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problems may respond to brief psychosocial intervention. Individual psychotherapy directed toward encouraging growth and development usually is considered the therapy of choice. Adolescents with identity problems often feel developmentally unprepared to deal with the increasing demands for social, emotional, and sexual independence. Issues of separation and individuation from their families can be challenging and overwhelming. Enlisting the concepts outlined by Erikson with regard to adolescent development, psychotherapy may include discussion of adolescent exploration (active search among alternatives for activities and friendships that fit) and commitment (demonstrated investment) in activities that promote independence and autonomy. Treatment is aimed at helping these adolescents develop a sense of competence and mastery about necessary social and vocational choices. A therapist's empathic acknowledgment of an adolescent's struggle can be helpful in the process.

REFERENCES Bleiberg E. Identity problem and borderline disorders in children and adolescents In: Sadock BJ, Sadock VA, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 8th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2005:3457. Boelen PA, Vrinssen I, van Tulder F. Intolerance of uncertainty in adolescents. *J Nerv Ment Dis.* 2010;198:194-200. Chabrol H, Leichsenring F. Borderline personality organization and psychopathic traits in nonclinical adolescents: Relationship of identity diffusion, primitive defense mechanism and reality testing with callousness and impulsivity traits. *Bull Menninger Clin.* 2006;70:160. Erikson EH. Identity and the life cycle: Selected papers. *Psychol Issues.* 1959;1:1. Ivanovic DM, Leiva BP, Perez HT, Olivares MG, Diaz NS, Urrutia MS, Almagia AF, Toro TD, Miller PT, Bosch EO, Larrain CG. Head size and intelligence, learning, nutritional status and brain development. *Head, IQ, learning, nutrition and brain. Neuropsychologica.* 2004;42:1118. Mackinnon SP, Nosko A, Pratt MW, Norris JE. Intimacy in young adults' narratives of romance and friendship predicts Eriksonian Generativity: A mixed method analysis. *J Personality.* 2011;79:3. Marcia J, Jossleson R. Eriksonian personality research and its implications for psychotherapy. *J Personality.* 2012;81:617- 629. Rossi NE, Mebert CJ. Does a quarterlife crisis exist? *J Genet Psychol.* 2011;172:141-161. Schwartz SJ, Mason CA, Pantin H, Wang W, Brown CH, et al. Relationships of social context and identity to problem behavior among high-risk Hispanic adolescents. *Youth Sci.* 2009;40:541-570. Thomas JJ. Adolescents' conceptions of the influence of romantic relationships on

friendships. *J Genet Psychol.* 2012;173:198–207. 31.18 **Psychiatric Treatment of Children and Adolescents** 31.18a **Individual Psychotherapy** Individual psychotherapy with children and adolescents generally begins by establishing rapport through developmentally appropriate psychoeducation regarding the target symptoms and disorders to be addressed. As a rule, the younger the child, the more

extensively family members participate in the treatment. Even among adolescents, family members are often directly involved in some components of the treatment in order to achieve the maximum benefit. In recent years, randomized clinical trials have provided a body of literature to support the efficacy of cognitive-behavioral psychotherapy for a wide range of childhood psychiatric disorders including obsessive-compulsive disorder (OCD), anxiety disorders, and depressive disorders. Additional therapeutic approaches including supportive, psychodynamic, and more recently, mindfulness-based stress reduction (MBSR), mindful meditation, and yoga are sometimes incorporated into psychosocial treatments, creating an “eclectic” mixture. The initial goal of any psychotherapeutic strategy is to establish a working relationship with the child or adolescent. In general, successful individual psychotherapeutic interventions with youth also necessitate establishing a therapeutic rapport with parents. To establish a therapeutic relationship with a child of any age requires a knowledge of normal development as well as an understanding of the context in which the symptoms emerged. Individual psychotherapy with children focuses on improving adaptive skills as well as diminishing specific symptomatology. Most children do not seek psychiatric treatment; typically, they are brought to a psychotherapist due to symptoms noted by a family member, schoolteacher, or, pediatrician. Children often believe that they are being taken for treatment because of their misbehavior or as a punishment for wrongdoing. Children and adolescents are the most accurate informants of their own thoughts, feelings, moods, and perceptual experiences; however, external behavior problems are often more accurately identified by parents or teachers. Psychotherapists for children frequently function as their advocates in interactions with schools, after-school programs, and community organizations. Individual psychotherapy with a child often takes place in conjunction with family therapy, group therapy, educational remediation, and psychopharmacological interventions. **PSYCHOTHERAPEUTIC TECHNIQUES AND UNDERLYING THEORIES** **Cognitive-Behavioral Therapy** Cognitive-behavioral therapy (CBT) is an amalgam of behavioral therapy and cognitive psychology. It emphasizes how children may use thinking processes and cognitive modalities to reframe, restructure, and solve problems. A child’s distortions are addressed by generating alternative ways of dealing with problematic situations. Cognitive-behavioral strategies have been shown in multiple studies to be effective in the treatment of child and adolescent mood disorders, OCD, and anxiety disorders. A recent study compared a family-focused CBT, the “Building Confidence Program,” with traditional child-focused CBT, with minimal family involvement for children with anxiety disorders. Both interventions included coping skills training and in vivo exposure, but the family CBT intervention also included parent communication training. Compared with the child-focused CBT, family CBT was associated with greater improvement on independent evaluators’ ratings and parent reports of child anxiety,

but not on children’s self-reports of improvement. Family-focused CBT has also been used in the treatment of pediatric bipolar disorder with promising results. One of the limiting factors in providing CBT to children with OCD, anxiety disorders, and depressive disorders is the lack of sufficient numbers of trained child and adolescent cognitive-behavioral therapists. A recent study

addressed the feasibility of combining a CBT via clinic-plus-Internet treatment. Children who received the clinic-plus-Internet treatment showed significantly greater reductions in anxiety from pretreatment to posttreatment, and maintained gains for a period of 12 months compared with children who received no active treatment, but were on a wait-list. The Internet treatment was acceptable to families and dropout rate was minimal.

Psychoanalysis and Psychoanalytic Therapy

Child Psychoanalysis. Child psychoanalysis, an intensive, uncommon form of psychoanalytic psychotherapy, involves three to four sessions a week and places an emphasis on unconscious resistance and defenses. In this approach, therapists anticipate unconscious resistance and allow transference manifestations to mature to a full transference neurosis, through which neurotic conflicts are ultimately resolved. Interpretations of dynamically relevant conflicts are emphasized in psychoanalytic descriptions, and elements that are predominant in other types of psychotherapies are included. In all psychotherapy, children should derive support from a consistently understanding and accepting relationship with their therapists. Remedial educational guidance is provided when necessary. In classic psychoanalytic theory, exploratory psychotherapy is applicable to patients of all ages and involves reversing the evolution of psychopathological processes. A principal difference noted with advancing age is a sharpening distinction between psychogenetic and psychodynamic factors. The younger the child, the more the genetic and dynamic forces are intertwined. The development of pathological processes generally is believed to begin with experiences that have proved to be particularly significant to children and to have affected them adversely. Although in one sense the experiences were real, in another sense, they may have been misinterpreted or imagined. In any event, to children, these were traumatic experiences that caused unconscious complexes. Being inaccessible to conscious awareness, the unconscious elements readily escape rational adaptive maneuvers and are subject to pathological misuse of adaptive and defensive mechanisms. The result is the development of conflicts leading to distressing symptoms, character attitudes, or patterns of behavior that constitute the emotional disturbance.

Psychoanalytic Psychotherapy. Psychoanalytic psychotherapy, a modified form of psychoanalysis, is expressive and exploratory and endeavors to reverse the evolution of emotional disturbance through reenacting and desensitizing traumatic events. This is achieved by having children freely express thoughts and feelings in an interview-play situation. Ultimately, therapists help patients understand feelings that they may have

avoided, as well as fears and wishes that have been self-defeating.

Behavioral Therapy

All behavior, whether adaptive or maladaptive, is a consequence of the same basic principles of behavior acquisition and maintenance. Behavior is either learned or unlearned. What renders behavior abnormal or disturbed is its social significance. Although theories and their derivative therapeutic intervention techniques have become increasingly complex over the years, all learning can be subsumed in two global basic mechanisms. One is classic respondent conditioning, akin to Ivan Pavlov's famous experiments, and the second is operant instrumental learning, which is associated with B. F. Skinner; the latter is also basic to both Edward Thorndike's law of effect, which is about the influence of reinforcing consequences of behavior, and to Sigmund Freud's pain-pleasure principle. Behavior therapy assigns the highest priority to the immediate precipitants of behavior and deemphasizes remote underlying causal determinants that are important in the psychoanalytic tradition. Respondent conditioning theory asserts that only two types of abnormal behavior exist: behavioral deficits that result from a failure to learn, and deviant maladaptive behavior that is a consequence of learning inappropriate things. Such concepts have always been an implicit part of the rationale underlying all child psychotherapy. Intervention strategies derive

much of their success, particularly with children, from rewarding previously unnoticed good behavior, thereby highlighting it, and making it occur more frequently than in the past. Family Therapy Family therapies have been influenced by conceptual contributions from systems theory, communications theory, object relations theory, social role theory, ethology, and ecology. The core premise entails the idea of a family as a self-regulating, open system that possesses its own unique history and structure. This structure is constantly evolving as a consequence of dynamic interaction between the family's mutually interdependent systems and persons who share a complementarity of needs. From this conceptual foundation, a wealth of ideas has emerged under rubrics such as family development, life cycle, homeostasis, functions, identity, values, goals, congruence, symmetry, myths, and rules; roles, such as spokesperson, symptoms-bearer, scapegoat, affect barometer, pet, persecutor, victim, arbitrator, distractor, saboteur, rescuer, breadwinner, disciplinarian, and nurturer; structure, such as boundaries, splits, pairings, alliances, coalitions, enmeshed, and disengaged; and double bind, scapegoating, and mystification. Increasingly, appreciation of the family system sometimes explains why a minute therapeutic input at a critical junction may result in far-reaching changes. Justin was a 14-year-old boy from a middle-class family enrolled in the 9th grade at a public school. He was brought in by his parents for treatment of a long-standing

history of shyness and anxiety in social situations, which was more evident now that most of his peers were getting together after school and he was spending his weekends alone. Evaluation revealed social anxiety disorder as the primary disorder. Justin was initially resistant to treatment despite his wish to feel more comfortable with other people and in social situations with peers. After much discussion and some pressure from his parents, Justin began to attend a cognitive-behavioral group treatment for adolescents with social anxiety. Justin became mildly agitated each time he was scheduled for a session; however, once he arrived, he was able to participate. He began, a 16-session course of treatment combining education, cognitive restructuring, behavioral exposure, relapse prevention, and four sessions of parent involvement. As treatment progressed, Justin increased his visibility at school, and even attended a school football game with a few peers. Justin told his therapist that he wanted to go to the next school dance but was afraid that he would be embarrassed and would have to go home before the dance was over. The therapists designed several exposures whereby the various things that could happen at a dance were presented to Justin, including being offered alcohol or drugs, having a good time dancing, being left alone or ignored by his friends, or being turned down if he asked a girl to dance with him. As it turned out, Justin's few school acquaintances ignored him and left him at the dance. Justin, prepared for this less-than-desired outcome in his group experience, asked two girls to dance, and forced himself to interact with other peers. To his surprise, despite his shyness, one girl agreed to dance with him. He considered the evening a success. Justin subsequently went to another social event with a new group of peers who seemed more accepting of him. In Justin's case, the importance of practicing responses to potential rejections in the safety of his treatment group was crucial to his success at the dance, and it increased his motivation to continue treatment. Through his treatment, Justin became more and more appropriately prepared, through behavioral exposure and practice, to handle what might previously have been awkward and discouraging situations. (Adapted from a case contributed by Anne Marie Albano, Ph.D.) Tim was a 3-year-old child, developing normally and quite verbal, until he started preschool, at which time he suddenly refused to speak at all outside his home. Tim had begun preschool shortly after his parents had separated and his father had left the home. Prior to his parents' separation, Tim was highly verbal and developmentally ahead of

many children his age in language skill. Although he was observed constantly in preschool, he was never “caught” speaking to peers. He was described as a compliant child who didn’t smile as easily as the other children, who played with others and followed requests without problem but would not speak. During his psychiatric evaluation, it was revealed that Tim enjoyed eating Froot Loops in a favorite cup as a treat. Treatment was designed to provide incentive for speaking through the delivery of a reinforcement of high value, the Froot Loops. Hence, Froot Loops became available only in the preschool and the therapist’s office and, temporarily, were not available in his home. The therapist enacted a process of graduated shaping of communication behaviors—first nonverbal and then vocal

noises—and trained the preschool teacher to do the same. Froot Loop boxes were kept in full view of Tim at all times during the initial phase of treatment and, when he was “caught” gazing at the box, the therapist or teacher would prompt Tim for acknowledgment that he wanted the treat. Pointing, looking, and nodding in their direction resulted in receiving four Froot Loops. Next, Tim was asked to make a sound or ask for the Froot Loop to receive the reward. This step was accomplished as he grunted and eventually said, “Loop.” Finally, prompts to ask for the Froot Loops in a sentence were enacted, and Tim complied with this demand. This phase of treatment took 2 days at the preschool and 2 hours of therapy to accomplish. Eventually, the boxes of Froot Loops were removed from the environments, but the teacher kept the cereal with her to deliver four Loops whenever Tim made sounds or spoke in school. This shaping procedure took an additional 3 days to result in Tim speaking to the teacher and peers, albeit in short sentences. The treat was faded—that is, delivered on a variable ratio schedule of every three to eight times that he spoke, to promote further speaking and decrease the association with the treat. By the end of the second week of training, Tim was speaking at the level he had achieved prior to his parents’ separation. Tim’s parents were cautioned to allow Tim to speak for himself in social situations (e.g., order his own food at a restaurant, say hello to others, make his own requests before providing a treat) as a way of relapse prevention. (Adapted from a case contributed by Anne Marie Albano, Ph.D.) Jenna was a 13-year-old teen with a family history of anxiety and depression. Her parents brought her to treatment because of recurrent obsessions involving contamination and germs, with corresponding compulsions during which she had convinced her parents to check her food, while she washed her hands repeatedly until they became raw and bleeding. Evaluation revealed a fear that, unless her parents checked her food for bugs or germs, the meal was likely contaminated. Jenna’s parents, attempting to ease her fear, would physically pull apart her food and examine it to her satisfaction, often spending upward of 1 hour before each meal. However, this process caused much distress and discord between Jenna and her family. Jenna’s hand washing had generalized to almost every daily activity—after opening a door, reading a book, using a pencil, or touching any object that she deemed dirty. Jenna’s evaluation led to a recommendation of behavioral therapy utilizing exposure and response prevention. This consisted of formulating a hierarchy of her obsessions and compulsions, from the least upsetting (checking food prepared by her mother) to the most upsetting (touching something that was wet or slimy and then touching her mouth). Systematically, the therapist engaged Jenna first in a series of imaginal exposures to a scene (e.g., you take a bite of hamburger and something tastes gritty to you and you realize that your mom did not check the burger) until her anxiety dropped to an acceptable level. The drop in anxiety typically took approximately 25 minutes. Next, the scene was enacted in vivo, whereby foods were introduced with “contaminants” in them (e.g., putting pieces of uncooked rice into the burger to mimic “grit”), and Jenna ate the food without having her parents check. As treatment progressed,

Jenna learned that her chronic fear of becoming sick was not

likely to occur. Similarly, washing rituals were addressed by having her touch items with various substances coating them and then touching her face and mouth. Jenna's treatment entailed a 14-session program during which her parents were taught to assist her with these exposures in the home. Her parents were also instructed to refrain from engaging in her rituals. Relapse prevention plans were added to expand her range of food choices and situational contexts (cafeterias, food stands, restaurants) for exposure. By the end of treatment, Jenna was eating without the need for checking and with minimal anxiety. Moreover, she was engaging in a wide range of activities without the need to wash after touching each object. (Adapted from a case contributed by Anne Marie Albano, Ph.D.)

Supportive Psychotherapy Supportive psychotherapy is particularly helpful in enabling a well-adjusted youngster to cope with emotional turmoil engendered by a crisis. It also is used to treat disturbances related to traumatic experiences, losses, mild mood disorders, and mild forms of anxiety. A 6-year-old boy was brought for treatment because of long-standing severe aggression and destruction of property. In addition to an evaluation for medication, the child was seen in twice-weekly psychoanalytically oriented psychotherapy. The beginning sessions were marked by the repeated need to set limits and contain the child's aggressive behaviors. Two months into treatment, he began to pump himself up, roar, and announce that he was "the Incredible Hulk." He would then proceed to stomp around the play therapy room, attempting to destroy the toys. The therapist then suggested, "You know you can't really be the Hulk. You can pretend that you are the Hulk, and then maybe we can play this together." After a number of similar exchanges, the child gradually allowed the therapist to join in the game with him. Over the next 6 months, the boy was able to modulate his behavior in that he was able to "play the part" of the Hulk, but without destroying property, and limiting himself to actions that were less aggressive. He was able to understand that he could pretend to be the Hulk without literally trying to be the Hulk. (Adapted from a case contributed by David L. Kaye, M.D.)

Combined Psychodynamic and Behavioral Therapy Probably the most vivid examples of the integration of psychodynamic and behavioral approaches are demonstrated in the milieu of child and adolescent inpatient, residential, and partial hospital or intensive outpatient treatment programs. Behavioral change is initiated in these settings, and its repercussions are explored concurrently in individual psychotherapeutic sessions, so that the action in one arena and the information

stemming from it augment and illuminate what transpires in the other arena.

Alternative and Complementary Psychosocial interventions: Mindfulness-Based Stress Reduction (MBSR), Mindfulness Meditation, and Yoga Mindfulness-Based Stress Reduction (MBSR), a psychoeducational training program leading to applying the practice of mindfulness into everyday life was studied in adolescent psychiatric outpatients. Mindfulness practices focus on paying sustained attention to moment-to-moment stimuli without engaging in cognitive judgments or self-criticism, and promoting an attitude of acceptance. In adults, this practice has been shown to facilitate improved coping and decrease symptoms of anxiety, stress, and in some cases, self-harming behaviors. The current study was a trial of approximately 100 adolescents aged 14 to 18, with heterogeneous diagnoses, who were randomized to a waitlist control group receiving treatment as usual (TAU), which consisted of individual or group therapy, or to manualized sessions of MBSR for 2 hours per week for 8 weeks. The MBSR group was led by trained instructors who facilitated the use of mindfulness practices by the participants during formal sessions and encouraged practice at home as well. The participants were tested diagnostically at the end of the

8-week study period and again at 3 months following the end of the study. The results found that both the MBSR and the TAU groups reported significantly reduced anxiety, depressive, and somatization symptoms, and improved self-esteem; but only the MBSR group reported significant declines in perceived stress, obsessive symptoms, and interpersonal problems. Furthermore, although more than 45 percent of the MBSR group showed changes in diagnoses at the end of the study (such as no longer meeting criteria for a mood disorder) none of the TAU group was found to have remitted from a diagnosis. Mindfulness meditation practices have been applied in various forms to a multitude of psychiatric conditions including mood disorders, chronic pain syndromes, anxiety disorder, and ADHD. Mindfulness, according to Kabat-Zinn, is characterized by paying complete attention to the present moment without judgment, with an ability to be aware of inner and outer experiences in the present. There are many forms of meditation which incorporate mindfulness, and both MBSR, and Mindfulness-Based Cognitive Therapy (MBCT) developed by Teasdale, can be considered forms of mindfulness meditation. There is evidence based on neuroimaging studies that mindfulness meditation can induce specific brain states. One study indicated that Vipassana meditation is associated with activation of the rostral anterior cingulate cortex as well as the dorsal medial prefrontal cortex. There is evidence to suggest that mindfulness meditations can improve attention, and that these changes may lead to clinically important improvements. Yoga originated in ancient India, and while there are many varieties, key components include physical postures, controlled breathing, deep relaxation, and meditation. Randomized controlled trials using yoga have provided evidence of its benefit as an adjunctive intervention in mild depression, sleep disturbance, and attention problems.

Clinical trials comparing yoga to cooperative game playing or physical exercises in children with ADHD found moderate improvements in ADHD symptoms when yoga was added as an adjunct to medication. There is some evidence suggesting that yoga may be beneficial as an adjunctive intervention for mild depression, even in the absence of medication and potentially for schizophrenia, as an adjunct to medication. THE ROLE OF PLAY Observing play and engaging in play with children can be extremely informative in assessing developmental abilities, and in understanding sensitive situations. This is particularly relevant for young children, and for children who have experienced trauma, which is difficult to describe in words. Although the choices of play material vary among therapists, the following equipment can constitute a well-balanced playroom or play area: multi-generational families of dolls of various races; dolls representing special roles and feelings, such as police officer, doctor, and soldier; dollhouse furnishings with or without a dollhouse; toy animals; puppets; paper, crayons, paint, and blunt-ended scissors; a sponge-like ball; clay or something comparable; tools such as rubber hammers, rubber knives, and guns; building blocks, cars, trucks, and airplanes; and eating utensils. The toys should enable children to communicate through play. Therapists should avoid fragile objects that can break easily, that can result in physical injury to a child, or that can increase a child's guilt. Psychotherapy with children and adolescents generally is more directed and active than it is with adults. Children usually cannot synthesize histories of their own lives, but they are excellent reporters of their current internal states. Even with adolescents, a therapist often takes an active role, is somewhat less open-ended than with adults, and offers more direction and advocacy than with adults. Nurturing and maintaining a therapeutic alliance may require educating children about the process of therapy. Another educational intervention may entail assigning labels to affects that have not been part of a youngster's experience. The temptation for therapists to offer themselves as a quasi-parent role model for children may stem from helpful educational attitudes toward children. Although this may

sometimes be an appropriate therapeutic strategy, therapists should not lose sight of the potential pitfalls of engaging in a highly parental role with their child and adolescent patients. **PARENTS AND FAMILY MEMBERS** Parents and family members are involved in child psychotherapy to varying degrees. For preschool-age children, the entire therapeutic effort may be directed toward the parents, without any direct treatment of the child. At the other extreme, children can be treated in psychotherapy without any parental involvement beyond the payment of fees and transporting the child to the therapy sessions. Most practitioners, however, prefer to maintain an alliance with parents to obtain additional information about the child. Probably the most frequent parental arrangements are those developed in child

guidance clinics—that is, parent guidance focused on the child or the parent-child interaction and therapy for the parents' own individual needs concurrent with the child's therapy. Parents may be seen by their child's therapist or by someone else. Recently, increasing efforts have been made to shift the focus from the child as the primary patient to the child as the family's emissary to the clinic. In such family therapy, all or selected members of the family are treated simultaneously as a family group. Although the preferences of specific clinics and practitioners for either an individual or a family therapeutic approach may be unavoidable, the final decision regarding which therapeutic strategy or combination to use should be derived from the clinical assessment.

CONFIDENTIALITY The issue of confidentiality takes on greater meaning as children grow older.

Very young children are unlikely to be as concerned about this issue as are adolescents.

Confidentiality usually is preserved unless a child is believed to be in danger or to be a danger to someone else. In other situations, a child's permission usually is sought before a specific issue is raised with parents. Advantages exist to creating an atmosphere in which children can feel that all words and actions are viewed by therapists as simultaneously both serious and tentative. In other words, children's communications do not bind therapists to a commitment; nevertheless, they are too important to be communicated to a third party without a patient's permission. Although such an attitude may be implied, sometimes therapists should explicitly discuss confidentiality with children. Most of what children do and say in psychotherapy is common knowledge to the parents. The therapist should try to enlist parents' cooperation in respecting the privacy of children's therapeutic sessions. The respect is not always readily honored, because parents are naturally curious about what transpires, and they may be threatened by a therapist's apparently privileged position. Routinely reporting to a child the essence of communications with third parties about the child underscores the therapist's reliability and respect for the child's autonomy. In certain treatments, the report can be combined with soliciting the child's guesses about these transactions. A therapist also may find it fruitful to invite children, particularly older children, to participate in discussions about them with third parties. **INDICATIONS** Psychotherapy usually is indicated for children with psychiatric symptoms or disorders that interfere with their ability to function at home and in school, and causes significant distress. A developmental perspective always informs psychosocial interventions with a given child, so that it matches that child's cognitive function and emotional maturity. If a psychotherapy situation is not effective, it is important to determine whether the therapist and patient are poorly matched, whether the type of psychotherapy is inappropriate to the nature of the problems, and whether the child is cognitively