Fifth Edition

Edited by

H. Thompson Prout & Alicia L. Fedewa

Counseling and Psychotherapy with Children and Adolescents

Theory and Practice for School and Clinical Settings

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Preface

This is now the fifth edition of this volume. As noted in the Preface of the fourth edition, the impetus of the first edition was really based on a lack of books and resources on child/adolescent counseling and psychotherapy. My—how things have changed! In our preparation for this volume, we did a number of things. First, we reviewed the four earlier volumes and looked at the "trajectory" of how the field has grown and expanded. This was an interesting examination—the area now has multiple intervention and treatment options and a much stronger empirical base. Second, we looked at trends in the field—where children and adolescents were being treated, what are the issues and problems facing today's youth, and what are the range of treatment options. Importantly, what are the most contemporary approaches?

Our goal for this volume remains much the same as the first volume—to provide a comprehensive overview of major approaches for helping children and youth experiencing social-emotional difficulties. We also feel it is important to understand the context of child/adolescent treatment. Ethical and legal concerns, diversity issues, and issues relating to disabilities potentially all have impact regardless of theoretical approach. In the first volume, we used the term *intelligent eclecticism*. We obviously believe in the importance of theory as being the base of our interventions but we also encourage professionals not be bound to a single theory. Our belief is that professionals can utilize a range of perspectives and blend approaches depending on the circumstances, and thoughtfully (i.e., intelligent eclecticism) develop comprehensive approaches to working with children and youth. It is also clear that counseling and therapy with youth does not occur in a vacuum—comprehensive interventions that include counseling and therapy also should consider the various systems that impact children. In addition to direct work with a child, successful interventions often include teachers, parents, other family members, and community social supports.

We made a number of changes in this volume. We added chapters on solution-focused approaches and a chapter on play therapy. We also eliminated some chapters in order to be able to present what we judged as the most contemporary perspectives. This volume also includes several new chapter authors who are leaders in their respective fields.

All chapters are thoroughly updated to reflect the most current literature and evidence-based therapy in child psychotherapy.

In a volume of this nature, we offer sincere thanks to our chapter authors. We thank these colleagues who reviewed the book and provided valuable feedback: Callen Fishman, PsyD, assistant professor, Division of Counseling and School Psychology, Alfred University; Cindy Plotts, PhD, professor, School Psychology Program, Texas State University at San Marcos; Mendy Mays, EdD, assistant professor, Department of School of Professional Counseling, Lindsey Wilson College; Maxine L. Rawlins, PhD, professor, Department of Counselor Education, Bridgewater State University; Melissa Laracuenta, PsyD, clinical associate professor, Fordham University. We also thank Wiley for its support and encouragement on this project. Rachel Livsey and Melinda Noack have been extremely helpful as the project has progressed.

Instructor's supplements are available at www.wiley.com/go/prout. The supplements include instructor's manuals, test banks, and PowerPoint slides.

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Counseling and Psychotherapy with Children and Adolescents

Historical, Developmental, Integrative, and Effectiveness Perspectives

H. THOMPSON PROUT AND ALICIA L. FEDEWA

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 unique aspects of child and adolescent therapy, a multimodal research/efficacy issues and evidence-based approaches. 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. 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 20th 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. At the University of Pennsylvania in the United States, Witmer had established a clinic for children in 1896 that focused on school adjustment and in 1909 Healy founded what is now the Institute for Juvenile Research in Chicago. 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 children and their 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.

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. In recent years, cognitive-behavioral approaches have become prominent as a treatment modality.

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 [IDEA]), 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.

In the past 10 to 15 years, child and adolescent treatment has been in the identification of treatments that are evidence based (e.g., Kazdin, 2003; Weisz & Kazdin, 2010). 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 (1994) 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.

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.

The Centers for Disease Control (2013) released an updated survey of the status of children's mental health. Among the highlights of this report include the increasing rate for internalizing disorders (e.g., depression, anxiety), behavioral disturbance (ADHD, conduct), and autism spectrum disorders. The report noted that up to 1 in 5 children in the United States may experience a mental health disorder in any given year. Adolescent issues included substance use/abuse disorders and suicide. Labeling children's mental health as an important public health issue, the report called for increased understanding of the mental health needs of children, research on risk factors and prevention, and continued research on effectiveness of treatment and prevention efforts. Sadly, this report seems to echo studies from many years ago and points to even more needs in the child/adolescent population.

DEVELOPMENTAL ISSUES

The child/adolescent mental health professional 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 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. 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.

An understanding of child and adolescent development appears critical for effective therapeutic interventions. The first involves an understanding of the developmental stage theorists, with the works of Freud, Piaget, Kohlberg, and Erikson being the most notable. It is beyond the scope of this book to detail this large knowledge and research base on human development, but comprehensive human development text should be on the shelf of every therapist.

As an example, we have personally found that Piaget's theory of cognitive development provides an excellent base assessing intellectual development and planning interventions accordingly. 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 (e.g., see Wadsworth, 2003). Piaget allows us to select developmentally appropriate modes of interacting with the child and to set appropriate goals for cognitive change.

For example, children in the concrete operations stage solve problems involving real or observable objects or events. They have difficulty with problems that are hypothetical and entirely verbal, making verbally oriented or more abstract counseling interventions inappropriate at this developmental stage, while children in formal operations can engage in broader and more abstract and generalizable problem solving.

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.

Both Steinberg and Morris (2001) and Smetana, Campione-Barr, and Metzger (2006) view adolescence in context beyond the typical developmental theories with an emphasis on interpersonal and societal contexts. Issues of parent-adolescent relationships, broader family relationship (e.g., siblings, extended family), peers, romantic relationships, and connection with community and school all impact the individual adolescent. Dolgin (2010) notes that today's adolescent is dealing with a wide range of issues. Social media and cell phones have become prominent as well as diversity issues. Adolescence is marked by biological and cognitive changes and a range of identity issues—education, sexual identity, educational aspirations, ethnic identity, and gender issues. Dolgin (2010) alsð notes that there really is no typical family constellation that is common to adolescents. The adolescent is faced with many developmental issues and now with a different set of cognitive skills to process and analyze these changes. The lability often seen in adolescents is likely the norm.

The child/adolescent therapist will find much in theory and research in child and adolescent development that pertains to psychological interventions with these groups. It is difficult to imagine developing and carrying out treatment plans without a firm grounding in these areas. Developmental theory and broader contextual perspectives provide us with a framework to systematically, if not scientifically, work with children and adolescents and more objectively gauge our therapeutic progress with them.

UNIQUE ASPECTS OF PSYCHOTHERAPY WITH CHILDREN AND ADOLESCENTS

In addition to the developmental issues previously discussed, a number of other issues related to the child's development and situation have an impact on the psychotherapeutic relationship. These factors relate to the direct work with the child or adolescent and stem from some of the differences between child/adolescent psychotherapy and adult psychotherapy.

Children and adolescents bring a different motivation for treatment into the counseling situation. Whereas the adult is usually aware that a personal problem exists, the