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Psychosocial Therapies for Children and Adolescents: Overview and Future Directions

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The assessment and psychosocial treatment of children must consider developmental phase and stage, developmental tasks, the nature of the disorder (does it affect a narrow sector or one developmental line or is there a broad disruption of development?) and biological contributions (including constitution, maturational rate, and factors such as the onset of puberty). Treatments can be distinguished along dimensions, including theoretical emphases, degrees of definition of the treatment, scope, the "patient" (child, family), duration, frequency of contacts, combination with other modalities, etc. Similarly, choice of treatment is based on many factors, including the clinician's expertise, availability of resources, wishes of parents, cost, etc. Future research should be grounded in a theory of child development *as well as a* theory of therapeutic action. *Treatments should be well defined and currently practiced, provided by experts, and arise from realistic situations. The study of therapies bridges basic and applied research and provides data of profound relevance for theories of child development.*

As a nation, we increasingly are aware of the importance of responding to the emotional and psychiatric problems of children and adolescents. This concern led to the Institute of Medicine (1989) report *Research on Children and Adolescents with Mental, Behavioral and Developmental Disorders* and the mental health plan of the National Institute of Mental Health which emerged on the basis of its recommendations. Epidemiologic, service utilization, educational, judicial, and other types of data document the large and perhaps increasing numbers of children whose lives are burdened by developmental and psychiatric difficulties. The roots of these problems lie in many different domains (Schorr, 1988). Mental disorders of children re-

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flect the complex interactions between the biology of brain maturation and the multifaceted nature of experience over the course of development. They are found in every type of family and community context, in every social class, and among all ethnic groups. There are, however, some groups that are at particular risk, where multiple factors combine to make children and adolescents particularly vulnerable. Thus, at this moment, we are particularly aware of the trauma of multigenerational adversity in the inner cities, the difficulties of American Indian children, the problems of the rural poor, the strains posed by homelessness and family breakup, as well as the impact of agents such as marked prematurity, HIV, cocaine, and alcohol on the development of children (National Commission on Children, 1991). As risk factors accumulate, the probability of disorders increases.

From 8% to 10% of all American children have some type of diagnosable mental disturbance and up to 20% of children growing up in inner-city poverty are impaired to some degree in their social, behavioral, and academic functioning (Costello, 1989; Institute of Medicine, 1989; Offord, Boyle, Szatmari, et al., 1987; Rutter, 1989). The cost of these conditions — in suffering for the children and their families, in the effects on community resources, in the loss of productivity, and in the need for long-term intervention — is staggering. Given this scope of difficulty, it is important to find and implement methods for reducing risk. There are models — such as Head Start (Zigler & Muenchow, 1992) — that can guide the development of national, population-based, public health interventions for large populations of children in jeopardy. The National Commission on Children (1991) recommended other preventive approaches, including strategies for dealing with multigenerational poverty, helping to preserve families, improving schools, and assuring access to preventive and therapeutic medical services. These broad-based psychosocial approaches are critical, in light of the enormous numbers of children at risk and already burdened by disorders. Yet we should be aware that enhanced attention to children at risk is likely to result in more "case finding." The numbers of identified children in need of treatment are thus likely to increase, in spite of, or as a result of, increased attention to childhood mental disorders.

Thus, while supporting the importance of early and enduring preventive efforts, there is a profound need to improve treatments for children and families and to make effective treatments accessible. Also, for many major types of disturbances, there is little or no knowledge about what, if any treatments, definitely alter natural history. For these reasons, at the same time as we advocate for prevention and public health interventions, it is important to recognize and address the specific therapeutic requirements of children with disorders. What do we know and what do we need to learn about the types of treatments that can be helpful for children and

adolescents who experience emotional and psychiatric disturbances, and their families?

THE CONTEXT OF TREATMENT

At the outset, it is useful to recognize the diversity of conditions and situations for which children come to therapy. While categorical diagnoses are useful landmarks in defining the children who come for care, they are limited in conveying the nature of the pathways into treatment or the actual reasons for needing care as these might be presented in a diagnostic formulation. The clinical conditions — the diagnoses — include problems within the family, problems in a child's behavior that disturb others, the recognition of the child's emotional suffering by adults, the conditions of the child's life that draw attention to him or her or that lead to the recognition for care (such as divorce or the involvement in some type of trauma, such as witnessing or being the victim of aggression), biological burdens with which the child must deal (such as chronic medical conditions), and difficulties that reflect, in large part, dysfunctions in the development of brain processes (as in the pervasive disorders, tic syndromes, and language disorders of childhood) (King & Noshpitz, 1991).

Children rarely are brought to mental health services or enter treatment, outside of some research protocols, for a single, definable reason. More generally, a child is in treatment because of a confluence of vectors: problems expressed in his or her behavior, in a particular family, at a particular moment in the child's life, in a particular school situation. It is unusual for there to be a single site of the difficulties. More often, the child is having problems in multiple different areas — at home, in school, and with friends. And the child typically earns more than one categorical diagnosis. On inpatient services, in particular, children may satisfy the criteria for four or five diagnoses — attention deficit hyperactivity disorder (ADHD), conduct disorder, learning disability, a chronic medical condition — and their problems may reflect many sources of strain — constitutional, familial, intrapsychic, and communal. Finally, the disorders and problems which bring children into therapy are often of very long duration, relative to the children's ages. The children may have been suffering for years, with one type of problem or another, and those close to them may have worried and suffered because of them from the very first years of their lives. Many children have gone for years with serious emotional troubles and no treatment. Others have had different treatments — from schools, parents, pediatricians, and general practitioners — before coming into the care of

experts knowledgeable about the evaluation of childhood disorders and the broad range of child psychiatric treatments.

The central role of biological and constitutional factors in childhood disorders, the appearance of disorders during the course of development, the close interplay with family and community, and the persistence of the disorders for large proportions of the child's lifetime before treatment is obtained distinguish these conditions from those of adults. We often deal with children whose behavior has been off-track for much of their lives and those whose premorbid levels of functioning were compromised. In contrast with adults, where symptoms and disorders are more discrete and where areas of functioning may be well preserved in the face of serious problems in one sector, the problems of children who come for treatment are broad and diffuse. The recent interest in comorbidity reflects, in another way, the fact that the edges of disorder are not sharply defined in childhood and that underlying dysfunctions and external adversity may find expression in many different areas of functioning, including the rate of development, specific symptoms, and physical symptoms. All of these issues must be considered in thinking about the pathways toward (and barriers to) service delivery, the context in which treatment is entered, and the goals of therapy.

CONCEPTUALIZING PSYCHOSOCIAL THERAPIES

Conceptualization of the reasons and context for child psychosocial therapies must take account of the nature of development and the enormous transitions, in every sector, from the youngest patients, perhaps in their toddler years, through adolescents on the cusp of entering young adulthood. Even when one might be able to delineate a pattern of symptoms that satisfies the current sense of a categorical disorder — such as autism or depression — developmental factors and the emergence of new capacities, competencies, and tasks are salient in considering treatment and its goals (Brady & Kendall, 1992; Kaslow, Rehm, & Siegel, 1984; Kazdin, 1984). The treatments of an overanxious 3-year-old and an overanxious 15-year-old are far more different than the treatment of strep throat across the life span. Even the diagnosis of disorders — such as attentional and overactive disorders — must be based on developmental assessment. Nothing stands still.

Thus, assessment and treatment must consider developmental phase and stage, developmental tasks, the nature of the disorder (does it affect a narrow sector or one developmental line or is there a broad disruption of development?), and biological contributions (including constitution,

maturational rate, and factors such as the onset of puberty). Along with the child's development, there are concurrent changes in his or her environment and developmental context. Family, community, and school change along with the child; the child experiences different aspects of the world in different ways, and he or she confronts different responsibilities, opportunities, and potential traumas.

THE GOALS OF PSYCHOSOCIAL TREATMENTS

Psychosocial therapies are a diverse array of techniques aimed at a diverse array of targets. Their nature and scope are so broad that it is difficult to speak of them as a type of treatment. On the one side of the spectrum, psychosocial therapies may consist of one or two meetings with parents or a child to provide comfort and support and help them cope with a specific difficult experience or situation (e.g., the death of a relative) or a particular developmental crisis (such as the birth of a sibling). At such times, there may be relatively nonspecific indications of distress (e.g., sleep problems, worries, irritability) or more clearcut symptoms (e.g., enuresis, temper tantrums, extreme sadness). A good deal of useful caregiving of this type is provided by pediatricians and ministers, as well as by mental health professionals.

On the other side of the spectrum, psychosocial therapies may be introduced programmatically in a child's and family's life because of a long-standing derailment of development and persistent behavioral and emotional symptoms (pervasive overactivity, depression, recurrent aggression towards others, low self-esteem). These psychosocial therapies are guided by explicit theories and are offered by individuals with specific training and expertise. The "classical" paradigm of such a therapy within child psychiatry is dynamically oriented psychotherapy in which a child (and family) are provided with the opportunity for engagement with a professional skilled in understanding children and trained in providing a treatment defined by specific psychological techniques (O'Brien, Pilowsky, & Lewis, 1992). The goals of such treatments are quite broad — to help a child resolve internal conflicts and resume a normal process of development (Freud, 1965).

Between one-shot "crisis intervention" aimed at helping healthy children navigate a rocky period of life and many-year child psychoanalysis aimed at helping disturbed children function more adequately, there is every shade of therapeutic ambition and clinical intensity. The different approaches to psychosocial treatment can be subdivided and distinguished along various dimensions, including:

1. Theoretical emphases (e.g., behavioral, cognitive, or psychodynamic)
2. Degree of definition of "the treatment" and how well defined the procedure is (e.g., structured approach with specific techniques that can be taught to practitioners without much training; semistructured approach; or more open-ended, responsive approach requiring and permitting a great deal of clinician judgment)
3. Scope (e.g., emphasis on target symptoms or emphasis on providing new skills and improving overall functioning)
4. The "patient" being treated and the role of the institutional context (individual therapy, family therapy, or work with day care providers, teachers, childcare workers, etc.)
5. Duration of treatment (short-term treatment, lasting weeks or months, or long-term treatment, lasting 6 months to years)
6. Frequency of contacts between caregivers and patients (episodic or as needed, monthly, weekly, several times weekly)

Further dimensions could be added to this list, such as the combination of psychosocial therapies with other modalities, particularly the use of psychoactive medication. But it is quickly apparent that there are very many possible combinations of these variables. This subdivision suggests the diversity of approaches that can be used and studied. For example, a child may receive a psychosocial treatment that is behaviorally oriented, attempts to provide new skills, involves the family in therapy, goes on for a few months, and involves weekly visits. Any of these variables can be altered. Or the child may receive a very different treatment that is dynamic, long-term, and involves three or more sessions a week. The parametric transformations are infinite and the topology is thus overly rich. In addition, these types of treatments can be placed in a matrix of other approaches that are used simultaneously.

There is no child who is outside the responsibility of a school system. The largest single site of psychosocial intervention for children with behavioral difficulties occurs within schools or in close relation with the educational system. For many children with disruptive disorders, for example, a range of school-based interventions often has been tried (such as discipline, retention in grade, formal attempts at behavior modification, suspension from classes, psychological evaluation, and special programming or classroom placement) before the child is seen for psychosocial therapies within the context of the mental health system. In addition, especially in the United States, children are likely to receive medication for behavioral difficulties; the vast majority of such medication is prescribed by family physicians and pediatricians, not mental health professionals. For children who

are receiving care within the mental health system, psychosocial therapies, especially with the most difficult conditions, are generally integrated with, or provided alongside of, other treatments that the child may receive, including special education, tutoring, family guidance, and individual therapy for parents.

For most children involved in psychosocial therapies, and for most therapists, it is generally not enough to try to stop a child from doing something that is unwanted (e.g., oppositionality) or to get him or her to do something that is desirable (e.g., going to school). More often than not, there is a need to provide new social, adaptive, and emotional competencies. Thus, children with conduct disorders not only require therapies to help them solve their disputes with less hostility but also to learn new social skills to help them form friendships and share in group activities (Dogde, Pettit, McClaskey, & Brown, 1986). Similarly, depressed and anxious children need help in acquiring skills and interests that provide pleasure. Even when a child is seen as needing help because of a focal difficulty or single, traumatic experience (e.g., witnessing a violent episode), therapeutic engagement often elicits broader-gauged difficulties in need of intervention. For children and adolescents with developmental disorders, goals include helping them in many sectors of life (social, communicative, adaptive, emotional) and developing long-term supportive environments and opportunities.

For many children with psychiatric disorders, intervention requires different levels of intervention in relation to care, from work with families and other caregivers through major reorganization in a child's living or care situation (e.g., dealing with family placement, work with foster and social work agencies, locating a suitable residential placement).

The scope of "psychosocial therapies" thus is enormously broad. The systematic evaluation of structured approaches to treatment, as reported in the scientific literature on therapeutic trials, encompasses only a narrow sector of what actually is done in the "real world" of psychosocial intervention with psychiatrically disturbed children. For example, the children included in many studies (e.g., trials of treatment of hyperactivity or classroom disruption) are identified on the basis of being within the top percentiles of overactivity as rated by teachers. They are not actual psychiatric patients. The study of such statistically defined groups and the artificial explication of "the therapy" from the broader clinical context of actual care may account, at least in part, for the difficulty in extending laboratory findings to clinical practice. In general, treatments work best in the hands of the developers and less well in the complex, muddled world of clinical reality. Far more research is needed on the ways in which treatment actually is provided, what types of treatments can be mounted in clinical practice, and what works and for whom.

THE SOCIAL CONTEXT OF TREATMENT

In sharp contrast with most adult patients, children are brought to treatment by others who care about them — most often by their parents. Frequently, their parents seek help at the suggestions of others who know and care about them — pediatricians, family physicians, school teachers and social workers, ministers, or other caring adults, especially grandparents. Sometimes, the seeking of care is demanded of the parents as a condition for a child's remaining in a school, and thus both child and parent may feel coerced into treatment. Most often, even if the child has been provided some explanation for treatment, which generally is meager, the child does not really understand why he or she is coming for therapy. This is understandable for the youngest patients who do not have frameworks that allow them to understand why their behavior and feelings are deviant or out of the ordinary. It is even true for young adolescents, who may see themselves as normal or as victims, but not as in need of therapy for their own personal and autonomous difficulties. This realization may only slowly or never really emerge during the course of therapy.

Not only do parents bring children for therapy, work with children is always in the context of the family and school. This compares quite distinctly to the work with adults. Generally we do not even see, yet alone speak with, an adult patient's spouse, and it is quite rare for a therapist to discuss an adult in therapy with his or her employer, even if the patient wishes for such an intervention. Yet, in psychosocial work with children, it is taken for granted that parents, teachers, and pediatricians will work in some type of collaboration, and that they may be cotherapists. Since the inception of modern child psychiatry in the orthopsychiatric and child guidance movement before World War II, the multidisciplinary and multimodal approach to treatment has been virtually the standard of practice. It is typical for psychosocial interventions with a child or adolescent to involve the child individually, his or her parents and sibs, and his or her school, and for the child to receive dynamically oriented therapy along with special education and medication.

CHOICE OF PSYCHOSOCIAL THERAPY

The choice of psychosocial approach is based on many different factors, in addition to the child's specific clinical presentation. These include:

- The clinician's expertise

- The clinician's theoretical orientation in relation to different clinical situations and types of disorders
- The availability of resources
- The wishes of parents and other adults
- The child's willingness to participate (including his schedule and other demands on his time)
- Economic factors (what type of insurance the parents have, if any; the limits on length and intensity of treatment defined by the insurance; the family's ability to pay)

There is rarely a one-to-one correspondence between a categorical diagnosis and a treatment strategy. The family is burdened by the need to choose among alternatives and the clinician has the responsibility of providing information and guiding the selection of treatments. Researchers have preferred to study explicit, sharply defined treatments and to focus on one, well-defined disorder. But real clinical work is at the opposite end of the spectrum, as children usually have several disorders (or very broad-based conditions) and receive several therapies. As noted above, when research studies use nonclinically referred patients and restrict other parameters for inclusion in research, their relevance to ongoing clinical work may be limited. Finally, there is a remarkable paucity of studies on economic factors in relation to the choice and availability of different kinds of psychosocial therapy. As insurance providers become more active in defining the type and scope of treatments that will be covered, and as the nation considers new approaches to health care financing, there will be a greater need for data on the short- and long-term financial implications of providing different types of treatment.

BASIC PREMISES OF PSYCHOSOCIAL TREATMENTS

Regardless of differences among psychosocial treatments, these therapies are premised, to a greater or lesser extent, on a concept which has guided clinicians throughout the course of the history of psychotherapy: that an adult with special training can mobilize a process of therapeutic change, through interaction of one type or another with a child (O'Brien et al., 1992).

This premise embodies one of the most fascinating phenomena of human life: that we are changed by the people we interact with, that another person can make a difference not only in how we feel at the moment but in how we function. The complexities which underlie the ways in which a therapist may alter another's functioning fall under many theoretical ru-

brics. The research task is to define, and the therapeutic task is to facilitate, this process of internalization — the ways in which a child takes in aspects of another person in such a way that this new internal representation can serve as a new or renewed regulation of the child's behavior and affects. The process of therapeutic change involves not only changes in behavior but a more persistent, generalized alteration of psychological structures and functions. These concepts seem intuitive, but their empirical validation has been arduous. Parents obviously make some differences in the lives of their children, and teachers change us, more or less, by the knowledge and skills they impart. Similarly, shocking, traumatic experiences may lead to shorter-no longer-term alterations in our thinking and affects. But can an occasional encounter of an hour or two a week with a benign adult who listens, talks, and plays change a child's functioning? If so, how? By what he or she says? By the model of living the therapist presents? By the changes that are effected in other parts of the child's world (e.g., the changes that result in parental attitudes, rearrangements of the child's living situation, schooling, etc.)? These questions are at the core of thinking about therapeutic action; they also suggest why the study of therapy is such a fascinating topic with relevance beyond the boundaries of clinical work and into the general field of socialization as such.

There is a second premise of many psychosocial approaches: This premise concerns the importance of *understanding* in the course of therapy. It is rooted in the phenomenon that a good deal of life is involved in trying to understand the lives that we are leading; self-reflection and attempting to understand one's mind are major activities of mental life. As a corollary, we generally believe that changing an individual's understanding of herself or himself will affect that individual's life and how she or he feels about it. Parents and caregivers spend a good deal of time and sweat in trying to change others by altering their understanding of themselves. In this emphasis on understanding, on cognition, most psychosocial therapies, from Freud to cognitive and educational treatments, converge. The premises are shared even by behavioral approaches that emphasize the importance of making explicit and helping the child to understand the contingencies of reinforcement that have shaped and continue to operate on his or her behavior. Therapies thus can be subdivided by the theories and actual practices that underlie how a therapist hopes to change a child's understanding of his or her life and how the therapist hopes that this understanding will influence the child's feelings, behavior, and symptoms.

It is a truism that the assessment of the need for treatment and of the gains of therapy must be developmental: Where is the child along the many lines of development at the start, how does treatment facilitate de-

velopment, and is he or she, at the end, better launched on his or her development? Within this framework we can now ask how enhanced self-understanding may positively influence development. Surprisingly, when therapy has gone well for a child, the child will often remember very little of what transpired. The understanding gained during treatment becomes a part of the person, rather than being experienced as a theory learned from outside. This transformation is a hallmark of successful internalization (Loewald, 1980).

ONGOING RESEARCH STUDIES

An important body of scientific literature already is available to document the efficacy of psychosocial therapies for children and adolescents (Kazdin, 1987b, 1988, 1993). The treatments that have been most rigorously examined have tended to be shorter-term, cognitive, and behavioral therapies with relatively narrow treatment goals (Kendall, 1992). Yet, there is an increasing richness in the range of variables being considered and in the theory guiding the interventions and assessment of outcome (Kendall, this issue). It is far more difficult to rigorously study broader-based, multimodal, and longer-duration interventions — similar to the standard of practice in outpatient child psychiatry and psychology. Yet sophisticated investigators have succeeded in conducting such research and demonstrating the efficacy of treatment of specific conditions, such as conduct disorder.

Therapies with a psychodynamic and psychoanalytic frame of reference and approach have not been as well studied as cognitive and behavioral therapies. Yet there is increasing interest in attempting to develop methods for evaluating the process and outcome of such therapies (Kernberg et al., 1991). A recent study has shown that it is possible to reliably assess major themes within sessions of dynamically oriented interviews with children (Marans et al., 1991). A strong indication of the potential for such research is a new study being conducted at the Centre in London created by Anna Freud, formerly called the Hampstead Clinic and now bearing her name. Fonagy and Target (1992) and their colleagues are reviewing the more than 600 cases of child and adolescent psychoanalyses that have been conducted at the Anna Freud Centre during the past two decades. They have computerized hundreds of variables concerning children's symptoms and difficulties and the course of treatment, e.g., the nature of therapist–child relationship, modes of expression of major dynamic themes, behavior within sessions and in other contexts, development of transference. Such studies will help clarify effective approaches for specific diffi-

culties, children, and families. The Anna Freud Centre research program suggests the possibility of other archival and followup studies on treatment, as well as the even more critical need for prospective, multicenter studies of intensive psychosocial treatments.

A RESEARCH PROGRAM ON PSYCHOSOCIAL THERAPIES

Based on the current status of research on psychosocial therapies and advances in developmental psychopathology and related fields, there are a number of important avenues to be pursued that promise fruitful results. A great deal can be learned from the history of research on adult psychotherapy. A range of desirable (or ideal) characteristics can be cited in relation to shaping this program of research (Kazdin, 1987a, 1988; Kendall & Morris, 1991):

1. The treatments should be grounded in a *theory of child development* as well as a *theory of therapeutic action*. That is, the therapies should reflect current understanding of the nature of children's development, developmental psychopathology, and potential approaches to altering behavior and facilitating development.
2. The psychosocial treatments should be well defined, currently practiced, and have a track record of implementation. There should be experts who believe in the effectiveness of the treatment. A treatment should not be evaluated until clinicians have used it for a long enough period of time to feel that it is practical and useful.
3. The therapeutic approach should be well documented and sufficiently "manualized" to permit training, replication, and systematic assessment.
4. Treatments should be provided by expert clinicians who are trained in understanding children and families, not only one specific disorder or treatment. The clinicians should be experienced and recognized by peers as doing good clinical work.
5. The research on treatments should arise from realistic situations. The clients should be real patients, referred for care.
6. There should be access to the raw data of the treatment, through methods such as videotaping and observation through one-way screens.
7. Initial, periodic, and final assessments should be broad-based and clinically relevant not only to specific symptoms but to the functioning of the child and family in varied contexts. This type of

assessment should include varied methods with proven reliability and validity, including semistructured and structured information from interviews, observations, and relevant testing (neuropsychological, projective, adaptive).

8. The full range of additional treatments must be documented and their effects considered. These include interventions with the family and at school, the use of medications, etc.
9. The design and carrying out of research on psychosocial therapies will generally require and benefit from the skills, interests, and orientations of varying disciplines. It would be ideal to include the expertise of therapists from different orientations who could look at the same data from different perspectives, e.g., to include behavioral therapists in studies of dynamically oriented treatments and analysts in the study of cognitive therapies. In addition, developmental psycholinguists, experts in cognitive development, social workers, anthropologists, and others would add considerably to understanding the nature of the child's difficulties, what he or she can extract from interventions, and the familial and community context of treatment that may have a great bearing on how disorders are presented and how treatment is experienced by the family and child.
10. For the immediate future, research programs on psychosocial treatments for children would perhaps be most wise to focus on the process of treatment and the nature of therapeutic action, rather than on demonstrating efficacy or the superiority of one treatment over another. This does not mean that summative evaluations are not important. Indeed, there is a real need to know which children benefit from which types of treatment. However, a single-minded preoccupation with these questions would be premature. Before we reach this point, a great deal more work needs to be done in relation to assessing children and families and also defining treatments, mounting them in ways which can be studied, developing research groups, establishing valid and reliable measures, and conducting the studies in ways which exemplify clinical sensitivity and ethical rigor.
11. In the future, the study of psychosocial therapies would be enriched by closer integration of the research and findings of this type of research with other aspects of developmental research. These associated fields of study include basic research on social, cognitive, and emotional development; the study of children's emerging theories of mind, the quality of peer relations, the modulation of aggression, and the impact of family dynamics; the

influences of ethnicity, gender, social class, and family background on children's development; and the neurobiology of development.

12. Finally, psychosocial therapies need to be studied within the overall context of research on the implementation and delivery of services. Research on service delivery, especially for children and adolescents with serious emotional disorders, is critical to understanding how to better provide treatments for children with psychiatric disorders. The study of systems of care includes a range of issues: who comes for care, what facilitates or reduces the likelihood of a family and child receiving treatment and remaining in care, what kinds of treatments can be provided in what types of settings, how treatments are disseminated and professionals instructed in their use, how much treatments cost, how the costs relate to immediate and longer-term costs and benefits, etc. Research on innovations in service delivery — e.g., case-management techniques, methods for improving service integration and linkage, the use of family support services — is closely related to understanding the potential benefits of psychosocial interventions and treatments, especially for the most burdened children and families.

The study of therapy, within academic psychology, has often been split off from other modes of inquiry, leading to an impoverishment of both. Studies of psychosocial therapies may provide information available from no other source concerning the child's strongest emotions, unconscious processes, modes of sublimation and of defense, styles of symbolizing and understanding experience, and nature and capacity for forming and using intimate relations. Sigmund Freud was among the first to show how psychosocial clinical engagement is a source of privileged data about mental functioning, and Anna Freud and the child analytic pioneers continued the tradition of seeing their approach as both a theory, method for research, and a treatment. For other treatments as well, the response of children and families to interventions of different types reveals a great deal about the workings of their minds, their adaptability, and the actual functioning of the family and its relations to the community.

In summary, the field of psychosocial treatments is vast and there are numerous methodological and theoretic complexities. The design of studies will be far easier than their execution. Yet the clinician is given a privileged access to children because he or she offers hope for reducing distress and being helpful. Thus, the information that can be derived from well-conducted studies of important treatments may not only be useful in guiding clinical work, it may provide knowledge about children's inner lives and

thoughts that is available in no other way. In this sense, the study of psychosocial therapies bridges basic and applied research and can offer the most profound data for rigorous examination.

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