CHAPTER

1

Counseling and Psychotherapy with Children and Adolescents

Historical, Developmental, Integrative, and Effectiveness Perspectives

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The psychological treatment of children's problems is the focus of several professions and is carried out in many settings and situations. Although theoretical viewpoints are wide-ranging and essentially rooted in adult-based theories, the child or adolescent presents a unique challenge to the child mental health worker. Children are not simply little adults. Their treatment cannot be viewed as scaled-down adult therapy; their developmental stages, environments, reasons for entering therapy, and other relevant factors necessitate a different, if not creative, approach to therapy. The child/adolescent therapist must have an expanded knowledge base of the human condition and a different perspective of what constitutes therapy or counseling.

This book is about psychotherapy and mental health counseling with children and adolescents. It brings together in a comparative format the major theoretical views of psychological treatment of children and highlights major issues in the area. A number of concerns, however, cut across the theories and are relevant to any provision of mental health services to children. This introductory chapter describes some of these issues: Historical perspectives, the mental health needs of children and adolescents and the need for services, developmental issues, the unique aspects of child and adolescent therapy, a multimodal research/efficacy issues and evidence-based approaches. Throughout this chapter, the terms *counseling* and *psychotherapy* are used interchangeably.

HISTORICAL PERSPECTIVES ON THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS

Many major advances in clinical mental health work can, in some way, be traced to Freud. Mental health work with children is no exception. Freud's classic case study of "Little Hans" in 1909 is generally viewed as the first reported attempt to psychologically explain and treat a childhood disorder (S. Freud, 1955). Although Freud did not directly treat Little Hans's phobia, he offered a psychoanalytic explanation of the problems and guided the father in the treatment of Hans. This case study is recognized as providing the base for Freud's theories on the stages of psychosexual development. Freud's interest in childhood disorders apparently waned at this point, and it was not until 1926 that his daughter, Anna, presented a series of lectures entitled "Introduction to the Technique of Psycho-analysis of Children" to the Vienna Institute of Psychoanalysis. These lectures generated considerable interest and established Anna Freud as a pioneer in child psychotherapy. Shortly thereafter, Melanie Klein (1932), emphasizing the symbolic importance of children's play, introduced free play with children as a substitute for the free association technique used with adults, thus inventing play therapy. Although these two camps disagreed on many issues, they have remained the dominant voices in the child psychoanalytic field, with most analytic work being a spin-off of either A. Freud or Klein.

At approximately the same time (the early 20th century), other forces were beginning to put more emphasis on work with children. In France in 1905, Alfred Binet completed initial work on his intelligence test, which was used for making educational placement decisions in the Paris schools. This work provided the base for the psychometric study of individuals and had great impact on child study and applied psychology. At the University of Pennsylvania in the United States, Witmer had established a clinic for children in 1896 that focused on school adjustment and in 1909 Healy founded what is now the Institute for Juvenile Research in Chicago. These events provided the base for the child guidance movement, emphasizing a multidisciplinary team approach to the diagnosis and treatment of children's adjustment and psychological difficulties. The child guidance model involved treating both the children and their parents. The increased interest in clinical and research work on children's problems led to the founding of the American Orthopsychiatric Association in 1924, an organization of psychologists, social workers, and psychiatrists concerned with the mental health problems of children.

Through the 1940s and into the 1950s, psychoanalytic psychotherapies were used almost exclusively in the treatment of children. In 1947, Virginia Axline published *Play Therapy*, describing a nondirective mode of treatment utilizing play. Nondirective play therapy was, in effect, a child version of Carl Rogers's adult-oriented client-centered therapy. Both nondirective play therapy and client-centered therapy represented the first major departures from psychoanalytic thought, differing in conceptualization of the

therapeutic process and content in the role of the therapist. Rogers's impact on adult psychotherapy was paralleled and followed by Axline's impact on child therapy. The next major movement in psychotherapy was the rise of the behaviorally based approaches to treatment. Although the principles and potential applications of behavioral psychology were long known, it was not until the 1960s that behavior modification and therapy began to be used frequently in clinical work with children. In recent years, cognitive-behavioral approaches have become prominent as a treatment modality.

The mental health treatment of children and adolescents has also been affected by two policy and legislative mandates. First, the community mental health movement was strongly influenced by the passage in 1963 of the federal program to construct mental health centers in local communities and begin a move away from large institutional treatment. This movement grew not only because it was mandated by a federal program but because it represented a philosophy that mental health interventions are more likely to be successful when carried out in the community where the maladjustment is occurring. The new programs emphasized early intervention and prevention of mental disorders. The second mandate, with a similar philosophical base, involved the provision of special education services to all handicapped children, including emotionally disturbed and behavior-disordered children and adolescents. Exemplified initially by Public Law 94–142 (now the Individuals with Disabilities Education Improvement Act [IDEA]), this movement has not only expanded the role of public education in provision of services to these children but also allowed more children to remain in their home communities. Psychotherapy and mental health treatment, if deemed a part of the total educational program of a child, has become by law and policy an educational service.

In the past 10 to 15 years, child and adolescent treatment has been in the identification of treatments that are evidence based (e.g., Kazdin, 2003; Weisz & Kazdin, 2010). Various terms have been used to describe these treatments including *empirically validated* or *supported treatments*, *evidence-based practice*, or simply *treatments that work*. Efforts have also been made to quantify the degree and strength of support for the treatments, for example, the number of studies showing evidence of effectiveness. Studies are examined with the specification of treatment (i.e., age, setting, presenting problem), use of treatment manuals or clearly specified intervention procedures, and evaluation of outcome with multiple measures. Procedures must be replicable and independent replication studies are often included in criteria for a treatment to be labeled as evidence based.

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS: A CHRONIC PROBLEM

There are well-documented estimates of large and perhaps increasing numbers of children who are experiencing significant mental health problems. These needs have been apparent for some time. Studies in the 1960s and 1970s clearly showed the pervasiveness

of problems at that time. In a study of children in public school, Bower (1969) estimated that at least three students in a typical classroom (i.e., 10% of school-age children and adolescents) suffered from moderate to severe mental health problems; many of these children were disturbed enough to warrant special educational services for the emotionally handicapped. In 1968, Nuffield, citing an estimate of 2.5 to 4.5 million children under the age of 14 in need of psychiatric treatment, found indices of only 300,000 receiving treatment services. This figure represented services to roughly 10% of those in need. Berlin estimated in 1975 that each year there would be 6 million school-age children with emotional problems serious enough to indicate the need for professional intervention. Cowen (1973) noted a smaller group (1.5 million) in need of immediate help but estimated that fewer than 30% of these children were receiving this help.

There has been little change in the reduction of problems. Kazdin and Johnson (1994) noted that incidence studies show between 17% and 22% of youth under the age of 18 have some type of emotional, behavioral, or developmental problem. This represented between 11 and 14 million of the 64 million youth in the United States with significant impairment. They noted that many of those with disorders are not referred for treatment and are not the focus of treatment in the schools. Kazdin and Johnson (1994) also noted that there are high and increasing rates of at-risk behaviors, including antisocial and delinquent behaviors, and substance abuse. Doll (1996), in a synthesis of epidemiology studies, notes a similar rate of 18% to 22% with diagnosable disorders, translating this to the analogy of a school of 1,000 students with 180 to 220 students in the school having a disorder in the clinical ranges. Doll sees the need for broad-based policies at all levels (i.e., school, district, governmental) to address these significant needs. Regardless of the estimate of incidence, it is clear that many children and adolescents with problems are not identified by educational, mental health, and social service institutions as having emotional difficulties and thus are not referred for or provided treatment services.

Reviews (Huang et al., 2005; Tolan & Dodge, 2005) have noted this continued problem despite many government panels formed to address the problem. It is estimated that 1 in 5 children have a diagnosable disorder, with 1 in 10 having a disorder that substantially impacts functioning at home, at school, or in the community. Further, there continues to be limited or difficult access to appropriate mental health services, both for families with financial resources and those with more limited means.

Children and adolescents remain critically underserved populations, despite ample recognition of the problem based on nearly 40 years of research documenting needs. The mental health needs of children present an enormous service delivery shortfall; and with funding problems continuing in the human services, the gap between need and available services is likely to continue. Preventive services may be a cost- and resource-efficient mode for dealing with part of this problem, but the provision of quality counseling and psychotherapeutic services will be a crucial component in the total mental health

system. Tolan and Dodge (2005) call for a fundamental policy shift to development of a comprehensive mental health care system for children that includes treatment, support, and prevention.

Huang et al. (2005) have described a "vision for children's mental health" that would address the complex needs of children and adolescents, including:

- Development of comprehensive home- and community-based services and supports.
- Development of family support and partnerships.
- Development of culturally competent care and reducing disparities in access to care.
- Individualization of care.
- Implementation of evidence-based practice.
- Service coordination and designation responsibility.
- Prevention activities for at-risk groups with earlier identification and intervention, including programs for early childhood.
- Expansion of mental health services in the schools.
- The components of this vision are clearly consistent with the theme of this book.

The Centers for Disease Control (2013) released an updated survey of the status of children's mental health. Among the highlights of this report include the increasing rate for internalizing disorders (e.g., depression, anxiety), behavioral disturbance (ADHD, conduct), and autism spectrum disorders. The report noted that up to 1 in 5 children in the United States may experience a mental health disorder in any given year. Adolescent issues included substance use/abuse disorders and suicide. Labeling children's mental health as an important public health issue, the report called for increased understanding of the mental health needs of children, research on risk factors and prevention, and continued research on effectiveness of treatment and prevention efforts. Sadly, this report seems to echo studies from many years ago and points to even more needs in the child/adolescent population.

DEVELOPMENTAL ISSUES

The child/adolescent mental health professional must be familiar with human development for a number of reasons. With the exception of severe psychopathology or extreme behaviors, much of what is presented as problematic in children may simply be normal developmental deviation. What is considered pathological behavior in adults may not be abnormal in children or adolescents. Knowledge of development and the normal behavioral ranges at different ages is crucial to discriminating between truly deviant

behavior and minor developmental crises. Development in children and adolescents may follow sequences with expected orders for the appearance of certain behaviors and characteristics yet still tend to be highly variable. Children's personalities are quite unstable when compared with expectations of stability in adults. Related to this instability is the evidence that indicates normal development is often marked by a number of behavior problems. The child/adolescent therapist must be able to sort out these "normal" problems from those that may represent more serious disorders.

Awareness of development will also aid the therapist in clinical decision making at various points in the treatment process. Appropriate goal setting is important to any therapeutic venture. It provides a direction for our work, allows us to monitor progress, and tells us when we are done. The child/adolescent therapist sets these goals in a developmental framework and does not expect an average 8-year-old to acquire, in the course of therapy, the problem-solving cognitive abilities or the moral judgment of a 10-year-old. To set goals above developmental expectations is almost ensuring that the intervention will fail. This knowledge of development also allows the therapist to choose appropriate content and to decide what level of therapeutic interaction is best suited for the child. Within these developmental age expectations, the therapist must also be sensitive to developmental delays in children. Delays, particularly in cognition and language, dictate goal setting, yet they must be distinguished from behavioral or emotional disorders. These delays may also be major contributing factors in the development of disorders. On the other end of the spectrum, we need to be cautious not to set limited goals for developmentally advanced children. Although we are not advocating psychological assessment as a prerequisite for treatment, in most cases, the child/adolescent therapist will need to assess developmental levels of their clients early in the intervention.

An understanding of child and adolescent development appears critical for effective therapeutic interventions. The first involves an understanding of the developmental stage theorists, with the works of Freud, Piaget, Kohlberg, and Erikson being the most notable. It is beyond the scope of this book to detail this large knowledge and research base on human development, but comprehensive human development text should be on the shelf of every therapist.

As an example, we have personally found that Piaget's theory of cognitive development provides an excellent base assessing intellectual development and planning interventions accordingly. Piaget suggested that maturation, physical experience, social interaction, and equilibration (the internal self-regulating system) all combine to influence cognitive development. At different periods, the type of information that can be processed and the cognitive operations that can be performed vary. Cognitive development is a coherent and fixed sequence with certain cognitive abilities expected at certain ages (e.g., see Wadsworth, 2003). Piaget allows us to select developmentally appropriate modes of interacting with the child and to set appropriate goals for cognitive change.

For example, children in the concrete operations stage solve problems involving real or observable objects or events. They have difficulty with problems that are hypothetical and entirely verbal, making verbally oriented or more abstract counseling interventions inappropriate at this developmental stage, while children in formal operations can engage in broader and more abstract and generalizable problem solving.

Probably no single developmental period provides more confusion and consternation for parents, teachers, and clinicians than adolescence. It is characterized more by a developmental phase than by a set, sequenced series of stages. Mercurial behaviors, many of them disturbing, seem to "possess" the adolescent.

Both Steinberg and Morris (2001) and Smetana, Campione-Barr, and Metzger (2006) view adolescence in context beyond the typical developmental theories with an emphasis on interpersonal and societal contexts. Issues of parent-adolescent relationships, broader family relationship (e.g., siblings, extended family), peers, romantic relationships, and connection with community and school all impact the individual adolescent. Dolgin (2010) notes that today's adolescent is dealing with a wide range of issues. Social media and cell phones have become prominent as well as diversity issues. Adolescence is marked by biological and cognitive changes and a range of identity issues—education, sexual identity, educational aspirations, ethnic identity, and gender issues. Dolgin (2010) also notes that there really is no typical family constellation that is common to adolescents. The adolescent is faced with many developmental issues and now with a different set of cognitive skills to process and analyze these changes. The lability often seen in adolescents is likely the norm.

The child/adolescent therapist will find much in theory and research in child and adolescent development that pertains to psychological interventions with these groups. It is difficult to imagine developing and carrying out treatment plans without a firm grounding in these areas. Developmental theory and broader contextual perspectives provide us with a framework to systematically, if not scientifically, work with children and adolescents and more objectively gauge our therapeutic progress with them.

UNIQUE ASPECTS OF PSYCHOTHERAPY WITH CHILDREN AND ADOLESCENTS

In addition to the developmental issues previously discussed, a number of other issues related to the child's development and situation have an impact on the psychotherapeutic relationship. These factors relate to the direct work with the child or adolescent and stem from some of the differences between child/adolescent psychotherapy and adult psychotherapy.

Children and adolescents bring a different motivation for treatment into the counseling situation. Whereas the adult is usually aware that a personal problem exists, the

child may not agree or recognize that there are problems or concerns. Although others may encourage adults to seek professional help, in most cases they will decide whether to enter treatment. The child is unlikely to voluntarily initiate entering into therapy. This decision is usually made by an adult in the child's environment, with some varying degree of acceptance/compliance/resistance from the child. The involuntary nature of the child/adolescent client in many cases may yield little or no motivation on the part of the client to engage in a relationship with the therapist or not even an admission that any change is necessary. Thus, the first step in many interventions may be simply to establish some type of relationship with the child and to come to some agreement that change is necessary. Without developing some motivation in the client to at least examine the current situation, even if done nonjudgmentally, it will be difficult to make significant progress.

An aspect related to motivation is the child/adolescent's lack of understanding of both the therapeutic process and the treatment objectives. The adult is likely to recognize the need to "get something out of therapy" and to have certain expectations of what is supposed to happen in the counseling situation. The adult usually will be able to verbalize some expectations and goals and to engage in some role-appropriate "client behaviors," (e.g., talking, reflecting, responding to questions). Children may have no clear view of what the therapy situation presents. This blurred view may range from having total misinformation to seeing the therapist as an agent of their parents, the school, the courts, or some other individual or institution that forced the initiation of treatment. The therapist may initially have to simply educate the child about therapy, explaining what it is and what it is not. Children may bring in distorted or stereotyped ("Oh, so you're the shrink. Where's your couch?") perceptions of therapists. This author is reminded of one extremely anxious 12-year-old boy who failed to respond to the usual reassuring techniques in an initial therapy session. After some gentle probing, it was learned that the young man had watched one too many late-night horror movies in which the fiendish doctor had done bizarre things to his subjects. Somehow the boy had associated coming to the mental health clinic with the scenes in movies where the hero gets wired to a machine and is never the same again. When I (H.T. Prout) reassured him that the use of electrodes was not part of my approach and that we were simply going to talk about problems he was having at home and school, he visibly relaxed and began to volunteer all sorts of information.

Even as therapy progresses, it is necessary to monitor these perceptions. The child who views the therapist as the person he plays games with once a week is unlikely to focus on the tasks necessary to facilitate change. Similarly, there may be little agreement as to what changes are needed and what mutually acceptable treatment objectives are to be established. The therapist is likely to be faced with the predicament of reconciling, on the one hand, the goals of those who initiated treatment (e.g., parents,

teachers) and, on the other hand, the child or adolescent client's own view of what is needed. A parent-referred adolescent who has been arrested three times for shoplifting may verbalize a goal of having his parents "get off my case." Although this position may be a factor in the acting out, it is not likely to produce an appropriate therapy objective, given the referral problem. Thus, the therapist must negotiate with the client appropriate goals, objectives, and topics or content for the counseling. These goals may not necessarily be in total agreement with the aims of the referral source or the therapist, but they will provide a starting point. Objectives can always be renegotiated as the relationship develops. Further, the therapist needs to demonstrate to the child or adolescent client that the client will get something out of counseling. Initially, this demonstration may take a form as simple as providing an interesting format. This accomplishment can lead to the establishment of a more congruent set of objectives.

Another major difference between child and adult therapy is the child's more limited verbal and linguistic development, which is also related to the limitations in cognitive development. Children may be unable to think in more abstract terms and may have even more difficulty verbally describing and discussing their thoughts and emotions. This limited verbal ability is one of the main reasons play has been used as a medium of therapy. Play and other nonverbal techniques allow expression without creating anxiety or frustration for the child because of an inability to find the correct verbal description. Further, the child may not have the receptive vocabulary to fully understand what is being asked in the interview situation. This author once observed a psychiatric interview of a 7-year-old girl in which the resident asked the child if she ever had any hallucinations. The little girl, obviously not knowing what was meant by the word "hallucination," happily responded, "Oh, yes, all the time," whereupon the resident made note of this finding and continued the interview along other lines. Therapy must be geared at the appropriate developmental level for both the child's expressive and receptive language capabilities. While not de-emphasizing the worth of "talk therapy," alternative modes of expression should be investigated for use in conjunction with verbal interactions. The therapist may also find it useful to teach the child labels and verbal mediators for emotional experiences. This course of action can involve using the traditionally accepted labels for feelings or using the child's own terminology. An 8-year-old girl once accurately described several symptoms consistent with "feeling depressed." The girl, however, felt more comfortable generally describing the state as one of "yuckiness."

Children also differ from adults in terms of their dependence on environmental forces and changes. Children are reactors to changes in their living situations rather than initiators of change. They have relatively little power to take action to eliminate or prevent environmental causes of stress. They react to parental divorces, family moves, and school and peer pressures. The child's disturbance may actually be a relatively normal reaction to upheaval or stress in the environment. Yet, children cannot divorce their parents,

change schools, or move at will. Because the child is dependent on the environment, it is more important for those in the environment to be involved in treatment. Where the adult is more likely to seek treatment independently, the child is less likely to be treated in isolation. Even if children make significant progress in individual therapy, they still do not have the options available to adults in dealing with the environment. In some cases, therapy may even proceed on the notion of helping the child cope with a stressful situation, rather than assuming that change will be forthcoming in the environment. For example, an 11-year-old can exert little impact on the drinking and resulting behavior of an alcoholic parent yet may be assisted in finding ways to deal with the problem that make the stress more manageable.

Another factor that contributes to the difference between child therapy and adult therapy is that the child's personality is less likely to be set than the adult's. The child, whose defenses are not as well established, is more pliable and amenable to therapeutic influence once the relationship and cooperation are established. The personality is still developing and changing rapidly, yielding a greater potential for change. But at the same time, this situation presents a somewhat more labile client and can result in inconsistent responses in therapy session. The child has a greater range of normal emotional and behavioral responses as a result of the unformed nature of the personality. The therapist, therefore, can be more flexible and must anticipate and not be discouraged by seemingly broad swings of emotion and behavior in the course of treatment. The plasticity of the child's personality is also an asset in the working out of a preventive model that heads off disturbing patterns with appropriate intervention prior to the crystallization of the personality.

As unpredictable as adolescents' behavior is to those in their environment, a similar unpredictability exists in the therapeutic relationship. Adolescents entering the therapy situation are characteristically impatient, intolerant, and uncommunicative. They may fail to elaborate on any details of the current situation or difficulties presented. They may deny any responsibility for the current problems, preferring to place blame elsewhere, or may actually have almost no insight into the reasons they have been referred for treatment. Picture a 16-year-old male sitting in your office, slouched in a chair, a cap and long hair covering his averted eyes. His first words and only complete sentence for the next hour are: "I don't want to talk to no f—king shrink." A reflective statement on your part that he must be upset about something only brings a muffled grunt. A series of your best open-ended questions elicits only a series of unelaborated "Yes's," "No's," "I don't know's," "Maybe's," and "It's the damn teachers." Your feeble attempts to introduce humor or to discuss *safe* topics bring only more grunts, a few eye rolls, or no response at all. His posture throughout the seemingly never-ending hour remains essentially unchanged. This initial session represents the base on which you will build your therapeutic relationship with the young man. It is little wonder that many therapists

avoid such interactions. Despite our best rationalizing that the adolescent is reacting to the situation and not to us, it is often difficult to come out of such an unproductive session feeling as though we made progress and that our skills are up to the task of helping the adolescent.

Depending on the level of development and maturity, work with the adolescent may range from gamelike approaches utilized with younger children to therapy that resembles interventions with an adult presenting similar problems. Most adolescents will not be candidates for insight-oriented, in-depth therapy involving the reworking of previous experiences. Goals may range from better self-understanding with some personality reorganization to simple stabilization and improved functioning without major personality change.

Unstructured probing, queries about deep personal feelings, or challenging the adolescents to explain their misbehavior will likely produce further uncooperativeness or yield a strong emotional response. Beginning with factual information in a nonjudgmental manner will help allay initial anxieties. The therapist needs to explain how the relationship will differ from those with parents, teachers, peers, and others. The goal at this level is to achieve engagement with the adolescent and then implant the initial seeds for establishing a motivation. The initial agreement from the adolescent may simply be to return to another session.

The adolescent therapist will be more active in comparison with the adult therapist. Long silences, noncommittal responses, and long periods of formulating answers to the adolescent's concerns should be avoided. Adolescent therapists may find they talk with these clients relatively more than with adult clients. Explaining thoughts explicitly, phrasing questions concretely, and, in general, using a direct approach will facilitate work with the adolescent. Many of the interpretive leads and nondirective probes used with adults may be perceived by the adolescent as trickery and may add to resistance. Therapists need to present themselves as genuine. A spontaneous, conversational approach that is more akin to talking with a casual friend is recommended. The adolescent is likely to be curious about the therapist's "real life," and the therapist's responses to such questions should be matter-of-fact and nonevasive. While not attempting to influence values, the therapist should be willing to share personal opinions and attitudes with the adolescent. Acknowledgment of the adolescent's feelings about various issues and situations is helpful; the therapist should be particularly aware of the current teenage values, fads, slang, and so on, and be sensitive to the pressures related to adolescents' social and emotional developmental levels. The therapist needs to communicate a liking of, and interest in, the adolescent. This is best done indirectly because the adolescent will recognize the artificiality of an "I like you." A sincere commitment to engage with the adolescent in mutual problem solving, along with other concrete gestures and expressions of interest, is most helpful. Finally, the therapist must work at

maintaining a balance along the continuum of independence-dependence. Adolescents should not be treated like children; yet they should not be given signals that they are entirely free to make all of their own life decisions.

INTEGRATION: MULTIMODAL AND MULTISYSTEMIC

This book borrows (and somewhat bastardizes) the term *multimodal* initially introduced by Lazarus (1976) to describe the overall philosophy implicit in the subsequent chapters. Lazarus (2006, 2009) has been refined to some degree with the current model being fairly consistent with cognitive-behavior therapy. Lazarus presented his BASIC ID, an acronym for seven interactive modalities that are investigated as potential points of intervention for problems. The modes are Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs-Diet. This approach presents a comprehensive method of identifying problems and then deciding the most effective way to intervene. Keat (1979, 1990, 1996) expanded on this approach with his own acronym, BASIC IDEAL, by adding E for Educational or school pursuits, A for Adults in the child's life (parents, teachers, relatives), and L for Learn the client's culture.

This book takes a broad view of what is "psychotherapeutic" for a child or an adolescent. By multimodal, we refer to the many types of interventions to help troubled children and adolescents. Kazdin (2000) identified more than 500 terms that have been used in the research and case study literature to describe interventions with children and adolescents. This nearly exhaustive list points to the many interventions we have available to facilitate therapeutic change with children and adolescents. There also exists a range in each alternative. Educational measures, for example, can range from resource room help to a full-time structured placement. Parental interventions may involve parenting classes or perhaps therapy for the parents. In most cases, a multimodal, or combined, approach will be used. For example, children may receive individual therapy, their parents may receive counseling, and the teacher may conduct a behavior management program. Although it is desirable to intervene in the most efficacious and cost-efficient manner, we do not make assumptions that one technique is preferable to or more therapeutic than others. At this point, neither research nor clinical experience is able to identify whether a child with a low self-concept, for example, is helped more by 2 hours a week of individual therapy or by having a teacher who is trained to consistently provide positive successful school experience. We do not know whether group social skills training is more beneficial than family therapy. What we do know is that several types of intervention have some benefit for children and adolescents. The more interventions and systems that can be combined—the more modalities that are involved in the treatment—the more likely it is we will realize our overall therapeutic goals. This approach is not a "let's try everything" plan. It involves careful assessment of

problems, selection of appropriate interventions, and coordination and communication among those providing services. As long as our treatment programs are not excessively costly or time-consuming, interventions involving several modalities are indicated.

This multimodal view also implies two other basic assumptions. First, professionals with a variety of backgrounds are involved in child treatment. A teacher with a bachelor's degree in special education may be working with a child who is receiving individual therapy from a psychiatrist who has completed a child psychiatry fellowship program. A high school guidance counselor may work individually with an adolescent whose family is in therapy with a licensed psychologist. A further assumption here is that a person does not have to be called a therapist to have therapeutic impact on a child. The second, related, assumption involves the settings where treatment takes place. Troubled children and adolescents receive treatment in, among other places, classrooms, schools, agencies, clinics, group homes, and hospitals. In this book, we do not make the artificial distinction between counseling and psychotherapy. We assume that a similar core of principles and techniques can be adapted to many settings. Although the presenting problems may differ depending on the setting, we believe, for example, that a cognitively oriented school counselor will function in a manner relatively similar to a cognitively oriented psychiatrist in an inpatient setting. The overriding concern is the development of effective, coordinated, and multifaceted interventions.

Multisystemic therapy (MST) treatment was originally developed for interventions with antisocial and delinquent youth (Henggeler, Schoenwald, Borduin, & Rowland, 1998). The approach is based on social-ecological theory that includes treatment considerations at the individual, family, peer, school, and community levels. In this perspective, the individual child or adolescent is viewed as at the center of a variety of interacting and interdependent systems. Treatments aimed at these various systems can be done simultaneously and can ultimately impact the individual. All these levels are viewed as potentially contributing to the development of emotional and behavioral problems, as well as to the maintenance of the difficulties. The MST approach also emphasizes treatment in the natural environment.

More recently, MST treatment has expanded to intervene with a broader range of psychological problems (Curtis, Ronan, & Borduin, 2004; Henggeler, Schoenwald, & Rowland, 2002; LaFavor and Randall, 2013; Rowland et al., 2000). Typically, MST has dealt with children and adolescents with more serious and pervasive problems. A number of basic tenets underlie MST:

- Multisystemic therapy seeks to identify risk, protective, and maintaining factors in the natural environments.
- Multisystemic therapy is family-based and shares some of the systemic perspectives of other family therapy approaches. However, MST tends to be more intense

and emphasizes more linkages between the children/adolescents, their family, and other units in the broader natural social network.
- Treatments are goal-based with families having primary input in designation and selection of goals.
- Treatments heavily involve caregivers and aim to alter the networks on a longer term basis for maintenance of gains and changes.
- Treatments emphasize strengths and positives of the clients and their network and work at increasing responsibility across persons in the network.
- Multisystemic therapy has a problem-solving, present, and action-oriented focus.
- Treatments identify sequences between and among units in the network and seek to alter the sequences to facilitate change.

Although the overall theme of this book is on theories, these theories provide options in MST, particularly at the individual, family, group, and school level.

RESEARCH AND EFFICACY

The effectiveness of psychotherapy has been controversial for many years, and this has been particularly notable in the child and adolescent area. The child and adolescent area is confounded/complicated by both developmental factors and systemic and family factors. Attempts to summarize research have been through traditional critical literature reviews with meta-analysis the more contemporary approach.

Historical and Traditional Reviews

Since Eysenck's (1952) classic and much-debated study on the effectiveness of psychotherapy with adults, researchers and clinicians have pondered the question, "Does psychotherapy work?" Eysenck's study, generally recognized as having spawned considerable research in psychotherapy, reviewed a number of studies of psychotherapy outcome with neurotic adults. His evaluation concluded that the percentage of treated clients who improved was not substantially different from the spontaneous remission rate (i.e., those individuals who improved without psychotherapy). He found that roughly two-thirds of each group, treated and untreated, reported improvement. Eysenck concluded that there was little evidence to support the effectiveness of psychotherapy with adult neurotics. Eysenck's data and methodology have been cited, reanalyzed and reinterpreted, and criticized and condemned ever since. Despite its controversial nature, his study is important for the discussion, research, and examination of the therapeutic venture it has fostered.

Systematically and carefully studying the psychotherapy effectiveness question is one of the most difficult research areas in the behavioral sciences. Understanding the process of psychotherapy and its relationship to behavior change is an extremely

complex proposition. The six volumes of the *Handbook of Psychotherapy and Behavior Change* (Bergin & Garfield, 1971, 1994; Garfield & Bergin, 1978, 1986; Lambert, 2004, 2013) point to both the methodological complexity and the enormity of the issues. These volumes have attempted to bring together current empirical knowledge and data on psychotherapy. To utilize current research findings or to attempt research in this area, we must be aware of the problems facing researchers:

- Psychotherapy represents a wide variety of techniques, in some ways preventing a clear, unambiguous definition of psychotherapy.
- Psychotherapy differs depending on the theoretical orientation of the therapist, the length of time of the treatment, and the format (i.e., individual, group, marital, parent, family consultation).
- The clinical definition of client populations may be ambiguous and thus limit generalizability.
- Clear definition of symptomatology and the client characteristics may vary in studies and be somewhat a result of the setting. Would two studies of treatment of anxious children produce similar results if one were conducted in a school and one at a clinic? Similarly, there are subgroups that might be studied separately (e.g., males versus females, Blacks versus Whites, disadvantaged, children).
- Therapists vary in age, sex, training, orientation, competency, style, and personality characteristics. Outcome could be affected by any one of these. Some research has studied the client/therapist match issue (i.e., whether a certain type of therapist works best with a certain type of client).
- Research can focus on process or content variables, or outcome. Process studies examine what goes on in therapy, typically some client/therapist interaction variable. Outcome studies examine whether the person is improved or whether there is behavioral or affective change following intervention. Although some studies attempt to relate process to outcome, both have been and continue to be studied extensively.
- In outcome studies, what represents appropriate measures to gauge *therapeutic change*? Do rating scales, personality tests, client report, therapist rating, or the reports of significant others validly and reliably reflect genuine change? What represents improvement?
- Other methodological issues exist. Are single-subject research designs appropriate for studying the general effectiveness of techniques? What represents an appropriate control group for those who receive treatment? Both those people on waiting lists for treatment and defectors (those who fail to return to the clinic for therapy) have been used in comparison studies. Do these groups represent ones that are clinically comparable to the experimental group?

- Psychotherapy does not occur in isolation. How do we account for other extraneous variables that may affect our results?
- What are the long-term effects of our interventions? Does a 1-year positive follow-up on clients treated for depression mean that these individuals will also suffer fewer problems with depression in the subsequent 5 or 10 years?

Psychotherapy research with children and adolescents presents some special research problems. Levitt (1971), an early critic of psychotherapy with children and adolescents, noted that because the child is a developing organism, many of the symptomatic manifestations of essentially normal children tend to disappear as a function of development. Some problems like temper tantrums, enuresis, specific fears, and sleep disturbance tend to go away in time. Levitt (1971) notes, "There is some reality in the common-sense notion that children 'grow out' of certain behavior problems" (p. 477). This makes it difficult to sort out the effects of therapy versus the effects of maturation. Similarly, some problems that are indicative of underlying emotional disturbance may disappear as a function of development yet reappear in another form that Levitt calls "developmental symptom substitution" (p. 477). For example, a child successfully treated for enuresis at 8 years of age might be classified, for research purposes, as "cured" or "improved" yet present serious problems as an adolescent. Extending this view somewhat, research on the effects of childhood psychological treatment on later adult adjustment is difficult to do, yet this issue is an important one. Levitt also notes that, although the child may be the identified patient in clinical studies, persons other than the child may actually be the direct focus of treatment, thus making the isolation of treatment effects difficult.

In reviewing psychotherapy research studies, we are left with certain impressions. Because of the difficulty in conducting research in this area, it is possible to critically examine almost any single study and dismiss its results or offer alternative explanations of the findings on methodological grounds. The orthodox experimental psychologist who spends the day in a rat laboratory might smirk at some of our research conclusions. But because we work with humans who have difficulties in living and because the alleviation of these difficulties is a complex process, we must take a somewhat softer view of the research. We must examine the literature with the understanding that few, if any, studies are going to answer absolutely the question, "Does psychotherapy work?" Rather, we must continue to critically examine the data and conclusions and to glean from the research those implications that relate most directly to our clinical work. This proposal is made not to support sloppy research or blanket acceptance or rejection of findings but to support a flexible and open-minded view of the current literature and status of the psychotherapy venture.

The effectiveness of psychotherapy with children has been chronicled in reviews by Levitt in 1957, 1963, and 1971, and in a review by Barrett, Hampe, and Miller in 1978.

Levitt's 1957 study was modeled after Eysenck's (1952) study of the effectiveness of adult psychotherapy. Surveying reports of evaluation at both the close of therapy and at follow-up and comparing them with similar evaluations of untreated children, Levitt found that two-thirds of the evaluations at close and three-fourths at follow-up showed improvement. Roughly the same percentages were found in the untreated control groups. Levitt wrote: "It now appears that Eysenck's conclusion concerning the data for adult psychotherapy is applicable to children as well; the results do not support the hypothesis that recovery from neurotic disorder is facilitated by psychotherapy" (p. 193). Levitt noted, however, that his evaluation "does not prove that psychotherapy (with children) is futile" (p. 194) and recommended "a cautious, tongue-in-cheek attitude toward child psychotherapy" (p. 194) until additional evidence became available. The 1963 study utilizes a similar methodology and again concluded that the hypothesis that psychotherapy facilitated recovery from emotional problems could not be supported. Some of the 1963 data did suggest that comparisons should be made in diagnostic categories. Levitt also found that improvement rates tended to be lowest for cases of antisocial acting out and delinquency and highest for identifiable behavioral symptoms like enuresis and school phobia. The 1971 review departed slightly from the previous reviews and looked at a wider range of modalities than just child psychopathology. These included the effects of inpatient versus outpatient treatment, drug therapy, type of special class placement, and the use of mothers as therapists. Although individual studies showed some effectiveness, the overall conclusion again pointed to a lack of proof that these interventions are generally helpful. Levitt (1971) also focused on two identifiable diagnostic classifications, juvenile delinquency and school phobia, for further examination. School phobia tended to respond favorably to treatment, but Levitt questioned whether treatment was simply removing the symptoms of more serious underlying core problems that would surface in some other form later. Conventional psychotherapy with delinquents appeared to be generally ineffective, but some moderately positive results were found in examining more comprehensive treatment programs for delinquents. In addition to still questioning the effectiveness of child psychotherapy, Levitt was able to provide some preliminary conclusions. He noted that many of the principles on which traditional psychoanalytically based child guidance treatment have been based are now being challenged by research. The evidence at that time did not support the necessity of involving the mother in treatment, the relative insignificance of father involvement, the relationship of outcome to intensity of treatment, the desirability of encouraging the expression of negative feeling, ignoring undesirable behavior, or the notion that the home or family situation is likely to be more therapeutic than other child-care settings. In other words, many principles that had guided, and probably still do guide, much of traditional child treatment simply are not supported in the research. Rigid orthodoxies are not empirically supported, although few of the innovative treatments are definitely supported either. Levitt called

for more studies of treatment of specific diagnostic classifications and more long-range follow-up studies.

Two other reviews of treatment bear mentioning. First, Abramowitz (1976) reviewed efficacy studies of group psychotherapy with children, reaching a conclusion similar to the reviews of individual therapy. Definitive conclusions are not possible at this point, and, based on available data, favorable responses to group therapy are not indicated. However, if a group therapy approach is indicated, the feasibility of using a behavioral approach might be considered first. Second, Tramontana (1980) has reviewed psychotherapy outcome research with adolescents and offered conclusions not much different from other reviews. Noting a sparseness in the adolescent literature, Tramontana (1980) found no clear evidence of effectiveness but found the area to be fraught with research methodology problems.

Thus, through the 1980s, the dominant research conclusion was that psychotherapy was not effective with children and adolescents. Weisz, Doss, and Hawley (2005) reviewed 40 (1962 to 2002) years of research on psychotherapy for child and adolescent mental health problems. Their review was intended to both summarize and critique the knowledge base. They concluded that these initial conclusions about effectiveness had a number of problems in the existing research. Among these problems were poorly defined theoretical perspectives, few randomized clinical studies, poor descriptions of sample characteristics (including diagnoses), most studies not detailing ethnicity or racial characteristics, small sample sizes, and poorly defined treatment targets.

Weisz et al. (2005) noted some progress methodologically more toward the end of the period they studied. Yet, they felt the conclusion of earlier researchers regarding the ineffectiveness of child/adolescent psychotherapy was not warranted.

Meta-Analyses

The reviews previously noted could all be classified as evaluating the child psychotherapy research literature through the traditional critical literature review approach. The systematic approach of meta-analysis is now the standard for summarizing psychotherapy research. This approach combines the results of efficacy studies by evaluating the magnitude of the effect of treatments. Smith and Glass (1977) popularized this statistical approach in the psychotherapy literature. In a meta-analysis, each outcome result in a controlled study is treated as one unit of magnitude of effect or *effect size* (ES). The effect size is calculated by subtracting the mean of the control group (M_c) from the mean of the treated group (M_t) and then dividing the difference by the standard deviation of the control group (SD_c): $ES = M_t - M_c/SD_c$. The effect sizes are averaged to determine average effects across and between treatments. The effect size is a standard score that indicates how many standard deviation units a treatment group differs from an untreated control group. A positive effect size indicates improvement or the beneficial

effects of treatment. For example, an effect size of 1.00 indicates that untreated subjects at the mean of their group (i.e., the 50th percentile) would be expected, on average, to rise to the 84th percentile (i.e., a one standard deviation improvement) with treatment. Evaluating across all types of counseling and psychotherapy, Smith and Glass (1977) found an average effect size of .68.

Cohen (1988) proposed guidelines for interpreting effect sizes: a "small" effect size is .20, a "medium" effect size is .50, and a "large" effect size is .80. Cohen noted, however, these guidelines may be different for each field of study.

As the meta-analytic approach has evolved, many meta-analyses have been completed on the effectiveness of child/adolescent counseling and psychotherapy. Casey and Berman (1985) analyzed studies done with primarily younger children (under age 13) who received some form of psychotherapy, while Prout and DeMartino (1986) evaluated studies of children and adolescents who received interventions for school-based or school-related problems. Respectively, they found effect sizes across treatments of .71 and .58. These overall effect sizes are generally consistent with the meta-analyses done primarily with adult subjects. Using a model for evaluating the relative size of treatment effects proposed by Cohen (1988), these effect sizes fall into the "moderate" effect size category. The importance of some of these initial meta-analyses was best summarized by Casey and Berman (1985). Despite some shortcomings in the diagnostic and methodological areas, they felt that the available outcome studies demonstrated the efficacy of treatment across a range of therapeutic approaches and problems. Specifically, they noted: "Clinicians and researchers need not be hesitant in defending the merits of psychotherapy with children" (p. 397).

Since those initial meta-analyses, there have been numerous studies focusing on both the general effectiveness of child/adolescent psychotherapies as well as studies on specific approaches (e.g., cognitive-behavior therapy [CBT]) and for specific disorders (e.g., depression). A summary of all these studies is beyond the scope of this chapter. Two recent reviews summarize the current state of the research. Zirkelback and Reese (2011) reviewed a number of broad-based meta-analyses conducted between 1985 and 2006. Effect sizes ranged from .30 to .97, with most falling into the "medium" range of effectiveness. Zirkelback and Reese (2011) concluded, noting effect sizes averaging around .70 (+/–), that a treated child or adolescent is generally better off than a child not provided treatment. Weisz (2014) examined some of the same meta-analyses and found a similar range and typical effect size, but cautioned about the generalizability across contexts (e.g., disorders, settings).

In the first edition of this book, we noted that the outcome research on child and adolescent psychotherapy left us with an unclear and confusing impression (Prout, 1983). The available reviews at the time did not support effectiveness, nor did they prove the ineffectiveness of child/adolescent therapeutic interventions. Yet, at the same

time, they pointed to the complexity of the issue and the methodological problems in conducting research in this area. Although there remain some unresolved questions concerning the efficacy of child and adolescent therapeutic interventions, the array of meta-analyses present systematic reviews indicating some degree of benefit to these interventions. The question of effectiveness is more clearly answered at this point. Further, data appear to support the greater efficacy of certain types of interventions, notably those falling in the broad category of cognitive-behavioral interventions. There is now support that therapeutic interventions with children and adolescents are a viable clinical activity. Nonetheless, we continue to recommend a cautious, thoughtful, and examining approach to child and adolescent treatment.

THE ROLE OF EVIDENCE IN PRACTICE

As the practice of counseling and psychotherapy has evolved, there has been increasing evidence from both within and beyond the mental health professions that our interventions and treatments are beneficial. Two perspectives address this issue. First is *evidence-based practice*, which is associated with empirically supported treatments. The second is often called *practice-based* evidence, which examines the role of client/patient feedback in the therapeutic process. Although there has been some controversy comparing the approaches, we feel that they are not incompatible with one another.

Empirically Supported Treatments

Although there are different definitions of empirically supported treatments (ESTs), these treatments generally refer to therapies that have been evaluated in a randomized control study, have clearly defined treatment targets and/or diagnoses, have a clearly established treatment protocol (e.g., a treatment manual) that can be replicated, have shown significant treatment outcome benefits, and have been shown to be effective in more than one study (http://www.div12.org/empirically-supported-treatments). The Society of Clinical Psychology maintains the website that summarizes the current status of treatment in several areas (http://www.div12.org/empirically-supported-treatments). Sources of information specifically dealing with children and adolescent include *Evidence-Based Psychotherapies for Children and Adolescents* (Weisz & Kazdin, 2010) and *Treatments that Work with Children: Empirically Supported Strategies for Managing Childhood Problems* (Christophersen & Vansoyoc, 2013).

The EST approach has become very prominent in recent years. It has been criticized for being perhaps too narrow in dealing with actual problems in practice. Notably, the EST approach is typically tied to a specific disorder or problem. In practice, children and adolescents often present with multiple problems (e.g., an adolescent with a conduct

disorder and depression) or comorbidity. Additionally, there still remains large gaps in the child/adolescent EST literature; that is, some problems do not yet have an associated EST or the EST literature does not match the child characteristics or treatment context.

Practice-Based Evidence

Practice-based evidence is associated with the use of systematic feedback and monitoring of client/patient status during the course of treatment. Duncan (2013) argues that the relationship aspects of therapy remain integral to effectiveness and that the relationship is enhanced by soliciting feedback from the client/patient, with collaborative monitoring of outcome. Duncan feels that this process is one of the core ingredients to therapeutic progress regardless of therapeutic approach.

The systematic monitoring of progress is typically on a session-by-session basis. The child/adolescent therapist has options in two well-developed and tested progress monitoring approaches. Duncan and his colleagues have developed various versions of the Outcome Rating Scale (ORS), initially developing an adult version (Miller, Duncan, Brown, Sparks, & Claud, 2003) and followed by child versions (Duncan, Sparks, Miller, Bohanske & Claud, 2006). These scales are brief visual analogue self-report ratings of general status and well-being. More detailed information on these scales can be found at https://heartandsoulofchange.com. Similarly, Lambert and his colleagues (Burlingame, Wells, Lambert, & Cox, 2004) developed youth versions of outcome questionnaires (OQ) modeled after adult versions of their outcome measures. The youth versions include questionnaires for parent and youth. Information on the OQ measures can be found at (http://www.oqmeasures.com). Both the ORS and OQ approaches are designed to be completed quickly and are a regular part of ongoing treatment.

CONCLUSION

This chapter has provided an overview of the broad area of the psychological treatment of children and adolescents. Many issues are important to those who do clinical work with children. The mental health needs of children create enormous demands that the social services and mental health delivery system have not yet even closely met. The child/adolescent therapist must be aware of developmental factors and plan and conduct treatment accordingly. Further, the therapist must be aware of the unique aspects of the therapeutic relationship with children and adolescents. A multimodal, combined approach to treatment is advocated, necessitating a broad view of what may potentially be therapeutic for the child/adolescent client. Finally, the question of efficacy has become somewhat less debatable since the earlier editions of this book. There is now moderate but clear support for the general effectiveness of child and adolescent

therapeutic interventions although the evolving literature and research base continue to point to the complexity of the issue. The professional has expanded options with evidence-based practice and practice-based evidence strategies.

REFERENCES

Abramowitz, C. V. (1976). The effectiveness of group psychotherapy with children. *Archives of General Psychiatry*, *33*, 320–326.

Axline, V. (1947). *Play therapy*. Boston, MA: Houghton Mifflin.

Barrett, C. L., Hampe, I. E., & Miller, L. (1978). Research on psychotherapy with children. In S. L. Garfield & A. D. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 411–436). New York, NY: Wiley.

Bergin, A. E., & Garfield, S. L. (Eds.). (1971). *Handbook of psychotherapy and behavior change*. New York, NY: Wiley.

Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York, NY: Wiley.

Berlin, I. M. (Ed.). (1975). *Advocacy for child mental health*. New York, NY: Brunner/ Mazel.

Bower, E. M. (1969). *The early identification of emotionally handicapped children in school* (2nd ed.). Springfield, IL: Thomas.

Burlingame, G. M., Wells, M. G., Lambert, M. J., & Cox, J. C. (2004). Youth Outcome Questionnaire (Y-OQ). In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcome assessments: Volume 2: Instruments for children and adolescents* (3rd ed, pp. 235-273). Mahwah, NJ: Lawrence Erlbaum.

Casey, R. J., & Berman, J. S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin*, *98*, 388–400.

Centers for Disease Control and Prevention. (2013, May 16). *Mental health surveillance among children—United States, 2005–2011*. *MMWR 2013*;62(Suppl.):1–35.

Christophersen, E. R., & Vansoyoc, S. L. (2013). *Treatments that work with children: Empirically supported strategies for managing childhood problems* (2nd ed.). Washington, DC: American Psychological Association.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Cowen, E. (1973). Social and community interventions. *Annual Review of Psychology*, *24*, 243–271.

Curtis, N. M., Ronan, K. R., & Borduin, C. M. (2004). Multisystemic treatment: A meta-analysis of outcome studies. *Journal of Family Psychology*, *18*, 411–419.

Dolgin, K. G. (2010). *The adolescent: Development, relationships, and culture* (13th ed). Upper Saddle River, NJ: Pearson.

Doll, B. (1996). Prevalence of psychiatric disorders in children and youth: An agenda for advocacy by school psychology. *School Psychology Quarterly*, *11*, 20–47.

Duncan, B. (2013). What makes a master therapist? *Psychotherapy in Australia*, *20*, 58–66.

Duncan, B., Spark, J., Miller, S., Bohanske, R., & Claud, D. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. *Journal of Brief Therapy*, *5*, 71-87.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, *16*, 319–324.

Freud, S. (1955). *Analysis of a phobia in a 5-year-old boy*. London, England: Hogarth Press. (Original work published 1909)

Garfield, S. L., & Bergin, A. E. (Eds.). (1978). *Handbook of psychotherapy and behavior change* (2nd ed.). New York, NY: Wiley.

Garfield, S. L., & Bergin, A. E. (Eds.). (1986). *Handbook of psychotherapy and behavior change* (3rd ed.). New York, NY: Wiley.

Henggeler, S. S., Schoenwald, S. K., Borduin, C. M., & Rowland, M. D. (1998). *Multi-systemic treatment of antisocial behavior in children and adolescents*. New York, NY: Guilford Press.

Henggeler, S. S., Schoenwald, S. K., & Rowland, M. D. (2002). *Serious emotional disturbance in children and adolescents: Multisystemic therapy*. New York, NY: Guilford Press.

Huang, L., Stroul, B., Friedman, R., Mrazek, P., Friesen, B., Pires, S., & Mayberg, S. (2005). Transforming mental health care for children and their families. *American Psychologist*, *60*, 615–627.

Kazdin, A. E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. New York, NY: Oxford University Press.

Kazdin, A. E. (2003). Psychotherapy for children and adolescents. *Annual Review of Psychology*, *54*, 253–276.

Kazdin, A. E., & Johnson, B. (1994). Advances in psychotherapy for children and adolescents: Interrelations of adjustment, development, and intervention. *Journal of School Psychology*, *32*, 217–246.

Keat, D. B. (1979). *Multimodal therapy with children*. New York, NY: Pergamon Press.

Keat, D. B. (1990). *Child multimodal therapy*. Norwood, NJ: Ablex.

Keat, D. B. (1996). Multimodal therapy with children: Anxious Ashley. *Psychotherapy in Private Practice*, *15*, 63–79.

Klein, M. (1932). *The psychoanalysis of children*. London, England: Hogarth Press.

LaFavor, T., & Randall, J. (2013). Multisystemic family therapy. In A. Rambo, C. West, A. L. Schooley, & T. V. Boyd (Eds.), *Family therapy review: Contrasting contemporary model* (pp. 100–108). New York, NY: Routledge/Taylor & Francis.

Lambert, M. J. (Ed.). (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change*. Hoboken, NJ: Wiley.

Lambert, M. J. (Ed.). (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed.). Hoboken, NJ: Wiley.

Lazarus, A. A. (1976). *Multimodal behavior therapy*. New York, NY: Springer.

Lazarus, A. A. (2006). *Brief but comprehensive psychotherapy: The multimodal way*. New York, NY: Springer.

Lazarus, A. A. (2009). General principles and empirically supported techniques of cognitive behavior therapy. In W. T. O'Donohue & J. E. Fisher (Eds.), *Cognitive behavior therapy:*

Applying empirically supported techniques in your practice (2nd ed., pp. 440–444). Hoboken, NJ: Wiley.

Levitt, E. E. (1957). The results of psychotherapy with children: An evaluation. *Journal of Consulting Psychology*, *21*, 186–189.

Levitt, E. E. (1963). Psychotherapy with children: A further evaluation. *Behavior Research and Therapy*, *60*, 326–329.

Levitt, E. E. (1971). Research on psychotherapy with children. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 474–494). New York, NY: Wiley.

Miller, S., Duncan, B., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, *2*, 91-100.

Nuffield, E. J. (1968). Child psychiatry limited: A conservative viewpoint. *Journal of the American Academy of Child Psychiatry*, *7*, 210–212.

Prout, H. T. (1983). Counseling and psychotherapy with children and adolescents: An overview. In H. T. Prout & D. T. Brown (Eds.), *Counseling and psychotherapy with children and adolescents: Theory and practice for school and clinic settings* (pp. 3–34). Tampa, FL: Mariner.

Prout, H. T., & DeMartino, R. A. (1986). A meta-analysis of school-based studies of psychotherapy. *Journal of School Psychology*, *24*, 285–292.

Rowland, M. D., Henggeler, S. W., Gordon, A. M., Pickrel, S. G., Cunningham, P. B., & Edwards, J. E. (2000). Adapting multisystemic therapy to serve youth presenting with psychiatric emergencies: Two case studies. *Child Psychology and Psychiatry Review*, *51*, 30–43.

Smetana, J. G., Campione-Barr, N., & Metzger, A. (2006). Adolescent development in interpersonal and societal contexts. *Annual Review of Psychology*, *57*, 255–284.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*, 752–760.

Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Annual Review of Psychology*, *52*, 83–110.

Tolan, P. H., & Dodge, K. A. (2005). Children's mental health as a primary care and concern: A system for comprehensive support and service. *American Psychologist*, *60*, 601–614.

Tramontana, M. G. (1980). Critical review of research on psychotherapy with adolescents: 1967–1977. *Psychological Bulletin*, *88*, 429–450.

Wadsworth, B. J. (2003). *Piaget's theory of cognitive and affective development: Foundations of constructivism* (5th ed). Upper Saddle River, NJ: Pearson.

Weisz, J. R. (2014). Building robust psychotherapies for children and adolescents. *Perspectives on Psychological Science*, *9*, 81–84.

Weisz, J. R., Doss, A. J., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, *56*, 337–363.

Weisz, J. R., & Kazdin, A. E. (2010). *Evidence based psychotherapies for children and adolescents*. (2nd ed.). New York, NY: Guilford Press.

Zirkelback, E. A., & Reese, R. J. (2011). A review of psychotherapy outcome research: Consideration for school-based mental health providers. *Psychology in the Schools*, *47*, 1084–1100.