# DIAGNOSTIC VARIABLES IN THE NON-SUCCESSFUL YOUTH-CLIENT PSYCHOTHERAPY INTERVENTIONS: A SUGGESTION FOR SCHOOL PSYCHOLOGISTS

*By*

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**Abstract**

*The paper focused on possible variables that school psychologists need to look for in non-successful youth-clients' psychotherapy interventions and why understanding and keying the variables may be of benefits to successful youth-clients' psychotherapy processes. Before discussions on the conceptualized variables; efficacies of successful psychotherapy intervention outcomes were cited for referral to widen experiences in handling youth-clients' psycho-personal-social needs and problems. These variables therefore include: negative therapeutic alliance, inappropriate identification of youth-clients' personal characteristics and of the individual who is providing psychotherapy intervention, nature of youth-client needs and problems, inability to control dropout during therapy intervention processes and breach of psychotherapy professional boundaries. Recommended steps to overcome the variables include, continuous building of hope in youth-client, talk about the end of therapy and the possible gain to derive and the need for school psychologist to make conscious efforts towards objectivity by actively avoiding any interaction or discourse outside of therapeutic issues.*

**Keywords:** Diagnostic Variables, Non-Successful Youth-Client, Psychotherapy Intervention, Psychologists

## Introduction

Youth is defined as the period that immediately follows childhood and terminates at the stage of youth adulthood (Olawale, 2009 cited in Aminu, 2010). Youth stage is a period when the individual is yet to attain a full adult status; comprised of adolescence period. While, youth-client can be conceptualise as individual (e.g. male or female) irrespective of their psychological, social and personal characteristics but visits or needs the assistance or help of a school psychologist that provides psychotherapy intervention or treatment. McCarthy, Gregory & Aarons (2003); Adeloye, et al (2008); Akinboye (2003) and Akinade (2012), observed that youth-clients' psychotherapy issues usually include long periods of discomfort, impaired functioning, bizarre behaviour, disruptive behaviour, school dropouts, youth unemployment and underemployment, alcohol and drug abuse, sexual behaviour; unwanted pregnancies, youthful marriages, sexually transmitted infections and juvenile delinquency.

On the other hand, psychological intervention or otherwise called Psychotherapy is an intimate, subjective, evolving intervention that uses the principles of psychology to try to treat / prevent mental disorders, anti-social or maladaptive behaviour and to improve the life of children, youth and adult who is unhappy or disturbed (Wolfgang, 2001 cited in Aminu, 2010, and 2017; Aminu & Williams, 2012; Lambert & Ogles, 2004; Wampold, 2001, 2007).

Many of the youth behaviour concerns or problems particularly with school and college students, such as absenteeism, attention-seeking behaviour, chronic behaviour, deficiencies in academic work, disruptive noise, drug abuse, test anxiety, social isolation and withdrawal, masturbation, shyness and peer

reinforcement of undesirable behaviour (Wolfgang, 2001; Okoli, 2002; O'Donohue & Ferguson, 2006; Odoemelam, 2006 and Akinade, 2012), had refused to change, modified or positively influenced due to non-proper understanding, clarification, application, adoption or adaptation of key procedures and concepts that continue to serves as aids to all successful psychotherapy interventions by the school psychologist / counsellor. Although, the problem seems not to rest purely with the school psychologist and counsellor but rather with the fact that no single course of programme or experience presents the key conceptual issues as a whole for study. The implication of this is that, psychotherapy youth-client interventions may need to combine on the work experiences, personal researches and interest to key into the development and changes in psychotherapy field.

Researches have shown that youth disturbing behaviour problems continue to be handled with recorded successes using different psychotherapy interventions and strategies. Therefore, sharing successful youth-clients psychotherapy interventions outcomes becomes a necessity for the school psychologist and counsellor. Before discussing the roles played by conceptualized variables toward non-successful psychotherapy interventions, it will be worthy to cite research outcomes that shows the efficacy of how psychotherapy interventions, treatments, style and techniques successfully modify, change or influenced youth behavioural concerns or problems. For example, a wide range of psychotherapy treatment options were used to minimise the duration, severity, and recurrence of youth mental disorders and also used to maximise the duration between episodes in youth behaviour problems (Benish, Imel, & Wampold, 2008)).

Other successful psychotherapy intervention outcomes were psychotherapy for psychopathology (Becker & Conway, 2009; Davis & Berman, 2008 and Gillis, Gass & Russell, 2008), uses of cognitive behavioural therapy for anxiety (Glass & Myers, 2001; Koocher, 2008 and Behar, Friedman, Pinto, Katz & Jones, 2007), for depression (Bettmann & Jasperson, 2009; Russell, 2007 and Russell, 2006), for management of anger Meyer (2007; Koocher, 2008 and Glass & Myers, 2001), for management of antisocial behaviour (Aminu & Williams, 2012 and Aminu, 2010) and management of criminal offending (Gillis, Gass & Russell, 2008 and Davis & Berman, 2008).

There were other recorded cases of successful use of pharmacotherapy for management of depression (Bettmann & Jasperson, 2009), successful treatment outcomes was recorded with the use of multi-systemic therapy for management of antisocial behaviour and psychiatric symptoms (Becker & Conway, 2009), rational emotive therapy was also used for management of anxiety, disruptive behaviours and self-concept (Koocher, 2008); in similar vein, management of family-based crime prevention programs for offending outcomes, delinquency and antisocial outcomes (Farrington & Welsh, 2003); residential treatment programs for internalising problem behaviour and externalising problem behaviour (Knorth, Harder, Zandberg, & Kendrick, 2008). Art psychotherapy was successfully used in the management of anxiety (Campbell, 2010); music therapy for mental illness (Gitman, 2009).

Recently, adventure therapy was successfully used for prevention, early intervention and treatment modality for youth with behavioural, psychological and psychosocial issues (Lambert & Ogles, 2004). To the Association for Experiential Education (2012), adventure therapy utilises an eclectic therapeutic approach by drawing on aspects of cognitive-behavioural, systemic, existential, and psychodynamic and occupational therapy. In one instance reported by Norton, Carpenter, & Pryor (2015), Wilderness Adventure Therapy (WAT) outcomes based on participants' pre-program, post-program, and follow-up responses to self-report questionnaires with sample of 36 adolescent out-patients, with mixed mental health issues who completed a 10-week, manualised WAT intervention. The overall result indicated short-term standardised mean effect size that was small, positive, and statistically significant (0.26), with moderate, statistically significant improvements in psychological resilience and social self-esteem.

Total short-term effects were within age-based adventure therapy meta-analytic benchmark 90% confidence intervals, except for the change in suicidality which was lower than the comparable benchmark. The short-term changes were retained at the three-month follow-up, except for family functioning (significant reduction) and suicidality (significant improvement). For participants in clinical ranges pre-program, there was a large, statistically significant reduction in depressive symptomology and large to very large, statistically significant improvements in behavioural and emotional functioning. Recorded by Norton, Carpenter, & Pryor, (2015), the changes were retained at the three-month follow-up. The American Psychological Association also ascribed to the evidence of psychotherapy treatments (APA Presidential Task Force on Evidence-Based Practice, 2006).

Following the writer's experience, school psychologists and counsellors in Nigeria context have not fully key into the use of psychotherapy as in line with professional demand especially when compared with developed countries such as America where psychotherapy is seen and offered as part of health demand for their citizens. In view of this, key variables that frequently interfere with successful use of psychotherapy based on empirical data were discussed with the intent that at the end, they will gear up the school psychologists and counsellors to see more reasons why they need to embrace the application and use of various psychotherapy interventions and treatments. The conceptualized variables of this write up include:

**Negative Therapeutic Alliance**: Starting from Glass & Myers (2001); Koocher (2008); Behar, Friedman, Pinto, Katz & Jones (2007); Bettmann & Jasperson (2009); Russell (2007); Russell (2006); Meyer (2007); Koocher (2008); Glass & Myers (2001); Gillis, Gass & Russell (2008), Davis & Berman, (2008), and Akinade (2012), definitions of therapeutic alliance according to consensus opinions, applicable to any therapeutic approach and for these reasons, therapeutic alliance is viewed as the "pan-theoretical concept that involves formulation which underlines the collaborative relationship between patient (youth-client) and therapist (school psychologist or counsellor) in the common fight to overcome the youth-client's suffering and self-destructive behaviour. Therapeutic alliance consists of three essential elements:

- Therapist and Client agreement on the goals of the treatment,
- Therapist and Client agreement on the tasks and,
- The development of a personal bond made up of reciprocal positive feelings between therapist and client.

It should be noted that throughout psychotherapy processes, once optimal therapeutic alliance is not created and achieved there is no miracle that can produce success on the parts of therapist and client. The moment client and therapist cannot share beliefs with regard to the goals of the treatment and view the methods used to achieve these as efficacious and relevant, interventions cannot be successful. This was why Bettmann & Jasperson (2009); Russell (2007); Russell (2006); Meyer (2007); Koocher (2008); Glass & Myers (2001) and Akinade (2012), all believed that client and therapist must accept to undertake and follow through their specific tasks. Agreement on the goals of treatment and agreement on the tasks will only develop if there is a personal relationship of confidence and regard, since any agreement on goals and tasks requires the client to believe in the therapist's ability to help and the therapist in turn must be confident in the client's resources. Majority of psychotherapists such as Norton, Carpenter, & Pryor, (2015), Johnson et al., (2005) and Crowe & Grenyer (2008) discovered that therapeutic alliance influences intervention outcomes and that interventions not healing in its own right, but as an ingredient which enables the patient to accept, follow, and believe in the treatment. This conceptual interpretation gives an alternative to the previous dichotomy between the therapeutic process and intervention procedures, considering them interdependent (Glass & Myers, 2001; Koocher, 2008; Behar, Friedman, Pinto, Katz & Jones, 2007).

Establishing therapeutic alliance in group therapy or intervention slightly differ from individual therapy. One conceptualization of therapeutic alliance in group psychotherapy first is that in group psychotherapy there are multiple therapeutic agents. For example, in some group settings we may have two co-therapist, the members of the group, and the group as a whole. Thus, we have to consider more than one relational level within the group: member to therapist alliance (the same as individual therapy), member to member alliance, group to therapist alliance, and member to other members as a whole alliance. Under this complexity of adapting the alliance concept to a group context, some authors have found a solution the systemic model of alliance (Gillaspy, 2002 and Johnson et al., 2005). The systemic model of therapeutic alliance according to these authors was in congruence with multiple interpersonal subsystems. These subsystems involve (a) a self-to-therapist alliance, (b) group-to-therapist alliance, (c) self-to-members alliance, and (d) other-to-therapist alliance. Under this point of view, an alliance can be conceptualized as the totality of the alliances formed (Gillaspy et al., 2002; Johnson et al., 2005; Cuijpers, et al., 2008, Lambert, 2004; Karver, et al., 2006; Norcross, 2011; Shirk & Karver, 2003 and Wampold, 2007).

**Inappropriate Identification of Youth-clients' Personal Characteristics:** Personality characteristics of the youth client significantly influence the failure or success of any psychotherapy intervention. Many at times, chosen psychological intervention and school psychologist failed to attain client or treatment goal due to improper diagnoses or identification of client personality make up. In most instances, non-successful psychotherapy interventions were traced to failure of school psychologist or counsellor to consider client's characteristics and context. Youth-client characteristics consist of culture, race, ethnicity, spirituality, sexual orientation, age, physical health, motivation for change, gender and others whereas the context involves the type of family and support networks, vocational status, cultural milieu, and concurrent services such coordination and cooperation of the school psychologist with agents like psychiatric, case management, physical and social services (Barlow, 2004; Hollon, Stewart, & Strunk, 2006; Imel, Malterer, McKay, & Wampold, 2008 Wampold, 2010).

In many non-successful psychotherapy interventions, youth-client personality, and status might have failed to interact with those of the client, in terms of the client's reaction to the therapist, the therapist reaction to the client, and to their interaction (Wampold, 2010). Variations in level of success in psychotherapy interventions outcomes were also significantly influenced by youth-client characteristics such as chronicity, complexity, social support, and intensity and by therapist and context factors than by particular diagnoses or specific intervention (Behar, Friedman, Pinto, Katz & Jones, 2007).

**Personal Characteristic of the School Psychologist:** School psychologist or counsellor that is unaware of his or her own psychological processes and allow self-own process or own material into the therapy process without the need for such in therapeutic process may continue to record failure in his or her therapy interventions. The therapist needs to constantly monitor or analyse his or her own reaction to the youth-client. This process may be used to determine if these reactions are reasonable given the youth-client presentation or are based on school psychologist issues (APA Presidential Task Force on Evidence-Based Practice, 2006 and APA Continue Education in Psychology, 2010).

Similarly, School psychologist that failed to be aware of the best research evidence related to the particular youth-client, in terms of treatment, problems, social context. Failure to understanding the biological, social, and psychological bases of the disorder or problem experienced by the youth-client, sophisticated set of interpersonal skills, including verbal fluency, interpersonal perception, affective modulation and expressiveness, warmth and acceptance and empathy, persuasive and convincing may continue to record failure in therapy intervention offered (APA Presidential Task Force on Evidence-Based Practice, 2006 and APA Continue Education in Psychology, 2010). Research evidence also suggests that failure of the school psychologist to identify ways of improving different forms of psychotherapy by

attending to how to fit the interventions to the particular youth-client's needs may continue to record no-success (Norcross, 2011 and Aminu & Williams, 2012).

Another segment of the school psychologist's personal characteristics that may be implicated in recorded cases of non-successful psychotherapy interventions is failure to continually improve and develop ones therapy skill toward intensive practice with model based feedback, conferences, collaborations, inquiries, investigation and feedback on the progress of clients. These processes enables the school psychologist make specific changes and determine the outcomes that were produced by such changes are critical to improvement but the feedback is most useful if imbedded in a coherent model of therapy so that the individual providing therapy intervention can make specific changes and determine the outcomes produced by such changes. Therefore, school psychologist who cannot achieve expected or more than expected progress with their youth-clients generally will continue to record failure in the provided therapy intervention (Duncan, Miller, Hubble & Wampold, 2010).

**Nature of Youth-client Needs/Problems:** Inability of the school psychologist providing therapy intervention to provide an intervention plan that is consistent with the explanation provided to the client or by the client. Once the client accepts and identify a gap or no connection between his explanation or the school psychologist's explanation and the intervention plan thus, failure will be obtained. School psychologist that failed to keep improving in the field of psychotherapy processes may lack experience to manage youth-client explanation or nature of need to selecting appropriate therapy intervention. But if the client explanation has congruence with the intervention plan, the process will make sense and client compliance will be increased. As it is popularly claimed in psychotherapy field, the intervention plan must involve healthy actions—the effective psychologist facilitates the youth-client to do something that is in their best interest; different treatment approaches involve different actions, but the commonality is that all such actions are psychologically healthy (Hollon, Stewart, & Strunk, 2006 and Imel, Wampold, Miller & Fleming, 2008).

**Inability to Control Dropout during Psychotherapy Intervention Processes:** School psychologists who are unable to control youth-client dropout during intervention proceedings may end up having incomplete and no satisfactory results. For example, Jamie (2015) discovered that 20% of youth clients end therapy prematurely. As it was rightly said by leading experts in the field of psychotherapy that reducing dropout is arguably the best way psychotherapists, and school counsellors can boost their effectiveness, since studies show that clients who terminate therapy early have poorer outcomes compared with clients who complete treatment (Barrett, Chua, Crits-Christoph, Gibbons & Thomspon, 2008 and Swift, Greenberg, Whipple & Kominiak, 2012). "Even the most expert therapist using treatments with the strongest empirical support cannot be effective if patients drop out of treatment prematurely," (Pope & Keith-Spiegel, 2008). Therefore, school psychologist's ability to reduce rates of drop out will increase the rates of completed intervention and thereby, may lead to successful intervention outcomes. Youth-client that failed to complete duration of treatments is similar to a malaria patient that failed to complete anti-malaria treatment.

**Possible Breach of Psychotherapy Professional Boundaries:** Psychotherapy ethics for psychotherapists / school counsellors are presently discussed under the concept "professional boundaries or boundaries between therapists/school psychologists and clients" (Pope & Keith-Spiegel, 2008; Zur, 2017 and Barnett, 2017). To Zur, (2017), boundaries between therapist and client come in many forms. For instance, from crisp to fuzzy and this may exist in various influential contexts; crossing them has many potential effects. For Pope & Keith-Spiegel (2008) noted, "Nonsexual boundary crossings can enrich psychotherapy, serve the treatment plan, and strengthen the therapist-client working relationship. They can also undermine the therapy, disrupt the therapist-client alliance, and cause harm to clients".

Experts in psychotherapy intervention understand that one cannot possibly avoid all nonprofessional interactions with one's clients especially, in the context of establishing emotionally meaningful relationships, very often regarding intimate matters that the client has not spoken of to anyone else but the school psychologist providing intervention must be cautious of the boundaries as exploitation is not the only harmful result of boundary crossings. For instance, it was said that, "the professional therapeutic relationship is secured within a reliable set of boundaries on which both therapist and client in particular can depend" (Pope & Keith-Spiegel, 2008). Whenever ethical boundaries blur during therapy process, conflicts which are more likely to arise include negative therapeutic alliance, disinterest (as opposed to lack of interest) and sometimes legal issues and non-successful therapy result outcomes. In short, the therapy relationship should remain a safe sanctuary (Barnett, 2017).

**Recommendations**

The school psychologist continuously aiming at successful psychotherapy interventions with their youth-clients, the following steps will be useful:

i. To improve or change negative therapeutic alliance: School psychologist providing psychotherapy interventions or treatments needs to make conscious efforts to sustain objectivity by actively avoiding any interaction or discourse outside of therapeutic issues and relationship.
ii. To prevent youth-client dropping out of psychotherapy interventions: Youth-client distinct needs, problems and treatments should be constantly monitored and evaluated. School psychologist providing intervention need to constantly build hope in their client. For example, from beginning to the end of each stage of intervention or therapy the psychologist may talk about the end of therapy and the possible gain to derive. This technique promotes the expectation of the client and the therapist will be able to address the problems, take care of things, gives a goal to work toward right from the beginning. Similarly, it makes youth-client adjusts their expectations to something reasonable and it reminds them that in may be so and so duration of period the goal will be achieve.
iii. Another strategy of preventing youth-client dropping out of psychotherapy interventions is for the school psychologist providing intervention, the need to talk with the client about the possibility that the client may think about dropping out and that it can be helpful if the client discuss it with the psychologist. This approach prevents and allows the youth-client to feel free because at some point the client may have that feeling and decides to act on it or feel bad about bringing it up. But if the school psychologist starts by opening up that possibility, it later frees the youth-client up to talk about it when those feelings do arise and they can together resolve any reason to be given by the client. Another strategy to keep clients away from dropping out of interventions or treatments is to engage them by playing a role in choosing the type of intervention or treatment the youth-client will get, why this is important and what the challenges to putting it into practice are.
iv. To avoid breach of possible professional boundaries: From the beginning of interventions and treatments, the school psychologist providing intervention may honestly and sincerely have discussions with the youth-client on boundaries that is, ethical issues. When school psychologist from initial stage discusses boundaries with the client, the psychologist will achieve initial informed consent. This consent is highly recommended. The psychologist should be familiarised and guided by the youth-client's cultural traditions, faith, gender, geography such as rural and urban, semi-urban and semi-rural setting, personality and vulnerabilities and other peculiarities. In situations where psychologist relationship with the youth-client become complex, the suggested strategy is that the school psychologist educates clients on boundary issues.
v. To avoid inappropriate identification of youth-client personal characteristics: Before staring any psychotherapy intervention or treatment, school psychologist needs to possess a competent skill that will always be used to match selected intervention, treatment, style and technique to a given youth-client's needs. For instance, Barrett et al. (2008) observed that ability to select appropriate

psychotherapy intervention, treatment, style or technique requires a clear vision, unencumbered by the psychologist personal agendas and problems. For example, school psychologist experiencing stress, for example, can spiral downward to distress, then impairment, and finally improper behaviour during intervention process (Jamie, 2015; Aminu, 2010; Aminu & Williams, 2012; Aminu & Ogidan, 2014; Aminu, 2016; Aminu, 2017a and 2017b, Barrett, Chua, Crits-Christoph, Gibbons & Thomspon, 2008; Swift & Greenberg, 2012; Swift, Greenberg, Whipple & Kominiak, 2012).

**Conclusion**

Following empirical evidences, psychotherapy interventions and treatments are significantly effective and there is no specific evidence that one form of intervention is better than another, but there are convincing evidences to show that therapists who established warm and positive therapeutic alliance, appropriately identify personal characteristics of the client and their needs before selection of intervention or treatment and personal competence of the therapist, ability to control dropout during intervention processes and for the therapist to be mindful and cautious of psychotherapy professional boundaries; proves the efficacy and recorded successes in psychotherapy interventions and treatments.

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