Psychology Texts

For: M.A Students on Clinical Child and Adolescents Psychology

Arranged By : Dr Hamid Kamar zarin

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PREFACE

The Handbook of Child and Adolescent Clinical Psychology is a comprehensive, thorough and practical guide to modern child and adolescent clinical psychology. It covers all central concerns for practitioners in a single manual, including: conduct problems, emotional problems, learning disabilities, child protection, somatic illness, major depression, suicide, drug abuse, schizophrenia, divorce, foster care, and bereavement. This volume has been written as a core textbook in the practice of clinical child and adolescent psychology for postgraduate psychology students who are undertaking a professional training program in clinical psychology. The aim has been to offer an overall set of conceptual frameworks for practice and then to cover most of the problems commonly encountered in clinical work with children and adolescents. The approach is multi-systemic in so far as it rests on the assumption that children's psychological problems are most usefully conceptualized as being nested within multiple systems including the child, the family, the school and the wider social network. It is also multi-systemic in so far as it assumes that assessment and intervention must address the systems relevant to the aetiology and maintenance of the particular problem with which the child presents. Ecological models of child development and family-based intervention strategies have been a particularly strong influence on the development of this approach. The approach is developmental because it takes account of the literature on individual lifespan development, developmental psychopathology, and the family lifecycle. The approach is pan-theoretical in so far as it rests on an acceptance that useful solutions to youngsters' difficulties may be developed by considering them in the light of a number of different theoretical perspectives rather than invariably attempting to conceptualize them from within a single framework or theoretical model. Biological, behavioral, cognitive, psychodynamic, stress-and-coping, family systems, ecological and sociological theories are the main conceptual frameworks considered within this approach. This book is divided into three sections: The first chapter provides the conceptual models human behaviors followed by general clinical psychology foundations and introduction to training issues in clinical child and adolescents. Chapter two represents theoretical models and approaches of clinical child and adolescent's psychology. Chapter three deals with some clinical problems of early and middle childhood and adolescents followed each one by assessment and treatment guidelines in brief. Also The extended and developed version of this book is under revision and preparation by our great editor Mrs., Monirosadat Hosseini (PhD on TESOL, **PN** university).

Dr. Hamid Kamar zarin july 2015-.PN university of Iran. TEHRAN,IRAN

CHAPTER 1

NORMAL DEVELOPMENT

This book is primarily concerned with psychological problems that occur during the first 18 years of life. The first 18 years are a period during which the most profound changes occur in physical, cognitive and social development. A summary of important normative findings from the fields of developmental psychology and psychopathology will be presented in this chapter.

However, the development of the individual child is primarily a social process and the family is the central social context within which this development occurs. We will therefore begin with a consideration of the family lifecycle.

The family lifecycle

Families are unique social systems in so far as membership is based on combinations of biological, legal, affectional, geographic, and historical ties. In contrast to other social systems, entry into family systems is through birth, adoption, fostering or marriage and members can leave only by death. Severing all family connections is never possible. Furthermore, while family members fulfill certain roles which entail specific, definable tasks such as the provision of food and shelter, it is the relationships within families which are primary and irreplaceable.

With single parenthood, divorce, separation and remarriage as common events, a narrow and traditional definition of the family is no longer useful for the practicing clinical psychologist (Walsh, 1993). It is more expedient to think of the child's family as a network of people in the child's immediate psychosocial field. This may include members of the child's household and others who, while not members of the household, play a significant role in the child's life; for example, a separated parent and spouse living elsewhere with whom the child has regular contact; foster parents who provide relief care periodically; a grandmother who provides informal day care and so forth. In

clinical practice the primary concern is the extent to which this network meets the child's developmental needs (Carr, 1995).

Having noted the limitations of a traditional model of the family structure, paradoxically, the most useful available models of the family lifecycle are based upon the norm of the traditional nuclear family with other family forms being conceptualized as deviations from this norm (Carter and McGoldrick, 1989).

In the first two stages of family development, the principal concerns are with differentiating from the family of origin by completing school, developing relationships outside the family, completing one's education and beginning a career. In the third stage, the principal tasks are those associated with selecting a partner and deciding to marry. In the fourth stage, the childless couple must develop routines for living together which are based on a realistic appraisal of the other's strengths, weaknesses and idiosyncrasies rather than on the idealized views (or mutual projections) which formed the basis of their relationship during the initial period of infatuation. Coming to terms with the dissolution of the mutual projective system which characterizes the infatuation so common in the early stages of intimate relationships is a particularly stressful task for many couples. However, it is usually easier for individuals to manage this process if they have experienced secure attachments to their own parents in early life (Skynner, 1981).

In the fifth stage, the main task is for couples to adjust their roles as marital partners to make space for young children. This involves the development of parenting roles, which entail routines for meeting children's needs for:

• safety

• care

• control

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• intellectual stimulation.

Developing these routines is a complex process, and often difficulties in carrying this out lead to a referral for psychological consultation. Routines for meeting children's needs for safety include protecting children from accidents by, for example, not leaving young children unsupervised, and also developing skills for managing the frustration and anger that the demands of parenting young children often elicit. Failure to develop such routines may lead to accidental injuries or child abuse. Routines for providing children with food and shelter, attachment, empathy, understanding and emotional support need to be developed to meet children's needs for care in these various areas. Failure to develop such routines may lead to a variety of emotional difficulties. Routines for setting clear rules and limits; for providing supervision to ensure that children conform to these expectations; and for offering appropriate rewards and sanctions for rule following and rule violations meet children's need for control.

CONCEPTUAL MODELS OF HUMAN BEHAVIOR: IMPLICATIONS FOR CHILD THERAPY

In extraordinary amount of theory and research has been generated that has a bearing on child therapy (Morris & Kratochwill, in press). As a result, tremendous amounts of data have been accumulated concerning the origins, development, influences, and variations in human behavior. Nevertheless, the wealth of information has clearly not resulted in any integrated view of human performance. Indeed, the current state of knowledge generated from the various conceptual models has not only resulted in the lack of an integrated view of human functioning, but has yielded various conceptual positions that are diametrically opposed and has spawned debate in the evidence-based practice movement (Kratochwill & Shernoff, 2004). Because our understanding of human behavior is influenced by basic assumptions concerning the "why" of behavior, assessment and treatment practices often become inextricably interwoven with the particular conceptual model of human functioning held by the psychologist. Different models, with their different perspectives on behavior, yield vastly different assessment

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approaches and data that are used in making decisions relative to assessment and intervention. In this section, we review some models of human behavior that influence contemporary psychological practices.

The models reviewed include the medical or biogenetic model, intra psychic disease model, psych educational process test-based model, and behavioral model. These various models have been discussed by others in the professional literature, and due to space limitations we are not able to discuss them in detail or cover other models (see Kratochwill & Morris, 1993, for coverage of other models). The models differ in their conceptualization of deviant behavior and assessment procedures and devices (sometimes), as well as the nature of the intervention implemented. Each model is discussed in the context of various components and considerations in its use.

Medical or Biological Model

Components

The medical model is one of the oldest approaches guiding assessment and treatment. The medical model can be applied in either a literal or a metaphorical context (Phillips, Draguns & Bartlett, 1975).We view the model in its literal sense. That is, abnormal biological systems can be traced to some underlying biological pathology which is then treated. For example, defective hearing (symptom) may be traced to some type of infection (the cause), which may be treated with antibiotics. The prevalence of medical problems in children is actually quite high (see Bear & Minke, 2006, for an overview of various problems). A variety of health problems may be found in children in the school setting, including those children who are chronically ill and those with nutritional disorders (under-nutrition, obesity), hearing and visual disorders, dental problems, disorders of bones and joints, infectious disorders, respiratory disorders, allergic disorders, urinary disorders, and drug-related problems. It seems clear that a medical model is appropriate to deal with the diversity of medical problems in the schools. The medical model is a disease-based model. The pathology is assumed to be within the individual, although the causes may be environmental. Some theorists consider biological deviations to be the necessary and sufficient factors in the development of the pathology; others claim that chemical or neurological anomalies are the necessary but not sufficient condition for pathogenesis. Here, environmental conditions may or may not catalyze a constitutional predisposition to pathology.

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Considerations

Medical model procedures are clearly justifiable when there is no basis for assuming physiological change in the organism as a result of the socio-cultural environment. Controversial practices characterize medical model procedures when they are used to interpret measures of learned behavior (e.g., various forms of disruptive behavior in children, academic skill deficits).Although genetic, developmental, neurological, and biochemical factors all undoubtedly influence behavior, in reality these factors are not discrete entities. They are interwoven with one another as well as with environmental factors.

Applications of the medical model influence assessment and treatment in various ways. Organic factors may not always be the cause of an observed medical or physical problem. There is growing recognition that psychological factors may affect a physical condition and that physical symptoms may have no known organic or physiological basis. In the past, various concepts such as "psychosomatic" or "psycho-physiological" have been used to describe the psychological basis for physical or somatic disorders. However, such perspectives may be of limited usefulness because they imply a simplistic relation between psychological factors and a distinct group of physical disorders when, in fact, there may be a complex interaction of biological, environmental, psychological, and social factors contributing to various physical disorders (Siegel, 1983). Long ago, Lipowski (1977, p. 234) noted:

> The concept of psychogenesis of organic disease . . . is no longer tenable and has given way to the multiplicity of all disease . . . the relative contribution of these factors [social and psychological] varies from disease to disease, from person to person, and from one episode of the same disease in the same person to another episode. . . . If the foregoing arguments are accepted then it becomes clear that to distinguish a class of disorders as "psychosomatic disorders"

and to propound generalizations about psychosomatic patients is misleading and redundant. Concepts of single causes and cirilinear causal sequences for example, from psyche to soma and vice versa, are simplistic and obsolete.

The point here is that even in the treatment of physical disease, psychological factors may be involved. Exclusive reliance on medical (drug) interventions may bias treatment in the sense that psychological (or other) aspects of functioning may be ignored. Problems most often arise when behavioral measures that can be influenced by a variety of environmental circumstances are used to assess the potential organic origins of a

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perceived symptom. The more the individual differences observed on a behavioral measure are influenced by environmental factors, the more the measure has the potential of being biased. Such a circumstance may arise when the environmental factors that influence the measure differ across cultural groups.

Psychodynamic Model

Components

The psychodynamic model proposes that maladaptive behaviors are symptoms resulting from underlying processes analogous to disease in the literal sense. This model is sometimes labeled the medical model in psychological and psycho-educational practice. Because conceptualization and treatment of abnormal behavior initially resided largely within the domain of medicine, the medical model was extended to treatment of abnormal behavior, both medical and psychological. The historical developments of the model are not reviewed in detail here; instead, the reader is referred to several historical sources that discuss this approach (e.g., Alexander & Selesnick, 1968; Kraepelin, 1962). The psychodynamic approach can be characterized by the following:

(a) uses a number of procedures, (b) intended to tap various areas of psychological functioning, (c) both at a conscious and unconscious level, (d) using projective techniques as well as more objective and standardized tests, (e) in both cases, interpretation may rest on symbolic signs as well as scorable responses, (f) with the goal of describing individuals in personological rather than normative terms (Korchin & Schuldberg, 1981, p. 1147). As is evident in this characterization, the psychodynamic approach is aimed at providing a multifaceted description and inferences. This process is said to promote a unique and individual approach to child assessment.

The psychoanalytic model represents one example of the psychodynamic disease paradigm, as do many other dynamic models of human functioning. The dynamic approach to assessment of deviant behavior is best elucidated in the context of assumptions held about the internal dynamics of personality (W. Mischel, 1968).

Traditionally, dynamic approaches inferred some underlying constructs that account for consistency in behavior. Assessment is viewed as a means of identifying some sign of these hypothetical constructs, which are of central importance in predicting behavior. This *indirect sign paradigm* in assessment (cf.W. Mischel, 1972, p. 319) includes the use of a large variety of projective tests (e.g., Rorschach, TAT, Human Figure Drawings, Sentence Completion Tests) as well as objective personality inventories

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(e.g., MMPI-A for adolescents, MMPI-II, California Psychological Inventory) that are still used in contemporary practice.

A second feature of the traditional psychodynamic approach is that it assumes that behavior will remain stable regardless of the specific environmental or situational context. In this regard, test content is of less concern and may even be disguised by making items ambiguous, as is true in projective testing (Goldfried & Linehan, 1977). Indeed, a particular response to a projective test is rarely examined in view of the overt qualities of the situation in which the test occurred, but rather is interpreted in the context of a complex theoretical structure.

Psychometric Test-Based Model

The psychometric test-based model bears similarity to the psychodynamic disease model in that underlying processes, specifically process deficits, are said to account for learning and behavior problems. In many respects, this model can be considered a part of the dynamic model; however, a psychometric approach is characterized by the use of a variety of individual and group tests to compare individuals along various trait or construct dimensions. In trait theory approaches, various personality structures are said to account for an individual's behavior (W. Mischel, 1968, 1974).

Trait theorists disagreed on what traits explained certain patterns of behavior, but generally agreed that certain behaviors were consistent across time and settings and that these patterns are expressions or signs of underlying traits. In contrast to the psychodynamic position, trait assessors traditionally placed a high premium on objective administration and scoring of tests. Attempts usually were made to establish formal reliability and validity of the various measures used. On empirical grounds, historically this statistical approach proved generally superior to the more clinical method in predicting behavior (cf. Korchin & Schuldberg, 1981), but questions have been raised over the manner in which the research reflects the reality of decision making in actual clinical practice.

Closely related to the psychometric approach is the psycho-educational process model used by many practicing school psychologists. The model can be considered analogous to the psychometric trait model in that assessment focuses on internal deficits, except its context is psycho-educational rather than personality or emotionally oriented. Because a variety of cognitive, perceptual, psycholinguistic, psychomotor, and neuropsychological processes or abilities have been cited as causes of children's academic failure, norm-

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referenced cognitive (e.g., WISC, McCarthy, Stanford-Binet), perceptual (Bender Visual Motor Gestalt Test, Developmental Test of Visual Perception, Developmental Test of Visual-Motor Integration), psycholinguistic (e.g., Illinois Test of Psycholinguistic Abilities), and psychomotor (e.g., Purdue Perceptual-Motor Survey) tests are used to assess these abilities. Most of these assessment procedures follow a diagnostic- predescriptive approach. Ysseldyke and Mirkin (1982, p. 398) noted:

All of the diagnostic-perspective approaches based on a process dysfunction viewpoint of the nature of exceptionality operate similarly. When students experience academic difficulties it is presumed that the difficulties are caused by inner process dysfunctions or disorders. Tests are administered in an effort to identify the specific nature of the within child disorder that is creating or contributing to learning difficulties. Disorders or deficits are test named (e.g., figure-ground deficiencies, auditory sequential memory deficits, body image problems, eye-hand coordination difficulties, visual association dysfunctions, and manual expression disorders). Specific interventions are developed to "cure" the underlying causative problems.

Behavioral Model

Components

Technically, there is no one model of behavior therapy, and contemporary behavior therapy, despite commonalities, is characterized by a great deal of diversity. Historically, the different approaches in behavior therapy include applied behavior analysis (e.g., Baer, Wolf, & Risley, 1968; Bijou, 1970), mediational stimulusresponse model (e.g., Rachman, 1963; Wolpe, 1958), social learning theory (e.g., Bandura, 1969, 1977b), and cognitive-behavior modification (e.g., Meichenbaum, 1974, 1977; Mahoney, 1974; Mahoney & Arnkoff, 1978.)

Applied Behavior Analusis

This form of behavior therapy developed from the experimental analysis of behavior (cf. Day, 1976; Ferster & Skinner, 1957; Sidman, 1960; Skinner, 1945, 1953, 1957, 1969, 1974). It emphasized the analysis of the effects of independent events (variables) on the probability of specific behaviors (responses). Contemporary applied behavior analysis focuses on behaviors that are clinically or socially relevant (e.g., various social behaviors, learning disorders, mental retardation, social skills) and adheres to certain

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methodological criteria (e.g., experimental analysis, observer agreement on response measures, generalization of therapeutic effects).

Advocates of applied behavior analysis use a more restrictive sense of the term "behavior" than other areas represented in the field of behavior therapy: behavior as the overt activity of an organism. Internal feelings and cognitions are typically not considered a major focus for the techniques of therapy, research, and practice. However, it must be stressed that applied behavior analysis focuses on the behavior of an individual as a total functioning organism, although there is not always an attempt to observe, measure, and relate an organism's entire response taking place at one time (Bijou, 1976; Bijou & Baer, 1978).

Many intervention procedures associated with applied behavior analysis are derived from basic laboratory operant research (e.g., positive and negative reinforcement, punishment, time-out, response cost, shaping, fading stimulus control; see Bijou, 1976; Gelfand & Hartmann, 1975; Kazdin, 1980; Sulzer-Azaroff & Mayer, 1977). Assessment emphasizes the individual application of these procedures and a functional evaluation of their effectiveness (Bijou & Grimm, 1975; Emery & Marholin, 1977). Behavior analysis refers to the study of organism-environment interactions in terms of empirical concepts and laws for understanding, predicting, and controlling organism behavior and repeated measurement of well-defined and clearly observable responses (Bijou, 1976; Bijou, Peterson, & Ault, 1968; Bijou, Peterson, Harris, Allen, & Johnson, 1969).

Neobehavioristic Mediational Stimulus-Response Model

The noebehavioristic mediational stimulus-response (S-R) model is derived from the work of such learning theorists as Pavlov, Guthrie, Hull, Mower, and Miller (e.g., Eysenck, 1960, 1964; Rachman, 1963; Wolpe, 1958). These approaches are characterized by "the application of the principles of conditioning, especially classical conditioning and counter-conditioning to the treatment of abnormal behavior" (Kazdin & Wilson, 1978, p. 3). Although intervening variables and hypothetical constructs play a role in assessment and intervention, covert activities are most commonly defined in terms of a chain of S-R reactions, with cognitive formulations de-emphasized.

A number of treatment procedures such as counter conditioning and systematic desensitization have been used to treat anxiety reactions, phobic patterns, and other strong emotional disorders in children (Morris & Kratochwill, 1983; Morris,

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Kratochwill, Schoenfield, & Auster, in press). Systematic desensitization, based originally on the principle of reciprocal inhibition (Wolpe, 1958), has been successfully used to treat a wide range of child and adult problem behaviors (see Morris & Kratochwill, 1983; Morris et al., in press). Assessment in the meditational S-R model relies on survey schedules (e.g., fear survey schedules), self-support data, and direct measures of client behavior (as in the use of behavioral avoidance tests).

Cognitive-Behavior Therapy

A unifying characteristic of the cognitive-behavior therapy approach was an emphasis on cognitive processes and private events as mediators of behavior change (Kendall, 1981b). The source of a client's problems were said to be related to the client's own interpretations and attributions of his or her behavior, thoughts, images, self-statements, and related processes (Kazdin &Wilson, 1978). Contemporary cognitive-behavior therapy emanates from Ellis's (1962) rational-emotive therapy, Beck's cognitive therapy, and Meichenbaum's self-instructional training.

Treatment strategies are quite diverse and include such techniques as problem solving, stress inoculation, self-instructional training, coping skills training, language behavior therapy, thought stopping, and attribution therapy. These techniques represent procedures not generally addressed by other behavior therapy approaches (e.g., applied behavior analysis). Assessment in cognitive-behavior therapy tended to be quite broad-based, taking into account many different dimensions of behavior.Yet there was still an emphasis on defining the nature of the target problem, whether overt or covert. In some cases, a more traditional functional analysis of behavior, which emphasizes a careful examination of environmental antecedents and consequents as related to a certain response repertoire, was recommended (e.g., Meichenbaum, 1977).

Some specific purposes for cognitive assessment were outlined by Kendall (1981a, pp. 3–4):

1. To study the relationships among covert phenomena and their relationship to patterns of behavior and expressions of emotion.

2. To study the role of covert processes in the development of distinct psychopathologies and the behavioral patterns associated with coping.

3. To confirm the effects of treatment.

4. To check studies where cognitive factors have either been manipulated or implicated in the effects of the manipulation.

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Social Learning Theory

Social learning theory is based on the original work of Bandura and his associates (e.g., Bandura, 1969, 1971, 1977b; Bandura&Walters, 1963) and has evolved considerably over time. Bandura noted that in addition to outcome expectation, a person's sense of his or her ability to perform a certain behavior mediates performance. He referred to these latter expectations as efficacy expectations or self-efficacy, and suggested that they have important implications for treatment. Psychological treatment and methods were hypothesized to produce changes in a child's expectations of self-efficacy, as in the treatment of phobic behavior. Self-efficacy was said to determine the activation and maintenance of behavior strategies for coping with anxiety-eliciting situations. Self-efficacy expectations were also said to be modified by different sources of psychological influence, including performance-based feedback (e.g., participant modeling), vicarious information (e.g., symbolic modeling), and physiological changes (e.g., traditional verbal psychotherapy; cf. Kazdin & Wilson, 1978). Intervention procedures such as symbolic modeling (e.g., Bandura, 1971), direct modeling (Bandura, 1977b; Rosenthal, 1976), and self-modeling (Brody & Brody, 1977) have been associated with the social learning theory approach.

For example, modeling historically has been used to treat a variety of children's fears (e.g., animal fears, inanimate fears, dental and medical fears; Morris & Kratoch will, 1983; Morris et al., in press), socially maladjusted children (e.g., social withdrawal, aggression), distractibility, and severe deficiencies (e.g., conceptual models of human behavior: implications for child therapy (autism, mental retardation) as well as a wide range of academic behaviors (cf. Zimmerman, 1977). In all these approaches, social learning theory stressed that human psychological functioning involved a reciprocal interaction between the individual's behavior and the environment in that a client is considered both the agent as well as the target of environmental influence, with assessment focusing on both dimensions of behavior.

GENERAL CLINICAL PSYCHOLOGY FOUNDATIONS

The birth of clinical psychology as a profession was really the birth of clinical *child* psychology, when, in 1896, Witmer established the first psychological clinic to treat youth with behavior and learning problems (Hothersall, 2004). Thus began an era in which clinical psychology began to define itself, through journals devoted to clinically relevant research and practice (e.g., *Psychological Clinic; Journal of Consulting*

Psychology, now published as the *Journal of Consulting and Clinical Psychology*), establishment of psychological testing and treatment clinics (e.g., the Juvenile Psychopathic Institute in Chicago and Judge Baker Foundation in Boston), a focus on training (e.g., increased availability of textbooks, university courses, and internships; development of training standards), and establishment of professional organizations such as the American Psychological Association (APA) Section on Clinical Psychology (Edelstein & Brasted, 1991; Hothersall, 2004).

Although some of the earliest work in clinical psychology focused on youth, various social forces, notably the need to evaluate large numbers of military personnel during World Wars I and II, moved substantial focus to adults. Nonetheless, as a profession, clinical psychology did not differentiate between child- and adult focused professionals. Indeed, the 1949 Boulder Conference on graduate training in clinical psychology, on which many of our standards of graduate education are still based, emphasized the need to avoid specialization and to focus on broad training across many age levels (Raimy, 1950).

Over the last 110-plus years, the profession of clinical psychology has grown, matured, and increasingly complex (Prinstein & Roberts, 2006). Clinical psychologists engage in activities ranging from basic and applied research to assessment and diagnosis, prevention and intervention, consultation, teaching and training, and public policy development, in settings as diverse as universities and research institutions, medical settings, schools, businesses, and government. They address the behavioral and emotional disorders, personality disorders, physical and mental disabilities, medical issues, and environmental stresses affecting individuals from infancy to late adulthood. Thus, it is not surprising that many leaders in the field (e.g., Roberts, 2006; Tuma, 1983) have questioned the wisdom, and even the ability, of continuing to pursue the type of generalist training espoused at the Boulder Conference. In essence, it is no longer feasible (if it ever was) for clinical psychologists to master the universe of relevant literature and skills required for professional competence as generalists. This has created an interesting dilemma for the profession. On the one hand, current standards for training, as operationalized by the field's accrediting body (APA Committee on Accreditation; CoA), still call for broad and general training in clinical psychology. On the other hand, providing such generalist training by itself is increasingly likely to produce graduates who are ill prepared to make positive contributions to the profession. So how can clinical training address the challenge of

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providing broad foundational education in clinical psychology without drowning students in an ever expanding sea of knowledge? There are many possible answers to this question, and given the complexity of the issues, multiple solutions almost certainly need to be implemented. But one first step in addressing the question is to acknowledge that general training in clinical psychology does not have the same meaning that it did in 1949 and to create training environments that retain the core aspects of clinical psychology while allowing focused experience in subfields or specialty areas. Interestingly, several leaders in the field (e.g., Roberts, 2006; Roberts & Sobel, 1999; Tuma, 1983) argue that is exactly what has happened in most clinical programs, albeit somewhat covertly. Roberts and Sobel suggest that "current use of the term *clinical psychology* is today not as generally clinical as it might have been in earlier times. Today, clinical psychology typically represents only adult clinical psychology and only superficially represents a generalist clinical psychology" (p. 483). From this perspective, clinical (adult) psychology and clinical child psychology represent parallel paths to balancing the demands of breadth and focus.

Emerging Child Clinical and Pediatric Identities

During the 30 years following the Boulder Conference, several leaders in psychology education noted the existence of large numbers of unserved youth with behavioral and emotional problems or health-related issues, but a shortage of professionals with sufficient training to address the needs of these youth (Ross, 1959; Tuma, 1983; Wohlford, 1978; Wright, 1967). The fields of clinical child and pediatric psychology began to emerge, with professional organizations (e.g., APA Section on Clinical Child Psychology, now Division 53; APA Society of Pediatric Psychology, now Division 54), journals, and conferences. Graduate programs offering specialty training also started to emerge across the country, but there was little consistency in what comprised clinical child or pediatric training experiences

(Roberts, Borden, Christiansen, & Lopez, 2005; Tuma, 1983). Indeed, when Tuma surveyed members of APA child, pediatric, and youth and family sections and divisions, respondents reported receiving a wide array of educational experiences to prepare them for working with youth and families, ranging from on-the-job or postgraduate training to elective coursework to more formal degree programs. Thus, leaders in clinical child and pediatric graduate training mounted several efforts to define

these specialties, including training conferences, task forces, and journal sections devoted to training issues.

Developing Pediatric Psychology Identity

At the same time that the profession was defining goals and training recommendations for clinical child psychology, psychologists who worked with children in medical settings were also defining the roles and preparation of pediatric psychologists. These early efforts did not take place in formal training conferences or task forces, but in surveys of the field and articles published largely within the pediatric psychology community. Perhaps the most common theme of training in pediatric psychology, aside from its obvious focus on integrated attention to psychological and medical health, was its variability. For example, in the late 1960s and early 1970s, Routh (1970, 1972) described pediatric psychology practicum experiences offered by some medical school departments of pediatrics. However, as Routh's surveys suggested, clinical psychology students were not necessarily the ones who took advantage of these opportunities; pediatric psychology practicum training was just as often sought by students in school, developmental, counseling, or other areas of psychology. By the 1980s, pediatric psychology training had become aligned with clinical psychology (La Greca, Stone, & Swales, 1989; Routh & La Greca, 1990). Variability in training experiences was still evident, though. La Greca and colleagues (1989; Routh & La Greca, 1990) surveyed university graduate programs that had produced at least four graduates identified as pediatric psychologists by virtue of their membership in the Society of Pediatric Psychology. Of 41 programs surveyed, over 66% provided pediatric psychology practica, but fewer than 25% offered a course on the topic. Interestingly, only 17% of programs provided both didactic and applied pediatric experience, and 27% provided neither! Routh and La Greca noted that it is conceivable that students might gain experience in pediatric psychology during graduate training through their research and then complete more formal training during internship or postdoctoral training. This is consistent with results of an earlier survey (La Greca, Stone, Drotar, & Maddux, 1988) suggesting that graduate training in clinical and developmental psychology provided the ideal foundation for later specialization in pediatric psychology. Nonetheless, pediatric psychology training at the graduate level has continued to evolve, despite the lack of formal training guidelines. It was not until the twenty-first century that such guidelines

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were published (Spirito et al., 2003); we discuss these guidelines in "Curriculum Domains."

Clinical Child Psychology

The current definition of clinical child psychology supported by APA Division 53 Clinical Child Psychology and approved by CRSPPP (2005) states: Clinical child psychology brings together the basic tenets of clinical psychology with a thorough background in child and family development. Clinical child psychologists conduct research and provide services aimed at understanding, preventing, and treating psychological, cognitive, emotional, developmental, behavior, and family problems of children across the age range from infancy through adolescence. Of particular importance to the Clinical Child Psychologist is an understanding of the basic psychological needs of children and how the family and other social contexts influence children's socioemotional adjustment, cognitive development, behavioral adaptation, and health status. There is an essential emphasis on a strong empirical research base recognizing the need for the documentation and further development of evidence-based assessments and treatments in clinical child and adolescent psychology.

Central to this definition are several themes. First, clinical child psychology's foundations are those of clinical psychology generally, including a focus on assessment, diagnosis, prediction, treatment, and prevention of psychopathology and adjustment problems, and an emphasis on scientifically based knowledge and application. Because the populations of interest range from infancy through adolescence, clinical child psychologists must have a thorough understanding of child and family development. Thus, the clinical child psychologist's view of pathology is based on a developmental psychopathology framework, understanding child maladjustment in the context of normal behavior and development (Rutter & Sroufe, 2000).

A second theme is the role of context in children's adjustment. Clinical child psychology explicitly emphasizes the notion that child adjustment and development do not occur in a vacuum, but in context. Understanding the relevant contexts is important for conceptualizing youths' emotional and behavioral problems, as well as for treating them effectively. To put it colloquially, contexts are usually part of the problem, and almost certainly part of the solution. Thus, for clinical child psychologists, treating children in context is both a luxury (that many clinical adult psychologists, who see individual clients during an office visit, do not have) and a necessity. As our brief

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definition implies, the family context has central importance in children's development and adjustment. This makes sense given that the family has typically been with the children since birth, observing and participating in their development over time and across multiple contexts. Thus, clinical child psychologists must have an understanding of family structures and systems, as well as of the personalities and issues of individuals who make up the family. How family members relate to one another regarding such issues as rules, boundaries, and values and how they share experiences and emotions influence the lessons that youth learn and carry into their relationships and roles throughout life (Minuchin, 1985). In addition, understanding family members' health and adjustment is helpful for contextualizing youth adjustment problems that may have a genetic basis (e.g., Moffitt, 2005).

Beyond the family, several other contexts are important. Schools, neighborhoods, peer groups, and religious and extracurricular organizations can have a large influence on social, emotional, cognitive, and behavioral adjustment, especially as children reach school age and adolescence and spend more time in school and peer settings (Lerner, 2006). Broader contextual factors, such as the child's culture of origin and racial/ethnic group, should also be considered (La Greca & Hughes, 1999; Roberts, 1998). Ecological models, such as Bronfenbrenner's (Bronfenbrenner & Morris, 2006) model that considers the reciprocal interplay between a developing individual and the many environments in which he or she interacts as the determining factors in youth adjustment, are mainstays of clinical child approaches to understanding and intervening with children. Thus, for clinical child psychologists, it is routine to go beyond individual or family-focused assessment and treatment and to incorporate school, peer, and community settings in assessment, consultation, and intervention.

Finally, clinical child psychology endorses the view that psychological theory and practice are necessarily based on science, and further emphasizes that well-trained clinical child psychologists will be scientist-practitioners, integrating both science and application into their training and professional identity. The scientist practitioner training model was endorsed at the Hilton Head Conference and continues to be considered a central aspect of clinical child psychology training (La Greca & Hughes, 1999; Tuma, 1985).

Relationship to Other Areas of Professional Psychology

General Clinical Psychology

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As noted earlier, the scope of clinical psychology has evolved since its description at the Boulder Conference; as the knowledge base has expanded, the notion of a generalist, competent across all ages and problem areas, has become increasingly unrealistic. As Roberts (2006) suggests, few clinical training programs actually provide generalist training, but instead focus on adults. Clinical child and pediatric psychology also provide focused training on a subset of the life span. However, the core aspects of clinical psychology, including a focus on understanding, assessing, preventing, and treating maladjustment in the context of established scientific methods and broader foundations in psychology, are integral parts of training in clinical child psychology. In addition, although clinical child and pediatric training focus on children and families, they also include educational background in adult development and psychopathology and the ability to work with parents and other adults who are part of the child's life. And beyond a focus on individual clients, clinical child and pediatric psychology emphasize systems and contexts and conducting research and intervention in interdisciplinary teams.

Although clinical child and pediatric psychology are more focused than generalist clinical psychology, they could be considered broader than many clinical (adult) programs (Roberts, 2006). In their discussion of clinical training in the twenty-first century, Snyder and Elliott (2005) maintain that most clinical (adult) psychology has been characterized by a focus on individuals' weaknesses, or psychopathology. They call for clinical psychology to broaden its horizons to encompass a focus on people's strengths and to consider not just person factors, but also environmental context. Interestingly, as several authors note in their responses to Snyder and Elliott's thought-provoking article, this seems to be exactly what clinical child and pediatric psychology have been doing for years (Kendall, 2005; Roberts, 2005). Thus, clinical child and pediatric psychology training models may provide a guide for clinical adult programs that seek to broaden their perspectives to encompass client strengths and contexts.

School Psychology

School psychology shares many similarities with clinical child and pediatric psychology, including a focus on assessment, intervention, prevention, and health promotion with youth and families, a scientist-practitioner approach, and sensitivity to contextual and diversity issues in addressing youth adjustment (Reynolds & Gutkin, 1999). School psychology, however, emphasizes educational and learning processes

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and environments. Relevant practice may extend to learners of all ages, including adults, and often takes place in an educational setting. Assessment is frequently focused on evaluation of students' intellectual, achievement, psychological, and behavioral functioning, particularly with regard to how these areas influence learning effectiveness. Common activities of school psychologists also include consultation with parents and educators, program development and evaluation of educational programs, and advocacy for education-relevant legislation. Thus, the day-to-day activities of applied clinical child, pediatric, and school psychologists may look quite similar: involving work with children and adolescents in their relevant contexts, on issues that affect their health and adjustment, using approaches that are supported by empirical literature.

Similarities are also evident in research and academic training contexts. Like research conducted by clinical child and pediatric psychologists, school psychologists' research may examine issues such as child emotional, behavioral, and developmental disorders and health; child adjustment and health promotion; and contextual factors such as families, peer groups, schools, culture, ethnicity, and economic disadvantage. Again, the major difference is one of relative emphasis, with school psychologists more likely to research areas relevant to learning or adjustment within the learning environment. Finally, as one of the three types of accredited programs in professional psychology (along with clinical and counseling psychology), school psychology graduate program curricula include foundational training in diverse bodies of knowledge within psychology (e.g., social, cognitive, and biological bases of behavior), research methods, normal and abnormal development, and professional ethics, as well as area-specific knowledge in assessment, intervention, and prevention (APA, 2005). Like clinical child and pediatric psychologists, school psychologists complete a predoctoral internship and supervised postdoctoral experience for licensure.

TRAINING ISSUES

Training in clinical child and pediatric psychology addresses multiple purposes and, as such, serves many masters. Academically, clinical child and pediatric psychology are usually (although not always) part of psychology departments, along with other sub-disciplines such as social, cognitive, developmental, experimental, and quantitative psychology. Housed within liberal arts and sciences colleges or divisions, department priorities typically involve the traditional combination of research, graduate and

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undergraduate teaching, and service to the campus and academic community. Professional psychology programs are somewhat unique within departments in their additional priority of training graduate students for careers in professional health service. Thus, accreditation, applied practicum and internship training, and preparation for licensure must be considered. Because accreditation provides standards for evaluating professional training programs, we discuss accreditation issues first, and then examine the context, goals, and curricula of clinical child and pediatric training programs.

Clinical Training

Clinical child and pediatric psychology might be considered adolescents in the field of professional psychology (Prinstein & Roberts, 2006). They have matured to the point of cohesive self-definitions that are accepted by the professional community and that guide training within the specialties. But these developments are relatively recent. Although interest in psychological treatment of youth dates back to the end of the nineteenth century, the need for specific training in child-related service provision was not vocalized until more than 50 years later, and formal initiatives to develop training standards and implement them consistently lagged even further behind. Fortunately, for both clinical child and pediatric psychology, adolescence has come with emergence of clear and complex identities that are grounded in the broad foundations of clinical psychology, integrated with related fields of human development and health psychology, and sensitive to the importance of context and diversity in addressing the needs of youth and their families. Adolescence has also come with increased autonomy and respect from the professional community, thanks to the passionate efforts of leaders in these areas. Thus, clinical child and pediatric psychology have become legitimate specialties within clinical psychology.

The current chapter focuses on issues involved in preparing aspiring psychologists for careers in clinical child psychology and pediatric psychology. We begin by highlighting some important foundational issues in general clinical psychology. We then discuss the emergence and definitions of clinical child and pediatric psychology and examine their relationship to other fields in psychology and associated disciplines. Next, we discuss training models and important components of clinical child and pediatric training at the graduate, internship, and postdoctoral levels. Finally, we address some of the current challenges in clinical psychology training, such as balancing broad and general training

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with more focused depth, defining and assessing professional competence, and identifying and addressing workforce issues.

Training Goals

In preparing graduates for careers in the science and practice of clinical child and pediatric psychology, the field has emphasized several goals and competencies. For example, in the Division on Child, Family, and Youth Services (APA Division 37) training guidelines that were the basis of some of the work at the Hilton Head Conference, Roberts and colleagues (1985, p. 72) outlined four primary goals of training:

1. Training should provide at least minimal entry level skills for providing professional psychological services . . . on behalf of children, adolescents, and their mentors (e.g., parents and teachers) in a range of settings (e.g., home, school, institutions, and medical clinics). . . .

2. Training should provide the scientific basis for professional psychological applications.

3. Training should include specialized research contributing to an understanding of children, families, and psychological development, as well as in the evaluation of therapeutic interventions.

4. Child-, youth-, and family-related issues should be integrated into psychology-based courses at all levels, regardless of specialty designation.

More recently, La Greca and Hughes (1999, p. 441, Table 5) identified five competencies important for clinical child psychologists: (1) multicultural competencies; (2) delivery and evaluation of comprehensive and coordinated systems of care; (3) collaborative and inter professional skills; (4) empirically supported assessment and treatments for promoting behavioral change in children, families, and other systems; and (5) entrepreneurial and supervisory skills. La Greca and Hughes argue that these competencies, reflecting the thinking of many educators in child-focused professional psychology, are increasingly important for effective clinical child practice in our society.

Separated by almost 15 years of developments in clinical child and pediatric psychology, these two sets of goals represent both foundational goals that are central to the definitions of clinical child and pediatric psychology as well as more progressive goals that reflect the evolution of professional psychology. In particular, the theme of

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empirically based assessment and intervention targeting youth in their environmental and cultural contexts has echoed throughout even the earliest definitions of the field. Likewise, the importance of an interdisciplinary perspective is one of the hallmarks of clinical child and pediatric psychology and a central goal for training and professional competence. Development of a scientist-practitioner identity is also fundamental and is reflected in the clinical child psychologist's research training as well as professional competence in evaluation of service delivery.

A clinical scientist identity, based on the newer clinical science training model that emphasizes preparing students for careers that include generation, application, and dissemination of clinical science research (Academy of Psychological Clinical Science, 2007; McFall, 1991), would also be consistent with this goal. Roberts et al.'s (1985) goal of infusing child-related issues into all clinical psychology curricula, regardless of specialty designation, underscores the importance of having a broad developmental base in all clinical psychology training. Assuming that clinical child and pediatric psychology training would of course attend to child issues, this goal seems more relevant to general or adult-focused clinical training programs. The importance of this goal for clinical child and pediatric training seems to lie primarily in its call for all clinical psychology training to view child issues as a legitimate part of broad and general training.

Some of La Greca and Hughes's (1999) competencies reflect newer or elaborated goals that have emerged in concert with changing issues and needs in society. Multicultural competence, although implicit in early definitions and goals emphasizing contextual views of child adjustment, is an explicit part of current-day competence for child psychologists. Increased attention to multicultural issues is especially important given the growing diversity of the U.S. population as well as priorities noted by APA, the CoA, and the National Institutes of Health. Finally, entrepreneurial and supervisory skills extend beyond the traditional purview of clinical psychology, but are important for preparing clinical child and pediatric psychologists for both applied and academic careers. In applied settings, these skills are important for helping clinical child psychologists function effectively as part of treatment teams that may include junior or in-training members and for maintaining fiscally viable practices. In academic settings, having faculty who have received formal training in supervision is clearly an essential component of providing high-quality practica. Entrepreneurial skills are becoming increasingly important for academics.

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As funding for higher education becomes tighter, universities are encouraging their faculty and departments to develop diverse sources of funding for their research and training. On the national level, psychologists are becoming increasingly active participants in legislative activity relevant to health care and education (e.g., through the APA Practice and Education Directorates, the Society for Research in Child Development's policy fellowships). To effectively influence the business and legislative sectors, convincing non psychologists of the importance of supporting our efforts to address child health, psychologists must speak the language of these professionals.

TRAINING CONTENT: CURRICULUM DOMAINS

As with all professional psychology programs, clinical child and pediatric psychology curricula are shaped in part by accreditation requirements for clinical programs. However, as noted earlier, accreditation requirements are designed to allow individual training programs to define their goals and methods for attaining them. So how can clinical child and pediatric programs best integrate their training goals and accreditation requirements into a curriculum that prepares competent psychologists? As several investigators have noted, this is apparently not an easy task to do well; even after definitions and goals of clinical child and pediatric psychology were developed, training programs differed widely in their curricula and did not

always meet minimal training goals for these specialty areas (Roberts et al., 1998; Zeman et al., 1999).

Recent advances in professional psychology have paved the way for both greater specificity of clinical child and pediatric curricula and increased flexibility in implementation. First, starting in 1996, changes to accreditation guidelines and procedures facilitated innovation in how professional psychology programs can articulate, meet, and evaluate their training goals (Roberts et al., 1998). Second, the field has begun moving from activity-based to competency-based models of training. This is reflected in accreditation guidelines and in recent writings and conferences on professional competencies (Kaslow et al., 2004; Sumerall, Lopez, & Oehlert, 2000).

Both clinical child and pediatric specialties have articulated curriculum recommendations that fit with these developments. In 1998, Roberts and colleagues outlined a model for training clinical child psychologists based on work begun by the National Institute of Mental Health work group on improving training for child and youth service providers (Wohlford, Myers, & Callan, 1993). Roberts et al.'s training

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model included 11 domains of training considered important for clinical child psychologists. Several years after the clinical child training model was published, the Society of Pediatric Psychology charged a task force with developing similar guidelines for training pediatric psychologists (Spirito et al., 2003). The resulting guidelines, adapted from the clinical child model, include 12 domains of training, with 11 overlapping with the clinical child model and the final domain specific to pediatric psychology.

Although coursework is a common way to meet curricular requirements, competence in many of the domains of training requires practical experience. The clinical child and pediatric training models acknowledge this, describing student training as a three-level sequence: *exposure* to the content and processes of clinical psychology through didactic training and observation, *experience* that involves mentored practice of the relevant skill, and *expertise* that is obtained through extensive exposure and experience and enables independent practice. By the end of graduate training, students should have had at least some exposure to and experience with each domain, although they may not have expertise in any. Internship is an opportunity to gain more experience and develop expertise in some areas, and by the time students have completed postdoctoral training and are ready for licensure, they should have established sufficient expertise to support independent practice with a variety of youth and family issues. Next we outline the 12 recommended domains of clinical child and pediatric psychology training, from graduate through postdoctoral training, and offer comments about potential ways of providing didactic, applied, and research training in these domains.

Life Span Developmental Psychology

From a developmental psychopathology perspective, complete understanding of youths' adjustment problems requires an understanding of individual and contextual factors in normal development (van Eys & Dodge, 1999). At a minimum, coursework should expose students to current theory and research on life span development across social, emotional, cognitive, behavioral, and physical domains, as well as to the role of individual (e.g., sex, race) and contextual (e.g., family, peer, culture) factors in development. Practical experiences in assessment and intervention should involve youth from a variety of developmental levels and contexts, with particular emphasis on issues such as how developmental factors impact youth psychopathology and response to treatment. For pediatric psychology students, didactic and practical experiences should

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focus on issues relevant to child and adolescent health, such as the impact of disease process on cognitive development or the role of adolescent autonomy seeking on adherence to medical regimens. Student research should also incorporate developmental issues, addressing age, gender, and context in the specific research questions and methods, or at least conceptualizing the research from a developmentally informed perspective.

Beyond the minimum, several training programs integrate clinical child and developmental training more fully. In their survey of child-focused clinical programs, Zeman et al. (1999) found that programs characterizing themselves as clinical developmental required more developmental courses than other programs, averaging just over five required developmental courses versus none or one course required by clinical child programs or clinical programs with a child emphasis.

These programs also encourage student research mentored by developmental faculty, attendance at developmental conferences (e.g., Society for Research in Child Development, Society for Research on Adolescence), and publication in developmental as well as clinical journals. An example of a clinical child developmental program is the joint effort of the clinical and developmental programs at the University of Missouri–Columbia. Students admitted to the clinical child developmental program essentially complete requirements of both clinical and developmental training areas. Practically, this means that in addition to courses required for the clinical child program (including courses in normal development, developmental psychopathology, child assessment, child interventions, and family systems and interventions), joint program students take two additional courses in cognitive, social, and emotional development; explicitly incorporate developmental content into thesis and dissertation research and comprehensive examination; and participate in both clinical and developmental faculty labs.

With foundational knowledge of normal development, students can conceptualize deviations from typical or adaptive functioning. During graduate training, courses and seminars should expose students to abnormal behavior across the life span, as well as current research on trajectories of risk and resilience. Supervised practica with various forms of psychopathology in children, adolescents, and adults allow students to gain experience conceptualizing and diagnosing psychopathology. Again, a variety of settings, including youth in clinic, family, community, school, and medical settings,

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give graduate students experience in incorporating context into their understanding of youth psychopathology.

Child, Adolescent, and Family Assessment

Becoming a competent clinical child or pediatric psychologist requires a thorough understanding of assessment issues, including how to evaluate the empirical foundations and utility of a variety of assessment methods, how and when to use them, and how to interpret their results for both applied and research purposes. Relevant assessments for youth go beyond tests or measures that youth complete (e.g., intelligence tests) and include evaluations of youth functioning by others (e.g., caregiver reports of adaptive functioning, school reports of academic achievement), as well as evaluations of the systems in which youth function (e.g., parent-child and parent marital relations). Assessment also goes beyond standardized tests and includes clinical conceptualizations, functional analysis, and a general hypothesis-testing framework. Both clinical work and research benefit from a scientific approach to generating questions and using appropriate assessment to address them.

Students should develop an understanding of how developmental factors such as age, sex, ethnic background, and cultural conventions can influence assessment validity, and how to conduct multi-method assessments that can maximize the strengths and contributions of the multiple methods and reporters. Finally, students should obtain experience in interpreting and disseminating assessment results and in assessment reports for clinical purposes as well as in research reports. Roberts et al. (1998) suggest a minimum of two semesters of coursework and associated practica devoted to exposing students to all relevant assessment issues and methods and allowing them to gain experience with several assessments and develop expertise with at least a few. Overall, understanding the conceptual and psychometric aspects of assessment seems most critical to competence as a clinical psychologist.

If students leave graduate training with expertise in how to formulate assessment questions, design developmentally and contextually sensitive assessment plans, and integrate results from multi-method assessment, as well as exposure to the mechanics of assessment, they should be able to quickly master specific assessment tools as needed.

Intervention Strategies

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Training in interventions should reflect the core values of clinical child and pediatricpsychology: empirically and contextually based treatment that is developmentally and multiculturally sensitive and interdisciplinary. This is a tall order, calling for treatment that is both standardized and individualized. To be effective at delivering the standardized aspects of treatment, clinicians in training must be familiar with empirically supported treatment techniques and protocols, including how, when, and with whom to use them. For example, during graduate training, students should be exposed to many of the treatments considered well-established or probably efficacious, as defined by APA Division 12 (Division of Clinical Psychology) and Division 53 (Society of Clinical Child and Adolescent Psychology) task forces (Chambless et al., 1996, 1998; Lonigan & Elbert, 1998), including parent training and multi-systemic therapy for oppositional and conduct disorders, behavioral parent training and problem-solving skills training for Attention-Deficit/Hyperactivity Disorder, interpersonal and cognitive therapy for depression, cognitive-behavioral therapy and family anxiety management for generalized and separation anxiety disorders, exposure and relaxation therapies for anxiety disorders, and behavior therapy for childhood obesity. Although exposure to some of these treatments may be limited to didactic coverage in courses or readings, experience with at least some of the treatment protocols should occur during graduate school, with additional opportunities to develop experience and expertise coming during internship and postdoctoral training.

Clearly, the list of evidence-based treatments is incomplete, and even when such treatments exist, they frequently do not have demonstrated equal applicability across multiple ages, socioeconomic groups, cultural groups, or family constellations. Thus, it is also essential for students to gain experience in how to handle situations in which there is no prescribed, empirically supported treatment. Two general approaches are valuable here. First, familiarity with the developmental and clinical literatures on the relevant treatment moderators can help guide treatment decisions. For example, clinicians might use the literature on differences in effective parenting styles across socioeconomic or racial/ethnic groups (McLoyd, 1998) to tailor family treatment for a low-income ethnic minority family. Second, using their scientist-practitioner framework, students should become expert at evaluating their treatments as they deliver them. This way, even treatments that do not have established empirical support can be appraised empirically.

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Prevention, Family Support, and Health Promotion

A comprehensive approach to dealing with child and adolescent adjustment issues includes attending not just to diagnosed disorders, but also to factors that place youth at risk for disorder or maladjustment and factors that promote resilience and healthy adjustment. Thus, clinical child and pediatric psychologists should have a knowledge base in youth and family healthy adjustment and prevention science, as well as research and applied competence in prevention and health promotion. Such experiences can come from coursework in typical development and resilience, applied experiences in schools or primary care facilities, and interventions that focus on health promotion issues such as parent-child relationship enhancement, social skills training, healthy eating or obesity prevention, and reduction of risky sexual behavior.

Social Issues Affecting Children, Adolescents, and Families

Many of the challenges to youth adjustment are the social-environmental issues that influence children and families. Clinical child and pediatr ic psychologists should be aware of the sorts of social issues particularly relevant to youth, both generally and in their home communities. For example, as many as 50% of children have been exposed, either directly or indirectly (e.g., through media reports), to traumatic events such as natural disasters or violence in their homes, schools, communities, or the world (Bell &Allwood, 2007). Thus, trauma exposure is a major public health issue and one that all clinical child and pediatric psychologists will almost certainly encounter. Another important public health concern is youth access to mental health services; as many as 20% of youth are estimated to be in need of psychological services, yet only about one third of these youth receive needed services (Department of Health and Human Services, 1999). For both of these issues, clinical child and pediatric psychologists can make positive contributions in several ways, including identifying youth in need of treatment, participating in prevention programs to reduce risk for maladjustment, and participating in child advocacy efforts that can impact both individual children's lives as well as broader public policy and legislation. Involvement in Society for Research in Child Development's Office for Policy and Communications, APA's Public Interest Directorate, or state or local government can be effective ways for clinical child and pediatric psychologists to leverage their influence.

TRAINING OUTCOMES

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There are undoubtedly many ways that successful outcomes for graduate students in clinical child and pediatric psychology can be defined. During graduate training, success can be evaluated by examining student retention, performance on program tasks (e.g., course grades, percentage of students passing comprehensive examinations), participation in professional activities such as conference presentations and publications, and more subjective issues such as personal and financial stability (e.g., the toll that graduate training takes on students' health, personal relationships, and financial debt). Postprogram outcome variables might include student program completion statistics (e.g., the likelihood that students will complete their graduate training and obtain relevant internships, the total debt load incurred to obtain the graduate degree), professional competence (e.g., number of graduates who attain licensure, diplomate status, or other demonstration of competent practice), and career tracks and success (e.g., the number of graduates who secure relevant jobs, research and mentoring productivity of graduates in academic positions, career satisfaction and longevity). Obviously, many of these outcomes are fairly subjective, multiply determined, and may not even be accessible to graduate programs. For example, the field is currently struggling with the best ways to define and assess professional competence (Kaslow et al., 2004; Roberts et al., 2005; Rodolfa, Kaslow, Stewart, Keilin,&Baker, 2005). Similarly, graduate programs are often unaware of students' personal issues unless they are clearly affecting professional functioning, and even if aware, are often in a poor position to evaluate the extent to which graduate program stresses versus other factors contributed to student health problems, relationship breakups, or decisions to leave a program or the field. Despite these limitations, however, training programs should routinely collect and evaluate data on student outcomes. At a minimum, these data are useful for the self-evaluation that programs can use to identify areas for growth (and that CoArequires). Beyond that, sharing these data with potential students and professional colleagues has the potential to improve training in the field as a whole.

For many years, the Council of University Directors of Clinical Psychology (CUDCP; the training council for scientist-practitioner and clinical science–oriented clinical doctoral programs) has supported a resolution strongly encouraging all member programs to make trainee outcome data available to the public. Programs collect and share information on program attrition, time to degree completion for graduates, and the percentage of students who obtain predoctoral internships. In addition to helping

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prospective graduate students evaluate training programs, these data have been useful in evaluating how clinical programs fare on these basic outcomes. For example, recent years have seen an increasing imbalance between the number of internship slots available through the Association of Psychology Postdoctoral and Internship Centers (APPIC; 2006) match system and the number of students applying for these slots, with only 77% of applicants being matched to internships on National Match Day in 2006. However, a survey of CUDCP programs indicated that 86% of students from CUDCP programs secured internships on the 2006 Match Day, and 92% of students ultimately obtained an internship through the match, internship clearinghouse, or other methods (Collins &Callahan, 2006). Although these data are not specific to clinical child or pediatric training, they do suggest that students trained in scientist-practitioner programs are faring better than the national norms.

Recently, the CoA has instituted a requirement that all accredited training programs make similar data available to the public (APA, 2006b). Specifically, beginning January 1, 2007, the CoA requires that training programs provide information on time to completion (including mean, median, and percentages of students completing the program in under 5, 6, 7, and more than 7 years), program costs (e.g., tuition, fees, any certain or possible adjustments to costs such as waivers, fellowships, or assistantships), internship placement (including APPIC match rates and overall placement rates through other methods, rates of paid and half-time internships), and attrition (i.e., the number and percentage of students who fail to complete the program for any reason). Additionally, beginning in 2008, programs will be required to report the number and percentage of graduates who have become licensed psychologists in the preceding decade.

Broad versus Specific Training

As we discussed earlier, a central issue in the growth of clinical child and pediatric psychology has been how best to balance general (thus far primarily adult-focused) training in psychology with specialized coursework and clinical experiences that focus on child or pediatric psychology.As the field evolves in the twenty-first century, it is critical to evaluate whether broad and general training, as it is currently defined, keeps clinical psychology training stagnant. Further, we foresee attaining an appropriate balance as becoming more difficult as the technology of the field advances and expands. Clinical research is reaching deeper into existing problems and stretching into

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novel areas. For example, the development and validation of new assessments, preventions, and treatments translates into additional skills and educational content that students must master to be competent psychologists upon graduation.

The question remains whether specialization at the level of clinical child or pediatric psychology is appropriate and beneficial to students. Or put another way, are clinical child and pediatric psychology more of a specialty than clinical adult psychology? To date the field has taken steps to define itself as such, and many leaders in the field have embraced this definition.Yet, clinical child and pediatric psychology are not the only fields to deal with this issue. Leading clinical gerontologists, health psychologists, and clinical neuroscientists also struggle with these same training decisions (Roberts, 2006). What is potentially lost in specialization's overemphasis in one area is the scope of clinical psychology as a whole. As currently implemented by many programs, specialized child clinical or pediatric tracks often take a life span developmental and systemic approach to psychology that ensures broad training (Prinstein & Roberts, 2006; Roberts, 2006). One potential resolution to these specialization issues is to define core curricula as a set of skills that are common to all psychologists, such as training in scientific methods, data analytic techniques, and general clinical skills. In addition, training in core areas of psychology would provide content that takes a life span developmental and systemic approach. Then the focus on clinical adult or clinical child psychology would be considered at the same level in terms of specialization. This would alleviate the "adult clinical plus" model that permeates many training programs, in which students who are interested in working primarily with youth populations end up taking similar numbers of clinical classes plus additional classes or seek additional training opportunities with children (La Greca & Hughes, 1999; Roberts, 2006). Clearly, however, the significant challenge of this approach is to provide students with sufficient exposure to the burgeoning literature in important areas without extending an already lengthy training process.

Graduate students in clinical psychology fall on both sides of the argument. In a recent survey of over 1,000 graduate students in programs affiliated with the CUPCP, almost three quarters of clinical psychology graduate students report specializing within their graduate training, and over half of those who reported not specializing plan on doing so before the end of their graduate training (Luebbe, Green, & Malcolm, 2006). Further, just under 50% of those who reported specializing indicated that their specialty was a recognized or formal track within their program, and over 60% of students reported that

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their specialty area was a large influence on their choice of graduate programs. Interestingly, students reported specializing in a variety of ways beyond the types of populations (e.g., child) with whom they work. Students also consider themselves specializing in certain disorders, research areas, theoretical models of therapy, and specific skills such as statistics. These results suggest that graduate students want to and already are specializing during their graduate training. This makes a strong argument for officially recognizing certain specialties. Yet, these results also suggest that the word "specialty" has varied meanings, and students are finding opportunities to specialize within their current programs regardless of whether such specialties are officially recognized. Overall, designing curricula that provide broad but focused training remains a critical issue as clinical child and pediatric psychology grow.

Teaching and Training Activities

As was briefly noted earlier, surveys conducted 20 years apart by Tuma and Pratt (1982) and Cashel (2002) have both found that a sizable number of clinical child psychologists work in some type of academic setting. Both found that approximately20% worked in college and university settings, often in graduate departments of psychology. Likewise, both found that many worked in medical school settings (51% in the Tuma and Pratt survey and 29% in the Cashel survey). Employment was usually in departments of pediatrics or psychiatry.

Clinical child psychologists employed in these settings are frequently involved in training of some type. In university departments of psychology, where the academic training of clinical child psychologists often takes place, teaching can take several forms. It can involve teaching basic psychology courses (e.g., introductory psychology, personality, abnormal psychology) or teaching academic courses relevant to specialty training (e.g., developmental psychology, developmental psychopathology, child assessment, child treatment, evidence-based practice). Teaching in this setting can also involve a supervisory role in the context of various clinical practica, where the primary focus is on helping the psychology trainees develop important conceptual and clinical skills. Importantly, teaching and mentoring may also take place in the context of the student's research training, which, ideally, should at some point involve research with clinical populations so the trainee can learn how clinical knowledge can inform research and how good clinical research can inform clinical practice.

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For those clinical child (or pediatric) psychologists working in medical schools, teaching formal didactic courses may be less common than teaching seminars relevant to aspects of clinical practice and the clinical supervision of trainees (e.g., interns, postdoctoral fellows, psych techs). Not infrequently, psychologists working in this setting are asked to contribute to the behavioral science curriculum of medical students or to coteach courses such as "Introduction to Patient Evaluation," which are often designed to help medical students learn clinical interviewing and relationship-enhancement skills that will serve them well as professionals working with patients.

The teaching possibilities for clinical child psychologists are many. They are also important, as the quality of training that future clinical child psychology (or other) trainees receive is likely related not only to the trainees' ultimate level of professional competence but also to the quality of care that the trainees provide children and families upon completion of training.

The Training of Clinical Child Psychologists

Over the years there has been a dramatic increase in the number of clinical child psychology training programs, which has been prompted, in part, by the shortage of a sufficient number of adequately trained psychologists to meet the mental health needs of children (Knitzer, 1982). In the 1976–1977 edition of the American Psychological Association's *Graduate Study in Psychology,* only eight graduate programs self-identified as offering specialty training in clinical child psychology (Johnson, 2003).Asurvey of graduate training programs in 1982 was able to identify only 15 doctoral programs that provided clinical child specialty training (Roberts, 1982). By 1995, the Directory of Graduate Programs in Clinical Child/Pediatric Psychology (Tarnowski & Simonian, 1995) listed more than 100 programs in the United States and Canada that *self-reported* offering training in clinical child or pediatric psychology, although many of these would likely not meet strict criteria for a formal training program. Indeed, it seems likely that the number of graduate training programs offering quality specialty training in clinical child psychology is well below this number.

Given the need for *adequately trained* clinicians to meet the mental health needs of children *and* the increasing number of programs offering training in clinical child and pediatric psychology, considerable attention has been given to developing training guidelines to ensure adequate preparation of those entering the field. Over the years, three efforts in this regard are especially noteworthy. First was the work of a task force

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of theAPADivision of ChildYouth and Family Services (Division 37), which proposed initial general guidelines (academic coursework, research experiences, and applied training in assessment and therapy) for training psychologists for working with children, youth, and families (see Roberts, Erickson, & Tuma, 1985). This work was followed by the national conference on "Training Clinical Child Psychologists," held at Hilton Head, South Carolina, in May 1985. Here, participants, who were leaders in the fields of clinical child and pediatric psychology, endorsed the general recommendations of the Division 37 Task Force and a scientist-practitioner model of training that emphasized training clinical child psychologists to function both as scientist and clinician and agreed on a range of other recommendations for clinical child training at the graduate, internship, and postdoctoral levels (Johnson & Tuma, 1986; Tuma, 1985). A more recent attempt to integrate and elaborate on the Hilton Head conference guidelines resulted from the efforts of a National Institute of Mental Health Center for Mental Health Issues Task Force, which held a subsequent training conference at the University of Kansas in 1993. The results of these efforts, detailed by Roberts et al. (1998), represent an elaborate and well-considered framework for the professional training of individuals desiring to work with children and families. It was recommended that trainees be exposed to a wide range of didactic and applied training experiences in (a) life span developmental psychology; (b) life span developmental psychopathology; (c) child, adolescent, and family assessment; (d) intervention strategies; (e) professional, ethical, and legal issues pertaining to children, youth, and families; (f) research methods and approaches to system evaluation; (g) issues of diversity; (h) prevention, family support, and health promotion; (i) the role of multiple disciplines and service delivery systems; (j) social issues affecting children, youth, and families; and (k) specialized applied experiences in assessment, intervention, and consultation.

These recommendations indicated that clinical training in these areas should be designed to progress sequentially from simple exposure to the development of expertise in various areas, that they should involve structured research experiences relevant to the specialty, and that internship training should build on predoctoral training and provide a foundation for postdoctoral work. This framework appears to provide an excellent foundation for clinical child specialty training. Building on these guidelines, additional training recommendations related specifically to pediatric psychology training have been outlined by Spirito et al. (2003).

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A significant issue in clinical child psychology training is that, at present, there are few quality assurance mechanisms to ensure that graduate programs purporting to offer specialty training do, in fact, offer training consistent with recommendations repeatedly endorsed by professional organizations representing the specialty. This is, in part, due to the fact that historically there has been no mechanism for the accreditation of specialty programs apart from clinical, counseling, and school psychology. Thus, although graduate programs in these areas are required to conduct self-studies and meet APA Committee on Accreditation standards to initially get or maintain accreditation, there are currently no provisions to ensure that clinical training in specialty tracks (where most of clinical child training takes place) is consistent with existing specialty training guidelines. It is clear that many existing clinical child psychology training programs provide quality graduate education in this area, as evidenced by a strong clinical child training faculty, a formal sequence of required clinical child training experiences (that are consistent with specialty training guidelines), and their having a strong track record of turning out successful clinical child psychologists. Quality assurance mechanisms are necessary to ensure that all programs purporting to offer clinical child training meet these standards.

CLINICAL CHILD PSYCHOLOGY: PRESENT AND FUTURE

Clinical child psychology, along with pediatric psychology, has grown rapidly over the past several decades. Since the 1960s, when the first interest groups related to clinical child psychology were organized, the field has grown in the number of professionals identified with the area and in the number of graduate programs designed to train clinical child psychologists. Likewise, as noted, the area has developed clinical training guidelines in an initial attempt to ensure that those trained in the area are trained well.

After many years of being viewed as a subspecialty of clinical psychology, clinical child psychology has now been formally recognized as a separate specialty in professional psychology, and the primary organization representing the area, the Society of Clinical Child and Adolescent Psychology, has evolved from being a section of the APA Division of Clinical Psychology to being an APA division in its own right, as has the Society of Pediatric Psychology. In the short time since its inception, research productivity of the members of the specialty has grown at an ever-increasing rate. Much of this research has been published by two journals maintained by these divisions, the *Journal of Clinical Child and Adolescent Psychology* and the *Journal of Pediatric*

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Psychology, which have grown from humble beginnings to currently enjoying the status of first-rate psychology journals. Cutting-edge research in the area of clinical child psychology is also regularly presented at the biannual Kansas Conference on Clinical Child and Adolescent Psychology, and current research in the area of pediatric psychology is presented at the biannual National Conference on Child Health Psychology.* The growth of the area is also highlighted by the fact that it is now possible for evidence of excellence in clinical child practice to be recognized through specialty board certification in clinical child psychology through the American Board of Clinical Child and Adolescent Psychology.

As suggested in the formal petition to the APA for specialty recognition in 1998, the area of clinical child psychology has indeed become a "well-developed, legitimate, and formally recognized area of clinical and research specialization, characterized by the development of an ever increasing body of specialized knowledge and a vibrant, diverse, and specialized area of practice" (Commission for the Recognition of Specialties and Proficiencies in Professional Psychology, 1998, p. 2). Given the rapid growth of the specialty during the past 20 to 25 years, questions arise as to where the specialty of clinical child psychology will go in the future. Here, change and advancement are likely on several fronts.

First, it seems likely that the evolving nature of the field will bring about significant changes in the practice of clinical child psychology in the years to come and result in new and different role functions for those identified with this area. As noted earlier, it appears that clinical child psychology has begun to experience a significant shift in the theoretical orientation of new clinical child psychologists coming into the field. There is clear movement toward an increasing number of practitioners with behavioral and cognitive-behavioral theoretical orientations and fewer clinical child psychologists with a predominantly psychodynamic orientation. Given this trend, in the future we will likely continue to see a de-emphasis on training in projective techniques and other more subjective assessment measures

and an increased emphasis on more objective and evidence-based assessment measures. This is likely to be accompanied by a corresponding training emphasis on more evidence-based treatments for childhood disorders, which at this point seem to be interventions that are primarily behavioral or cognitive-behavioral in nature. These already evident trends in clinical training will likely also be reflected in the clinical practice of those clinical child psychologists entering the workforce.

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It is also likely that the impact of managed care will continue to influence clinical practice in terms of assessment and treatment approaches as evidence-based assessment and treatment methods are likely to become increasingly favored for reimbursement.

Consistent with these projections, it is safe to predict that the next several years will see an increased focus on clinical child psychology research related to various aspects of evidence-based practice. This will likely include expanded efforts in researching evidence-based treatments for children and adolescents, including treatments other than those based on behavioral and/or cognitive-behavioral principles, and increased research focus on evidence-based assessment as well as research on the *integration* of evidence-based assessment and evidence-based treatment methods.

As regards child and adolescent treatment we can also expect to see a significant increase in research on the effectiveness of those child treatments that have been determined to be efficacious. It is clearly important to conduct research to document significant treatment effects in the research setting; it is also essential to document the effectiveness of these treatments in applied clinical settings. This research on effectiveness is essential and will likely become a major focus of child treatment research in the near future. Related to the issue of effectiveness, one can safely predict an increasing focus on finding ways of disseminating empirically supported treatments so they are likely to be used in clinical practice as well as researching ways of individualizing manualized treatments to ensure treatment fidelity while also making them more flexible and hence more palatable to practitioners (Kendall & Beidas, 2007). Continued advances in this area of research and the increased dissemination of evidence-based approaches to treatment are likely, over time, to have a significant impact on the role functions of clinical child practitioners in terms of their increasing reliance on empirically based methods of treatment. This would be a very positive outcome for children.

The changing roles of clinical child psychologists have also been highlighted by Prinstein and Roberts (2006) who have noted that, upon completing their graduate training, new clinical child psychologists are increasingly obtaining positions in new settings such as schools, primary care, and corporations that involve new role-related activities such as consulting, public policy, program evaluation, and the supervision of nonpsychology health care professionals. Regarding this trend, Prinstein and Roberts suggest that significant modifications of professional training will likely be needed to

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prepare clinical child psychologists for assuming these new employment opportunities and diverse professional roles in the future.

Chapter 2

THEORETICAL MODELS

PSYCHODYNAMIC

What is the future of psychodynamic psychotherapy with children? Although psychodynamic treatment has a rich theoretical and clinical underpinning, there is a relatively small empirical base for treatment effectiveness. Because of the nature of psychodynamic treatment, it has been difficult to carry out empirical studies. These studies are beginning to occur, but there is a long way to go to catch up with cognitive-behavioral approaches. The psychodynamic approach encompasses two categories of information important to the field of child psychotherapy. One is a number of psychological constructs that provide a way of understanding child development. Many of these constructs have empirical support. The second category is a wealth of psychotherapy techniques with children that have emerged from a psychodynamic understanding of the child. Of particular importance is the use of pretend play in therapy. This chapter reviews the psychological constructs and the treatment techniques. Empirical evidence is presented as much as possible, with guidelines for future research. Implications for treatment and prevention programs are discussed.

Psychodynamic Therapy

The psychodynamic approach focuses on the internal world of the child (Russ, 2006). What is the child thinking and feeling, and how does he or she experience other people and their environment? A developmental perspective is used to understand underlying cognitive, affective, and interpersonal processes (Shirk & Russell, 1996). The level of development of these processes and the interaction

among them largely determines the child's behavior, relationships, and internal state. The psychodynamic framework is applied to understand these internal processes and childhood disorders. This psychodynamic understanding determines the specific intervention approach and techniques to be used with a particular child.

Historically, psychodynamic approaches evolved from psychoanalytic theory and therapy. As Fonagy and Moran (1990) pointed out, many forms of psychodynamic therapies are based on the psychoanalytic conceptualization of child development. Children's play was especially important in psychoanalytic approaches in that it was used as a vehicle for communication with the therapist. Also, the therapist actively worked to establish a positive relationship with the child (Freud, 1927). Anna Freud (1966) made significant contributions to psychoanalytic theory with her work on the ego and mechanisms of defense. Melanie Klein, in a different approach, developed

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early concepts in object relations theory and interpersonal relations (Tyson & Tyson, 1990). Klein also utilized active interpretation of children's play.Amajor goal of psychoanalytic and psychodynamic therapy is to return the child to normal developmental pathways (Freud, 1965; Shirk & Russell, 1996). Psychodynamic therapy differs from psychoanalytic therapy in that it has more focused treatment goals, is less frequent and intensive, and is more flexible in terms of types of interventions used and the integration of other theoretical perspectives and techniques (Fonagy & Moran, 1990; Russ, 1998; Tuma & Russ, 1993).

In most forms of psychodynamic therapy, the therapist and child meet individually once a week for a session of 45 to 50 minutes. The basic understanding between the therapist and the child is that the therapist is there to help the child express feelings and thoughts, understand causes of behavior, and form a relationship with the therapist (Freedheim & Russ, 1992). Goals of treatment are also discussed. Play is a major tool in the therapy. Traditionally, the child has usually structured the

hour, chosen the topic to discuss, chosen the toys to play with, and has determined the pace of the therapy. But as therapy has become more short term, therapists are becoming more active and directive within the psychodynamic framework in focusing on specific topics and directing the play (Russ, 2004). Also, for most child therapists, parent guidance, parent therapy, and parent education and consultation with the school are essential components to the therapy. For a review of the practical issues that arise in psychodynamic therapy and for case presentations, see Chethik (2000), Kessler (1966, 1988), and Russ (2004).

Structure-Building Approaches

A second major form of psychodynamic therapy is the structure-building approach, which is used with children with deficits in object relations and interpersonal processes (Russ, 1998). For children with impaired object relations, self/other boundary disturbances, and problems distinguishing reality from fantasy, the therapist uses techniques that foster the development of object permanence, self/other differentiation, modulation of affect, and impulse control. The major mechanism of change

is the development of these internal processes. The development of object relations is especially important. Mahler (1968) articulated the separation-individuation process and described the development of object constancy and object representations. Blank and Blank (1986) have pointed out that object relations plays a major role in the

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organization of other intrapsychic processes. Children with severely impaired object relations, such as borderline children and children with psychotic and characterological disorders, have early developmental problems in a variety of areas. Also, they tend to have severe dysfunction in the family and often a genetic predisposition.

In a structure-building approach, empathy on the part of the therapist is a much more important intervention than interpretation (Kohut &Wolfe, 1978). Kohut and Wolfe discussed the failure of empathy from the parent that is the major issue in faulty parent-child interaction. Because of the frequency of this occurrence in the interaction between the child and parent, empathy from the therapist around the history of empathic failure becomes an important part of therapy. It is the empathy from the therapist that results in the therapist's being internalized and becoming a stable internal figure for the child. Chethik (1989) and Russ (2004) present cases of psychotherapy with borderline children. Often, help with problem solving and coping is used with these children as well. Therapy with these children is usually long term (1 to 2 years).

Psychodynamic Constructs

There are a number of psychodynamic constructs and hypotheses that are associated with psychodynamic theory. Research that investigates these constructs and hypotheses helps to build empirical support for psychodynamic theory. Although not directly investigating psychodynamic therapy, empirically supported constructs should guide therapy research in terns of what to focus on and what therapy techniquesto emphasize.Westen (1998) reviewed the research literature and identified a number of psychodynamic constructs and propositions that have been supported. Much of the research has been carried out in cognitive, social, developmental, and personality psychology. Often, psychodynamic terminology is not used or referredto. Concepts are placed in a more contemporary cognitive-affective framework. Westen identified the following constructs and principles of psychodynamic theory that have received significant empirical support: unconscious processes, ambivalence and conflict, importance of childhood origins of personality and social

dispositions, mental representations of self and others, and developmental dynamics.

Primary process thinking is another construct that has a large body of research support (Holt, 1977; Suler, 1980). Primary process thinking refers to drive-laden oral, aggressive, and libidinal material and illogical thinking related to that material (Holt,

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1977). Holt described primary thought as an early, primitive system of thought that was drive-laden and not subject to rules of logic or oriented to reality.

Affect and affect-laden cognition are a large component of primary process.

A large number of studies have found a relationship between access to primary process thinking and creativity, as psychoanalytic theory predicts, in adults and children (Russ, 1996; Suler, 1980). Russ has discussed these relationships within current cognitive-affective conceptualizations. The finding in a large number of studies that access to primary process thinking relates to measures of creativity

supports the psychoanalytic theory that access to drive-laden thinking is important in the creative process. Repression of threatening drive-laden thoughts, images, and memories leads to a general intellectual restriction, which in turn constricts associative thinking. Access to a broad network of associations is important in most measures of creativity. Empirical support of this psychoanalytic theory is important in psychotherapy, where one goal is to help the child gain access to unconscious,

repressed content so that the child can bring higher order problem-solving skills to daily problems and stressors.

Pretend play is a key resource for children. The important role of play in child development is not a concept that is unique to psychodynamic thinking. However, play has been a major technique in psychodynamic therapy and is viewed as having a central function in child development.

Short-term Psychodynamic Psychotherapy

Short-term psychotherapy (6 to 12 sessions) is a form of psychodynamic psychotherapy frequently used with children (Messer & Warren, 1995). The practical realities of HMOs and of clinical practice in general have led to briefer forms oftreatment. Often, the time-limited nature of the therapy is by default, not by plan (Messer&Warren, 1995). The average number of sessions for children in outpatient therapy is 6 or fewer in private and clinical settings (Dulcan & Piercy, 1985).

There is little research or clinical theory about short-term therapy with children (Messer & Warren, 1995). A few research studies have shown that explicit time limits reduced the likelihood of premature termination (Parad & Parad, 1968), and that children in time-limited therapy showed as much improvement as those in long-term therapy (Smyrnios & Kirby, 1993). The time is right for the development of theoretically based short-term interventions for children. Messer and Warren suggest that the

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developmental approach utilized by psychodynamic theory provides a useful framework for short-term therapy. One can identify the developmental problems and obstacles involved in a particular case. They also stressed the useof play as a vehicle of change and, as Winnicott (1971) has said, of development. They suggest that the active interpretation of the meaning of play can help the child feel understood, which, in turn, can result in lifelong changes in self-perception and experience. In other words, the understanding of the metaphors in a child's play could give the child insight or an experience of empathy, or both. This lasting change could be accomplished in a short time.

As previously discussed, Chethik (1989) developed focal therapy to deal with specific stressful events in the child's life. Basic principles of psychodynamic therapy are applied in this short-term approach, with the basic mechanism of change being insight and working through. Chethik views this approach as working best with children who have accomplished normal developmental tasks before the stressful event occurred.

In general, brief forms of psychodynamic intervention are seen as more appropriate for the child who has accomplished the major developmental milestones. Proskauer (1969) stressed the child's ability to quickly develop a relationship with the therapist, good trusting ability, the existence of a focal dynamic issue, and flexible and adaptive defenses as criteria for short-term intervention. Messer and Warren (1995) concluded that children with less severe pathology are more responsive to brief intervention than children with chronic developmental problems. The Muratori et al. (2003) study that found that short-term intervention with anxious and depressed children was effective is consistent with this conclusion. The research and clinical literature suggest that internalizing disorders are most appropriate for brief psychodynamic intervention (Russ, 2004). The therapist is active, at times directive, and uses all mechanisms of change in the therapy. Insight and working through are essential, but modeling, rehearsal, and problem-solving strategies are also part of the therapy. Children with major deficits in object relations and those with early developmental problems need longer term structure-building approaches.

Shelby (2000) described the importance of using developmentally appropriate interventions in brief therapy with traumatized children. Working with traumatized children in Sarajevo, she used play and drawing. She described an experiential mastery technique in which children drew pictures of the thing that frightened them. Children were encouraged to verbalize their feelings about the drawing. They were also

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instructed to do anything they wanted to the drawing. Shelby described how this and other developmentally appropriate brief play interventions, although not empirically tested, helped a number of these traumatized children to integrate traumatic events and return to "normal developmental functioning" (p. 72).

Structured play techniques would be especially useful in short-term therapy. The MacArthur Story Stem Battery (MSSB), although designed as an assessment tool, can be used to structure the play situation. In an innovative approach, Kelsay (2002) used the MSSB to structure play therapy. The MSSB is a set of story beginnings (e.g., parents arguing over lost keys), and the child is asked to complete the story. The therapist can choose appropriate story stems tailored to the issues that the child is dealing with. This structured approach could move the therapy to central issues more quickly.

Structured play techniques have also been used with very young children. Gaensbauer and Siegel (1995) described structured play techniques with toddlers who have experienced traumatic events. They conceptualized the mechanisms of change when play is used as being similar to those in older children with PTSD. With these very young children, the therapist actively structures the play to recreate the traumatic event. Gaensbauer and Siegel outlined three purposes of structured play reenactment. First, play enables the child to organize the fragmented experiences into meaningful narratives. Second, the interpretive work by the therapist helps the child understand the personal meanings of the trauma. Third, there is desensitization of the anxiety and fear and other negative emotions associated with the trauma. They stressed that the key element that enables the child to use play adaptively, rather than in a repetitive fashion, is the "degree to which affects can be brought to the surface so the child can identify them and integrate them in more adaptive ways" (p. 297).

BASIC CONCEPTS AND PRINCIPLES

Historically, the systems theory developments that inspired and were infused by early family therapies presented exciting and revolutionary challenges to the practices and theories of the times. Systems theory was held to differ from psychoanalytic approaches by emphasizing relational as opposed to intrapsychic processes, and by taking a holistic and multidirectional view of pathological behavior and its treatment (Bateson, Jackson, Haley, & Weakland, 1956; Lidz, Cornelison, Fleck, &Terry, 1957a, 1957b;Wynne, Ryckoff, Day, & Hirsch, 1958). But the sheer number of different thrusts within this

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emerging field and the complexity of some of the early theoretical formulations and writings meant that it would be many years before coherence in the field began to emerge. Accounts of "systems theory" and its pertinence to families and individual development often seek to trace the history of how principles governing physical systems came to be applied to social systems. In such accountings, special homage is often accorded the creative writings of von Bertanffly (1968). As Patricia Minuchin (1985) noted, however, the writings of Bateson (1972, 1979) and other family theoreticians more directly concerned with the functioning of human systems (e.g., Jackson, 1957; S. Minuchin, 1974; Watzlawick, Beavin, & Jackson, 1967) had a more formative impact on most practicing clinicians of the time.Among the most essential of systems tenets, outlined by P. Minuchin (1985) and others (e.g., Bornstein&Sawyer, 2006; Cox&Paley, 2003) are the following:

- Systems are organized wholes, and their constituting elements or subsystems are interdependent.

- Interconnected subsystems have their own integrity, are organized hierarchically, and are separated by boundaries.

- Patterns in a system are circular and not linear.

- Stable patterns are maintained over time through homeostatic processes.

- Open systems do adapt, change, reorganize, and develop.

Several important talking points follow from these central tenets. First, when clinicians consider any family system, they should find it possible to identify both a family group reality wherein patterns of organization governing the functioning of the overall unit operate as organized patterns in their own right, and a variety of subsystem realities that may or may not themselves mirror the same patterning and rules of the broader system. Most families are composed of multiple subsystems—among them, marital subsystems, parent-child subsystems, sibling subsystems, parent-grandparent and child-grandparent subsystems in multigenerational family systems, and so on. When clinicians and researchers assess family dynamics, they regularly detect logical interconnections among different subsystem levels; for example, high levels of distress in the marital subsystem typically coincide with evidence of impaired parenting of one or more children in the family (Erel & Burman, 1995). They also find that subsystem functioning both affects and is affected by broader systemic functioning, as when marital strife between a husband and wife within their dyadic marital subsystem comes

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to disrupt collaboration in effectively coparenting children at the family group level (Belsky, Crnic, & Gable, 1995; McHale, 1995). In other cases, such linkages are not as overt or easily detected, as hen family members as a unit collude to obscure problematic alignments or abuse within a particular dyadic subsystem in the family (Wynne, 1961).

Historically Important Ideas and Lines of Influence:

Family Therapy and Family Psychology

The view that children's behavioral problems are inextricable from their family group context and that they are most effectively addressed through family collective approaches has been active for nearly a century. Richmond (1917), echoing practices of the social work movement of her time, posited that child adjustment problems had to be understood in their family context, advocated work with family units, and emphasized the palliative role of family cohesion. Yet even as she wrote, common practice then as now was for children's mothers (and seldom fathers) to attend such family sessions. In clinical psychology, mainstream practice did not follow suit in assuming social work's collectivist stance through most of the first half of the twentieth century, even though positions developed by Sullivan,

Horney, and Fromm emphasized the interpersonal nature of psychiatric disorders. The work of these pioneering figures, however, was not truly systemic in that treatment approaches seldom moved to involve family members; such inclusion was usually construed as a violation of client confidentiality.

During the 1950s, John E. Bell, Nathan Ackerman, and a handful of other clinicians broke from these long-standing traditions and began conducting conjoint therapy when seeing problem-referred children. This significant reconceptualization of work with child cases helped catalyze the gradual spread of family-level approaches and came to spark many generative debates and discussions among clinical psychologists. Herein were the gentle beginnings of a family therapy movement, guided by the clarion call that individual psychopathology signaled dysfunctional family systems. Distressed children were said to have accepted an assignment from the family to be its "identified patient" (IP), while the child's symptomatology came to be understood as serving a "messenger" function communicating dire problems at work in the broader family system. Yet even as the IP broadcast these messages, his or her problems were also playing some functional role in protecting the family and maintaining its balance (as when redirecting parents' attention away from their own strife and onto the child's

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problems). Moreover, this function often eluded the conscious awareness of some or all of the family's members. Based on this premise that child behavior problems were telegraphing broader system dysfunction, family practitioners argued that it was senseless to excise a child from his or her family system to treat the child's behavior problems, and then return him or her to the very same context that had catalyzed the development and supported the maintenance of those problems to begin with. Rather, logic dictated attempting to effect change at the root source, alleviating the child's suffering by fostering meaningful change in the functioning of the child's family system.

There were many different pathways toward such ends charted by pioneers of the family therapy movement. Given space limitations, we highlight only some of the principal and most enduring contributions of various perspectives and underscore a few commonalities among approaches. However, we caution readers that by doing so we necessarily obfuscate much of the important detail and richness of theory differentiating the disparate approaches, and we recommend consulting original sources for fuller readings of theory exposition. As an orienting comment, it is probably fair to say that all of the major early schools of thought—including psychoanalytic, Bowenian, contextual, experiential, strategic, structural, communication, and behavioral therapies—shared a few things in common. All acknowledged mutual contributions by all family members to the problems they encountered, shared the therapeutic goals of helping family members assume greater responsibility and delimit blame, and aspired to clarify and enhance intra family communication patterns (Kaslow, 1982; Nichols&Schwartz, 1998). How the therapies sought to do so, what each took as their point of entry, how much each privileged the intrapsychic world or privileged external interpersonal relations, and how much emphasis each gave to the role of past as opposed to contemporary, here-and-now relationships—even insofar as differing in defining who actually constituted the family (and in multigenerational and extended kin frameworks, how far this reach needed to go)—varied greatly. Yet all approaches sought essentially similar ends: greater role flexibility and adaptability, greater clarity and specificity of communications, a more equitable balance of power among the family's co-parenting figures, and promotion of greater individuality and differentiation of members within a cohesive family collective. Hence family cohesion, adaptability, and communication are some of the common themes tying together different approaches (Olson, Russell, & Sprenkle, 1980). In most accounts Ackerman, who was a

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psychoanalyst and child psychiatrist by training, is hailed as the pioneering figure in the family therapy movement; his early publications, *The Unity of the Family* and *Family Diagnosis: An Approach to the Preschool Child,* are counted among the field's seminal works. Perhaps the most provocative conceptual advances early on in the family therapy movement, however, emanated from work with families of young men and women diagnosed with Schizophrenia. Among the innovative clinicians bucking a therapeutic tradition of segregating schizophrenic individuals from their families when providing treatment (and involving the family members only on a need-to-know basis) was Murray Bowen, who strove to treat the schizophrenic person's entire family unit. Bowen believed that the introduction of an outside person into disturbed relational systems had the potential to modify relationships within that system, but he emphasized the importance of the therapist's keeping the intensity of therapeutic focus within the family unit rather than siphoning it into an intense transference relationship.

This stance, which broke with psychoanalytic convention, was one defining feature of the Bowenian approach. Bowen's theory described how individual family members in troubled families experienced difficulty differentiating within a relatively closed-off emotional family system (in 1974, Bowen portrayed families with schizophrenic members as characterized by an "undifferentiated family ego mass"), and he was among the first family theorists to explicitly outline the role that multigenerational transmission played in family pathology. But perhaps the most central of all Bowen's many major contributions was his exposition of emotional triangles as the basic building blocks of families, and of how a third person helps to stabilize inherently unstable dyads. While similar ideas were developed by several other theorists, as outlined later, Bowen helped specify why it is that triangulation breeds stress; to the extent that one family member becomes responsible for or tries to change the relationship of two others, that person shoulders the stress for the others' relationship. Stress within emotional triangles thus came to be seen as a positional phenomenon; assuming responsibility overburdened younger, less differentiated family members, in particular, by trapping them in problematic relationships that they were ill equipped to handle (Friedman, 1992).

ASSESSMENT AND EVALUATION

As may not be surprising given the vast array of different approaches and areas of emphasis represented by different schools of thought, no standard or universally agreed

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upon set of assessment practices or techniques for evaluating families has ever emerged. Many students trained in family therapy approaches are introduced to some of the innovative ways of gathering information about families, such as completing detailed genograms (McGoldrick & Gerson, 1999)—sometimes indispensable in multigenerational formulations and interventions—and some are introduced to structured checklists or inventories (which help to organize and structure behavioral therapies). But most family therapists do not define formal assessment phases during which they systematically partake in standard assessment protocols or procedures. This is certainly not to imply that assessments are not conducted or are thought of as unimportant, but only that a cataloguing of different assessment tools in this section would badly misrepresent this facet of clinical work with families. Rather, we summarize here some of the major issues attended to by most systems therapists in the early stages of working with families. Besides explicitly seeking information and clarity during family interviews about certain critical life events (e.g., domestic violence, sexual abuse, extramarital affairs, drug and alcohol abuse), most family systems approaches give special credence to the behavioral sequences and interactions that are revealed during early contacts with families. Such interactions are thought to reveal much of what is necessary to know about family communication patterns, boundaries, rules, and hierarchies. What family members do during assessments is as important as and sometimes more important than what they say, and hence very few family assessments take place without some direct observation of the family's interaction patterns. How early assessments are conducted, how directive therapists are during initial evaluations, and what the goals of early contacts are do differ from school to school, though there are some commonalities. First, most family therapists take pains during the early stages of work with families to listen to and take stock of the family's account of the presenting problem. During this stage, each family member is usually allowed a voice, and therapists acknowledge each person's perspective on the problem. This process is usually navigated in as open-ended a way as is possible before additional detail is sought. The additional detail, when solicited, is geared to identify important details and to contextualize the problem with respect to time, place, and key players involved (including important individuals and systems outside of the immediate family). Information is also obtained about how the family has already tried to deal with the problem.

On the basis of these early assessments, interventionists are able to draw some preliminary hypotheses about structural and communication problems in families. From both session content and from observation of interaction sequences, the family hierarchy and the roles of different family members in the family's dynamics begin to become apparent. From observed family process patterns and sequences, the therapist is able to speculate about triangles, coalitions, and problematic boundaries within the system. This is particularly so when all of those principally involved in the maintenance of the problematic patterns are in attendance; understanding of family dynamics and communication patterns in families often shifts significantly when a sibling or live-in grandparent who had been absent during earlier family sessions subsequently attends a session and a different sequence pattern or alliance structure is revealed. Ultimately, however, an important aim for most therapies, not just structural approaches, is to develop an understanding of the invisible structures maintaining the referral problem.

Family therapy's revolutionary insight was that the problems of any given individual are a function of the whole family, and this systems viewpoint continues to guide virtually all contemporary family therapy practice. The field has undergone a dizzying number of changes in its 50-year history, and in at least certain schools of practice there have been some major breaks with long-standing traditions of focusing on interaction over cognition and on privileging relationships over individuals. Yet the hallmarks of systems approaches—thinking triadic ally about behavior problems, focusing on family process over content, understanding that families are open systems embedded in extra familial systems—remain as fresh as ever. They will undoubtedly continue to have enduring impact and, when embraced, promise to infuse critically important insights into effective clinical practice.

DEVELOPMENTAL PSYCHOPATHOLOGY

Developmental Psychopathology as a Scientifics Discipline is Relevant to Behavioral and Emotional Disorders of Childhood and Adolescences. A wealth of information has accumulated in recent years about the causes, correlates, and underlying mechanisms of child and adolescent mental disorders. At the same time, treatment strategies are becoming increasingly evidence based. The major goal of this volume is to provide up-to- date, conceptually and developmentally derived information about (a) risk factors for child and adolescent psychopathology and (b) the major conditions and disorders that come to clinical attention.

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Intervention strategies are not emphasized herein, as such information would require a set of chapters fully as long as the present contents. For a recent compendium of evidence- based treatments for child and adolescent disorders, see Silverman and Hinshaw (2008). To contextualize and put into perspective why this topic area is so important, it is necessary to consider the levels of impairment and pain linked with child and adolescent psychopathology. Think, for instance, of the hopelessness and despair associated with depression in youth; the major limitations on life choices—and the sheer loneliness—so often imposed by many forms of Anxiety Disorder; the disorganization and chaos 4 Developmental Psychopathology as a Scientific Discipline related to Bipolar Disorder; the personal, family, school, and peer- related disruptions incurred by deregulated attention and impulse control; the havoc wreaked by severely aggressive behavior on individuals and even entire communities; or the isolation and lost opportunities linked to Autism and other Pervasive Developmental Disorders. Similar portraits pertain to eating disorders, substance use and abuse, schizophrenia-spectrum conditions, and the beginnings of personality disorders. Overall, the personal and family confusion, grief, emptiness, and lost opportunities incurred by conditions such as these are deeply felt by all who are affected.

Furthermore, emotional and behavioral problems in children and adolescents are distressingly prevalent and often lead to serious impairments in such crucial life domains as academic achievement, interpersonal competencies, and independent living skills (for thorough accounts, see Mash & Barkley, 2003; Wolfe & Mash, 2006). These conditions incur massive pain for individuals, families, and communities at large, triggering major economic burdens for caregivers, school districts, and health care systems. From a developmental perspective, not only are the major child and adolescent disturbances likely to persist across the lifespan, but the majority of mental disturbances experienced by adults have their origins in childhood and adolescence (Kessler, Berglund, Demler, Jin, & Walters, 2005).

Over and above the clinical and policy- related concerns raised by child and adolescent psychopathology, during the past century these conditions have begun to engage serious scientific efforts aimed at understanding their etiology, individual- level and systems-related maintaining factors, and empirically supported prevention and intervention efforts. After millennia of professional and scientific neglect of childhood psychopathology, we have now entered a time of rapid progress. The study of child and

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adolescent disorders is a major endeavor, and increasingly sophisticated efforts have begun to bear fruit in terms of scientific advances.

Conceptual bases for integrating developmental processes into the study of child and adolescent psychopathology have been present for several centuries, spanning fields such as embryology, systems theory, philosophy, and genetics (Cicchetti, 2006; Gottlieb & Willoughby, 2006). Yet it is only in the past several decades that developmental psychopathology (DP) has taken formal shape as a perspective on behavioral and emotional disturbance throughout the lifespan, and as a major conceptual guidepost for the study of both normal and atypical development (for initial efforts, see Achenbach, 1974; Sroufe & Rutter, 1984). During this period, DP has exerted a major force on clinical child psychology, child psychiatry, developmental psychology, mental health services research, and a number of other disciplines in the behavioral and neurological sciences. New courses have been formed at major universities, journals have been created, and Developmental Psychopathology as a Scientific Discipline, governmental agencies have taken on the DP moniker to define their missions. It is remarkable how pervasive the DP perspective has become, galvanizing a host of clinical and scientific efforts.

In the book that follows, a key objective is to bring to life the core tenets and principles of DP into a guide for students, clinicians, and scholars that can facilitate deepened understanding of the major forms of child and adolescent behavioral and emotional disturbance. To meet this aim, we have asked leaders in the fi eld to present up- to- date material that is at once developmentally based, clinically relevant, and directly inclusive of the types of psychobiological formulations that are gaining ascendancy in the entire mental health enterprise. Thus, our intention is to supplement the kinds of developmental, process- oriented constructs typically linked to DP with appreciation of core findings in behavioral and molecular genetics, neural pathways, and brain plasticity that have risen to prominence in recent years. In our instructions to the volume's contributors, we asked explicitly for coverage of historical context, epidemiologic factors, diagnostic issues, sex differences, cultural variables, developmental processes, and important psychobiological mechanisms that could illuminate the pathology under discussion. In providing these guidelines, we were clear that emphasis on neural and neuro-physiological processes must not be reductionist. Indeed, psychosocial and family factors—which served as the predominant modality throughout much of the last century—interact and transact with biological risk variables

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to produce both maladaptation and healthy adaptation throughout development (for a compendium of integrative work focusing on adolescents, see Romer & Walker, 2007). Thus, we asked contributors to consider multilevel models, emphasizing transaction across a range of individual and contextual factors in the formation of psychopathology. Indeed, it is important to note that modern views of behavioral and molecular genetics have placed into sharp relief the unique and interactive roles that environmental and cultural forces exert on development (e.g., Cicchetti & Curtis, 2006; Rutter, Pickles, Murray, & Eaves, 2001).Given page limitations and the desire for focused rather than exhaustive coverage, each chapter is relatively brief, with the goal of providing cogent, recent, and incisive commentary on conceptual issues, clinically relevant material, neuro-scientific advances, and interactive models. It is our sincere hope that readers will use these contributions as a springboard for further exploration of conceptual frameworks, empirical research on etiology and mechanisms, and implications for prevention and treatment.

Above all, we hope to provide a window into the integration of genetic, biological, psychological, and contextual forces that conspire to create costly and impairing patterns of maladaptive development. The utter complex Developmental Psychopathology as a Scientific Discipline of the enterprise is daunting and challenging; despite the considerable advances that have been made, the road ahead is long.

Key DP Concepts and Principles

What characterizes a truly developmental view of psychopathology, as opposed to the kinds of descriptive, symptom- focused presentations that still dominate most classification systems and that still permeate all too many texts and articles? As discussed in key treatises (e.g., Cicchetti &

Cohen, 2006; Mash & Dozois, 2003; Rutter & Sroufe, 2000; Sameroff, Lewis, & Miller, 2000), several core points are commonly viewed as central to the DP perspective. These include the necessity of (a) interweaving studies of normal development and pathological functioning into a true synthesis; (b) examining the developmental continuities and discontinuities of traits, behavior patterns, emotional responses, and disorders; (c) evaluating evidence across multiple levels of analysis (from genes to cultures, including the intermediate levels of individuals, families, schools, and neighborhoods); (d) incorporating distinct perspectives, including clinical

and developmental psychology, child and adolescent psychiatry, genetics, neurology, public health, philosophy of science, and many others, into a truly multidisciplinary effort; (e) exploring both risk and protective factors and their interplay, so that competence, strength, and resilience as well as pathology and impairment can be understood; (f) involving reciprocal, transactional models of influence in the field's causal models, through which linear patterns of association and causation are replaced by probabilistic, dynamic, nonlinear, and complex conceptual models; and (g) capturing the importance of social and cultural context in understanding the function and meaning of behavioral and emotional patterns.

Three related principles bear emphasis. The first is that multiple pathways to pathology exist. Indeed, disparate routes may lead to a common condition or outcome, exemplifying the construct of equifinality. For example, aggressive behavior could result from physical abuse, from a heritable tendency toward dis-inhibition, from injury to the frontal lobes, from coercive parenting interchanges with the developing child, from prenatal and perinatal risk factors acting in concert with early experiences of insecure attachment or parental rejection, or from different combinations of these vulnerabilities and risk factors (e.g., Raine, Brennan, & Mednick, 1997). In other words, separate causal influences may well yield similar clinical end states. In addition, the concept of multi-finality pertains when a given risk factor or initial state leads to disparate outcomes during the course of development across different individuals. For instance, abuse Key DP Concepts and Principles 7 may or may not lead to severe maladaptation, depending on a host of intervening factors; extremes of inhibited temperament may produce shyness and social withdrawal, but other, healthier outcomes are also possible, depending on the presence or absence of additional risk or protective factors (for discussion, see Cicchetti & Rogosch, 1996).

Second, DP models place strong emphasis on person- centered research designs, in which the typical practice of examining global effects of one or more risk / protective variables across an entire sample or population is supplemented by consideration of unique subgroups—whether defined by genotypes, personality variables, socialization practices, neighborhoods, or other key factors—and their unique developmental journeys across the lifespan (see Bergman, von Eye, & Magnusson, 2006). Another way of putting this is that developmental continuities and discontinuities may well differ across homogeneous subgroups of participants. Even in variable centered research, key moderator variables and mediator processes must always be considered (e.g., Hinshaw,

2002; Howe, Reiss, & Yuh, 2002; Kraemer et al., 2001), to ensure that (a) results are applicable to subsets of participants grouped on the basis of the moderator variable of interest (male versus female participants, those from different ethnic groups, or those with different patterns of comorbidity) and (b) underlying mechanisms of change, gleaned from mediator variables, are considered explicitly.

Third, given the rapid growth in recent years of genetic and genomic models as well as brain imaging methods, DP researchers in the twenty- first century must pay increasing attention to the role of the brain, and to neuro-scientific principles in general, in order to account for the wide range of extant pathologies and their devastating impacts (see Cicchetti & Curtis, 2006). Clearly, we have come a long way from the mid- twentieth century, when biological and temperamental factors were virtually ignored in accounts of child development and psychopathology. To put into perspective just what a brain-based view entails, consider the following mathematical calculation: Adults have a "best estimate" of approximately 100 billion neurons in their brains; children are probably born with even higher numbers. Indeed a major developmental "task" over the earliest years of postnatal development is the pruning and migration of such neurons and their synaptic connections into a working, functional, and effi -cient brain. As to the rate of neural development during the 40 weeks of human gestation, one can calculate the following quotient: Divide 200 billion (a fair estimate of the number of neurons with which an infant is born) by the number of seconds in 40 weeks. The result—of dividing 2 times 10 to the 11th power by this denominator, which is 2.4192 times 10 to the 7th power (i.e., the number of seconds)—is the astonishing figure that, on average, the embryo and fetus are producing around 8,000 new neurons every sec8 Developmental Psychopathology as a Scientific Discipline and throughout the entire course of prenatal development. This average is not constant, of course, given that the neural tube and brain do not even form for some weeks; thus, in some crucial periods, this figure is far higher (see Giedd et al., 2006, for additional information on the precise timing of neural development across pregnancy and childhood).

Given such a staggering rate of development, a key question involves the joint influence of genes, hormones, nutrition, life experiences, and contextual influences on the plasticity of the brain's development—that is, the ultimate fate of this vast number of neurons—across childhood and adolescence. The number of potential synapses associated with any given neuron is large, making for an incalculably vast number of possible interconnections.

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Without transactional processes, multilevel models, computational frameworks, and a host of new information and technology related to developmental neuroscience, we will not be able to solve the problem of gaining deep understanding of relevant mechanisms (see also Romer & Walker, 2007). All of the issues, terms, concepts, and principles described in the previous paragraphs have been stated and restated across a large number of articles, chapters, and books that promote and explicate DP models.

Indeed, detailed discussion of any one of them could easily fi ll a volume unto itself. The challenge for the current chapter is to encapsulate these tenets, in order to foreshadow and illuminate the content of the remaining chapters on specific risk factors and specific disorders. In addition, explanations of these concepts too often remain at a rather global and abstract level, leaving unresolved precisely what they suggest for the investigation and treatment of behavioral and emotional disorders. In the following section, I therefore try to bring a number of these precepts to life. Because of this full coverage immediately following the current chapter, this topic is not emphasized herein, although integrating across multiple levels of analysis is essential to all work in DP (for a series of papers on this topic, see Cicchetti & Dawson, 2002).

Normal and Atypical Development Are Mutually Informative As opposed to the study of discrete, mutually exclusive categories of disorder, DP models emphasize that phenomena defined as abnormal represent aberrations in normal developmental pathways and processes—and, accordingly, that without understanding typical development, the study of pathology will remain incomplete and decontextualized. For example, illuminating the nature of Attention- Defi cit / Hyperactivity Disorder (ADHD) Key DP Concepts and Principles requires thorough understanding of the normative development of attention, impulse control, and self- regulation (Nigg, 2006; Nigg, Hinshaw, &Huang- Pollack, 2006). Similarly, investigations of Autism must take into account the development of interpersonal awareness and empathy, which typically takes place over the fi rst several years of life, to gain understanding of the devastating consequences of failure to attain such development (Dawson & Toth, 2006). Additional examples exist across all forms of disordered emotion and behavior. Although considered set- breaking at the outset of modern DP conceptions, this point is now taken for granted: Few would doubt the wisdom of understanding developmental sequences and processes associated with healthy outcomes as extremely relevant to the elucidation of pathology.

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Intriguingly, however, the process is conceptualized as a two- way street, with the view that investigations of pathological conditions—sometimes referred to as adaptational failures in DP conceptualizations (e.g., Sroufe, 1997)—can and should provide a unique perspective on normal developmental mechanisms. In other words, it is posited explicitly that the study of disrupted developmental progressions can facilitate our understanding of what is normative.

This core tenet of DP—that mutual interplay between the study of normality and pathology, along with the perspective that progress in each domain depends on progress in the other—is now widespread. One of the best examples comes from neurology, which has a long tradition of utilizing the study of disrupted neural systems for enhancing understanding of healthy brain functioning and vice versa. For instance, "split- brain "patients (those who have had their cerebral hemispheres separated to provide relief from intractable seizures) provide unprecedented insights into normative brain processes and into the separable functions subserved by the right versus left hemispheres. This separation of functions becomes particularly evident with the severing of the large, interconnected structure known as the corpus callosum (see discussion in Gazzaniga, Ivry, &Mangun, 1998). Such induced hemispheric separation throws into sharp relief the typical inter hemispheric communication and collaboration that takes place. Other neuroscience examples abound (see Cicchetti & Curtis, 2006; for a specifi c example, the study of phenylketonuria, or PKU, has implications for elaborating the normative development of executive functions; Diamond, Prevor, Callender, & Druin, 1997). But how accurate is this perspective for DP? In other words, outside of neurological formulations, can investigations of pathology inform normal development? To reiterate, it is now commonly accepted that the more we know about basic emotion, cognition, attention, memory, social awareness, self- regulation, and the like, the greater the benefit for investigations 10 Developmental Psychopathology as a Scientific Discipline of psychopathology. Almost no forms of mental disorder constitute clearly demarcated, qualitatively distinct categories or taxa, so processes applying to individuals near the peak of the bell curve are likely to apply to those further out on the continuum as well. Indeed, nearly all forms of mental pathology appear consistent with a quantitative, dimensional perspective (Beauchaine, 2003), emphasizing the need for fl ow of information from normal developmental pathways to pathological functioning.

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Yet regarding the other direction, what has been learned about normal developmental processes from studies of child and adolescent psychopathology?

I have pondered this question for some time, prompted by a probing inquiry during a colloquium discussion from my eminent Berkeley colleague Alison Gopnik. My initial take was that we have not gained the kinds of dramatic insights about typical psychological development from studies of child and adolescent psychopathology that have been realized in neurology. Part of the reason is that pathological functioning is almost always multifaceted and complex, which makes it quite difficult to pinpoint areas of specific dysfunction that could inform how normal development occurs in their absence. In other words, there are few equivalents to the surgical procedures of creating lesions in certain brain tracts or to single- gene forms of pathology such as PKU.

Yet consider the work on Autism by Baron- Cohen (2000; see also Baron- Cohen, Leslie, & Frith, 1985, and the review in Dawson & Toth, 2006). Relevant fi ndings suggest that the lack of social connectedness experienced by individuals with Autism may relate to a failure in attainment of a basic theory of mind, which deals with the developing realization that other humans have mental states that differ from one's own. Most normal 4- and 5- year- olds can master theory- of- mind tests, suggesting that basic social understanding is predicated on a domain- specific cognitive module that, once operative, occurs almost automatically. On the other hand, a high percentage of youth with Autistic Disorder, even those with high levels of intellectual functioning, do not "pass" such psychological tests, revealing that they have not come to the normally automatic realization that fellow humans have different minds and different psychological perspectives from their own.

Intriguingly, however, a number of individuals with high- functioning Autism can eventually learn to pass the kinds of experimental tests used to test for theory of mind. Through effortful processing, they can and do deduce that other children and adults have a different understanding than they do. Yet this theory- of- mind ability does not mean that their social interactions automatically become smooth and effortless. Indeed, the laborious kinds of calculations and inferences made by people with high functioning Autism to understand interpersonal dynamics are not usually.

Key DP Concepts and Principles accompanied by smooth, effortless social interactions (e.g., Grandin, 2006).A key implication is that "normal" social- cognitive and social functioning is highly automatic and intuitive, qualitatively distinct from the ability to deduce social situations analytically in Autism—which is time consuming, not

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perceived as very skillful by peers, and probably quite different from the way the process works in typically developing individuals. Thus, disruptions in social cognition and social performance by persons with Autism may help to clarify the automatic and highly developed nature of the social cognitions and processes that underlie skilled interpersonal performance in normal development.

Another example pertains to work on the reward sensitivity of individuals with ADHD (e.g., Sagvolden, Johansen, Aase, & Russell, 2005).Here, considerable evidence reveals that, in people with this condition, withholding of rewards leads to rather sudden decrements in task performance, presumably related to a dopaminergic ally mediated problem with responding during extinction. In other words, ADHD is associated with large performance decrements when rewards are suddenly stopped.

This insight may help to understand the mechanisms—largely mediated by subcortical, dopaminergic brain structures—by which typically developing individuals can maintain behavior during extinction, with mutual enhancement of the understanding of basic developmental processes and mechanisms underlying deregulated attention and impulse control.

A third instance, noted extremely briefly, pertains to the horrific "experiments of nature" that occur when infants and toddlers are subjected to brutal institutionalization and lack of human contact during the earliest years of development (for review, see O'Connor, 2006). Intensive study of this topic has revealed essential information about rates of recovery during placement into stable homes, implications for attachment theory, the development of specifi c symptom patterns (e.g., inattention and over activity as opposed to aggression; see Kreppner, O'Connor, Rutter, & the English and Romanian Adoptees Study Team, 2001), and the presence of social and cognitive "catch- up"—all of which are extremely informative about the normal- range development of secure relationships, emotional and behavioral functioning, and cognitive performance. I urge readers to seek other parallels regarding the ways in which knowledge about pathological functioning might elucidate normative processes.

CHAPTER 3

PSYCHOLOGICAL PROBLEMS IN CHILDHOOD AND ADOLESCENTS

PROBLEMS OF EARLY CHILDHOOD

Sleep Problem in early childhood

Where children have sleep problems, particularly settling and night-waking problems, and parents have tried over a period of months or years to solve the problem with little success, further family difficulties occur that may compound the sleep problems. These problems include exhaustion, parental depression, marital discord, deterioration in parent-child relationships, and reduction in number and quality of socially supportive interactions (Douglas, 1989; Horne, 1992; Skuse, 1994; Stores, 1996).

A wide variety of solutions have been tried in most families referred to clinical psychologists with children's sleep problems as the central concern. These may include sedation, night feeding, ignoring night-time crying, having the child sleep alone, having the child sleep with the parents, having a fixed bed time, having a variable bed time, prayer, faith healing and so on. An abundance of conflicting advice from a variety of professional and nonprofessional sources will have been offered. When parents arrive in the psychologist's office they are invariably at their wits' end. It is therefore critical that the psychologist's approach to helping parents and their children solve such problems is both well informed on the one hand and sympathetic and supportive on the other.

Many children have settling and night-waking problems from birth. Others develop them following some precipitating event or set of circumstances. Such precipitating factors may be biological or psychosocial. Biological factors include serious illness or injury. Stressful life events, particularly separation from the primary care giver (usually the mother) or the occurrence of an event that threatens the child or the family such as a house burglary, are the most common psychosocial factors contributing to the development of settling and waking difficulties in children who have already developed a robust sleep routine. These precipitating factors may lead to physical discomfort and/or anxiety and heightened arousal which the child is unable to regulate. So the child has difficulty falling asleep or returning to sleep after being awakened by physical discomfort or nightmares.

Treatment

For each child, a unique sleep-management program is required. Such programs are developed in the light of the formulation and typically include some of the following strategies, which are based on the behavioral principles of shaping, fading, discrimination

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training, extinction and reinforcement and on cognitive principles of script and schema development (Douglas and Richman, 1985):

• Gradual reduction or elimination of day-time sleeping

• Gradual reduction or elimination of pre-sleep feeds or drinks

• The development of pleasant bed-time routines

• Gradual or sudden movement of bed-time routines from a time when the child is highly likely to sleep to an earlier time

• Gradual or sudden provision of opportunities to use self-soothing skills while the child is first going to sleep

• Gradual or sudden provision of opportunities to use self-soothing skills following night waking

• coaching children in self-soothing relaxation skills

• reward training and extinction For some of these strategies the choice is between an abrupt or sudden change and a gradual change because infants typically respond to sudden changes in routines with persistent crying and because this is particularly stressful for both the child and the parents, where possible gradual change procedures are preferable. Also, most parents will have received advice to use sudden change procedures and found these to be ineffective and distressing, so will be reluctant to try them again. For example, most parents will have been advised to let their children cry until the child falls asleep. Many parents manage this approach for three or four consecutive nights but eventually lift the child to prevent the crying, which had become intolerable for them. This invariably leads to the child's crying persisting for more than five or six nights after this. The duration of the crying also extends, so many parents revert to lifting, rocking or soothing the child and give up attempts to help the child develop self-soothing skills.

Learning and communication difficulties

Intellectual disability

Both the DSM IV and the American Association for Mental Retardation (AAMR) (American Association for Mental Retardation, 1992) give a definition of intellectual disability that is functional rather than medical or psychopathological. Intellectual disability is construed as entailing functional limitations (in intelligence and adaptive skills) in specific environments (home, school, community) and therefore as requiring specific supports to live a normal life within these contexts. In contrast the ICD-10 takes a traditional medial approach. The AAMR

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(American Association for Mental Retardation, 1992) states that to diagnose, classify and identify the needs of people with intellectual disabilities, four dimensions are required, and these are included in their diagnostic assessment system:

• Dimension I: intellectual functioning and adaptive skills

• Dimension II: psychological and emotional status

• Dimension III: physical, health and etiological factors

• Dimension IV: environmental factors.

The AAMR system, unlike the DSM IV and ICD-10 systems, abandons the traditional mild, moderate, severe and profound subcategories for intellectual disability. Within the AAMR system, a person may, for example, be diagnosed as intellectually disabled requiring extensive support in the areas of self-care and communication.

Available evidence points to the importance of organic influences in the etiology of moderate, severe and profound intellectual disability; and to the central role played by polygenetic and socio-cultural factors in the etiology of mild intellectual disability (Scott, 1994). The moderate, severe and profound group tends to have organic pathology in up to 75 per cent of cases; less social disadvantage; and parents who tend to have normal intelligence. In cases where only a mild level of disability is present, the children's parents tend to have lower levels of intelligence; there is a greater degree of social disadvantage; and organic pathology is only present in about 10–25 per cent of cases.

Individuals in the mild range tend to fare better than those in the severe, moderate or profound ranges with respect to adaptive behavior; conduct and emotional problems; pervasive developmental problems; health problems; additional sensory or motor handicaps; shorter life expectancy; and reduced fertility (Scott, 1994). About 50 per cent of cases in the mild range show good social adjustment with minimal professional support. However, the rate of conduct, emotional and pervasive developmental problems in populations of cases with intellectual disability does not decrease over time. It remains stable at 25–50 per cent (Scott, 1994).

Typically, clinical psychologists who work with families containing a child with an intellectual disability are required to offer assessment and intervention services to deal with the following five broad problem areas:

• Psycho-education

• Organization of appropriate supports and periodic review

• offering life-skills training for the child

• providing consultancy to manage challenging behavior

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• counselling during lifecycle transitions and supporting families in dealing with the grief process

Treatment

Psycho-education

The aim of psycho-education in cases of intellectual disability is to help parents and other family members understand their child's diagnosis and its implications for the child's development. It is very difficult for most parents to acknowledge and appreciate the implications of the diagnosis of intellectual disability, since the diagnosis violates their expectations associated with having a completely healthy child. Most parents experience shock and denial (two elements of the grief process described below). Psychologists on multidisciplinary teams have a responsibility to help team members give parents and family members a clear, unified and unambiguous message about the diagnosis, since this is what the parents require to work through their denial and get on with the process of accepting their child's disability and dealing with it in a realistic way. The diagnosis should include information on the status of the child on the four axes of the AAMR diagnostic system. Thus, parents should be given information on the normative status of their child's cognitive abilities and adaptive skills; psychological and emotional status; biological factors; and supports necessary for the child to live a normal life. The way in which such supports may be accessed should also be clarified. The main pitfall in psycho-education is to give parents ambiguous information which allows them to maintain the erroneous belief that their child has no disability or a transient condition that will resolve with maturation.

Organization of appropriate supports and periodic review

Following the first comprehensive assessment and feedback of diagnostic information, as part of a multidisciplinary service, clinical psychologists may have a role in organizing and arranging the delivery of appropriate supports for children with intellectual disabilities and their families. The appropriateness of these supports in meeting the changing needs of the child and the burden of care shouldered by the family require periodic review and revision. For good practice in this area, the child and family's support needs must be clearly stated in concrete terms; the precise action plans for arranging supports must be agreed with the family and the professional network; the precise roles and responsibilities of members of the professional network in providing supports must be agreed; the way in which the provision of supports will be resourced financially must be agreed; and the timetable of periodic review

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dates must be drawn up. Central to this type of system is the concept of a key worker who holds administrative responsibility for ensuring that the child's support plan is implemented. Even the most robust system of this type will flounder without an organizational structure which requires key workers to take responsibility for co-coordinating the implementation of support plans. The terminology used to describe these individualized support plans varies from country to country. However, the principles of good practice remain the same. Also the precise role of the clinical psychologist in relation to other professionals, including educational and school psychologists, will vary depending upon local and national policy.

Life-skills training

The Portage program (White and Cameron, 1987) offers a highly structured way of empowering parents to coach their children in the development of a variety of life skills in a systematic manner. In addition, the principles of behavior modification may be used for designing skills-development programs and training parents and school staff to implement these to help the child develop life skills (Yule and Carr, 1987).

Challenging behavior

When self-injurious, aggressive and destructive behavior occur, assessing the contextual factors that maintain these problems, and developing programs to help children with intellectual disabilities and members of their networks resolve these difficulties, are an important part of the psychologist's role. Interventions to reduce the frequency of challenging behaviors should be based n a thorough functional analysis of the immediate antecedents and consequences of such behaviors which may maintain them. A wider ecological assessment is also required to identify both personal attributes and relatively enduring features of the physical and social environment which may predispose children and their careers to become involved in mutually reinforcing patterns of behavior that maintain aggressive and self-injurious behavior (Oliver, 1995).

Two common behavioral patterns that may maintain self-injurious behavior (but which may equally apply to aggressive behavior) have been described in detail by Oliver (1995). In the first pattern, a period of social isolation leads the child to a state of heightened need for social contact, and challenging behavior occurs. In response to this, the career provides social contact until the child's need for contact is satiated. When the child's need for contact ceases, it is more likely that the child will engage in challenging behavior again, since this has been positively reinforced by the career's attention. It is also more likely that the career will

provide social contact in response to challenging behavior, since giving attention leads the adult ultimately to experience relief (associated with negative reinforcement) when the challenging behavior ceases.

In the second pattern, the career places demands upon the child and, in response, the child engages in challenging behavior which leads the adult to cease placing demands upon the child. When the episode ceases, the child is more likely in future to engage in challenging behavior when demands are placed upon him, because in the past this has led to a cessation of demands (negative reinforcement). The adult is more likely to stop making demands in response to challenging behavior since this has led to a cessation of the child's challenging behavior (negative reinforcement).

Environmental predisposing factors for challenging behavior include disruptions of the sleep-waking cycle; disruptions of daily routines; life transitions; living in authoritarian social environments entailing many demands; living in social environments where there is limited contact with careers or teachers, due to high staff-student ratios; living in social environments where careers provide few routines and little structure for the child; living in environments where careers are not sensitive to fluctuations in the child's moment-to-moment needs and frustration tolerance (Oliver, 1995).

Personal predisposing factors for challenging behavior include a greater degree of intellectual disability; fewer adaptive behaviors; more limited expressive language; co-morbid autism; co-morbid sensory and motor disabilities; and the presence of particular syndromes such as Lesch-Nyhan, Smith-Magenis and Tourette's. Many of these predisposing factors limit the availability of alternative responses of equivalent efficiency through which the child can alleviate the need to make social contact with careers or reduce the demands made by careers (Oliver, 1995).

A functional analysis will suggest potential interventions, and these may fall into three broad categories: stimulus-control strategies, contingency-management strategies, and functional equivalence training. Stimulus-control interventions aim to alter the antecedent conditions that give rise to the problem. Contingency-management interventions aim to alter the consequences of the challenging behavior so that it is no longer reinforced. Functional equivalence training aims to provide the child with a more adaptive response that is as efficient as the challenging behavior for meeting the child's need that was met by the challenging behavior (Yule and Carr, 1987).

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Family grief counseling at lifecycle transitions

Parents, siblings and other family members may require counseling at critical lifecycle transitions such as the diagnosis of intellectual disability; the transition to school; leave school; entering supported employment; leaving home; the onset of parental decline; and parental death.

Initially, when parents are informed that their child has an intellectual disability, a grief process is set in motion which includes the sub-processes of shock; denial; emotional turmoil involving disappointment, anger and guilt; and acceptance. The way the news of handicap is broken affects parents' satisfaction with the consultation service received. The following factors are particularly important: the approachableness of the clinician; the degree to which the clinician understands the parent's concerns; the sympathy of the clinician; and the directness and clarity of communication (Quine and Rutter, 1994).

Throughout the lifecycle at each transition, the family is reminded of the loss of the able bodied child that was initially expected and the grief process recurs, albeit in a progressively attenuated form (Goldberg et al., 1995). Lifecycle transitions are particularly strong triggers for family grief processes, since they entail unique features when compared with lifecycle transitions associated with able-bodied children. For example, the transition to school may entail a higher level of concern because of fears that the disability may prevent the child from forming peer relationships and fitting in. The leaving-home transition may occur later in life, if at all. The impending death of the parents may be a particular source of anxiety, since a major concern may be who will care for the disabled child when the parent has died. An important function of the clinical psychologist is to help families both mourn their disappointments and also celebrate the achievements of their children with intellectual disabilities. This may involve offering family counseling or therapy, or offering support and supervision to key workers providing this service.

Specific language delay

A distinction may be made between secondary language delay (due to intellectual disability, autism, hearing loss or some such condition) and specific language delay. Specific language delays may be sub-classified as expressive delays, which are the most common, and mixed receptive-expressive delays, which are the most debilitating (Whitehurst and Fischel, 1994; Rapin, 1996). This distinction is the central organizing principle in the classification of language disorders in DSM IV and ICD-10. A case example of a child with a receptive expressive language delay is presented in Box 8.2. Diagnostic criteria for specific language

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delays from DSM IV and ICD-10 are presented in Table 8.5. Children with receptive delays only are very rare. In addition to these distinctions, it is useful to describe language difficulties in terms of phonology, semantics, syntax, pragmatics and fluency.

Up to 17 per cent of 2-year-olds, 8 per cent of 3-year-olds, and 3 per cent of 5-year-olds have expressive language delay. The male: female ratio is between 3:1 and 5:1. The majority of children with specific language delay recovers by 5 years of age and has few later adjustment problems (Whitehurst and Fischel, 1994).

Between 2 and 3 per cent of 6–7-year-olds have phonological disorders, but most outgrow these problems, and only 0.5 per cent of 17-year-olds present with this problem, which is more prevalent in boys than girls. The vast majority of children with phonological problems in the pre-school years have no later academic or adjustment problems (Whitehurst and Fischel, 1994).

The prevalence of stuttering among children is about 1 per cent and it is three times more common among boys than among girls. Up to 60 per cent of cases recover spontaneously before the age of 16 years (American Psychiatric Association, 1994).

Co-morbid conduct problems are common among children with specific language delays, particularly children with severe receptive-expressive disorders. Baker and Cantwell (1982) found that conduct problems occurred in up to 95 per cent of cases of specific receptive expressive language disorder, 45 per cent of cases of expressive language disorder, and 29 per cent of cases of articulation disorder.

Specific reading retardation is common among children whose specific language disorder persists beyond the pre-school years. Bishop and Adams (1990) found that specific reading retardation occurred in only 3–7 per cent of children with specific language delay whose language problem resolved by 5.5 years of age. However, 35–46 per cent of cases with persistent specific language disorders developed specific reading retardation at school.

Assessment and intervention

Psychological assessment of language problems should ideally be conducted by a multidisciplinary team. A full pediatric assessment of the child should be conducted to detect the presence of problems such as otitis media and to rule out the presence of neurological and medical conditions such as Duchenne muscular dystrophy. An audio-logical examination should be conducted to rule out hearing impairment.

In addition to routine interviewing, observation and completion of behavior checklists and adaptive behavior scales, assessment should involve the administration of standardized

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receptive and expressive language tests along with a measure of non-verbal intelligence. Where measures of non-verbal intelligence, receptive and expressive language, and adaptive behavior all fall to standard deviations below the mean (or a standard score of 70), then the language problem is secondary to intellectual disability. Where the non-verbal intelligence score is within the normal range, and receptive or expressive language quotients fall 1.5–2 standard deviations below average, a diagnosis of specific language disorder may be made and reference should be made to diagnostic criteria.

Specific language delay may be distinguished from the following three syndromes (Bishop, 1994):

• Autism

• Landau-Kleffner syndrome

• Elective mutism.

Specific language delay may be distinguished from autism by a number of features. Autistic children show more echolalia, pronominal reversal, stereotyped utterances and lack of gesture undue sensitivity to noise and lack of imaginative play.

Specific language delays which are present from birth are distinguished in ICD-10 from acquired aphasia with epilepsy (Landau-Kleffner syndrome). In this syndrome, a child with normal cognitive and linguistic skills loses expressive and receptive language skills while retaining normal intelligence. Concurrently there are EEG bilateral temporal lobe abnormalities and seizures consistent with a diagnosis of epilepsy. The onset of the Landau-Kleffner syndrome occurs between ages 3 and 7. About a third of cases recover and two-thirds retain a severe mixed receptive-expressive language disorder. The cause of the disorder is unknown but it is presumed to be due to an inflammatory encephalitic process.

Specific language delays and Landau-Kleffner syndrome should be distinguished from elective or selective mutism. This is a condition in which the child's speech and language abilities remain intact but are not used in particular circumstances for psychosocial reasons. Typically, children with this condition speak to family members and close friends privately in the home but not to teachers or to people in public. The parents may be asked to tape record a private conversation with the child, and this provides sufficient information to make the differential diagnosis. A family-based approach to the management of this condition has been described elsewhere (Carr, 1997).

In cases of specific expressive language disorder, there is little evidence to suggest that preschool interventions add much to recovery rates, which occur due to maturation (Bishop, 1994; Whitehurst and Fischel, 1994). Parents may be given this information, and advised not

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to try to coerce the child to talk and to accept that intervention may be offered if no improvement has occurred by the time the child has reached 5 years of age. However, behavioral parent training may be offered to help parents manage co-morbid conduct problems.

Autism and pervasive developmental disorders

Autism and other pervasive developmental disabilities entail substantial social, communicative and behavioral problems (Cohen and Volkmar, 1997). The early and accurate identification, evaluation, and management of children with these problems are essential. Working in partnership with parents and teachers is central to good practice in this area. As youngsters move towards adulthood, promoting skills for independent living, in so far as that is possible within the constraints entailed by the disability, becomes the primary goal. The outcome for children with autism is poor. Up to 60 per cent are unable to lead an independent life and only 4 per cent reach a stage where they are indistinguishable from normal children (Gilberg, 1991). Children with a non-verbal IQ in the normal range and some functional language skills at the age of 5 have the best prognosis. However, underestimating the potential of children with pervasive developmental disorders to develop life skills is the major pitfall to be avoided. Catherine Maurice's account of how she used behavioral methods to help two of her own children achieve a high level of functioning should offer hope for parents and professionals who treat children with this disorder (Maurice, 1993).

Classification and epidemiology

Children who show extremely marked abnormalities in their capacity for reciprocal social interaction, in communication and language development, and in the development of symbolic play, and in addition display restricted, repetitive patterns of activities and interests from infancy, are classified within ICD-10 and DSM IV as having pervasive developmental disorders. Autism, first described by Leo Kanner in 1943, is the most common of these disorders, with a prevalence rate of 2–5 per 10,000. The male: female ratio for autism is 3 or 4:

1. While the syndrome of autism will be the central focus for this chapter, a number of other less common pervasive developmental disorders listed in both ICD-10 and DSM IV deserve some elaboration (Volkmar, Klin, and Cohen, 1997). Asperger's syndrome, like autism, is characterized by abnormalities in reciprocal interactions and restricted, repetitive patterns of activities and interests. However, it differs from autism in so far as no delay in language

development or intellectual development occurs. Often people with Asperger's syndrome have outstanding memories for facts and figures (Klin and Volkmar, 1997).

Rett's syndrome, like autism, is also characterized by abnormalities in social and language development and accompanied by repetitive behavior patterns. However, it is not evident from birth. Rather, the onset of the disorder occurs at between 5 and 30 months and is accompanied by a deceleration in head growth. Among the most noticeable features are the loss of purposeful hand movements and the development of stereotyped hand-washing movements. Severe or profound intellectual disabilities accompany Rett's syndrome and epilepsy occurs in most cases before adolescence. The syndrome has only been observed in girls (Van Acker, 1997).

Childhood disintegrative disorder (or Heller's syndrome) entails the social, communicative and behavioral features of autism but follows a period of normal development of at least two years (Volkmar, Klin, Marans, and Cohen, 1997).

It may be seen that DSM IV provides a further category for pervasive developmental disorders not otherwise specified, while ICD-10 provides four additional undefined categories to classify cases that do not fit into four fairly well-defined syndromes. These additional categories have little validity.

Diagnosis and clinical features

A triad of deficits typifies most autistic children (Volkmar, Klin and Cohen, 1997). These are often called Wing's triad, after the eminent researcher Lorna Wing. These deficits occur in social development, language and behavior, particularly imaginative or make-believe play. Abnormalities in social behavior which first appear in infancy include the absence of eye-to-eye signaling; the absence of the use of social or emotional gestures; a lack of reciprocity social relationships; attachment problems such as an inability to use parents as a secure base; little interest in peer relationships; lack of empathy; and little interest in sharing positive emotions such as pride or pleasure with others. Language development in autistic children is usually delayed, and the language of autistic children is characterized by a variety of pragmatic abnormalities including pronominal reversal, echolalia, neologisms and speech idiosyncrasies. With pronominal reversal, the child uses the pronoun you in place of the pronoun I. With echolalia, the child repeats the exact words that someone has said to him with the same intonation. Autistic children rarely engage in extended conversations focusing on social or affective topics and display little creativity in language use. The behavior of autistic children is characterized by stereotyped repetitive patterns and confined in its range

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by the restricted interests that most autistic children display. There is also a strong desire to maintain routines and sameness and a resistance to change. Imaginative or make-believe play is virtually absent.

In addition to these social, linguistic and behavioral deficits, children with autism may have a variety of associated features, particularly in the affective, cognitive and physical domains, deserving clinical inquiry. The affective and emotional expressions of autistic children are typically inappropriate to the social context within which they occur. Intense tantrums and negative emotional displays may occur as an expression of resistance to change. In addition many autistic children have fears and phobias.

In the cognitive domain, it is noteworthy that about 75 per cent of children with autism have IQs below 70 and the characteristic profile is for the non-verbal or performance IQ score to be greater than the verbal IQ. An IQ above 50, especially a verbal IQ above 50, is a particularly significant protective factor associated with a better prognosis. Age-appropriate language development at 5 years is also a good prognostic sign. Some youngsters with autism have islets of ability. For example, they may be able to play many tunes by ear or remember a catalogue of facts. However, the most noticeable cognitive deficit in autism is an inability to solve social or interpersonal problems.

In the domain of physical development, up to a third of autistic children develop epilepsy in late adolescence. Many have elimination problems including encopresis and enuresis. Some also develop physical complications due to self-injurious behavior such as head banging or biting.

Profiling

In profiling strengths and weaknesses of youngsters with autism and other pervasive developmental disorders, it may be useful to categorize them under the following headings (which are not mutually exclusive) for the purposes of treatment planning
• Problem-solving abilities both verbal and non-verbal; academic and life-skills development
• Communication skills and language development
• challenging behaviors such as aggression or self-injury
• Family's coping resources.
These broad categories for profiling strengths and weaknesses map onto the four main classes of goals of comprehensive treatment programs, which are to enhance communicative skills; foster the development of problem-solving skills; decrease challenging behaviors; and help parents to cope with the pervasive developmental disorder (Rutter, 1985c).

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Treatment

There is no cure for autism (Cohen and Volkmar, 1997). At best, youngsters with this condition may be helped to develop skills to compensate partially for their communicative, cognitive and behavioral deficits, and parents may be helped to cope with their children more effectively so that youngsters and their families can lead as normal a life as possible.

Comprehensive programs which exemplify best practice involve the following components:

• Psycho-education in which parents are given information about their child's diagnosis, prognosis and available services

• Advice and support in arranging educational placement

• Family-based approach to long-term management

• structured teaching as a central method for designing learning activities

• Behavior modification as a central approach for teaching skills and dealing with challenging behavior

• Self-care and educational-skills training

• Communication-skills training

• Management of challenging behavior.

The first step in treatment is explaining the diagnosis and making the disorder coherent to parents. The following points may be useful in explaining autism.

Autism is a disorder which is caused by biological factors that are poorly understood. It is a chronic, life-long, neuron-developmental disability, not a time-limited, emotional reaction to a stressful family situation. Children with autism cannot guess what others are thinking or feeling and so cannot predict their behavior. They also have a strong wish to maintain predictable routines and to live in an orderly world. These core difficulties make it hard for them to share attention with others and jointly watch an event. They make it difficult for autistic children to show warmth towards others, to empathize with others, to communicate effectively, to hold conversations which involve turn taking and respecting the other person's viewpoint, and to adapt flexibly to changing circumstances. The desire for predictability may lead to the development of rigid routines and habits that involve repetition. This desire for predictability may lead as well to little creativity. People with autism also have difficulty developing a conscience, since this involves imagining the effect that their actions have on others. The difficulty that people with autism have in imagining what others think is that they may find other people (whom they view as unpredictable) very threatening, particularly if they disrupt their routines. This may lead to aggression towards others who attempt to change

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their routines. Often this aggression is expressed in an extreme way, since the child with autism has little awareness of the impact the expression of aggression has on others. Repetitive self-harm, since it is highly predictable, may be experienced as desirable or pleasurable.

In the long term, with structured teaching and skills training, youngsters with autism can learn to communicate with others, care for themselves, avoid challenging behavior, and manage productive work routines, provided a highly structured approach to teaching is taken which takes account of their need for a highly predictable environment. The degree of independence they gain as adults is dependent upon the level of structured teaching they receive as children.

Autism, Asperger's syndrome, Rett's syndrome, and Heller's syndrome are the principal pervasive developmental disabilities. They entail substantial social, communicative, cognitive, and behavioral problems. The majority of children with these disorders are unable to lead independent lives as adults. While autism and Asperger's syndrome are present from birth, Rett's and Heller's syndromes emerge after a period of relatively normal development during the pre-school years. The prevalence rate for autism, the most common of the pervasive developmental disorders, is 2–5 per 10,000, and it is more common in boys. While psychogenic aetiological theories of autism were popular in the past, the available evidence now suggests that autism is a neuro-developmental disability rather than an emotional reaction to a stressful family environment. Central cognitive deficits in the following areas have been implicated in the development of autistic symptomatology: information processing, social understanding, emotion perception, theory of mind, central coherence and executive function. Currently there is no cure for autism. Diagnostic and compensatory treatment programs are the principal type of intervention offered by clinical psychologists as members of multidisciplinary and multiagency teams. The early and accurate identification, evaluation, and management of children with these problems are essential. Clinicians work inpartnership with parents to enhance children's communicative skills, to foster the development of problem-solving skills, and to decrease challenging behaviors.

PROBLEMS OF MIDDLE CHILDHOOD

Fear and Anxiety Problems

Fear is the natural response to a stimulus which poses a threat to well-being, safety or security. This response includes cognitive, affective, physiological, behavioral and relational aspects (Herbert, 1994; Barrios and Hartman, 1988; Silverman and Kurtines, 1996). At a

cognitive level, the stimulus or situation is construed as threatening or dangerous. At an affective level, there are feelings of apprehension, tension, and uneasiness. At a physiological level, autonomic arousal occurs so as to prepare the person to neutralize the threat by fighting or fleeing from danger. With respect to behavior, the individual may either aggressively approach or confront the danger, especially if she is trapped, or apprehensively avoid it. In the face of extreme threat, however, the person may become immobilized. The interpretation of situations as threatening and the patterning of aggressive or avoidant behavior are both determined by and have an impact on the relational context within which they occur. For children this context usually includes parents, siblings, school teachers and peers. From this analysis, it is apparent that fear is an adaptive response to danger. It is adaptive for the survival of the individual and, from an evolutionary perspective; it is adaptive for the survival of the species.

Development of fears and anxieties

From infancy through childhood into adolescence, the types of stimulus which elicit fear change, and these changes parallel developments in the individual's cognitive and social competencies and concerns (Ollendick, King and Yule, 1994; Klein, 1994; Morris and Kratchowill, 1991). In the first six months, extreme stimulation such as loud sounds or loss of support elicits fear. However, with the development of object constancy and cause-and-effect schemas during the latter half of the first year, a normal concern about separation appears and the child fears strangers and separation from care takers. In the toddler years, during the pre operational period, as the skills required for make believe and imagination develop, but those for distinguishing fantasy from reality are not yet acquired, the child comes to fear imaginary or supernatural creatures. At this time the child's mobility also increases, and she comes to fear potential burglars. In middle childhood, as the child's awareness of the natural world and of the world portrayed by the media develops, she comes to fear natural disasters such as floods or thunder and lightning and to have media-based fears such as those of disease epidemics. In middle childhood, failure in academic and athletic performance at school becomes a source of fear. With the onset of adolescence, which is the period of formal operational thinking, the capacity for abstract thought emerges. The youngster can project what will happen in the future and anticipate with considerable sophistication potential hazards, threats and dangers in many domains, particularly that of social relationships. Fears about peer rejection emerge at this stage.

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A distinction may be made between normal adaptive fears, which are premised on an accurate appraisal of the potential threat posed by a stimulus or situation, and maladaptive fears, which are based on an inaccurate appraisal of the threat to well-being (Ollendick, King and Yule, 1994). Such maladaptive fear is usually referred to as anxiety. With phobic anxiety, the eliciting stimuli are confined to a clearly defined class of objects, events, or situations. For example, a child with a dog phobia may appraise all dogs to be potentially dangerous because they may bite, and experience intense fear when approached by a dog that has been shown to be tame and well trained. With generalized anxiety, the class of eliciting stimuli is less circumscribed and many aspects of the environment are interpreted as potentially threatening, even when there are no reasonable grounds for anticipating danger. Thus the person experiences a high ongoing level of anxiety. Spielberger (1973) has referred to phobic and generalized anxiety as state and trait anxiety. State anxiety is an acute, transient experience which occurs in specific situations. Trait anxiety is a stable, enduring, chronic condition characterized by hyper-arousal. Spielberger (1973) has developed a useful set of self-report questionnaires to measure state and trait anxiety in children.

Phobias

The Revised Fear Survey Schedule (Gullone and King, 1992) is useful for identifying specific fears. When it is clear that the child's anxiety is confined to a specific group of stimuli or situations such as the dark, particular animals, dental treatment, or a specific medical procedure, the child and the parents may be given an explanation of the cognitive, affective-somatic and behavioral components of anxiety. If no clear precipitating event caused the phobia, it is sufficient to say that being frightened of potentially dangerous situations is a good survival skill but that for some children it becomes over-developed and generalizes to situations which are not dangerous for reasons we do not understand. These fears become self-perpetuating when children enter feared situations briefly and then withdraw before their anxiety has reached a peak and begun to subside. The next time the same situation will be even more frightening for them. Treatment following from this understanding of phobic anxiety involves exposure to feared situations until anxiety subsides. Children may be offered the choice of flooding or systematic desensitization as potential treatment options (Silverman and Rabian, 1994). In both treatments children need to understand that they will be required to confront their fear until it dies. They also need to understand that this confrontation will not occur until they have learned the skills necessary to manage the anxiety they will feel in the frightening situation. The pros and cons of

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flooding versus systematic desensitization need to be explored with children and their parents. On the positive side, flooding is a relatively brief treatment and may involve a single 3-hour session.

However, it may be quite distressing. Systematic desensitization is typically far less distressing. However, it is a prolonged treatment and may require six or eight sessions. Where children and parents opt for systematic desensitization, they first work with the psychologist to develop a hierarchy of frightening situations from the most frightening to the least frightening. The hierarchy should contain about 10 steps. For darkness phobia, the hierarchy may include in vivo situations such as lying in bed in the dark with the door open and the landing light on. It may also include imaginal situations such as imagining lying in bed with the light out. Gradations may be included in the hierarchy. For example, lying in bed with the landing light on and the door fully open may be one feared situation. A more frightening gradation of the same situation may be lying in bed with the landing light on and the door half open.

Once the hierarchy has been established, relaxation and coping skills training (as described in the section on general treatment principles) may be conducted. Parental involvement, particularly in supervising home-based practice, is very useful. If it is feasible, children may be offered opportunities to observe a live or video-taped model using relaxation and coping skills to manage anxiety in situations similar to those in their hierarchy of frightening situations. Once this groundwork has been laid, a series of sessions is devoted to exposing children to the feared situations in the hierarchy while in a relaxed state and monitoring their anxiety level on a 10-point scale. If children's anxiety increases noticeably while they are in a frightening situation, they should be prompted to use their relaxation skills and self-instructional skills to manage the anxiety and reduce it to a tolerable level. Social reinforcement should be offered for all efforts to master each of the steps in the hierarchy. In addition a reward system may be used so that a certain number of points are earned for mastering each step in the hierarchy. These points may be accumulated and exchanged for an item from a reinforcement menu.

Home practice may supplement clinic-based treatment. For example, if a child with a fear of needles has managed handling a syringe and needle in the clinic, at home under parental supervision she may be given the task of spending 20 minutes per night handling the needle and syringe or engaging in some activity that involves handling this equipment, such as injecting a doll with water. For young children, the process of desensitisation may be transformed into a series of increasingly challenging games. For example, Mikulas and

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Coffman (1989) describe a desensitization program for fear of darkness in which the child listens to a story about the adventures of Michael (a boy who is afraid of the dark) and Uncle Lightfoot, who helps him to play games which progress from trying to find a toy dog while wearing a blindfold up to searching a dark house for a noisy toy animal. The child then plays this series of games with her parents under the supervision of the therapist as a playful type of desensitization.

Where children and their parents opt for flooding rather than systematic desensitisation, extensive preparation should precede the flooding session. Training in relaxation and coping skills should be conducted and the child should be given an opportunity to observe a live or video-taped model managing the feared situation. Some time should be spent in cognitive rehearsal so that the child enters the flooding situation armed with both a well-rehearsed plan and a set of coping skills for managing the anxiety. In particular the child and parents must be aware that anxiety will escalate during the flooding session, despite the use of coping strategies. It will then reach a peak and gradually decline, and the session will end once a stable low level of anxiety has persisted for an agreed period of time, such as 10 minutes. Adequate time should be scheduled for flooding sessions, since the process may extend over a number of hours and if the child leaves the flooding sessions before the anxiety begins to subside, then the phobia may be exacerbated by the treatment.

Flooding may be completed within a single long session. Sometimes two or three such sessions are required. In each session the child is exposed to a highly feared stimulus and prompted to use relaxation skills and self-instructions to cope with the situation. Throughout each session anxiety is monitored regularly on a 10-point self-report rating scale. Within the flooding sessions, the child may receive social reinforcement or points at fixed intervals for enduring the anxiety and be prompted to use relaxation and self-instructional skills to cope with the anxiety. At the end of the session, if a points system has been used the child should be given an immediate opportunity to exchange the points earned for an item from a reinforcement menu established prior to the session.

Social phobias

The Social Phobia Anxiety Inventory for Children (Beidel et al., 1996) and the Revised Social Anxiety Scale for Children (LaGreca and Stone, 1991) are both useful in the clinical assessment of social anxiety. In assessing children with a social phobia it is worth taking into account the literature on shyness (Asendorpf, 1993). A distinction may be made between unsociability, temperamental shyness, and social-evaluative shyness. These states are distinct

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from social non-acceptance due to excessive aggression. Unsociable children simply have a low need for interaction with others. They are not frightened of social situations and simply prefer a low level of interaction with others. Temperamentally shy children show behavioral inhibition in new social situations, but not with family members or peers whom they know well from an early age, and this characteristic is relatively stable over time. Adjustment of the temperamentally shy or unsociable children depends upon the goodness of fit between their personality attributes and the culture. Children who show social-evaluative shyness are shy in familiar peer-group situations, have low self-esteem and fear non-acceptance by peers.

Both temperamental shyness and social-evaluative shyness may predispose youngsters to developing social phobia. Social phobia is an intense fear of particular social situations and an avoidance of these. The most common stimuli associated with social phobias are public speaking; interacting in social situations; eating, drinking and writing in public; and using public toilets (Beidel and Randall, 1994).

Cognitive and behavioral models of social phobia point to the complexity of the dynamics in this condition and its self-reinforcing nature (Albano and Barlow, 1996; Clark and Wells, 1995). At the heart of social phobia is the belief that one will behave in an embarrassing way in social situations and be negatively socially evaluated by others for doing so. This anxiety compromises youngsters' performance in social situations and confirms their expectations of behaving in an embarrassing way. That is, they blush, stammer, tremble, experience memory blanks and so forth, and others respond to this in negative or ambiguous ways. Socially anxious youngsters interpret these reactions of others as negative evaluation. In response to these types of experience they develop safety behaviors either to modify their embarrassing behavior, so as to create a good impression, or to create avenues for escaping from the scrutiny of others quickly, should they engage in embarrassing behaviors. Safety behaviors involve focusing largely on internal somatic and psychological events rather than outwards on the behavior of others. So the youngsters' self-preoccupation precludes accurately interpreting positive responses of others to their behavior. They selectively attend to the negative reactions of others and after each social interaction ruminate about these. This leads to a confirmation of their beliefs that they are socially inept and have once again been negatively evaluated by others. A vicious cycle develops where in social situations expectations of behaving in embarrassing ways lead to anxiety. This is managed by engaging in safety behaviors and inaccurately monitoring the responses of others. In post-mortems of these events, social phobics interpret the reactions of others as confirming a view of the self as socially inept and likely to be negatively evaluated in the future. It is quite probable that

with children and adolescents, this process is exacerbated by residing in a threat- and danger oriented family culture and by advice from parents and others such as 'Concentrate on relaxing' or 'Think of what you are going to say first and don't say the first thing that comes into your head.' These types of injunction encourage an inward focus and prompt the youngster to engage in safety behaviors.

Concurrent family and group sessions are probably the most useful format for treatment of youngsters with social phobias. In psycho educational sessions the cognitive, affective-somatic, and behavioral aspects of anxiety may be explained in general and then the specific model of social phobia outlined above may be described in family sessions. This provides a rationale for advising parents to reward children for discarding safety behaviors, and for all proactive attempts to increase the number, duration, and quality of their social interactions with peers and others. Where children have developed a constricted lifestyle, family-based sessions may be used as a forum within which to explore ways in which the child can have greater contact with peers by joining clubs, recreational classes, and youth organizations.

Alongside a series of family sessions, a group-based treatment context is particularly useful for the treatment of youngsters' social phobias, since it provides the audience required for exposure to the feared stimulus (the expectation of negative evaluation by others) (Albano and Barlow, 1996). The core of the treatment is to provide the children with repeated exposure to situations in which they speak in front of the group without engaging in inwardly focused safety behaviors for managing anxiety associated with fear of negative evaluation. A hierarchy of 10 increasingly threatening situations may be drawn up and youngsters may be offered opportunities to face these challenges in front of the group and to receive feedback on the adequacy of their performance. Where youngsters lack the social skills for initiating and maintaining social interactions they may be coached in these, so that they have the skills to perform in social situations. Often, one of the primary obstacles to performing well in social situations and receiving positive feedback is a predominantly internal focus and a preoccupation with engaging in avoidant safety behaviors. One way to help children give up these inwardly focused safety behaviors is to offer them video-taped feedback on the heightened social performance associated with not engaging in such inward-focused routines (Clark and Wells, 1995). Early in treatment, one of their episodes of talking to the group is videotaped. During this particular episode they are encouraged to engage in all of the inwardly focused safety behaviors they typically use to manage their fear of negative evaluation. Later in treatment, one of their talks to the group in which they do not use safety behaviors is videotaped. They then view and compare these two video tapes and see that the

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safety behaviors they use to manage anxiety detract from their social self-presentation, and this challenges their beliefs about the value of engaging in such behaviors. As their beliefs in the importance of safety behaviors and their social ineptness weaken, they become freed to be outwardly focused rather than inwardly focused when managing anxiety-provoking social situations, and to be open to positive feedback from these more socially appropriate interactions.

Panic disorder

The Childhood Anxiety Sensitivity Index (Silverman et al., 1991) and the Panic Attack Symptoms and Cognitions Questionnaire (Clum et al., 1990) provide useful information in the assessment of panic attacks. The Panic Attack Symptoms and Cognitions Questionnaire were developed for use with adults, but can be used cautiously with adolescents. It is probably unsuitable for use with children. For secondary agoraphobia the Agoraphobia Scale (Ost, 1990) and the Agoraphobia Cognitions Questionnaire (Chambless et al., 1984) may also be used cautiously in the assessment of adolescents.

There is probably a progression from separation anxiety through to panic disorder for some but not all children, and the quality of panic attacks changes as the child matures from childhood to adolescence (Ollendick, Mattis, and King, 1994; Nelles and Barlow, 1988). Preadolescent children probably attribute panic to external rather than internal factors and so do not catastrophize like adolescents, who have the cognitive maturity to interpret physiological sensations in catastrophic terms. The child says 'When I do an exam my heart beats faster.' The adolescent says 'Even though I know I can do the exam, I notice my heart beating faster. I must be going mad or about to die!' In panic disorder youngsters are aroused by situations they interpret as threatening or by physical exertion and respond with hyperventilation. They perceive the somatic changes that go with hyperventilation as a sign of distress and focus inwardly on these. Their catastrophic cognitions about the somatic changes exacerbate arousal and hypersensitivity. The panic escalates. They develop expectations of recurrence and typically avoid unsafe situations. This normally evolves into secondary agoraphobia. If they do enter an unsafe situation they withdraw before their anxiety reaches a peak and so their avoidance behavior is negatively reinforced. The youngster's family, friends, and physician encourage an inward focus on somatic sensations and avoidance of feared situations. In doing so, they maintain the panic attacks and secondary agoraphobia. This type of understanding of the condition is useful to include as part of

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psycho educational input to parents and youngsters suffering from panic with secondary agoraphobia.

Treatment involves enlisting parental support to help youngsters develop relaxation and self-instructional coping skills, so that they will be able to undergo exposure programs for both feared internal somatic signs of hyper arousal and feared external stimuli, such as being some distance away from the safety of the home. Because of the dearth of studies on the treatment of panic disorder and agoraphobia in adolescents and children, the approach described here is based on evidence which supports the use of family-based approaches with youngsters that have other anxiety disorders, and on the literature which supports the uses of exposure-based approaches to the management of panic disorder and agoraphobia with adult populations (Dadds et al., 1992; Shapiro et al., 1993; Côté and Barlow, 1993).

Relaxation skills training with youngsters who have panic disorder is sometimes complicated by the fact that focusing inward on changes in muscle tension may lead to increased tension rather than relaxation, because of the tendency of youngsters with panic disorder to misperceive internal cues and catastrophize about them. Where this type of problem occurs, visualization may be used as an alternative to progressive muscle relaxation, and youngsters may be invited to focus not on their somatic state but on relaxing imagery.

With self-instructional training, much of the work involves helping youngsters see that misunderstanding the significance of fluctuations in arousal and construing them as dangerous leads to the release of adrenaline and to an escalation of anxiety. In addition, hyperventilation leads to increased arousal. In order to overcome the fear of hyper arousal, the youngster should be given the opportunity to enter into such a state voluntarily by hyperventilating at a rate of 30 breaths per minute, and then to wait and see if some catastrophic event occurs (Barlow and Cerny, 1988). When this is done on a number of occasions, the youngster learns that internal signs of arousal are not harbingers of doom.

Youngsters may then be trained to change their breathing pattern to regular, slow; deep breaths (inhale for a count of three and breathe out for a count of six). This pattern of slow breathing contributes to relieving the symptoms of hyper arousal. It is very useful if the parents are present and participate in supporting the youngster through these very taxing exposure sessions.

When exposure to internal arousal cues has been completed and these cues no longer arouse excessive anxiety, exposure to travelling away from the safety of the home may be conducted. It is most effective to conduct this type of treatment in vivo. A gradual desensitization or complete flooding approach may be used. The pros and cons of both may

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be discussed with the youngster and the parents. With desensitization the youngster and parents construct a hierarchy of about 10 steps, from standing outside the front door of the home to being a few miles away from home. Then arrangements are made for the youngster to enter these situations and remain in them until arousal reaches a peak and then drops to an acceptable level. Self-instructional coping skills and relaxation skills may be used to help the youngster reduce arousal in each of the situations. With flooding, the youngster agrees to travel a long way from the house and remain at this location until arousal reaches peak and subsides. For both gradual desensitization and flooding, the parents or psychologist or both may accompany the youngster on exposure-treatment outings. In both flooding and desensitization sessions, anxiety is regularly monitored on a 10-point self-report rating scale. Where panic disorder and secondary agoraphobia have led to a disruption of the youngster's schooling, liaison with school staff during assessment and when planning the return to school is vital. The same procedures should be used for school liaison as were described in the section on school refusal.

Diagnosis and clinical features

With separation anxiety, inappropriate fear is aroused by separation from an attachment figure. Although not the only cause of school refusal, it is one of the most common causes of this complaint. Separation anxiety with chronic school refusal is a serious condition, since it has such a poor prognosis if left untreated. As many as a third of youngsters with this condition go on to develop panic disorder and agoraphobia (Tonge, 1994).

Phobic anxiety is the intense fear which occurs when faced with an object, event, or situation from a clearly definable class of stimuli which is out of proportion to the danger posed by the stimulus, and leads to persistent avoidance. In DSM IV specific phobias are distinguished from social phobias and agoraphobia. Specific phobias are subdivided in DSM IV into those associated with animals, injury (including injections), features of the natural environment (such as heights or thunder), and particular situations (such as elevators or flying).

With social phobias the principal fear is of being evaluated by other, unfamiliar people and behaving in an embarrassing way while under their scrutiny. Social phobia leads to a constriction of social life. When youngsters experience generalized anxiety, they have an ongoing apprehension that misfortunes of various sorts will occur. Their anxiety is not focused on one particular object or situation. With panic disorder, there are recurrent, unexpected panic attacks. These attacks are experienced as acute episodes of intense anxiety and are extremely distressing. Youngsters come to perceive normal fluctuations in autonomic

arousal as anxiety provoking, since they may reflect the onset of a panic attack. Commonly secondary agoraphobia develops. The youngster fears leaving the safety of the home in case a panic attack occurs in a public setting.

Post-traumatic stress disorder (PTSD) occurs in many children following a catastrophic trauma which the children perceived to be potentially life-threatening for themselves or others. In PTSD children have recurrent, intrusive memories of the trauma that lead to intense anxiety. The children try to avoid this by suppressing the memories and avoiding situations that remind them of

Clinical features in the domains of perception, cognition, affect, arousal, behavior and interpersonal adjustment are given. With respect to perception, the five disorders differ in the classes of stimuli which elicit anxiety. With separation anxiety, the stimulus is separation from the care giver. For phobias it is specific creatures (e.g. animals), events (e.g. injury), or situations (e.g. meeting new people) that elicit anxiety. With generalized anxiety disorder, the person interprets many aspects of her environment as potentially threatening. In panic disorder, somatic sensations of arousal such as tachycardia are perceived as threatening, since they are expected to lead to a full-blown panic attack. With PTSD, internal and external cues that remind the person of the trauma that led to the disorder elicit anxiety. Cognitions in all five anxiety disorders have the detection and/or avoidance of danger as the central organizing theme. In separation anxiety, children believe that they or their parents will be harmed if separation occurs. With phobias, the child believes that contact with the feared object or creature, or entry into the feared situation, will result in harm, such as being bitten by a dog in the case of dog phobia or being negatively judged by strangers in the case of social phobia. With generalized anxiety, children catastrophise about many features of their environment. For example, they may fear that the house will burn down, their parents' car will crash, they will be punished for soiling their clothes, their friends will leave them, and so forth. In panic disorder, the child believes that further panic attacks may be fatal, and often secondary beliefs evolve that lead to agoraphobia; that is, youngsters believe that provided Table 12.2 Diagnostic criteria for separation anxiety disorder in DSM IV and ICD-10 CLASSIFICATION they stay in the safety of the home, the panic attacks are less likely to occur. With PTSD, there is a belief that provided the memories of the trauma are excluded from consciousness, the danger of re-experiencing the intense fear and danger associated with the trauma that led to PTSD can be avoided.

In all five of the anxiety disorders, the beliefs about threat and danger are accompanied by an affective state characterized by feelings of tension, restlessness, and uneasiness. If the child is

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compelled to approach the feared stimuli, outbursts of anger may occur. For example, children with separation anxiety may have aggressive tantrums if forced to remain at school while their mothers leave. A similar display of anger may occur if children with water phobia are carried into a swimming pool by well-intentioned parents trying to teach them to swim. In PTSD, in addition to the affective experiences of uneasiness and tension, an affective experience of emotional blunting, arising from the child's attempt to exclude all affective material from consciousness may develop.

The patterning of arousal varies depending upon the frequency with which the youngster comes into contact with feared stimuli. With separation anxiety, hyper arousal occurs only when separation is threatened, and with specific phobias it occurs only in the presence of the feared object. With generalized anxiety disorder, there is a pattern of ongoing continual hyper arousal. With panic disorder and PTSD, there is a moderate level of chronic hyper arousal punctuated by brief episodes of extreme hyper arousal. These occur in panic disorder during panic attacks and in PTSD when memories of the traumatic.   Avoidance behaviors characterize all anxiety disorders. With specific phobias, these may lead to only a moderate constriction in lifestyle. For example, a child may refuse to engage in sports or athletics or to cycle because of an injury phobia. However, with separation anxiety, generalized anxiety disorder, panicsorder and PTSD, the avoidance behavior may lead the youngster to become house-bound. With PTSD, alcohol or drug abuse may occur. Alcohol and drugs are used to reduce negative affect and suppress traumatic memories.

Interpersonal relationships are affected by different anxiety disorders in different ways. With simple phobias there may be minimal disruption, although conflict with parents, teachers, or peers may occur, where the youngster refuses to conform or co-operate with routine activities so as to avoid the feared stimuli. For example, parent-child conflict may occur if a child refuses to get in an elevator at a shopping mall because of claustrophobia. With separation anxiety, panic disorder, generalized anxiety, and PTSD, complete social isolation may occur and the youngster's peer relationships and school attendance may cease. A more detailed account of each of these five types of anxiety disorder will be given below after a consideration of aetiological theories.

Treatment

General treatment principles

Multi systemic anxiety-management programs should aim to alter maintaining factors and capitalize upon protective factors and include some or all of the following elements:

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• Psycho-education about the nature of anxiety and its treatment

• Training in monitoring symptomatology

• Exposure to feared stimuli until habituation occurs

• Relaxation skills training

• Cognitive restructuring

• Rehearsal following observation of a model for coping with exposure to feared stimuli

• reward systems to increase motivation to follow through on exposure

• Family involvement in treatment

• School involvement in treatment where avoidance is school based

• Individual exploratory work

• Liaison with other professionals, particularly in medicine if there are anxiety-based somatic symptoms

• Referral of parents for treatment of psychological and marital problems if appropriate.

A description of the principles of clinical practice for each of these elements follows. These descriptions are informed by the literature on effective treatments for anxiety disorders and on clinical experience (Ollendick, King and Yule, 1994; Dwivedi and Varma, 1997).

In educating parents and children about anxiety it is useful to explain that anxiety has three different parts: thoughts about being afraid; physical feelings of being afraid; and behavior patterns that help the child avoid the situations of which she is frightened. This may then be elaborated as follows. It is the thoughts of being afraid and the habit of seeing situations as dangerous that are at the root of anxiety. A child who is afraid of dogs sees the dog as a danger, because she automatically thinks of the possibility that the dog could bite her. There is, of course, an alternative. The dog could be seen as a child's best friend. If the child elected to see the dog this way then the child would have no thoughts of being afraid. The physical feelings that follow from the dangerous thoughts are the second part of anxiety. The thoughts of being afraid of a dangerous situation lead to the body getting ready to fight the danger or run from it. This physical part of anxiety (autonomic hyper arousal) involves adrenaline flowing into the blood-stream, the heart beating faster, a quickening of breathing and the muscles becoming tense. The faster breathing may lead to dizziness. The tense muscles may lead to headaches or stomach pains. Sometimes these physical changes, like a racing heart beat, dizziness or pains, are frightening themselves, and this leads to more physical changes. The thoughts of being afraid and the physical feelings that go with them lead the child to try to escape from the frightening situation or to avoid it. This is the third part of anxiety, the behavior patterns that the child uses to avoid frightening situations. If the child is forced to

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CLASSIFICATION face the situation without training, she may become so frightened that she kicks and screams to try to escape. Parents and teachers usually try this forceful approach to help the child face the situation until the fear dies, but then back off when they see how distressing it is for the child. After that, they allow the child to get into a habit of avoiding the frightening situation.

Unfortunately this makes the anxiety worse. What the child needs to learn to master the anxiety is to get into training so that she can handle rising anxiety and then go into the frightening situation and use all her training to cope with it. Treatment involves getting into training for handling anxiety and then facing the frightening situation until the anxiety dies.

In the end, the only way to get rid of anxiety, dangerous thinking, anxiety feelings, pains, dizziness, and avoidance behavior patterns is to go into the frightening situation and stay there until the anxiety dies. Treatment cannot work the other way around. It is not possible to get rid of anxiety and then go into the frightening situation.

Monitoring

Monitoring cognitive, affective-somatic and behavioral aspects of anxiety, and monitoring the use of various coping skills in frightening situations, allow progress through treatment to be tracked by the child, the parents and the psychologist. At the simplest level the child may be trained to identify the affective and somatic experiences that contribute to his discomfort when he is in an anxiety-provoking situation. Each child has his own unique constellation of affective and somatic experiences that underpin discomfort. Some feel anxiety in their stomachs and develop abdominal pains. Others find they hyperventilate and become lightheaded.

Still others become restless and move about in an agitated way. Careful interviewing and the use of drawings, puppets, and metaphors may be used to help children articulate the core affective-somatic component of their anxiety experience. Once this has been identified, children may be invited to rate the intensity of this experience on a 10-point scale when they enter a frightening situation. This scale may also be used during relaxation training to indicate the impact of the relaxation exercises on the child's affective-somatic state.

Children may be trained to identify anxiety-provoking cognitions ('dangerous thoughts') which occur in frightening situations. In family sessions, a series of situations that are ambiguous may be presented and family members may be invited to offer a range of possible threatening and non-threatening interpretations of these situations. This can open up a discussion about habits that family members have for interpreting situations in threatening or

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non-threatening ways and sensitize parents and children to the types of interpretation that they typically make. Kendall (1992) has developed a booklet for use in individual and group therapy contexts that is helpful for teaching cognitive self-monitoring skills (and other skills for anxiety management in children). In one section, it contains cartoons in which the protagonist appears in a range of ambiguous situations which are open to a wide variety of interpretations. The child is invited to write down (in the thought bubble over the cartoon character's head) what the character is thinking. The therapist uses these responses and the fact that there are less danger-oriented alternatives to help the child recognize the role of cognitive appraisal in generating anxiety. Once the child has grasped the idea that situations are open to a variety of interpretations, 'dangerous thoughts' may be monitored along with fear ratings and description of the situations in which they occur. Later the child can be trained to challenge 'dangerous thoughts', to test out alternative interpretations and to reward himself for doing so. The development of Challenge-Test-Reward (CTR) skills is the central focus in the approach to cognitive restructuring for anxiety, which is described below.

Approach and avoidance behavior in frightening situations may be monitored by inviting the child or the parents to note which type of behavior occurs in these situations. For example, with children who have a fear of the dark, whether children sleep in their own beds or their parents' beds may be recorded. For youngsters with agoraphobia, the distance they travel from the house each day may be recorded. For children with a dental fear, the number of minutes they could tolerate sitting in the dentist's chair may be counted.

Coping responses, such as the use of relaxation skills; coping self-statements; self-reinforcement; support from parents, teachers or peers; or reinforcement from parents for approach behavior, may be monitored by asking the child or parent to name the coping strategy that was used in each situation where the child was exposed to the feared stimulus or anticipated such exposure.

This form may be easily simplified by removing one or more columns and such simplified versions may be useful in the early stages of assessment and treatment, particularly with younger children.

Exposure

A central underlying feature of all effective psychological treatments for anxiety is exposure (Ollendick, King and Yule, 1994). That is, in order to overcome the anxiety, the child must be exposed to the feared stimulus until the anxiety subsides. This exposure may involve coping with a graded hierarchy of about 10 increasingly threatening stimuli for relatively

brief periods or facing a highly threatening situation for a protracted period. When the child is exposed to a graded hierarchy of situations and is trained to cope with each situation by using relaxation skills to reduce anxiety, this is referred to as systematic desensitization. 'Flooding' is the term used to describe treatment which involves prolonged exposure to highly feared stimuli. Desensitization sessions are far less stressful than flooding sessions, but usually a greater number of sessions are required for desensitization. The child may be exposed to the actual feared stimuli (in vivo) or to a cognitive representation of the feared stimulus (in imagination). In vivo exposure tends to be the more effective, although it requires more time and organization to set up.

Relaxation training

To manage exposure, the child may be trained in a variety of coping skills, particularly relaxation, cognitive restructuring, and self-reinforcement (Ollendick, King and Yule, 1994). Relaxation skills allow the child to alter physiological arousal level. They may be taught by a psychologist or other professional, by a parent or by a peer, or may be learned from an audio tape. When relaxation is taught to children by their parents under a psychologist's supervision, it has the added benefit of disrupting anxiety-maintaining parent-child interactions. Customized relaxation tapes are a useful adjunct to direct instruction, but relaxation tapes without instruction are of little clinical value.

When coaching parents in relaxation instruction, the process first should be modeled by going through the exercises with the child while the parents observe. Use a slow, calming tone of voice and repetition of instructions as required helping the child achieve a relaxed state. Before and after the exercises check out with the child how relaxed he feels on a 10-point scale, where 1 reflects complete relaxation and 10 reflects extreme anxiety. Most children will report that even on their first trial, they achieve some tension reduction. This should be praised and interpreted to the child and the parents as an indication that the child has the aptitude for developing and refining her relaxation skills. The parents may then be invited to instruct the child in completing the exercises daily and to praise the child for completing the exercises.

For a minority of children, the relaxation exercises lead to increased tension. This may occur because the child is made aware through completing the exercises of body tension that is normally ignored. Alternatively it may occur because focusing attention on somatic processes during the exercises induces anxiety. With youngsters who have had panic attacks, this is particularly common because they are sensitized to construing fluctuations in physiological

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functioning as signaling the onset of a panic attack. In such instances, work on only one or two muscle groups at a time and keep the training periods very short. With some such children it may be necessary to abandon the muscle-relaxation exercises completely and concentrate on training them in visualization or focusing on an external, repetitive, calming visual or auditory stimulus as a means of attaining a relaxed state. The important thing is to find a routine that the child can reliably use to reduce the subjective sense of anxiety as indicated by her status on a 10-point anxiety rating scale.

In such instances, ask the child to describe an alternative relaxing scene, such as being in a wood or on top of a mountain and use this instead. Biofeedback-assisted relaxation is as effective as progressive muscle relaxation in reducing arousal in adults, and this is also probably the case with children (Shapiro and Shapiro, 1982). Portable skin-conductance biofeedback units are now widely available for this purpose. However, biofeedback equipment increases the cost of treatment. It also does not provide opportunities for enhancing parent-child relationships in the way that parent-assisted relaxation training does.

Modeling and rehearsal

Rehearsal, following observation of a model that has used both relaxation and CTR cognitive restructuring skills to cope with exposure to feared stimuli, enhances the learning process (Prins, 1994). The more like the child the model is and the greater the esteem in which the model is held, the better. Because parents (or primary carers) are held in very high esteem and children identify with parents as part of the developmental process, parents may be coached in modeling good anxiety-management skills for their children. Where parents have developed a threat- and danger-oriented family culture, helping them model good day-to-day anxiety-management skills for their children may reduce the impact of the threat-and danger-oriented family culture on their children.

In addition to this family-based intervention, models that are similar to the child may be particularly effective in helping children develop anxiety-management skills. Thus, a child who has had an anxiety problem but resolved it through using relaxation and cognitive restructuring skills during exposure is the ideal model. This type of modeling may be offered within a group therapy program for children with anxiety problems which run concurrently with family-based treatment sessions. Youngsters who have made progress in overcoming their fears may act as models for those who have not yet done so. Alternatively, a video tape of a child coping with exposure may be used as a model. This may be appropriate, for

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example, when dealing with anxiety associated with medical procedures. After observing the model the child may imitate the model's coping processes as a form of rehearsal.

Reward systems

To increase the child's motivation to follow through on the process of exposure to the feared stimuli, a reward system is a key part of most anxiety-treatment plans. The child may receive praise and encouragement for each episode of exposure along with some tangible reward. In addition, points may be given for each episode of exposure and accumulated to obtain items from a reinforcement menu. In developing such a system, a list of exposure situations should be drawn up and ranked in order of difficulty. Points may then be allocated to each situation, with the greatest number of points being earned by coping with the most difficult situation. Alongside this list of exposure situations, a list of desired rewards should be drawn up and rank-ordered in terms of their perceived value to the child. Then the number of points required to earn each of these rewards on the reinforcement menu should be written down opposite the item. The numbers of points required to earn items from the reinforcement menu should be such that the child may accumulate enough points to learn something from the reinforcement menu by successfully coping with three or four anxiety-provoking situations. This type of long-range reward system, which yields weekly rewards, should be used in conjunction with an immediate reward system, where praise and prizes are issued for managing each successful exposure to a feared situation. Once reward systems are in operation, parents may be coached in how to complement them with systematic ignoring of worry-talk, to help the child break the habit of ruminating about harmless events.

Family and school involvement

The chances of treatment gains being maintained are increased if the family are centrally involved in coaching the child in coping skills, managing the exposure process and implementing the reward system (Dadds et al., 1992). This is because this process of family involvement challenges the family's threat-oriented culture if one is present; it disrupts family-based interactional patterns which maintain the child's threat-oriented cognitive set and avoidance behavior; it makes full use of the parents' problem-solving potential; and it provides an outlet for parents' desire to help their child recover. School involvement is important where the child experiences anxiety in school or going to school. School staff may assist with supporting and rewarding the child for exposure to feared school-based situations. This issue will be discussed more fully below in the section on school refusal.

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Individual exploratory work

Youngsters with generalized anxiety disorders or multiple co-morbid anxiety disorders sometimes have a small set of core underlying fears that their basic needs for safety, security, and protection will not be met. These underlying fears may find expression in anxiety about multiple stimuli and situations. In cases where exposure and coping-skills training is ineffective, individual exploratory work may be conducted to identify those core danger related beliefs or fear schemes. This type of work may progress from an initial exploratory review of children's multiple expressed fears. Common themes may be sought by the therapist and the child in a collaborative way so that eventually core underlying fears are identified (Wolfe, 1992). Drawing, art work, play and other media may be used to help youngsters conduct such explorations (O'Connor, 1991). This type of work may provide clearer targets for exposure work and for the use of challenge, test and self-reward skills.

Treatment of specific anxiety disorders

The treatment programs for specific types of anxiety disorder outlined below are premised on the general principles outlined in the previous section. Cases of separation anxiety are typically referred when the child refuses to attend school (Blagg, 1987). The child's underlying belief when separation anxiety occurs is that a catastrophe will occur if the parent and child are separated and this may lead to the parent or the child or both being harmed. This theme may preoccupy the child when faced with the prospect of separation and also recur as a theme in nightmares. Some children experience intense episodes of separation anxiety when they awake from such nightmares and ask to sleep with their parents or siblings. When separation is anticipated or threatened, pronounced hyper-arousal of the autonomic nervous system may occur, resulting in tachycardia, stomach aches, headaches, nausea and vomiting. In some instances children may faint. These physical symptoms commonly lead to many visits to the family doctor and occasionally to pediatric investigations. Children may feel misunderstood and disbelieved when such investigations fail to identify a discrete organic cause for these somatic complaints. Children and parents may interpret such findings to mean that the abdominal pains and headaches are being construed by the medical team to be either imaginary or factitious.

If physically forced to separate from the parent, the child usually becomes tearful and may cling to the parent or try to prevent separation by, for example, locking the car doors if the child has been driven to school. Attempts to force the child to separate may also lead to aggressive tantrums, kicking, screaming, and other dramatic displays of anxiety. Commonly

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such displays result in the child being allowed to remain with the attachment figure and so the child's avoidance behavior is negatively reinforced, thus making it more probable that it will recur. A number of such incidents will typically have occurred before the child is referred for psychological consultation. In other cases, the children will separate from the parents and go to school but be returned home when he appears to be ill with abdominal pains and headaches.

The management of separation anxiety and school refusal is complicated by the fact that it may often begin when the child has a viral condition. Thus, parents and involved professionals may have difficulty interpreting the degree to which initial somatic complaints and those that occur during relapses have a viral basis or are due to anxiety or are a combination of both. Also, simple formulations of the child's behavior as a reflection of organic illness or misbehavior may lead to polarization among parents and involved professionals. Such polarization makes it difficult for parents and professionals to co-operate in helping the child return to school and manage the anxiety.

It is important to mention that not all cases of school refusal reflect separation anxiety. When school refusal occurs in 5- or 6-year-olds at the beginning of primary school it is most commonly associated with separation anxiety. When school refusal occurs at 11 or 12 years of age at the transition to secondary school, both separation anxiety and other factors may be involved. For instance, the child may fear some aspect of the school experience such as being bullied by peers, being victimized by teachers, entering into an unknown environment, fearing academic or athletic failure, and so forth. Later in adolescence, if school refusal occurs it may reflect separation anxiety, avoidance of particularly threatening situations within the school, and also the onset of other psychological problems such as depression, obsessive-compulsive disorder (OCD), Tourette's syndrome or eating disorders. Where a child refuses to go to school, all of these areas deserve careful assessment (Blagg, 1987).

The most effective available treatment for school refusal is a behavioral problem-solving approach which involves all significant members of the child's social network, including parents, teachers and in some instances peers (Blagg, 1987). Blagg's method, which is successful in over 90 per cent of cases, involves first a thorough assessment of factors associated with the child, the family, the school, and the wider professional system that may be contributing to school non-attendance.

Child-related factors include separation anxiety; depression; other psychological adjustment problems; and physical ill health, notably viral infections. Children may also refuse to go to school because of fear of specific events at school. Children with learning difficulties and

attainment problems may develop a fear of academic failure and this may underpin their school refusal. Children with physical disabilities or physical co-ordination problems which lead to poor performance in athletics may refuse to go to school because of their fear of athletic failure. Children with physical characteristics about which they are embarrassed, such as delayed physical maturity or obesity, may refuse to go to school because of fears of being taunted by peers during athletics because of their physical characteristics.

Family factors that may contribute to school refusal include parental confusion, anxiety or anger over the meaning of the child's school refusal and related somatic complaints, and parental conflict about the management of the situation. Parents may inadvertently reinforce school refusal by insisting on school attendance but relenting when the child escalates his protests to a dramatic level. Parents may mismanage school refusal because they derive secondary gains from the child staying at home. For example, the child may provide the home maker (usually the mother) with companionship. Parents may also mismanage school refusal because parental psychological adjustment problems may compromise their capacity to manage the child's difficulties. Such parental problems may include anxiety, depression, substance abuse, or learning difficulties. Wider family stresses such as bereavement, unemployment, separation, birth of a child or moving house may place such demands on parents that they have few personal resources remaining to help their child develop a pattern of regular school attendance. Children from families in which siblings have a history of school refusal may develop school refusal themselves by imitating their older siblings' behavior.

School-based factors which may contribute to the development of school refusal include bullying by peers, victimization by teachers, threatening events occurring while travelling to or from school, poor academic performance, and poor athletic performance.

Fear is the natural response to a stimulus which is perceived as posing a threat to well-being, safety, or security. This response includes cognitive, affective, physiological, behavioral, and relational aspects. A distinction may be made between normal adaptive fears, which are premised on an accurate appraisal of the potential threat posed by a stimulus or situation, and maladaptive fears, which are based on an inaccurate appraisal of the threat to well-being.

Children are referred for treatment of an anxiety problem when it prevents them from completing developmentally appropriate tasks such as going to school or socializing with friends. As children's cognitive abilities develop, the stimuli that elicit normal fear and abnormal anxiety change from the predominantly concrete (e.g. animals) to the more abstract

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(e.g. negative evaluation). The overall prevalence for anxiety disorders in children and adolescents is approximately 2–9 per cent, and in clinical samples there is considerable comorbidity both among different anxiety disorders and between anxiety disorders and other problems, such as those involving conduct or over activity and intentional deficits.

Distinctions are made in DSM IV and ICD-10 between separation anxiety, phobias, generalized anxiety, panic disorder, and PTSD. These different anxiety problems vary in terms of the stimuli that elicit anxiety, the patterning of hyper arousal, the significance of differing aetiological factors in their development, and their impact on interpersonal adjustment.

Biological factors appear to play a role in the aetiology of some anxiety disorders. Genetic factors have been implicated in the aetiology of all of the anxiety disorders with the exception of PTSD. A dysregulation of the GABA system may underpin phobic and generalized anxiety, and abnormalities of the adrenaline and noradrenaline systems may occur in panic disorder.

Somatic problems

Children and adolescents may be referred for psychological consultation with the central focus being a somatic complaint. Somatisation or conversion symptoms; pain; adjustment to chronic illness; and preparation for anxiety-provoking medical and dental procedures are among the more common reasons for referral. In this chapter common childhood problems in each of these areas will be addressed. Other conditions where somatic factors are involved, such as enuresis and encopresis, sensory impairment, head injury, eating disorders, drug abuse and injuries arising from physical abuse, are discussed in other chapters. However, before addressing specific somatic presentations, a consideration of the development of children's concepts of illness and pain will be given and some frameworks within which to conceptualize somatic problems will be presented. From a clinical perspective, the assessment and management of somatization problems and the management of chronic childhood illness must take account of children, conceptions of illness and pain, which evolve as children mature, and the wider psychosocial context within which illness occurs.

Development of the concept of illness
The development of the child's concept of illness is determined by both cognitive maturation and experience of, or exposure to, illness (Bibace and Walsh, 1979). Children's

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understanding of the causes of illness progresses through a series of stages which is, broadly speaking, consistent with Piaget's theory of cognitive development. Prior to age 3 years, illness is defined by children in terms of a single symptom, and the cause of illness is understood to be remote. For example, a child may say that tummy aches are caused by the man on the television. Between 3 and 5 years children still conceive of illness in single-symptom terms, but use the concept of contagion to explain the aetiology of the diseases. So a 5-year-old may explain that you catch measles if you go too near another child who has them. Magical thinking may also occur during this stage, and children may wonder if something that they did caused their illness or if the illness is a punishment for wrong doing. Such magical ideas may persist as a feature of children's thinking into teenage years and, since they can cause unnecessary distress, deserve clinical exploration. With the transition that occurs between 5 and 7 years to concrete operational thinking, most children develop a more sophisticated idea about the symptomatology and aetiology of illness. Most illnesses are construed at this stage as entailing multiple symptoms and being caused by internal processes such as ingesting germs. So children at this stage begin to develop health-related behaviors such as washing their hands before eating to remove germs, or exercising to keep their body healthy. As children approach adolescence and the onset of formal operational thought, they can give detailed physiological explanations of illnesses. So an 11-year-old may say that lung cancer is caused by cells growing too quickly and this in turn is due to their being covered in tar from cigarette smoke. Teenagers can offer sophisticated psychophysiological explanations for the aetiology of illnesses. For example, a diabetic teenager may explain that his blood sugar level is affected by his diet, insulin intake, level of physical activity and stress level.

Development of the concept of pain

The development of the child's concept of pain is affected by both cognitive maturation and the child's experience of pain (McGrath, 1995). Prior to 18 months children can indicate that they are in pain by crying or simple verbalizations but are unable to conceptualize or verbalize different levels of pain intensity. Rating scales rather than self-report scales are probably the best way to assess changes in pain levels in children at this stage of development (McGrath, Johnson et al., 1985). Children of 18 months can verbalize the fact that pain hurts. They can localize pain in their own bodies and they can identify pain in others. They can understand that their experience of pain may be alleviated by asking for medicine or receiving hugs and kisses from careers. They may also try to alleviate pain in others by offering to hug them. At about 2 years more elaborate descriptions of pain occur and children

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can more clearly attribute pain to external causes. By 3 or 4 years of age children can differentiate between differing intensities and qualities of pain and verbalize these. So in assessing children as young as 3, it is possible to ask them about how much pain they feel and how stingy or hot it feels. Poker chips or counters may be used as concrete symbols of pain, and children as young as 3 years may be asked to indicate the intensity of their pain using such concrete symbols (Hester et al., 1990). By 3 years children are also aware that specific strategies such as distraction may be used to cope with pain. So children at this age may be aware of playing and when they hurt themselves they may feel better by distracting them from the pain. Between 5 and 7 years children become more proficient at distinguishing between differing levels of pain intensity and may be able to use face scales to indicate fluctuations in pain experiences (Bieri et al., 1990). On face scales, children indicate the intensity of their pain by selecting, from an array of faces expressing a variety of levels of pain, a face which most closely reflects their own experience of pain. Between the ages of 7 and 10 years children can explain why pain hurts, and once they reach adolescence they can explain the adaptive value of pain for protecting people from harm.

Treatment

Certain general principles for the management of somatic problems may be reduced from the treatment outcome literature and clinical experience (e.g. Campbell and Patterson, 1995; Roberts, 1995; Minuchin et al., 1978; Lask and Fosson, 1989; Sanders et al., 1994). These will be elaborated in this section. In subsequent sections guidance will be given on how these general principles may be adapted for specific types of somatic problem, such as recurrent abdominal pain, headaches or diabetes. A psychological approach to somatic complaints may include one or more of the following elements:
• Close liaison with referring physician
• careful contracting for assessment
• Thorough child and family assessment
• Careful contracting for treatment
• Family-based approach
• psychoeducation
• monitoring of symptoms
• Relaxation-skills training
• Cognitive-restructuring and self-instructional-skills training
• coaching parents in contingency management

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• Relapse-management training

• arranging family membership of a support group.

Liaison with referring physician

Work closely with the referring physician and other members of the medical team including the family physician, the paediatrician, nurses, physiotherapist, and so forth. If possible, clarify the precise question to which the referrer requires an answer. In some instances these questions will be highly specific; for example, a request to help a youngster with diabetes improve adherence to a self-care regime. In others requests may be more global; for example, a request to offer an opinion on the management of a child with recurrent abdominal pains and headaches. If possible, clarify the referrer's views of the somatic problem. For children to resolve somatisation and conversion symptoms, to manage pain, or adhere to complex regimes in managing chronic illness, they need a clear, consistent message from all members of the family and health-care network. Often they receive conflicting and confused messages, with one parent or health-care professional emphasizing the primary role of physiological factors while the other parent and other health-care professionals may define the problem in intrapsychic terms. Given the child's need for clarity and the potential for confusion, it is essential that the referring physician and the psychologist understand each other's positions clearly and work towards a shared view of the problem and a shared management plan.

Contracting for assessment

Parents and children may have difficulty understanding the relevance of a psychological consultation when the chief complaint is somatic. This difficulty may be based on a belief that symptoms are due either to organic factors or to psychological factors. Thus, part of the process of offering a contract for assessment involves inviting families to accept the view that in all illnesses both psychological and physiological factors contribute to the development of symptoms; the perception of symptoms; adherence to management plans; and adjustment to illness-related stresses. It is useful to use concrete examples to illustrate these points. For example, Stresses like changing jobs or going into a new class reduce the efficiency of the immune system in fighting infections.

If people are engrossed in an activity like playing rugby, they may not perceive pain associated with injuries. If youngsters are sad, angry or confused about their illness and its treatment, they may not follow their treatment program properly and so become worse.

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Illnesses may place a strain on all family members, and it may be useful to explore the best way to manage this stress.

If the parents remain confused about the relevance of a psychological assessment, include the referring physician in a further contracting meeting and invite her or him to explain why a purely medical approach to the problem is not in the child's best interests.

Assessment

Supplement this protocol with assessment procedures that have been developed for the specific somatic complaint with which the child presents. Details of areas of inquiry for clinical interviews for a variety of somatic complaints, such as recurrent abdominal pain, headaches, asthma and diabetes, are given later in the chapter. If these assessment procedures suggest the presence of other difficulties, such as learning problems, mood problems, risk of self-harm, possibility of child abuse, or anticipatory grief associated with a life-threatening illness, extend the assessment to cover these issues, which are described in other chapters. Following assessment, construct a formulation outlining the predisposing, precipitating, maintaining, and protective factors for the core problem. Then construct a psychological case management plan based on the formulation. This plan will usually include feedback to the referring physician and appropriate members of the treatment team; feedback to the family; and contracting for further treatment.

Contracting for treatment

If the assessment sessions have been used as an opportunity to build a good working alliance with the child and the parents, and if a shared position has been developed by the psychologist and the other members of the multidisciplinary team, particularly the referring physician, then contracting for further treatment is less likely to be problematic. The most common problem which occurs at this point in the psychological consultation process is that the parents or the child are unable to accept a multi-factorial explanation of the presenting problems which includes both biological and psychosocial factors. The main pitfall to avoid when this happens is becoming involved in a heated argument. Rather, it is most helpful to adopt a position of respectful curiosity, and inquire about the conditions under which they would be able to accept a multifactorial explanation for the problem. In some instances, such acceptance will not be possible, particularly with conversion symptoms, because the loss of secondary gains to the entire family may not be worth giving up the symptom for. If the family accepts the formulation and a contract for further treatment, it may include psycho

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education, individual work for the child focusing on self-monitoring skills and symptom-management strategies, and family sessions focusing on coaching the parents in contingency management and optimizing family support for the child.

Family-based treatment approach

A family-based approach to illness management aims to help family members communicate clearly and openly about the illness, symptoms and related issues; to make clearer family boundaries and increase the autonomy of the child in symptom management; to decrease the emotional intensity of parent-child interactions related to the symptom; to encourage joint parental problem solving with respect to the symptom; to optimize the parents' support of the ill child and siblings; and to optimize parents' use of health-care resources and support groups. To achieve these aims some treatment sessions may be conducted with children to help them develop symptom-management skills such as relaxation exercises, breathing exercises, visualization, distraction, and self-instruction. However, other treatment sessions should involve the parents and siblings, who may become marginalized as family life becomes organized around the ill child.

Monitoring of symptoms

For all somatic complaints, it is useful to train children and/or parents to record information regularly about the symptom, the circumstances surrounding its occurrence, and treatment adherence. Intensity ratings, frequency counts, durations and other features of symptoms may be recorded regularly. Intrapsychic and interpersonal events that happened before, during and after the symptoms may also be noted. The amount of medication used; particular foods that were eaten; particular exercises that were completed; and results of tests such as blood sugar or peak-flow meter readings may all be monitored in standard ways on a regular basis. When inviting parents and children to use a monitoring system, the chances of their co-operating are better if a simple system is used to start out with. Later, more complex versions of it may be developed. For example, children with headaches may record the intensity of their pain three times a day for a week to start out with. Later, when they have become used to the practice of self-monitoring, they may be invited also to record information about medication usage. It may be used to monitor fluctuations in symptomatology and adherence to health-care regimes involving medication, diet and exercise programmes.

Relaxation-skills training

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Stressful events which increase physiological arousal may precipitate, maintain or exacerbate many symptoms including pain, asthma attacks, epileptic seizures and changes in diabetic blood-sugar levels. For this reason, training in tension-reduction skills is a core element of most treatment programs described in this chapter. The progressive muscle relaxation exercises, breathing exercises and visualisation skills may be taught to children who present with somatic complaints.

Cognitive coping strategies

The degree to which children focus their attention on their symptoms; the way in which they evaluate them; and the behavioral and interpersonal patterns that they develop related to their symptoms all influence children's overall psychological adjustment to somatic complaints. In certain situations, it may be appropriate for children to learn to distract themselves from their symptoms by thinking about something else or becoming engrossed in an activity that prevents them from thinking about their condition. Distraction may be useful in coping with various types of pain, particularly recurrent abdominal pain, which may arise from focusing on minor fluctuations in internal physiological states and catastrophising about these. Children may be helped to develop their own distraction routines, such as listening to their favorite music or story on a personal stereo, playing with a favorite toy or reciting favorite poems.

Where children have developed a habit of catastrophising about symptoms or misinterpreting benign bodily sensations, they may be trained to challenge these negative thoughts. In CTR self-instructional training children are invited to challenge these catastrophic thoughts by asking themselves what the other possible interpretations of the situation are; to test out what evidence there is for the catastrophic outcome and the other, less threatening outcomes; and to reward themselves for testing out the less catastrophic interpretation of the situation.

Where children have developed debilitating behavior patterns and interpersonal routines in response to their symptoms, they may be helped to break out of the sick role by planning alternative ways of acting and managing their interpersonal relationships. That is, they may be invited to plan ways to replace illness behavior or pain behavior with well behavior.

Relapse-management training

Recurrence of illness-related adjustment problems is inevitable with chronic conditions such as asthma, diabetes, epilepsy and migraine. Planning how such recurrences will be managed should be covered in the final sessions of a time-limited episode of psychological

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intervention. The child and parents may be helped to envisage how they will use the symptom management skills, contingency-management procedures, and clear communication to manage such relapses.

Support groups

For most chronic illnesses like epilepsy or asthma parents and children benefit from joining a support network of families containing children with similar problems. Such networks provide social support, relevant information on the child's condition, and available resources for its management. In most countries, national organizations for a wide variety of chronic illnesses have been established. Many of these have set up self-help support groups that meet regularly. Some arrange major annual summer camps for children and other highly supportive activities. It is useful to help families with chronically ill children make contact with these organizations and join appropriate support groups.

Recurrent abdominal pain

In recurrent abdominal pain (RAP), repeated stomach aches are the central complaint (Apley, 1975; Sanders et al., 1994; Lask and Fosson, 1989; Bonner and Finney, 1996; Garralda, 1992). RAP may occur as part of a wider constellation of somatic complaints including nausea, vomiting, headache, and limb or joint pains. It occurs in 10–20 per cent of school-aged children and accounts for 2–4 per cent of paediatric consultations. It is most common in the 5–12-year age group and is equally common among boys and girls. Episodes of abdominal pain may vary in length from a few minutes to a couple of hours and the frequency of such episodes may vary from more than one daily to a couple of times a month. Episodes of pain may occur at any time of the day but rarely at night. Sometimes episodes of pain occur in anticipation of separation from parents or going to school. In these instances, it is probable that separation anxiety is the central difficulty. A full paediatric examination and laboratory investigations must be normal for a diagnosis of RAP to be made. RAP often begins with an episode of gastrointestinal illness with abdominal discomfort as one of the symptoms. There are three main courses for the condition: about a third of children with RAP have a good prognosis, about a third develop chronic tension or migraine headaches, and about a third continue to have recurrent abdominal pain.

The causes of RAP are still unclear and available evidence has not identified a single constellation of aetiological factors. However, clinical observations and the results of small, uncontrolled studies have led to many interesting hypotheses (Apley, 1975; Sanders et al.,

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1994; Lask and Fosson, 1989; Bonner and Finney, 1996; Garralda, 1992). Abnormal physiological processes which have been suggested to make children vulnerable to the condition include decreased gastrointestinal motility, chronic stool retention, lactose intolerance and irritable colon. Stressful life events have been posited as a possible aetiological factor for RAP. Anxiety, depression, difficult temperament, fastidiousness, high achievement orientation, dependency, and inadequate coping strategies are the principal personal characteristics that have been observed in some instances to characterize children with RAP. Hypotheses implicating parental anxiety, depression, preoccupation with health concerns, a family history of illness, and patterns of family interaction that reinforce illness behavior have also been mentioned in the literature.

Treatment

Results of the assessment should be integrated into a concise formulation where predisposing, precipitating, maintaining and protective factors are specified. A case-management plan based on the formulation may then be developed. Such an intervention plan should be family based and may include psycho-education, pain-management-skills training and contingency management. A well-designed, controlled treatment-outcome study, using such a package, has shown that this type of behavioral family therapy is more effective in the management of RAP than routine paediatric care is (Sanders et al., 1994). Such family-based behavioral programs may usefully be supplemented with increased dietary fiber. A controlled trial of increased fiber showed that it can lead to a significant reduction in RAP (Feldman et al., 1985). Such dietary interventions should be arranged in consultation with a dietician.

Psycho-education treatment

Psycho-education should begin by affirming the reality or validity of the child's experience of pain and dispelling the idea that because no current, identifiable, physiological basis for the child's pain can be found, the pain is therefore not real, feigned, imaginary or a sign of serious psychological disturbance. All pain has both a physical basis and a psychological basis. Physical factors that cause pain include muscle tension, tissue damage and infection. Psychological factors include the attention we give to the pain and our reactions to the sensations we perceive. Here is an example that may be used to explain the role of physical and psychological factors in pain perception. A sailor who is injured while sail-boarding in high winds may feel no pain because he pays little attention to the sensation caused by the tissue damage. The same person may experience excruciating pain for weeks following a

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stomach upset, because he expects to feel such pain and directs attention to the stomach. Thus, children with RAP usually have begun with a pain determined largely by gastrointestinal infection, tension or tissue damage. This pain then persists because they expect it to and the expectation may cause tension, which leads to further pain and patterns of behavior that are used to deal with the pain, like focusing on the pain, talking about it, and not engaging in distracting activities like playing or going to school. RAP and the patterns of behavior associated with it, both the child's and the parents', are like bad habits. RAP can therefore be managed like a habit. The child may be trained in skills to reduce tension and be distracted from the pain. The parents may be coached in how to reward the child for using these pain-management skills.

Pain-management skills

Pain-management skills include self-monitoring; progressive muscle relaxation; breathing exercises; visualization; positive self-instructions; and distraction by engaging in competing activities. This allows the youngster to see the links between the occurrence of the stomach pains, precipitating specific situations, and possible reinforcing events that follow from the occurrence of the pains. She also learns what internal dialogues are associated with the occurrence of the pains.

The muscle relaxation, breathing and visualization exercises for anxiety control may be used with children who have RAP. Youngsters may be trained to use the CTR approach to cognitive restructuring also described in Chapter 12 to help them cope with pain-inducing cognitions. They may learn as well to praise themselves when they cope with pain successfully, by relaxing, challenging pain-inducing thoughts, or distracting themselves. Finally, youngsters may be helped to plan lists of competing activities in which they may engage when they experience pain.

Contingency management

Parents may be trained to reinforce all well behavior with praise and a structured reward chart points system. They may also be trained to ignore non-verbal pain behavior and respond to verbal complaints of RAP pain by prompting the child to use pain-management skills. With non-RAP pain, parents should be encouraged to respond with appropriate care and attention.

Relapse management

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In the final sessions, relapse management may be discussed and families may be encouraged to plan strategies for managing recurrences of abdominal pains. Sanders et al. (1994) found that two key sets of skills that parents and children learned from behavioral family therapy using a program like this predicted a positive response to treatment. These were the children's use of pain-control skills and parents' use of contingency management skills. When RAP occurs as part of a school-refusal syndrome, and extreme anxiety accompanies early-morning episodes of abdominal pain, the approach to assessment and treatment for school refusal is more appropriate than the protocol offered here.

Conversion symptoms

Conversion symptoms are motor or sensory symptoms which occur in the absence of a clearly identifiable underlying organic pathology or injury (Garralda, 1992). With conversion symptoms, usually following an injury, illness or accident in which a sensory or motor function was impaired, loss of function continues despite the absence of an organic basis for the continued dysfunction. The presentation mimics the child's conception of a disorder.

Thus, children who develop conversion symptoms have often been sensitized to health problems through family- or school-based experiences. The dysfunction may not correspond to the known anatomical pattern of innervations of the affected organs. For example, children may present with glove or stocking anaesthesia. Common examples of conversion disorder in children include limb pain with gait abnormalities; numbness or paralysis (following limb injury or accident); chronic cough (following influenza); and pseudoseizures (with epilepsy).

Both parents and children are usually strongly opposed to a psychological explanation for the physical symptoms and point to the genesis of the disorder in a well-founded organic illness or physical injury. Conversion symptoms rarely occur in children under 7 years of age. Where children present with physical and mental fatigue as the core symptoms and an accompanying low mood and low activity levels, the most common current terms for such conditions are post-viral fatigue syndrome or myalgic encephalomyelitis. Latterly the condition was known as neurasthenia, although in ICD-10, neurasthenia is distinguished from post-viral fatigue syndrome. Fatigue syndromes may develop during a viral illness but remain after the illness has cleared. Typically medical and laboratory investigations are negative. The degree of disability shown by children suffering from fatigue syndromes is extraordinary and may exceed that shown by children with juvenile arthritis or cystic fibrosis (Garralda, 1996).

The aetiology of fatigue syndromes is poorly understood. A build-up of life stress and consequent immune-suppression as a possible explanation is currently receiving some

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attention (Garralda, 1996). Others argue that fatigue syndromes are best conceptualized as a conversion disorder and treated accordingly (Lask and Fosson, 1989).

Three hypotheses, elaborated in an earlier section of this chapter, drawn from the psychodynamic, family therapy and behavioral traditions, are particularly useful in the clinical management of conversion symptoms (Garralda, 1992; Lask and Fosson, 1989; Sarafino, 1994; Wood, 1994). These are that conversion symptoms allow the child to avoid a feared or conflictual situation; that they permit the expression of aggression, dependency or other strong emotions, which the child perceives to be prohibited within the family context; and that they are maintained by the way in which the child is treated by family members and other members of the child's social network.

PROBLEMS IN ADOLESCENCE

Drug Abuse

Habitual drug abuse in adolescence is of particular concern to clinical psychologists because it may have a negative long-term effect on the adolescents and an intergenerational effect on their children. For the adolescent, habitual drug abuse may negatively affect mental and physical health; criminal status; educational status; the establishment of autonomy from the family of origin; and the development of long-term intimate relationships (Newcomb and Bentler, 1988). The children of habitual teenage drug abusers may suffer from drug-related problems such as foetal alcohol syndrome, intrauterine addiction or HIV infection (Pagliaro and Pagliaro, 1996).

Cases of drug abuse vary widely in their presentation. These cases differ along a number of dimensions including the pattern of drug-using behavior; the types of drug used; the impact of the drugs used; the overall personal adjustment of the teenager; and the presence of other personal or family-based problems. Clearly drug abuse itself is not always a unidimensional problem and it may occur as part of a wider pattern of life difficulties. The definition and classification of drug abuse is therefore a complex challenge. In this chapter, after considering the classification, epidemiology and clinical features of drug abuse, a variety of theoretical explanations concerning its aetiology will be considered along with relevant empirical evidence. The assessment of drug abuse and a family-based approach to treatment will then be given. The chapter will conclude with some ideas on how to prevent drug abuse in populations at risk.

Classification

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To deal with the extraordinary complexities of defining and classifying drug-related problems, in DSM IV and ICD-10 drug problems are classified on Axis 1 on the basis of the following three parameters:

• The behavioral pattern of use

• The effects of the drug when it is taken or unavailable

• The type of drug used.

Related life stresses and overall level of adjustment are rated on other axes. Within both ICD-10 and DSM IV a distinction is made between drug dependence and drug abuse. While drug abuse refers to drug taking that leads to personal harm, drug dependence refers to those situations where there is a compulsive pattern of use that may involve physiological changes that accompany the phenomena of tolerance and withdrawal. In both DSM IV and ICD-10 distinctions are made between the effects of drugs that occur immediately after they are taken (intoxication); when they are unavailable after habitual use (withdrawal); and when they lead to certain types of symptom (for example, delirium, anxiety or psychosis). Each drug leads to characteristic intoxication and withdrawal syndromes. These are not documented in ICD-10.

Epidemiology

Experimentation with drugs in adolescence is common (Schinke et al., 1991; Farrell and Taylor, 1994). Major US and UK surveys have shown that by 19 years of age approximately 90 per cent of teenagers have drunk alcohol; 60 per cent have tried cigarettes; 50 per cent have used cannabis; and 20 per cent have tried other street drugs such as solvents, stimulants, hallucinogens or opiates. The prevalence of drug abuse and dependence is harder to gauge and varies with the population studied and the definitions used. A conservative estimate based on a review of available surveys is that between 5 per cent and 10 per cent of teenagers under 19 have drug problems serious enough to require clinical intervention. These epidemiological results show that less than half of those youngsters who experiment with street drugs go on to develop serious drug-abuse problems.

Clinical features

Because of the heterogeneity of states, stages and types of drug abuse, outlining a concise set of salient clinical features is problematic. However, some guidelines may be offered on the behavioral, physiological, affective, perceptual, cognitive and interpersonal features deserving attention in the assessment of cases of substance abuse (Bailey, 1989; Schinke et al., 1991; Buckstein, 1995; Farrell and Taylor, 1994; Pagliaro and Pagliaro, 1996). Drug

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abuse is associated with a wide variety of behaviour patterns. These patterns may be described in terms of the age of onset; the duration of drug abuse; the frequency of use; the range of substances used; and the amount used. Thus useful distinctions may be made between adolescents who began abusing drugs early or later in their development; between those who have recently begun experimenting with drugs and those who have a chronic history of drug abuse; between daily users, weekend users, and occasional users; between those that confine their drug abuse to a limited range of substances such as alcohol and THC and those that use a wide range of substances; and between those who use a little and those who use a great deal of drugs. Chronic and extensive daily poly drug abuse with an early onset is associated with more difficulties than experimental, occasional use of a limited number of drugs with a recent onset. The former usually entails a constricted, drug-focused lifestyle and multiple associated physical and psychosocial problems, whereas the latter does not. A consistent finding is that only a minority of youngsters progress from experimental to habitual drug abuse and from the use of a single legal drug to multiple legal and illegal drugs. Behavioral patterns of drug abuse evolve within specific contexts and drug-using behavior often comes to be associated with particular locations, times, modes of administering the drug, physiological states, affective states, control beliefs and social situations. With recreational experimental drug use, weekly oral drug taking at peer-group gatherings while in a positive mood state may occur and youngsters may have strong beliefs that they are in control of their drug-taking behavior. With habitual drug abuse, solitary daily injections to prevent withdrawal and alleviate negative mood may occur. This type of drug abuse may be accompanied by strong feelings of being unable to control the frequency of drug abuse or to cut down on the amount taken.

Physiological features of drug abuse may be grouped into those associated with intoxication; those that follow intoxication; those associated with withdrawal following the development of dependence; and medical complications which arise from drug abuse. It may be found that, broadly speaking, stimulants and hallucinogens lead to physiological changes associated with increased arousal such as tachycardia and blood pressure changes. In cases of extreme intoxication, cardiac arrhythmias and seizures may occur. On the other hand, extreme intoxication following the use of alcohol, sedatives, solvents and opioids leads to physiological changes associated with reduced arousal such as drowsiness, stupor and coma. Withdrawal from dependence-producing stimulants entails significant disruption of sleep and increased appetite. Withdrawal from sedatives and alcohol is particularly dangerous because, as part of a syndrome of autonomic hyperactivity, grand mal seizures may occur. Withdrawal

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from opioids leads to a syndrome characterized by nausea, vomiting, diarrhoea and muscle aches. There is a wide variety of medical complications associated with drug abuse, and these range from injuries sustained while intoxicated, through liver or kidney damage due to the toxicity of substances abused, to infections including hepatitis and HIV arising from non-sterile injections. With all street drugs there is a risk of death by intentional or accidental overdose or poisoning due to impurities in the drug.

A central reason for many forms of drug abuse is to induce pharmacologically a pleasant affective state. It is therefore not surprising that for many drugs, including alcohol, stimulants, hallucinogens, and opioids, elation is a central feature of initial intoxication. With sedatives, in contrast, intoxication leads to apathy. Many polydrug abusers refer to drugs by their primary mood-altering characteristics. Thus, a distinction is made between uppers and downers, and particular cocktails of drugs or sequences of drugs are used to regulate mood in particular ways. Negative mood states typically follow intoxication, for most classes of drugs. This is particularly true for drugs such as opioids or cocaine that lead to tolerance and dependence. The intense negative mood states which characterise withdrawal syndromes associated with such addictive drugs motivate habitual drug abuse. The health problems, financial difficulties and psychosocial adjustment problems that evolve as part of habitual drug abuse may also contribute to frequent and intense negative mood states, and paradoxically motivate drug abusers to use more drugs to improve their mood state. Negative mood states typically include some combination of depression, anxiety and anger. At a perceptual level, some types of drug, but particularly hallucinogens, lead to pronounced abnormalities during intoxication and withdrawal. In the 1990s widely used hallucinogens include LSD (known as acid) or MDMA (known as E). The hallucinations and perceptual distortions that occur during intoxication are not always experienced as pleasant.

Drug abuse may have an impact on interpersonal adjustment. Within the family, drug abuse often leads to conflict or estrangement between adolescents and their parents. At school, drug abuse may lead to conflict between the adolescent and teachers both because of declining academic performance and because of antisocial behaviour, such as theft or aggression, associated with drug abuse. Youngsters that abuse drugs within a peer-group situation may become deeply involved in a drug-oriented subculture and break ties with peers who do not abuse drugs. Some youngsters develop a solitary drug-using pattern and become more and more socially isolated as their drug using progresses. Within the wider community, drug related antisocial behaviour such as aggression, theft and selling drugs may bring youngsters into contact with the juvenile justice system. Drug-related health problems and drug

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dependency may bring them into contact with the health service. Conflict between drug abusers and health-care professionals may arise in situations where youngsters expect to be offered prescribed drugs (such as methadone) as a substitute for street drugs (such as heroin) and this does not occur.

Drug abuse often occurs with other co-morbid psychological problems including conduct disorder, ADHD, specific learning difficulties, mood disorders, anxiety disorders, schizophrenia and bulimia. The relationship between these co-morbid psychological problems and drug abuse is complex. Any or all of them may precede drug abuse and contribute in some way to the development of drug-using behaviour. In addition, drug abuse may precipitate or maintain these other psychological problems. For example, the use of hallucinogens may precipitate the onset of schizophrenia. Chronic polydrug abuse may lead to learning difficulties and chronic alcohol use can lead to amnesic syndrome. Amphetamine usage may lead to anxiety problems. Drug dependence may lead to chronic conduct problems such as assault and theft. Negative drug-related experiences, such as losses and drug-related accidents, may lead to mood disorder, which in turn may lead to further drug use. Drug abuse is also an important risk factor for suicide in teenagers.

Treatment

In a review of methodologically robust studies, Liddle and Dakof (1995a, 1995b) concluded that a multi-systemic approach to drug abuse, involving family-based intervention and individual therapy, is the most effective available treatment for adolescent drug abusers. Multi-systemic family-based approaches have been shown to be effective for engaging abusers and their networks in therapy; for reducing drug abuse; for improving associated behavior problems; for improving the overall family functioning; and for preventing relapse.

A central assumption of family-based intervention is that drug abuse is maintained by inappropriate patterns of family functioning. For example, in some of the best-controlled studies of family therapy for adolescent drug abusers, Szapocznik and Kurtines (1989) found that drug abuse was associated with a lack of clear parental alliance and intergenerational boundaries between the drug abuser and the parents; a lack of flexibility in problem-solving strategies or chaotic problem-solving strategies; a lack of conflict-resolution skills; extreme enmeshment or disengagement; difficulty negotiating a lifecycle transition such as a family member leaving home; and a family perception of the drug abuser as a problem independent of the pattern of interaction around him. These patterns may include criticism, overprotection,

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excessive nurturance, excessive attention, or denial of all other problems. Family-based intervention aims to reduce drug abuse by engaging families in treatment and helping family members change these patterns of family functioning in which the drug abuse is embedded. Effective family-based treatment programs for adolescent drug abuse involve the following processes, which, while overlapping, may be conceptualized as stages of therapy (Stanton and Heath, 1995):

• Engagement, problem definition and contracting

• becoming drug free

• facing denial and creating a context for a drug-free lifestyle

• Family reorganisation

• Disengagement.

What follows is an outline of how to work with adolescents and their families using this framework.

The engagement stage

During the engagement phase, the goal is to develop a strong working alliance with a sufficient number of family members to help their adolescent change his drug-using behavior. The engagement process begins with whoever comes for treatment concerned that the adolescent stop using drugs. From that person's account of the drug abusers' problem and the pattern of interaction in which it is embedded, other family members who are central to the maintenance of the problems or who could help with changing these problem-maintaining patterns may be identified. The psychologist may then ask about what would happen if these other people attended treatment. This line of questioning throws light on aspects of resistance to engagement in treatment.

Often those family members who attend initially (for example, the mother or the drug abuser or the sibling) are ambivalent about involving other family members in treatment. They fear that something unpleasant will happen if other family members join the treatment process. Adolescents may fear that their parents will punish them. Mothers may fear that their husbands will not support them or that they will punish the adolescent. Fathers may fear that their wives will mollycoddle the adolescent and disregard their attempts at being firm. The task of the psychologist is to frame the attendance of other family members in a way that offers reassurance that the feared outcome will not occur. The seriousness of the problem may always be offered as a reason why other family members will not do that which is feared. So the psychologist may say:

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Joey isn't here. But from what you say, at some level, he is very concerned about this drug problem too. Because we all know that there is a risk of death here. Death from overdose, AIDS, or assault is very, very common. Most families I work with are like you and Joey. They put their differences to one side to prevent the death of one of their own. So let's talk about the best way to invite Joey to come in. The discussion then turns to the most practical way to organize a meeting. This may involve an immediate phone call, a home visit, an individual appointment for the resistant family member outside office hours, or a letter explaining that the psychologist needs the family member's assistance to prevent further risk to the drug-abusing adolescent.

In each meeting with each new member of the network, the psychologist adopts a non-blaming stance and focuses on building an alliance with that family member and recruiting her or him into treatment to help deal with the drug abuse. Many parents are paralyzed by self-blame and view family-based treatment as a parent-punishing process. Often this self-blame is heightened as it becomes apparent that patterns of family interaction are maintaining the drug-using behavior. The psychologist must find a way to reduce blame while at the same time highlighting the importance of the family being engaged in treatment. Here is one way to do this:

You asked me are you to blame for Sam's addiction. No you are not. Are there things you could have done to prevent it? Probably. But you didn't know what these were. If you don't know this part of Dublin and you park below the bridge, and when you go back to your car there is a dent in it, are you to blame for the dent? No. Because you didn't know it's a rough area down there. But the next time, you are responsible, because you know parking there is bad news. Well, it's the same with drug abuse. You're not to blame for what happened. But you are partly responsible for his recovery. That's a fact. Drug abuse is a family problem because your child needs you to help recover. You can help him recover. You can reduce the risk of his death. I know you sense this and that's why you're here.

The engagement phase concludes when important family members have agreed to participate in a time-limited treatment contract with the goal of the adolescent becoming drug free. Useful specific strategies for engaging youngsters and parents in treatment have been described by Liddle (1995). Begin by identifying the youngster's and parents' agendas, which may be quite different. Youngsters may wish to be understood and taken seriously, to learn better street survival skills, or to resolve parent-adolescent conflicts. Parents may wish their youngsters to stop taking drugs, pursue their education, and conform to parental house rules.

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Concreteness and specificity in identifying such agendas or goals is critical. Assume that youngsters and parents will have difficulty forming a good working alliance and engaging in treatment with very good reason. Youngsters with extensive treatment histories and parents with a history of failing to help their youngster may be wary of being pathologized, judged and misunderstood. Thus, an approach that privileges their viewpoint and the identification of their strengths and potential, and de-emphasizes their deficits, will facilitate engagement. Engagement of parents is enhanced by allowing ample time to ventilate emotions. This allows parents to feel understood. However, during ventilation, be vigilant for instances where parents express an emotionally charged wish to help their child escape from a drug-abusing lifestyle just one more time. Such expressions may be amplified and expanded as a motivational platform from which parents may become committed to following through on treatment. Engagement of parents is also enhanced through psycho-education. This involves giving them accurate information on adolescent development, drug abuse, and ways in which individual, family, school and peer-group interventions can alter drug-taking behavior.

Becoming street-drug free

Once the family agrees to participate in treatment, the psychologist tells the family that for treatment to be effective, drug use must stop first, and once that has happened, alternatives to a drug-based lifestyle may be discussed, not vice versa. If alternatives to a drug-based lifestyle and changes in family relationships are discussed first with the expectation that this will lead to drug use stopping, then treatment will probably fail. If the adolescent is not physically dependent on drugs, then a date for stopping should be set in the near future and a drug-free period of 10 days after that date set, during which the parents take responsibility for round-the-clock surveillance of the adolescent, both to comfort him and to prevent drug use. If the adolescent is physically dependent on drugs, plans for detoxification should be made. Home-based detoxification with medical back-up may be possible in some cases. Home-based detoxification requires the family to agree a 24-hour rota to monitor the adolescent and administer medication periodically under medical direction.

Alternatively, hospital-based detoxification may be arranged. However, home-based detoxification has the advantage of giving the family a central role in the recovery process. Following home-based detoxification, family members will be less likely to become involved in patterns of behavior that maintain drug abuse in the future. They will also be less likely to blame the treatment team when relapses occur during the recovery process, and more likely to take some responsibility for dealing with these relapses.

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In some instances, where opiate-dependent drug abusers are unwilling to become drug free, participation in a methadone maintenance program is an alternative to detoxification. Methadone is typically prescribed for people addicted to heroin as an alternative to either detoxification or continued use of street drugs. Family-based treatment in conjunction with methadone maintenance has been shown to lead to a significant reduction in the use of street drugs in comparison with methadone maintenance alone (Stanton and Todd, 1982). However, a problem with methadone maintenance is that drug dependence (albeit prescribed-drug dependence) continues to be central to the adolescent's lifestyle and to the organization of the family.

Confronting denial and creating a context for a drug-free lifestyle

Where adolescents have developed a drug-oriented identity and lifestyle, participation in self-help programs such as Nar-Anon is essential. These programs provide the unique combination of peer support and confrontation required to erode the denial that characterizes many adolescents who have become habitual drug users. Such drug users deny their physical and psychological dependence on drugs; the impact of their drug-related behavior on their emotional and social development; the impact of their drug-related behavior on their family relationships; and their drug-related crimes.

If access to a self-help group is unavailable, such groups may be set up and facilitated by a psychologist. In this type of group, each member must begin by stating congruently and honestly her experience of being dependent on drugs and not in control of her life. Members must describe repeatedly and congruently the ways in which their use of drugs has affected their relationships with all significant people in their lives and their evaluation of themselves. They must make an inventory of everyone they have wronged as a result of their drug abuse and make reparation. They must make commitment to an alternative drug-free lifestyle. The role of the facilitator is to encourage group members to confront each other's denial when they engage in various distortions, minimizations and rationalizations for their drug-related behavior. The facilitator must also encourage members to support each other when they have shown courage and honesty in owning up to the destructive drug-related behavior for which they have been responsible.

As group members give up denial and accept the support of the group, unresolved personal issues related to emotional development and identity formation may emerge. These include unresolved grief associated with losses and bereavements or reactions to trauma such as physical or sexual abuse.

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Adolescents who have experimented with drugs or been involved in mild recreational drug use usually do not require group work where the focus is on denial. Rather, they require individual or group work to help them develop assertiveness skills for avoiding peer pressure to engage in further drug use, or social-anxiety-management training to help them deal with social pressure if this underpins their recreational drug taking.

Family reorganization

The central task in family reorganization is to help the family disrupt the patterns of interaction which have evolved around the adolescent's drug-related behaviors. These drug-related behaviors include obtaining money and resources to get drugs; antisocial actions carried out when under the influence of drugs; and conduct problems such as breaking rules about curfew times, school non-attendance, homework non-completion, theft, destruction of property and so forth. To alter interactional patterns around drug abuse and drug-related deviant behavior, family members must be helped to set very clear, observable and realistic goals both with respect to the adolescent's behavior and with respect to the parents' behavior. Broadly speaking, the goals for the adolescent will amount to conforming to a set of house rules which specify minimum behavioral standards at home. The main goal for the parents will be to retain a parental alliance with respect to enforcing the house rules. Resolving conflict about the precise behavior expected of the adolescent, the consequences for compliance and non-compliance, and the way in which both parents will work jointly to support each other is a central part of this work. Communication training, problem-solving training and the use of points-based reward systems in the manner described for adolescent conduct may be incorporated into this stage of treatment as appropriate.

Parents should be asked to err on the side of treating adolescents as somewhat younger than their age in years during the early part of this phase of treatment. They should agree to relax the house rules by negotiation, as their adolescents show that they have the maturity to remain drug free and follow the house rules.

Concurrently, the psychologist should hold a number of sessions with the parents, in the absence of the teenager and siblings, to help the parents draw a boundary around their marital system by planning time together without the children. The goal here is to foster mutual support between the parents and to DE triangulate the adolescent, who may have been stuck in the position of a go-between with one parent looking to the child rather than his or her spouse for support.

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Disengagement

Once a stable, drug-free period has elapsed and new routines have been established within the family which disrupts drug-abuse-maintaining family patterns, disengagement may occur. Relapse prevention is central to the disengagement process. It involves identifying situations which may precipitate relapse and helping the youngster and family members identify and develop confidence in their coping strategies for managing these. Dangerous situations tend to be those where there is high stress, low mood, lessened vigilance, and greater opportunity for drug availability and use. Coping strategies include positive thinking, distraction, avoidance, and seeking social support.

One-person family treatment

Not all youngsters are lucky enough to have families who are willing or able to engage in conjoint family treatment. Unfortunately, individual supportive or exploratory psychotherapy is of little benefit for adolescent substance abusers, and in some instances these types of intervention may exacerbate drug abuse by helping adolescents find historical reasons to account for their current problems. An alternative to traditional individual approaches is one-person family treatment (Szapocznik and Kurtines, 1989). In one-person family treatment, during the engagement phase the psychologist identifies the part of the client that wants to recover and develops an alliance with that part. Treatment goals and a time frame for the treatment contract are agreed. Then, to clarify the patterns of interaction in which the drug-related behaviors are embedded, the psychologist invites the adolescent to describe the roles other family members take with respect to her when she engages in drug-related behavior.

When the psychologist has a good idea of what these behaviors are, he can role play one or more family members and check out how the adolescent responds to her mother, father, siblings and so forth, and which aspects of their behavior are maintaining the drug-using behavior.

This will yield a fairly accurate description of the pattern of interaction around the presenting problem. To change the drug-abuse-maintaining patterns of family interaction, the psychologist maps out these patterns on paper with the adolescent and coaches him or her to act differently at home to change the family's behavior. For example, if a regular interaction involves the adolescent's father calling him 'a good-for-nothing junkie', and this is followed by the mother attacking the father and calling him a 'waster and a lush', the adolescent might be coached to say:

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We're all in this together. We always fight with each other. It solves nothing and I'm stopping right now.

Or if the mother has confided to the adolescent that she knows her husband is having an affair and this hurts her deeply, the adolescent might be coached to say:

Mum, talk to him about it. Don't bring that stuff to me.

These changes in the adolescent's behavior will disrupt patterns of behavior associated with drug-using behavior. Each treatment session begins with a review of the way in which changes in the adolescent's behavior affected drug-using-related interaction patterns within the family. For one-person family treatment to be effective, it is useful if it is coupled with attendance at a drug-abusers' self-help program such as Nar-Anon (NA), and with regular urinalysis to monitor drug abstinence objectively.

Prevention

Many approaches to preventing drug abuse have been shown to be ineffective (Schinke *et al.,*1991; Pagliaro and Pagliaro, 1996). These include giving factual information only; giving factual information coupled with anxiety-provoking information or moral appeals; and offering alternative interpersonal or risky activities, so that adolescents can get a natural high rather than a drug-induced high. The most promising preventative interventions are school based skills-training programs coupled with community-based parent-training programs, embedded in a multiagency and multi-professional, community-wide, co-operative network (Schinke *et al.,* 1991; Pagliaro and Pagliaro, 1996).

In the most effective school-based skills-training programs, youngsters are targeted during their pre-teens and are trained in an array of social and interpersonal skills necessary to resist inducements to smoke, drink alcohol or use street drugs. These skills include identifying and avoiding situations where there is a risk of being pressurized into drug abuse; assertiveness skills to resist peer pressure; cognitive skills to resist media persuasion to smoke and drink; interpersonal problem-solving skills to look for alternatives in complex social situations where drugs are being used; communication skills; self-control skills; self-monitoring and self-instructional skills for building confidence; and self-regulation and relaxation skills for reducing tension. These skills are taught through live or video-tape demonstration, instruction, rehearsal, feedback, reinforcement and home practice. Parent groups may be run concurrently with school-based skills training. The parents' groups aim to network parents into a cohesive organization, keep them informed of the skills-training curriculum in which

the children are engaged, and coach them in how to support the children in using the skills taught in the school-based classes.

The child-focused skills training and the parent training, to be maximally effective, should be conducted within the context of a co-operative, multiagency and multi-professional, community-wide network. Within this network, policy and guidelines for practice should be developed to reduce drug availability and treat youngsters who become involved in drug abuse at an early stage. This network should include professionals and representatives from law enforcement, justice, education, health services, social services, probation, child protection, self-help organizations such as AA and NA, and other relevant agencies within the public and private domains.

Habitual drug abuse in adolescence is of particular concern to clinical psychologists because it may have a negative long-term effect on adolescents and an intergenerational effect on their children. A conservative estimate is that between 5 and 10 per cent of teenagers under 19 have drug problems serious enough to require clinical intervention. A distinction is made between drug dependence and drug abuse. While drug abuse refers to using drugs in such a way that the person is harmed, drug dependence refers to those situations where there is a compulsive pattern of use that may involve physiological changes that accompany the phenomena of tolerance and withdrawal.

Drug abuse is associated with a wide variety of behavior patterns which may be described in terms of the age of onset; the duration of drug abuse; the frequency of use; the range of substances used; and the amount used. Physiological features of drug abuse may be grouped into those associated with intoxication; those that follow intoxication; those associated with withdrawal following the development of dependence; and medical complications which arise from drug abuse. At an affective level, negative mood states typically follow the euphoria of intoxication, for most classes of drugs. At a perceptual level, some types of drug, but particularly hallucinogens, lead to pronounced abnormalities during intoxication and withdrawal. With respect to cognition, most street drugs lead to impaired concentration, reasoning and judgment during intoxication and withdrawal. Long-term regular drug abuse in many instances leads to impaired cognitive functioning. Drug abuse may have an impact on interpersonal adjustment leading to family-, school- and peer-group-based difficulties.

Drug abuse often occurs with other co-morbid psychological problems, including conduct disorder, ADHD, specific learning difficulties, mood disorders, anxiety disorders, schizophrenia and bulimia. The relationship between these co-morbid psychological problems and drug abuse is complex. Explanations for drug abuse have focused on biological

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predisposing factors; intrapsychic deficits; cognitive-behavioral learning processes; family systems factors; societal factors; multiple risk factors; and change processes involved in recovery and relapse. Research conducted to test these various theories has led to the identification of biological, psychological and social factors which increase vulnerability to drug abuse, may precipitate its onset, or may maintain habitual drug abuse.

Because of the complex aetiology of drug abuse, a multi systemic approach to assessment and treatment is essential. Effective treatment programs for adolescent drug abuse are typically family based and progress through a series of stages. These include engagement; becoming drug free; facing denial and creating a context for a drug-free lifestyle; family reorganization; and disengagement. Effective prevention programs involve child-focused skills training and parent training, conducted within the context of a co-operative, multiagency and multi-professional, community-wide network.

Schizophrenia

Schizophrenia is a seriously debilitating condition. Research on schizophrenia follows from two principal traditions, the first represented by Kraepelin (1896) and the second by Bleuler (1911). While Kraepelin defined the condition as principally characterized by a large constellation of observable symptoms (such as delusions, hallucinations, thought disorder, etc.) and a chronic course, Bleuler defined the condition in terms of a disturbance in a circumscribed set of inferred psychological processes. He speculated that the capacity to associate one thought with another, thoughts with emotions, and the self with reality were impaired or split. Hence the term 'schizophrenia' came from the Greek words for split and mind. He argued that observable symptoms such as delusions and hallucinations were secondary to these central, disrupted psychological processes, and reflected the person's attempt to cope with the world despite his disrupted psychological processes. Up until the late 1970s, Bleuler's tradition, associated with a broad definition of schizophrenia, predominated in the US, whereas in the UK, Ireland and Europe, Kraepelin's narrower definition held sway. Following the landmark US-UK diagnostic study (US-UK Team, 1974) that highlighted the extraordinary differences between the way schizophrenia was defined in America and Britain, there has been a gradual move towards developing an internationally acceptable set of diagnostic criteria.

 The two definitions provided for schizophrenia include delusions, hallucinations, disorganized speech and bizarre behavior as central to the definition of schizophrenia. They

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also include negative symptoms which involve a restriction of activity, speech and affect as important features of the condition. The DSM IV system is more cautious in requiring evidence of deterioration in social or occupational functioning and proof that the symptoms have persisted for six months before a diagnosis can be made. With ICD-10 a diagnosis may be made after a month and there is no requirement for evidence of deterioration in social or occupational functioning. While the DSM IV and ICD-10 diagnostic criteria have been developed for use with adults, a growing body of studies has shown that these systems may be used reliably with children (Asarnow, 1994). The marked variability among people with schizophrenia in symptomatology, course, treatment response and possible aetiological factors has led to the development of a variety of subclassification systems. Also, many psychotic conditions which closely resemble schizophrenia have been identified. In ICD-10 and DSM IV, symptomatology, rather than inferred biological or psychological aetiological factors, is used as a basis for sub-typing the schizophrenia.

Cases where psychomotor abnormalities such as excitability or negativism predominate are classified as catatonic. Cases are classified as hebephrenic in the ICD-10 and disorganized in the DSM IV when inappropriate or flat affect is the principal feature and where there is disorganization of behavior and speech. In both ICD-10 and DSM IV, when cases do not fall into the three categories just mentioned, they are classified as undifferentiated. Beyond these four principal subtypes, a variety of other categories have been proposed to take account of unclassifiable cases. For example, simple schizophrenia refers to cases where negative symptoms are present in the absence of positive symptoms. In an appendix to DSM IV, an alternative three-dimensional system for coding symptoms is proposed. The psychotic dimension covers positive symptoms such as hallucinations and delusions. The negative-symptoms dimension covers restricted behavior, speech and affect. Both of these dimensions draw on the two-syndrome hypothesis outlined in a later section of this chapter (Crow, 1985). The third dimension covers disorganization in effect, speech and behavior. This approach, where dimensionally assessed processes are sub-typed rather than syndromes, may prove to be more clinically useful than the current sub-typing system, which has little clinical validity.

In clinical practice, the boundaries between schizophrenic disorders and other conditions are often difficult to define clearly. These conditions include:

• Mood disorders

• Personality disorders (particularly schizoid and schizotypal)

• Pervasive developmental disorders such as autism

• Drug-induced psychoses.

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It is often difficult to distinguish between cases showing these different disorders, and also studies in children have shown that there is considerable co-morbidity. About a third of children who meet the diagnostic criteria for schizophrenia also meet the criteria for depression, and about a third meet the criteria for conduct disorder (Asarnow, 1994). The boundaries between schizophrenic disorders and mood disorders have been dealt with in the ICD and DSM systems by proposing mixed disorders such as schizoaffective disorder or post psychotic depression. Where aspects of symptomatology are insufficient for a diagnosis of schizophrenia, ICD-10 and DSM IV indicate that in youngsters over age 18 years, diagnoses of personality disorders may be given. Less extreme levels of social withdrawal and aloofness than that typical of people with schizophrenia are the primary characteristic of the schizoid personality disorder. People showing eccentricities which fall just short of thought disorder and delusions may be diagnosed as having schizotypal personality disorder. Extended periods of observation and a referral for toxicological tests will usually throw light on cases of drug-induced psychoses. Autism may be distinguished from schizophrenia by the absence of sustained delusions and hallucinations.

The prevalence of schizophrenia is 1 per cent in populations over 18 years of age. This is an international cross-cultural finding, replicated in Ireland by NiNuallain in the 1980s, although prior to NiNuallain et al.'s (1984) work, methodologically flawed studies suggested that the incidence of schizophrenia in Ireland was higher than in other countries. There are few reliable data on the epidemiology of schizophrenia in youngsters under 18 years of age. Among children and teenagers, there are more male cases than females, but in adulthood, equal numbers of both genders are affected (Asarnow, 1994). This suggests that the age of onset is earlier for males. Among children and adolescents with schizophrenia, about a quarter have a single episode with a good outcome, about a quarter have multiple relapses but with good functioning between episodes, and the remaining 50 per cent of cases have a poor outcome (Asarnow, 1994).

The following characteristics may be predicative of a good outcome (Asarnow, 1994; Mari and Streiner, 1994; Neale and Oltmanns, 1980):

• Good pre-morbid adjustment

• Rapid onset

• precipitating stressful life events

• Family history of affective disorder (rather than schizophrenia)

• Additional affective features in the case's presentation

• Favorable life situation to return to

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• Low incidence of family psychopathology

• Adolescent (rather than child)

• Female (rather than male)

Clinical features

The clinical features of schizophrenia are presented in Table 18.2. Psychotic episodes may last from one to six months, although some extend to a year. They are usually preceded by a prodromal period of a number of weeks. Psychotic episodes may be shortened and the severity of symptomatology ameliorated through early detection and the use of pharmacological and psychological treatment as outlined below. Interepisode functioning may vary greatly, and better interepisode functioning is associated with a better prognosis. The duration of remission between episodes may be lengthened through the use of maintenance medication, family intervention to reduce the amount of stress to which the adolecent is exposed, and the use of stress-reducing coping strategies.

At a perceptual level, adolescents with schizophrenia describe a breakdown in perceptual selectivity, with difficulties in focusing on essential information or stimuli to the exclusion of accidental details or background noise. In a florid psychotic state, internal stimuli (or thoughts) are interpreted as originating from another source and experienced as auditory hallucinations. Adolescents may perceive voices as varying along a number of dimensions.

Voices may be construed as benign or malevolent, controlling or impotent, all-knowing or knowing little about the person; and the person may feel compelled to do what the voice says or not. Hallucinations that are perceived to be malevolent, controlling and all-knowing, and which the adolescent feels compelled to obey, are far more distressing than those which are not construed as having these attributes. Challenging beliefs about voices which make them distressing to youngsters is central to the cognitive-behavioral treatment of hallucinations (Chadwick et al., 1996).

At a cognitive level, formal thought disorder occurs in schizophrenia and is characterized by a difficulty in following a logical train of thought from A to B. Judgment may be impaired and unusual significance accorded to unrelated events, so that delusions occur. Delusions, from a cognitive-behavioral perspective, are beliefs or inferences that have been drawn to explain why a particular set of events has occurred. Delusions may vary in the degree of conviction with which they are held (from great certainty to little certainty); the degree to which the person is preoccupied with them (the amount of time spent thinking about the belief); and the amount of distress they cause. From a cognitive-behavioral perspective these

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are the three main dimensions along which delusions and changes in delusional beliefs are assessed (Chadwick et al., 1996).

Particular sets of delusions may entail a confused sense of self, particularly paranoid delusions, where adolescents believe that they are being persecuted or punished for misdeeds, or delusions of control, where there is a belief that one's actions are controlled by others.

At an emotional level, during the prodromal phase anxiety or depression may occur in response to initial changes in perceptual selectivity and cognitive inefficiency, and a key part of relapse prevention is learning how to identify and manage prodromal changes in affect. During the florid phase, high arousal levels may occur in response to the experience of delusions and hallucinations. Inappropriate affect may be present, particularly in hebephrenic schizophrenia, where the youngster responds not to the external social context but to internal stimuli such as auditory hallucinations. Flattened affect may also occur, particularly in chronic cases where high levels of medication have been taken for extended time periods. In response to an episode of psychosis, the sense of loss may give rise to post-psychotic depression.

At a behavioral level, during the prodromal phase, sleep disturbance, impulsive behavior and compulsive behavior may be present. During psychotic episodes, goal-directed behavior is impaired and in chronic cases, negativism, mutism and catatonia may occur.

At an interpersonal level, a deterioration in relationships with family members may occur. Social withdrawal from interaction with peers may occur, and at school there is usually a marked decline in academic performance and in participation in sports and non-academic activities, such as music and drama.

Assessment

In the management of cases of suspected childhood or adolescent psychosis, the first priority is to assess risk of self-harm or harm to others. Occasionally prodromal impulsivity may lead to dangerous behavior. The next priority is to clarify symptomatology and rule out other conditions such as autism, drug-induced psychosis, mood problems, and OCD. Careful interviewing using the diagnostic criteria is important here. Standardized rating scales may also be useful in making a diagnosis. Rating scales for the full constellation of psychotic symptomatology and for specific symptoms are listed in Table 18.4. Careful observation and a series of interviews with multiple informants over a number of sessions will typically be necessary to assess symptomatology. Multidisciplinary involvement is particularly important

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in cases where youngsters present with psychotic features. From the earliest stages in these cases, team work between clinical psychology and psychiatry is recommended.

Specific categories of predisposing, precipitating, maintaining, and protective factors deserving assessment where psychotic features are the central concern.

Predisposing factors

Both personal and contextual factors may predispose youngsters to developing psychotic symptoms. At a personal level, a genetic vulnerability as indicated by a family history of disorders on the psychotic or schizophrenia spectrum may predispose youngsters to develop schizophrenia. Youngsters may also develop a vulnerability to schizophrenia as a result of intrauterine adversity as indicated by obstetric complications or maternal illness, particularly viral infection during pregnancy. Deregulation of the dopaminergic mesolimbic system and neuroanatomical abnormalities, notably enlarged ventricles, may also predispose adolescents to develop schizophrenia, although these biological factors are rarely assessed routinely. At a contextual level, a history of family disorganization and social disadvantage may predispose youngsters to develop schizophrenia.

Precipitating factors

Schizophrenia may have an acute onset or an insidious onset and prognosis in the former case is better. The onset of an episode of schizophrenia may be precipitated by a build-up of stressful life events or the occurrence of lifecycle transitions. Personal or family illness or injury, child abuse or bullying may all precipitate the onset of schizophrenia. So too may the transition to adolescence; having a sibling leave home; birth of a sibling; or bereavements within the family. Parental separation, moving house, changing schools, losing friends, parental unemployment, or increased financial hardship within the family may all precipitate the onset of a psychotic episode. All of these events place a sudden increase in demands on the youngster's coping resources.

Maintaining factors

Psychotic problems may be maintained by a range of personal and contextual factors. Delusions and related negative emotional experiences may be maintained through cognitive distortions that involve selective misinterpretation of stimuli in a self-referent way, such as interpreting a car horn as an enemy signal. Hallucination-related distress is maintained

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through negative interpretations of hallucinations; for example, interpreting voices as belonging to the devil and as having the power to force one to behave in distressing ways. Dysfunctional coping strategies such as social withdrawal may maintain negative symptoms such as inactivity and poverty of speech. At a biological level hyper arousal may maintain the condition by making it more likely that hallucinations and delusions will occur and more attractive to engage in negative symptoms.

With respect to contextual maintaining factors, patterns of interaction that involve confused communication, criticism or over-involvement may maintain schizophrenia by leading to a sustained level of stress-related hyper arousal. These types of interaction are probably more likely to occur in chaotically organized families; in families where there is marital discord and in families where the father is relatively uninvolved. Such communication may also occur in families where the adolescent is triangulated into parental conflict, with one parent taking an over-involved stance with respect to the adolescent and the other adopting a critical position. The symptoms of schizophrenia may be maintained, too, through inadvertent reinforcement by well-meaning family members who respond positively to the adolescent's symptoms.

Such patterns of parenting and family organization may be partially maintained by parents' personal experience of personal psychological difficulties. Where parents have insecure internal working models for relationships, low self-esteem, low self-efficacy, an external locus of control, immature defenses and poor coping strategies, their resourcefulness in managing their children's difficulties may be compromised. Parents may also become involved in problem-maintaining interactions with their adolescents if they have inaccurate knowledge about schizophrenia and are unaware of the importance of the family in creating a low-stress environment to aid recovery and prevent relapse.

Psychotic symptoms may also be maintained by high levels of stress, limited support and social disadvantage within the family's wider social system, since these features may deplete parents' and siblings' personal resources for dealing constructively with the adolescent's condition. Educational placements which are poorly resourced and where teaching staff have little time to devote to home-school liaison meetings may also maintain psychotic symptoms, especially if teachers interact with the adolescent in critical or over involved ways.

Within the treatment system, a lack of co-ordination and clear communication among involved professionals, including family physicians, paediatricians, psychiatrists, nurses, teachers, psychologists and so forth, may maintain children's psychotic problems. It is not

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unusual for various members of the professional network to offer conflicting opinions and advice on the nature and management of schizophrenia to adolescents and their families. These may range from viewing the child as ill and requiring medication only for the management of the illness to seeing the child as healthy but deviant and deserving punitive management. Where co-operation problems between families and treatment teams develop, and families deny the existence of the problems, the validity of the diagnosis and formulation or the appropriateness of the treatment program, then the child's difficulties may persist. Parents' lack of experience in dealing with similar problems in the past is a further factor that may compromise their capacity to work co-operatively with the treatment team, and so may contribute to the maintenance of the child's difficulties.

Formulation

The formulation should specify how specific precipitating factors triggered the onset of the psychosis and the predisposing factors that rendered the youngster vulnerable to developing the condition. The way in which the condition and its symptoms are maintained by patterns of interaction and intrapsychic factors, particularly cognitive distortions and attributions, should be specified. Protective factors which have a bearing on prognosis should also be mentioned.

Treatment

The approach to management of schizophrenia set out here is based on a view of schizophrenia as a recurrent episodic condition, which is currently only partially understood, and for which there is no cure or definitive solution. Pharmacological and psychological treatment aim to alter the course of the condition by shortening active periods and lengthening periods of remission so that children and adolescents with this condition may lead as normal a lifestyle as possible.

A diagnosis of schizophrenia according to ICD-10 criteria cannot be made for a month, and with DSM IV, a period of six months is required. In practice, with both first-episode cases and cases which are referred because of relapses, the best approach is to intervene immediately, with both pharmacological and psychosocial interventions, to ameliorate the psychotic symptoms and support the adolescent and family. Early intervention is important, since if left untreated youngsters may develop entrenched delusional belief systems and patterns of dysfunctional behavior involving negative symptoms. Furthermore, patterns of family interaction may evolve which maintain these symptoms.

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Treatment for adolescents and young adults with a diagnosis of schizophrenia should be multi-systemic and include the following components:

• Pharmacological therapy to control positive symptoms, including delusions, hallucinations and associated interventions to ensure adherence

• family intervention to help family members understand the concept of schizophrenia and interact with the adolescent in a way that is maximally supportive and minimally stressful individual or group-based cognitive-behavioral therapy focused on helping the adolescent understand the disorder, cope with its symptoms and control environmental stress levels

• Contingency management targeting negative symptoms

• Group work for parents to provide them with education and support.

Unfortunately most of the research on treatment, which informs the discussion below, has been conducted with adults. However, it is important to note that in three of the major trials of family intervention for people with schizophrenia, adolescents were included (Mari and Streiner, 1994). Until trials with children and adolescents have been reported, treatment of younger cases is guided by the results of studies conducted on adult populations.

Pharmacological treatment

Treatment with first-generation anti-psychotic drugs, such as chlorpromazine, haloperidol or flupenthixol, or second-generation anti-psychotic preparations, such as clozapine, risperidone, olanzapine and sertindome, is the main approach to pharmacological intervention for psychotic conditions in children and adolescents (Perry *et al.,* 1997). While these antipsychotic agents control positive symptoms of schizophrenia, they have short-term side effects such as Parkinsonism, which is often controlled by an anti-Parkinsonism agent such as cogentin. Tardive dyskinesia, an irreversible neurological condition, is one of the tragic long-term side effects of neuroleptic drug usage. For this reason, ideally the lowest possible dose of neuroleptic medication should be used (Werry and Taylor, 1994).

For a considerable proportion of people with a diagnosis of schizophrenia, residual positive symptoms including hallucinations and delusions persist. Many patients on medication, while not actively psychotic, develop negative symptoms including restricted affect, limited speech and a lack of goal-directed behavior. Despite pharmacological treatment, up to 80 per cent of cases relapse within 2–5 years, especially if low dosages of medication are used to minimize side effects (Tarrier, 1994a). For these reasons individual and family-based psychological interventions are particularly important for people with a diagnosis of schizophrenia.

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Family intervention

The results of six major studies show that family interventions reduce relapse rates at two years from about 70 per cent to about 25 per cent in families with high expressed emotion containing a member with a diagnosis of schizophrenia (Mari and Streiner, 1994). Some families with a person who has a diagnosis of schizophrenia require more help than others. Research on expressed emotion has shown that where family members are excessively critical or excessively over involved, the chances of a relapse are highest, and it is these families who most require help in learning how best to manage their symptomatic teenager. Families where more than one relapse occurs per year; families in which there are repeated heated or violent arguments; families which call the police; families which phone the clinic frequently seeking reassurance; and single-parent families are all more likely to show high expressed emotion and to require family intervention.

Manuals outlining the principles of intervention with families in which an adolescent has a diagnosis of schizophrenia have been developed by Falloon *et al.* (1993) and Kuipers *et al.* (1992), and guidelines for treatment are presented in Barrowclough and Tarrier (1994). These sources outline the type of family intervention that has been found to lower levels of expressed emotion and to reduce relapse rate among people with a diagnosis of schizophrenia. What follows is based on this work.

Effective intervention combines family work with pharmacological treatment, individual treatment, and psycho-education in an integrative and coordinated way. It should be extended over at least a year and further if possible, within the context of a chronic-care model of service delivery. Effective family intervention begins with a thorough assessment, and intervention plans are based on the formulation that arises from the assessment.

Patterns of family interaction that have evolved around the youngster's symptoms, which may inadvertently be exacerbating the symptoms, should be assessed in particular detail.

Engagement

During the engagement phase, adopting a non-blaming stance with respect to the parents is particularly important, since many parents inappropriately blame themselves for the occurrence of their child's symptoms. Following a thorough assessment of the teenager's symptoms over a period of weeks, a diagnosis of psychosis may be given, usually by the physician involved in the case. After six months a DSM IV diagnosis of schizophrenia may be given. In either case, relatives are informed that the adolescent has a condition, either psychosis or schizophrenia, which is due to the interaction of vulnerability towards the disorder with a build-up of life stress. Evidence for both the predisposition and the build-up

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of life stress should be drawn from the history constructed during the assessment phase. The teenager and the family are then invited to participate in a series of sessions at their home or in the clinic to help them understand the condition and how best to manage it and prevent relapse. This invitation may be met with resistance since families may have had negative therapy experiences in the past, be suspicious of the therapist, or fear being blamed or making things worse.

When the therapist is faced with resistance, the three important strategies to adopt are, first, to be persistent and regularly re-present the invitation to participate in therapy; second, to be positive and concerned in all contacts with family members at which invitations to engage in therapy are offered; and third, to be flexible about the time and place where appointments are offered.

In conducting home-based family sessions, it is important to convey to the family that the sessions are occasions for working on methods for handling problems rather than social visits. The main dangers to be avoided are being so businesslike as to be rude on the one hand and allowing casual social conversation to take over the session on the other. The rationale for family treatment should be that living with an adolescent who has schizophrenia is stressful and implementing a home-based care plan for the adolescent is demanding and complex, and families may benefit from guidance with this. Also, adolescents with schizophrenia are sensitive to stress from others, for example the sort that is expressed when someone has had a hard day, and a family support program may help the family member develop skills to shield the adolescent from this type of spill-over.

Working in a co-therapy team
Working with families where a teenager has a diagnosis of schizophrenia can be complex and tiring. The family's emotional response to the condition is often intense, and communication and problem-solving routines may be very ineffective because of this. One way to cope with the demands of working with these families, without burning out, is to work with a co-therapist.

For example, a clinical psychologist might work with a community-based psychiatric nurse. In selecting a co-therapist, try to choose someone with whom you can have a respectful, flexible, and trusting working relationship. Before each session, jointly plan a set of aims to be achieved and arrange who is to do what during the session. One way of co-working is for one therapist to be the interviewer and the other to observe the interview and take notes if necessary. When the observer has an input to make, it is useful if this is made by discussing it

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openly with the other therapist in front of the family. When both therapists have discussed the input, the observer withdraws into the role of observer again and the interviewing therapist asks the family for their views on the issue. A second style of co therapy involves dividing the family into subsystems and each therapist working with one subsystem. For example, one therapist may work with the parents and another with the symptomatic child, or one therapist may work with the males in the family and another with the females.

A vital part of co-therapy is debriefing after each session. Debriefing involves resolving any feelings of conflict that arose during the session between the therapists, and also reflecting on progress that was made with the family during the session and on possible avenues for future work with the family. The importance of resolving conflicts between the therapists cannot be over-emphasized. Often, deep-seated family conflicts become transmitted to the therapists, who adopt the positions of different family members and feel an urge to act out repetitive, unproductive patterns of interaction which characterize the family with which they have been working. Debriefing is one way to minimize this type of interaction pattern mirroring in the co therapy team.

Psychoeducational sessions

In the early sessions, usually the first two or three, the main agenda is education. The parents and adolescent are given the leaflets to read before the meetings and the psychologist spends the sessions reading through each of the points, asking the family how they fit with their experience, and discussing this with a view to helping the family develop a frame of reference into which they can incorporate their experience of the adolescent's condition. The educational sessions help the family to view schizophrenia as a condition to which the adolescent was vulnerable and the onset of which was precipitated by stress. This framing of the aetiology of the condition absolves the family from blame and guilt. The explanation of the positive symptoms (thought disorder, hallucinations and delusions) in concrete terms helps parents empathize with their symptomatic adolescent and so paves the way for a reduction in criticism. The explanation of the negative symptoms (flattened affect, withdrawal, lack of volition, hygiene problems) and their lack of response to medication helps the family avoid critical or hostile attempts to persuade the symptomatic teenager to conform instantly to parental expectations in these areas. The outline of the roles of medication, individual cognitive therapy, and family intervention offers the family a clear rationale for taking steps to ensure that the adolescent takes medication and that therapy sessions are attended. The information on family treatment clarifies for family members that

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therapy will focus on helping the parents to reduce stress and increase support for their symptomatic family member. Finally, the information on prognosis offers the family hope by drawing an analogy between diabetes and schizophrenia as a chronic condition which, with proper management, can allow an independent lifestyle.

Aims of later sessions

After the psycho-educational sessions, the family are invited to use the sessions to develop routines and solve problems that make family life predictable and calm, so that the symptomatic adolescent will feel maximally supported in his or her attempts to cope with the illness and move towards independence, and will be minimally stressed while living in the family context.

At a structural level, the broad aims of these therapy sessions are to help parents in two-parent families to co-operate in their care of all of the children but particularly of the adolescent with a diagnosis of schizophrenia. Where one parent has been shouldering the burden of care, this may involve helping both parents share the load more equally. A second structural aim is to help the parents strengthen the boundary between themselves and the symptomatic adolescent, so that the youngster can move towards independence and the parents can spend more time with each other in a mutually supportive relationship. In single-parent families, the structural aim is to help the parent develop supportive links with members of the extended family and broader social network and strengthen the boundary between the single parent and the adolescent. This permits the youngsters to move towards independence and the single parents to develop an alternative focus for their energies and interests.

Where there is a high level of over involvement or enmeshment between one parent (usually the mother) and the symptomatic adolescent, the guilt that typically underlies the over involvement may require considerable exploration and acknowledgement. However, the psychologist's message must be that parents do not cause schizophrenia, but can help youngsters make as good a recovery as possible by promoting independence, allowing the development of autonomy and respecting the adolescent's privacy.

Within these family sessions, broad structural aims are achieved by coaching family members in communication skills and problem-solving skills and then helping them to use these skills to make structural changes.

Communication-skills training

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Family members may be invited to discuss a particular issue, such as how the next weekend should be spent, with a view to clarifying everyone's opinion about this. As they proceed, the therapist may periodically stop the conversation and point out the degree to which the family's typical communication style conforms to or contravenes the guidelines for good communication. All approximations to good communication should be acknowledged and praised. Alternatives to poor communication should be modeled by the therapist. Typically there are problems with everyone getting an equal share of talking time, with the symptomatic family member usually getting the least. Often messages are sent in a very unclear way, and listeners rarely check out that what they have understood is what the speaker intended. While two sessions should be exclusively devoted to explicitly training family members in using the guidelines, coaching in communication skills occurs throughout most of the sessions that follow the preliminary psycho-educational sessions, in so far as from time to time the psychologist should acknowledge particularly good examples of clear communication and model alternatives when poor communication occurs.

Problem-solving-skills training

In families where an adolescent has a diagnosis of schizophrenia, each member is able to identify particular problems associated with living with the symptomatic youngster that she or he would like solved. With problem-solving training, all such problems should be listed and prioritized as a series of goals. Big problems should be broken down into smaller problems and vague problems should be clarified before this prioritizing occurs. Families have a better chance of achieving goals if they are specific, can be visualized and are moderately challenging. In prioritizing goals it is important to explore the costs and benefits of goals for each family member, so that ultimately the list of high-priority goals are those which meet the needs of as many family members as possible.

Common goals include arranging exclusive time that the parents can spend together without their symptomatic adolescent, and arranging ways in which adolescents can take on some age-appropriate responsibilities, such as meeting friends, cleaning their own clothes, managing money, ensuring that they have private living space free from parental intrusion, and taking medication regularly.

Once the list of target goals has been agreed, ways of achieving these goals are explored. This usually involves coaching family members in problem-solving skills.

Family members should be asked to try to use these guidelines to solve a particular problem, and this attempt is observed by the treatment team. Feedback on problem-solving skills that

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were well used is given and alternatives to poor problem-solving skills are modeled by the therapists. Common pitfalls for family members include vague problem definition; trying to solve more than one problem at a time; and evaluating the pros and cons of solutions before all solutions have been listed. This is an important error to correct, since premature evaluating can stifle the production of creative solutions. Often families need to be coached out of bad communication habits in problem-solving training, such as negative mind reading where they attribute negative thoughts or feelings to others, blaming, sulking and abusing others. At the end of an episode of problem-solving coaching, family members typically identify a solution to the problem and are invited to try out this solution before the next session, and a plan is made to review the impact of the solution on the problem in the next session. It is important always to review tasks that clients have agreed to do between sessions.

Reframing

Many parents believe that they are responsible for their adolescent's condition and feel intense guilt. This guilt may lead them to become over-involved in their adolescent's life, to the point where they prevent the development of independence. Many mothers show this response. For many fathers, guilt often fuels an angry response to the symptomatic adolescent, and the father criticizes the youngster for his unusual behavior. Often the negative symptoms, such as social withdrawal or poor hygiene, are the focus of this criticism. All family members experience grief at the loss of the way their adolescent used to be before the onset of the symptoms, and also a sense of loss concerning the hopes and expectations they had of the child, which now must be modified.

Part of the role of the psychologist is to help family members express these emotions, but in such a way that the critical, over-involved or despairing presentation of the emotions with respect to the symptomatic adolescent is minimized. The psycho-educational sessions, by helping family members understand that much of the youngster's behavior is not motivated by malicious intentions, go some way to help parents reduce criticism. Reframing statements about emotional states made by family members is a second technique that can be used to minimize the negative impact of intense emotional expression. For example, if a parent expresses criticism by saying:

I can't stand you. You're driving me crazy too, this may be reframed as:

It sounds as though you really miss the way Johnny used to be and sometimes these feelings of loss are very strong.

If a parent expresses over-involvement by saying:

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I have to do everything for you because you can't manage alone, this may be reframed by saying:

It sounds as though you find yourself worrying a lot about Johnny's future and wondering whether he will be able to fend for himself.

In response to parental statements like:

You make me so miserable with your silly carry-on. Sometimes I think what's the point, a reframing may be offered as follows:

When you see Johnny's symptoms, it reminds you of how he was before all this. Then you find your mood drops and this sadness and grief is hard to live with.

All of these reframing involve labeling the emotional experience as arising out of underlying positive feelings that the parent has for the symptomatic adolescent. The reframing also describe the emotions as arising from the way the parent is coping, rather than being caused exclusively by the symptomatic teenager. That is, they give the message that the parent *owns* the feelings; they are not *imposed* on the parent by the adolescent. Reframing is a process that occurs throughout therapy rather than being covered in a couple of sessions.

Conflict management

Where parents and symptomatic youngsters become involved in escalating patterns of conflict that may result in violence, a structured approach to conflict management should be used. The co-therapy team should allow the parent and the adolescent an uninterrupted period of time each to outline how the conflict occurred or is occurring from his or her point of view.

Once both viewpoints have been elicited, the co-therapists may then discuss possible ways that a compromise could be reached in a respectful manner in the presence of the family, thus modeling non-violent conflict management. If the conflict has escalated to an extreme degree, one co-therapist may meet with the parents to find out their viewpoint and another meet separately with the adolescent to find out his. Subsequently both factions may meet with both co-therapists, who discuss the conflict in the presence of the family, with one co-therapist acting as an advocate for the adolescent and the other speaking as an advocate for the parents. When a successful resolution of the conflict is reached, therapists should help families plan ways in which conflicts at home may be managed in future. These may include avoiding specific situations that precipitate conflict; allowing a cooling-off period of a few minutes when angry exchanges occur; using turn taking as each side presents their position; and calling in the therapy team or the family doctor when a resolution cannot be reached.

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Relapse prevention and disengagement

Signals that may herald relapse, such as the build-up of life stress or the occurrence of prodromal symptoms, may be discussed during the disengagement phase. Plans for reducing stress, increasing medication, and avoiding catastrophic interpretation of symptoms may be made. Plans for booster sessions may also be discussed.

Cognitive-behavioral treatment

Cognitive and behavioral treatment methods require a thorough, fine-grained contextual assessment of each specific symptom, taking account of activating events (As); beliefs and associated cognitive distortions and misattributions (Bs); and resultant distressing emotions or maladaptive behavioral consequences (Cs) (Chadwick *et al.,* 1996; Haddock and Slade, 1996; Tarrier, 1994a). During this fine-grained cognitive-behavioral analysis, visual analogue scales are a particularly useful way to assess the magnitude of beliefs (Bs) and responses (Cs). Beliefs about voices heard as auditory hallucinations (which are in cognitive-behavioral terms defined as activating events) may be assessed as varying along a number of dimensions.

Voices may be construed as benign or malevolent, controlling or impotent, all-knowing or knowing little about the person; and the person may feel compelled to do what the voice says or not. Delusions (which in cognitive-behavioral terms are defined as beliefs) may vary in the degree of conviction with which they are held (from great certainty to little certainty) and preoccupation (the amount of time spent thinking about the belief). For both hallucinations and delusions, the amount of emotional distress they cause in terms of anxiety, depression, anger, and so forth may be rated on visual analogue scales. So also may behavioral responses such as avoidance, level of activity or aggression.

A variety of cognitive and behavioral methods have been developed to help control certain aspects of schizophrenia, and for each of the following methods there is a small but growing body of literature indicating its effectiveness (Tarrier, 1994a, 1994b; Hemsley, 1994; Chadwick *et al.,* 1996; Haddock and Slade, 1996):

• Stimulus-control methods, which aim to alter situations or stimuli associated with the occurrence of symptoms

• Cognitive methods, which aim to change delusional belief systems

• Methods that facilitate the development of coping strategies for managing symptoms.

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It is useful in engaging adolescents to ask about the level of distress that they experience and to offer to help explore ways of changing that. An extended period of two to six sessions may be required to establish sufficient understanding and trust to introduce challenges to clients' belief systems. Psycho-education about diathesis-stress models of schizophrenia tend to jeopardize the engagement process, and this type of intervention is probably best left until later.

Stimulus control

Here the client and therapist identify specific situations where, for example, hallucinations occur, then isolate that aspect of the situation which precipitates the symptoms, and work to change it. Where internal tension or a high state of arousal associated with external environmental pressures is associated with hallucinations, systematic desensitization may be used to eliminate the antecedent (arousal) which precipitates the hallucinations. Where high levels of auditory stimulation precipitate hallucinations, the use of ear plugs, or calming music listened to through head phones from a personal stereo, may reduce this, thus reducing the frequency of the hallucinations.

Group work for parents

Parent groups have been shown to reduce expressed emotion in families with a member with a diagnosis of schizophrenia, and an approach to running such a group is given in Kuipers *et al.*'s (1992) treatment manual. Parent groups should ideally contain no more than 12 members and meetings should be of about 90 minutes' duration, occurring fortnightly over a period of about nine months. They may be open or closed, and ideally should be run in the evenings in a convenient location to minimize temporal and geographic barriers to attendance. To recruit parents into a relatives' group, it is useful to meet them at their homes for a couple of sessions of psycho-education, and then offer the group as a place where they can discuss with other parents in similar circumstances how best to manage the process of living with an adolescent who has a diagnosis of schizophrenia. The specific aims of relatives' groups are:

• To help lower parental criticism and over-involvement

• to help parents ventilate distressing feelings, such as sadness, anger and anxiety, associated with the adolescents' condition to provide a forum for group problem solving where parents can brainstorm solutions to the various difficulties that arise from living with an adolescent with a diagnosis of schizophrenia

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• To provide parents with a support network to counter feelings of isolation and stigmatization.

In the first meeting the ground rules of turn taking, support, respect, trust and a commitment to problem solving are established, by the therapist inviting each person to recount her or his story briefly, in about 5–10 minutes, emphasizing things that she or he has done to keep going through difficult times. The therapist's role is to ensure that everyone gets a fair turn, with less forthcoming members being facilitated and the highly verbal being limited to 10 minutes maximum. All subsequent meetings should open with a round where each person has a turn to say what has happened since the previous meeting.

Initially themes raised for discussion in the group are practical (e.g. how to deal with the adolescent's poor hygiene) or educational (e.g. what happens if medication is not taken). The therapist's role is to encourage the group to use its collective experience to solve these problems, and only offer expert information if the group lacks this. If parents agree to try a particular solution as homework, this should be reviewed in the next group.

In later sessions, as trust develops, parents use the group to process distressing emotions such as guilt for possibly causing their adolescent's condition; grief associated with the loss of their child's health; anger at their adolescent's unusual behavior; fear that the adolescents will harm themselves or others; anxiety about who will care for the adolescent later in life when they are unable to; and anger at service providers for their inadequacies. With emotional issues, the therapist's job is to facilitate emotional expression and processing on the one hand, while on the other hand encouraging the group to support members who are processing distressing emotions by acknowledging the value of their listening and empathizing.

Summary

Schizophrenia is a complex disorder or group of disorders which affects 1 per cent of the population over 18 years of age. It has its onset in late adolescence or early adulthood. The condition is marked by positive symptoms such as delusions and hallucination and negative symptoms such as inactivity and poverty of speech. While, in the past, a broad definition of schizophrenia was used in North America and a narrow definition used in Europe, there is now considerable international agreement on a narrow-band definition of schizophrenia. In differential diagnosis, it should be distinguished from autism, affective conditions and adolescent precursors of adult personality disorders on the schizophrenia spectrum, particularly schizoid, schizotypal and paranoid personality disorder.

In the biological domain, genetic factors, dopamine system dysregulation, and neuroanatomical abnormalities associated with pre- and perinatal insults have all been implicated in the aetiology of schizophrenia. The two-syndrome hypothesis offers an integration of these findings. This hypothesis entails the view that a distinction may be made between Type 1 schizophrenia, which is a genetically inherited disease marked by a dysregulation of the mesolymbic dopaminergic system and characterised by positive symptoms, and Type 2 schizophrenia, which is a neuro developmental disorder arising from pre- or perinatal insults marked by chronic negative symptoms. In the psychological domain, cognitive deficits, cognitive biases, management of prodromal symptoms, and family-and community-based stresses have all been implicated in the genesis and maintenance of schizophrenia, and a variety of focal theories have been developed to explain the role of these specific factors. Diathesis-stress models of schizophrenia have also been developed, which argue that for the symptoms of schizophrenia to occur, a biologically vulnerable individual must be exposed to environmental stress. The interaction of the vulnerability factors with the stress factors leads to the occurrence of the symptomatology. Symptoms are subsequently maintained by ongoing exposure to environmental stress and by the way in which the person reacts to this stress and copes with the unusual experiences associated with schizophrenia.

Assessment premised on multi-factorial diathesis-stress models of schizophrenia addresses predisposing, precipitating and maintaining factors in the biological, psychological and contextual domains. Treatment programs premised on diathesis-stress models involve antipsychotic medication to address deregulation of the dopamine system; family intervention to reduce family-based stress; and individual intervention to enhance personal coping strategies.

Mood Problems

Depression in childhood or adolescence may be a particularly distressing experience for both the young person and other family members, particularly parents. Unfortunately the outcome for depression in childhood and adolescence is not favorable. Available evidence suggests that while the majority of youngsters recover from a depressive episode within a year, they do not grow out of their mood disorder (Harrington, 1993; Kovacs, 1997; Reynolds and Johnson, 1994). Major depression is a recurrent condition, and depressed youngsters are more likely than their non-depressed counterparts to develop episodes of depression as adults although they are no more likely to develop other types of psychological problem. Double

depression—that is, an ongoing persistent mood disorder (dysthymia) and an episodic major depressive condition; severe depressive symptoms; maternal depression; and the absence of co-morbid conduct problems have all been shown in longitudinal studies to be predictive of worse outcomes. While depressed youngsters with conduct difficulties have been found to be less at risk for recurrent episodes of depression, they are at greater risk for the development of relationship problems in adulthood.

Diagnosis and classification

There are marked similarities between these three diagnostic systems. All three include depressed mood, depressive cognition, and suicidal ideation as central to a depressive episode. However, the DSM and ICD systems include vegetative or somatic features, which are absent from Achenbach's system. It is noteworthy that Achenbach's empirically derived syndrome, in addition to excluding vegetative features from its depressive syndrome, includes anxiety. The co-occurrence of anxiety and depression is dealt with in the DSM and ICD systems by giving two diagnoses.

The ways various conditions which involve depressed mood have been classified in DSM IV and ICD-10. Both systems make a distinction between primary mood disorders and other conditions where affective symptoms are a secondary feature. Within the primary mood disorders, both systems make distinctions between uni-polar and bipolar mood disorders and between severe episodic disorders and the milder but more persistent conditions of dysthymia and cyclothymia, which in earlier classification systems may have been termed depressive neuroses. Both systems provide a category for schizoaffective disorder for cases that show features of schizophrenia and depression, although only ICD-10 provides a specific category for post-psychotic depression. Both systems also provide a category for adjustment disorder with depressed mood. ICD-10 is unique in recognizing depressive conduct disorder as a distinct syndrome. Children who show features of major depression and conduct disorders would receive a dual diagnosis within the DSM IV system.

The distinctions between primary and secondary mood problems; between unipolar and bipolar conditions; and between recurrent and persistent disorders have replaced distinctions used in earlier classifications systems. These include:

• Neurotic and psychotic

• Endogenous and reactive

• Overt and masked.

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Reviews of the classification of mood disorders identify the following reasons for abandoning these earlier distinctions (Kendell, 1976; Farmer and McGuffin, 1989; Harrington, 1993; J.Williams, 1992). The neurotic and psychotic distinction, based originally on inferred psychodynamic etiological factors and differences in observable symptoms, has been discarded because inferred psychodynamic etiological differences have not been supported by empirical evidence. The endogenous-reactive distinction has been abandoned because evidence from stressful-life-event research shows that almost all episodes of depression, regardless of quality or severity, are preceded by stressful life events and in that sense are reactive. The recognition that youngsters with depression may show co-morbid conduct disorders has rendered the concept of masked depression unnecessary, since the term was often used in child and adolescent psychology to classify depressed youngsters who masked their low mood with angry outbursts of aggressive or destructive behavior.

For children and adolescents the reliability of diagnoses of depression in epidemiological studies ranges from 0.36 to 0.9 . Thus, it appears from the better conducted studies that even with standardized interview schedules and clear diagnostic criteria, it is often difficult to diagnose depression reliably. Depression is not a rare condition and is more prevalent among adolescents than among children (Harrington, 1993). In community samples, prevalence rates of depression in pre-adolescence range from 0.5 to 2.5 per cent and in adolescents from 2 to 8 per cent. Depression is very common among clinic referrals. In clinic studies about 25 per cent of referrals have a major depression.

Depression quite commonly occurs in conjunction with other disorders, particularly in children referred for treatment. In community studies of childhood depression, co-morbidity rates of 10–17 per cent have been found for conduct disorder, anxiety disorders, and attention deficit disorder. In community studies of the anxious depressed syndrome of the Child Behavior Checklist, co-morbidity rates of 15–28 per cent were found for the aggressive behavior, attention problems and somatic symptoms syndromes of the Child Behavior Checklist. In clinic studies of referred cases with the Child Behavior Checklist anxious depressed syndrome, co-morbidity rates of 30–43 per cent were found for the aggressive behavior, attention problems, and somatic symptoms syndromes of the Child Behavior Checklist.

It has been mentioned that in ICD-10 children who show both serious conduct problems and depression are given a diagnosis of depressive conduct disorder. This is because these children have a distinct profile. Children with depressive conduct disorder or who meet DSM diagnostic criteria for both conduct disorder and depression have greater mood variability,

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have a worse response to imipramine, show higher rates of substance abuse in adulthood, and have lower rates of depression in adulthood (Harrington, 1993).

Sex differences in the distribution of depression have consistently been found. Depression is equally common in pre-adolescent boys and girls but more common in adolescent girls than in boys. This greater preponderance of depression among teenage girls than among boys is similar to the sex distribution of depression among adults. The relative contribution of biological factors and psychosocial factors to this sex difference in prevalence is currently unclear. Hypotheses about differential impact of hormonal changes in puberty on boys and girls and differing role demands on male and female adolescents deserve exploration.

Clinical features

The depressed child has usually suffered a loss of some sort. It may be a loss of an important relationship, a loss of some valued attribute such as athletic ability or health, or a loss of status. With respect to perception, having suffered a loss, depressed children tend to perceive the world as if further losses were probable. Depressed children selectively attend to negative features of the environment, and this in turn leads them to engage in depressive cognitions and unrewarding behavior patterns, which further entrench their depressed mood. In severe cases of adolescent depression, youngsters may report mood-congruent auditory hallucinations. We may assume that this severe perceptual abnormality is present when youngsters report hearing voices criticizing them or telling them depressive things. Auditory hallucinations also occur in schizophrenia. However, the hallucinations which occur in schizophrenia are not necessarily mood congruent.

With respect to cognition, depressed children describe themselves, the world and the future in negative terms. They evaluate themselves as worthless and are critical of their academic, athletic, musical and social accomplishments. Often this negative self-evaluation is expressed as guilt for not living up to certain standards or letting others down. They see their world, including family, friends and school, as unrewarding, critical and hostile or apathetic. They describe the future in bleak terms and report little if any hope that things will improve. Where they report extreme hopelessness and this is coupled with excessive guilt for which they believe they should be punished, suicidal ideas or intentions may be reported. Suicide will be discussed in detail in a later section of this chapter. Extremely negative thoughts about the self, the world and the future may be woven together in severe cases into depressive delusional systems. In addition to the content of the depressed youngsters' thought being bleak, they also display logical errors in their thinking and concentration problems. Errors in

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reasoning are marked by a tendency to maximize the significance and implications of negative events and minimize the significance of positive events. Concentration and attention difficulties lead to difficulties managing school work or leisure activities demanding sustained attention.

With respect to affect, low mood is a core feature of depression. Depressed mood is usually reported as a feeling of sadness, loneliness or despair and an inability to experience pleasure. Alternatively irritability, anxiety and aggression may be the main features, with sadness and inability to experience pleasure being less prominent. This is not surprising, since normal grief is characterized by sadness at the absence of the lost object, anger at the lost object for abandoning the grieving person, and anxiety that further losses may occur. Depressed children and adolescents may show some cocktail of all three emotional processes, i.e. depressed mood, irritability, and anxiety.

At a behavioral level, depressed youngsters may show either reduced or slowed activity levels (psychomotor retardation) or increased but ineffective activity (psychomotor agitation). They may show a failure to engage in activities that would bring them a sense of achievement or connectedness to family or friends. Where youngsters become immobile, this is referred to as depressive stupor. Fortunately this is rare.

Somatic or vegetative features such as loss of energy; disturbances of sleep and appetite; weight loss or failure to make age-appropriate weight gain; abdominal pains or headaches; and diurnal variation in mood are all associated with more severe conditions. Teenagers may also report losing interest in sex. These features of depression are consistent with findings that deregulation of neurophysiological, endocrine, and immune functions are associated with depression and that sleep architecture is also affected. This material will be mentioned in more detail in the section on biological theories of depression.

At an interpersonal level, depressed children report deterioration in their relationships with family, friends, teachers, and other significant figures in their lives. They describe themselves as lonely and yet unable to take, or unworthy of taking, steps to make contact with others.

Assessment

In the management of mood problems, the first priority is to assess risk of self-harm. A structured approach to the assessment and formulation of suicide risk is presented later in this chapter. Once suicide risk has been managed it is appropriate to begin a more thorough assessment.

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A second priority is to determine whether the depression is a response to a child-abuse situation, which requires a child-protection intervention. Where children are exposed regularly to physical, sexual or emotional abuse or neglect, offering a contract for treatment outside of a statutory child-protection framework may reinforce the pattern of abuse.

The third priority in cases where children or adolescents present with mood disorders is to clarify the nature and extent of symptomatology. The fourth priority is to establish the context within which the depression has arisen. A framework may be used as a template for identifying important predisposing, precipitating, maintaining and protective factors that emerge in interviews with the child, the parents, other family members, school staff, and significant members of the child's network. What follows is a discussion of the elements contained in that framework which are drawn from the empirical and clinical literature on depression in adolescents and children (Harrington, 1993; Reynolds and Johnson, 1994; Oster and Caro, 1990; Mufson *et al.,* 1993; Stark and Kendall, 1996; Asarnow *et al.,* 1993). These areas should be covered within the context of the assessment protocol.

Predisposing factors

Both personal and contextual factors may predispose youngsters to developing depression. A genetic vulnerability as indexed by a family history of mood disorders, early loss experiences, exposure to non-optimal parenting experiences, and parental depression are among the more related losses, such as difficulties associated with pre- or perinatal complications and early illness or injury. Psychosocial losses may include bereavements, separations, and institutional important predisposing risk factors for mood disorders. Loss experiences may include health care, social disadvantage, and loss of trusting relationships through abuse. A punitive, critical and authoritarian non-optimal parenting style, where the parent focuses on the child's failures rather than his successes, may render the child vulnerable to depression. The child as a result of such parenting may be sensitized to failure experiences and threats to his autonomy.

Neglectful parenting, on the other hand, may sensitize the child to loss of relationships and threats of abandonment. Neither of these types of parenting fosters secure attachment and the development of secure internal working models for trusting intimate relationships. Parental depression or drug or alcohol abuse may sub-serve these problematic parenting styles. Marital discord and family disorganization may also create a context where these types of non-optimal parenting occur. Personal characteristics of the adolescent, such as low intelligence, difficult or inhibited temperament, low self-esteem and an external locus of

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control, may predispose adolescents to develop depression. Low intelligence may be associated with failure to achieve valued academic goals. Difficult or inhibited temperament may compromise the youngster's capacity to regulate mood, and this in turn may interfere with the development of supportive relationships. Negative self-evaluative beliefs and the belief that important sources of reinforcement are beyond personal control may render youngsters vulnerable to self-criticism and helplessness, which are part of the depressive experience.

Precipitating factors

Loss experiences associated with the disruption of significant relationships, and loss experiences associated with failure to achieve valued goals, may all precipitate an episode of depression in children and adolescents. Relationships may be disrupted through illness, parent-child separations, parental divorce, moving house, moving school, bullying, or abuse. Failure to achieve valued goals and threats to autonomy may occur with exam failure and illnesses or injuries that prevent success in sports or leisure activities.

Maintaining factors

Both personal and contextual factors may maintain depression. Personal cognitive factors that maintain low mood include negative automatic thoughts and cognitive distortions that arise from negative cognitive schemas, particularly those associated with threats to attachment and autonomy. A depressive attributional style, where internal, global, stable attributions are made for failure experiences and external, specific, and unstable attributions are made for success, can also maintain depression. Low mood may be maintained by high levels of self-criticism and low self-efficacy beliefs. Other important cognitive factors that maintain depression include selectively monitoring negative aspects of one's actions, engaging in high levels of punitive self-talk or punishment, and engaging in little positive self-talk or self-reinforcement.

Self-defeating behavioral patterns that arise from social-skills deficits, particularly engaging others in depressive conversations which lead them to avoid future interactions, may maintain depressed mood. Depression may be maintained or exacerbated by using dysfunctional coping strategies, particularly substance abuse and self-harming gestures. Immature defenses for dealing with perceived threats such as denial or reaction formation may also maintain depressed mood. At a biological level, depression may be maintained by dysregulation of the amine system governing reward and punishment processes; dysregulation of the endocrine

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system and the immune system governing defence against illness; and desynchrony of the sleep-waking cycle.

Within the youngster's family or school context a variety of factors maintain mood problems. These include ongoing inescapable abuse, bullying or punishment in the absence of adequate support, or being in an unsupportive educational placement. Ongoing interactions with parents or primary carers characterized by excessive criticism, neglect, or excessive over-involvement may maintain depression, as may family circumstances where the youngster is blocked from achieving developmental tasks such as developing autonomy. These parenting patterns may be subserved by confused family communication, family disorganization, and triangulation, where the depressed youngster is caught between the conflicting parental demands. These types of difficulty may arise in family contexts where parents have high levels of stress, including social disadvantage; low levels of social support; marital discord; low father involvement; physical illness; or psychological problems, including depression.

Where parents have insecure internal working models for relationships, low self-esteem, low self-efficacy, an external locus of control, immature defences and poor coping strategies, their resourcefulness in managing their children's depression may be compromised. Parents may also become involved in problem-maintaining interactions with their children if they have inaccurate knowledge about the role of psychological factors in the genesis and maintenance of depression.

Within the treatment system, a lack of co-ordination and clear communication among involved professionals, including family physicians, paediatricians, nurses, teachers, psychologists and so forth, may maintain adolescents' depression. It is not unusual for various members of the professional network to offer conflicting opinions and advice on the nature and management of adolescent depression. These may range from viewing the child as psychiatrically ill and deserving in-patient care, anti-depressant medication and permissive management to seeing the child as delinquent and requiring strict behavioral control. Where co-operation problems between families and treatment teams develop, and families deny the existence of the problems, the validity of the diagnosis and formulation, or the appropriateness of the treatment program, then the adolescent's difficulties may persist. Parents' lack of experience in dealing with similar problems in the past is a further factor that may compromise their capacity to work co-operatively with the treatment team, and so may contribute to the maintenance of the adolescent's difficulties.

Protective factors

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The probability that a treatment programme will be effective is influenced by a variety of personal and contextual protective factors. It is important that these be assessed and included in the later formulation, since it is protective factors that usually serve as the foundation for therapeutic change. Youngsters with less severe mood disorders which are clearly episodic, and who also show co-morbid conduct problems, are less at risk than those with double depression (severe episodic mood disorder superimposed on a persistent milder mood problem) and no conduct problems. At a biological level, physical fitness and a willingness to engage in regular physical exercise are protective factors. A high IQ, an easy temperament, high self-esteem, an internal locus of control, high self-efficacy and an optimistic attributional style are all important personal protective factors. Other important personal protective factors include mature defense mechanisms and functional coping strategies, particularly good problem-solving skills and a capacity to make and maintain friendships. Within the family, secure parent-child attachment and authoritative parenting are central protective factors, particularly if they occur within the context of a flexible family structure in which there is clear communication and high marital satisfaction, and both parents share the day-to-day tasks of managing home life.

Good parental adjustment is also a protective factor. Where parents have an internal locus of control, high self-efficacy, high self-esteem, an internal working model for secure attachments, an optimistic attribution style, mature defenses and functional coping strategies, then they are better resourced to manage their children's difficulties constructively.

Accurate knowledge about the role of psychological factors in recovery from depression is also a protective factor.

Within the broader social network, high levels of support, low levels of stress, and membership of a high socioeconomic group are all protective factors for depressed adolescents. Where families are embedded in social networks that provide a high level of support and place few stressful demands on family members, then it is less likely that parents' and children's resources for dealing with health-related problems will become depleted. A well-resourced educational placement may also be viewed as a protective factor.

Educational placements, where teachers have sufficient time and flexibility to attend home-school liaison meetings, if invited to do so, contribute to positive outcomes for depressed adolescents.

Within the treatment system, co-operative working relationships between the treatment team and the family and good co-ordination of multi-professional input are protective factors. Families are more likely to benefit from treatment when they accept the formulation of the

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problem given by the treatment team and are committed to working with the team to resolve it. Where families have successfully faced similar problems before, then they are more likely to benefit from treatment, and in this sense previous experience with similar problems is a protective factor.

Formulation

Following thorough assessment interviews, a case formulation may be drawn up which links predisposing, precipitating, maintaining and protective factors to depressive symptomatology; potential treatment goals; and possible plans for reaching these.

Treatment

Thorough assessment typically reveals that youngster's mood problems are maintained by personal factors, family-based factors, school-based factors and possibly factors within the child's wider network. While it is useful for the core intervention to target the child in his family, interventions with the school or ward staff in hospitalized cases, or focusing on the parents in multi-problem families, may be necessary. In the treatment protocol given here, I have attempted to integrate those techniques which have been shown to be effective in the cognitive-behavioral literature with well-established systemic, interpersonal and social learning-based approaches to working with families (Williams, 1992; Kaslow and Rehm, 1991; Oster and Caro, 1990; Carr, 1995; Mufson *et al.,* 1993; Lewinsohn *et al.,* 1994). The following elements are contained in this approach to treatment:

• Psycho-education

• self-monitoring

• Interventions focusing on activity

• Interventions focusing on changing family relationships

• Interventions focusing on cognition

• Social skills and social problem-solving training

• School interventions

• Medication

• Management of parental mood problems

• relapse management.

Psycho-education

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Psycho-educational input is appropriately offered early in the consultation process so that the adolescent and his family share a common understanding of depression with the treatment team. However, throughout therapy it is necessary to remind clients from time to time about various aspects of this way of conceptualizing depression. Depression is explained as a complex condition involving changes in mood, biological functioning, thinking, behavior, and relationships. Vulnerability to depression may be due to genetic factors or early loss experiences. Current episodes of depression arise from a build-up of recent life stress. These activate the vulnerability, which then comes to be maintained by depressed thinking, action, and relationships. Genetic vulnerability may be explained as a nervous system that 'goes slow' under pressure and disrupts sleep, appetite, and energy. This going-slow process leads to depressed mood. Early-loss-related vulnerability may be explained as a set of memories about loss that have been filed away, but are taken out when a recent loss occurs. The files inform the youngster that more and more losses will occur and this leads to depressed mood. Treatment centres on helping youngsters and their families learn how to control and change patterns of thinking, action and relationships that maintain depression. It is important to highlight that the youngster's thinking processes or beliefs, behavioral routines, and ways of managing relationships, which maintain depressed mood, are under conscious control, so treatment will focus on coaching the youngster to change these three things. The role of the family is to help the youngster develop new beliefs, routines, and ways of managing relationships which protect him from becoming stuck in low moods. Within this context, protective factors, particularly social support from the family, may be mentioned. This allows the youngster and the family to view themselves as a problem-solving team.

Somatic state has also been included in the model. It may be mentioned that in adults, antidepressant medication may be used to regulate sleep and appetite and increase energy levels, but unfortunately adolescents tend to metabolize anti-depressant medication before it can have an opportunity to be effective. The results of treatment trials show that it is no more effective than placebos with teenagers. This aspect of psycho-education is particularly important in cases where a parent has been effectively treated for depression with antidepressants.

If parents or youngsters are unable to understand this model of mood problems, repeatedly trying to enlighten them, in my experience, evokes resistance rather than co-operation. In these cases, it may be possible to offer a very simple program which has demonstrated effectiveness, i.e. relaxation training over eight sessions (Wood *et al.,* 1996). If parents understand the model but disagree with it, repeated argument is more unlikely to lead to

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acceptance. This typically occurs in families where a parent or other family member has been treated with anti-depressants for a mood disorder and believes that the same treatment is the most appropriate for the teenager. Our primary responsibility in such cases is to let parents know that the evidence for the efficacy of anti-depressants with adolescents is not great and that little is known about possible long-term adverse effects. Good practice is to resort to antidepressants only in instances where psychological interventions have not been effective.

Self-monitoring

Self-monitoring and goal setting may be introduced together in the earliest stages of therapy. The youngster and the family are invited to set very small achievable goals, which, if reached, would clearly demonstrate that improvement was occurring; for example, having at least one period in the day when the youngster's mood rises at least one point on a 10-point scale, or having three periods of a half day in a week when a mood rating of at least 5 was achieved.

The idea of tracking progress towards these mood-change goals by diary keeping may be introduced at this point. It is best at this early stage to invite the adolescent to keep a simple type of diary which should be completed each time the youngster notices a significant change in mood. The diary may be organized in three columns with the following headings:

• The date and time of the entry

• A mood rating on a 10-point scale

• The activity that preceded the mood rating.

This type of diary helps adolescents and parents develop an awareness of the link between activity and mood. The diary should be reviewed in each session and links made between carrying out particular activities or engaging in particular types of relationship and mood. Youngsters may find from this type of diary that particular types of event are associated with higher moods. Such events may include physical activity, manageable challenges, cooperative activities, and so forth. They may also identify events that lower mood, such as inactivity, watching TV, solitary playing of video games and so forth. This type of self-monitoring provides a basis for introducing a number of interventions associated with scheduling activities linked with higher moods. These include scheduling graded tasks; scheduling physical exercise; scheduling pleasant events; scheduling age-appropriate challenges; and relaxation training, all of which are discussed below. The youngster may be invited to complete one or more of these types of task both in the session and between sessions, and to note their impact on mood in the diary.

A more sophisticated approach to diary keeping may be introduced later in therapy in which an additional fourth column is added, where *relationship events* which preceded a mood rating are made. In particular, the person to whom the youngster was most recently talking and the degree to which that relationship or conversation was experienced as supportive or stressful may be noted. This diary should include the following columns:

• The date and time of the entry

• A mood rating on a 10-point scale

• The activity that preceded the mood rating

• The relationship that preceded the mood rating.

Reviews of this type of diary allow teenagers and their parents to track the relationship between mood and certain types of social interaction that commonly occur within the family or peer group. It is not unusual for parents to learn that conversations intended to cheer their child up actually depressed them further, whereas fairly neutral exchanges led to improvements in mood. Family members may also become aware of the negative impact of conflict and triangulation on the teenager by reviewing this type of diary. This type of information provides a basis for relationship-focused interventions including family communication training; family problem-solving training; providing support; and renegotiating role relationships. The impact of using these skills in family conversations on the youngster's mood may be tested in treatment sessions and also between sessions, and the results noted in the diary.

Later a new column may be added to the diary, in which youngsters record the *thoughts* or ideas that went through their minds and which contributed to their mood rating. Training in capturing negative automatic thoughts and understanding cognitive distortions should precede this self-monitoring assignment, and this will be discussed below. In this type of self-monitoring task the following five columns should be included in the diary:

• The date and time of the entry

• A mood rating on a 10-point scale

The activity that preceded the mood rating

• the relationship that preceded the mood rating

• The thoughts that the person had about the activity or relationship that contributed to the mood rating.

Reviewing this type of diary allows the adolescent and family members to see that the youngster's interpretation of events contributes to negative mood. This provides a rationale for teaching the challenge test reward (CTR) routine for challenging negative automatic

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thoughts. Conducting this type of training in family sessions is particularly important in families where a parent suffers from depression, since it provides such parents with a strategy for being less critical of the depressed child. Many depressed parents attribute negative intentions and qualities to their children who subsequently develop depression, and unless this process can be modified, youngsters may find that it contributes to relapses.

Once youngsters have become proficient in using diaries that allow the impact of activities, relationships and thoughts on mood to be tracked, two additional columns may be added in which coping strategies used to alter mood and the impact of these on mood are noted.

Interventions focusing on activity

Through psycho-education and diary keeping, adolescents and their families discover that activity directly affects mood. Small tasks, pleasant tasks and age-appropriate challenges all improve mood, whereas large tasks, unpleasant events and being blocked from facing age appropriate challenges lead to a depressed mood. Physical exercise and relaxation also promote a positive mood. In the light of this, there are certain interventions which help youngsters develop activity patterns that improve mood. These include:

• scheduling graded tasks

• scheduling pleasant events

• remembering pleasant events

• scheduling age-appropriate challenges

• scheduling physical exercise

• using relaxation skills.

Scheduling graded tasks

Depressed youngsters may report that there are things that they feel they should do or want to do but believe that they cannot, because the tasks appear to be overwhelmingly demanding. In scheduling graded tasks, the youngster is invited to break large, insuperable tasks into small, manageable tasks, complete these, and receive reinforcement for doing so. Parents and youngsters may be invited to work together in a treatment session, break a big task into smaller tasks, and agree on a reward system using points or tokens, whereby the adolescent will be reinforced for completing each small component of the large task.

Scheduling pleasant events

Parents and youngsters may be invited to draw up lists of pleasant events, such as going for a walk together or watching a film, which the adolescent believes are associated with improved mood, and plan to carry these out.

Remembering pleasant events

Parents may be shown how to schedule a period each evening to help youngsters review their day and remember all the positive things that have happened, list these, and post them on the fridge door or the child's bedroom wall.

Scheduling age-appropriate challenges

Where adolescents and their parents have become entrenched in patterns of interaction appropriate to the pre-adolescent stage of development, families may be invited to arrange for adolescents to work gradually towards dealing with age-appropriate challenges. These may include travelling independently to meet friends, shopping for their own clothes, planning to stay overnight at a friend's house and so forth.

Scheduling physical exercise

Youngsters and their parents may be invited to increase gradually the amount of daily physical exercise the teenager takes, since inactivity maintains low mood and regular exercise, particularly aerobic exercise, improves mood.

Using relaxation skills

Youngsters may be trained either directly or through their parents in using the relaxation, breathing, and visualization skills. These skills are particularly useful where the youngster experiences irritability and anxiety as part of the mood disorder. They may also be used with sleep problems. Parents may be shown how to help their children practice relaxation exercises at bed time to facilitate sleep onset.

Interventions focusing on family relationships

Both preliminary assessment interviews and the results of self-monitoring tasks typically provide evidence that the adolescent's mood is influenced by family relationships, notably those characterized by confusing communication, conflict, criticism, over-involvement, and triangulation. Furthermore, role-relationship difficulties associated with family transitions including the onset of adolescence, parental separation, bereavements and so forth may contribute to depression. On the other hand, parental support, clear communication, nonconflictual approaches to solving relationship problems, and clear roles tend to be associated with positive moods. The interventions which may be used to promote the types of family relationship which improve mood are:

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- Family communication training and problem-solving training
- facilitating support
- renegotiating role relationships.

Family communication training and problem-solving training

With communication training, where the core skills are turn taking, making points unambiguously, listening, summarizing, and checking the accuracy of what was heard, a central difficulty that many families containing depressed teenagers have is avoiding mind reading. That is, it is not unusual during communications training for depressed parents to attribute negative intentions and ideas to their depressed adolescents, and vice versa. The challenge in communication training is to coach family members in avoiding this pitfall, by listening carefully and accepting what is said at face value. With problem-solving training, where the main steps are defining problems in small, solvable terms, brainstorming options uncritically and then selecting the best option, a difficulty in families with depressed members is the premature criticism of possible solutions, which creates a culture within which no one ventures new ideas lest they be criticized. Family members require careful coaching in the skill of delaying evaluation of options until a large number have been generated. Without this, creative solutions to family problems which maintain the adolescent's depression may be more difficult to find.

Facilitating support

Supportive conversations may be scheduled for time-limited periods, such as 30 minutes at a set time each day. The role of the supporting family member is to use listening skills learned in the communications-training exercise, and do no more than summarize what the depressed adolescent has said and check that the supporting family member has understood the adolescent correctly. No attempt should be made by the supporting family member to cheer depressed adolescents up or to make suggestions about how they might solve their problems. Family members require coaching in this very difficult skill, since even the most patient parent or sibling will have urges to talk the adolescent out of her depression.

Renegotiating role relationships

Role-relationship difficulties which maintain depression may be characterized by over-involvement, criticism, and problems associated with divided loyalties. What follows is some strategies for renegotiating these problematic role relationships. Where parents have become over-involved with their child and regularly engage in intrusive interactions, this non-

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supportive pattern may be disrupted by offering them the opportunity of having a break from caring for the depressed child, by passing the responsibility of caring for the depressed adolescent over to the less involved parent. This type of intervention may be particularly useful in families where the over-involved parent is inadvertently blocking the adolescent's completion of age-appropriate developmental tasks, such as developing autonomy and maintaining privacy. In such instances, often the more the peripheral parent argues for the over-involved parent to allow the adolescent some space, the more over-intrusive the over-involved parent becomes. This intervention of placing the peripheral parent in charge of the adolescent's welfare disrupts this pattern of triangulation.

Where one parent has become highly critical of their youngster and her depressive behavior, the parent and child may be encouraged to join forces to defeat or overcome the depression, which may be externalized and personified as a black knight, a dragon, a monster or some other mythological entity. The central feature of the intervention is that the parent and child join in a strong alliance against the depression, so the child feels supported by the parent. I have found this intervention particularly useful in families where one parent (typically the father) has become very critical of the child, while the other parent (typically the mother) sympathizes with the child's position.

In families where parents are separated or divorced, often depressed adolescents find the experience of divided loyalties very distressing. They feel that they must choose between being loyal to one parent or to the other, but either of these positions entails the loss of a relationship with a parent. This experience of divided loyalties is exacerbated when a parent expresses his or her anger and disappointment concerning the ex-partner to the adolescent. In such instances, with coaching from the psychologist, the adolescent may be helped to explain to the parents the extraordinary anguish that this type of triangulation causes and to ask the parents to make a commitment never to ask the teenager to take sides again, because she is loyal to both parents and will remain so. Where adolescents have difficulty facing their parents and saying this, they may write them a letter containing these sentiments and read it out to the parents in the session. The parents, in reply, may be coached to agree to the adolescent's request. Where parents cannot consent to this, it is vital that they understand the consequences of this for the adolescent, i.e. chronic psychological problems including depression.

Interventions focusing on cognition

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The techniques described in this section are family-based variations of interventions developed for use with individual adults in cognitive therapy. Because children's belief systems are inextricably bound up with their parents' belief systems, I have found that this family-based approach to cognitive therapy is particularly useful with adolescents.

Interventions which focus on cognitions begin by teaching both parents and youngsters to identify automatic thoughts and their impact on mood. The adolescent and parents may be asked to give a current mood rating on a 10-point scale and then identify the thought they are telling themselves that accounts for that rating. A challenge may then be posed to the youngster to complete a difficult arithmetic problem or puzzle. After the adolescent has tried to solve the problem for a minute or so, the psychologist may then ask her to give a mood rating and the automatic thought that underpins it. Usually, there will be a drop in mood associated with a negative thought arising from failure to solve the puzzle. In this way the link between automatic thoughts and mood is established. It may be pointed out that the automatic thought (for example, 'Because I can't do it quickly I'm stupid') could conceivably be replaced with another thought (for example, 'If I had a calculator I'd be finished now') that might lead to a less depressed mood rating. The adolescent may be invited to keep track of automatic thoughts and related mood states using the self-monitoring system described earlier.

Reviewing self-monitoring forms throws light on situations that led to mood changes and the automatic thoughts that occurred in these situations. Parents and adolescents may be helped to develop specific routines for challenging or neutralizing negative automatic thoughts. Three methods deserve particular mention:

• The *c*hallenge *t*est *r*eward (CTR) method

• Reattribution training

• focusing on positives.

*C*hallenge *t*est *r*eward (CTR) method

Challenging negative automatic thoughts involves generating alternative self-statements that could have been made in a specific situation in which a negative automatic thought occurred, and then looking for evidence to *test* the validity of this alternative. Finally, when this task has been completed and the youngster shows that the depressive automatic thought was invalid, he engages in self-*reward* or self-reinforcement. So, for example, one alternative to the automatic thought 'He didn't talk to me so he doesn't like me' is 'He didn't talk to me because he is shy.' If there is evidence that the person in question never injured me before

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and on a couple of occasions smiled at me, then the more valid statement is that the person is shy.

The CTR method may be taught within family sessions, and the family may be asked to think about how much evidence there is for each of a series of negative automatic thoughts and possible alternatives. They may then be coached in praising themselves for testing out the alternatives efficiently. Parents may be invited to prompt adolescents to use their CTR skills in situations where low mood occurs.

Social skills and social problem-solving training

Group activity programs and a group therapy format may be used to help teenagers develop social skills so that they can initiate and maintain positive interactions with peers. Common problems with depressed teenagers include avoidance of initiating conversations; engaging in depressive, self-critical or pessimistic talk, which other teenagers find aversive; and withdrawing from complex social situations. These difficulties in turn lead to exclusion from peer-group activities. Social skills training should aim to help youngsters learn strategies for tracking peer-group conversations, identifying opportunities for contributing, making contributions to conversations and activities that benefit themselves and others, and generating solutions to complex social situations. Youngsters may be coached in social skills by first being given a rationale for the skill; second, observing a model of the appropriate skill; and then practicing it and receiving verbal or video-taped corrective feedback and reinforcement.

A useful rationale is to explain that most peer groups want new members that are going to give something good (like companionship or good humour) rather than take something away (like replacing a good mood with a bad mood). When you are depressed, this takes some planning, because the depression forces you to give nothing and take away any good mood there is. Coaching in social skills is a way of beating depression, by planning to give companionship and good humour rather than taking it away. In the long run using social skills may lead to getting some friendship back.

Following this type of rationale, the psychologist may show a video tape of an appropriate and inappropriate way of initiating a conversation, or a conversation in which a youngster gives good humour or engages in depressive talk. In some of our groups I have taped clips from TV programs to use as models. In others, I and my colleagues modeled the interactions ourselves.

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With rehearsal, youngsters are invited to imitate the behavior demonstrated by the model. It is important that all approximations to positive social skills be praised and suggestions for improvement be made tactfully. Video-taped feedback, in my clinical experience, is only useful when significant improvement has been made which can clearly be pointed out to the youngsters viewing the tape. If their performance is poor, the process of watching themselves engage in poor social skills on video tape may exacerbate their depression.

Once basic social skills such as joining, initiating, and maintaining conversations have been mastered, training in social problem solving may begin. Here, youngsters generate a list of difficult social situations that they fear handling, such as being criticized, snubbed, laughed at or embarrassed, and are asked to generate as many possible alternative ways of dealing with these problems as possible. Positive and negative possible outcomes of all these options may be explored, and the group may then be coached in how to implement the most favorable solution. Again, video clips from soap operas and group members' favorite TV programs may be used to illustrate difficult peer-group interactions and solutions to these interpersonal problems.

School interventions

Work with the school should help the child's teacher understand the formulation and develop supportive patterns of interaction with the child. Where children have become withdrawn, teachers may be helped to create opportunities where the depressed child can interact with peers.

Medication

Available evidence offers little support for the effectiveness of anti-depressant medication with depressed children, despite its unequivocal effectiveness with adults (Gadow, 1992). However, the main reason to consider the use of anti-depressants as an adjunct to psychosocial intervention, in cases where psychosocial interventions alone have been ineffective, is the fact that in all published studies some children and adolescents have responded to treatment.

Prescription of anti-depressants and the monitoring of side effects is the responsibility of a physician, who shares the care of a client with a clinical psychologist.

Management of parental mood problems

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Interventions which focus on parental mood problems, a reduction of parental stress, and the amplification of parental support should be prioritized if it is clear from the formulation that these factors will compromise the parents' capacity to help the adolescent recover. Many youngsters referred for treatment come from families where one or both parents are depressed.

In such instances, it is important to ensure that depressed parents are referred immediately for treatment, if they are to be able to engage effectively in family work to help their youngsters recover. Where particular life stresses and support deficits, such as marital conflict, conflict within the extended family, social isolation, inadequate accommodation, financial difficulties, work related difficulties and so forth, are severe enough to prevent any therapeutic progress, in a minority of instances it may be necessary to address these first. However, where possible, the focus of the work should be on helping the family to help the child to recover. Success with this goal may increase parents' self-efficacy so that they are empowered to tackle their other life difficulties with greater confidence.

Relapse management

Depression is a recurrent disorder, and while 90 per cent of episodes may resolve with intensive short-term intervention within 12 months, most children relapse. Therefore brief therapy must be offered within the context of a longer-term care program. Children and parents may be trained to identify and cope with relapses and invited to re-contact the clinical psychology service in the event of a further episode of depression.

Managing resistance

A central guideline for working with depressed adolescents is to set tasks where there is a very high chance of success. So psychoeducational input should be pitched at the youngsters' ability level. Easy self-monitoring tasks should be given before progressing to more complex ones. Simple and small homework assignments focusing on activities, relationships, and cognitions should be given first before moving on to more challenging invitations. Where youngsters have difficulty completing tasks, responsibility for this should be taken by the psychologist, who probably asked more of the youngster and the family than they were ready for. It is very easy when working with depressed youngsters from families in which one of the parents is depressed to fall into a pattern of criticism and blaming the family for lack of progress. The challenge is to establish and maintain a good working alliance and find a pace of work which suits the family.

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Summary

Mood disorders in children and adolescents constitute a serious problem because of the high rate of relapse. While equal numbers of children develop mood problems, in adolescence there is a sharp rise in the prevalence of depression among girls. Prevalence rates may be as high as 8 per cent among teenage girls. Within DSM IV and ICD-10 the main distinctions are between primary and secondary mood disorders; recurrent major and persistent minor mood problems; and unipolar and bipolar mood disorders. Major and minor unipolar disorders are probably the most commonly seen in clinical practice. A low mood; negative cognitive set; self-defeating behavioral patterns; disruption of sleep and appetite; and conflict or social withdrawal from important relationships at home and at school are the main clinical features. Psychoanalytic theories of depression point to the importance of early separation or bereavement and critical parenting styles in developing a vulnerability to depression. Behavioral theories point to lack of reinforcement or poor self-reinforcement skills in the maintenance of depression. Cognitive theories highlight the role of negative interpretation of ambiguous events in the maintenance of depression. Systems theory underlines the role of problematic family relationships in maintaining low mood. Biological theories point to the importance, in the aetiology of depression, of genetic factors; dysregulation of the neurotransmitter systems in the reward and punishment centers of the brain; endocrine dysfunction; immune system dysregulation; disruption of the sleep-waking cycle; and in some instances seasonal biological changes. Because of the complexity of mood problems and the uniqueness of each case, intervention programmes should be based on a comprehensive case formulation arising from a thorough multi-systemic assessment. Available evidence suggests that with children and adolescents, multi-systemic intervention based on the principles of cognitive-behavioral therapy, family systems therapy and social learning theory is the treatment of choice. Few adolescents respond to anti-depressant medication, and so medication should only be considered if psychological therapy has been ineffective.

Where adolescents present with threats of self-harm or self-injurious behavior, the youngster and significant network members should be interviewed. This should be followed with an exploration of the details of the adolescent's suicidal ideation, suicidal intention, and self-injurious behavior. Demographic, historical, and health-related risk factors and protective factors should also be identified. These should be integrated into a formulation, and a plan for risk reduction should be developed and implemented.

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GLOSSARY

Chapter 1

Advocacy: حمایت
Align with: تراز با
Alleviate: کم کردن
Aspiring: مشتاق
Assessor: مامور ارزیاب
Autonomy: استقلال
Bias: تعصب
Body image problems: مشکلات مربوط به تصور از بدن خود
Burgeoning: رو به رشد
Caregiver: پرستار
Cognitions: شناخت
Cohesive: انسجام
Colloquially: محاوره ای
Conceptual: **مفهومی**
Constitutional: مشروطه
Contextualizing: تخصصی سازی
Controversial: اجتماعی و فرهنگی
Coping skills training: آموزش مهارت مقابله
Counter-conditioning: شرطیسازی
Covert: پنهان
Covertly: پنهانی
Curricula: برنامه های آموزشی
Deficit: نقص
Deviant: انحرافی
Devote: اختصاص دادن
Diametrically: **کاملا**
Didactic: آموزشی
Discrete: گسسته، مجزا
Disseminating: نشر و گسترش
Dissemination: اشاعه اطلاعات
Distractibility: حواس پرتی
Elective: انتخابی
Emanates: نشات گرفته
Empirical: تجربی
Encompass: در بر گرفتن
Endorse: صحه گذاردن
Entity: موجودیت
Entrepreneurial: کار آفرینانه
Espoused: مورد حمایت
Evolve: تکامل یافتن

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به صراحت:Explicitly
نوعی درمان که از سیستم درمان خانوادگی :Family Constellations
استفاده می کند
از لحاظ مالی:Fiscally
ویژگی متمایز :Hallmarks
فروتن، محقر:Humble
پیاده سازی:Implement
در واقع :In essence
به طور جدایی ناپذیری :Inextricably
استنتاج کردن:Infer
استنتاج :Inference
یکپارچه :Integrated
فعل و انفعال:Interplay
در هم آمیخته **:Interwoven**
درون روانی **:Intrapsychic**
پرسشنامه :Inventory
قابل توجیه **:Justifiable**
مشروع:Legitimate
تحت اللفظی**:Literal**
طولی:Longitudinal
عامل اصلی:Mainstay
ناسازگار :Maladaptive
مجازی**:Metaphorical**
بالغ شدن بر :Mount
منسوخ :Obsolete
آشکار :Overt
ادراک شده **:Perceived**
ادراکی:Perceptual
نفوذ کردن:Permeates
دادخواست:Petition
عملی:Practicum
استعداد، **زمینه:Predisposition**
مطرح، پیشنهاد کردن**:Propound**
روانشناختی **:Psychoeducational**
درکی و روانی:Psycholinguistic
روانی حرکتی:Psychomotor
حوزه :Purview
عاطفی- منطقی:Rational-emotive
متقابل:Reciprocal
باز پرداخت:Reimbursement
مقیم شدن، مبتنی بودن بر :Reside
حالت ارتجاعی:Resilience
پاسخ دهنده :Respondent
آموزش خود محور :Self-instructional training

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Service-oriented: سرویس گرا
Socio-cultural: اجتماعی و فرهنگی :
Spawn: ایجاد کردن
Substantial: قابل توجه
Tenable: قابل دفاع
Tenets: عقاید
Trace: ردیابی کردن، ترسیم کردن
Traumatic: پس از سانحه
Vacuum: خلاء
Vibrant: مرتعش

Chapter 2
Advocated: حمایت شده
Cataloguing: فهرست نویسی
Coincide: مصادف شدن
Collectivist: جمع گرا
Collude: تبانی کردن
Distress: پریشانی
Dyadic: دوتایی
Empathy: همدلی
Explicit: صریح
Facet: شکل
Hierarchically: به صورت سلسله مراتبی
Holistic: جامع
Homage: تجلیل
Homeostatic: متعادل
Inextricable: حل نشدنی
Libidinal: وابسته به شهوت جنسی
Multidirectional: چند جهته
Obfuscate: مبهم و تاریک کردن
Obscure: مبهم
Palliative: تسکین دهنده
Partake: سهیم بودن
Pertinence: شایستگی
Posit: فرض کردن
Predisposition: استعداد
Privilege: مزیت
Proposition: پیشنهاد

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Provocative:محرک

Psychoanalytic:روانکاوی

Reenactment: اجرا یا نمایش مجدد

Siphon:برداشتن

Spark: جرقه

Speculate:اندیشیدن

Stance:حالت

Chapter 3

Able-bodied: سالم

Abrupt: ناگهانی

Adjunct:کمکی

Affirm: تایید

Agenda: دستور کار

Agoraphobia:هراس از مکانهای باز

Alleviate:کاهش

Alliance: اتحاد

Ameliorated: بهبود

Amnesic:مبتلا به فراموشی

Anguish: غم و اندوه

Antecedent: سابقه

Anxiety-provoking:محرک اضطراب

Apathetic:بی تفاوت

Aphasia:زبان پریشی

Apprehension:نگرانی

Aptitude: استعداد

Arousal:انگیختگی

Articulation: بیان

Assertiveness: ابراز وجود

Attainment: تهیه

Auditory:شنوایی

Aversive: بد

Bereavement: سوگ

Biofeedback-assisted relaxation: آرام سازی بواسطه زیست بازخورد

Bizarre:عجیب و غریب

Bleak:تاریک و دلگیر

Bulimia:پرخوری

Burglars:سارق

Cannabis: شاهدانه

Catatonic:حرکات خشک وقالبی به همراه خشکی عضلات

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Cessation: قطع

Circumscribed: محدود

Cocktails: کوکتل مشروبات الکلی

Coerce: مجبور

Co-morbid: هم مرضی

Compelled: مجبور

Compensatory: جبرانی

Compulsive: اجباری

Conceptualizing: مفهوم

Concise: اجمالی

Concrete: بتنی، محکم

Congruent: متجانس

Conjoint: متقارن

Connectedness: ارتباط

Construe: تفسیر

Contagion: سرایت

Contingency: احتمالی

Cope with: کنار آمدن با

Debilitating: ناتوان کننده

Debrief: اطلاعات کسب کردن

Delinquent: متخلف

Delusions: هذیان

Deterioration: تخریب

Discrimination: تبعیض

Distortions: تحریف

Distressing: ناراحت کننده

Diurnal: روزانه

Elaboration: پیچیدگی

Empathize: همدردی

Endogenous: درون زاد

Engross: اشغال کردن

Entail: مستلزم بودن

Enuresis: ناتوانی در دفع ادرار

Epilepsy: بیماری صرع

Epileptic: صرعی

Erode: ساییده شدن

Erroneous: اشتباه

Escalates: شدت

Estrangement: بیگانگی

Etiological: سببشناختی

Exacerbate: تشدید

Expectancy: امید

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Explicitly:به صراحت
Fading: محو شدگی
Fatigue:خستگی
Feigned:جعلی
Florid: پوشیده از
Flounder:دست و پا کردن
Gauge: اندازه
Habitual:همیشگی
Habituation:خوگیری
Hallucinogen: توهم زا
Harbingers:منادی
Hierarchy:سلسله مراتب
Hostile:دشمن
Idiosyncrasies:خصیصه های ذاتی
Imitate:تقلید کردن
Immobilized:بی حرکت
Impend:مشرف بودن
Implement:پیاده سازی
Inadequacies: کمبود
Inducements: انگیزه
Ineptness:ناشایستگی
Ingesting germs: میکروب های هضم کننده
Insidious:موذی
Intrauterine:درون زهدانی
Inward-focused: تمرکز باطنی
Irritability:کج خلقی
Lessened:کاهش
Liaison:ارتباط
Lush: با شکوه
Malevolent: بدخواه
Marginalized: به حاشیه رانده شده
Marital discord: اختلاف زناشویی
Mollycoddle: ادم ناز پرورده
Nausea: تهوع
Negotiation: مذاکره
Nurturance:محبت
Obstacles: موانع
Onset:شروع
Perceptual:ادراکی
Pervasive:فراگیر
Phonology:صدا شناسی
Pragmatics:واقع بین
Precipitating: مستعدکننده

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Precludes: مـانـع

Predispose: زمـيـنـه را مـهـيـا سـاختـن

Probation: عفـو مـشـروط

Pronominal: ضمـيـری

Pros and cons: مـزايـا و مـعـايـب

Psychoses: جنـون

Punitive: تـنـبـيـهـی

Reciprocity: عمل مـتـقـابـل

Recreational: تـفـريـحـی

Recurs: تـکرارهـا

Reinforcement: تـقـويـت

Relapse: عـود

Relapse-management: مـديـريـت عـود بـيـمـاری

Reluctant: بـی مـيـل

Remission: بـخشش

Salient: چشمگيـر

Satiated: سيـرچشم

Schema: طرح

Sedation: تـسکيـن

Self-reinforcing: تـقـويـت خـود

Self-soothing: خـود تـسکيـنـی

Semantics: علم مـعـانـی

Settle: مـستقـر شـدن

Spill-over: سرريـز

Stammer: لـکنت

Subside: فـروکش کـردن

Sulk: تـرشرويـی

Syntax: تـرکيـب نـحوی

Tachycardia: افـزايـش ضربـان قـلب

Tantrums: کج خـلق

Tremble: لـرزه

Triangulation: مـثلث بـندی

Turmoil: پـريـشانـی

Underpin: پـی ريـزی کـردن

Undue: غيـر ضروری

Unequivocal: بـدون ابـهـام

Vigilance: مـراقـبت

Volition: اراده

Vulnerability: آسيب پـذيـری

Waster: مـصرف

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