ESSENTIAL RESEARCH FINDINGS IN CHILD AND ADOLESCENT COUNSELLING AND PSYCHOTHERAPY
THERAPY OUTCOMES: WHAT WORKS FOR WHOM?

PETER FONAGY, LIZ ALLISON AND ALANA RYAN

This chapter discusses

• What we mean by evidence-based practice
• The evidence base for the treatment of different kinds of childhood problems with different forms of psychological therapy
• The limits of our knowledge about what works for whom
• The implications of the evidence base for clinical practice and research

Introduction

While the evidence base for what works for whom remains limited, there is an increasing body of research that clinicians can draw on to inform their practice with children and young people. In order to make the best use of the information that is available, it is important both to be familiar with the existing evidence and to be aware of its limitations.

What do we mean by evidence-based practice?

We need to begin with a caveat. Evidence-based practice (EBP) cannot be assured by ‘choosing’ a treatment from a list of approved options. Historically, there has been a tendency to assume that a treatment can be ‘branded’ once and for all as an EBP so
that no further reflection on how, or for whom, to implement it is needed. It is extremely important to avoid idealizing evidence in this way. While the existence of evidence increases the chances of a treatment being effective, it does not guarantee success. Reviews of the empirical literature aim to identify what works, but systematic study of the literature actually reveals that many of the people who receive evidence-based treatments experience no change. It is very important that our statements about the effectiveness (or ineffectiveness) of particular approaches in this chapter are read with this caveat in mind. Research on the features of practising evidence-based care in mental health has identified that in addition to being consistently science-informed, it is organized around client intentions, culturally sensitive (it considers the context in which the clinician is practising relative to the context in which the evidence was originally gathered), and continually monitors the effectiveness of interventions, adapting as necessary to serve the client better [APA Presidential Task Force on Evidence-Based Practice, 2006; Spring, 2007]. This chapter focuses on the first item in this set of components, but it should not be forgotten that the latter require an active stance on the clinician’s part (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). For example, the endpoint for a given treatment will be more appropriately determined by ongoing assessment of outcome for a particular child than by the average length of treatment derived from a number of randomized controlled trials (RCTs; see Box 5.8) [Daleiden & Chorpita, 2005].

How can child and adolescent counsellors and therapists use this chapter?

While it may not be necessary to read through this whole chapter, when thinking about setting up a service, or when a new referral comes in, the practitioner may want to look at the relevant section of this chapter before considering treatment recommendations. The findings reported here should then of course be considered alongside other factors informing the practitioner’s judgement, such as client preference.

Overview of the evidence for the treatment of childhood problems with psychological therapies

Below we briefly review the evidence for the use of psychological therapies to treat a range of diagnosable childhood disorders. We also consider evidence for the psychological treatment of the difficulties associated with experiences of maltreatment.

Box 5.1 Defining mental health problems in childhood

This chapter is organized according to DSM-IV (American Psychiatric Association, 1994) rather than DSM-5 categories (American Psychiatric Association, 2013) because the
What works for whom?

Research literature we are considering has mostly used the former. However, there is current controversy about the validity of DSM diagnostic categories which cannot easily be dismissed (see, for example, Cuthbert & Insel, 2013). Specifically, many within the research community have acknowledged that using the outcomes data from short-term, highly controlled interventions with somewhat arbitrarily defined client groups to inform the design of the services provided for a set of long-term, quite heterogeneous conditions, is problematic. Similarly, others have challenged the hegemony of medical diagnoses, noting that adherence to strict diagnostic criteria is not the only way we can define a problem. In any setting, we encounter a child, not a diagnosis, and they may not fall neatly into a particular diagnostic category. These issues have also led to the emergence of alternative definitional approaches such as the National Institute of Mental Health’s Research Domain Criteria (RDoC) project, which aims to develop a more integrative research classification system for mental disorders. This system is based on dimensions of neurobiology – which considers how the nervous system influences cognitive and behavioural patterns – and observable behaviour that cuts across the current diagnostic categories.

Anxiety disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
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<tbody>
<tr>
<td>Generalized anxiety disorder (GAD)</td>
<td>A form of anxiety which can be triggered by many different things and which can occur on a daily basis. It can be longer-lasting than other anxiety subtypes.</td>
</tr>
<tr>
<td>Social anxiety disorder (SAD)/Social phobia (SP)</td>
<td>A form of anxiety prompted by a persistent and intense fear of day-to-day social situations. It can result in the person being unable to participate in social events or peer group activities.</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder (OCD)</td>
<td>A form of anxiety disorder which is characterized by the presence of inescapable unpleasant thoughts and urges which are temporarily relieved by the repetition of certain routines or processes.</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>An anxiety disorder which manifests following a particularly stressful or alarming experience. Symptoms can include continuous re-experience of traumatic memory, insomnia, irritability and unwillingness to address and process the traumatic memory.</td>
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Cognitive behavioural therapy (CBT)

Meta-analyses offer strong support for CBT as a good place to start when considering how to treat anxiety (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; In-Albon & Schneider, 2007; Ishikawa, Okajima, Matsuoka, & Sakano, 2007; James, Soler, & Weatherall, 2005), although it should be noted that RCTs in which CBT was compared with a credible alternative treatment are relatively scarce.
Box 5.2  Why meta-analysis?

In a given study, the size of the sample has a substantial impact on the likelihood of finding a statistically significant difference between treatment and control conditions. Meta-analyses pool multiple studies and summarize outcomes by plotting and aggregating the differences between the means obtained in treatment and control conditions. This method substantially increases the reliability of the estimate of the likely size of treatment effects even when the studies on which it is based are relatively small. For this reason, in this chapter we often consider available meta-analyses before turning to individual studies. However, it should be kept in mind that if there is a limited evidence base or significant heterogeneity among studies, meta-analytic estimates should be treated cautiously.

Children and young people with generalized anxiety disorder (GAD), social anxiety disorder (SAD) or social phobia (SP) who are treated with certain CBT packages, such as Coping Cat, Coping Koala and FRIENDS, improve more than those on a waiting list for the same treatment (Kendall, 1994; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Lau, Chan, Li, & Au, 2010; Silverman, Kurtines, Ginsburg, Weems, Lumpkin, & Carmichael, 1999). These programmes aim to help children and young people recognize anxiety warning signs, while also teaching relaxation and resilience strategies. Coping Cat has two main parts: skills training and skills practice, and involves one-to-one work with a therapist. Coping Koala and FRIENDS are programmes which bring many children together to work with a therapist in a group setting. By working as part of a team, Coping Koala and FRIENDS enable children to share common experiences and develop ways to beat anxiety collectively. In fact, research shows that about 50–60 per cent of those treated with these programmes are likely to recover. Studies of Coping Cat have shown that its effects last for up to a year, and possibly even longer (Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Kendall et al., 2008). However, this kind of treatment for anxiety does not seem to reduce the risk of developing a mood disorder (anxiety or depression) later in life. We do not know very much about how CBT performs when compared with an attention placebo, that is, an alternative control treatment which is akin to CBT in terms of time and effort, but which has no therapeutic value or treatment as usual (TAU), namely the care routinely offered for the person’s condition in a community clinic. The few studies that have been done so far suggest that its effects may be much smaller than when it is compared with a wait-list control (Barrington, Prior, Richardson, & Allen, 2005; Southam-Gerow, Weisz, Chu, McLeod, Gordin, & Connor-Smith, 2011). When CBT treatment takes place in a community clinic, it may not be significantly more effective than usual treatment, but there are not enough studies to be sure about this, and usual treatment probably includes many of the effective components of CBT.

Group CBT appears to be as effective as individual CBT and is cheaper (Liber et al., 2008; Manassis et al., 2002). Individual CBT may possibly be better at improving depression and other internalizing disorder symptoms (i.e. non-verbalized negative mood patterns which can also manifest as withdrawal, somatic problems and anxiety) (Saavedra, Silverman, Morgan-Lopez, & Kurtines, 2010), but more studies are needed to confirm whether this is the case. While we do not know whether involving families in individual and group CBT leads to better or worse outcomes, or makes no difference, there is evidence to suggest that when parents themselves are very anxious, involving them in the child’s treatment can be helpful.
What works for whom?

[Cobham, Dadds, & Spence, 1998]. Indeed, recent analysis suggests that for children aged nine or younger, training the parents in CBT methods may be just as effective as child-focused CBT [Waters, Ford, Wharton, & Cobham, 2009].

CBT can be made more accessible in various ways, including bibliotherapy and computerized CBT (cCBT), sometimes enhanced with telephone or email contact. While the first method encourages the young person to explore specific texts which may boost resilience to anxiety, the second approach uses short online courses to help children and young people and their families learn specific coping techniques. Neither treatment necessitates seeing a therapist, yet treatment effects have been maintained for up to a year [Spence et al., 2011]. We need to know more about how cCBT compares to clinic-based CBT for young people with anxiety. One study has suggested that it is just as effective [Spence et al., 2011], although only about a third of the young people recovered. Clearly, more research is needed. Giving teachers, nurses, parents and the affected children themselves a role in delivering treatment also increases its accessibility [e.g. Galla et al., 2012].

However, CBT may not work for everyone with an anxiety disorder. The existing evidence suggests that it may be less effective with more severely affected and less well-supported children [e.g. Southam-Gerow, Kendall, & Weersing, 2001]. Its effectiveness also depends on the quality of the service, and it is unlikely to work if delivered by clinicians who have not received adequate training.

The effects of CBT for obsessive-compulsive disorder (OCD) have been shown to last for as long as six to nine months after the end of treatment [e.g. Piacentini et al., 2011]. Less input from the therapist may be needed when the treatment includes use of client workbooks [Bolton et al., 2011]. CBT is less likely to work for children and young people with a family history of OCD, unless they also receive antidepressant medication, such as selective serotonin reuptake inhibitors (SSRIs) [Garcia et al., 2010]. We do not yet know for sure how large an impact we can expect CBT to have on OCD in children and young people. It appears possible that as few as 12 sessions of CBT can have a modest impact on OCD, and that daily sessions over a short period may be as effective as weekly sessions over several weeks [Storch, Lehmkuhl, Ricketts, Geffken, Marien, & Murphy, 2010], but more studies are needed to confirm these suggestions. It may be possible to deliver CBT for OCD effectively in ordinary clinical settings [Williams, Salkovskis, Forrester, Turner, White, & Allsopp, 2010], although its effects may be somewhat reduced; but again more research is required to substantiate this.

Trauma-focused CBT (TF-CBT), which uses cognitive and behavioural techniques to help children overcome traumatic experiences, is an effective treatment for post-traumatic stress disorder (PTSD) [Cary & McMillen, 2012], especially in treating trauma in sexually abused children and young people.

Several other therapies that use different components of TF-CBT also seem to be more effective than no treatment, including short-term cognitive processing therapy, which aims to help those who have experienced a trauma understand how this experience has affected their day-to-day lives, while also providing practical advice on how to manage their emotions [Ahrens & Rexford, 2002]. The feasibility of treating children as young as three with TF-CBT has been explored [Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011], but there is not enough evidence yet to be confident that this is a reasonable approach.

School-based CBT programmes for children and young people exposed to violence, such as the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), have been shown to produce small but significant effects [Kataoka et al., 2003; Stein et al., 2003]. CBITS can be administered either by clinically trained professionals or
by school personnel without clinical training. It may be that while school-based treatments such as CBITS are more accessible than TF-CBT, they are somewhat less effective; but more research is needed to determine whether this is the case.

We do not know whether or not narrative exposure therapy (NET), which is based on the narrative exposure component of TF-CBT, is effective. The studies conducted so far have produced conflicting results (Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; Schaal, Elbert, & Neuner, 2009).

Other behavioural therapies

Simple phobias, such as an irrational fear of school, can be treated effectively by in vivo exposure (Roth & Fonagy, 2005), that is, receiving a gradual introduction to that which is feared. However, educational support may be just as effective (Silverman et al., 1999). School refusal can also be effectively treated by exposure (Last, Hansen, & Franco, 1998). Social effectiveness therapy (SET), a behavioural therapy programme which combines exposure with social skills training, is an effective treatment for social phobia (e.g. Beidel, Turner, & Young, 2006), and one study suggested that it was significantly more effective than SSRI treatment (with fluoxetine) (Beidel, Turner, Sallee, Ammerman, Crosby & Pathak, 2007). It is possible that SET may be slightly more effective than CBT for social phobia, but this hypothesis needs to be tested.

Exposure and response prevention (ERP) supported by cognitive interventions is an effective treatment for OCD. ERP works by breaking the association between the young person’s obsessive thoughts and the subsequent behavioural compulsions which arise due to their stress or anxiety (Lewin, Storch, Geffken, Goodman, & Murphy, 2006).

We do not know whether eye movement desensitization and reprocessing (EMDR) for trauma symptoms in children and young people is effective (Field & Cottrell, 2011).

Psychodynamic psychotherapy

When psychodynamic psychotherapy is offered to parent and child (i.e. to families) rather than individual children, it can be effective (Lieberman, Van Horn, & Ghosh Ippen, 2005), especially where maltreatment or family trauma is involved (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011). Individual psychodynamic psychotherapy may be helpful for younger children with anxiety disorders (Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003). Apart from these exceptions, we do not know whether or not psychodynamic therapies for children and young people with anxiety disorders are effective.

Box 5.3 Difficulties with evaluating psychodynamic psychotherapy

Psychodynamic psychotherapy is quite widely used, especially to treat children with entrenched and complex problems who have not responded to treatments for which there is a stronger evidence base, yet there have been few attempts to evaluate its effectiveness.
systematically (as is also the case with humanistic therapy and counselling), and the available studies often do not meet the methodological standards applied to the evaluation of much briefer and more goal-directed therapies. This is partly because of the complexities of designing such studies and partly because of their much greater costs. Until recently, child psychotherapies have rarely been manualized, and therefore grouping studies according to clinical method has not been possible. Studies of psychodynamic therapy have also tended to be less rigorous in identifying the diagnostic categories they address, or else have decided that it is not a fit with the model to design their research in relation to psychiatric diagnoses. Almost all studies of ‘internalizing’ children and young people consider a mixed group of anxious children with SAD, GAD, SP and OCD, with a limited number whose primary diagnosis may have been depression. In our subsequent discussions of treatments for specific diagnoses readers will note that often there is no mention of psychodynamic or humanistic approaches; this is because of the lack of available good quality evidence on whether or not they are effective for the problems we discuss.

Depression

Cognitive behavioural therapy

Whether it is provided individually or in a group setting, CBT appears to be an effective treatment for depression in young people (Munoz-Solomando, Kendall, & Whittington, 2008; Weisz, Jensen-Doss, & Hawley, 2006), although brief CBT does not reduce the chance of experiencing a subsequent episode (Birmaher et al., 2000). While many people suffering from depression do benefit from CBT, we do know that it is less likely to be of assistance to some. For instance, it is less effective where there are high levels of family conflict (Birmaher et al., 2000), where there is a history of sexual abuse (Barbe, Bridge, Birmaher, Kolko, & Brent 2004), or where cases are particularly complex, for example, where an adolescent is showing symptoms of emerging personality disorder (Birmaher et al., 2000). However, differences between CBT and other active treatments tend to disappear in longer-term follow-up studies (Birmaher et al., 2000). We do not know whether booster sessions of CBT improve outcomes, as different studies have reached different conclusions about this (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Kroll, Harrington, Jayson, Fraser, & Gowers, 1996).

There is strong evidence for two particular CBT programmes: a highly structured, group-based intervention for depressed pre-adolescent girls (9–13 years) called ACTION (Stark, Hargrave, Hersh, Greenberg, Herren, & Fisher, 2008), and the Coping with Depression (CWDA) course for older teenagers (Clarke, Lewinsohn, & Hops, 1990). Both programmes are also effective with sub-threshold cases of depressive disorder (Beardslee et al., 2013; De Cuyper, Timbremont, Braet, De Backer, & Wullaert, 2004). Another version of CBT, the Pittsburgh programme, has been found to be more beneficial in the short-term than family therapy or more general therapy (Brent et al., 1997); the research undertaken to evaluate the Pittsburgh programme also found CBT to be less effective for individuals with a history of sexual abuse (Barbe et al., 2004) but more effective for those experiencing suicidal thinking (Birmaher et al., 2000). It is unclear whether or not the Manchester programme of CBT for depression – a CBT manual which emphasizes explicit, tangible and shared goals, developed through
clear structured sessions – is effective. Although the initial results of the programme were promising, especially for younger or less severely affected children and young people, a larger trial found that it brought no extra benefit when used in addition to the use of the SSRI fluoxetine (Goodyer et al., 2008).

Adopting a CBT approach to patient case management, i.e. ensuring that support for individuals with depression in community settings draws on some of the principles of this form of therapy, has been shown to improve outcomes in primary care [e.g. Lusk & Melnyk, 2011]. Furthermore, applying CBT principles may also reduce the risk of depression. cCBT packages seem to produce comparable results to face-to-face counselling in the short-term at least [Merry, Stasiak, Shepherd, Frampton, Fleming, & Lucassen, 2012], but more studies are needed to confirm this.

Interpersonal psychotherapy

There is some evidence that therapy that is orientated towards the child or young person’s relationships and their effect on mood; for example, interpersonal psychotherapy for adolescents [IPT-A], may be effective. However, when IPT-A is compared to other psychological treatments rather than attention placebo or minimal treatment, the results are not exceptional – it comes out as roughly as effective or slightly less effective [Rosselló & Bernal, 1999; Rosselló, Bernal, & Rivera-Medina, 2008]. IPT-A may be better than CBT for more severe depression in some contexts [Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010], but more studies are needed to confirm this.

Family therapy

Family therapy is more effective than non-directive supportive therapy, but seems less effective than CBT [Brent et al., 1997]. Attachment-based family therapy (ABFT), a form of therapy which focuses on intra-familial relationships with the aim of fostering a secure filial bond, may be particularly helpful with young people with severe levels of suicidal thinking [Diamond et al., 2010] – a group that has been observed to do poorly in conventional counselling. Multifamily psychoeducational approaches – structured programmes which provide families with information about specific disorders and skills training regarding how best to cope with them – may be more effective than doing nothing [Fristad, Verducci, Walters, & Young, 2009].

Psychodynamic psychotherapy

Psychodynamic psychotherapy may be better than doing nothing for young people with depression [Muratori et al., 2003] and may be as effective as systemic family therapy [Trowell et al., 2007], but more research is needed to confirm these suggestions. An adaptation of parent–child interaction therapy (PCIT), which draws on attachment theory in order to foster a safe and supportive relationship between parent and child, may be beneficial for pre-adolescent depression, but, again, further research is needed to confirm this [Lenze, Pautsch, & Luby, 2011].

Although we know that these different psychological therapies can, to varying degrees, have positive effects on childhood depression, a recent Cochrane review has
concluded that there is still not enough evidence to say whether psychological therapies, antidepressants or a combination of the two is most effective for treatment of the disorder (Cox et al., 2014).

Non-directive supportive therapy

Following a systematic review of the literature, the NICE Guideline for the treatment of depression in children and young people recommended non-directive supportive therapy, which would include person-centred or humanistic approaches, as part of its stepped care model, recommending it for the treatment of mild depression without significant comorbid problems or signs of suicidal thoughts, if it still persists after a period of watchful waiting (National Institute for Health and Clinical Excellence, 2005). This recommendation was based on studies (Brent et al., 1997; Vostanis, Feehan, Grattan, & Bickerton, 1996) in which non-directive supportive interventions were used as comparators in studies of family therapy and CBT. Children and young people in these groups were found to benefit, and this recommendation still stands in the updated recommendations issued in 2015.

Conduct disorder

<table>
<thead>
<tr>
<th>Oppositional defiant disorder (ODD)</th>
<th>Oppositional defiant disorder is characterized by a persistent pattern of defiance, anger and irritability when the child is confronted with authoritative figures, such as parents or teachers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct disorder (CD)</td>
<td>Unlike ODD, conduct disorder entails violation of others’ basic rights or of age-appropriate social norms or rules. CD may be diagnosed on the basis of aggressiveness to people and animals, property destruction, deceptiveness or theft and/or serious rule violations.</td>
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</table>

Treatment for children under 11

Parent training

Given that social and familial environments can have a profound effect on the development or continuity of many mental health issues, therapy for parents which highlights how best to respond to their child’s difficulties can be very beneficial. This is particularly true for conduct disorder (CD), for which parent training has been found to have a positive impact on children’s behaviour (Drugli, Larsson, Fossum, & Morch, 2010). Training can be applied to a wide range of conduct problems and delivered effectively in various settings. However, it does not work for everyone, and while families at greatest risk often do respond to parent training, a substantial subgroup of families are not suited to this type of treatment and are likely to drop out (Fernandez & Eyberg, 2009; Hutchings, Bywater, Williams, Whitaker, Lane, & Shakespeare, 2011).

Parent training may be more effective if the child does not have other mental health difficulties, when the conduct problems are less severe, when the family has fewer socio-economic disadvantages, and when the parents are together and
parental conflict and stress is low (Lundahl, Risser, & Lovejoy, 2006; Reyno & McGrath, 2006). Similarly, if the parents have high levels of social support and no history of antisocial behaviour or psychiatric difficulties themselves, a better outcome may be observed. More research is needed to confirm all these suggestions, however. It is unclear whether the effectiveness of parent training can be enhanced by adjunctive treatments, i.e. additional psychological or pharmacological treatment, for higher risk families, as different studies have reached different conclusions about this (Lundahl et al., 2006; National Institute for Health and Clinical Excellence, 2009).

It is also possible for parents to learn the necessary skills themselves, using a method known as self-directed parent training; however, it is unclear whether this is as effective as therapist-led parent training. Supportive evidence primarily stems from studies of parent training as a preventive measure, and requires confirmation in studies using clinical samples (Lundahl et al., 2006). This is especially important as there is also research showing that fidelity to treatment protocol and a high level of therapist skill are important in ensuring the success of parent training (Scott et al., 2010; Webster-Stratton & Reid, 2010).

Specific programmes for which there is evidence of effectiveness are discussed in Box 5.4.

**Box 5.4 Parent training**

Parent training is a behavioural family intervention conducted mainly with the child’s parents, with limited therapist–child contact. Parents are encouraged to focus on prosocial behaviours rather than on the elimination of conduct problems. Treatment packages for which there is an evidence base include:

- **The Incredible Years Program**: a videotape modelling group discussion programme using a standard package of videotapes aimed at parents. The therapist leads a discussion of the interactions shown in short (two-minute) scenes on the videotapes and suggests structured homework exercises, including teaching play and reinforcement skills, effective limit-setting and non-violent discipline techniques, as well as problem-solving approaches.
- **Triple P – Positive Parenting Program**: an intensive parent training programme for parents of children with severe behavioural difficulties or who are at risk of developing such problems. Combines three delivery formats: group (eight sessions for groups of 10–12 parents, with telephone follow-up sessions), individual (10 sessions) and self-directed (a 10-week self-help programme augmented by telephone consultations).
- **Oregon Social Learning Center (OSLC) Program**: links the emergence of antisocial behaviour to coercive patterns of family interaction. Combines group treatment and individual family treatment. Homework is supported with midweek telephone calls aimed at promoting collaborative contact. Aims to replace coercive interactions with positive practices in five dimensions: (1) skill encouragement (scaffolding), (2) limit-setting, (3) monitoring of activities, whereabouts, peer contacts, etc., (4) problem-solving and (5) positive involvement (showing love and interest).
- **PCIT**: a two-phase therapy programme designed to teach parents to build a warm and responsive relationship with their child and to teach the child to behave appropriately. In the first phase (child-directed interaction), parents learn non-directive play skills.
similar to those used by traditional play therapists. The aim is to change the quality of the parent–child relationship. In the second phase (parent-directed interaction), the parent learns, within the play interaction, to direct the child’s play with clear, age-appropriate instructions. The emphasis is on consistent consequences, praise for compliance, and time-out for non-compliance.

While parent training can be a very powerful tool that works across cultures and different ethnic communities, it requires considerable involvement from the families concerned, and this can make it harder to get parents either to take up the treatment or to continue with it. For particularly ‘hard-to-reach’ or disadvantaged families, delivering parent training on a flexible, one-to-one basis rather than in a group setting produces better results [Lundahl et al., 2006]. Improving positive parenting rather than reducing harsh or negative parenting is the most important factor in improving problem behaviour.

We do not know enough about how improvements in CD are maintained in the long-term following parent training. It seems that the programmes requiring the greatest input and commitment from both therapist and client/family are most likely to result in a long-term improvement, but we do not have enough evidence on whether intervening with parent training programmes might make the child less likely to become involved in criminal activity or substance use in adolescence [Lochman, Wells, & Lenhart, 2008; Lochman & Wells, 2003]. More long-term follow-up studies are needed on all children with CD.

We also need more evidence as to whether it might be more effective to combine parent training with CBT for the child than to use either approach on its own, particularly in the case of children who have not benefited from parent training [Lochman, Boxmeyer, Powell, Barry, & Pardini, 2010; National Institute for Health and Clinical Excellence, 2009].

**Box 5.5  Defining evidence-based treatments: General or specific?**

Labels such as ‘parent training’ or ‘CBT’, attached in the mind of a reader to the conclusions of a study, will no more describe the content of the intervention than the label ‘holiday’ is likely to predict a family’s experience of a specific summer vacation. There is a rapidly developing science of adherence measurement, which enables us to assess how closely treatment delivered in a particular context matches the protocol as originally designed. But in order to maintain the integrity of the combination of techniques that a particular EBP entails, there is a tendency to over-specify approaches, which can become a barrier to implementation. This is associated with a potential disadvantage for manualized therapies. When dealing with broad/heterogeneous groups of children exposed to multiple risk factors, such as poverty, poor parental mental health or negative peer influence, as well as children who suffer from multiple, co-occurring mental health disorders (comorbidities), the inflexibility of treatment manuals may prevent clinicians from recognizing and addressing specific issues that exist alongside the core presenting symptom that led to the children’s inclusion in the trial. Treatment as usual, on the other hand, does have that flexibility, and can often be quite good. This makes it harder to demonstrate effectiveness of new interventions.
Cognitive behavioural therapy

CBT appears to be less effective than parent training as a treatment for conduct disorders in children (Bennett & Gibbons, 2000), although one meta-analysis suggested that when CBT was conducted in a clinical setting, the superiority of parent training over CBT was less pronounced (McCart, Priester, Davies, & Azen, 2006).

Cognitive behavioural methods that are designed to increase a child’s self-control [i.e. anger management, social skills training] are moderately effective, although we know this mostly from studies of one particular intensive treatment package, the Coping Power Program, which requires its counsellors to undergo intensive training and needs a parenting component to achieve long-term effects on substance abuse and delinquency (Lochman & Wells, 2004).

Another child-oriented intervention – problem-solving skills training with parent management training, which combines elements of the Oregon Social Learning Center Program with cognitive approaches – improves the child’s behaviour as well as improving family relations and reducing familial stress and parent dysfunction (Kazdin, 2010). These improvements are maintained at one-year follow-up. This intervention is less likely to be effective if the child is suffering from another mental health problem, belongs to an ethnic minority, has lower socio-economic status and/or has impaired cognitive and academic skills (Kazdin, 1997; Kazdin & Wassell, 2000; Kazdin & Whitley, 2006). It is more likely to work if the alliances between therapist, child and parent(s) are good.

Psychodynamic psychotherapy

There are no studies to show that psychodynamic treatments are effective for children with conduct problems. In the few studies available, the rates of improvement for psychodynamic therapy are lower than for other treatments, while the number of sessions needed is higher (Midgley & Kennedy, 2011).

School-based interventions

School-based interventions designed to change how teachers behave will not produce clinically significant improvements in individual children in the absence of other concurrent interventions. While classroom contingency management is helpful in controlling the behaviour of children while in that setting, it does not have a wider effect outside the classroom (Walker, Colvin, & Ramsey, 1995). If parents provide reinforcement by using similar strategies at home, e.g. to manage homework, the effectiveness of classroom-based support for behavioural problems may be enhanced (Forgatch & Ramsey, 1994; Kahle & Kelley, 1994).

School-wide anti-bullying interventions, which may include parent training, improved playground supervision, disciplinary methods, school conferences, videos, information for parents, classroom rules and classroom management, can reduce the amount of bullying that takes place in school (Farrington & Ttofi, 2009). We do not know how effective school-wide anti-bullying interventions are at reducing conduct problems or how many children participating in these interventions have oppositional defiant disorders or conduct disorder diagnoses.

Given that children with conduct problems often have distorted understandings of their social environment, it is possible that social learning theory-based interventions
which modify and expand the child’s interpersonal appraisal processes may be effective, but more research is needed to confirm this (National Institute for Health and Clinical Excellence, 2013).

**Treatment for young people**

**Family-based approaches**

Multimodal treatments combining different components (e.g. individual, family and/or group work) and involving the different systems that form the context for the adolescent’s behaviour (family, school, peers, etc.) and which also have a family focus are the most likely to produce benefits that are maintained in the long-term, if they are well implemented (National Institute for Health and Clinical Excellence, 2013). The most effective of these treatments are intense, well-defined, yet capable of responding flexibly to unexpected situations, and deliver a range of interventions via the same therapist. However, even the most effective of these leave at least half of the young people treated with significant clinical problems.

In terms of specific family-based approaches, we know that multisystemic therapy (MST) is effective, and multidimensional family therapy (MDFT) also has an impact on CD (Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle, Dakof, Henderson, & Rowe, 2011; Office of Program Policy Analysis and Government Accountability, 2007). Both are integrative and comprehensive family-based approaches which can be applied across many different contexts. Aligned to this, a similar 12–17 week programme of brief strategic family therapy, which focuses on the problem behaviours of the child as well as entire family functioning, can reduce behavioural problems (Santisteban et al., 2003). It is unclear whether brief strategic family therapy has a direct impact on delinquency. We do not know for sure whether multidimensional treatment foster care (MTFC) (an approach heavily influenced by the Oregon model, which involves placement with a specially trained foster family along with a package of other treatments) or functional family therapy (FFT, a phased, manualized and time-limited family therapy that aims to achieve changes in patterns of interaction and communication) are effective treatments for CD. Some studies have found benefits whereas others have failed to confirm this, and failures of replication may be associated with inadequate implementation of these interventions (Biehal, Ellison, & Sinclair, 2011; Sexton & Turner, 2010; Waldron, Slesnick, Brody, Turner, & Peterson, 2001; Westermark, Hansson, & Olsson, 2011). Thus far, behavioural parent training based on the Oregon model appears ineffective for young people and can be harmful when combined with group-based treatment for the adolescent (Dishion & Andrews, 1995).

**Box 5.6 MST and MDFT**

**Multisystemic therapy (MST)**

This is an ecological intervention that aims to impact on the entire milieu in which the young person operates. Constituent treatments include techniques from systemic and structural
family therapy, parent training, marital therapy, supportive therapy related to interpersonal problems, social skills components, social perspective training, behavioural methods and cognitive therapy techniques, as well as case management with the therapist acting as an advocate to outside agencies. Interventions are individualized and flexible but documented in treatment manuals. A family focus is key to the intervention.

Originally developed to treat conduct disorder, MST has also been used to treat self-injurious behaviour, substance use disorder, maltreated children and their parents.

Multidimensional family therapy (MDFT)

MDFT combines a highly structured manualized therapy with a flexible treatment delivery system titrated to the needs of the youth and family. It addresses multiple domains systematically: (a) within the adolescent, (b) within parents and other family members, (c) in the interactions between these individuals and (d) in extrafamilial systems (peers, education, etc.). Therapy consists of three phases: (a) establishing a foundation, (b) facilitating change and (c) consolidating change and ‘launching’ the adolescent.

Originally developed to treat substance use disorder in adolescents, MDFT has been used to treat conduct disorder.

Cognitive behavioural and social learning approaches

When cognitive behavioural and social learning approaches to CD in young people are tailored to the individual’s specific needs and abilities and properly implemented, they are moderately effective, although change is less evident when these individuals are followed up. CBT may help to prevent adolescents in residential settings from reoffending. Social and problem-solving skills programmes and anger management training can produce improvements in social functioning and aggression (Sukhodolsky, Kassinove, & Gorman, 2004), but these improvements are only seen in the setting in which training takes place. Training in moral reasoning does not seem to have much of an impact on adolescent behaviour (Landenberger & Lipsey, 2005; Lipsey, Landenberger, & Wilson, 2007).

We do not know which of the many multicomponent CBT packages currently available delivers the greatest improvements, as this has not been systematically studied. The efficacy of alternative versions is likely to be influenced by what element or aspect of the package is most dominant. In fact, innovative reformulations of traditional CBT which place greater emphasis on personal acceptance and the therapeutic relationship, for example dialectical behaviour therapy (DBT) and mindfulness-based cognitive therapy, may have a positive impact on CD (Biegel, Brown, Shapiro, & Schubert, 2009; Drake & Barnoski, 2006), but more studies are needed to confirm this.

School-based interventions

Individual and group school-based treatments that target selected young people moderately reduce aggressive and disruptive behaviour regardless of differences in approach.
The Family Check-Up Program is an effective school-based treatment program targeting selected high-risk young people and their families (Dishion & Kavanagh, 2003). However, it must be noted that in the school setting, comprehensive treatment programmes are less effective than better targeted approaches (Wilson & Lipsey, 2007). The first tests of new school-based treatments usually produce the best results; when attempts are made to reproduce their effects on a larger scale these interventions have had partial success at best.

Integration with juvenile justice provision

Psychosocial treatments can be effectively integrated with juvenile justice provision, and when programmes divert juveniles from court processing this can reduce the likelihood of reoffending, especially when they are linked up with therapeutic services. In the United States, state-wide implementations of evidence-based community programmes have reduced crime and residential placements, although not all such implementations work equally well (Petrosino, Turpin-Petrosino, & Guckenburg, 2010). Residential programmes for antisocial youth which remove children from their social and familial networks for a set duration can make them worse rather than better. Wilderness programmes, which aim to tackle behavioural problems by supporting self-management and boosting resilience through outdoor adventure programmes, have a small positive impact on rates of reoffending and may improve family functioning (Bandoroff & Scherer, 1994; Harper & Russell, 2008). Wraparound services that seek to ‘wrap’ individualized services and support around the young person, rather than imposing a predetermined programme on them, seem to improve young people’s living situations, but otherwise their impact on CD is small (Suter & Bruns, 2008, 2009).

High-quality implementation (carrying out the treatment in a way that is consistent with the treatment developers’ original intention) seems to be as important as the type of intervention in producing good outcomes, since ‘generic’ psychosocial treatments such as mentoring and group counselling can be effective if they are implemented well and aimed at high-risk offenders. Multicomponent interventions (which offer different types of therapy in various combinations, but are not integrated by an overarching focus or set of principles) are ineffective (National Institute for Health and Clinical Excellence, 2009).

Surprisingly, older teenagers and those at higher risk of offending are slightly more likely to benefit from treatment (Andrews & Bonta, 2006; Lipsey, 2009). Treatments have the smallest impact on sexual offenders (Redondo, Garrido, & Sánchez-Meca, 1997).

Attention deficit hyperactivity disorder

ADHD is characterized by reduced levels of concentration or attention, impulsivity, and overactivity or restlessness. There is no clear dividing line between extremes of normality and truly abnormal degrees of these behaviours.

Behavioural parenting approaches (i.e. approaches focused on modifying the child’s behaviour) combined with advice to the child and teachers are effective for mild ADHD (Piffner, Yee Mikami, Huang-Pollock, Easterlin, Zalecki, & McBurnett, 2007). Where ADHD is more severe and impairing, a multimodal approach combining behavioural
psychosocial interventions with children and parents, school consultation to help the child’s teachers work with them effectively, and medication is effective (Jensen et al., 2007). Behaviour therapy alone is less effective than treatment with medicines known as psychostimulants (such as methylphenidate), which can help to bring hyperactive and aggressive behaviour under control. Behaviour therapy improves the ability to carry out instructions and complete tasks assigned and reduces disruptiveness, but this is unlikely to generalize beyond the classroom. In cases of impairing ADHD when medication cannot be monitored intensively, either a behavioural approach combining work with parents, child and school consultation, or standard medical care are effective.

It is unclear whether CBT is effective for ADHD, as the few available studies have reached different conclusions about this; it may be the behavioural component that is effective (Abikoff, 1991; Pliszka & AACAP Work Group on Quality Issues, 2007). More studies are needed in this area.

Social skills interventions that aim to foster cooperation and reciprocal exchange do not seem to improve peer relationships for children with ADHD, but, again, more studies are needed to confirm this (Cousins & Weiss, 1993).

We do not know whether systemic, psychodynamic or humanistic therapies are effective for ADHD, as this has not been systematically studied.

**Tourette syndrome**

Children and young people with Tourette syndrome experience repetitive and involuntary motor and vocal tics, such as blinking, shrugging or other more complex movements, or obscene language. The causes of these tics are not well understood.

Habit reversal (where the young person learns a response that is incompatible with the tic in order to stop themselves from performing it) seems to be an effective treatment for children and young people with Tourette syndrome and chronic motor tics (brief, uncontrollable, spasm-like movements) (Azrin & Peterson, 1990). There is no evidence for other behavioural treatments because this has not yet been the subject of significant research.

One study suggests that parent training may help to reduce disruptive behaviour in children with Tourette syndrome and ADHD, but further research is needed to confirm this (Scahill et al., 2006). Parent training appears ineffective in managing tics in children and young people with Tourette syndrome and chronic motor tics comorbid with ADHD.

**Psychotic disorders**

<table>
<thead>
<tr>
<th>Schizophrenia</th>
<th>A long-term condition which may lead a person to believe that their false thought patterns are actually reality. Symptoms may include hallucinations, delusions and behavioural changes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder</td>
<td>This disorder is characterized by experience of extreme and long-lasting mood swings. Persons with the disorder have rotating periods of depression and mania, such that they can feel low and lethargic, but then euphoric and overactive.</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>A mood disorder that combines bipolar disorder symptoms with psychotic symptoms. The disorder affects the mind such that patients may be confused as to reality and may experience hallucinations.</td>
</tr>
</tbody>
</table>
Findings from adult studies suggest that psychosocial treatment may be a promising line of approach to schizophrenia and bipolar disorder in children and young people, but too few studies have been done to enable any specific recommendations (Miklowitz, Biuckians, & Richards, 2006; Pavuluri, Graczyk, Henry, Carbray, Heidenreich, & Miklowitz, 2004). The only statement about psychosocial treatments for schizophrenia in children and young people that we can make with a degree of confidence is that cognitive remediation – a treatment which uses continuous behavioural exercises to boost memory power and attention – is ineffective (Pilling et al., 2002). There are a number of preliminary findings from single studies that require confirmation. It is possible that providing families with education about schizophrenia and working with them to reduce expressed emotion (criticism, hostility and emotional over-involvement) may reduce the need for later institutional care, although it is unlikely to influence relapse (Rund et al., 1994). An intervention described by the authors as ‘supportive counselling’ may be more acceptable, and therefore more effective, than CBT in reducing symptoms of schizophrenia in young people (Haddock, Lewis, Bentall, Dunn, Drake, & Tarrier, 2006). In this study both CBT and supportive counselling were carried out by the same five research therapists and the latter aimed to provide emotional support by developing a supportive relationship fostering rapport and unconditional regard for the client. Actively treating ongoing substance abuse and helping the young person to establish social networks may reduce the risk of disengagement with treatment.

It is possible that family interventions aimed at education, communication skills, stress reduction and problem-solving may reduce symptoms of bipolar disorder, but more research is needed to confirm this (Miklowitz et al., 2006).

There is no evidence of sufficiently high quality to allow us to make any statements about the effectiveness or otherwise of treatments for children and young people with schizoaffective disorder.

### Pervasive developmental disorders

<table>
<thead>
<tr>
<th>Pervasive developmental disorder (PDD)</th>
<th>The umbrella term used to denote disorders such as autism which involve delays in social skills such as communication and socialization.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism</td>
<td>A condition that affects how people perceive the social environment and interact with others. It is characterized by persistent problems in social communication and restrictive behaviours or interests.</td>
</tr>
<tr>
<td>Asperger’s syndrome</td>
<td>Like autism, this is a condition that affects how people perceive the social environment and interact with others; however, it is not accompanied by learning difficulties and language skills may be higher.</td>
</tr>
</tbody>
</table>

Intensive behavioural treatment of young children with an autistic spectrum disorder (ASD) can improve their ability both to express themselves verbally and to listen to and understand others as well as their behaviour (Peters-Scheffer, Didden, Korzilius, & Sturmaey, 2011). By this we mean that, with additional behavioural help, autistic children can be supported to convey their feelings with a greater degree of clarity, as well as participate with more confidence in peer exchanges. Our knowledge of how best to
treat autism is, however, quite limited. Parent training may be helpful for children and young people with ASDs, but more research is needed (McConachie & Diggle, 2007). Similarly, one intervention, the Social Stories approach, which attempts to help the child to acquire social skills through the use of short, personalized stories to explain what happened or might happen in a particular situation, may be beneficial, but better designed studies are needed to confirm this (Karkhaneh, Clark, Ospina, Seida, Smith, & Hartling, 2010). Additionally, there is some evidence to suggest that CBT may be helpful for comorbid anxiety in children and young people with ASDs; however, more research is required (Chalfant, Rapee, & Carroll, 2007). There are no high-quality studies of sibling training, social skills training, video self-modelling, music therapy, self-management training, sensory integration therapy, or massage therapy for children and young people with ASDs. It is unclear whether educational interventions or courses teaching theory of mind are beneficial for children and young people with ASDs, as the available studies reach different conclusions about this and it is uncertain whether the benefits are lasting (Fisher & Happé, 2005; Ozonoff & Miller, 1995).

Social skills and problem-solving skills training, the Social Stories approach and CBT may be helpful for children with Asperger’s syndrome, but more studies are needed (Sofronoff, Leslie, & Brown, 2004; Solomon, Goodlin-Jones, & Anders, 2004). CBT seems to be helpful for children with Asperger’s and comorbid anxiety (Sofronoff, Attwood, & Hinton, 2005).

Self-injurious behaviour

Self-injurious behaviour (SIB) is increasingly common in young people. It is frequently associated with other difficulties, and many young people affected by it have a poor prognosis.

Brief hospital treatment seems to be helpful for young people with highly risky SIB (Hintikka, Marttunen, Pelkonen, Laukkanen, Viinamäki, & Lehtonen, 2006; Katz, Cox, Gunasekara, & Miller, 2004). No studies have directly compared inpatient treatment and home-based treatment of SIB, so we do not know which approach is more effective. It is possible that brief hospital admission may make it easier for the young person to attend outpatient treatment once they have been discharged.

It seems likely that engaging the young person effectively is necessary for treatment to succeed, although there is very little evidence directly linking effective engagement with better outcomes. Various approaches to help young people engage with treatment for SIB have been tested with some success, including negotiating treatment agreements, telephone follow-up after SIB, ‘green cards’ that act as passes to make it easier for the young person to be admitted to hospital if needed, and manualized ‘therapeutic assessment’ (Cotgrove, Zirinsky, Black, & Weston, 1995; Donaldson, Spirito, Arrigan, & Aspel, 1997). There is some evidence to suggest that manualized psychological treatments result in greater engagement and retention in treatment than TAU, but these results should be treated with caution, as there are numerous ways in which such results could be biased in favour of manualized treatments.

A few studies have looked at the effect of intensive treatment packages such as MST (home-based) and DBT (which can be delivered in various settings) on SIB (Huey et al., 2004; Rathus & Miller, 2002). MST (which involves a high proportion of family therapy) and ABFT have shown promise, but more research is needed (Diamond et al., 2010).
MST also involves intervening within the young person’s wider social system. Although intuitively it may make sense that a cross-cutting intervention would be effective for tackling SIB, results for both MST and DBT have been mixed. Another systemic approach influenced by MST, the Youth-Nominated Support Team for Suicidal Adolescents (YST-1), was found to be no more effective than TAU (King, Kramer, Preuss, Kerr, Weisse, & Venkataraman, 2006).

Box 5.7  Dialectical behaviour therapy (DBT)

Dialectical behaviour therapy is based on CBT but also draws on Eastern philosophy and meditation practices and selected elements of other approaches, such as psychodynamic psychotherapy, client-centred counselling and gestalt. It encourages individuals to accept themselves as they are in the present and targets maladaptive behaviours by teaching skills of emotional regulation, core mindfulness, interpersonal effectiveness and distress tolerance.

There is hardly any research on whether or not individual CBT approaches to SIB are helpful, although problem-solving approaches have been highlighted as deserving further study. Group-based CBT and cognitive behavioural family therapy for SIB are no more effective than TAU, and group-based CBT is more expensive.

Mentalization-based treatment (a psychodynamic approach which involves individual and family treatment focused on the participants’ capacity to understand their own and others’ behaviour in order to reduce impulsive behaviour and help them to manage their feelings) may be an effective intervention for SIB in young people, especially where there is judged to be a risk of progression to borderline personality disorder. Given encouraging results from one trial by the programme developers, further research is warranted (Bleiberg, Roussow, & Fonagy, 2012).

Eating disorders

| Anorexia | This is a mental health disorder where weight and shape concerns are driven by negative thoughts and feelings about the self. Characterized by severe weight loss, restrictive eating and compensatory behaviours, i.e. excessive exercise and/or self-induced vomiting. |
| Bulimia | Like anorexia nervosa, bulimia nervosa is characterized by restrictive eating and compensatory behaviours, i.e. excessive exercise and/or self-induced vomiting, however it differs in that people with bulimia typically maintain weight within the normal range due to recurrent cycles of binge eating and purging. |

Anorexia

In situations where the young person is at serious physical risk, inpatient treatment is necessary. Although clinicians agree that specialist inpatient units are needed to treat anorexia, we do not know for sure what setting is best, as very few studies have
looked at this. There is no clear evidence either for or against such specialist units (Gowers et al., 2010). Manualized family therapy is an effective treatment for anorexia (Lock, 2015). Even where there are high levels of family conflict, family therapy is still effective if the adolescent is seen separately from the parents (Lock & Gowers, 2005).

It is unclear whether or not manualized CBT is a helpful treatment for anorexia. Some studies have shown that family therapy achieves better results, but one study has found that CBT reduced the need for hospitalization compared to TAU (Gowers et al., 2010).

Bulimia

Manualized family therapy seems to be an effective treatment for young people with bulimia, and manualized individual CBT may also be effective [Le Grange, Lock, Agras, Bryson, & Jo, 2015]. It is unclear whether family therapy or individual CBT produces better results with bulimic adolescents. One study found that in the short-term the individual approach was better, but by 12-month follow-up both treatments were equally effective [Schmidt et al., 2007].

Substance use disorders

The many forms of substance abuse, the difficulty of reaching or even identifying many young substance users, and the lack of trials with no-treatment control groups limit the generalizability of the conclusions we can draw from the available research. Given that many substance use disorders (SUDs) resolve spontaneously with age, the lack of such trials means we cannot say for sure that treatment is preferable to no treatment.

It is unclear whether specialist SUD services based in low-stigma settings or with outreach capacity produce better results than treatment integrated into generic child and adolescent mental health services (CAMHS), as this has not been studied systematically. Likewise, we do not know whether it is better to treat young people in outpatient or inpatient settings, as the available studies are of poor quality and reach different conclusions. Although we know that inpatients need active, ongoing follow-up post-discharge, we do not have enough evidence to know which of the available specific community outreach programmes are most effective.

Lower level substance abuse disorders

Brief CBT and motivational approaches, which support individuals to move beyond negative impulses for substance use by challenging harmful thought cycles, can prevent young people moving from low-level to serious use. In fact, when combined these two approaches tend to be more effective [Dennis et al., 2004]. CBT often takes place in group settings, but we do not know how helpful the group setting might be; the number of studies is small and, while most suggest groups are effective, sometimes the results have been contradictory. There have been concerns that being in a group setting may make matters worse because the young people could have a negative influence on one
another; however, there is no strong evidence to support these claims, as long as appropriate boundaries are maintained (Burleson, Kaminer, & Dennis, 2006).

Family/systemic therapy is a helpful treatment for lower level drug misuse; this approach can also be successful in combination with the use of CBT or motivational treatments (Austin, Macgowan, & Wagner, 2005; Latimer, Winters, D’Zurilla, & Nichols, 2003). Family/systems approaches can also help the young person to continue with their treatment and address other behavioural problems that often go hand-in-hand with SUD.

Although there is a well-established evidence base for 12-step programmes for treating adult addiction (i.e. Alcoholics Anonymous), we do not know whether or not an adapted version of this model for young people is effective, as there have been only a few studies with equivocal results (Kelly, Myers, & Brown, 2000).

Serious substance abuse disorders

Sadly, although our knowledge of effective interventions for SUDs continues to expand, we still do not know how best to identify and treat young people who are likely to have the worst outcomes; here, as across many other disorder domains, more research is needed.

A number of intensive programmes of treatment are available for SUDs that are particularly high risk, entrenched, or complex. These include MST, MDFT and the Adolescent Community Reinforcement Approach (A-CRA), a form of contingency management treatment which reinforces changes in behaviour with the aid of small prizes or tokens (Austin et al., 2005; Curtis, Ronan, & Borduin, 2004; Dennis et al., 2004). There are also briefer programmes that combine the use of CBT, motivational enhancement therapy and family therapy. All these treatment programmes may be effective in a meaningful number of cases, but more rigorous research is needed. In addition, we do not know whether any one particular programme is more effective than another, as the available studies have been conducted with very different groups and in very different settings.

Maltreatment

In this section we discuss treatments for the harmful effects of childhood maltreatment. The impact of maltreatment is wide-ranging, may be evident immediately or arise later, and the effects often endure into adulthood.

Physical and emotional abuse and neglect

Physical and emotional abuse and neglect can result in various kinds of emotional and behavioural difficulties. Among younger children, we have some evidence that group work focusing on developing cooperative and imaginative play can help with social and behavioural difficulties (Udwin, 1983). Violent delinquency in maltreated young people has been successfully reduced by a school-based violence prevention programme (Crooks, Scott, Wolfe, Chiodo, & Killip, 2007). CBT may be helpful for aggressive young people who have been physically abused (LeSure-Lester, 2002).
Exposure to interpersonal violence

Exposure to violence between parents or carers can result in PTSD, for which TF-CBT can be effective (Cohen, Mannarino, & Iyengar, 2011). PTSD in young children resulting from exposure to violence between parents and carers may be helped by child-parent psychotherapy. This is a specialist form of therapy which aims to foster a secure bond between parent and child following child trauma-exposure. One study found that providing mothers who had experienced intimate partner violence (IPV) with a safety plan and information about services available to them reduced the internalizing and externalizing behaviours of children exposed to the IPV (McFarlane, Groff, O’Brien, & Watson, 2005). Further work is needed to confirm these findings. Internalizing behaviours and harmful attitudes to violence can be improved by age-appropriate group work with children in a community setting to address their knowledge, attitudes and beliefs about family violence, their emotional adjustment and social behaviour, and externalizing behaviours are improved if this is supplemented by a parenting group (Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007).

Sexual abuse

The effectiveness of treatments for children who have suffered sexual abuse has been quite widely investigated, and several meta-analyses of the available studies have found large to moderate effect sizes, which tend to be smaller in controlled studies. There is specific support from meta-analyses for psychotherapy (defined very broadly as any intervention designed to alleviate psychological distress, reduce maladaptive behaviour, or enhance adaptive behaviour through counselling, structured or unstructured interaction, a training programme or a predetermined treatment plan) (Harvey & Taylor, 2010), group treatment (Reeker, Ensing, & Elliott, 1997) and CBT combined with supportive, psychodynamic, or play therapy (Harvey & Taylor, 2010; Hetzel-Riggin, Brausch, & Montgomery, 2007; Sánchez-Meca, Rosa-Alcázar, & López-Soler, 2011). Play therapy, which enables children to process particular difficult events or emotions, does not seem to be effective when used on its own. In the case of the meta-analysis looking at psychotherapy, overall outcome and symptoms of PTSD were found to improve the most; moderate improvements were found for internalizing and externalizing symptoms, self-esteem and sexualized behaviour; and there were small to moderate improvements in coping and social skills. One meta-analysis, which looked at a range of treatments, found that longer treatments and more sessions produced larger effects, and older girls who had experienced sexual abuse within the family benefited more (Sánchez-Meca et al., 2011). In the case of group treatment, treatments that focused on the child only (compared to the child and their non-abusing parent) and those that lasted longer were both associated with larger effect sizes (Trask, Walsh, & Dilillo, 2011). Group treatment effects rose with age and were larger for the two studies that had a majority of boy participants (Trask et al., 2011).

CBT for the emotional and behavioural difficulties of sexually abused children – and specifically for anxiety – may be effective, although the available studies are not all of high quality (Macdonald et al., 2012). Group CBT with parallel parent work for sexual behaviour problems has a lasting effect (maintained at 10-year follow-up). TF-CBT including the mother and child may be effective for PTSD in sexually abused children (Cohen, Mannarino, & Knudsen, 2005). It is unclear whether or not CBT for
depression in sexually abused children is helpful, as studies have reached different conclusions about this and a review found only a small effect size (Macdonald, Higgins, & Ramchandani, 2006).

It is possible that individual psychodynamic psychotherapy for sexually abused girls may help to relieve symptoms of depression, anxiety and PTSD (Trowell et al., 2002). More research is needed to confirm these suggestions.

Interventions for children with particular disorders following maltreatment

Group or individual CBT may be helpful for PTSD in maltreated children. EMDR therapy, an integrative psychotherapy designed specifically for trauma victims, and the anxiety medication propranolol may also be helpful (Ahmad, Larsson, & Sundelin-Wahlsten, 2007; Wethington et al., 2008). EMDR requires the patient to evoke an image of an event causing him or her anxiety, while tracking the therapist's finger as it is moved rapidly and rhythmically from side to side; at the same time, they generate cognitive coping statements. More research is needed to confirm these suggestions.

Interventions including parents to reduce the likelihood or recurrence of child maltreatment and improve the child’s functioning

Parents whose children have been abused are difficult to engage and often drop out of treatment. PCIT, which draws on both attachment and social learning theory to foster supportive filial relations, can reduce parental maltreating behaviour and, to a limited extent, some of the child's difficulties. In preschool-age children, an attachment-based intervention which aims to demonstrate how the mother's personal history can affect her present-day relationship with her child, known as preschooler–parent psychotherapy, can help children who have developed harmfully negative ways of thinking about themselves and parent–child interactions (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). Another very similar form of attachment-based psychotherapy – infant–parent psychotherapy – can increase rates of secure attachment among young children who have been maltreated (Cicchetti, Rogosch, & Toth, 2006). By this we mean that the process of therapy has enabled children who have previously been abused, and who are consequently very suspicious and afraid of adults, to successfully develop trusting and caring relationships with their primary caregivers. Overall, there is evidence in the form of several studies to support attachment-based interventions for maltreated young children and their carers, not only to increase attachment security, but also to reduce disorganized attachment, which is characterized by unpredictable behaviour, chronic mistrust of adults, lower levels of social competence and externalizing problems (Bernard, Dozier, Bick, Lewis-Morrarty, Lindhiem, & Carlson, 2012; Cicchetti et al., 2006; Moss, Dubois-Comtois, Cyr, Tarabulsy, St-Laurent, & Bernier, 2011).

MST can be effective in reducing parental maltreatment and improving the maltreated child’s functioning (Swenson, Schaeffer, Henggeier, Faldowski, & Mayhew, 2010). Parent training and CBT are effective in reducing excessively harsh and abusive parenting. A psychoeducational parenting intervention addressing parenting skills, the mother’s self-care and the fostering of adaptive competencies in the child may help to decrease young maltreated children’s disorganized attachments (Cicchetti et al., 2006).
When it comes to interventions designed to reduce the likelihood of having to remove children from the family into foster care, treatments within family preservation programmes are unlikely to have any benefits (Dagenais, Begin, Bouchard, & Fortin, 2004; Littell & Schuerman, 1995). These preservation programmes are short-term, family-focused services for families in crisis, which aim to ensure that children can safely remain within their homes provided the parents receive additional assistance. Home visitation programmes also aim to ensure that the child does not have to be taken into an alternative care setting; however the evidence for their efficacy is rather mixed, with available studies reaching different conclusions (Macmillan, Wathen, Barlow, Fergusson, Levanthal, & Taussig, 2009).

When children are placed in foster care, it is imperative that they are not returned to their original family setting until their wellbeing and safety can be guaranteed. An intervention for maltreated children placed in foster care that involved assessment of parents and the parent–child interaction, and intensive work on these factors, succeeded in identifying parents who could not resume care of their children and reducing maltreatment of the children who returned to or remained with their parents, but was associated with longer stays in foster care (Zeanah et al., 2001). More research is needed to confirm the effectiveness of this approach.

Similarly, an intensive family reunification programme which emphasizes the necessity of support for family functioning, parenting and risk factors, may lead to a greater rate of rehabilitating children in foster care back to the home (Fraser, Walton, Lewis, Pecora, & Walton, 1996).

### Change of caregiver as an intervention

Regular foster care does not reduce subsequent difficulties in fostered children compared to similar maltreated children who remain in the family home. Because children who are fostered are often very troubled, and it is not possible to randomly allocate them to foster care for research purposes, it is hard to measure how successful foster care can be, and we do not know whether regular foster care is better than leaving maltreated children at home, as the available studies have reached different conclusions. When children who remain in alternative care are compared with those who returned home, one study found that returning home was associated with poorer outcomes in terms of internalizing and externalizing behaviours, social adaptation, self-harm and educational progress (Taussig, Clyman, & Landsverk, 2001).

An attachment-based intervention, Attachment and Biobehavioral Catch-up, used with foster parents of very young children lowered the levels of the hormone cortisol in children’s saliva (an indicator of stress) and reduced their behavioural problems (Bernard et al., 2012). The success of this intervention is likely to be down to its comprehensive design which, through weekly sessions, equipped carers with the skill-set to recognize child distress, nurture children’s emotional expression and respond with warmth and affection irrespective of the child’s behavioural problems.

For those in middle childhood in foster care, there is evidence that MTFC for the foster parents increases rates of successful placements (i.e. placements that do not break down), improves foster parents’ ability to encourage and support the child’s good behaviour, and reduces the child’s behaviour problems. Two studies of MTFC have suggested that it may increase secure attachment and increase the rate of subsequent permanency of placement among preschool-age children, but more research is needed to confirm this (Fisher & Kim, 2007; Fisher, Burriston, & Pears, 2005).
The limits of our knowledge about what works for whom

As this review has shown, our knowledge about what works for whom is subject to some important limitations.

We know very little about appropriate treatment for a number of common conditions.

Box 5.8 Randomized controlled trials (RCTs) and their limitations

The great benefit of a RCT is that it enables the researcher or clinician to be more confident that the treatment was responsible for the outcomes observed, since, in principle, randomization ensures the even distribution of other factors that might affect the outcomes. While RCTs have often been thought of as the gold standard for a clinical trial, some caveats need to be kept in mind. A trial shows what can be achieved with a particular treatment under somewhat artificial conditions. The quality of the care available in the community may be different. People with multiple diagnoses are often excluded from trials and yet comorbidity is very common. Similarly, the common exclusion of those who cannot speak English means that the samples are often not representative of the communities they come from. By and large, RCTs are not designed to detect harmful effects of treatment. The results of RCTs are applied to less homogeneous populations with comorbidities, who are usually treated over longer periods of time, in clinical situations that at best vaguely resemble the cutting-edge clinical settings in which they were tested. Recognition of this issue has led reviewers to distinguish efficacy from effectiveness studies, with the second category more directly concerned with outcomes in a ‘real world’ practice setting (Seligman, 1996).

Indicators of a high-quality randomized controlled trial include:

- The study asks a clearly defined research question focused on the problem being studied.
- Randomization has been done in a way that ensures even distribution of known and unknown factors that might influence outcomes (confounding variables) and creates a control group that is as similar as possible to the treatment group. In smaller studies, special techniques such as block randomization and stratification may be needed to ensure that the size and characteristics of the groups are balanced.
- The researchers use allocation concealment techniques (such as use of a central telephone randomization service) to ensure that they do not know in advance who will be assigned to which group.
- Those responsible for collecting and analysing the data do not know who is in which group (this is known as ‘blinding’).
- After randomization, it is usually the case that some people drop out of the study. Studies that analyse data from both treatment completers and study drop outs are regarded as of higher quality than studies that only consider treatment completers. This is known as intention to treat analysis.
- The sample size of the study is large enough to allow the study to detect a difference between the groups, if such a difference exists. This is referred to as the study’s statistical power, as determined by its power calculation. If the study is not large enough, it is said to be underpowered and in this situation a finding of no difference may not be valid. Better quality studies will include discussion of the study’s statistical power.

For a more detailed discussion, see (Akobeng, 2005).
More research is needed on subgroups of children and young people that are known to respond poorly to treatment. Even the most effective treatments are not effective for everyone who receives them. There is a need to investigate whether or not better results can be achieved with alternative methods.

Not all psychological treatments have been evaluated equally well. Systemic and psychodynamic psychotherapies are both widely provided in clinics, often when other, more evidence-based treatments have failed. Humanistic therapies and counselling are also very frequently offered. Research is urgently needed on whether some children in some situations might derive specific benefits from these approaches and what the effective elements are. It would be helpful to investigate whether components of these treatments could become part of an EBP protocol that clinicians could use in relation to particular clinical challenges. For example, managing ruptures in the treatment alliance (Safran, Muran, & Eubanks-Carter, 2011) could be helpful across a range of modalities.

Limitations of the available evidence

A number of limitations of the evidence base need to be taken into account. Too many ‘evidence-based’ interventions are backed up by just one or two studies. Studies conducted by researchers not involved in the development of the treatment which aim to replicate the results of the original studies are needed. To take a finding as ‘fact’ it must be supported by multiple independent studies, also known as ‘replication studies’. Furthermore, the registration of all RCTs with the ISRCTN registry, the primary clinical trial registry recognized by WHO and the International Committee of Medical Journal Editors (ICMJE), and the publication of data from those trials, whether the outcomes are positive or negative, are essential if we are to interpret the evidence correctly.

Most published studies focus on symptoms and diagnoses as primary outcomes. However, to be truly effective, a treatment also needs to impact on other important areas, such as relationships with peers, family relationships, academic functioning and service utilization. When the focus is on diagnosis and/or symptoms, findings are inconsistent: some studies report complete remission of symptoms while others describe varying levels of reduction. Given the heterogeneity of many disorders and the clinical importance of sub-threshold cases, it is unwise to evaluate outcomes solely in terms of whether clients continue to meet criteria for a particular diagnosis.

Despite some improvements, too many reported studies still have significant methodological flaws. Sample sizes are often so small that studies are underpowered to find meaningful results. The bias towards publishing positive results from studies with small sample sizes leads to frequent failures of replication. Sample ages can also be a problem, with very wide age ranges reported in a sample and/or widely differing age of onset or time since onset of diagnosis within the sample. In depression research, large differences in outcome between clinically referred depressed young people and those recruited through advertisements have been reported, which are not attributable to greater severity. This indicates that even if an intervention is found to be effective in a study using a community population sample, this may not be the case for clinical patients. We must be cautious about extrapolating findings – especially, given that too many study samples still comprise non-distressed/non-referred participants.

Often studies have either no follow-up period or only a very brief one; as such we know very little about how long treatment should be continued once it has been shown to be effective. The value of intensive or extended psychological treatments and booster sessions has not been systematically evaluated in many contexts.
While it is now generally accepted that adverse effects of medication must be monitored and reported, this is rarely the case with psychological treatments, in which adverse events are almost universally assumed to be part of the presenting problem and associated difficult relationships and interactions. If psychological treatments can be beneficial, we can assume that they may also have the power to cause harm. Adverse outcome data have not been consistently collected or reported. For example, in studies of treatments for depression, it cannot be taken for granted that self-harm is a feature of the diagnosis rather than an adverse effect of treatment.

CBT has often been compared with therapies which, according to the criteria of Wampold [1997], are non bona fide (bona fide therapies are those with adequate therapist training, individualized treatment based on face-to-face meetings with the client, and inclusion of psychologically valid components). A meta-analysis by Spielmans, Pasek, & McFall [2007] attempted to identify the active ingredients in CBT for anxious and depressed children. The meta-analysis aggregated the results of studies in which CBT treatments were compared with other therapies. CBT was found to be significantly more effective than non bona fide treatments, but there was no evidence from direct comparisons to suggest that CBT was more efficacious than other bona fide treatments. There was only one comparison between CBT and a bona fide non-CBT treatment, which found that the two interventions were equally effective.

We often do not know how treatments that appear to be effective would compare with TAU in the real world when delivered by community clinicians to children with a variety of comorbid disorders. There are several reasons for this. Firstly, many well-designed trials compare new treatments with no-treatment control groups. Secondly, increasingly treatment trials have strict adherence guidelines to ensure we know exactly what has been delivered and evaluated, but this is not always easy to replicate in community settings. Manualized psychological treatments have become increasingly commercialized, which can mean that some evidence-based treatments are too expensive for services to adopt. Thirdly, while children with comorbid diagnoses are often excluded from treatment trials, comorbidity is the rule rather than the exception in community settings.

Box 5.9 How can we find out whether EBPs work in the real world?

To address our lack of knowledge about how apparently effective treatments compare with TAU in the real world, we need true pragmatic trials (i.e. taking place in usual clinical rather than specialized research settings) using quite simple protocols that are easy for practising clinicians to learn and deliver in community clinic settings. We also need to develop and evaluate effective methods to enable the delivery of effective treatments by community clinicians. Weisz, Doss and Hawley (2005) suggest that development of new interventions should take into account contextual variables such as characteristics of the practice setting. Under their deployment-focused model, development and evaluation of the intervention should take place in the context and with the clients who are representative of the intended application. EBPs should be part of an ongoing evolution of therapy, and routine practice settings should work with researchers to adapt interventions as appropriate to the context and evaluate these modifications (Garland, Plemmons, & Koontz, 2006).
We have seen that research has confirmed the effectiveness of a variety of multicomponent treatment packages for certain diagnoses. However, we do not know which elements of these packages are most helpful in particular clinical situations, and they are not usually compared against each other but instead tend to be compared to inactive conditions such as a wait-list control. We also do not know whether in some situations combinations of treatments may be more effective than individual treatments. In clinical practice, different treatments are more likely to be administered sequentially.

Box 5.10  A modular approach to psychological therapy

EBPs for depression, anxiety and conduct problems in young people produce mixed results in trials with the comorbid, complex cases seen in practice. In one study (Weisz et al., 2012) a multisite randomized effectiveness trial compared standard manualized treatment (one of three EBPs: CBT for depression, CBT for anxiety and behavioural parent training for conduct problems) with modular treatment allowing clinicians to use elements of the three separate treatment protocols more flexibly and with usual care. Eighty-four community clinicians were randomized to one of three conditions for the treatment of 174 clinically referred children aged 7–13. Outcomes were assessed using weekly youth and parent assessments. A standardized diagnostic assessment was also conducted before and after treatment. Modular treatment produced significantly steeper trajectories of improvement than usual care and standard treatment and youths receiving modular treatment also had significantly fewer diagnoses than youths receiving usual care after treatment. In contrast, outcomes of standard manualized treatment did not differ significantly from outcomes of usual care. The modular approach may be a promising way to build on the strengths of evidence-based treatments, improving their utility and effectiveness with referred youths in clinical practice settings.

Implications for clinical practice and research

We know that most conditions are under-recognized, that intervening earlier can reduce the risk of development of comorbid disorder, and that effective intervention can actually prevent subsequent episodes of disorder. Thus, there is an empirical case for early assessment and intervention services.

The available evidence on treatment for child mental health problems is based on standardized diagnostic criteria. Thus, it is important that treatment choice is informed by adequate diagnosis. However, given the high rates of comorbidity in child mental health disorders, clinicians will often need to decide which disorder[s] should be prioritized. A flexible approach is needed allowing for review, reassessment and further intervention as necessary. The resources of a multidisciplinary team are likely to be required to enable this to happen. In a school setting this may involve routine liaison between the school counsellor and Special Educational Needs Co-ordinator (SENCO), with additional input from external service support when required.

There is consistent evidence across disorders that benefits for the child are associated with the direct involvement of family and/or caregivers in assessment and appropriate therapeutic intervention. Children also benefit more when information is routinely sought from agencies such as schools and social services that are also involved with the child and family (Kazak et al., 2010). CAMHS should be designed
to enable well-integrated multi-agency involvement, with good communication between the different agencies. Research is needed to determine the service context and the characteristics of individual therapists best placed to engage hard-to-reach families with multiple problems, particularly in families where there is or has been child maltreatment, substance misuse and/or conduct disorder.

We need to be mindful of the risk that the rise of certain well-publicized evidence-based interventions will stifle innovation. It is important that services are able to deliver EBPs, but such interventions will never work for everyone. We need to be able to develop alternative interventions alongside existing evidence-based approaches to mitigate the risk of complacency or offering interventions that are not as helpful to children and young people as they could be.

Conclusion

A great deal of work needs to be done to make psychological treatments genuinely accessible. The proportion of children and young people who need mental health interventions is increasing, while the availability of resources for interventions is not keeping pace and may even be on the decline (Kazdin & Blase, 2011). Current specialist CAMHS provide insufficient access for a large proportion of the children who need them. New sustainable models of delivery are needed.

A genuinely ecologically sound mental health service for children and young people will require the empowerment of communities, schools, peers and families, as well as the child, to deliver evidence-based services in healthcare delivery structures and other contexts that are safe, resilience-enhancing and readily accessible.

We need to stop pretending that psychotherapy is like a chemical carefully purified in the laboratory, distinct from the millions of other molecules which we come across in our day-to-day lives. Therapy is a social experience and as such is best integrated with all the other social experiences which help us navigate life’s ups and downs: education, sport, peer relationships, music and theatre, to name but a few. Psychological therapy should be integrated with the rest of a child’s life, not removed from it, if it is to generalize and to change behaviour and experience in all these contexts.

The next generation of therapies will be preventive and resilience-building; positive as opposed to symptom-focused. As the principles of psychological and brain development become clearer to science, the application of these principles to the encouragement of healthy development has the potential to reduce the prevalence of distress and increase the proportion of young people who go through life without a diagnosis of mental disorder.

Recommended reading

Questions for reflection

- Did any of the findings presented in this review surprise you? Why?
- In which of the areas of uncertainty identified above do you feel it would be most important to conduct further research?
- In what ways could you use the findings presented here to inform your clinical practice?

References


