

# **Part III: Services**

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**Chapter 5**  
**Therapies**

## INTRODUCTION

The specific techniques used to treat children with mental health problems vary depending on the nature and severity of a child's problems, the orientation of mental health professionals, and the resources available to finance and house treatment services. Although some treatment methods have been devised especially for children, most are adaptations of procedures used with adults.

This chapter describes the principal treatment methods currently used with children by mental health professionals:

- . individual therapy,
- group and family therapy,
- milieu therapy,
- crisis intervention, and
- psychopharmacological (drug) therapy.

In practice, most of these techniques are used in combination with one another.

## INDIVIDUAL THERAPY

The paradigm for mental health treatment has traditionally been individual therapy—the one-on-one encounter of a therapist and a patient. Over the past 50 years, there have developed a large number of individually based therapies based on theories as disparate as psychoanalysis and operant conditioning. Each theory has spawned various approaches to individual therapy that have been adapted for use with children.

Three broad categories of treatment approaches used with individual children are described below:

1. *psychodynamic therapy*, which focuses on the development of insight;
2. *behavioral therapy*, which is based on behavioral learning theories and relies on positive and negative reinforcements to create changes in behavior; and
3. *cognitive therapy*, which is based on cognitive learning theories and trains individuals to use new patterns of thinking.

Each of these approaches, though developed to deal with individual patients, can also be used as part of group and family therapy. Furthermore, although psychodynamic, behavioral, and cognitive therapy are based on distinct theories, in practice, many clinicians use an eclectic therapeutic approach.

### Psychodynamic Therapy

All forms of therapy for children involve bringing about changes in their cognition, emotions, and behavior (260). What distinguishes psychodynamic approaches is their emphasis on cognition and emotions and the concomitant idea that changes in these two realms will be followed by changes in behavior. When psychodynamic approaches are used with children, they often involve elements that are usually not emphasized with adults and that blur distinctions between psychodynamic and other therapeutic approaches with children. These include clarification of conscious feelings and thoughts and aid in the development of alternative problem-solving and coping strategies. The accentuation of these techniques in work with children reflects children's early stage of cognitive and psychosocial development.

Psychodynamic therapy with children is usually accompanied by other interventions. Most often it is accompanied by therapy with the child's parents. The involvement of individuals in the child's environment reflects the fact that children are more dependent than adults and less able to change their environmental conditions.

Psychodynamic child therapy requires considerable resources. A highly trained clinician must provide the therapy, several individuals in the child's environment need to be involved, and frequent therapy sessions may be needed. Psychodynamic child therapy usually involves once- or twice-weekly meetings between therapist and child. There is no predetermined length of treatment, and treatment can last from a few weeks to a few years (9). Because of the resources needed, it is probably more typical that individual therapy with children is psychodynamically informed rather than a pure instance of the psychodynamic model.

A number of mechanisms are thought to account for therapeutic change in psychodynamic child therapy. An emphasis on one mechanism or another may depend on a child's age, the child's relevant strengths and weaknesses, and the severity of the child's problem (207).

Emotional expression by the child and the labeling of emotions by the therapist are primary mechanisms in psychodynamic therapy. The expression of feelings is thought to aid the child by providing him or her with an opportunity for catharsis. The labeling of feelings by the therapist is believed to enable the child to place the feelings in context, thereby reducing his or her sense of being overwhelmed. The therapist's intervention is also thought to help the child understand the connections between thoughts, feelings, and behaviors. The goal is to replace the acting-out of conflicts with feeling, thinking, and verbalization.

Psychodynamic therapy is also hypothesized to aid in the development of ego structure (i. e., a sense of self), which is particularly important for children whose problems began early and who lack self-esteem and impulse control (361). In addition, psychodynamic therapy can provide a child with a "corrective emotional experience." This occurs because the child's usual expectations (e.g., rejection or punishment) are not met, and eventually the "automatic" connections between feelings (e.g., between anger and guilt) no longer occur. Finally, psychodynamic therapy is believed to produce change because it instills hope in the child and fosters the belief that the important people in his or her life are caring and concerned.



*Photo credit Charter Colonial*

In play therapy, problems are approached through games in order to put children at ease.

Despite a well-described theory of the mechanisms of psychodynamic therapy, there are few empirical data to guide decisions about which mechanisms should be emphasized in the treatment of specific problems and particular types of children. Substantial clinical literature suggests that an insight-oriented approach that focuses on widening children's understanding is most applicable for children with relatively good functioning and circumscribed internal conflicts. Children with major developmental problems and limited introspective abilities are probably better served with an approach that stresses problem-solving skills (207,272,481,537).

Psychodynamic therapy is contraindicated in situations in which the parents are unwilling to support the treatment and situations in which the problem is best addressed by altering a child's environment (via the family or school). It is also contraindicated for children who do not have the ability to form a working relationship with a therapist (274).

## **Behavioral Therapy**

Behavioral therapy was developed more recently than psychodynamic therapy, but it is more widely applied in treating children (553). Behavioral therapy assumes that a child learns persistent pathological behavior from his or her ex-

perience with the social environment. Therapists using behavioral techniques systematically analyze the child's problem and environment and identify the specific behaviors to be modified. As part of the assessment, frequency counts of maladaptive behaviors may be carefully collected, along with data on the situation within which the maladaptive behavior occurs. Then specific behavioral techniques are applied in an effort to change specific problem behaviors.

### Models of Learning on Which Behavioral Therapies Are Based

Several models of learning underlie behavioral therapy methods. The most commonly applied model is operant *conditioning*. This model assumes that learning results from the consequences of behavior (611). Behavior that leads to rewarding consequences is said to be positively reinforced and, as a consequence, is presumed to increase, while behavior that leads to unrewarding or punishing consequences is presumed to decrease. In behavioral therapy based on operant conditioning, adaptive behavior is explicitly rewarded, while maladaptive behavior is either explicitly not rewarded, leads to a delay in reward, or is punished. Thus, for example, children who have problems with aggression and who learn to interact appropriately with classmates may receive special rewards. Some residential treatment settings use "token economies" in which children "earn" tokens that are redeemable for privileges.

A second model for behavioral therapy is *reciprocal inhibition* (716). This model holds that children "learn" an inappropriate, anxious reaction (e. g., a phobia) to an aspect of the environment. Behavioral therapy based on the reciprocal inhibition model usually involves training patients in systematic desensitization—i. e., substituting relaxation or other appropriate behaviors to break the patient's association between a feared object and an inappropriate reaction (37).

A third paradigm, *social modeling or observational learning* (37), is an elaboration of operant conditioning (252). According to this paradigm, an individual learns new behavior by observing another person successfully carrying out the new behavior and being rewarded for it. For example,

observing another child approach a dog could be used to help a child patient overcome a dog phobia.

### Applications of Behavioral Therapies

Behavioral therapies are applied in the treatment of children with specific intellectual and developmental disorders, behavior disorders, emotional disorders, and psychophysiological disorders.

**Intellectual and Developmental Disorders.**—In the case of mental retardation or pervasive development disorders (PDDs), behavioral therapy is not intended as a "cure." It has been used, however, as a major tool for training severely disturbed children to communicate with others and to develop self-care skills (252). Children are trained to use language (305), to develop household skills like telling time and counting change, and to develop social and educational skills. Behavioral methods are sometimes prescribed as specific, intensive, time-limited procedures, but more often they are integrated into a treatment setting's program. For example, meals can be used as part of a behavioral treatment program to teach children to make requests (252). Operant conditioning relying on positive reinforcement has been the mainstay of this training.

Behavioral therapy has often been used in seeking to limit tantrums, self-mutilation, and other self-destructive behaviors in children with PDDs (410). Punishment is used occasionally (e.g., the use of electric shock to stop head-banging), although considerable public and scientific controversy exists about the side effects and ethics of using punishment with children (641).

**Behavior Disorders.**—A number of behavioral techniques have been developed for treating children with attention deficit disorder with hyperactivity (ADD-H) (129). The contingency management approach requires that parents and teachers use a structured system of rewards contingent on appropriate, attentive behavior by the children.

Behavioral therapy is frequently used with conduct-disordered children in residential juvenile justice facilities. The focus is on improving delinquent children's social or educational skills, while

decreasing delinquent behavior within the residential setting (252). Operant conditioning is the primary technique, and token economies are used frequently, but techniques such as behavioral contracting are also employed (591).

**Emotional Disorders.**—Behavioral techniques have a long history of use in treating children's phobias—a subset of anxiety disorders. Whether desensitization, modeling, or other techniques are employed, most seek to reduce children's anxiety so that they will approach (physically or symbolically) and eventually confront the feared object. Behavioral techniques have not been extensively developed for treatment of emotional disorders other than anxiety.

**Psychophysiological Disorders.**—Most psychophysiological symptoms are believed to be amenable to behavioral treatment. Therapists have adapted behavioral techniques such as relaxation training, self-control training, and operant conditioning to teach children with stereotyped movement disorders to have greater control over their bodies.

The use of operant conditioning techniques is especially common with enuretic and encopretic children. One such technique, the bell-and-pad technique, for example, places a special device on an enuretic child's bed that sounds a wake-up alarm on contact with a child's urine, teaching the child to associate sleeping with continence (450). Operant conditioning techniques have also been used to treat patients with eating disorders such as anorexia nervosa.

**Parent Training in Behavioral Therapy.**—Training parents to use behavioral techniques with their children is increasingly favored and has great potential for expansion (251). The application of behavioral techniques by parents has an inherent logic in that parents are responsible for their children and can be directly involved as soon as a problem is identified. It is also an important approach to consider in light of resource constraints and the desirable policy of providing treatment for disturbed children in the least restrictive environment. For some children, a home environment in which the parents apply behavioral techniques can replace the behaviorally programmed environments of residential treatment settings such as

psychiatric hospitals and residential treatment centers (RTCs). For the implementation of many behavioral techniques, fairly little training is needed.

Many parents of severely disturbed children have received training in operant conditioning and other behavioral management techniques used in residential treatment settings (398,585). Parents of children with some of the less severe psychophysiological problems have also received training in behavioral techniques, including for example, the bell-and-pad treatment for enuresis. The most common application of parent training is, by far, to childhood behavior problems. These problems can range from tantrums in a toddler, to disruptive classroom behavior (27), to adolescent delinquency. Parents are also reported to have conducted successful behavioral treatments for school phobia (285) and night-time fears (251, 343).

A frequent combination of behavioral procedures taught to parents includes:

1. providing positive reinforcement for appropriate behaviors (usually in the form of attention or praise);
2. avoiding inadvertent reinforcement (e.g., negative attention) for disruptive behavior that is not severe ("extinction"); and
3. segregating children by themselves for more severe disruptive behavior (554).

The use of behavioral contracts is encouraged in some families with conduct-disordered children (252).

Although the techniques of behavioral therapy are relatively simple, especially compared to those of other individual psychotherapies, the analysis of a child's behavior is usually complex, especially when there are multiple dysfunctions. In addition, designing reinforcement schedules and redesigning a child's environment can be more complex than mere description would suggest.

Parents can learn appropriate behavioral techniques from self-help manuals (487), as well as directly from professionals (429). Self-help manuals vary in their quality and their grounding in empirical evidence (235). Since self-help techniques are largely out of the hands of professionals once the books are written and distributed,

little is known about the extent, manner, and effectiveness of their use.

### **Cognitive Therapy**

Clinical and research findings indicate that thinking processes of disturbed children are different from those of other children (399,674). Such findings have led to cognitive treatment modalities that attempt to alter the way disturbed children think about their behavior and their environments. Although the way in which cognitive interventions attempt to change thinking varies greatly, two broad classes of cognitive interventions can be identified. One class of cognitive interventions tries to alter the thinking that takes place during a child's troublesome behavior—e.g., by having impulsive, distractible children verbally describe their actions to themselves as they do them (433). The other class of cognitive interventions tries to influence how children think about themselves and others.

Cognitive interventions are used to help children with many types of problems: behavior, learning, emotional, and social problems. One cognitive method derived from theories about neuropsychological functions (399) trains children to use speech as a tool to slow down and focus their learning and behavior (433). Other cognitive interventions train children in such aspects of learning as the amount of time used to respond to a question (436), the visual scanning of educational material, question-asking strategies (143), and analytic abilities (164). Peers and adults who use effective strategies are often used as models.

## **GROUP AND FAMILY THERAPY**

Group and family therapeutic approaches are rooted, in part, in theories of individual behavior. They are also based on distinct theories of peer and family relations. Because of the importance of peers and family members or other adults in a child's life, group and family therapy are often used to treat children with mental health problems. The purpose of group therapy is not simply to reduce the cost of treatment by providing treatment to several children simultaneously.

For emotionally disordered children with phobias, therapists have used behavioral models combined with cognitive training to demonstrate that a feared object or situation can be confronted (351). In addition, various cognitively based training programs have been used to teach emotionally disordered children to solve interpersonal problems more effectively. Other cognitive training programs aim to improve young people's ability to understand and think through social situations (their "social cognition") (643). Such cognitive training may include procedures that teach children the consequences of their behavior for others (621), or train them to take the perspective of others—and to know thereby what behavior would be best in the relationship (643). There may be a significant educational component to these cognitive interventions. For example, some learning groups offer children concrete information about how to improve their social skills (376). Some cognitively based training has focused on training delinquent adolescents the skills necessary to manage group living or a job interview (574).

Cognitive methods are also used with families of disturbed children. For example, some therapists have taught social problem-solving skills to families, especially families of behavior-disordered children (16,347).

In summary, cognitive therapeutic interventions have wide applicability. Cognitive approaches are incorporated in many therapies, and although cognitive approaches require trained mental health professionals, they can be adapted in many settings.

Rather, the goal is to treat aspects of a child's problem which involve interaction with peers and significant adults.

### **Group Therapy**

Although group therapy incorporates elements of other treatments, it is nevertheless a distinct treatment modality. The effectiveness of group therapy is thought to arise from interpersonal

processes within the therapeutic group (722). Therapeutic groups are believed to develop an indigenous "culture" (507) and to allow individuals to develop new ways of relating. The strengths of one child become a model for other children, while the entire group can help an individual child address a weakness (230).

The therapist's task in group therapy is to help the group develop helping capacities and to perform organizing and caretaking functions within the group (582). Children in group psychotherapy are a heterogeneous population, and psychotherapy groups are not usually targeted to a particular disorder; most groups aim to address problems in relationships and identity that cut across disorders. Group therapy is thought to be particularly useful for children experiencing difficulties in peer relationships.

Group psychotherapy for children is adapted to the developmental level of the group. Therapy groups for young children are usually organized around group play and activity-oriented social behavior, while adolescent therapy groups rely more heavily on discussion. Particularly for adolescents, the structure of group therapy depends on the level of social relationships among group members.

Group therapy is not always conducted by group therapy specialists. It is sometimes provided by therapists of various orientations (e.g., behavioral and cognitive). Therapists who do not specialize in group therapy typically consider the dynamics of the group less central than other processes. For example, a behavioral therapist may intend group therapy primarily to provide mutual reinforcement for improved behavior or peer modeling (342). Group psychotherapy is often provided as an adjunct to other modalities, particularly individual psychotherapy or family therapy.

## Family Therapy

Although most child therapists point to the importance of the family in understanding and treating children, family therapists are distinguished by their unique way of reconceptualizing a set of symptoms. For family therapists, problems do not lie within the child (as suggested by traditional

psychiatric diagnosis), but are manifestations of disturbed interactions within a family. A child's symptom is viewed as an indicator of larger family problems and as a response that serves a function for the entire family. Thus, for example, a child's symptom can deflect attention away from more fundamental difficulties such as strife in the parents' relationship (402,442). Because of its functional and protective role, the symptom is reinforcing to the family, and families are psychologically invested in maintaining it. Although family therapy does not necessarily involve the presence of every family member at each session (67), family therapists believe that a child cannot change if the family does not change as well (203,442).

Several models have evolved within family therapy, and each offers different techniques for intervening to produce change. Zimmerman and Sims (736) describe three models: dynamic, systems, and behavioral.

Dynamic models for family therapy are characterized by their reliance on insight as the main method of producing change. Frequently, the focus of insight is on pathological patterns of functioning that are carried from the parents' own past into the present family situation. These patterns may involve conflicts over autonomy and dependency (704), developmental failures that have occurred over generations and are being "projected" onto a child in the current family (612), or situations in which a child's symptom represents an "invisible loyalty" to transgenerational themes (65). Insight into the way in which patterns from the past affect the present is believed to produce growth in all family members, allowing the child to give up the symptomatic behavior.

Systems models for family therapy encompass a diverse group of theorists and techniques. One such model is structural family therapy, an approach most closely associated with Minuchin (443,445). Structural family therapy is aimed at changing the family's psychosocial organization with the expectation that this will produce a change in the experiences of individual members. Family structure, according to Minuchin, is the "invisible set of functional demands that organizes the way in which family members interact" (442). Aspects of family structure that maintain or are

the result of dysfunction include family boundaries, alignments, and the balance of power. For example, Minuchin (442) notes that families with an anorectic child are frequently characterized by enmeshed relationships, restrictions on individual autonomy, and lack of conflict resolution. Therapy involves firming up the boundaries between the parental and child subsystems, breaking the facade of mutual agreement between the spouses, and helping them to negotiate conflict. This approach does not preclude separate medical attention for the anorectic child. It does, however, propose that the family, rather than the child, is the matrix within which change must occur.

A related systems model is strategic family therapy (171, 172,269,270,684). Strategic family therapists accept the idea that an individual's symptom serves the function of stabilizing and maintaining a balance in the family system. Their approach in therapy, however, is to focus largely on the symptom itself. Specific techniques are used to re-

veal the changeability of the symptom and to make the previously covert functions and control of the symptom more overt and obvious to all family members. Strategic family therapy does not rely on insight to produce change, and the course of treatment is frequently brief (736).

A third model of family therapy is behavioral family treatment developed by Patterson (487, 490,497). Designed for use with families of conduct-disordered children, Patterson's approach is based on the observation that parents of these children tend to reinforce the occurrence of aggressive behavior and discourage the occurrence of prosocial behaviors (491,492). Parents are trained in the techniques of social-learning-based child management. Through exposure to programmed texts and participation in a parent training group, parents are taught to define, track, and record both deviant and prosocial behaviors in their children and to devise behavioral contracts which specify the consequences of specific behaviors at home.

## MILIEU THERAPY

Milieu therapy involves utilizing daily living in a therapeutic setting to teach patients social and educational skills, to explore patients' emotional life and patterns in relating to others, and to provide patients with ongoing support.

The setting in which milieu therapy is provided is either a hospital, an RTC, or a day treatment center. Every aspect of daily life in this setting is shaped to contribute to a child's recovery. Such disparate areas of life as a child's evening routine or how he or she reacts to conflict with another child become opportunities for professional and other staff to intervene and help a child learn more adaptive behavior.

Interventions in milieu therapy can be as prosaic as teaching children to replace rough physical contact with a special handshake or as profound as pointing out a parallel between children's

reaction to the staff and their relationship to their family (639). In many therapeutic milieus, the intensive therapeutic relationships that develop with several different staff are thought to give children a chance to re-create and then work out a number of interpersonal difficulties. Behavioral programs are often used as the basis of milieu therapy.

Milieu treatment also includes the group programs used to meet some of the children's needs for education, recreation, and a sense of community. For example, community meetings are held to review events within the hospital and explore their relationship to patients' difficulties. Groups led by professional staff in art therapy, music therapy, and recreation may allow patients to express feelings about their predicament and, at the same time, learn better ways to adapt.

## CRISIS INTERVENTION

Crisis intervention is an outpatient treatment based on clinical and other evidence that a major upheaval in a child's life, such as the loss of a family member, can pose an acute threat to the child's mental health (388). Unlike several other approaches, crisis intervention programs often intervene within children's homes. Crisis intervention is sometimes used as an alternative to hospitalization for acute mental health problems. The major goal is to help children and families return to their previous level of functioning. Crisis intervention is usually completed within 6 weeks and often within days (388), but it is often followed by other outpatient treatment.

Crisis intervention techniques emphasize practical steps to defuse threatening situations and to provide family members with coping resources. Specific contracts and emergency plans, for example, are made with family members to lower the level of tension. Suicide prevention is a focus of intervention when necessary, and crisis inter-

vention services are typically offered intensively on an as-needed, off-hours basis. Often, a crisis intervention specialist arranges for additional emergency services, such as emergency caretaking for children to relieve some of the stress on an acutely disturbed parent.

Crisis intervention with children necessarily involves the family; a tenet of the approach is that parents must be helped to develop coping skills necessary to manage in a crisis. The Homebuilders program exemplifies a crisis intervention model that works within children's homes (350). Homebuilders staff begin by uncovering the nature of the family crisis from all viewpoints, defusing tension by letting family members vent their frustrations and concern, and helping the family develop alternative behavioral, cognitive, and emotional means to deal with the critical problem. After the initial intervention(s), contact is maintained until clients are referred to and then receive continuing services.

## PSYCHOPHARMACOLOGICAL (DRUG) THERAPY

Psychoactive medication is a small but growing modality of treatment for children's mental health disorders. Although widely used with adults, psychoactive medication has only recently been regularly prescribed for children.

The range of children's mental health problems for which drugs have been prescribed has increased over the last decade. Yet psychopharmacological treatment is not regarded as a panacea for the treatment of any disorder, and there appears to be consensus on the necessity of combining drugs with other treatments.

### Stimulants

ADD is one of the few childhood syndromes commonly treated with drugs. The drugs used usually are stimulants, including methylphenidate (Ritalin®) and dextroamphetamine (Dexedrine®). Even though ADD children are generally overactive, stimulant drugs act to increase their atten-

tion span. The mechanism underlying the effects of stimulant drugs is not well understood; the best understanding is that such drugs stimulate areas of the brain responsible for maintaining arousal and focusing on specific functions (121). Drug treatment alone is rarely sufficient, and psychological interventions with the child, family, and/or his school environment are usually combined with medication (577).

### Neuroleptics

Some children with severely disabling disorders—autism, brain injury, mental retardation—exhibit behaviors that are dangerous to themselves or others. They may, for example, hit other children or destroy furniture when they become excited. Some may develop disabling preoccupations or harmful delusional ideas. Usually, attempts will be made to control their behavior without the use of medication, but in some cases,

neuroleptics—also known as antipsychotic medication—will be used.

Neuroleptics may significantly reduce hyperactivity, aggressiveness, and agitation in severely impaired children (89). It should be noted, however, that neuroleptic medication is used not as a treatment to reverse severe disorders, but rather as a means of reducing troublesome symptoms associated with a disorder. Trifluoperazine (Stelazine™) and haloperidol (Haldol®) appear to be the two neuroleptics of choice (89) for such applications, partly because they have fewer sedative effects than other neuroleptics. Recent research (89) has demonstrated that haloperidol reduces stereotyped movements, hyperactivity, deficits in attention, and difficult behaviors in autistic children, and can also be associated with an increase in intellectual functioning. Neuroleptics have little or no direct effect on symptoms such as difficulties in relating to others, although they may have an indirect effect on social functioning by reducing symptoms like agitation. Typically, neuroleptics are used as adjuncts to intensive psychotherapy and other treatments (89).

One concern about most neuroleptics is their sedative effect. Neuroleptics sometimes affect cognitive functions necessary for relating to others,

for learning, and for carrying on daily life—all functions that clinicians aim to increase in severely disabled children. Major tranquilizers can also reduce a child's motivation. Furthermore, the side effects of tranquilizers can be very uncomfortable and sometimes are a source of impairment. Possible side effects include a continuously dry mouth, tremors, and cardiovascular changes. With prolonged use, antipsychotic medications can lead to tardive dyskinesia—an often irreversible movement disorder characterized by uncontrollable repetitive movements of the tongue, lips, head, or neck.

### Antidepressants

Antidepressant treatment of childhood depression began in the 1960s (333), but it has not received widespread clinical application. With recent increased interest in childhood depression, research is being conducted on the use of antidepressant medication, especially the tricyclic antidepressants widely used with adults. Drugs have also been used to treat some specific childhood anxiety disorders, although most of these disorders are considered best treated psychologically rather than with drugs (121).

## CONCLUSION

The mental health treatments outlined in this chapter are based on diverse theories of children's actions, reactions, and mental disturbances. Some mental health treatments used for children have been developed in response to particular childhood problems, but the majority are adaptations of treatments used for adults and based on general theories of behavior. There is substantial var-

iation in treatment practice based on differing theoretical orientation. Analyzing treatments in terms of their psychodynamic, behavioral, and cognitive assumptions is useful in understanding how treatment decisions are made, although in practice, a number of approaches may be used. The effectiveness of mental health treatments used with children is considered in chapter 8.