Counselling Children and Adolescents A Developmental Framework

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Learning Objectives

Students should be able to:

- Assess how early developmental experiences impact on present psychological functioning with awareness of the various theories of development.
- Recognise behavioural, emotional and development problems in childhood and adolescence.
- Identify mental health problems commonly seen in children and adolescents, particularly in the Jamaican context.
- Conduct Clinical Interviews with children/adolescents and gather relevant information from informants.

Theoretical Perspectives

- Psychodynamic Perspectives Approaches
- Cognitive Approaches
- Behavioural & Social Learning Theories
- Biological Approaches
- Systems Theories

Psychoanalytic Theory - Basis for approach

- Psychoanalytic orientation of development aims to foster awareness of how the mind evolves through a series of mental organisations.

- Exploration of personal history is fundamental to the treatment process in contrast to post-modern theorists who focus on the 'here and now'. The psychoanalytic approach therefore enhances clinical sensitivity in bringing an understanding of the past and present.

- Developmental knowledge enhances our understanding of adult mental health and psychopathology (Gillmore & Meersand, 2015).

Psychodynamic Perspectives

- Emphasise the child's feelings, drives and developmental conflict. Young children must learn to cope with powerful innate emotions in socially acceptable ways (Freud,1917). Freud was convinced that problems resulted from early life experiences.
- Erikson emphasised the growth of autonomy/independence and the need to balance this with dependence on parents during early childhood. Children who are unable to resolve early psychosocial conflicts are likely to have difficulties with adjustment later in life. (Erikson, 1964)
- Adler theorised that all individuals are born with a sense of inferiority hence they strive for superiority, a driving force behind thoughts, emotions, and behaviours. Adler also believed that personality is affected by birth order and parenting style.

Beliefs of Psychodynamic Theorists

- Unconscious thought is a central theme, behaviour is merely a surface characteristic.
- To truly understand development, we have to understand the symbolic meanings of behaviour and the inner workings of the mind.
- Early experiences with parents extensively shape our development.

Freud’s Theory – Key Characteristics

- Sigmund Freud (1856-1939), is known as the ‘grandfather’ of psychoanalytic theory.
- Individuals go through five psychosexual stages of development –oral, anal, phallic, latency and genital.
- During the phallic (oedipal) stage the Oedipus conflict is a major source of conflict.
- Personality is made up of three structures -id, ego and superego. Conflicting demands of these structures produce anxiety.
- Defense mechanisms are used to resolve anxiety.

Psychoanalytic Perspectives – Contemporary theorists

- Freud's theory has undergone significant revisions.
- Many contemporary psychoanalytic theorists place less emphasis on sexual instincts and more emphasis on cultural experiences as determinants of an individual's development.
- Unconscious thought remains a central theme.

Erickson’s Psychosocial Theory

- Erick Erickson (1902-1994) developed a theory of psychosocial development.
- Erickson recognised Freud’s contribution but criticised his emphasis on psychosexual development.
- Erickson’s theory emphasizes eight psychosocial stages of development, the first five of which relate to childhood and adolescence.
- At each stage individuals experience a psychosocial crisis which could have a positive or negative effect on personality development. Successful completion of each stage results in a healthy personality.

Psychosocial Stages of Development

- **Infancy:** (first year) **Trust vs. Mistrust**. Infants explore the world and learn whether their environment is a safe place. Infants require a significant amount of attention and comforting from parents. They develop their first sense of trust or mistrust from caregivers.
- **Late Infancy & Toddlerhood**: (1-3 years) **Autonomy vs. Shame and Doubt**. Children begin to assert independence, develop preferences, and make choices. Stubbornness, defiance, and temper tantrums are common. If infants are restrained too much or punished too harshly they are likely to develop a sense of shame and doubt.
- **Early Childhood**: (3-5 years) **Initiative vs. Guilt**. Children learn about social roles and emotions. They are asked to assume responsibility (for their behaviour, bodies, toys and pets). Developing a sense of responsibility increases initiative. Guilt arises in children who are irresponsible and made to feel too anxious. Guilt is compensated for by a sense of accomplishment.
- **Middle & Late Childhood - (**6 years - puberty**) Industry (Competence) vs. Inferiority**. Children are enthusiastic about learning. Academic performance is very important at this stage. Children begin to display a wider and more complex range of emotions including feelings of inferiority and incompetence.

Psychosocial Stages of Development (cont'd) Adolescence - Identity vs. Identity Confusion

- Adolescents seek answers to who they are, what they are about and where they are going.
- Adolescents become more independent and begin to form identities based on experimentation with new behaviours and roles.
- Identity confusion occurs if parents do not allow adolescents to explore different roles in a healthy manner.
- Puberty usually occurs during this stage, bringing with it a host of physical and emotional changes.
- Changes during adolescent years may strain parent-adolescent relationships, especially when new behaviours go beyond experimentation and cause problems at school or home.

Cognitive Perspectives

- Cognitive theories, unlike the psychoanalytic approach, emphasise conscious thoughts.
- Children’s thoughts and concepts are therefore emphasised as organisers of their social behaviour.
- Children are able to judge what behaviours are appropriate for the differing genders.
- Piaget’s theory – Individuals go through four stages in understanding the world. Each stage is age related and consists of distinct ways of thinking.
- Cognitive stages: sensorimotor, preoperational, concrete operational and formal operational.

Piaget's Cognitive Stages

- **Sensorimotor –** birth – 2 years**.** Recognition of symbols – Shaking things, putting items in mouth.
- **Pre-operational** - 2-7 years**.** Recognition of words & images – development of memory and imagination. Thinking is based on intuition and still not completely logical. Complex concepts such as cause and effect, time, and comparison are not grasped.
- **Concrete Operational -**7-11 years – Elementary age, and preadolescent children demonstrate logical, concrete reasoning. Thinking becomes less egocentric and there is increasingly awareness of external events.
- **Formal Operational -**11 years – through adulthood – Thinking is done in more abstract, idealistic and logical ways**.** The stage of intellectual development.

Behavioural and Social Learning Theories

- Theories emphasize the importance of studying environmental experiences and observable behaviour to understand development.
- Skinner's Behaviourism – Development is observed behaviour, which is determined by rewards and punishment. The child's behaviour is shaped by external rewards and punishment as well as by role models.
- Rewards may also be internal - children may also behave in ways that augment self-esteem, pride and a sense of accomplishment.
- Bandura's Social Learning theory emphasizes reciprocal interactions among the person - cognition, behaviour and environment. Self-efficacy is viewed as the person factor that is especially important in children's development.

Eclecticism

- No theory of development qualifies as *the theory.*
- Many therapists draw upon what works from a broad range of theoretical perspectives.

Developmental Phase - Toddlerhood

- Theorists view this period as defined by critical advances in mental organisations - self-regulation and morals.
- Psychological achievements fundamental to an expansion of the child's inner world and deepening of personal identity and relationships include: bodily and mental self-other differentiation; internalisation of parental standards; language based communication and imitative play.
- Striving for autonomy and independent action with displays of negativism and oppositionality commonly observed, e.g. frequent use of word 'no' by two-year olds.
- Developmental stage is known for immediate gratification and emotional outbursts if denied, e.g. temper tantrums displayed by two-year olds.

Oedipal Phase (3-6 years)

- Period of major psychological development - generates an expansion of the child's potential for emotional expression, fantasy, self-regulation and relationships
- Sexual and gender identity become defining features of self.
- The Oedipal child shows avid curiosity about parental sexual activity and reproductive functions.
- Body differences arouse intense interest, as well as anxieties. Castration fears and fantasy intensifies.
- ***Oedipal complex*** – An emotional drama played out with central adult figures, which generates intense feelings of desire and jealousy.
- The Oedipal phase is considered by many to be the centrepiece of psychoanalytic theorising – helps in our understanding of adult fantasy, relationships and neuroses.

Psychiatric concerns during early childhood

- Neurodevelopmental disorders typically manifest early in development and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning
- Disorders include intellectual disabilities, communication disorders, specific learning disorders, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder and tic disorders.
- Neurodevelopmental disorders frequently co-occur; for example, individuals with autism spectrum disorder often have intellectual disability (intellectual developmental disorder), and many children with ADHD also have a specific learning disorder (APA, 2013)

Latency (6-10 years)

- Major changes seen in cognition, self-regulation and socialisation (self-control and social competence)
- At 6 years the child is more thoughtful, less quick to anger.
- Copes with anger and frustration in diverse ways – e.g. grumpy and uncorperative.
- Learning challenges will impact the latency child's sense of self and will affect developing capabilities for emotional regulation.

Psychiatric concerns during latency

- Include anxiety disorders e.g. separation anxiety disorder, generalized anxiety disorder, social anxiety disorder and specific phobias.
- Onset of disruptive mood dysregulation disorder (DMDD) - features chronic, persistent irritability.
- Many children with DMDD have symptoms that also meet criteria for ADHD and for an anxiety disorder. For some children, the criteria for major depressive disorder may also be met (APA, 2013).
- Also include disruptive, impulse control and conduct disorders (e.g. oppositional defiant disorder, intermittent explosive disorder and conduct disorder).

Pre-Adolescence & Early Adolescence (10 – 14 years)

- Emphasises a period of growth spurt
- Major physiological changes resulting in sexual and reproductive maturity hence a preoccupation with body image
- Massive brain remodelling – associated with higher level cognitive capabilities
- Commences the process of individuation – essential for identity development and responsible adulthood.

Pre-Adolescence & Early Adolescence (10 – 14 years)

- Period according to Erikson, is associated with a crisis of identity.
- Key to this phase – shift from parents to peer group – peer group status, parent-child conflict.
- Risk taking behaviours – bullying, sensation seeking and other high risk behaviours, peer coercion.

Psychiatric concerns during early adolescence

- Onset of depression and eating disorders, social anxiety disorder, increase in self-injurious and risky behaviours.
- Body dysmorphic disorder – common age of onset is 12-13 years, with high rates of suicidal ideation and suicide attempts in children and adolescents (APA, 2013).
- Disruptive, impulse control and conduct disorders e.g. (oppositional defiant disorder, intermittent explosive disorder and conduct disorder).

Middle and Late Adolescence (15-23 years)

- Intimate relationships assume growing significance
- Keen focus on preparation for life after high school and geographic separation from home and family.
- Psychiatric concerns - Onset of a majority of psychiatric illnesses including mood disorders, substance use, schizophrenia and personality disorders.

Common Disorders - Onset During Childhood or Adolescence

- Neurodevelopmental Disorders (ADHD, Specific Learning Disorder, Autism Spectrum Disorder, Intellectual Disability)
- Depressive and Bipolar Disorders (DMDD, MDD,)
- Anxiety Disorders (e.g. Separation Anxiety Disorder, phobias)
- Elimination Disorders – (Enuresis, Encopresis)
- Conduct Disorder
- Oppositional Defiant Disorder
- Substance Use Disorder
- Body Dysmorphic Disorder

ADHD

- ADHD is defined by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity.
- Many parents first observe excessive motor activity when the child is a toddler, but symptoms are difficult to distinguish from highly variable normative behaviours before age 4 years.
- ADHD is most often identified during elementary school years when inattention becomes more prominent and impairing.
- The disorder is relatively stable through early adolescence, but some individuals have a worsened course with development of antisocial behaviours.
- In most individuals with ADHD, symptoms of motoric hyperactivity become less obvious in adolescence but difficulties with restlessness, inattention, poor planning, and impulsivity persist.
- A substantial proportion of children with ADHD remain relatively impaired into adulthood.

ADHD – Functional consequences

- ADHD is associated with reduced school performance and academic attainment and social rejection.
- Children with ADHD are significantly more likely than their peers without ADHD to develop conduct disorder in adolescence and antisocial personality disorder in adulthood, **with increased likelihood for substance use disorders and incarceration.**
- The risk of subsequent substance use disorders is elevated, especially when conduct disorder develops.
- Individuals with ADHD are more likely than peers to be injured.

ADHD - Treatment Intervention

- Pharmacotherapy - stimulant medication to enhance attention and impulse control – e.g. Ritalin.
- CBT – widely used
- Parent counselling and training especially useful for parents of preadolescents
- Problem solving communication training (PSCT) -skill-oriented therapy for use with adolescents (integrates behavioural, cognitive and family-systems models)
- Classroom interventions

Disruptive mood dysregulation disorder (DMDD)

- The onset of DMDD must be before age 10 years, and the diagnosis should not be applied to children with a developmental age of less than 6 years. The core feature of DMDD is chronic, severe persistent irritability.
- Severe irritability has two prominent clinical manifestations, frequent temper outbursts and persistently irritable or angry mood that is present between the severe temper outbursts.
- Outbursts typically occur in response to frustration and can be verbal or behavioural (the latter in the form of aggression against property, self, or others).
- Many children with DMDD have symptoms that also meet criteria for ADHD and for an anxiety disorder, with such diagnoses often being present from a relatively early age. For some children, the criteria for major depressive disorder may also be met.

DMDD - Functional Consequences

- Chronic, severe irritability, such as is seen in DMDD, is associated with marked disruption in a child's family and peer relationships, as well as in school performance.
- Due to their extremely low frustration tolerance, children with DMDD generally have difficulty succeeding in school; they are often unable to participate in the activities typically enjoyed by healthy children; their family life is severely disrupted by their outbursts and irritability; and they have trouble initiating or sustaining friendships.
- Levels of dysfunction in children with bipolar disorder and DMDD are generally comparable. Both conditions cause severe disruption in the lives of the affected individual and their families.
- In both DMDD and pediatric bipolar disorder, dangerous behaviour, suicidal ideation or suicide attempts, severe aggression, and psychiatric hospitalization are common.

Treatment Intervention - DMDD

- Multimodal integrative treatment approach (includes medication, therapy, psychoeducation)
- Individual or group therapy is effective
- CBT widely used - anger management, impulse control, correction of cognitive distortions, assertiveness training)

Psychotherapy for Children and Adolescents

- Cognitive Behaviour Therapy (CBT)
- Dialectical Behaviour Therapy (DBT)
- Interpersonal Therapy (IPT)
- Psychodynamic Psychotherapy
- Play Therapy
- Group Therapy
- Family Therapy

CLINICAL INTERVIEWS - Purposes

- To build rapport and mutual respect between the interviewer and the child/adolescent.
- To learn about the child/adolescent's views on his/her functioning.
- To identify which presenting problem(s) would be targeted for intervention.
- To identify strengths and competencies.
- To assess the child/adolescent's views of different intervention options.
- To directly observe the child/adolescent's interaction style, affect and behaviour.

Conducting Clinical Interviews

- Establish interviewing strategies
- Consider children’s communication skills and levels of cognitive and social-emotional development
- Adapt style of questioning to fit the child’s developmental level
- Give attention to room setting and personal appearance.

Informants

- Parents
- Teachers
- Guidance counsellors
- Prior Assessments

RESOURCES

- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* – fifth edition (DSM-5). Arlington, VA: American Psychiatric Association
- Gilmore, K. J. & Meersand, P. (2015). *The little book of child and adolescent development*. New York, Oxford University Press