

SECTION I

Treatment Considerations and Contextual Issues

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CHAPTER 1

Development Considerations in Assessment and Treatment

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The developmental psychopathology approach emphasizes the interplay between psychopathology and cognitive, emotional, and social development of children and adolescents (Cicchetti & Cohen, 1995; Cicchetti & Toth, 1991). This approach has long been touted as essential to the conceptualization of psychopathology and intervention for children and adolescents. Despite its utility, few inroads have been made in integrating this approach into assessment and treatment. The developmental level of child or adolescent clients is important for therapists to consider during assessment, treatment planning, and therapy implementation.

ASSESSMENT

Despite significant improvements in the empirical basis for diagnostic categorization across the years, one area where there have been few changes is the integration of developmental changes into the diagnostic criteria. The diagnostic criteria for common childhood disorders often involve the application of adult criteria to children. Although the *Diagnostic and Statistical Manual* (5th ed.; *DSM-5*) (American Psychiatric Association [APA], 2013) includes descriptions of child manifestation of symptoms for some disorders, few disorders include guidance on how symptoms may manifest differently across children and adolescents of different ages. Thus, therapists are left to use their clinical judgment to apply *DSM* criteria in a developmentally sensitive manner.

The lack of attention to developmental variations in symptoms in the *DSM* and its application is consistent with a common misconception in psychopathology, the developmental uniformity myth (Kendall, Lerner, & Craighead, 1984), which holds that disorders manifest the same no matter the age of the individual. In fact, research indicates that psychological symptoms vary quite a bit across developmental stages.

For example, there are developmental differences in the frequency of specific anxiety disorders at different ages, with separation anxiety disorder more common in young children (ages 6 to 9) and social phobia more frequent in adolescents (Weems & Costa, 2005; Weems, Hammond-Laurence, Silverman, & Ginsburg, 1998). This may be related to physical developmental changes occurring during these ages, such as that young children learn individuation and independence from parents at ages 6 to 11 and experience fears related to loss or separation from parents (Weems & Costa, 2005) and adolescents emphasize peer relationships and social interactions (Warren & Sroufe, 2004; Westenberg, van Strien, & Drewes, 2001) and therefore more often experience anxiety related to social situations.

There are also differences in the rates of depression across childhood and adolescence, with low rates in children (less than 2%) and a dramatic increase in prevalence in adolescence (4%–8%) (Hankin et al., 1998), especially in females (Silberg et al., 1999). Bipolar disorder is also rare in

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young children but increases in prevalence around puberty, with 15 to 19 years of age as the typical age of onset (for a review, see Kim & Miklowitz, 2002).

There are also developmental differences in depressive symptoms over the long term. For example, children who have their first depressive episode before adolescence tend to have more severe, recurrent, and treatment-resistant major depressive disorder, and as many as 40% of children who have a depressive episode will have a second episode within 5 years (Kovacs et al., 1984). Childhood-onset bipolar disorder is also typically more chronic and treatment resistant than later-onset bipolar disorder (for a review see Kim & Miklowitz, 2002). Children are less likely to see their symptoms as causing functional impairment than are their parents or other reporters (APA, 1994; Langley, Bergman, & Piacentini, 2002). As such, it is essential for assessors to be sensitive to these developmental patterns in symptoms and to rely on multiple reporters in assessing child and adolescent psychopathology.

Despite the necessity of involving multiple reporters in the assessment of child and adolescent psychopathology, there is rarely agreement on symptoms (Achenbach, McConaughy, & Howell, 1987; Comer & Kendall, 2004; Grills & Ollendick, 2002; Rapee, Barrett, Dadds, & Evans, 1994). Parent-child agreement ranges from kappas of .09 for depressive symptoms to .32 for anxiety symptoms and .29 for symptoms of attention-deficit/hyperactivity disorder (Grills & Ollendick, 2002; Rapee et al., 1994). Children often report anxiety symptoms at higher rates and intensity than their parents (Bird, Gould, & Staghezza, 1992; Edelbrock, Costello, Dulcan, Conover, & Kala, 1986; Herjanic & Reich, 1997; Hodges, Gordon, & Lennon, 1990; Kolko & Kazdin, 1993; Lagattuta, Sayfan, & Bamford, 2012); however, it is unclear which report of child anxiety is more accurate or the weight that should be given to each reporter.

Some have suggested that the age of the child should influence the degree to which assessors rely on parent versus child report. For example, it has been suggested that parental report should be relied on in assessing children below the age of 11 because such young children experience difficulties in self-report of behavior or mood problems (Achenbach et al., 1987; Ollendick & Hersen, 1993) most likely due to their limited verbal ability and insight. Further, self-report questionnaires are not commonly recommended for children under the age of 8 because children of that age typically are unable to complete such measures without assistance (Beidel & Stanley, 1993). Others have suggested that children are not always able to respond to self-report measures appropriately; for instance, they are likely to respond to questions on questionnaires based on their emotional reaction to a statement rather than based on the frequency of the event (King & Gullone, 1990; McCathie & Spence, 1991). However, the format of assessment also may influence children's ability to complete a self-report questionnaire. Questionnaires with only three anchors are the most reliable and valid way to use such measures with children (Beidel, Turner, & Morris, 1995; Ollendick, 1983). Additionally, new information indicates that children as young as 4 can report on their daily emotional states when assessed using a pictorial Likert scale and simplified wording read to them by an assessor (Lagattuta et al., 2012). Thus the most important aspect of assessment of young children's self-report may be the use of developmentally sensitive tools and techniques.

In children and adolescents 8 years of age and older, it is common to include the child's self-report; however, the degree to which the child's report is relied on may vary by the type of symptoms being assessed. Some have suggested that child report is most accurate in cases of internalizing symptoms (Jensen, Xenakis, Davis, & Degroot, 1988) versus externalizing or behavior symptoms, which are more reliably observed by parents and teachers (Kendall, 2006).

When assessing children, it can be difficult to know when and how to ask about behaviors such as sexual involvement, use of drugs or alcohol, and suicidal and homicidal ideations. The consumption of alcohol is common in late adolescents, with 4 out of 5 twelfth graders reporting that they have drunk

alcohol, 50% to 62% of sixth graders reporting that they have tasted alcohol, and only 29% reporting that they have had more than a sip (Johnston, O'Malley, Bachman, & Schulenberg, 2002). This is an increase from fourth graders, where only 10% of children have had more than a sip of alcohol. Given this information and the increased rates of substance abuse in those who began drinking at age 11 and 12 (DeWit, Adlaf, Offord, & Ogborne, 2000), assessors should not assume that because a child is well below the drinking age he or she is not drinking. Therefore, while most children will not have consumed alcohol in large quantities, asking is likely recommended with children after the age of 11.

With regard to nicotine or illicit drugs, a similar pattern emerges. Sixty percent of high school seniors have smoked cigarettes; one third of them did so during the previous month. Further, 50% of high school seniors have used illicit drugs (drugs other than alcohol and nicotine) at some time in their lives (Johnston et al., 2002). Given that use of these substances is somewhat common in adolescents, assessors should be sure to ask about drug use, particularly given the association between drug use and psychological struggles (Deas & Brown, 2006; Kandel et al., 1999). Further, 7.8% of adolescents 12 to 17 years of age struggle with diagnosable substance abuse disorders; therefore, questions concerning these topics should be asked of children starting as early as late childhood (Kendall, 2006).

Other risky behaviors that should be assessed beginning in adolescence include sexual behaviors and the use of contraception. Twenty-one percent of adolescent males reported that they had sex by the age of 15 (Albert, Brown, & Flanigan, 2003; Sonenstein, Pleck, & Leighton, 1991) and 7.2% to 10% by the age of 13 (Albert et al., 2003; Kann et al., 1998). Similar rates were found in female adolescents (Albert et al., 2003). Close to 50% of high school students have had sex by the time that they graduate (Kann et al., 1998), with significantly higher rates among African American high school students (89% of males and 70% of females) (Kann et al., 1995). African American and Latino teens also report higher rates of sexual behaviors at earlier ages than Caucasians (Kann et al., 1998).

Although 57% to 74% of adolescents reported that they used contraception at their first sexual experience (Albert et al., 2003), only 10% to 20% of adolescents who are having sex use condoms consistently (DiClemente et al., 1992; Kann et al., 1995), a number that is lower in adolescents of diverse ethnicities (Airhihenbuwa, DiClemente, Wingood, & Lowe, 1992). Additionally, many adolescents have sex during monogamous relationships that are short term and therefore have multiple sexual partners over short periods of time (Overby & Kegeles, 1994). For that reason, it is important that assessment of adolescents includes assessment of sexual behaviors and the use of contraception in order to identify risky behaviors that adolescents may be engaging in as well as symptoms of psychological disorders that may be the target of treatment.

TREATMENT

Developmental sensitivity is equally important in therapy as it is in assessment. Although various types of child and adolescent therapy exist, as with adults, one of the most well-validated treatment options for children and adolescents is cognitive behavioral therapy (CBT) (Durlak, Fuhrman, & Lampman, 1991). CBT has been used with children and adolescents between the ages of 4 and 18, with the techniques included varying with the age and developmental level of the child.

Perspective Taking

One aspect of developmental level that is important to consider when choosing therapy techniques for children and adolescents is the child's level of perspective taking. Children between the ages of

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2 and 3 years are often able to describe their own basic feelings, such as sadness and anger; however, they are not able to understand that other people have feelings and thoughts separate from their own (Dunn, Brown, Slomkowski, Tesla, & Youngblade, 1991). Therapy techniques that require a child to think about the impact of their behaviors on others may not be effective with young children because of their limited perspective-taking abilities (Selman, 1980). As children develop cognitively, they begin to understand that others see things differently and that others may hold opinions different from their own. However, they dismiss these opposing thoughts and feelings of others as wrong because they differ from their own. Once children have reached adolescence, they begin to understand that others' thoughts and feelings, while different from their own, are not inherently wrong but instead represent an alternative and equally valid perspective (Chandler, 1988). Due to these developmental differences in children's perspective-taking abilities, it is important to consider the child's developmental level rather than assuming that lack of ability to consider others' feelings reflects psychopathology.

A child's ability to take the perspective of others also mirrors his or her ability to consider multiple potential solutions to a problem. Before the age of 14, it is difficult for children to understand and generate numerous solutions without significant scaffolding (Sternberg, 1977; Sternberg & Nigro, 1980). A child's level of perspective taking and ability to consider numerous solutions is an important consideration when implementing cognitive restructuring. Cognitive restructuring emphasizes the notion that there are numerous ways to interpret a situation and that it is one's interpretation that influences one's emotional response to the situation. Cognitive restructuring requires that a child be able to generate and fully consider various interpretations of the same situation. Due to the limited perspective-taking abilities of children before late childhood, it may be challenging for them to identify alternative explanations for situations, let alone to consider the accuracy of each. Therefore, while cognitive restructuring is known to be an effective CBT technique, it may be somewhat challenging for children to implement.

A much more simplistic version of cognitive restructuring may be used with younger children. For example, younger children may be able to identify positive or negative aspects of a situation. One way of doing so with young children is to have them pretend to be "detective positive" or "detective negative." Each detective looks for clues in a situation that are either positive or negative. This more simplistic way of engaging in cognitive restructuring may allow a child to combat a negative attentional or interpretive bias and to identify positive cues without having to engage in the more abstract cognitive restructuring techniques of comparing the evidence for and against a thought and then revising the thought.

Abstract Reasoning

It is also important to consider the level of a child's abstract reasoning abilities when choosing among the various available therapy techniques (Weisz & Weersing, 1999). Abstract reasoning is difficult for children of all ages and is not consistently developed until approximately age 15 (Piaget, 1970; Siegler, 1986). Because of the limited abstraction ability of most children, hypothetical thinking techniques, such as role-play and brainstorming about possible outcomes, are not always helpful with children (Weisz, 1997). However, it is possible to consider multiple outcomes to an event when phrasing this concept in a developmentally sensitive manner. Children as young as 3 have hypothetical reasoning capabilities as long as they are future oriented ("What if something different happened next time?") rather than past oriented ("What if this happened instead of what actually happened?") (Robinson & Beck, 2000). Thus, therapists can introduce children to the

concept that there may be various outcomes to an event by examining the possible outcomes that could occur in future situations that are similar to a current situation.

Causal Reasoning and Emotional Understanding

Another important developmental task that may influence the effectiveness of therapy techniques is causal reasoning. Causal reasoning is the understanding of complex cause-and-effect relationships—for instance, the connection among thoughts, behaviors, and emotions and understanding concepts such as rewards and punishments. Young children struggle to connect past events with current emotions or thoughts; therefore, therapeutic attempts to associate the past with the present often are unsuccessful with young children (Shirk, 1988). Young children also are likely to attribute events to conscious, concrete reasons or outside forces as opposed to psychological or internal experiences; therefore, often it is difficult for therapists to teach young children the ways in which emotions may influence one's behaviors.

Children have a limited ability to understand emotions in themselves and others (Izard, 1994), with young children (under the age of 3) able to identify only primary emotions, such as happiness, anger, sadness, and fear. Preschool-age children begin to understand emotions as they relate to themselves (emotions such as shame, pride, and guilt) but cannot describe having two feelings at the same time or blends of emotions (Harris, 1989; Harter, 1977). Preschool children also view experience and expression of emotion as synonymous, meaning they define emotional experiences by outside behavior (Nannis, 1985; Nannis & Cowan, 1987). For that reason, a child may state that a person is happy only if the individual is smiling and may not understand that emotions are internal and may be experienced but not expressed. Although this may impact a therapist's ability to teach a preschool child to inhibit emotional expression in situations, the ability of children of that age to recognize that facial expressions are linked to emotions provides an opportunity to teach them to identify their own cues for emotions, such as facial indications of fear, happiness, or sadness, and to begin to use words to describe their emotional experiences as a way of communicating their feelings. It is common for therapists to teach young children to recognize their own emotional experience by thinking about what they are expressing on their face and to convey these emotions using words rather than actions. For example, if a young child often acts out or throws temper tantrums when frustrated, a therapist may teach the child to express frustration by telling a parent that he/she is angry rather than acting out. This, when combined with the parental strategy of ignoring whining and temper tantrums that occur due to the child's attention seeking, may be an effective way of introducing adaptive emotion regulation and expression strategies with young children.

As children age (ages 6–10), they begin to see emotions as internal events that can be shared externally with others or kept a secret. Children of these ages also recognize that emotional experiences can be caused by external events (Carroll & Steward, 1984; Gnepp & Gould, 1985; Harris, Olthof, & Terwogt, 1981; Nannis, 1988). At around age 8 children also begin to understand the emotional experiences of others better and to recognize that the same situation can lead to different reactions in different people (Gnepp & Klayman, 1992). It is also around this age that children begin understanding that emotional experiences are not discrete and that an individual can experience multiple, and even opposing, emotions at the same time (Friend & Davis, 1993). By age 11 or 12, children can understand that they have control over their emotions and can choose whether to express or hide them (Nannis, 1985; Nannis & Cowan, 1987).

The emotional work that can be accomplished in therapy with children in middle childhood may involve the recognition of blends of emotions, conflicting emotions, and the link between

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events and subsequent emotions. Children's emotional understanding during this middle childhood phase provides them with the abilities necessary to comprehend most cognitive behavioral techniques, such as linking antecedent events, emotions, and behaviors; using behavioral techniques to impact the strength of emotions, such as relaxation techniques to reduce anxiety; and the negative reinforcement that occurs when one escapes from a feared stimulus. Many of the CBT packages developed for children were developed specifically for those between the ages of 7 and 12 in mind (Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Sanders, 1999; Webster-Stratton, 1992).

Language

When working with children, it is important to be aware of their language abilities. When talking with a child, a therapist should always use vocabulary that the child understands (Weisz & Weersing, 1999). The type of vocabulary that a therapist uses will vary by age and across children. It is also important to understand the role that language development has on a child's emotional understanding. It is believed that emotional competence is intertwined with the ability to use emotionally descriptive language (Beck, Kumschick, Eid, & Klann-Delius, 2012). Therefore, children who have not yet developed sophisticated emotional vocabularies will also struggle with understanding their own emotional experience and recognizing emotions in others, which will greatly impact the techniques that will be effective in therapy. For instance, until a child's emotional vocabulary has been fostered to a certain degree, training in emotion regulation techniques will not be effective. Further, children become better at perspective taking as they acquire more sophisticated vocabulary, particularly more verbs (Astington & Filippova, 2005). Therefore, a child's language level will impact the therapist's ability to utilize role-playing and other social problem-solving techniques that rely heavily on perspective-taking ability.

Therapy Format

Children are inextricably linked to their parents because they rely on their parents for all of their basic needs as well as many of their social and emotional needs. The younger the child, the more important their parents are going to be in the therapeutic process. This is illustrated in a study by Barrett et al. (1996), which found that children ages 7 to 10 benefited from family involvement in CBT but the addition of a family component was not more beneficial than individual CBT for children ages 11 to 14. Further, adolescents showed better treatment response to individual CBT than adolescents in individual CBT plus parent training (Cobham, Dadds, & Spence, 1998). Inclusion of parents, while particularly important in younger children, also seems to be particularly important when working with children with externalizing disorders and with eating disorders. This is because parental monitoring and parental regulation of behavior are of critical importance in the treatment of both behavior problems and eating dysfunctions in children and adolescents.

When working with children and adolescents, it is also important to determine if group therapy is appropriate. Group therapy for children can be extremely beneficial, particularly when used to teach social skills and build social connections and friendships, which can be relevant for a variety of presenting problems (Harrington, Whittaker, Shoebridge, & Campbell, 1998; Larson & Lochman, 2010; Rose & Edleson, 1987). However, group settings are not ideal for addressing conduct or delinquency problems in adolescents because of the tendency for antisocial teens to encourage and reinforce antisocial tendencies, a process known as deviancy training (Dishion, McCord, & Poulin, 1999; Steinberg, 2005).

Activity in Therapy

Therapy with children is going to involve quite a bit more activity than treatment with adults. Activity is important in keeping engagement with children. Further, teaching coping skills, cognitive restructuring, and emotional awareness will need to be accomplished through concrete means. Both engagement and clarity can be achieved through the use of play. Play can make common cognitive behavioral techniques, such as modeling and role-playing, more concrete and accessible. This can be done by using puppets to demonstrate skills, to externalize the problem, or to play various roles relevant to the child's life. Active play during therapy also can allow a child to brainstorm and communicate thoughts to the therapist in an enjoyable manner. For example, the "quick decision catch" of Pincus, Chase, Chow, Weiner, and Pian (2011) asks children and the therapist to pass a ball and to give a solution to a problem quickly when they catch the ball. Once solutions have been generated, the child must choose which solution he/she would use in the situation. Because this process occurs in the context of a game, it may increase a child's engagement while also helping the child with the process of decision making and solution generation.

The use of play to act out emotions and experiences allows the child and therapist to communicate without the demands on the child's expressive language, which, as explained previously, is slower to develop. It has been hypothesized that children do not naturally communicate through dialogue; they express their inner experience through the concrete world of play and activity. Therefore, play in therapy should be viewed as a vehicle for communication, particularly with younger children (Axline, 1947; Bratton, Ray, Rhine, & Jones, 2005; Kottman, 2001; Landreth, 2002; Schaefer, 2001).

SUMMARY

Many developmental considerations need to be made when assessing and treating children. These considerations include degree of parental involvement, use of group therapy, and implementation of games or activities. Overall, in order to make clinical work applicable to children of all ages, clinicians need to be sensitive to their client's cognitive, social, and emotional developmental stage and understand what therapeutic techniques utilize only the skills the child has acquired. For instance, many traditional social problem-solving techniques, including role-play, rely on the client having developed sophisticated perspective-taking skills. Such techniques would not be appropriate to employ with a young child who has not developed these skills. By considering the various developmental concerns discussed in this chapter, the clinician can be better prepared to offer efficacious assessment and treatment for children and adolescents across ages and developmental levels.

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