

Chapter 6

Evidence-Based Psychotherapy in Childhood and Adolescence



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In the early 1990s, a task force of Division 12 of the *American Psychological Association* (Society for Clinical Psychology) developed a set of criteria to establish a psychological intervention as an “empirically sustained treatment” (Chambless, 1993). This required that it meet two criteria: (1) it had to be described in a manual, to standardize procedures (the independent variable in question), and thus enable therapists to replicate what had been previously tested, and (2) there had to be experimental evidence proving its efficacy, which could come from two or more randomized clinical trials or from a set of single-case experiments¹ (Chambless & Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

The first report of the Division 12 task force, published in 1995, listed 18 empirically supported treatments and was updated several times in subsequent years (e.g., Chambless et al., 1998).² The focus, however, was on the adult population, with only a few of these treatments targeting childhood and adolescent disorders. In light of this, the Child Clinical Psychology section of Division 12 organized a new task force aimed at identifying empirically sustained psychological interventions for children and adolescents (Lonigan et al., 1998). Using similar criteria as the first task force, the result of this new task force culminated in a list of 27 empirically supported psychosocial interventions for depression, anxiety disorders, attention

¹For a brief explanation about different research method in psychotherapy, please refer to Leonardi 2017).

²Currently, a list of empirically supported treatments, their respective manuals, the clinical research on which they are based, and information on training in these therapies can be found at <www.div12.org/psychological-treatments>. It is worth noting, however, that Division 12 has been replacing the assessment of clinical trials or single-case experiments with systematic review with meta-analysis (Tolin et al., 2015), a method used to synthesize clinical research, explained later.

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deficit hyperactivity disorder, oppositional defiant disorder, and autism was published in 1998 in a special issue of the *Journal of Clinical Child Psychology* (which was later renamed the *Journal of Clinical Child and Adolescent Psychology*).

The impact of this work was enormous, which can be seen by the fact that the articles published in this special issue were cited 1140 times in less than 10 years (Silverman & Hinshaw, 2008). In 1999, the Clinical Child Psychology section of Division 12 became its own division – Division 53, currently titled *Society of Clinical Child and Adolescent Psychology* – and since then has been contributing to the development of evidence-based interventions for the prevention and treatment of mental health problems in children and adolescents (Erickson, n.d.).

After a long struggle between various theoretical, conceptual, methodological, and practical perspectives on empirically supported treatments (cf. Leonardi & Meyer, 2015), the American Psychological Association (2006) defined the concept of **evidence-based practice in psychology** as an individualized clinical decision-making process that occurs through the integration of the best available evidence (i.e., therapeutic procedures that are proven to produce positive outcomes and minimize negative outcomes) with clinical expertise (i.e., the ability to formulate the case, apply techniques, monitor progress, establish therapeutic relationship, etc.) in the context of the patient's characteristics, culture, and preferences (i.e., their goals, values, beliefs, context, and clinical status). From this perspective, the three elements of the definition – empirical evidence, professional repertoire, and patient idiosyncrasies – are fundamental in clinical decision-making, so that a professional practice that does not consider the interrelationship between the three components cannot be seen as **evidence-based practice in psychology**.

Waschbusch et al. (2012) point out five characteristics in common in evidence-based interventions for children: (1) they are systematized, extensively studied treatments, described in manuals; (2) they are based on reinforcement programs, both in sessions with therapist and at home and school, to strengthen appropriate behaviors; (3) they involve training of several types of skills, with the main agents of change being parents, teachers, or both; (4) they are behavioral or cognitive behavioral interventions, directed mainly to specific target behaviors; and (5) they typically include procedures to facilitate generalization and maintenance of gains over time.

Implementing evidence-based practice in everyday clinical practice may seem like hard work or even unfeasible, mainly because of the vastness of studies and the heterogeneity among them. In addition, often the therapist has little time available to devote to fundamental questions of critical consumption of research, such as the characteristics of the sample (if it was representative, randomized, and generalizable), the integrity of the procedure (i.e., if the intervention was really executed as planned), the definition of the dependent variable and the way to measure it, the experimental control (if it was adequate and replicable and has clinical meaning), and data analysis (if it assessed intention to treat, if it used appropriate statistical tests, and if it calculated clinical significance), among others. In this sense, it is difficult to know which evidence is reliable and, therefore, which should support the clinical practice, which prevents therapists from reaching a conclusion on the best conduct on each occasion (Norcross et al., 2008).

Many authors (e.g., Schlosser, 2006), taking into account all these difficulties, began to consider the systematic literature review as the first step toward evidence-based practice. This type of study has achieved such relevance because it is a rigorous and replicable protocol that allows comparative analysis of the results of many studies and thus obtains a synthesis of the effects of a certain intervention. Currently, most systematic reviews include meta-analysis, a statistical method that allows mathematically grouping clinical research that used different statistical tests and obtained discrepant results, giving rise to a set of data that represents a summary of the totality of experimental studies (clinical trials or single-case experiments).

Despite the immense prestige it enjoys in evidence-based practice, systematic reviews also present a risk of bias. An example of this is in the process of selecting the research to be included. An article (Kicinski et al., 2015) that examined this type of bias identified that statistically positive results are 27% more likely to be included in review papers in the health area. In addition, the same study found that, in systematic reviews on the safety of drug use, studies that point to a lack of evidence of side effects are 78% more likely to be included in the systematic review than those that reported side effects. To avoid this and other biases, it is essential that the entire data selection and analysis procedure be established and described before the review is conducted. Systematic reviews that respect standardized criteria for the selection and analysis processes of experimental researches may offer essential information about the quality of evidence of a given intervention (Atallah & Castro, 1998). Nevertheless, all this methodological rigor is not necessarily sufficient for the best clinical decision-making.

In 2000, the *Grading of Recommendations, Assessment, Development and Evaluation* (GRADE) working group was created with the purpose of developing a system to assess the quality of evidence and the strength of health recommendations through several factors, such as the methodological quality of the studies, the variability of the results, the balance between desirable and undesirable effects of the intervention, etc. (Guyatt et al., 2011). Currently, GRADE is considered the gold standard in the development of clinical *guidelines*.

Clinical guidelines are recommendations for clinical decision-making that are systematically developed and updated by experts in a given health area, which aim to help professionals offer the best available intervention based on research evidence (Graham et al., 2011). The system proposed by GRADE classifies the quality of evidence into four different levels: high (future research is unlikely to change the confidence in the effect estimates), moderate (future research may have an impact on the estimates), low (future research is very likely to change the estimates), or very low (any effect estimate is very uncertain). Evidence based on randomized clinical trials starts out as high quality, but can be revised if it shows factors such as inconsistencies in results, methodological problems, imprecision, or publication bias (Guyatt et al., 2008).

As for the strength of the recommendations, the GRADE system offers two categories: strong (desirable effects clearly outweigh the undesirable ones or clearly do not) or weak (there is no certainty about the relationship between desirable or undesirable effects). Other factors taken into account when evaluating recommendations

are patient preferences and values, as well as estimates of the appropriate use of health system resources, such as cost-effectiveness studies (Guyatt et al., 2008).

The set of clinical guidelines of the UK public health system, the *National Institute for Health and Clinical Excellence* (NICE), is considered one of the most consistent in the world, consisting of more than 120 clinical recommendations based on cost-effectiveness. In 2006, NICE abandoned its traditional classification system to adopt the GRADE system. With this, it began to adopt the practice of assessing confidence in effect estimates for each outcome, weighing both desirable and undesirable outcomes and costs, then generating a judgment on the strength of the recommendation (Thornton et al., 2013).

The NICE guidelines establish recommendations for the most appropriate services for most people with a particular diagnosis, condition, need, or belonging to a particular social group. It also recommends ways to promote and protect health and prevent illness and ways to configure health and social services. Finally, it also establishes how public organizations can improve the quality of health services³. With regard to child and adolescent health, NICE currently offers a total of 73 guidelines, covering everything from cochlear implants to fevers in under-5s.

This chapter aims to present a synthesis of the guidelines of NICE and Division 53 – *Society of Clinical Child and Adolescent Psychology* – of the *American Psychological Association* regarding psychological intervention practices in childhood and adolescence. In this sense, the text does not describe the elements and techniques that make up each intervention but offers a kind of guide so that the reader can more easily locate the empirically supported treatments for different clinical pictures.

Depression

The NICE clinical guidelines for depression in children and adolescents adopt a five-step model. The first step establishes that primary care health professionals are trained to identify symptoms of depression and assess risk factors, referring the child to mental health services when necessary. The second step refers to the abilities of health professionals specialized in depression to assess the referred children, using as tools interview instruments such as *Kiddie Schedule for Affective Disorders and Schizophrenia* [K-SADS] or *Child and Adolescent Psychiatric Assessment* [CAPA] and also nonverbal mood assessment in younger children. Of the two tools, only the K-SADS was translated and validated for the Brazilian population (Brasil, 2003).

For children with mild depression (step 3), NICE recommends a “watchful waiting” of 4 weeks after the first assessment. If symptoms have not remitted, nondirective supportive therapy, cognitive behavioral therapy (CBT) group, or guided self-help are offered as options for a limited period between 2 and 3 months.

³At: <www.nice.org.uk/process/pmg20/chapter/introduction-and-overview>

Children with moderate to severe depression (steps 4 and 5) should be offered specific psychological therapy for at least 3 months. NICE does not indicate a specific psychological approach and proposes that, in the initial period of treatment, it should be explained to the child and family members that there is no superiority relationship between psychological therapies. If the child is unresponsive to treatment after six sessions, referral for multidisciplinary assessment is considered to consider alternative treatment for the child or additional therapy for the parents. In children 5 to 11 years old who are unresponsive to psychotherapy, one may cautiously consider the use of an antidepressant (National Institute for Health and Care Excellence, 2019).

The *American Psychological Association's* Division 53 differs from NICE in that it places the major psychological approaches for depression in children at different ranks regarding the level of evidence⁴. Group CBT (comprehensive or technology-assisted) and behavioral therapy are classified as *might work*. Individual CBT, psychodynamic therapy, and family intervention are classified as “experimental,” that is, one level below on the scale (Weersing et al., 2017).

Despite the high prevalence rate and devastating effects of depression in children, there is little research regarding empirically supported treatments and issues such as comorbidity, family involvement, type of treatment (group vs. individual), and relapse prevention (Cummings & Fristad, 2008). A recent systematic review article (Weersing et al., 2017) concluded that the evidence for depression treatments for children is notably weaker than interventions for adolescents, with no treatment reaching “well-established” status.

There are numerous differences between the studies included in the systematic reviews that support the guidelines. Cummings and Fristad (2008) identified behavioral and cognitive techniques present in most of them. Among the behavioral techniques, exposure, contingency management, scheduling of activities, and relaxation training are highlighted. Among the cognitive techniques, the authors mention self-monitoring, identification of beliefs, and cognitive restructuring. In addition, such interventions seek to help the child in social relationships, offering training in social skills, verbal and nonverbal communication, and problem-solving. Most interventions also work with children's family members.

Attention Deficit Hyperactivity Disorder (ADHD)

The NICE clinical guidelines for treatment of ADHD are divided between children under 5 years and above this age. For children under 5 years, a parent coaching focus group is recommended as a first line of treatment. If symptoms are still having

⁴Division 53 classifies the interventions into five categories, according to their respective levels of effectiveness. The categories are (1) works *well*, (2) works, (3) *might work*, (4) *experimental*, and (5) *tested and does not work*.

a major impact on the child's life after coaching, consultation with a physician specializing in childhood ADHD is suggested.

For children older than 5 years, the recommendation is to provide information about ADHD as well as additional support for parents, including education and information about the disorder, advice on parenting strategies, and linking to school (with consent). The recommendation is that both parents participate. Medications are only recommended if symptoms are still significantly impacting the child's life even after environmental changes. For children who have benefited from medication but still have significant difficulties, CBT for children with ADHD is considered (National Institute for Health and Care Excellence, 2018).

In the clinical guidelines of the American Psychological Association Division 53, the interventions with the highest level of scientific evidence (level 1: *works well*) are behavioral interventions. Interventions with combined medication training and behavioral therapy are one level below (*works*), and neurofeedback training is classified as level 3 (*might work*) (Evans et al., 2014).

The most frequent empirically supported interventions in ADHD are behavior change strategies through parent training and school-based interventions (Pelham Jr. et al., 2017). Both typically include ADHD psychoeducation for parents and teachers to teach them to identify and praise appropriate behaviors and consistently use appropriate consequences for disruptive behaviors, as well as to help parents and teachers structure the school and home environment and generate realistic expectations (Hoza et al., 2008).

Other empirically supported treatment resources for ADHD are summer programs. Such programs are geared toward children ages 3 to 16 and generally last 7 to 8 weeks, 8 to 9 hours per day. Some of the strategies used are a scoring system for appropriate behavior, social reinforcement in the form of public praise or recognition, daily record cards, "prudent punishment," medical assessment, and school skills training (Pelham Jr. et al., 2017).

Autism

According to NICE guidelines, children with autism and their families should receive detailed information about autism and its treatment from the time of diagnosis, in a manner appropriate to their stage of development. Some interventions are not recommended under any circumstances: neurofeedback, auditory integration training, secretin, chelation therapy, and hyperbaric oxygen therapy.

Regarding problem behaviors, the initial recommendations are to anticipate and prevent them by identifying the factors that increase the likelihood of occurrence, for example, communication difficulties, body conditions (such as gastrointestinal problems and pain) or emotional conditions (anxiety, depression, etc.), noise levels, or lights, among others. The next step is to offer some possible interventions.

If specific aspects that cause the problem behaviors are not identified, a psychosocial intervention based on functional behavior analysis is recommended as the

first line of treatment. The interventions should, among other things, clearly identify the target behaviors, focus on quality of life outcomes, and access and modify environmental factors, taking into account the child's developmental stage (National Institute for Health and Care Excellence, 2013a). When psychosocial interventions are not effective, the use of antipsychotics is considered.

In relation to the *American Psychological Association's* Division 53 classifications of empirically supported treatments, applied behavior analysis (commonly referred to as "ABA") has resources divided into three different levels of evidence. Classified as level 1 (*works well*) are tailoring interventions according to IQ or developmental level and joint engagement in playful activities with caregivers and teachers. Among the interventions indicated as level 2 (*works well*) are the use of figures and symbols to make requests, imitation, language, and cognitive skills, among others. Among the interventions classified as level 3 (*might work*) are training in social skills rated by the teacher and training in the use of spoken words to engage or make requests and engagement with objects in the interaction with teachers and others (Smith & Iadarola, 2015).

It is important to note that, from this perspective, the term ABA refers to a philosophical, theoretical, and technical basis from which different interventions derive, such as DTT (*discrete trial training*), IT (*incidental training*), and PRT (*pivotal response training*). Among the common characteristics are the constant measurement of operationally defined behaviors, the systematic use of reinforcers, the basis in functional analysis, and the emphasis on generalization of learned skills (cf. Cooper et al., 2007).

Obsessive Compulsive Disorder (OCD)

The NICE guidelines for OCD present different recommendations depending on the intensity of symptoms and the degree of impairment experienced. When there is a mild level of impairment, guided self-help for children is recommended, as well as support and information for parents and caregivers. When the impairment caused by the disorder is greater, the recommendation is CBT, including exposure with response prevention, involving family members and caregivers, and adapted to the developmental stage of the child.

According to NICE, treatment should include a good therapeutic alliance, maintain optimism in the child and family, identify key treatment targets, engage the family and caregivers especially in exposure with response prevention (encouraging the return of the technique if new symptoms appear after the end of treatment), and involve teachers and other health professionals (National Institute for Health and Care Excellence, 2005).

Among the psychotherapeutic treatments listed by the *American Psychological Association* Division 53, individual CBT is categorized as level 2 evidence (*works*). Group CBT is one level below that (*might work*). At level 4 (experimental) is technology-based CBT, such as treatment through online social networks (Freeman

et al., 2014). The main resources used in CBT for OCD are exposure with response prevention, cognitive techniques, and family involvement.

Thus, it can be concluded that treatment is based on behavioral and cognitive conceptualizations of the disorder, combining exposure and response prevention techniques with cognitive restructuring (Franklin et al., 2017; Storch et al., 2008).

Anxiety

In recent decades, several treatments have been developed specifically for the treatment of anxiety in children. These have varying levels of evidence for efficacy (Silverman & Pina, 2008). However, NICE does not have a more comprehensive category for anxiety in children, although there are guidelines for social anxiety. As general principles for the treatment of this diagnosis, regular clinician supervision, use of outcome measures, engagement in monitoring, assessment of treatment adherence, and clinician competence are recommended. Regarding the approach, NICE recommends CBT focused on social anxiety for children as the most recommended, always considering the active involvement of parents and caregivers in treatment (National Institute for Health and Care Excellence, 2013b).

In the clinical guidelines of Division 53 of the *American Psychological Association*, six interventions were included in level 1, that is, in the category of treatments with the highest level of scientific evidence (level 1: *works well*): CBT, exposure techniques, modeling, CBT with parents, patient psychoeducation, and CBT combined with medication. One level below (*works*) are family psychoeducation, relaxation, assertiveness training, attention control, CBT for parents and children, cultural *storytelling*, hypnosis, and stress inoculation (Higa-McMillan et al., 2016). It is worth noting that most CBT-based treatments for anxiety include psychoeducation, somatic symptom management skills, cognitive restructuring, gradual exposure to feared situations, and relapse prevention plans (Kendall et al., 2017).

Disruptive Disorders

In this category, there are mainly two diagnoses: oppositional defiant disorder (ODD) and conduct disorder. NICE guidelines initially recommend selective prevention, where children at higher risk (low school performance, impulsivity, parental contact with criminal justice, abuse, low education, and low family income) are identified and offered preventive interventions such as emotional learning in the classroom and problem-solving programs.

The second point discussed in the guidelines is evaluation at two levels. The first level takes place in diverse *settings*, such as general health and social care systems, educational settings, and the justice system, among others. The second level is a comprehensive assessment conducted by a mental health or social care professional,

which should take into account factors such as patterns of negativity, hostility or challenging behavior, functioning at home and school and with friends, parenting quality, and history of some other mental or physical problem. It should also investigate learning difficulties, disabilities, neurodevelopmental conditions such as autism or ADHD, neurological disorders such as epilepsy or motor impairment, substance abuse, or communication disorders. The assessment should also make use of instruments and include an interview with parents/carers.

As for interventions for ODD or conduct disorder, the main NICE recommendation is parent training programs. The groups should have 10 to 12 parents and are composed of 10 to 16 sessions of 90 to 120 minutes duration. Interventions are based on social learning, using modeling, behavioral rehearsal, and feedback to improve parenting skills. Ideally, both parents should be involved in the program (National Institute for Health and Care Excellence, 2017).

In the *American Psychological Association's* Division 53 evaluation of empirically supported treatments, the interventions with the highest level of evidence (*works well*) are the combined treatments of behavioral therapy, CBT, and family therapy, such as multisystemic therapy or *Treatment Foster Care Oregon* (TFCO). Treatments that involve CBT or behavioral therapy alone or even skills training all have lower levels of evidence of effectiveness (Kaminski & Claussen, 2017).

Final Considerations

This chapter has presented a synthesis of the research evidence-based recommendations offered by NICE and the *American Psychological Association's* Division 53 on the best psychological treatments for some clinical conditions in children and adolescents. It is up to the reader interested in implementing these interventions to appropriate each of them in their respective manuals (books that describe step by step how to perform them). In addition, we suggest reading compendia that deepen the topics covered in this chapter and describe empirically supported interventions for other problems (posttraumatic stress, enuresis and encopresis, eating disorders, self-mutilation, chemical dependence, suicide, etc.). Some examples are the following books:

- Weisz, J. R., & Kazdin, A. E. (Orgs.). (2017). *Evidenced-based psychotherapies for children and adolescents*. Guilford.
- Theodore, L. A. (Org.). (2016). *Handbook of evidence-based interventions for children and adolescents*. Springer.
- Sturmey, P., & Hersen, M. (Orgs.). (2012). *Handbook of evidence-based practice in clinical psychology: Child and adolescent disorders*. Hoboken: Wiley.

In summary, it is hoped that this chapter has impelled the reader to act according to the model of evidence-based practice in psychology in the prevention and treatment of mental health problems in children and adolescents.

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