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The Science of Psychotherapy with Youth

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Children and adolescents face a wide range of mental health challenges. Like many adults, youth often experience depression, phobias, and externalizing problems. In fact, many disorders first emerge in the early years of life, such as intellectual disability, autism spectrum disorder, and attention-deficit/hyperactivity disorder. Even infants and toddlers face challenges related to sleep, feeding, or toileting. Other mental health challenges may not emerge until later childhood or adolescence, such as eating disorders and substance use. As such, the focus of this book is far ranging, covering the time from infancy through adolescence, and we will commonly use the term *youth* in the broadest sense to include infants, children, and adolescents.

Complicating the mental health challenges of youth are the ever-changing definitions used to describe these challenges. For example, most disorders identified in youth went through mild to moderate changes in the latest revision of the *Diagnostic and Statistical Manual* (DSM-5; American Psychiatric Association, 2013). Even further complicating these mental health challenges is the large range of untested, ineffective, and sometimes harmful treatment approaches that have been used widely since the early roots of psychotherapy.

On the one hand, Sigmund Freud's psychodynamic approach deserves some credit for helping to popularize ideas such as: (a) biology is not the only factor influencing human behavior, (b) childhood experiences affect development, (c) parenting matters, and (d) therapy can help people cope with mental health challenges. On the other hand, Freud's approach was largely based on untested, and often untestable, ideas. Freud's case of Little Hans, a five-year-old with a fear of horses, is one good example (Freud et al., 1909/2001). In his psychoanalysis of Little Hans, Freud credited the boy's erotic feelings toward his mother, fear of his father, the birth of his sister, castration anxiety, masturbation, and a repressed libido (among other equally dubious causes) as all contributing to the boy's fear. Additionally, Freud concluded that the boy's fear of being bitten by a horse was related to having previously been frightened by a penis.

Freud's intervention was to help make the parents and child aware of the connection between the boy's repressed unconscious wishes and his fear of horses. Over a century later, there is no evidence that Freud's approach to treating Little Hans is an effective way to deal with childhood phobias, and alternative interpretations of the case of Little Hans are more parsimonious than Freud's (Wolpe & Rachman, 1960). Over that same century, many other pseudoscientific treatments have flourished and continue to proliferate today (see the *Pseudoscience and Questionable Ideas* Side-Bar Box for more information about untested, ineffective, and harmful treatments).

Pseudoscience and Questionable Ideas

Many practitioners rely on pseudoscience when they treat youth with mental health challenges (Hupp & Jewell, 2015; Jewell et al., in press; Mercer, Hupp, & Jewell, in press). One major type of pseudoscience involves using treatments that have research showing they are ineffective. In addition to pseudoscientific treatments, practitioners also commonly implement treatments based on questionable ideas that are implausible and that do not have supporting evidence. Although it's important to keep an open mind about new untested treatments that may potentially work, caution is typically warranted for treatments until well-designed studies examine their effectiveness. As members of the skeptical community often like to say, "it's important to keep an open mind but not so open that your brains fall out."

The major goal of this book is to provide information to students, scholars, and practitioners about EBTs. As worthy of a goal that this is, research shows that teaching about EBTs is not enough. That is, even after learning about EBTs, some learners continue to believe in the effectiveness of ineffective therapies (Hupp et al., 2012). The good news is that the belief in ineffective treatments can be diminished if the ineffective treatments are also overtly addressed (Hupp et al., 2013). To that end, this book also has a companion book called *Pseudoscience in Child and Adolescent Psychotherapy* (Hupp, 2019), which covers:

- diagnostic controversies
- questionable assessment practices
- myths that influence treatment
- implausible treatments
- ineffective treatments
- potentially harmful treatments
- and even attempts to bash evidence-based approaches.

It may be a long time before evidence-based approaches are used more frequently than pseudoscientific approaches. To get to that point, it's going to take persistent and effective science communication. Thus, the companion book also includes side-bars written by science communicators from a variety of fields.

Similar to Freud, John B. Watson (1924), argued against the prevailing view that heredity alone is the primary factor influencing human behavior. Contrary to Freud, however, Watson provided an alternative conceptualization. Instead of focusing on the unobservable world of the unconscious, Watson emphasized the study of how the environment affects observable phenomena such as overt actions and even thoughts (which are at least observable to the person experiencing them). Unlike Freud's largely untestable ideas, Watson's theories of development were testable and thus contributed to the *science* of psychology. For example, Watson's study of Little Albert directly demonstrated how a new fear could be developed in an 11-month-old infant (Watson & Watson, 1921). Specifically, Albert showed no signs of fear to a white rat until the researchers began making sudden loud sounds when the rat was near. Soon, Albert showed fear of the rat even when no sounds were being made, and this fear even generalized to other white furry stimuli, such as rabbits. With this early understanding of classical conditioning, Watson was also able to apply this research to the treatment of anxiety disorders in a manner consistent with evidence-based approaches today.

This behavioral science of psychology continued rapid development with help from B. F. Skinner in books such as *Science and Human Behavior* (Skinner, 1953) that summarized his groundbreaking research demonstrating the many ways the environment can be changed to influence behavior including both "public events" (e.g., physical actions, language) and "private events" (e.g., thoughts, feelings), largely through operant conditioning. Albert Bandura (1974) agreed with these early behavioral theories and offered up observational learning as another way to influence behavior. Moreover, Aaron T. Beck (1963) conducted influential research on the role of cognitions in the development of psychopathology in adults, and his research was quickly applied to youth as well.

Early Attempts at Evaluating Psychotherapies

Despite the early progress made in developing scientific theories of human behavior, research examining psychotherapies was limited until the second half of the twentieth century. In 1952, only 19 published studies were included in Eysenck's seminal review of the effects of psychotherapy, and each of these studies involved drastic limitations that called into question the validity of the findings (Eysenck, 1952). Moreover, the therapies studied were classified as either "psychoanalytic" or "eclectic," and they focused on adults. Eysenck concluded that the existing literature as a whole lacked the scientific rigor needed to study the efficacy of psychotherapy and, thus, that there was no existing evidence that psychotherapy ameliorated mental health problems.

Eysenck called for more stringent definitions of comparative control subjects, recovery, and therapy type, all of which he argued were not provided in the literature.

Similar conclusions were made by early reviews of the child and adolescent mental health treatment literature that served as extensions of Eysenck's pioneering work. Specifically, a review of 18 available studies concluded that psychotherapy was not more effective than the passage of time alone (Levitt, 1957). Six years later, a review of 22 additional studies of psychotherapy with youth reiterated the same findings (Levitt, 1963). Importantly, these conclusions were based on studies with weak methodology including lack of randomization, small sample sizes, and nonspecific treatment approaches.

The field of clinical psychology has made great strides in both the quantity and quality of empirical research since the early reviews. By the late 1970s, Smith and Glass (1977) published one of the first meta-analyses that demonstrated that specific treatments targeting mental health produced positive outcomes. Shortly after, a more rigorous meta-analysis also reached a similar conclusion, that psychotherapy was associated with ameliorative treatment effects (Shapiro & Shapiro, 1982). A meta-analysis on child-focused psychosocial treatment also found evidence for the benefits of psychotherapy (Casey & Berman, 1985). The field of clinical psychology was quickly moving toward identifying evidence-based approaches that maximized therapeutic gains.

In the beginning of the 1990s, McFall proposed his "Manifesto for A Science of Clinical Psychology" (1991). The cardinal principle of McFall's manifesto was that scientific clinical psychology was the only legitimate form of clinical psychology. Specifically, McFall proposed that the public should only receive psychological treatments that have scientifically supported benefits with possible negative side effects ruled out empirically. Around this time, the field was beginning to demonstrate that the effects of child and adolescent mental health treatment differed based on a number of factors including child problems and treatment type (Weisz et al., 1987; Weisz et al., 1995). As Paul (1967) famously called for, an understanding was beginning to form of "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?"

Identifying Evidence-Based Treatment Packages

Members of the Clinical Psychology Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures were the first to undertake a systematic, standardized annual review of more than 400 adult-focused treatment studies. Their goal was to create and maintain a list of efficacious psychotherapies that would be regularly updated when new studies became available. The initial criteria used by the Task Force were adapted from those used by the Federal Drug Administration (Beutler, 1998), and a small number of treatments were widely studied and deemed efficacious (Task Force on the Promotion and Dissemination of Psychological Procedures, 1995). Importantly, the Task Force made no claims that the interventions

identified in the original review were the only effective treatments or should take precedence over other treatments (Beutler, 1998).

A more refined definition of empirically supported treatments (ESTs) was offered by Chambless and Hollon (1998). The authors defined ESTs as clearly specified treatments shown to be effective for a delineated population in a controlled setting. They also identified the randomized clinical trial as the gold standard for efficacy research. The article preceded a series of reviews for specific mental health problems in a special edition of the *Journal of Consulting and Clinical Psychology* (*JCCP*). A treatment was deemed *efficacious* if it: (1) led to statistically superior outcomes when compared to a control group; (2) was conducted with a treatment manual, specified population, reliable and valid outcome measures, and appropriate data analysis; and (3) showed superiority in at least two independent research settings. A treatment was classified as *possibly efficacious* if only one study demonstrated superiority and there was no conflicting evidence. Lastly, an intervention could be designated as *efficacious and specific* if the study met the same criteria as efficacious studies but had the additional benefit of having better comparison groups that included other interventions or placebos.

Efforts to define ESTs sparked a spirited discussion and debate among experts. Some researchers began to question the external validity of efficacy studies. For example, Seligman (1995) argued that *effectiveness* studies, conducted in the real world (e.g., community mental health settings), should be the mark of empirical support. He argued that *efficacy* studies were likely to give inflated results because they were conducted within highly controlled settings with narrow participant demographic characteristics. Seligman also called for treatment outcome researchers to consider that therapy is not typically of a fixed duration as it is in efficacy studies. Additionally, he argued that therapy is self-correcting in that if an approach is not leading to patient improvement another modality is tried, in part because many individuals seek therapy for multiple problems that may require multiple approaches. Lastly, Seligman said that treatment is focused on improving general functioning rather than symptom reduction. Chambless and colleagues contributed to the ongoing conversation by specifying that the intended focus of the preliminary list of ESTs was on efficacy rather than effectiveness trials. The subject of effectiveness would be broached once the initial list of treatments was identified (Chambless et al., 1998).

Since child-focused clinical psychologists had not been involved in the initial work on identifying ESTs, only treatment studies of adults were evaluated. Suzanne Bennett-Johnson, the President of Division 12 at the time, appointed a separate working group to extend the Division 12 Task Force's work to treatment of children and adolescents. Her appointees were the leadership of Section 1 of Division 12, the youth-focused members of the Division. As this youth Task Force was conducting the formal reviews, Section 1 was simultaneously in the process of moving from

Sectional status in Division 12 to Divisional status of the American Psychological Association.

The Society for Clinical Child and Adolescent Psychology (SCCAP; Division 53 of the American Psychological Association) was thus founded in 1999 and has been at the forefront of identifying treatments with research support for youth. The *Journal of Clinical Child & Adolescent Psychology* (*JCCAP* – the official journal of Section 1/ Division 53) introduced the first special issue on ESTs for child and adolescent mental health (Lonigan, Elbert, & Johnson, 1998). Two sets of criteria were put forth, one for *well-established* psychosocial interventions and one for *probably efficacious* psychosocial interventions. Similar to the initial Division 12 Task Force criteria (Chambless & Hollon, 1998), for a treatment to be well-established it had to be superior to a placebo or comparative treatments in at least two studies. To be probably efficacious a treatment had to be more effective than no treatment in two studies. Like before, the ideal study included random assignment, controlled conditions, manualized treatment, a fixed number of sessions, well-operationalized targets, blinded raters, clearly specified sample characteristics, and a follow-up assessment.

Ten years later, Division 53 released a second special issue with relevant updates (Silverman & Hinshaw, 2008). This second special issue replaced the term *empirically supported* with the term *evidence-based* and asked contributing researchers to discuss the effectiveness of treatments, which had not been emphasized in prior reviews. Another classification was also introduced – *experimental treatments* – which constituted treatments not yet tested in trials meeting Task Force criteria for methodology. This new category allowed for quick identification of treatments that may be widely implemented but not effective.

Rather than waiting another ten years before disseminating more updates, the *JCCAP* more recently started releasing follow-ups, called "Evidence Base Updates," as soon as five years later, across separate issues (Southam-Gerow & Prinstein, 2014). Review criteria used for Evidence Base Updates include five levels: well-established treatments; probably efficacious treatments; possibly efficacious treatments; experimental treatments; and treatments of questionable efficacy. In addition to having new authors update the previous reviews, some new topics (e.g., bipolar spectrum) have also been addressed for the first time.

Starting with the 1998 special issue, the SCCAP has emphasized the importance of manualized or operationalized interventions to ensure standardization of intervention procedures (see Barth et al., 2012). Using treatment manuals in this manner is necessary for other researchers and practitioners to readily replicate the specific components and procedures of the interventions employed. One side effect of emphasizing treatment manuals, however, is that several different "name-brand" therapeutic approaches can become identified as being evidence-based even though they are largely operating under the same principles of behavior change.

In the 1998 review, treatments for ADHD were evaluated as a group if they had comparable but not necessarily identical interventions – for example, behavioral parent training (Pelham, Wheeler, & Chronis, 1998). In contrast, however, the review of treatments for conduct problems (Brestan & Eyberg, 1998) identified specific published manuals as evidence-based. For example, Parent–Child Interaction Therapy, the Helping the Noncompliant Child program, the Positive Parenting Program, and the Incredible Years program were all identified separately as being probably efficacious for young children with disruptive behavior even though they were all derived from the same two-stage Hanf model of parent training (Reitman & McMahon, 2013), and they are very similar approaches. Thus, the use of manuals as a form of therapy differentiation in some (but not all) of the reviews led to some questions. Should therapists learn each manual or should they choose one? How should therapists decide which manual to choose? Is it the place of scholars to promote name-brand therapies or more generic, nonproprietary, therapeutic approaches?

Identifying Components of Evidence-Based Treatments

Most treatment packages are comprised of multiple distinguishable components, and analyzing treatments at the component level, rather than at the manualized treatment package level, is another way to identify evidence-based approaches. Bruce Chorpita and colleagues have been strong advocates for the component level of analysis (Barth et al., 2012; Bernstein et al., 2015; Boustani et al., 2017; Chorpita & Daleiden, 2009; Chorpita et al., 2011; Chorpita, Daleiden, & Weisz, 2005), and the multiple writings on this topic by these authors and others have led to the use of several terms.

Boustani et al. (2017) provide a helpful glossary of terms related to the component level of analysis. For example, they define the *common elements approach* as the identification of "specific practice techniques and strategies common across a defined set of selected treatments" and that occur within a specific context, such as treatment for a specific disorder (2017, p. 199). Although, the common elements approach aims to identify which elements are common across EBTs, there is generally not enough research to show which of the components are critically important to a treatment's success. However, occasionally research studies, such as those using dismantling designs, can help identify which elements are actually necessary.

Terms such "essential elements" or "effective ingredients" tend to denote either that the treatment element is necessary for the package to work or that the element can even work when used alone. This book, as reflected in the subtitle, uses the even broader term of "components" of EBTs. That is, most chapters discuss common elements as well as other elements that are used in EBTs even if they are not common across multiple EBTs. It would be reasonable to give more weight to elements that are used across EBTs, but it's still valuable to know about the other elements used in EBTs as

well. Other variations of terms conveying similar ideas include "practice elements," "behavioral kernels," and "principles of behavior change."

In the above example of several name-brand variations of behavioral parent training, these interventions share several common elements, including parent attention, effective commands, praise, and time-out. More broadly, Chorpita et al. (2011) have identified 41 components that are commonly used in psychological treatments for a variety of mental health challenges in youth. A few of the other examples of components include problem-solving, relaxation, exposure, cognitive restructuring, and modeling. Thus, some of these components are used in EBTs across multiple disorders, such as cognitive restructuring, which is often used in the treatment of depression, anxiety, and anger.

It is important to note that the common elements approach is best thought of as a complement to the system of identifying treatments based on their manuals. In fact, *modular* treatments include manuals that emphasize some necessary core components while also including some additional supplemental components that may be selected based on the needs of the youth (e.g., Chorpita, 2007). These days, treatment manuals tend to provide more flexibility for therapists in terms of both which components are used and the order in which they are implemented. There has also been a similar move toward *transdiagnostic* treatments, which involves using the same packages and/or components for multiple related disorders (e.g., anorexia and bulimia).

Similar to the common elements approach, another framework seeks to identify *common factors*. Whereas common elements involve specific techniques and strategies, common factors include "nonspecific factors of therapy that characterize many psychosocial interventions" (Boustani et al., 2017, p. 199). One example of a common factor is therapeutic alliance, or the degree to which the therapist and client have a good bond with each other, agree about the therapeutic methods, and share the same therapeutic goals (Bordin, 1979). Another example is the degree of client involvement in therapy, such as active participation (O'Malley, Suh, & Strupp, 1983). These common factors are discussed in the penultimate chapter of this book.

Interestingly, the component-based approach emphasized in this book is not novel but is a return to the early days of behavior therapy, in which the emphasis was on operationally defining the environmental manipulations that were used to produce behavior change. As discussed above, this was in stark contrast to the nonspecific therapies that for so long dominated the field of psychotherapy. McFall's "Manifesto" presaged the current movement of common elements and common factors.

Conclusion

This book is largely focused on the components of EBTs for specific disorders and related behaviors in youth. Most of the book emphasizes the components of well-established treatments if they have been identified. When there are not yet

well-established treatments, this book reviews the components of probably efficacious treatments, and when no treatments meet the criteria for well-established or probably efficacious, then the best available evidence was used to guide the selection of components to be reviewed.

The component-based analysis is meant to be a complement to the manual-based treatment package emphasis that has been dominant since Division 12 of the American Psychological Association first commissioned a task force to identify treatments that work. Beyond the components of EBTs, many other factors have the potential to influence the success of a particular treatment for a particular youth. The role of parents in the therapeutic process varies widely. Assessment before, during, and after therapy typically shapes interventions in profound and invaluable ways. Many clients present with more than one mental health challenge, and how well specific therapies work can partially depend on demographic characteristics as well as common factors that are shared across therapies. Many clients get medication in addition to, or instead of, psychosocial interventions. Taken altogether, it's a wonder that any therapist is ever able to deal with these interacting factors in a way that makes meaningful change in anyone's life. The good news is that new research is published every day to point therapists and their clients in a better direction, and this book has been designed to help in this difficult, but hopefully rewarding, process.

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