CHILD AND ADOLESCENT THERAPY

SCIENCE AND ART

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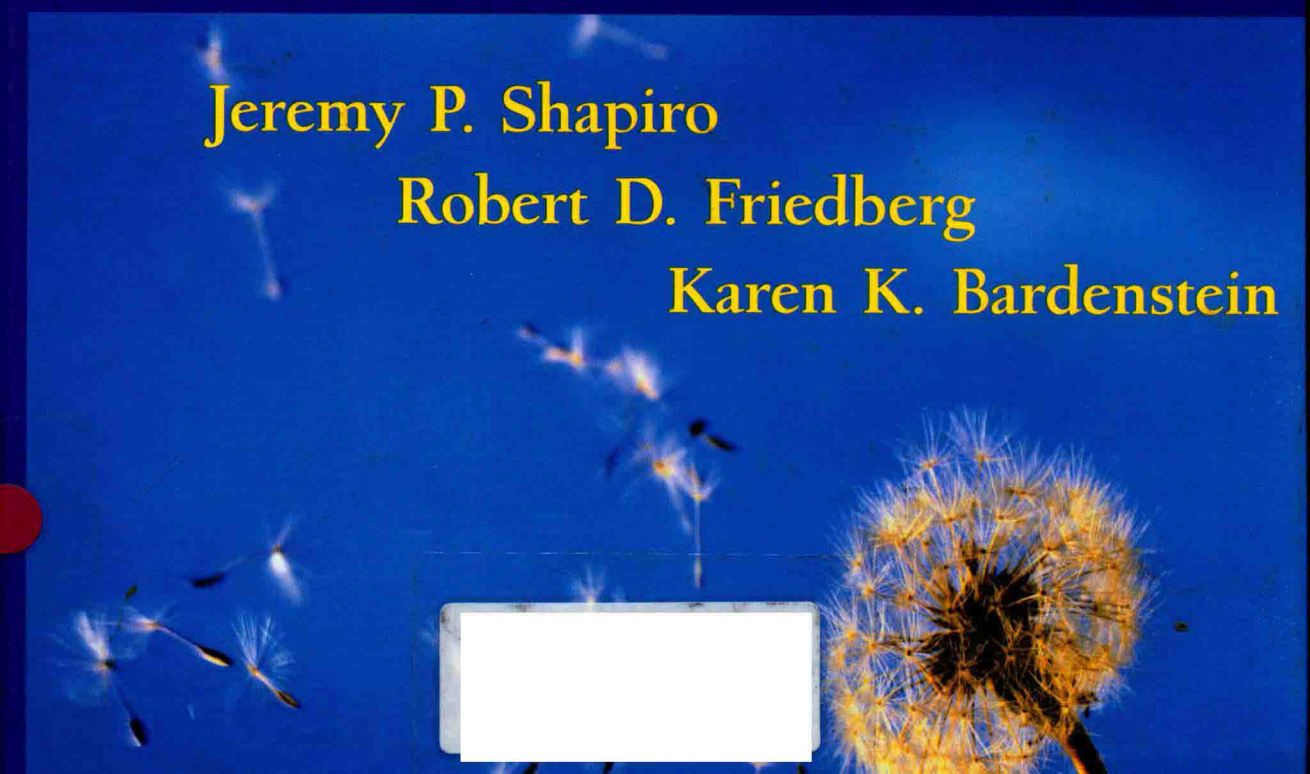

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Preface

The Therapist's Challenge

The purpose of this book is to equip readers with the skills and knowledge they need to provide effective psychotherapy to children and adolescents. We aim to provide an understanding of the major theoretical approaches, knowledge about the findings of outcome research, a feeling for what counseling is like, and training in a variety of therapeutic techniques. This is an academic text and, also, a how-to book. We view intellectual rigor and practical application as equally important and complementary objectives. Thus, the book is about theory, etiology, change agents, technique, meta-analysis—and what to say to the client.

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*; American Psychiatric Association, 2000) defines mental disorders as behavioral or psychological syndromes involving either significant distress (e.g., symptoms such as anxiety and depression) or significant functional impairment in life areas such as work, school, relationships, and compliance with social norms. Mental health problems involve behavior, emotions, relationships, and the cognitions and skills involved in these dimensions of functioning. Developmental issues are often important considerations in the diagnosis and treatment of young people.

Emotional and behavioral problems are not uncommon in youth. Approximately one child in five has a significant mental health problem (U.S. Public Health Service, 2001). This prevalence rate is quite consistent across a range of countries and cultures (World Health Organization, 2001). However, most youth who need treatment do not receive it; in the United States, only 6% of young people—less than one-third of those who need services—receive mental health care each year (Sturm et al., 2000).

Weisz (2004, p. 5) defined psychotherapy as, "an array of nonmedical interventions designed to relieve psychological distress, reduce maladaptive behavior, or enhance adaptive functioning through counseling, structured or unstructured interactions, training programs, or specific environmental changes." The common element linking these activities is this: Psychotherapy relies on *talking* as a method of ameliorating problems. Therapy is not alone in its purposeful use of conversation, and people have sought help by talking to trusted relatives, friends, and clergy for far longer than counseling has existed. But therapy is also a professional service and, to justify the remuneration they receive, counselors should be able to provide forms of help that laypeople cannot reliably offer. There needs to be something different about our talk.

Therapy fulfills a distinctive and rather remarkable function in our society. When something goes wrong with our cars, we go to automobile mechanics to fix the problem. When something goes wrong with our bodies, we go to physicians for treatment. When something goes wrong with our emotions or behavior, society recognizes psychotherapists as the people to call for help with these central aspects of self.

Given the deeply personal nature of the problems for which counseling is sought, clients and parents are in a position involving considerable vulnerability and trust. They are generally willing, just moments after meeting a stranger, to describe important, painful, and, perhaps, embarrassing aspects of their lives. Therapy is about issues that people do not usually discuss with full openness, such as love, rejection, anger, sex, happiness, unhappiness, and so forth. Clients and parents may be willing to disclose information and feelings they have never told anyone before just because the stranger sitting in front of them has a license indicating her commitment and ability to respond helpfully to this type of disclosure.

The trust that parents demonstrate by bringing their children to therapists imposes an important responsibility on these professionals. This responsibility may result in a feeling of pressure, which can be beneficial if it impels us to do our best for clients. It is an honor and a privilege to work with people on the deepest, most personal aspects of their lives and, in order to be worthy of this trust, we must do our best not to let our clients down.

Language is the main tool of the therapy trade. Although play and artistic activities sometimes supplement verbal communication with children, for the most part the work of therapy consists of a search for good words. Physicians have their laboratory tests, radiological devices, medicines, and surgical instruments; we have our words. At first, this might be an intimidating thought, because we are up against a lot. The causes of mental health problems include genetic abnormalities, poverty, family dysfunction, child maltreatment, trauma, irrational thoughts, maladaptive learning histories, and so forth. By the time a child becomes a therapy client, factors like these may have operated in his life day after day, month after month, for years. Confronted with forces like these, words might not seem like much.

When one of your authors (J. S.) was a graduate student in his first clinical placement, a client with severe problems resisted his invitation to counseling on the grounds that, "I don't see how talking about it will help." Jeremy did not have an adequate response; in fact, he was gripped by a fear that the young man was right, and talking about his unhappy life would do nothing to make things better.

Jeremy panicked prematurely. As we discuss in Chapter 8 on outcome research, therapy is generally an effective means of treating emotional and behavioral problems. During the past 100 years or so, clinicians and researchers have developed a number of methods that, for most clients, are at least moderately helpful. In a sense, this book represents a long, detailed response to the fear that therapy (i.e., mere talk) might be overmatched by the causes of mental health problems and might lack the power to create significant changes in damaged, troubled lives. The therapist's challenge is a daunting one but, most of the time, it can be met. Talking about problems—in certain, specific ways—really can help.

The chapters that follow describe these ways. In Part I, we present the major theoretical orientations and the therapeutic techniques associated with them. These theoretically based approaches are the tools of the therapist's trade and the main options from which clinicians select the strategies they will use with each client. In Part II, we apply these strategies to the mental health problems that are common in children and adolescents.

The web site associated with this book includes a number of forms and handouts that therapists can use with their clients. The forms can be printed out as they are, or you can modify the documents to customize them for particular clients. The web address is http://www.wiley.com/college/shapiro.

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Contents

PART I

THE TOOLS OF THE THERAPIST

1

Therapy Fundamentals

OBJECTIVES

This chapter explains:

- *The attitude or mind-set toward clients that is at the foundation of therapy.*
- *Therapeutic language, including some specific words and phrases that come in handy in counseling.*
- *What to do in the first meeting with children and parents.*
- *Strategies for achieving buy-in from youth who do not want therapy.*
- *What can and cannot be kept confidential from the youth's parents.*
- *Two client-centered therapy techniques: reflection of feeling and reflection of meaning.*
- *Techniques for helping clients open up, including therapeutic books and games.*
- *How to use play and art in child therapy.*
- *Collaboration with professionals in other child-serving systems.*
- *When and how to terminate therapy.*

Case Study

Simplicity

Brent, a 5-year-old African American boy, was having trouble in kindergarten. The teacher reported that his academic skills and peer relationships were age-appropriate, but there had been repeated incidents of disobedience toward the teacher, accompanied by tantrums. Brent was not physically aggressive, but he screamed and cried, and it sometimes took 10 to 15 minutes to bring him under control. His behavior was generally pleasant and appropriate in between these outbursts, which had occurred two or three times per week during the several months since school began.

Brent lived with his mother, who was a single parent and registered nurse, an older sister, and his maternal grandparents, who provided much day-to-day child-care. The caregivers reported that Brent saw his father once a month or so and seemed sad at the end of the visits. The caregivers said there were no problems with Brent's behavior at home, and they described him as a happy, energetic, co-operative child.

The therapist's impression of Brent was consistent with his caregivers' description. In both play and conversation, his behavior was organized and compliant. His play with puppets depicted exciting activities and interactions, with no unusual themes of distress or defiance. He loved playing catch with a foam ball the therapist had in his office. Because Brent had exhibited no problems prior to starting school, the counselor made a diagnosis of Adjustment Disorder with Mixed Disturbance of Emotions and Conduct.

While most of the chapters in this book are organized around specific theories of psychotherapy and categories of mental health disturbance, in this chapter we begin with basic therapeutic principles and procedures that cross-cut theoretical orientations and apply to most diagnoses. Research has produced a great deal of evidence that such shared or common factors of therapy are central to its effectiveness (Ahn & Wampold, 2001; Baskin, Tierney, Minami, & Wampold, 2003; Grissom, 1996).

This chapter may make therapy sound simple—and, in a way, it is. In another way, therapy is quite complicated, as the next 14 chapters will make clear. We will begin at the beginning and build an understanding of therapy from the ground up.

The Therapeutic Orientation toward Clients

While the activity of psychotherapy is based largely on theory and technique, there is a certain attitude that lies at the foundation of our endeavor. This attitude orients us to our job, organizes our efforts, and governs the interpersonal tone of our behavior with children and families. The idea behind the therapeutic orientation is so simple that it might sound like a cliché, but its ramifications are important to consider. The moment-to-moment behavior of therapists should convey that they are there to help the client with her problems and her life. This is the role of therapists as established by licensure and relevant laws.

Although this point seems obvious, it is worth making because parents and children sometimes fear their therapists are *not* there to help. Youth sometimes think that being brought to counseling represents a serious form of getting in trouble, and they may think the therapist's job is to punish them or to forcibly bring their behavior under control. Children and parents sometimes think that therapists are there to evaluate and judge them—to identify and point out their failures and inadequacies. This fear seems particularly common in low-income and ethnic minority families who feel intimidated by encounters with "the system" (S. Sue, 1998; Sue & Sue, 2002). Therapists should be alert to the possibility of these concerns in clients so they can counteract them either with explicit explanations of their role or by making sure to convey a help-focused agenda in their way of interacting with families. If families seem more concerned about your approval or disapproval than about benefiting from counseling, it may be useful to say something like: "Remember—You don't work for me; I work for you."

When counselors translate this attitude into behavior, they create an interpersonal environment that is therapeutic for clients. During the time they are together, the cli-

nician is devoted solely to the child's welfare, with no needs of his own involved in the relationship other than professional needs for remuneration and meaningful work.

The therapist models an attitude toward life that is adaptive and constructive. She does not hesitate to discuss any issue or experience, no matter how awkward or upsetting. The counselor's stance toward the client does not change whether the child reveals things about himself he considers wonderful or things he considers shameful; the therapist's unvarying desire is to understand and help.

The issue of counselors making judgments about clients has two aspects. The therapeutic attitude is based on unconditional acceptance, respect, and caring about the client *as a person*. However, this attitude does not include unconditional approval of all client *behaviors*. On the contrary—in many cases, our effort to assist clients necessarily involves helping them to change undesirable behaviors. This two-part attitude can be explained to children using words like the following:

> "I like *you*; I just don't like what you did. In fact, I like you too much to want you to go on doing what you did."

The idea of unconditional respect for clients generally makes sense to therapists when they read about it in a book but, in the midst of real clinical work with difficult clients, maintaining this attitude is not always easy. Our commitment to a humanistic, forgiving view of people is sometimes tested by contact with child and parent behaviors that are obnoxious, mean-spirited, and cruel. No one knows how to increase the resilience of the therapeutic attitude, but we try to provide some guidance by offering personal, experience-based reflections.

The therapeutic attitude seems based on an awareness of fundamental characteristics of human life. People, especially children, do not choose the situations in which they find themselves. They do not choose the family environments, neighborhoods, or schools that influence their development. People also do not choose the genetic endowments, physical constitutions, and neurophysiologically based temperaments that, operating from within, strongly influence their experience and behavior. Within these constraints, people try to do the best they can for themselves in the world, seeking happiness where opportunities present themselves and avoiding pain when dangers seem apparent. People become therapy clients when their efforts to adapt are disrupted by neurophysiological dysregulation, environments that are harmful or poorly matched to their needs, unrealistic thinking, and painful emotional states. As a result, clients often flail, grope, and fail in their efforts to be happy, sometimes leaving painful experiences for other people in their wake. But clients do not wake up in the morning and decide to spend the day making themselves and others miserable—these are unchosen outcomes.

Therapists' initial, natural response to obnoxious or purposely hurtful behavior is often emotional distancing, perhaps even revulsion. However, we find that the most effective response to this therapeutic challenge is, not distancing, but attending more closely to the parent or child, because increased awareness of the other person's experience usually counteracts anger and disrespect. Looking closely into a person's face, feeling the rhythm of her speech and movements, and perceiving the emotions, thoughts, and pain behind her behavior usually strengthen our appreciation of that person's humanity. When there is a threat to your therapeutic orientation, we suggest trying to imagine what life feels like, moment to moment, for the parent or child as she wakes up in the morning, goes about her day, and goes to sleep at night. If you try this, we predict