UNIT 1 PSYCHOTHERAPY WITH CHILDREN AND ADULTS

Structure

1.0 INTRODUCTION

Psychotherapy refers to a variety of techniques and methods used to help children and adolescents who are experiencing difficulties with emotion and behaviour. Although there are different types of psychotherapy, each relies on communication as the basic tool for bringing about change in a person's feelings and behaviour. Psychotherapy may involve an individual child, group, or family. For children and adolescents, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems.

Psychotherapy helps children and adolescents in a variety of ways. They receive emotional support, resolve conflicts with people, understand feelings and problems, and try out new solutions to old problems. Goals for therapy may be specific (change in behaviour, improved relations with friends) or more general (less anxiety, better self- esteem). The length of psychotherapy depends on the complexity and severity of problems. In this unit we would be discussing the

different types of psychotherapies which have been found to be effective with children and adolescents. The first half of this unit will cover psychotherapy with children, which will include psychodynamic psychotherapy (such as play therapy, working with parents), cognitive-behaviour therapy (behaviour modification, individual therapy, etc.) and family therapy. The second half would discuss about the most effective psychotherapies with adolescents for disorders such as depression, anxiety and conduct problems.

1.1 OBJECTIVES

After completing this unit, you will be able to:

- Describe the different types of psychotherapies used with children such as psychodynamic play therapy, cognitive-behaviour therapy and family therapy;
- Describe, understand and treat adolescent problems from developmental perspective; and
- Discuss the most effective psychotherapeutic methods for treating problems such as depression, anxiety and conduct disorders in adolescents.

1.2 PSYCHOTHERAPY WITH CHILDREN

In this section, we will describe and review three of the predominant approaches to working therapeutically with children: psychodynamic and play therapies, cognitive-behavioural therapy (CBT), and family therapy. Before dealing with each of these methods, however, it is important to realise that all psychosocial therapies with children need to be adapted to the context of maturational processes, and the social frame that supports or hinders them. Psychotherapy with children and adolescents, across orientations, aims to mobilise developmental processes appropriate to the child's age, replacing behaviours and other patterns typical of earlier development with more mature, adaptive capacities.

1.2.1 Psychodynamic Therapy with Children

Play and playing have always been at the core of psychodynamic approaches to working with children. The reasons for this are simple: the content, structure, and function of play are viewed as providing a window to understanding the nature of the child's anxieties and conflicts, and to assessing the internal and relational capacities he has available to organise and regulate his thoughts, feelings, and intentions. Psychodynamic child psychotherapy had its earliest beginnings nearly a hundred years ago, when Sigmund Freud used the principles of psychoanalysis to understand and treat (via the boy's father) the symptoms of Little Hans, a 5-year-old Viennese boy with a dread of horses. It was Hans's play, drawings, and fantasies that helped Freud uncover the conflicts and anxieties thought to lie beneath the child's fears, and that guided the interpretations of these fears that he passed along to the boy's father.

Freud's treatment of Little Hans was in essence the first psychodynamic child therapy, although his reliance upon verbal interpretation would differentiate his approach, derived directly from adult psychoanalysis, from that of psychoanalytically oriented therapy. Pioneered by his daughter, Anna, and another Viennese psychoanalyst, Melanie Klein, psychodynamic child therapy was

oriented around discovering the meaning and function of the child's play. Despite enormous differences in their view of early experience and psychic organisation, Freud and Klein together created the field of child psychoanalysis, and established it for a time as the primary means of treating children suffering from a wide array of psychological disturbances.

For both, play, like dreams, provided a window to the deepest parts of the child's soul, 'a royal road' to the unconscious. They and their followers were the first to fully recognise that children can express in play what they cannot express in words; indeed, until they are nearly adolescent, due to the constraints of development, and the nature of childhood defenses, play is their dominant mode of self-expression. Whereas words and insight were viewed as the primary agents of change in adult psychotherapy, the dynamic and therapeutic aspects of play were thought to be the dominant medium of change in child psychotherapy.

1.2.2 Psychodynamic Play Therapy

In the early days of psychodynamic child therapy, verbal interpretation of the unconscious meaning of the child's play was thought crucial to symptom remission and developmental advance. In this early view, resolution is only achieved via interpretation. But interpretation, per se, is no longer emphasised as the primary agent of change in child work; rather, what is thought to be curative is enhancing the child's symbolic, imaginative, and mentalising capacities by increasing the range, depth, and emotional richness of his play. This expansion of the child's capacity to acknowledge various aspects of his self-experience in the safety of play and fantasy is, many believe, what allows developmental progress. Mentalisation in play leads to the development of structures for containing feelings and understanding oneself and others.

The capacity to play is rooted in early relationship experience. Beginning with the earliest playful exchanges with the mother, the child slowly develops the capacity to recognise that he and she have separate and unique minds, and that ideas and feelings are not concrete realities, but rather states that, in play, can be reworked and transformed. The development of these capacities depends upon the establishment of intimate, secure relationships, which permit the discovery of the self and the other, and their separation. In relationships that are disturbed, however, these capacities are also disturbed; putting things into words and into play can be terrifying and disorganising.

It is for these reasons that the child's capacity to establish a relationship with the therapist (and, conversely, the therapist's capacity to establish a relationship with the child) is central to the treatment.

Play therapy is at the core two people, the child and the therapist, playing together. Children enter treatment with varying capacities to play, to talk, and to establish a relationship with the therapist. Most often these variations are linked to the nature and severity of developmental disruptions, emotional disturbance, and trauma. Sometimes the first job of the therapist is to help the child play, even a little. This may mean helping the child with the rudiments of telling a coherent story, it may mean helping him to imagine the inner life of the characters he has created, it may mean helping him find solutions in play that help to contain the intense feelings generated.

Because the relationship is so central to moving development forward, regularity is thought to be an especially crucial aspect of the process of play therapy. The processes inherent to the development of the capacity to pretend fully and imaginatively are complex, and require sustained periods of connection with the therapist. For this reason children are typically seen at least once a week, and many clinicians prefer to work with them twice or three times a week. In many clinical settings this may not be feasible, but there is evidence that increased frequency is critical to developmental change in seriously disturbed children. Equally critical to the child's progress is consistency. Children find change and disruption difficult, as their defenses are typically relatively tenuous or overly rigid; in either case, their capacity to engage in treatment is greatly helped by the therapist's sensitivity to the impact of these changes.

1.2.3 Working with Parents

Until recently, not much interest was taken in the psychodynamic child therapy of how to involve the parents in a child's individual treatment. Historically, the parent and his or her actual behaviour with the child were viewed as extraneous to the treatment process. While parents were typically seen occasionally for guidance and general 'catching up' on the child's home and school life, there was little conceptualisation of how to engage dynamically the parent in the child's treatment so as to change ongoing patterns of interaction and relatedness.

The first clinicians to work with the parents were Selma Fraiberg and her colleagues in their work on infant-parent psychotherapy (Fraiberg, 1980; Lieberman and Pawl, 1993). They were consulted by state welfare authorities to decide on troubled young mothers' capacities to care for their children, many of whom were showing signs of trauma and abuse at a very young age. Fraiberg and her colleagues were able to change the parent-child relationship in direct and dramatic ways by working with parents and infants together. They believed that the baby's presence in the room galvanised maternal affects and representations in ways that were transforming and healing, and allowed mothers to separate their own projections from the babies' affiliative and attachment needs. While this approach was virtually unheard of in the late 1970s, it has now become an accepted mode of working with parents and their infants and toddlers.

The aim of most parent work is to effect change in the dynamics and functioning of the actual parent-child relationship, as such changes are believed intrinsic to development in the child. One aspect of this work is to help parents understand critical aspects of their children's development; for example that a 4 year old's lie does not have the same significance or meaning as a 12 year old's. More importantly successful parent work involves engaging the parent's capacity for reflective functioning. Parent work helps a parent separate their own subjective experience of the child from the child's own thoughts, intentions and feelings. A parent's subjective experience of the child can be profoundly influenced by their own conflicts, or by the distorting effects of malevolent projections and representations. The work of the therapist is to help the parent hold the child and his or her subjective experience as separate in mind. This kind of work can powerfully help the parent to become better at managing the child's feelings and behaviour.

1.3 COGNITIVE BEHAVIOUR THERAPY WITH CHILDREN

CBT with children has its theoretical foundations in a number of related research traditions particularly behavioural science, social learning theory, cognitive developmental theory, and cognitive theory of emotional disorders.

In current practice, CBT with children and their parents has evolved from a loosely related set of theories, research findings, beliefs, and practice traditions, resulting in a diverse set of therapeutic techniques and practice. Some interventions emphasise the central role of children's cognitions in the etiology and maintenance of childhood disorders and thus aim to change cognitions, whereas others focus more on the behavioural mechanisms thought to be central to achieving change.

1.3.1 Behaviour Modification and Parent Training

Historically, techniques of change based on behavioural theory, such as behaviour modification, preceded more cognitive approaches. Behaviour modification applies the theory of classical and operant reinforcement to a wide range of childhood clinical problems such as anxiety disorders (phobias, obsessive-compulsive disorder) conduct problems and early developmental problems (sleep disturbance, enuresis). This approach is based on the notion that problem behaviours are likely to recur if the consequences of such behaviours are rewarding to the child. Formal treatments of this kind begin with a functional analysis, in which the antecedents and consequences of problem behaviours are systematically recorded so as to determine environmental and transactional patterns and responses that support these behaviours.

Interventions are planned to alter these behavioural patterns by focusing on reducing rewarding consequences, and increasing the positive consequences of pro-social behaviours. This approach is most commonly applied by working with the parent, using reported behaviour of the child in the school or home environment. Improvements with respect to reduced frequency or severity of problem behaviours are explicitly celebrated or rewarded. For example, parents are encouraged not to respond to angry outbursts or tantrums in young children with rewarding responses (attention, raised excitement) and to encourage more pro-social behaviours in achieving wishes or negotiating conflict.

Alternatively, treatment focuses on the behaviour and interactions taking place within the treatment session and explicitly structured sessions as opportunities to change the child's behaviour. For example in the Parent-child Game, therapist directly prompts parents (through a one-way screen using an earpiece) to follow behaviour modification principles in changing a child's behaviour.

Parent training has become one of the most widely used of the behavioural approaches. This method has been most comprehensively developed and evaluated by Webster-Stratton (Webster-Stratton and Herbert, 1993). The training can be delivered to parents either individually or in a group, and is typically brief (eight to 12 sessions) with a carefully prepared curriculum for each session. Video clips are used to illustrate common parent-child conflicts, and the emphasis is on structured homework exercises that facilitate the generalisation of skills

learned in therapy to the family environment. Initial sessions focus on positive interactions between the parent and child, particularly those that occur within the context of play. Behavioural principles of selective attention and reinforcement are illustrated and practiced through homework tasks, along with more cognitive components such as problem solving, negotiating turn taking and emotional recognition.

1.3.2 Individual Cognitive Behaviour Therapy

The CBT model is based on the proposition that childhood emotional disorders are maintained by cognitive biases which are manifested through fixed core beliefs, dysfunctional assumptions, and automatic thoughts about the world, self, or others and results in dysfunctional mood states, emotion or social interaction.

Typically there are four key components in CBT with children they are engagement, formulation, learning new skills, and applying change strategies. The construction of a shared, comprehensible formulation is central. Problems are defined in terms of a child's thoughts, feelings, and/or behaviour, usually linked to specific situations and rated by frequency and severity. This enables problems to be addressed sequentially and organised in a hierarchical way that allows the child (and parent) to determine what they are able to cope with. The person (child) in a more global sense is not the problem. This definition of the problem allows for explicit understanding about the solution that is being sought and allows the possibility of the child and the parent achieving success by reaching explicit targets of change. Behavioural techniques for noticing and rewarding positive change are usually integrated into this broader CBT approach.

In general, CBT sessions tend to have a more structured curriculum than nondirective therapies. The therapist is active, self-disclosing where appropriate, and adopts a psycho-educational, collaborative approach in which a range of activities within the session may be suggested. Kendall (2000) uses the metaphor of the therapist as being like a sports coach in which concepts of practice, preparation, and training are often referred to. The focus is on creating change both within the session but also more importantly in generalising change to the child's daily life. Practicing anger or anxiety management skills with the therapist in real life situations may be part of the treatment plan, as the intervention is not necessarily confined to the clinic room. In order to support the generalisation of new skills to the home environment, the curriculum often includes homework and record keeping tasks.

Initially activities may focus upon developing core skills such as: emotional recognition; separating thoughts, feelings, and actions; and activity monitoring and diary keeping. For example, poor discrimination between anxiety and anger feeling states may be more common in children with emotional behavioural difficulties. Similarly, improving a child's ability to regulate emotional states is likely to be dependent on their ability to monitor and notice internal states. Activities supporting strategies for change will be adopted depending on the formulation but may include a combination of behavioural and cognitive techniques such as relaxation training, problem solving, role playing, exposure, behavioural experiments, and testing the evidence for beliefs. Perhaps the most widely applied change technique is problem solving, in which children are guided to consider alternative options, to adopt a position of choice rather than powerlessness and to improve social perspective taking.

There are certain limitations to application of this approach. First, in contrast to adults, children are brought to therapy. Children may not collaborate if they perceive the reason for therapy as being critical of them, i.e., having a behaviour problem. Second, compared with adults, children's ability to make changes in their lives is restricted by their dependency on parents/caregivers. Third, children's interests and styles of interaction require that therapeutic methods not rely solely on verbal interaction. Some cognitive techniques for adults may be developmentally inappropriate and ineffective with children. There is a need to incorporate both the form and content of children's thinking for the cognitive components of CBT to become applicable. Thus, for younger children, their thinking and expectations of the world and others may be most readily revealed through symbolic play. Similarly, children may need narratives as a way of developing explanations about the world, rather than abstract ideas. Thus, for example, storytelling may have a greater role in cognitive restructuring than methods of Socratic questioning appropriate for adult CBT work. Finally, CBT interventions partly rely on the patient being able to report cognitive states in order that distortions can be effectively challenged. In general, children may have less practice (and less interest) in the recall of experience and monitoring internal states than adults. That is why such therapeutic tasks need to be carefully constructed to be within their cognitive developmental abilities.

1.3.3 Working with Parents

There has been a tendency in the child CBT literature to describe CBT independent of the role and relationship of parents and other family members. For example, Lochman et al. (1991) concluded that the "most striking deficiency in CBT programs has been the neglect of children's caregivers, especially parents". Working with the caregivers can be critical in strengthening treatment effects and in maintaining the generalisation of treatment effects over time. In addition, there is some suggestion that involvement of parents may increase treatment effectiveness.

Different CBT approaches with children have proposed different roles for parents that can be broadly identified as facilitator, co-therapist, or patient. As facilitator, the parent is predominantly involved in supporting the child's individual therapy and may meet with the therapist occasionally. As a co-therapist the parent may be actively involved in supporting the child in learning new skills and may be central to providing behavioural feedback and rewards.

In such instances, the parent is seen as closely collaborating with the therapist using agreed upon CBT technique. Alternatively, parents may be clients receiving treatment to cope with their own difficulties, which may be associated with the child's problem, either as part of a family approach or individually alongside the child's sessions. Typically, parents may be offered CBT to manage their own emotional and behavioural difficulties. In practice, parents may sometimes wish to move between these different roles during a child's treatment and, although some flexibility of relationship with the family is often essential, sudden changes in parental role can be disruptive for the child. In general, much work still needs to be done in developing models of CBT practice that are coherent with family roles, relationships, and individual differences.

1.4 FAMILY THERAPY

Family and systemic therapies believe that intervention must address the interactional patterns between people as well as their intra psychic processes. Gurman et al. (1986) have defined family therapy as any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and/or the functioning of the individual members of the family.

The last 10-20 years has seen a major change from individual to family systemic therapeutic approaches to children and families in clinical practice, within both the health and social services. However, it is important to recognise that family therapy is not about the creation, or maintenance, of traditional nuclear families. Family therapists have to recognise the diversity of configurations that families today bring to the task of rearing children and should strive to maintain a respectful and nonjudgmental approach to these differing choices.

1.4.1 Children and Young People in Family Therapy

Although family and systemic therapies have become one of the predominant forms of working with children's emotional and behavioural problems, surprisingly little has been written about children's perceptions of family work or about ways in which children might be more fully engaged in the therapeutic process. Most therapeutic models rely heavily on verbal communication and so might be seen to exclude younger children. In the past family therapy has been criticized for ignoring children and, in effect, conducting therapy in their presence without involving them. Children's worlds are often full of play, creativity, and activity and therapy must incorporate these concepts if it is to be meaningful to children.

Different schools of family therapy have addressed these concerns in different ways. These are:

Structural family therapy (Minuchin et al., 1967; Minuchin, 1974) assumes that problems in the child arise from underlying problems in the structure and organisation of the family. The therapist is interested in how the family makes decisions, and how the boundaries between individuals and subsystems within the family lead to relative engagement or distancing.

The therapist is often directive, attending to sequences and patterns of behaviour, and seeking to bring about change using techniques such as enactment and the encouragement of family members to practice new ways of behaving and communication in the session which ensures that all family members, including even quite small children are actively involved in therapy.

1.4.2 Brief Solution-Focused Therapy (Berg and de Shazer, 1993)

This therapy assumes that problems are maintained by the way difficulties are viewed and by the repetitive, behavioural sequences surrounding attempts to solve them. Families are seen as constantly changing and it is assumed that families will already have solutions to their own difficulties. The therapist sets clear goals with the family and focuses on solutions not problems. Underlying this emphasis on competence and solutions is a focus on challenging unhelpful

beliefs about the child and the problem as part of the process of generating new solutions. This focus on solutions can be helpful when working with children who are often worried that being brought for therapy is just another context in which they will be blamed for family difficulties. Solution-focused work is often active and, like structural therapies, can involve tasks and between session homework these practical activities provide a further opportunity for children to be actively engaged.

1.4.3 Narrative Therapy (White and Epston, 1990)

This therapy draws on the way that we all make sense of our experience by creating personal accounts or narratives. Therapy is a form of conversation that encourages reflection and can transform problem-saturated narratives into more positive accounts. The emphasis on language can be off-putting for children but techniques such as externalisation, which assist in separating the person from the problem, can help the child to feel less blamed and join the child with the family in fighting the problem. Narrative therapists also see those with problems as having expertise in solving them that may help children to feel engaged and less blamed, and the emphasis on narrative suggests the possibility of links with stories and storytelling ideas familiar to children. Narrative therapists also look for unique outcomes and positive exceptions concepts similar to the search for solutions and exceptions by solution-focused therapists, and this too may help children to feel less blamed.

There are a few recent studies looking at children's perspectives on therapy. Stith et al. (1996), for example, explored the experience of 16 children from 12 families in a qualitative study. Children, interviewed alone, wanted to be included in therapy and were keen to know more about their families, be involved in generating solutions and not feel blamed for problems. They did not want to be the sole focus of discussion. Even primary school children understood the purpose of therapy and found talking about problems helpful but their willingness to be involved increased with time and with the amount they knew about why their families were coming to therapy.

There are many important differences between approaches to the treatment of children. Treatments have been extended from traditional inpatient and outpatient settings to community contexts. There is an increased tendency, across orientations, to offer treatment in context: in relation to the family and perhaps the school, rather than focusing on the child alone.

Self Assessment Questions

1) Name the predominant approaches to working with children?

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2) What is the aim of psychodynamic child therapy?

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3) What is the goal of parent work in therapy with children?

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1.5 PSYCHOTHERAPY WITH ADOLESCENTS

Psychotherapy with adolescents differs in a number of substantive ways from psychotherapy with adults. Adolescence is a time of transition. Processes of cognitive, social, emotional, and physical maturation can affect the nature and course of symptoms. It is necessary to adapt our psychotherapeutic approaches in order to assist adolescents in managing such changes. There is a general consensus that it is important to adopt a contextual and developmental perspective for describing, understanding, and treating adolescents.

1.5.1 Developmental Considerations

Early research into the efficacy of psychotherapy for treating youth borrowed heavily from research with adults. Models, methodologies, instruments, and clinical techniques that had been found useful in clinical outcome research with adults were simply applied to a new sample: children and adolescents. It quickly became apparent, however, that processes responsible for the expression of behavioural and emotional difficulties among youth may differ from those of adults. Responding to this challenge, recent research has been more sensitive to developmental differences between children, adolescents, and adults.

A range of physical, social, cognitive, and emotional changes occur over the course of adolescence. These developmental changes and issues must be considered both when developing a clinical treatment plan, and when designing a clinical research project. Developmental changes include puberty, the emergence of formal operational thought, the emergence of an adult identity, increasing emphasis on relationships with peers, decreasing reliance on parents for guidance and support, the establishment of vocational goals, the emergence of sexual interests, and the consolidation of values, standards, and tacit beliefs.

1) **Puberty**

Puberty, for example, is accompanied by a range of changes, both hormonal and physical. The physical transformations that accompany puberty can be confusing,

exciting, and challenging. The effects of physical maturation on adjustment during adolescence, however, are complex. Significant individual differences exist in the age of onset of puberty and in the rate at which physical maturation occurs. Moreover, there can be asynchronies in development across physical, social, and emotional domains.

The effects of physical maturation on psychosocial development and adaptation appear to be mediated by a number of factors including gender, age of onset of puberty, the relative maturity of peers, and cultural, familial, and community beliefs about maturation. That said hormonal changes accompanying puberty appear to have broad effects on adolescent development. They have been associated with changes in expression of anger, oppositionality toward parents and other adults, sexual behaviour, aggression, mood, self-confidence, and level of psychopathology.

It is not clear, however, that relations between physical maturation and adjustment are direct. Rather, the effects of hormonal changes accompanying puberty appear to be mediated and moderated by psychological, familial, and social variables.

The effects of puberty on adjustment are clinically important for a number of reasons. Physical maturation during adolescence has significant effects on the social status of the individual, how they view themselves, how their peers see them, and how they are viewed by their family and the larger community. Others expectations for them will change as they mature. Teenagers who appear mature may not, however, be socially, emotionally, and cognitively mature, leading to confusion and conflict. Moreover, teenagers naturally experience a range of thoughts and feelings about their physical and sexual maturation. Their thoughts, fantasies, and expectations about these changes, and their effects on their life and relationships, are worthy of discussion during psychotherapy. This is particularly important when the teen is dissatisfied with the changes in their appearance or the ways that these changes have affected their relationships with others. Physical maturation and the social changes that accompany it have important effects on adolescent adjustment and can, as a consequence, complicate the practice of psychotherapy with adolescents.

2) **Cognitive Development**

Developmental changes in reasoning also influence emotional and behavioural adaptation during adolescence. As formal operational thought emerges, for example, adolescents may be better able to reflect upon their experiences and motivations, to develop and evaluate alternative interpretations of events, and to examine critically their beliefs and attitudes. As they develop hypothetico-deductive reasoning they will be better able to use insight-oriented and cognitive-behavioural interventions.

As formal operational thought emerges in adolescents, however, it may be applied in an egocentric manner. This may lead adolescents to believe that others are as concerned by their behaviour and appearance as they are (an imaginary audience) or that his or her emotions are both unique and significant (the personal fable). This can be accompanied by fluctuations in affect. Egocentric thought during adolescence can be associated with a tendency to personalise events, to magnify their significance, and to misperceive their consequences. Clinically, this can contribute to emotional lability as adolescents believe their emotional experiences

are more intense than those of their peers. It can also contribute to difficulties trusting others (including the therapist) based on the belief that no one really understands me. A central task in cognitive-behavioural psychotherapy (CBT) with adolescents, then, is to assist the individual to recognise these misperceptions and to develop more mature forms of reasoning.

3) **Autonomy and Independence**

Development of autonomy, a sense of personal efficacy, and an ability to function independently of one's parents and family are central tasks of adolescence. Peer support plays a critical role in accomplishing these tasks. Adolescents' sensitivity to the norms of their peer culture, as well as a desire for acceptance by their peers, can both assist with the process of becoming independent from ones family, and can lead them to become resistant to the authority of their parents and other adults. Moreover, it can lead them to question the beliefs, attitudes, expectations, and values of their families. Clinically disturbed adolescents may, as a result, show little concern for fitting their actions to the norms of adult society. Not surprisingly, such youth can find it difficult to form a trusting relationship with a therapist. This can be exacerbated by a tendency on the part of parents and adolescents to view their problematic behaviour as a normal part of growing up.

Adolescent oppositionality, resistance, and identification with negative aspects of their peer culture may be understood, then, within a developmental context. Difficulties becoming independent from one's parents can also be problematic. Insofar as anxieties and ambivalence about autonomy from one's parents, oppositionality, fluctuating self-image, and challenging of accepted beliefs are, in many ways, normal and adaptive parts of the adolescent experience, it can be difficult for clinicians to discriminate normal, healthy adaptation and problematic behaviour. The line between normative development and clinical disturbance is often a thin one.

Not all adolescents experience turmoil (most, in fact, are reasonably well-adjusted socially and emotionally), and not all turmoil is maladaptive. How therapists conceptualise turmoil can have important effects on how they develop clinical formulations and on how they approach treatment.

1.5.2 Depression

Studies suggest that several forms of psychotherapy can be helpful in treating clinical depression among adolescents. Two approaches that have received the largest amount of empirical interest and enjoy the strongest support are CBT and interpersonal psychotherapy for adolescents (also referred to as IPT-A).

A substantial body of research indicates that CBT can be effective for treating depression among adolescents. Although differences exist between cognitive-behavioural protocols, they tend to emphasise the development of specific skills that can be helpful for managing depressed mood. Skills addressed include developing a goal list, monitoring one's mood, engaging in pleasant activities, development of social skills, engaging in activities that provide a sense of accomplishment or mastery, relaxation, conflict resolution and negotiation, identification of cognitive distortions or biases, identification of maladaptive thoughts, rational disputation of maladaptive thoughts, and developing realistic counter-thoughts. Recently developed approaches to CBT tailor therapeutic

techniques to the specific needs of individual patients (Curry and Reinecke, 2003). A list of the specific cognitive-behavioural tasks used in CBT is presented in Table below

Table 1.1: Cognitive Behavioural Interventions for Depression

- Development of therapeutic rapport. Make adolescent and parents feel understood
- Develop shared problem list
- Develop and share rationale with adolescent and parents
- Mood monitoring
- Pleasurable events scheduling
- Mastery activities scheduling
- Rational problem-solving
- Realistic counter-thoughts (rational responding)
- Social skills/address social withdrawal
- Family communication (encourage expression of emotions, compromise)
- Assertiveness training (to address passivity)
- Review and consolidation of gains/relapse prevention
- Booster/follow-up sessions

1.5.3 Interpersonal Therapy

IPT, a form of psychotherapy developed by Gerald Klerman et al. (1984) for treating depressed adults, has been adapted for use with adolescents (Mufson et al., 1993). The approach focuses on addressing common interpersonal difficulties experienced by adolescents, including challenges associated with autonomy from parents, relationships with peers, and managing the loss of significant relationships. Explicit attempts are made to identify interpersonal factors that are associated with the cause and maintenance of the depressive episode. Information is gathered about the nature and quality of the adolescent's relationships, their expectations for the relationships, whether these expectations are being met, goals for their relationships, and how they have attempted to accomplish these goals. Particular attention is given to separations and losses, conflict, changes in roles, interpersonal deficits (including social withdrawal or isolation, social skills deficits, and social anxiety), and difficulties encountered in single family homes. Active attempts are then made to address difficulties identified in these domains.

To date, research on ITP-A has been positive. Completion of a 12-week ITP-A program has been associated with a significant reduction in symptoms of depression, improved social functioning, and an increased rate of remission from the depressive episode. Moreover, gains appear to be maintained over time. Although research is limited, ITP-A is a promising approach for understanding and treating depressed youth.

Apart from the above approaches, psychodynamic psychotherapy endeavors to treat depression by providing adolescents with insight into defenses used in coping

with the expression of drives, by identifying and rectifying recurrent relationships issues, by addressing feelings of narcissistic injury, or by establishing a more coherent, integrated, and authentic sense of self. Psychodynamic psychotherapy typically is nondirective, long term, and focuses upon the expression and interpretation of events within the therapeutic relationship as a means of bringing about clinical improvement.

Although it is widely used, little systematic research has been conducted examining the efficacy of psychodynamic psychotherapy with clinically depressed youth. No randomized controlled trials of these forms of psychotherapy have been published. Individual psychodynamic psychotherapy has not, then, been demonstrated to be an effective treatment for depression among adolescents. That said, preliminary evidence indicates that adolescents who receive intensive psychodynamic psychotherapy may benefit over time.

In conclusion, CBT and IPT appear to be effective in alleviating symptoms of depression among youth. Gains achieved appear to be reasonably stable over time. Evidence supporting the efficacy of psychodynamic and psychoanalytic psychotherapy is scant.

1.5.4 Anxiety

Several protocols have been developed for treating child and adolescent anxiety disorders. Controlled outcome studies completed over the past 15 years indicate that behavioural psychotherapy and CBT can be useful in treating generalised anxiety, school anxiety, specific phobias, panic, and obsessive-compulsive disorder among youth.

Based upon cognitive and behavioural models, these approaches help to alleviate anxiety by teaching children and adolescents to monitor their moods, anticipate situations in which they are likely to become anxious, identify specific distressing thoughts, and respond to these cues by actively using cognitive and behavioural coping strategies. Exposure and desensitisation, relaxation training, guided imagery, rehearsal of adaptive self-statements, and encouragement of adaptive coping attempts are frequently used.

Parent and family sessions are typically included in these treatment programs, both to address parental behaviours that may be maintaining the child's anxiety and to provide them with strategies for managing their child's anxiety at home. Cognitive strategies (which focus upon reducing cognitive distortions, developing coping skills, and enhancing perceptions of control or efficacy) and behavioural approaches (which emphasise desensitisation to anxiety-provoking stimuli and operant reinforcement of adaptive coping) are typically used together.

Types of anxiety experienced by children and adolescents vary with age. Forms of anxiety that may be normal at one age (such as a fear of separation from parents during the toddler years) may be quite inappropriate at a later age. The most common source of anxiety during adolescence is peer rejection, and the most frequent anxiety disorders are social anxiety, panic, and agoraphobia. As adolescents develop the capacity for hypothetico-deductive reasoning, they become increasingly able to envision a range of potential threats, dangers, and sources of social embarrassment.

Increasing rates of social anxiety among adolescents are due to the central importance given to peer relationships for negotiating independence from one's family and for developing mature sexual relationships. Cognitive-behavioural models suggest that anxiety disorders tend, as a group, to stem from unrealistic appraisals of threats related to normal fears. It is these appraisal processes that are the focus of treatment.

CBT has been found effective for treating school phobia, overanxious disorder, overanxious disorder and specific phobia, panic disorder, social anxiety, generalised anxiety, and obsessive-compulsive disorder. Although few long-term follow-up studies have been completed, those that have been published are promising. Results suggest, for example, that gains achieved in CBT may be maintained for up to 3 years.

Parents of anxious children and adolescents often experience high levels of anxiety themselves, and the possibility exists that this may lead parents to behave in ways that exacerbate and maintain their children's difficulties. At a minimum, clinicians should attend to the moods of their patient's caregivers and the ways in which this may affect the child's adjustment. If appropriate, parents might be referred for treatment to address their feelings of anxiety.

1.5.5 Conduct Disorders

Conduct problems, including aggressive behaviour, disobedience and defiance at home and at school, and major rule violations, are among the most persistent and difficult to treat clinical problems in adolescence. They are among the most common reasons for clinical referral, reflecting their high prevalence rates and the fact that they can be quite distressing to parents and school officials. Traditionally, serious conduct problems have been treated with long-term, dynamically informed psychotherapy aimed at low frustration tolerance, limited self-awareness, impaired empathy, compromised interpersonal relations, or a fragmented, non-cohesive sense of self.

Three treatments have been developed for and evaluated with conduct disordered adolescents.

The first is anger control training with stress inoculation (Feindler, 1991). At the core of this intervention is the view that youth with delinquent and aggressive problems have serious difficulties with the expression and regulation of anger. The treatment, then, principally aims at teaching youth a variety of coping strategies for reducing angry arousal. Therapy focuses on helping youth to identify anger provocation cues, to suppress immediate anger responses with self-instructions, to modulate arousal with relaxation or self-instructional techniques, and to consider consequences of aggressive behaviour or explosive anger. In addition, a portion of the treatment is directed toward training individuals to behave in an assertive rather than an aggressive manner. Treatment is offered in both individual and group formats, and typically is time limited (12-25 sessions). Although psychoeducation is given emphasis in this treatment therapists also model the components of anger management, and adolescents are made to role-play skills under varied conditions of anger arousal.

The second promising treatments for adolescent conduct disorder are family-based therapies. A growing body of research suggests that disrupted family

relations, poor parental monitoring, inconsistent discipline, and cross-generational continuities may contribute to aggressive and disruptive behaviour among youth. Based on these findings, family processes have been targeted for intervention.

Functional family therapy draws heavily on social learning formulations of noncompliance and aggressive behaviour. At the core of this intervention is the view that aggressive and disruptive behaviours are maintained through patterns of family interaction that unintentionally reinforce problem behaviours while failing to reward pro social behaviours. One recurrent pattern involves negative reinforcement. An adolescent may, for example, respond to limits or requests with aversive behaviours such as whining, arguing, or threatening.

His or her parent, in order to reduce the aversive interaction, responds by disengaging or withdrawing. The youth's aversive behaviour has been reinforced by the removal of the request, and the parents' disengagement is reinforced by the reduction in aversive interactions. Not surprisingly, over time, families with conduct-disordered youth appear to be quite disengaged and lacking in cohesion. Further, youth fail to comply with parental limits and requests.

1.6 FUNCTIONAL FAMILY THERAPY

This attempts to modify such dysfunctional family patterns by altering parental monitoring and disciplinary strategies. Parents are taught to use basic social learning principles for managing youth behaviour. Several additional components complement the core behavioural approach including family sessions designed to improve communication and increase family reciprocity, and sessions aimed at facilitating negotiation among family members.

1.6.1 Multisystemic Therapy (MST; Hengeler et al., 1998)

This is an integrative and comprehensive approach to treating youth conduct problems and antisocial behaviour. Unlike traditional, comprehensive treatments that remove the adolescent from his or her social environment through placement in residential treatment settings, MST aims at restructuring multiple levels of the youth's environment in order to promote pro-social functioning. Based on Bronfenbrenner's (1979) ecological model of development, individual behaviour is viewed within the context of multiple, nested contexts. Relevant context is not limited to the family, as in functional family therapy, but extended to the school, neighbourhood, peer group, and broader community, as well as to linkages among these systems.

MST draws upon methods from a number of empirically based treatments. For example, interventions at the family level might include communication training as well as methods from strategic or structural family therapy. Integration of specific interventions is guided by a core set of principles. MST begins with the assumption that the purpose of assessment is to understand the fit between identified problems and the functioning of multiple systems.

Psychiatric diagnosis is not the primary aim, instead MST therapists attempt to identify processes at multiple levels that support or impede adaptive functioning. In turn, therapeutic interventions attempt to use systemic strengths, for example, a committed extended family, as levers for change. All interventions are present

focused and action oriented. Typically, many interventions focus on specific contingencies that sustain problematic behaviours. Therapist and family agree upon specific, well-defined goals, and progress is closely monitoring, including family feedback on treatment fidelity.

Self Assessment Questions

1) What is interpersonal psychotherapy with adolescents?

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2) Name the three treatments which have been developed for conduct disordered adolescents?

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3) What is functional family therapy?

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1.7 LET US SUM UP

The three of the predominant approaches to working therapeutically with children are psychodynamic and play therapies, cognitive-behavioural therapy (CBT), and family therapy.

Psychodynamic child psychotherapy was the first psychosocial treatment specifically developed for mental disorders for children. Its aim is the developmental advancement of children whose symptoms are seen as an indication of a failure to progress socially, cognitively, or emotionally. While interpretation and insight represent an important feature of therapeutic process, more central are becoming able to play, and to establish a relationship with a therapist that is richly imbued with symbolic meaning, and aims to extend the child's capacity coherently to represent mental states. These representations allow the child to understand himself and others better, and to gain more control over what happens in his or her relationships as a result. For most child therapists, work with parents is important for both preschool and school-age children, its primary aim being to help parents understand their child's thoughts and feelings.

CBT with children currently encompasses a wide range of interventions to address childhood disorders and distress. In general, there is some evidence of the usefulness of CBT for a number of childhood disorders. More established behavioural approaches such as behaviour modification and parent training increasingly include cognitive factors for both parents and children, and the child is placed in a more central position in the therapeutic endeavor. This is ideologically welcome as it conveys respect for the child's perspective and experience. However, it remains unclear whether CBT is yet addressing critical cognitive factors that lead to childhood disorders.

There is evidence that family and systemic therapy is an effective treatment for some young people and systemic ideas can contribute to the delivery of other treatment modalities. The theoretical models and practical techniques of the current schools of systemic practice all acknowledge the importance of involving children and have all found creative ways of doing this. There is emerging evidence from qualitative research that even quite young children can understand, make sense of, and participate in systemic work. Careful explanation of the purpose and process of therapy, recognition of the expertise of the child and the provision of environments that are child friendly and promote play and creativity should maximize the involvement of children.

We can be optimistic about the benefits of psychotherapy for treating anxiety and depressive disorders experienced by adolescents. The treatment of conduct disorder remains a vexing problem, but the emergence of comprehensive and systematic interventions, such as MST, hold significant promise. The social environment (both family and peers) is important. It is important to attend to both stressors and social supports. Behavioral, emotional, and social difficulties experienced by adolescents can have pernicious effects that persist into adulthood. It is important, then, to include long-term assessments as a part of both clinical practice and research. We should, at the same time, attempt to insure that our interventions have broad, positive effects on adolescents' development.

1.8 UNIT END QUESTIONS

1) Describe the different psychotherapy approaches in treatment with children?
2) Discuss in detail the different developmental changes during adolescence?
3) Write about the psychotherapeutic approaches used for treating depression in adolescents?
4) What are the ways in which anxiety could be treated in adolescentgs?
5) Describe the different approaches used for treatment of conduct disordered adolescents?

1.9 SUGGESTED READINGS

Friedberg, R. D. and McClure, J. M. (2002). *Clinical Practice of Cognitive Therapy with Children and Adolescents: the Muts and Bolts.* New York: Guilford Press.

Plante, Thomas G. (2005). *Contemporary Clinical Psychology.* New Jersey: John Wiley & Sons, Inc.