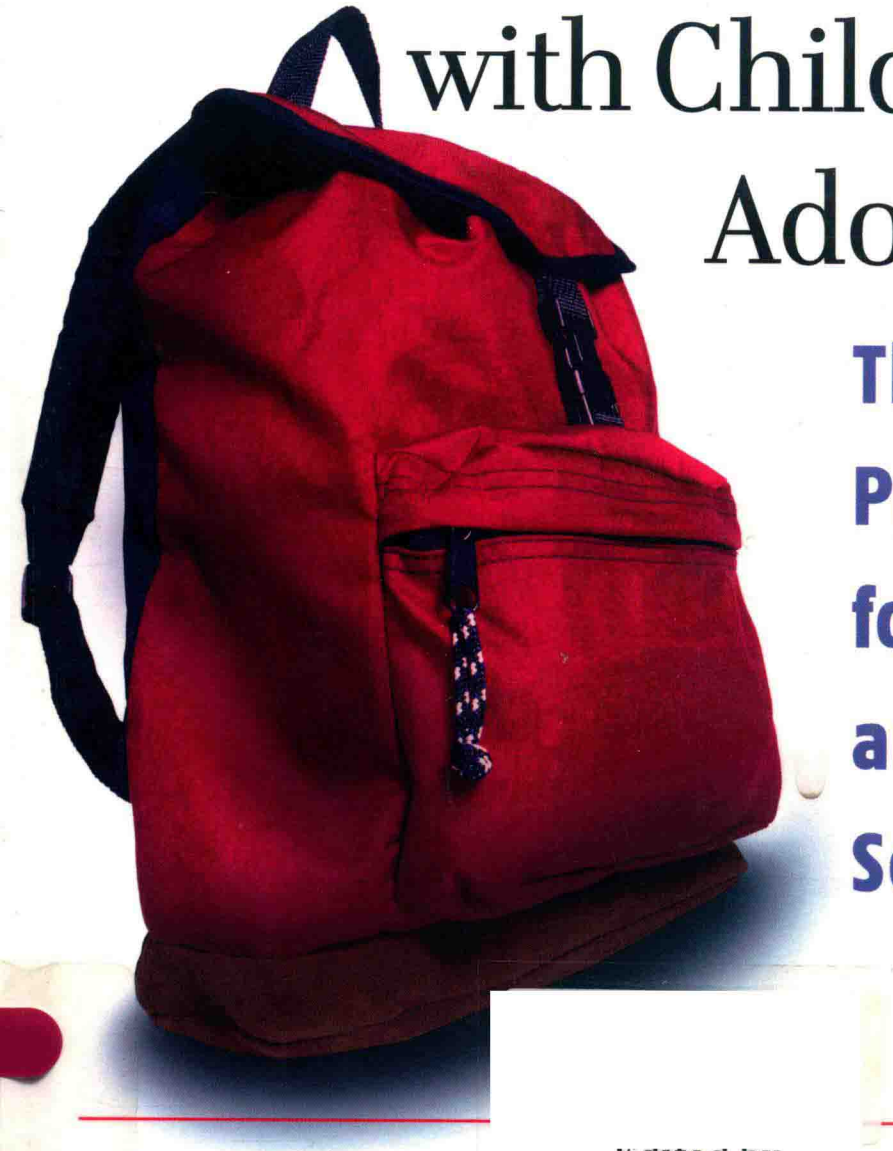
Fourth Edition

Counseling and Psychotherapy with Children and Adolescents

Theory and Practice for School and Clinical Settings



Edited by
H. Thompson Prout & Douglas T. Brown

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COUNSELING AND PSYCHOTHERAPY WITH CHILDREN AND ADOLESCENTS

To our now young adult children,
Alex, Lauren, and Adam
who have continued to teach us lessons
not available in books.

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Preface

As we began preparing the fourth edition of this book, it was interesting to review the Prefaces to the earlier editions. Most interesting was the Preface to the first edition: We noted that there really wasn't much scholarly work devoted to therapeutic interventions with children and adolescents. The impetus to the first edition was the lack of options in choosing textbooks for courses in counseling and psychotherapy with children and adolescents. At the time, books were either focused on single theories or were downward extensions of adult-based theory. Gratifyingly, this has changed.

Our aim in this edition is similar to the earlier editions—to offer comprehensive overviews of major theoretical approaches to interventions with children and adolescents. We continue to place great value on the understanding of theory while acknowledging the need to integrate approaches and to have multiple options for dealing with the array of child and adolescent social-emotional difficulties. We also strongly feel that legal, ethical, and multicultural issues cut across all intervention areas and that issues in working with children and adolescents with disabilities and health conditions is a major role for mental health professionals.

In this edition, all chapters have been updated to reflect the current status of the area. We are fortunate to have kept most of our earlier authors and to have added some highly qualified chapter authors. The most notable changes in this edition are in the cognitive-behavioral (formerly behavioral) chapter that reflects contemporary trends in that area and in the family systems chapter. In the family systems chapter, substantive content has been added on solution-focused approaches to intervention.

We wish to thank our chapter authors for their contributions and enthusiasm with this project. We also wish to thank Patricia Rossi of Wiley for her efforts in the development of this fourth edition and her patience!

H. Thompson Prout
Douglas T. Brown

Contents

Chapter 1

Counseling and Psychotherapy with Children and Adolescents: Historical Developmental, Integrative, and Effectiveness Perspectives

H. Thompson Prout

The psychological treatment of children's problems is the focus of several professions and is carried out in many settings and situations. Although theoretical viewpoints are wide-ranging and essentially rooted in adult-based theories, the child or adolescent presents a unique challenge to the child mental health worker. Children are not simply little adults. Their treatment cannot be viewed as scaled-down adult therapy; their developmental stages, environments, reasons for entering therapy, and other relevant factors necessitate a different, if not creative, approach to therapy. The child/adolescent therapist must have an expanded knowledge base of the human condition and a different perspective of what constitutes therapy or counseling.

This book is about psychotherapy and mental health counseling with children and adolescents. It brings together in a comparative format the major theoretical views of psychological treatment of children and highlights major issues in the area. A number of concerns, however, cut across the theories and are relevant to any provision of mental health services to children. This introductory chapter describes some of these issues: Historical perspectives, the mental health needs of children and adolescents and the need for services, developmental issues, the adolescent phase, the unique aspects of child and adolescent therapy, psychotherapy with adolescents, a multimodal view of treatment, practitioner concerns and patterns of practice, and research/efficacy issues are discussed. Throughout this chapter, the terms *counseling* and *psychotherapy* are used interchangeably.

HISTORICAL PERSPECTIVES ON THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS

Many major advances in clinical mental health work can, in some way, be traced to Freud. Mental health work with children is no exception. Freud's classic case study of "Little Hans" in 1909 is generally viewed as the first reported attempt to psychologically

explain and treat a childhood disorder (S. Freud, 1955). Although Freud did not directly treat Little Hans's phobia, he offered a psychoanalytic explanation of the problems and guided the father in the treatment of Hans. This case study is recognized as providing the base for Freud's theories on the stages of psychosexual development. Freud's interest in childhood disorders apparently waned at this point, and it was not until 1926 that his daughter, Anna, presented a series of lectures entitled "Introduction to the Technique of Psycho-analysis of Children" to the Vienna Institute of Psychoanalysis. These lectures generated considerable interest and established Anna Freud as a pioneer in child psychotherapy (Erickson, 1997). Shortly thereafter, Melanie Klein (1932), emphasizing the symbolic importance of children's play, introduced free play with children as a substitute for the free association technique used with adults, thus inventing play therapy. Although these two camps disagreed on many issues, they have remained the dominant voices in the child psychoanalytic field, with most analytic work being a spin-off of either A. Freud or Klein.

At approximately the same time (the early twentieth century), other forces were beginning to put more emphasis on work with children. In France in 1905, Alfred Binet completed initial work on his intelligence test, which was used for making educational placement decisions in the Paris schools. This work provided the base for the psychometric study of individuals and had great impact on child study and applied psychology (Schwartz & Johnson, 1985). At the University of Pennsylvania in the United States, Witmer had established a clinic for children in 1896 that focused on school adjustment (M. Erickson, 1997), and in 1909 Healy founded what is now the Institute for Juvenile Research in Chicago (Schwartz & Johnson, 1985). These events provided the base for the child guidance movement, emphasizing a multidisciplinary team approach to the diagnosis and treatment of children's adjustment and psychological difficulties. The child guidance model involved treating both the child and his or her parents. The increased interest in clinical and research work on children's problems led to the founding of the American Orthopsychiatric Association in 1924, an organization of psychologists, social workers, and psychiatrists concerned with the mental health problems of children (Schwartz & Johnson, 1985).

Through the 1940s and into the 1950s, psychoanalytic psychotherapies were used almost exclusively in the treatment of children. In 1947, Virginia Axline published *Play Therapy,* describing a nondirective mode of treatment utilizing play. Nondirective play therapy was, in effect, a child version of Carl Rogers's adult-oriented client-centered therapy. Both nondirective play therapy and client-centered therapy represented the first major departures from psychoanalytic thought, differing in conceptualization of the therapeutic process and content in the role of the therapist. Rogers's impact on adult psychotherapy was paralleled and followed by Axline's impact on child therapy. The next major movement in psychotherapy was the rise of the behaviorally based approaches to treatment. Although the principles and potential applications of behavioral psychology were long known, it was not until the 1960s that behavior modification and therapy began to be used frequently in clinical work with children (Graziano, 1975).

The mental health treatment of children and adolescents has also been affected by two policy and legislative mandates. First, the community mental health movement was strongly influenced by the passage in 1963 of the federal program to construct

mental health centers in local communities and begin a move away from large institutional treatment. This movement grew not only because it was mandated by a federal program but because it represented a philosophy that mental health interventions are more likely to be successful when carried out in the community where the maladjustment is occurring. The new programs emphasized early intervention and prevention of mental disorders. The second mandate, with a similar philosophical base, involved the provision of special education services to all handicapped children, including emotionally disturbed and behavior-disordered children and adolescents. Exemplified initially by Public Law 94-142 (now the Individuals with Disabilities Education Improvement Act [IDEIA]), this movement has not only expanded the role of public education in provision of services to these children but also allowed more children to remain in their home communities. Psychotherapy and mental health treatment, if deemed a part of the total educational program of a child, has become by law and policy an educational service.

The most recent movement in child and adolescent treatment has been in the identification of treatments that are evidence based (Kazdin, 2003). Various terms have been used to describe these treatments including empirically validated or supported treatments, evidence-based practice, or simply treatments that work. Efforts have also been made to quantify the degree and strength of support for the treatments, for example, the number of studies showing evidence of effectiveness. Studies are examined with the specification of treatment (i.e., age, setting, presenting problem), use of treatment manuals or clearly specified intervention procedures, and evaluation of outcome with multiple measures. Procedures must be replicable and independent replication studies are often included in criteria for a treatment to be labeled as evidence based.

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS: A CHRONIC PROBLEM

There are well-documented estimates of large and perhaps increasing numbers of children who are experiencing significant mental health problems. These needs have been apparent for some time. Studies in the 1960s and 1970s clearly showed the pervasiveness of problems at that time. In a study of children in public school, Bower (1969) estimated that at least three students in a typical classroom (i.e., 10% of school-age children and adolescents) suffered from moderate to severe mental health problems; many of these children were disturbed enough to warrant special educational services for the emotionally handicapped. In 1968, Nuffield, citing an estimate of 2.5 to 4.5 million children under the age of 14 in need of psychiatric treatment, found indices of only 300,000 receiving treatment services. This figure represented services to roughly 10% of those in need. Berlin estimated in 1975 that each year there would be 6 million school-age children with emotional problems serious enough to indicate the need for professional intervention. Cowen (1973) noted a smaller group (1.5 million) in need of immediate help but estimated that fewer than 30% of these children were receiving this help.

There has been little change in the reduction of problems. Kazdin and Johnson (1994) noted that incidence studies show between 17% and 22% of youth under the age of 18 have some type of emotional, behavioral, or developmental problem. This represented

between 11 and 14 million of the 64 million youth in the United States with significant impairment. They noted that many of those with disorders are not referred for treatment and are not the focus of treatment in the schools. Kazdin and Johnson also noted that there are high and increasing rates of at-risk behaviors, including antisocial and delinquent behaviors, and substance abuse. Doll (1996), in a synthesis of epidemiology studies, notes a similar rate of 18% to 22% with diagnosable disorders, translating this to the analogy of a school of 1,000 students with 180 to 220 students in the school having a disorder in the clinical ranges. Doll sees the need for broad-based policies at all levels (i.e., school, district, governmental) to address these significant needs. Regardless of the estimate of incidence, it is clear that many children and adolescents with problems are not identified by educational, mental health, and social service institutions as having emotional difficulties and thus are not referred for or provided treatment services.

Recent reviews (Huang et al., 2005; Tolan & Dodge, 2005) have noted this continued problem despite many government panels formed to address the problem. It is estimated that 1 in 5 children have a diagnosable disorder with 1 in 10 having a disorder that substantially impacts functioning at home, at school, or in the community. Further, there continues to be limited or difficult access to appropriate mental health services, both for families with financial resources and those with more limited means.

Children and adolescents remain critically underserved populations, despite ample recognition of the problem based on nearly 40 years of research documenting needs. The mental health needs of children present an enormous service delivery shortfall; and with funding problems continuing in the human services, the gap between need and available services is likely to continue. Preventive services may be a cost- and resource-efficient mode for dealing with part of this problem, but the provision of quality counseling and psychotherapeutic services will be a crucial component in the total mental health system. Tolan and Dodge (2005) call for a fundamental policy shift to development of a comprehensive mental health care system for children that includes treatment, support, and prevention.

Huang et al. (2005) have described a "vision for children's mental health" that would address the complex needs of children and adolescents, including:

- Development of comprehensive home- and community-based services and supports.
- Development of family support and partnerships.
- Development of culturally competent care and reducing disparities in access to care.
- Individualization of care.
- Implementation of evidence-based practice.
- Service coordination and designation responsibility.
- Prevention activities for at-risk groups with earlier identification and intervention, including programs for early childhood.
- Expansion of mental health services in the schools.

The components of this vision are clearly consistent with the theme of this book.

DEVELOPMENTAL ISSUES

The child/adolescent mental health worker must be familiar with human development for a number of reasons. With the exception of severe psychopathology or extreme behaviors, much of what is presented as problematic in children may simply be normal developmental deviation. What is considered pathological behavior in adults may not be abnormal in children or adolescents. Knowledge of development and the normal behavioral ranges at different ages is crucial to discriminating between truly deviant behavior and minor developmental crises. Development in children and adolescents may follow sequences with expected orders for the appearance of certain behaviors and characteristics yet still tend to be highly variable. Children's personalities are quite unstable when compared with expectations of stability in adults. Related to this instability is the evidence that indicates normal development is often marked by a number of behavior problems. The classic developmental study by MacFarlane, Allen, and Honzik (1954) pointed to a number of behaviors that parents considered to be problems yet were normative at different age levels. Sroufe (1991) emphasizes this, noting that age is important in distinguishing normal versus abnormal behavior. The child/adolescent therapist must be able to sort out these "normal" problems from those that may represent more serious disorders.

Awareness of development will also aid the therapist in clinical decision making at various points in the treatment process. Appropriate goal setting is important to any therapeutic venture. It provides a direction for our work, allows us to monitor progress, and tells us when we are done. The child/adolescent therapist sets these goals in a developmental framework and does not expect an average 8-year-old to acquire, in the course of therapy, the problem-solving cognitive abilities or the moral judgment of a 10-year-old. To set goals above developmental expectations is almost ensuring that the intervention will fail. This knowledge of development also allows the therapist to choose appropriate content and to decide what level of therapeutic interaction is best suited for the child. Within these developmental age expectations, the therapist must also be sensitive to developmental delays in children. Delays, particularly in cognition and language, dictate goal setting, yet they must be distinguished from behavioral or emotional disorders. These delays may also be major contributing factors in the development of disorders. For example, children with learning disabilities or mental retardation often display poor self-concepts and negative self-images as well as other socioemotional difficulties (Clarizio & McCoy, 1983). On the other end of the spectrum, we need to be cautious not to set limited goals for developmentally advanced children. Although we are not advocating psychological assessment as a prerequisite for treatment, in most cases, the child/adolescent therapist will need to assess developmental levels of their clients early in the intervention.

The study of development can be broken down into essentially two types of information that are relevant for counseling or psychotherapy. The first involves an understanding of the developmental stage theorists, with the works of Freud, Piaget, Kohlberg, and Erikson being the most notable. Freud's psychoanalytic view of human development emphasizes the psychosexual aspects and pleasure-seeking drives that affect the

child and adolescent. Development is seen as a series of developmental crises resulting in psychosexual conflicts that must be resolved for the individual to move on the next phase (Neubauer, 1972). While obviously most consistent with the psychoanalytic approach to treatment, Freud's description of the developmental phases and parent-child relationships provides a useful base for assessing socioemotional development. Similarly, Piaget's theory of cognitive development provides a parallel base for assessing intellectual development. Piaget suggested that maturation, physical experience, social interaction, and equilibration (the internal self-regulating system) all combine to influence cognitive development. At different periods, the type of information that can be processed and the cognitive operations that can be performed vary. Cognitive development is a coherent and fixed sequence with certain cognitive abilities expected at certain ages (Wadsworth, 1996). Piaget allows us to select developmentally appropriate modes of interacting with the child and to set appropriate goals for cognitive change. For example, a child in the concrete operations stage solves problems involving real or observable objects or events. He or she has difficulty with problems that are hypothetical and entirely verbal, making verbally oriented or more abstract counseling interventions inappropriate at this developmental stage.

Kohlberg (1964, 1973) has focused on the development of the understanding of morality, or what the individual believes would be the morally correct response to problem situations. Moral judgment is seen as a developmental, age-bound variable similar to the cognitive and psychosexual stages. At different ages, the individual has certain beliefs about the reasons for displaying moral behavior, the value attached to a human life, and the reasons for conforming to moral standards. Awareness of the stages of moral development can provide insights into the behavior of the child, provide content for therapy sessions, and also allow therapy to be conducted at levels commensurate with current moral development levels. Lowered stages of moral development have been hypothesized to be related to child deviance, particularly delinquency (Quay, 1979).

Erikson's (1963) developmental theory is based in psychoanalytic theory and emphasizes a series of psychosocial crises. At each stage, the individual encounters a crisis that he or she must resolve by acquiring a new phase of social interaction. An unsuccessful resolution of a psychosocial crisis impedes further development and can have a negative effect on the individual's personality. Although psychoanalytically based, Erikson places more emphasis on socialization and the demands of society. Erikson's work, along with the classic work of Havighurst (1951), is viewed by many as being particularly useful in understanding adolescent development. Taken together, these developmental stage theories provide the therapist with a comprehensive framework to view the child's current developmental levels.

The other child development information relevant to the child/adolescent therapist comes from the study of personality factors that are essentially specific developmental variables. In many cases, these factors are components of the major personality theories. Although the list of variables that have been studied is almost infinite, Clarizio and McCoy (1983) have described several that are particularly relevant for child and adolescent therapy because they are often the focus of a referral concern or interact with the problem. These developmental characteristics often follow developmental se-

quences similar to the stage theories. Certain periods will present behaviors that may be perceived as bothersome by parents or teachers but are, in actuality, part of the normal growth pattern.

Clarizio and McCoy (1983) cite dependency, anxiety and insecurity, aggressiveness, and achievement motivation as factors that are commonly involved in child and adolescent problems. In looking at each factor, we find a developmental pattern, behavioral manifestations, contributing factors to problematic instances of the factor, and adaptive and maladaptive outcomes. For example, dependency may involve child-adult relationships in which the child is often seeking help and physical contact, engaging in attention-seeking behavior, and maintaining physical proximity to the adult. These behaviors are relatively normal and expected with young children and their parents. As children get older, both the intensity of the dependency and the object of emotional dependence change. Maturing children become less dependent on their parents, with a resulting decrease in the dependent behaviors, and become more dependent on peers for approval and attention.

Certain parental patterns (e.g., overpermissiveness, overprotection) are seen as contributing to a child's overdependence and interfering with the move toward greater independence. The child who makes adequate progress in this area develops a sense of trust, is responsive to social reinforcers, and is able to display warmth toward others. The overly dependent child is more likely to become a passively dependent individual, submissive, and mistrusting of others. For dependency and other personality factors, a normal developmental progression is viewed as important to successful adult adjustment. Knowledge of these variables can be used in treatment planning and goal setting, in determining whether excessive or pathological behaviors are occurring at different ages, and in assessing contributing factors to problematic behaviors.

THE ADOLESCENT PHASE

Probably no single developmental period provides more confusion and consternation for parents, teachers, and clinicians than adolescence. It is characterized more by a developmental phase than by a set, sequenced series of stages. Mercurial behaviors, many of them disturbing, seem to "possess" the adolescent. Weiner (1992) notes that many people view normal adolescence as a disturbed state. He notes that normal adolescent development will be characterized by a range of distressing, turbulent, and unpredictable thoughts, feelings, and actions and that, as a consequence of such storm and stress, adolescents will normatively display symptoms that in an adult would suggest definitive psychopathology. This view yields two important aspects of adolescent psychotherapeutic work. First, the adolescent therapist must be cautious not to overinterpret typical and, perhaps, seemingly bizarre behavior, thoughts, or feelings as indicating severe psychopathology. Second, the therapist should not be surprised or upset by a rocky, unpredictable, and frustrating course of treatment.

The uniqueness of adolescence has long been recognized as a key crossroads in human development. They are making the transition from childhood to adulthood.