stimulation may lead to:⁵

- indiscriminate affection
- extremely demanding or attention seeking behaviors
- autistic like behaviors
- hyperactivity
- aggression (including acts of cruelty)
- temper tantrums
- no cause and effect thinking

³ <http://www.emedicine.com/ped/topic2646.htm>

⁴ Ibid.

⁵ Ibid.

Healthy attachment helps facilitate the following ⁶:

- the ability to think logically
- the development of a conscious
- the ability to cope with stress and frustration
- becoming self-reliant
- development of relationships
- the ability to handle fear and worry
- the ability to handle any perceived threat to self

Symptoms of Attachment Disorder may include:⁷

- superficially engaging and charming child
- a lack of cause and effect thinking
- indiscriminate affectionate with strangers
- destruction of self, others, and/or things
- developmental lags
- lack of eye contact
- preoccupation with fire, blood, gore
- cruelty to animals and/or siblings
- poor peer relations
- inappropriate demanding or clinging behavior
- stealing or lying
- lack of conscience
- poor impulse control
- fighting for control over everything
- hoarding or gorging food

Successful therapy with these youth will depend upon the therapist's willingness to use unconventional strategies. Some of these strategies are to 1) find and to face the depth of the feelings that these youth keep hidden, 2) revisit the trauma with the child and to communicate that by doing this together; the trauma is not bigger than the child, and the child can overcome it:⁸

Therapists need to be prepared to face the horrors that these youth have experienced if we ever hope to help them heal. Successful therapy needs to be challenging and at times may be intrusive. These interventions are always done while being loving and supportive. Critical goals of treatment may include but are not limited to:

- resolution of early losses
- development of trust
- modulation of affect
- development of internal control
- development of reciprocal relationships
- learning appropriate responses to external structure and societal rules
- correcting distorted thinking patterns
- developing self-respect

EXPERIENTIAL TREATMENT

From a therapeutic standpoint, one criterion for teaching patients effective interventions is using a developmental/contextual perspective that matches treatment to the patient's learning styles, cognitive abilities, developmental stage, and moral development stage. One cannot hope to maximize a patient's potential for personal change if the teaching style treats patients as subjects to be filled with standardized, single track, 'correct' ways of thinking and behaving. In our clinical practice we encourage patients to *become* authentically themselves. We try to avoid having a preset notion of what patients should do therapeutically. Experiential treatments allow patients to learn through self-exploration and self-discovery. This is not to say that we don't teach our patients standard and/or specialized pieces of information through classroom style education. We do. However, we encourage patients, once they have acquired this generalized knowledge, to internalize it in ways that work best for them. We try to give them several healthy and effective choices for therapeutic change, and promote such through frequently using experiential treatments.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.



Experiential treatments when used properly do not sound like or come across as therapy done *to* patients, but rather *with* them, and often with minimal direction. The challenge in using applied experiential treatments is to learn *with* patients, not just simply teach *at* them. Like with any other therapeutic process, when therapy goes well, both clinician and patient grow and learn.

Behaviors youth employ in particular situations (i.e., acting out when one does not get his/her way) are learned and strengthened through frequent repetition. Over time they become automatic responses to social and other situations. Undesirable, inappropriate learned behavior can be modified through experiential treatments, i.e. role-plays, because these interventions challenge the way youth traditionally think and react to real or perceived situations.

Most behavior is learned, and therefore can be unlearned or relearned. Unlearning requires the patient to focus on the acquisition of new behaviors and then rehearsing them, as one does in most learning situations. New behavior is not learned by simply describing it or telling someone about it. It does not become incorporated into one's life by simple re-enactment and/or one-trial learning. Practice and rehearsal is critical to the learning process. If children practiced social skills in the same manner they practiced sports, dancing, and electronic games, imagine the learning that would take place. Presenting patients with the same information in new and different ways enhances the learning experience.

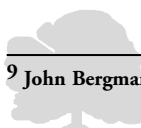
Verbal therapies (psycho-educational models and group treatment) alone do not often cover everything the patient needs, nor do they include the patient in exploration of what, in his/her eyes, are problem behaviors (versus the beliefs and observations of staff). Experiential treatments and using multiple intelligences can enhance learning and behavioral change.

When patients learn outside of personal experience, it is difficult for the patient to incorporate the acquired knowledge into personal behavior. It is an external rather than internal process. Taught knowledge through verbal/linguistic learning often squelches personal discovery. When youth are taught concrete thinking skills (traditional cognitive therapy) they simply accept information (and often do not use it) rather than explore and discover information by learning to think for themselves.

We believe it is important to challenge the thinking of our patients and help them develop interpersonal and social skills. Learning is enhanced when youth can be the developers of new thinking and behavior rather than just passive participants who learn by traditional and often routine methods. Experiential treatments can be used to help youth look inward for solutions and alternatives, but staff must be careful that the process does not become one of ***imitation*** rather than original ***self-discovery***.

Patients, for example, stereotype themselves through program labeling and by performing behavior through simple routines. In residential programs, patients traditionally learn to restrict themselves to a predictable or limited set of responses based upon program rules, regulations, peer critique, and staff feedback. Over time their thinking, behavior, and responses become automatic and more pronounced. Experiential treatments help us to more effectively see the patient's behavior which is the direct result of their thinking, and which is linked to their various personas both public and private⁹. The private persona however, is one we seldom see in patients. The patient's behavior (the behavior they present when coming into treatment), as in other life situations (how they behaved in their life in the community), is a learned and practiced routine (role) that is adaptive and automatic. If we continue to foster the same type of learning patterns in treatment, patients will learn a new role, the role of being a *patient in treatment*.

James Thompson (1999) notes that the use of experiential treatments, including role-plays, can be undermined by the juvenile justice system where there is inherent limiting of individual role-taking abilities and a negative reinforcement and solidification of certain behaviors. Many of our patients have been subjected to this process, especially if they have been in previous residential treatment settings, dysfunctional families, and substandard living environments. Once labeled as a criminal or learning-disabled person (i.e., juvenile delinquent, sex offender, retarded, learning disabled, etc.) the more likely it is for the patient to learn and live that label (role).



Punitive responses to crime and particularly incarceration (or secure residential treatment) tend to emphasize one role in the person to the detriment of all others. A youth detention sentence (or residential treatment) and the secure facility regime (program milieu) encourage a person to play the role of prisoner (patient) and criminal (offender/delinquent) twenty-four hours a day as opposed to student, son, daughter, friend, peer, athlete, etc. (Thompson, J., 1999).

When we design programs that have fixed, institutionalized standards of behavior, we very easily encourage the attributes that we are trying to avoid. Teaching a fixed standard of behavior encourages further fixed or rigid thinking and behaving (living the life of a patient with rules and regulations that do not parallel life in the greater community). Teaching a fixed standard of behavior attempts to replace one set of concrete behaviors with another and therefore does not challenge the core problems that are the stereotypical responses to social problems (Thompson, J. 1999).

In summary, we have found that the use of experiential treatment can play a critical role in the effective treatment of youth, as a counter balance to traditional techniques. While serious sit-down therapy in the form of individual, family, and group treatment, and psycho-educational classes are essential to any treatment process, such treatment/therapy has its limitations. To enhance the youthful patients' learning and personal growth, we encourage you to move beyond traditional methods. In addition to group, family, and individual therapy, we encourage the use of a wide range of treatments and modalities with youth including the use of experiential treatment.

