

General Principles for Psychotherapeutic Interventions in Children and Adolescents

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INTRODUCTION

Childhood and adolescent psychiatric disorders often go unrecognized in our country, despite this subpopulation constituting one of the largest segments of the whole population. Proper assessment and management of different psychiatric disorders at this age are of paramount importance, which will ultimately impact the course and outcome of the particular condition at later age.[1] Although medicines/drugs are required to treat many of these disorders, psychotherapeutic interventions remain a preferred choice for clinicians as well as for parents and family members. Assessing children and adolescents throws up multiple challenges to a treating physician. First, a child/adolescent may disagree with the parents or the doctor regarding the need for consultation or would not have come for the consultation in the first place. Second, the child/adolescent could have come for an entirely different problem, whereas the main problem remains unnoticed by the caregivers.[2] Moreover, children may report their symptoms but may not provide other details, such as duration and chronology of their symptoms. They may also hide the problem if it depicts them in a bad light or are embarrassing for them. Therefore, a clinician should gather information from multiple sources, i.e., the child, parents, teachers, and other caregivers. An elaborate history-taking by an astute clinician helps in proper case formulation and embarking upon a psychotherapeutic procedure.[2] There can be discrepancies in the report; nevertheless, multi-source information minimizes error in diagnosis and management. Psychotherapy is a form of psychiatric treatment that involves therapeutic conversations and interactions between a therapist and a child or family. It can help children and families understand and resolve problems, modify behavior, and make positive changes in their lives. The term “psychotherapy” usually includes supportive, re-educative, and psychoanalytic forms of psychotherapy. All can be used to treat child and adolescent psychiatric disorders depending on the kind of problem we encounter in clinical practice. Various forms of psychotherapy that are used in the treatment of child and adolescent psychiatric disorders include acceptance and commitment therapy, cognitive behavioral therapy (CBT), dialectical behavior therapy, family therapy, group therapy, Interpersonal Therapy (IPT), mentalization-based therapy, parent–child interaction therapy, play therapy, and psychodynamic psychotherapy. Before we embark on a psychotherapeutic engagement with a child or adolescent, we must be very sure regarding the nature of the problem at hand and what exactly we need to address or which behavior we want to modify. Parents also at times come up with unusual demands which are not keeping with the changing social milieu or in direct conflict with changing times (e.g., demanding a bar on the use of mobile phones completely for a 15-year-old adolescent).

This guideline outlines the special considerations that a clinician/counselor needs to make while doing psychotherapeutic interventions in children and adolescents. This guideline attempts to cover the important areas in this topic with focus on certain clinical conditions. However, this guideline is far from exhaustive and modifications may be necessary according to the clinical condition at hand. For purpose of this guideline, the term “child”/“children” will be used in references to children and adolescents. The term “child” and “adolescent” will be used for all children between 0 and 12 years of age and between 13 and 18 years of age, respectively.[2]

DATA SEARCH METHODOLOGY

The data search strategies for this clinical practice guideline included electronic databases as well as hand-search of relevant books, publications, or cross-references. The electronic search included PubMed and other search engines (e.g., Google Scholar and PsycINFO). Cross-searches of electronic and hand-search key references often yielded other relevant materials. The search terms used, in various combinations, were behavior therapy, psychotherapy, counseling, children, adolescents, etc.

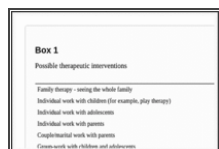
ESTABLISHING THE CONTEXT

While working as a professional with families, one needs to listen carefully and take different perspectives into consideration. The professional needs to be able to appreciate and see the world from a child or adolescent's eyes as well as from those of their parents. Childhood and adolescence are times of first encounters and intense experiences in the present. They are periods full of joy and sadness, excitement, and fear, as well as rapid growth and new learning. To engage children and adolescents as professionals, we need to take time to appreciate their experience and to understand the world they move in while recognizing their relationships with their families.[3]

When we engage with children, we also engage with their parents and the other significant members of their families. To be effective, we need to be sensitive to and appreciate the experience of being a parent in its ups and downs and its joys and sorrows. The lives of children and parents are so inextricably linked that we can hardly help one without helping the other.[3] Parents who bring their children to therapy also bring their own needs, concerns, and wishes. If we help parents with their own concerns, then we also help their children, and if we help children to change positively, then we also help their parents who care for them.

Working effectively with families also involves appreciating and understanding the professional context from which we operate. As professionals we bring our own perspective, and that of our profession, to the therapeutic process. This includes our personal style and beliefs as workers, the theoretical models we subscribe to, the standing and context of the agency we work for, and the values and goals of our profession as a whole.[3]

From a collaborative perspective, it is best to follow clients' preferences in deciding what way to intervene to help them. Of course, this is not without limits as professional responses to client(s) goals are largely determined by the function and context of the professional agency. For example, it would be advisable to run therapeutic groups with children in a school set-up, where they would be an attentive audience, compared to parents. The opposite is true for an adolescent mental health setting, where parents would be keen listeners, while the adolescents would prefer to stay away. There are many different therapeutic models and ways to provide therapeutic services [Box 1], all of which have validity.[3] For example, behavior problems can be improved by either working with the parents, or with the children, or with both as a family unit.

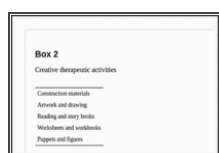


Box 1

Possible therapeutic interventions

ESTABLISHING THERAPEUTIC ALLIANCE

Counseling or working with children and adolescents therapeutically is a very different process than counseling adults. Children inhabit a different world than that of the adult and are at a different developmental level. They do not share the adult preference for language and verbal communication and the rules of adult conversation just do not apply to how children relate. Children like to communicate through play and creative activities [Box 2] as well as through conversation. Even adolescents who may appear to be more able to engage in adult conversation are at a transitional stage in their lives and share many of the preferences of younger children for structured activities and indirect and imaginative forms of communication.[3]



Box 2

Creative therapeutic activities

Establishing a rapport with children is extremely essential, and it should not be sacrificed for practicing purely paternalistic way of medicine. Clinician should respect child's autonomy, while at the same time, he/she should not compromise with what is best for the child. The best form of practice is shared decision-making, with selective paternalism where needed, while working with children and families.[4] While establishing rapport, clinician must not assume that communicating with parents is enough and that whatever intervention he/she applies is routed through the parents. Clinicians' and therapists' interaction with the child may have a bearing on intervention outcomes. Even though the child is reluctant about the need for a consultation, he/she is usually aware of the events and/or discussions that happen around him/her. Therefore, a face-to-face conversation with the child, with the acknowledgment of child's understanding of his/her problem, is fruitful in the long run.[2]

Play therapists are experts in using creative media to engage children in therapeutic conversation.[3] Ideally, they work within a designated play therapy room that has access to sand and water play, painting and artwork, dress-up materials, dolls, puppets, and construction play materials. While as a professional working in a different context (such as a child protection worker or a family therapist) you may not have access to a designated room or such an elaborate range of materials, it is still important to have access to some creative activities to complement verbal conversation fully to engage children and adolescents.

Challenges in establishing rapport

Clinician may face a huge hurdle in establishing rapport with the child when the remains mute during consultation. There can be several reasons for it. The clinician should examine various possibilities and manage them as they come. This usually warrants some extra time and labor on part of the clinician.[2] Table 1 enumerates the conditions that pose a challenge in establishing rapport and how to overcome the same.

Table 1 Challenges in establishing rapport		
Challenges	Underlying issues	How to go about
The "silent" child	Anxiety	How to warm up, progression or de-escalation of The clinician de-escalation

Table 1

Challenges in establishing rapport

TREATMENT SETTINGS

Psychotherapy for children and adolescents can be done in outpatient department, in inpatient setting, and/or in a consultation-liaison set-up. Whether done in an inpatient setting or outpatient department, the clinical setting should provide for adequate engagement of the child for the requisite length of time. The following factors need to be considered:

- Meeting a doctor can be intimidating for the children. Long waiting period can make them uncooperative and irritable during the interview
- Child clinics should have an attractive appearance, and toys, books, coloring pencils, and gaming zone should be made available. Walls painted in bright colors, with fables and cartoon characters, help in drawing attention of the child, and the child would be more happy to come back to the place, in case subsequent consultations are required
- The clinic can have few large blackboards with colored chalks to engage the child. Toys, papers, coloring pencils, Rubik cubes, and puzzle games should be there in the consultation room
- Drawing and play activities can help establishing rapport with the child and can be used as assessment tools, particularly with preschool children who may not be able to express their distressing experience verbally. All staff members in such clinics need to be trained in handling child and should be able to engage in activities with them.[2]

When done in a consultation liaison setting:

- The therapist should be sensitive to the severity of the physical illness the child/adolescent is suffering from
- Ideally, one of the parents or a caregiver should be present to make the child comfortable
- His/her privacy should be respected; if possible, he/she should be taken to a separate interview room for initial assessment
- Too long interviews are discouraged, and therapist may have to depend on the caregivers as the primary source of information. Frequent visit to the child or adolescent may be required
- Therapy should be limited to crisis intervention during the length of hospital stay, and once the child or adolescent is stabilized/discharged, he/she can be taken up for psychotherapy in an outpatient setting or he/she can be transferred to a psychiatry inpatient set-up and psychotherapeutic intervention can continue there.

ENGAGING PARENTS AS AGENTS OF BEHAVIOUR CHANGE

The decision to bring a child for psychological help is generally taken within the family. The cultural values of each household might also decide what type of childhood difficulties is regarded as serious which warrants intervention. These values may additionally decide whether intervention is specially welcomed, resented, or feared.

Because the family context is crucial in deciding a child's mindset toward psychological help, most of the child psychotherapists would like to meet the total family together as part of the preliminary assessment. Family meetings not solely provide a useful chance to discuss the total family's mindset toward referral but are also commonly an extra reliable way of mastering about family relationships than something the mother and father or youngsters can individually report.

In working with parents, the therapist offers a structure of how to respond to emotional misery which has some core elements:

- The first and foremost is to establish a dependable setting in which it is viable to discuss very upsetting things. As with a child's treatment, sessions for mother and father have regularity in time and space, and this helps to contain the childish elements which are aroused
- The second thing is the creation with the dad or mom of some shared language to describe painful emotional states. Finding phrases for despair/sorrow/anguish is a help in itself because it offers the comfort of feeling understood. Many lonely or emotionally-disadvantaged mother and father may discover the resources for understanding their kids through the journey of feeling understood and perception their personal kids through the trip of feeling understood
- Third is the valuing of boundaries and differentiation: differences between parents and children and between experiences on her/his behalf. Perhaps, this might be likened to the ordinary behavior of a crying infant; however, when the baby gets no response, the screams stay lodged in the baby's head in an unbearable way
- Fourth, parents may be a very useful agent in implementing certain therapeutic principles for the child or adolescent behavioral problem at home setting, e.g., time out, positive reinforcement, negative reinforcement, time management, activity scheduling, conducting exposure and response prevention sessions, and helping the child to complete home assignments given the therapist
- Fifth, some mother and father are more responsive to group therapy. The group provides the alleviation that others, too, share a sense of failure, whether it be losing one's temper, failing to drop the child to school on time or to make him/her sleep at the desired time at night, or bearing with child's failure at school, quarrelsomeness with siblings or delinquent behavior. Group work looks to be helpful when there is an experience of social isolation, robust feelings of failure, and an absence of supportive partners.

CLINICAL ASSESSMENT BEFORE THE PSYCHOTHERAPEUTIC ENGAGEMENT

The goal of clinical assessment is to have a case formulation that would help in deciding the management.[8] Signs and symptoms

as narrated by the child and caregivers or elicited by the clinician help in ascertaining the key areas that need to be addressed and also confirm or refute the presence/absence of a mental disorder. While doing an assessment, it is vital for the clinician to see the child in a psychosocial background, considering all the possible factors that could have played a role in precipitating and maintaining the particular disorder/behavioral problem, and to gather every detail regarding the illness so far, including the treatment history. Therapeutic alliance is very crucial in this context. If the child and his/her caregivers perceive a mutually beneficial relationship, the elicitation of facts becomes quite easy and so as the treatment which is then shared by the family also. [2] A good clinical assessment also provides a window of opportunity for the family/caregivers to reflect upon their own difficulties and working through it. Assessment also helps in deciding the nature of psychotherapy that has to be planned – whether it will be a short-term/long-term psychotherapy; crisis intervention/supportive kind of psychotherapy, or more extensive behavior therapy, or more rigorous psychodynamic psychotherapy to solve deep-rooted psychological conflict. Table 2 lists certain items which the clinician/psychologist should consider while planning psychotherapeutic interventions in children and adolescents.

Table 2	
Points to consider in clinical assessment from psychotherapeutic point of view	
Referral	<ul style="list-style-type: none"> "Who has referred the child?" "Why did they refer the child?" "Why did they refer the child now?" "Is there a referral letter? What is the key concern?" "Is there any administrative concern?" "Do the parents/child understand the consultation?" "How does the referral affect the child's life?"

Table 2

Points to consider in clinical assessment from psychotherapeutic point of view

ASSESSMENT FOR SUITABILITY FOR PSYCHOTHERAPY

Not every child can be taken up for psychotherapy. Before we consider a psychotherapeutic intervention for a child or adolescent, multiple factors need to be considered – nature of diagnosis, availability of alternative mode of treatment (particularly medicines) and how effective are they, client choice, motivation for engagement, availability of time both on the part of the parents and the therapist, ability to pay for the sessions, expertise of the therapist in that particular type of psychotherapeutic intervention, and intelligence level of the child/adolescent. Supportive psychotherapy may be suitable for all age groups, whereas a more elaborative kind of psychotherapy, e.g., CBT or psychodynamic psychotherapy is suitable for older children or adolescents. Table 3 shows the factors to be considered for suitability for psychotherapy in children and adolescent.

Table 3	
Factors to be considered in evaluation for psychotherapy	
Age	Supportive psychotherapy – all age group CBT/psychodynamic psychotherapy/family therapy
Duration of illness	Specify the target problem in relation to duration of illness
Severity of symptoms	Personal distress/family distress/social distress
Intelligence	Presence of normal intelligence is a prerequisite for

Table 3

Factors to be considered in evaluation for psychotherapy

Annexure 1 shows the template of a psychotherapy intake form for children and adolescents. Once the suitability for psychotherapy has been assessed, the sessions can start. Box 3 shows the do's and don'ts of psychotherapy with children and adolescents.[9]

Box 3	
Do's and Don'ts of psychotherapy	
Do's	
Be open	
Be flexible	
Be trustworthy	
Be approachable	
Be understanding	

Box 3

Do's and Don'ts of psychotherapy

Initial psychotherapy sessions with children and adolescents can be very challenging due to the need to balance assessment,

relationship building, caretaker/parent management, and case formulation with a client population that sometimes has little motivation for psychotherapy.

STRUCTURING PSYCHOTHERAPEUTIC SESSIONS

Shea proposed five stages of psychotherapeutic sessions: (a) the introduction, (b) the opening, (c) the body, (d) the closing, and (e) termination.[10]

Introduction and opening

There is something unique regarding the first contact between the child and the therapist. Because of formative issues and either negative desires or prompt negative transference responses, beginning associations can be expressly protective and antagonistic. It is not uncommon for juvenile customers to come up in the session and saying things such as “I’m not conversing with you and you can’t make me!” In such cases, setting up remedial collusion (portrayed prior) previously might be very useful.

Another underlying contact procedure or system is to give constructive consideration and show enthusiasm for the customer's novel individual characteristics. This could incorporate giving a genuine commendation on the customer's dress or communicating an enthusiasm for something the customer brought to treatment.

Secrecy is regularly an essential issue of worry for young people and ought to be talked about straightforwardly and legitimately. Psychotherapists ought to likewise impart referral data to customers. Children may ask why they have been referred and may assume that the referral clinician has provided inaccurate clinical data regarding him/her to the psychotherapist.[10]

When working with grown-ups, specialists frequently ask things such as “What brings you for consultation” or “How could I help you.” These openings are inappropriate for psychotherapy with kids and young people since they expect the nearness of knowledge, inspiration, and a craving for help – which could conceivably be right. Opening sentences that put importance on collaboration, emphasizing disclosure, and beginning a process of in-depth exploration of client goals are more appropriate in such scenario. For instance, “I’d prefer to begin by revealing to you how I like to function with kids and young people. I’m keen on helping you be fruitful. That is my objective, to assist you with being effective in here or out on the planet. I will likely assist you with achieving your objectives. Be that as it may, there's a farthest point on that. My objectives are your objectives just as long as your objectives are lawful and solid.”

Body

When working with children, the essential errands related with the body or center phase of the underlying meeting for the most part include evaluation, job acceptance (i.e., clarifying the diagnosis and treatment approaches in detail), and possibly beginning of a psychological intervention.[10]

Executing formal evaluation systems (e.g., Minnesota Multiphasic Personality Inventory and Rorschach) can be tricky with youths since they may not be fully aware of the requirement of such procedure or may be unduly suspicious of the motive of such procedure. Along these lines, psychotherapists ought to clarify and outline the reason and procedure of assessment.[11] Given the potential for youths to utilize carrying on safeguard components, holding on to manage tests until a sufficient helpful relationship has been set up is probably going to yield progressively substantial evaluation information. Meanwhile, less conventional appraisal strategies, for example, the wishes and goals and family constellation procedures, can be utilized to establish the therapeutic relationship and gather evaluation information.

Clinically, it would be prudent that psychotherapists ought not to depend exclusively on verbal conversations while treating children. Clinicians can intentionally choose games, toys, expressive art supplies, and different objects of attraction for their clinic.

Children may not be comfortable to use talking as a mode of self-improvement. Children can be encouraged to talk more freely by simple activities, e.g., modeling a piece of clay. The central matter of the story is that we ought not expect that children should discuss individual issues with an obscure adult from the beginning of therapy.[12]

It is a rule rather than exception that psychotherapists will be able to execute formal therapy during initial few sessions with children. Be that as it may, like the utilization of preliminary translations in psychoanalytic psychotherapy, it is feasible for psychotherapists to utilize a mellow understanding or relational input and afterward check the customer's reaction.

Closing and termination

Time management is the central topic of closing and termination. The end starts when 5–10 min is still left in the session and is the point at which the psychotherapist stops collating new information as well as does not actualize any new interventions. Closing is the ideal opportunity for consolidation and transition, yet in addition it incorporates a few meeting tasks.[12]

Psychotherapists should provide children with reassurance and support toward the end of the session. This can be as straightforward as, “I appreciated you for talking to me today” or “My gader that you intended not to meet me today, however you made it since we’re just about completed with our session.”

Psychotherapists should provide positive feedback toward the end minutes. This feedback should be spontaneous and should include references of customer conduct during the session. Models include “When you discussed your fellowships, I could truly perceive the amount you esteem dependability” and “You have an incredible comical inclination.”

Contingent upon the individual customer and the psychotherapist's hypothetical direction, it can likewise be valuable to request that the customer think about the session and remark or outline their feeling on the session's features.

It is standard for the therapist to focus upon the future toward the end of the session. As this procedure unfurls, two essential issues are probably going to develop: (a) the following session and (b) potential homework.

The next session The subsequent session(s) with children ought to be framed in a positive manner. Small remarks, for example, “I would like to see you one week from now” or “I am glad to work with you,” can add to setting uplifting desires. When working with young people, exceptional procedures might be utilized to fortify the treatment relationship and improve compliance. In particular, standard procedure of interpersonal psychotherapy for depression with adolescents (IPT-A) includes psychotherapists reaching the customer/parent over phone in between the first and second sessions.

Potential homework CBT approaches should be included in homework for the client at the very outset.[13] However, it is essential to remember that for young people, schoolwork assignments should be moderately basic, functional, and doable; otherwise, it might evoke resistance. At times, it very well may be useful to abstain from utilizing the word “schoolwork” or “homework” with children, particularly if they recently had negative school and schoolwork encounters. Alternatives terms such as “task,” “assignment,” or “project” can be used.

A BRIEF OVERVIEW OF DIFFERENT PSYCHOTHERAPEUTIC PROCEDURES IN CHILDREN AND ADOLESCENTS

Cognitive behavioral therapy

CBT involves that therapist and patient work as a team to examine and understand thoughts, feelings, and behaviors. Children may not be able to report their own feelings, thoughts, and behaviors. Moreover, thoughts, feelings, and behaviors of parents and other family members may have a bearing on the child. Therefore, the following areas should be explored before starting CBT with children and families.

Developmental perspective Therapist must adopt a developmental standpoint while working with youngsters and adolescents, which is critical for planning the intervention. Therapist should consider the child's stage of autonomy and independence. This means giving older adolescents enough autonomy and working through with their treatment goals and for younger adolescents making certain that they have ample help from parents and concerned caregivers.

- Position of caregivers and other individuals in the kid's existence should be described at the start of the therapy
- Role of persons and different family or systems variables must be analyzed in retaining the kid's difficulties
- Families, schools, and other structures may also play a pivotal role in maintaining child's symptoms by adapting to it accordingly
- In addition to individual session with the child, sessions focusing on parent, teacher, and other concerned adults at regular intervals are also vital
- Treatment in familiar and natural environment often produces faster and long-lasting benefit structured treatment sessions.

Treatment ideas should be tailored to children's developmental stage for the use of CBT with teens and adolescents. For example, because of lack of abstract thinking abilities in children, efforts to address cognitive biases, and distortions underlying anxiety, depression may be met with resistance.

Various techniques have been proposed to concretize goal cognitions and abstract concepts.

- Symptoms can be symbolized as persona that the infant can relate to who must be vanquished
- Obsessions in obsessive-compulsive disorder (OCD) can be blamed on an external agent, e.g., a pesky bug, whose ideas must be fought
- Children can also be encouraged to play the role of detective or team up with a detective in verifying assumptions and beliefs.

These developmental adaptations assist children in understanding ideas that are otherwise verbally explained, which may not be a suitable treatment vehicle for them.

Cognitive behavioral play therapy

With very younger kids, cognitive behavioral play therapy (CBPT) might also be indicated as it includes cognitive behavioral strategies into play-based interactions. Youngsters may have difficulty in appreciating principles of CBT; CBPT provides the opportunity for teaching and therapeutic work to happen during play. Many CBT ideas are modeled with puppets or different toys, e.g. demonstrating the child that a puppet gets over its worries the more it faces the challenges in environment. CBPT additionally borrows some principals from adult CBT, such as activity scheduling for a nonengaging child.

Other developmental considerations include the child's age, verbal felicity, cognitive flexibility, and duration, intensity, and frequency of the symptoms.

- Younger adolescents are benefitted more from behavioral techniques than cognitive ones, mainly because they are often unable to report cognitions that accompany symptoms and behaviors
- Teenagers can benefit from cognitive strategies, e.g., relaxation exercises, imagery, and autosuggestions. Children over the age of 9 might have improved capacity for reporting and understanding cognitions and might gain from cognitive components of therapy
- Each child needs to be personally evaluated; however, competency in language skills may make the application of cognitive strategies difficult for older children as well.

Family-related factors Kid's target symptoms should be seen within the family context for treatment planning in CBT. It is possible that significant others in the kid's life are accommodating the maladaptive behavior rather than discouraging it. For example, in

OCD, household may additionally tolerate complex rituals that intervene with day-to-day routine activities to avoid the temper tantrum of the child when the rituals would be forced to stop.

Parent/family involvement in therapy It is vital to have information about the family, and how parents think, behave, or emote, to understand the child's symptoms in a better way within a cognitive behavioral framework.

- Changes in household routines, dynamics, and discipline practices can be necessary for ushering modifications in child-focused symptoms
- Children may additionally want ongoing help from mother and father and other caregivers to comply with therapy goals and homework
- With older children, parents may want to learn for enabling their children to take responsibility of the homework or therapy goal, which in turn will reduce their own level of involvement
- Child's target symptoms may be a big source of household stress and parent/child conflict. It is helpful to teach parents who do not give reminders to their children about homework and treatment goals, rather the overall performance be evaluated by both the child and the therapist during treatment sessions. This strategy can be beneficial in decreasing poor parent–child interactions, especially with adolescents, till the time symptoms have abated.

Interpersonal psychotherapy

The basic premise of IPT is that the nature of interpersonal relationships can cause, maintain, or buffer against depression. IPT assumes that by improving one's relationship, one can alter the course of depressive episode. IPT educates humans about the connection between their mood and problems in relationships and teaches them how enhancing the interpersonal interaction skills and addressing those interpersonal issues can help them to get rid of depression.

IPT-A is active, is structured, and includes a big psychoeducational component. As therapy progresses, the adolescent gains more control on their relationship with caregivers and develops a greater problem-solving capability, that is, in keeping with their developmental stage. IPT-A emphasizes interpersonal competencies and capabilities training. Treatment works by addressing the interpersonal issues and strengthening the individual by increasing both independence and interdependence. IPT-A improves autonomy and helps individuation of the child, thereby making the treatment more desirable to them.

Psychodynamic therapy

In psychodynamic therapy, the therapist and toddler typically work together separately from the parents. The child can also have concern leaving the parent, either because for a preschooler, that is within the range of age-appropriate behavior, or because for an older child due to underlying conflicts.

By working with child without the parent in the room creates a zone of confidentiality and psychic safety within which the child and therapist can explore feelings, thoughts, and behaviors. If the parent is present, the child's spontaneity is restrained or stimulated in part by the possible reaction from the parent. When the child is seen alone, the therapist is in a better position to see how the child has internalized the authority of the parents.

In the beginning of therapy, children do not report to the therapist current events that provide a context for understanding the child's talk and play within the session because children are very oriented in the present moment and are defensive against affect. A meeting or phone call from the parents is important if the therapist is to know about these events.

The therapist strives to relate to the child as the “empathic participant” who approaches the child with the wish to know “what's it like to be you.” The therapist and child explore together rather than doing something to or for the child. Eventually, the therapist is with the child as the child examines and explores his/her own thoughts, feelings, and conflicts. The doctor–patient relationship in

psychodynamic therapy is collaborative and facilitative. A separate playroom is advantageous for young children who may be struggling to manage aggressive impulses.

The interpretive psychodynamic therapy with parent is initiated after a period of evaluation, crisis management, or possibly a trial of pharmacotherapy or another psychotherapy that has failed or has been incomplete in its effectiveness. It is important that the therapist and parents meet in an interpretive session or two to review the formulation of the child's diagnosis and prognosis in dynamic and developmental terms and to discuss a possible recommendation for intensive treatment and make the necessary arrangements. Intensive therapy implies two or more sessions per week. Psychoanalysis with sessions four or five times per week is indicated when the pathologic conflicts and maladaptive, regressive defenses are longstanding and pervasive in the child's response to a wide range of circumstances.

Group therapy

Group therapy is based on the concept that the group in its entirety is greater than the sum of its parts. Individuals are believed to take part in the team life as dictated by way of their singular needs and capacities, in interaction with shared group needs and capacities. Individual behavior displayed in a team context is usually believed to be a necessary expression by way of the team and to have relevance for the group.

Once the group is formed, its undertaking can be defined in two ways, rational work and/or primary assumption group life. Rational work is described as any undertaking that drives the group toward fulfillment of its task. For groups of teens and adolescents, it is necessary to observe that rational work should be expressed in developmentally appropriate form. For young children, this might be a range of recreational activities. For older youngsters and adolescents, extra dialog can be used.

In the initial phase of group formation, foundation is laid for team cohesion. Following this, the group enjoys a period of euphoria during which the group members feel relaxed and harbor great hope for becoming part of a group. This period is then followed by a relatively dull period when the compelling issues become more apparent. With able leadership, the team is then capable to move into a more real, hardworking part of its life. Ultimately, the members ought to go through the termination phase, in the course of which individuals need assistance to internalize and consolidate the gains and need to get prepared to separate from the group.

Group development can take one of the two forms: open-ended and shorter term, time-limited groups.

In open-ended groups, members are included and discharged as governed by their medical needs. The group stays in the hardworking developmental part as it incorporates new participants and disengages from departing ones.

For briefer, time-limited groups, group developmental stages are of lesser consequences.

Food It is beneficial to supply snack to show solidarity toward the group. Time spent consuming together as a group promotes intimate and satisfied interactions that frequently help in the therapy. The precise meals and drinks to be supplied ought to be very affordable and simple and be decided by the leaders of the group.

Family therapy

Family concept throws light upon human behavior and psychiatric disorders in the background of interpersonal relationships. This concept lays down the groundwork of family therapy [Box 4], which encompasses numerous clinical approaches that deal with psychopathology against the backdrop of family. Interventions are tailored to manipulate the family relations against the individual. This method is based on the fact that maladaptive behavior occurs in men and women involved in pathological processes inside the households or with significant others [Table 4]. Conversely, nice family interactions, such as high-quality parenting practices, secure attachment with the child, and emotionally nurturing family, are conducive to normal child development and protects from developing emotional problems in the child.

Table 4

Models of family therapy

Box 4

Goals, indications, and contraindications of family therapy

Family concept assumes that the relationships among the components are nonlinear; the interactions are cyclical instead of causative. The household system is nonsummative and consists of the assets and deficits of the persons and their interactions. A person's issues cannot be evaluated without considering the context in which they develop and the features that they serve. It is, therefore, concluded, that an individual cannot change unless his/her home environment changes.

DEALING WITH SPECIAL CLINICAL SITUATIONS

Mobile/small-screen addiction

Mobile and small-screen addiction is emerging as a major challenge both for the parents and psychotherapists in India. Parents often come to therapists with the complaint of their children being hooked to mobile and computers for hours together playing online games, using social networking sites, or even watching pornographic materials, neglecting their studies and compromising socialization, sleep, and self-care.

Benefits of mobile phone use include acquisition of knowledge, exposure to novel ideas, increased opportunities for social contact (although virtual) and giving and receiving support, and access to health-promotion messages and information. Risks of excessive mobile phone use include negative health effects on weight and sleep; exposure to false, fake, inappropriate, and harmful content and contacts; and compromised privacy and confidentiality.

Therapist in such situation has to be nonjudgment and refrain from making sweeping comments, e.g., children should not use mobile or mobile should be taken away from the child, as this would place the therapist in direct antagonism with the child/adolescent which would sabotage the therapy at the very beginning.

Rather, the therapist should try to engage the child or adolescent in a gentle conversation, probing into different aspects of gadget use, e.g., why does he/she like to use the gadget? What component of it would he find exciting? Wouldn't he/she like to meet people in person or socializing rather than being preoccupied with mobile or internet use? Does he/she fear meeting people? Does he/she think that people may not like him or her appearance? Is he/she not smart enough to be liked by people?. Therapist should also be aware that excessive indulgence in mobile phone use or social networking sites can be a manifestation of underlying anxiety or depressive disorder in a child or adolescent. In such cases, management of underlying cause can be helpful in bringing down the mobile or internet use.

Parents should be counseled to cut down their mobile phone usage as much as possible in front of the child. They should be told not to use mobile phone as a bribe to their children to make them eat or stop throwing temper tantrums or in lieu of keeping them engaged while they themselves are too tired to continue with the tough job of parenting the child after a days' of hard work.

Therapist should address the following issues:[14]

- Assess the extent and type of media used and convey the ideal media behaviors appropriate for each child or teenager and for parents. Limits should be enforced regarding the time and type of media used per day
- Children and adolescents should be promoted to do recommended amount of daily physical activity (1 h) and adequate sleep (8–12 h, depending on age)

- Children should be recommended not to sleep with devices in their bedrooms, including smartphones, tablets, and television. Avoid exposure to devices or screens for 1 h before bedtime
- Discourage using social media, listening to music, and other entertainment media while doing homework
- Family should enjoy media-free times together (e.g., family dinner) and media-free locations (e.g., bedrooms) in homes. Activities such as reading, teaching, talking, and playing together should be promoted which foster positive health and parenting skills.

Aggressive or violent behavior in child or adolescent

Violent behavior in children and adolescents can include a wide range of behaviors: explosive temper tantrums, physical aggression, fighting, threats or attempts to hurt others (including homicidal thoughts), use of weapons, cruelty toward animals, fire setting, intentional destruction of property, and vandalism. [Table 5](#) details the risk factors, warning signs, and management strategies for such children.

[Table 5](#)

Risk factors, warning signs and management strategies for violent and aggressive behavior in child or adolescent

Suicidal adolescent

Adolescent suicide and suicidal behavior is on rise in India as well as in whole world. Multiple factors can be responsible for such behavior, which include genetic factors, parental psychopathology, disturbed home environment, maltreatment of the child, childhood physical and sexual abuse; personality factors such as impulsivity, neuroticism, low self-esteem, hopelessness, and perfectionism; and presence of mental disorders such as schizophrenia, childhood bipolar disorder, depressive disorder, anxiety disorders, posttraumatic stress disorder, conduct disorder, and substance use disorders.

Recognition of suicidal ideation and suicidal plans is of utmost important. On part of the therapist, it is necessary to make caregivers aware of any risk which is evident. Confidentiality will sometimes take a back seat compared to save young person's life. One should look out for subtle symptoms of depression and patient should ideally be hospitalized in case of high risk.

Respect young person's perspective without necessarily agreeing with his/her understanding of situations. The formulation of safety plan is one of the most important aspects of the assessment and treatment of suicidality and involves preventing the access to the lethal agent, negotiating with the factors that led to the act of attempted suicide, and training in how to regulate one's emotion.

The no-harm contract is an agreement between the adolescent, parents, and clinician that if the adolescent develops suicidal impulses, he/she will inform parent or call the clinician or emergency room, and it is also a method for coping with suicidal urges when they occur. No-harm contracts may be either verbal or written.^[15]

Means restriction counseling – despite broad acceptance of the importance of means restriction, this aspect of suicide risk management has not been subject to rigorous evaluation.

EVIDENCE BASE OF PSYCHOTHERAPEUTIC APPROACHES FOR CHILDREN AND ADOLESCENTS

Research on psychotherapy outcomes, particularly with children, has a short but evolving history. Studies in the 1950s and 1960s suggested that therapy was no more useful than no treatment and the passage of time. There were many flaws in the research upon which this conclusion of no improvement from psychotherapy was based and it has taken the next half century to generate more studies and to reconsider the evidence for efficacy of psychotherapy. While problems continue to exist with the quantity, strength,

and generalizability of research on child psychotherapies, it is increasingly accepted that efficacious treatments do exist for child and adolescent disorders. Therefore, while adopting a psychotherapeutic approach for a childhood or adolescent psychiatric disorder, it is imperative to consider the evidence base of that approach for that particular condition. A detailed discussion of the evidence base of psychotherapeutic approaches for individual child and adolescent psychiatric disorder is beyond the scope of this clinical practice guideline. However, the authors would like to summarize few recent importance researches and their findings for psychotherapeutic approaches for certain childhood and adolescent psychiatric conditions, e.g., depressive disorders, anxiety disorders, OCDs, self-harm, autism spectrum disorders, attention-deficit hyperactivity disorders, and those who have been exposed to trauma and sexual abuse [Table 6]. Interested readers can also refer to the PracticeWise Evidence-Based Services Database which is uploaded and revised every 6 months in the official website of American Academy of Paediatrics for a more detailed recommendation in this field.[24]

Table 6

Summary of researches on psychotherapeutic approaches for childhood and adolescent psychiatric disorders/conditions

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There are no conflicts of interest.

ANNEXURE 1

Template of a “Psychotherapy Intake Form” for children and adolescents

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: ☐ Male ☐ Female

Physical Address: _____

Mailing Address: _____

Phone (Cell): _____

Messages okay? _____

Grade: _____

Race/Ethnic Origin: _____

Religious Preference: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g., religion) in your life? (Please describe)

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling.

What would you like to see happen as a result of counseling?

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ☐ Yes ☐ No

If yes, what did you find most helpful in therapy? _____

If yes, what did you find least helpful in therapy? _____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____ Yes _____ No

If yes, how often do you drink? ____ Daily ____ Weekly ____ Occasionally ____ Rarely

If yes, how much do you drink? _____ (#) per time.

Do you currently use Tobacco? _____ Yes _____ No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____ Yes _____ No

If yes, what drugs do you use? _____

If yes, how often do you use? ____ Daily ____ Weekly ____ Occasionally ____ Rarely

Have you received any previous treatment for chemical use? Y/N _____

FAMILY HISTORY

Are your parents married or divorced? _____

Do you think their relationship is good? (Y/N/Unsure) _____

If your parents are divorced, whom do you primarily live with? _____

How often do you see each parent? Mom _____ % Dad _____ %.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. _____

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or drug use
	Lack of honesty		Trauma
	Medical concerns		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job change or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

[Open in a separate window](#)

Other concerns not listed above _____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ___shy ___depends on the situation?

Are you happy with the number of friends you have? (Y/N)

Have you ever been bullied? (Y/N)

Are your parents happy with your friends? (Y/N)

Are you involved in any organized social activities (e.g. sports, scouts, music)?

SCHOOL HISTORY

Do you like school? (Y/N) _____

Do you attend regularly? (Y/N) _____

What are your current grades? _____

Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know: _____

CHILDREN AND ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____

Date of birth: _____

Mother's/Guardian's Name: _____

Phone Contact: _____

Mother's/Guardian's Physical Address _____

Mother's/Guardian's Mailing Address _____

Father's/Guardian's Name: _____

Phone Contact: _____

Father's/Guardian's Physical Address: _____

Father's/Guardian's Mailing Address: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc.)	Age	Sex	Type (bio, step, etc.)	Living with you? Y/N
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

[Open in a separate window](#)

(If additional space is need please list on the back of page)

Current reason for seeking Counseling for your Child/Adolescent

Briefly describe the problem for which your adolescent is seeking to have counseling for?

What would you like to see happen as a result of counseling?

What is most concerning right now?

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ☐ Yes ☐ No

If Yes, where: _____

Approximate Dates of Counseling:

For what reason did your son or daughter go to counseling?

Does your son or daughter have a previous mental health diagnosis? _____

What did you find most helpful in therapy?

What did you find least helpful in therapy?

Has your son or daughter used psychiatric services? Yes ____ No ____ If yes, who did they see?

If yes, was it helpful? N/A ____ Yes ____ No ____

Has your son or daughter taken medication for a mental health concern? Yes ____ No ____ Does your son or daughter have other medical concerns or previous hospitalizations? Y/N

If so, please describe: _____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child? Yes ____ No ____ If yes, describe:

Did your child have health problems at birth? Yes ____ No ____ If yes, describe: _____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ____ No ____ Not sure ____ If yes, describe: _____

Did your child have any unusual behaviors or problems prior to age 3?

Yes ____ No ____ Not sure ____ If yes, describe: _____

Has your child experienced emotional, physical, or sexual abuse?

Yes ____ No ____ Not sure ____ If yes, describe:

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) ____

If yes, please explain your concern:

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting, etc.? (Y/N) ____

If yes, please explain your concern:

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

FAMILY HISTORY

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent).

Father's Name: _____ Birth Date: _____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____

Occupation: _____

Place of Employment: _____

Assessment of current relationship if applicable: Poor ____ Fair ____ Good ____

Mother's Name: _____ Birth Date: _____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____

Occupation: _____

Place of Employment: _____

Assessment of current relationship if applicable: Poor ____ Fair ____ Good ____

PARENT'S MARITAL STATUS

☐ Single ☐ Married (legally) ☐ Divorced ☐ Cohabiting ☐ Divorce in process ☐ Separated

☐ Widowed ☐ Other _____

Length of marriage/relationship: _____

If divorced, how old was your child at time of divorce? _____

If divorced, how much time does your child spend with each parent? Mother _____%, Father _____%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

<input type="checkbox"/>	Fighting	<input type="checkbox"/>	Disagreeing about relatives
<input type="checkbox"/>	Feeling distant	<input type="checkbox"/>	Disagreeing about friends
<input type="checkbox"/>	Loss of fun	<input type="checkbox"/>	Alcohol or Drug use
<input type="checkbox"/>	Lack of honesty	<input type="checkbox"/>	Trauma
<input type="checkbox"/>	Medical Concerns	<input type="checkbox"/>	Infidelity (couple)
<input type="checkbox"/>	Education problems	<input type="checkbox"/>	Divorce/separation
<input type="checkbox"/>	Financial problems	<input type="checkbox"/>	Issues regarding remarriage
<input type="checkbox"/>	Death of a family member	<input type="checkbox"/>	Birth of a child
<input type="checkbox"/>	Inadequate health insurance	<input type="checkbox"/>	Job change or job dissatisfaction
<input type="checkbox"/>	Inadequate housing/feeling unsafe	<input type="checkbox"/>	Other

[Open in a separate window](#)

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home?

Please describe as much as you feel comfortable.

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders?

If so, please describe:

YOUR CHILD/ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

What personal qualities would you say your son or daughter has?

Who are some of the influential and supportive people, activities (e.g., walking) or beliefs (e.g., religion) in your son or daughter's life? (Please describe)

Is there anything else you would like me to know:

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