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Research on counselling and psychotherapy with children and young people: a systematic scoping review of the evidence for its effectiveness from 2003-2011

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Executive summary

Objectives

Therapeutic work with children and young people is receiving more resources and attention in the UK, as shown in the recent development of a national strategy for school-based counselling in Wales (Pattison et al, 2007). This arises from recognition of the mental health needs of children and young people. In 2004, BACP published a review of the effectiveness of therapeutic interventions with children and young people (Harris and Pattison, 2004). This study updates that review and seeks to answer the same questions. In addressing the overall question – Is counselling and psychotherapy effective for children and young people? – three sub questions were identified:

1. Which types of counselling and psychotherapy interventions work?
2. For which presenting problems?
3. For whom?

These questions informed the 2004 review and this update.

The nature of the review

The 2004 review was informed by the BACP definition of counselling at the time of publication, that:

> “Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be ‘sent’ for counselling.” (Harris and Pattison, 2004)

This study takes on board the updated (2012) BACP definition of counselling, particularly in relation to counselling in schools:

- “Counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing.
- Counselling can be an effective early intervention strategy for children and young people who have emotional, behavioural or social difficulties, with the aim of alleviating, lessening or preventing these problems from becoming more complex, costly and requiring referral to specialist services.
- School-based counselling is a professional activity delivered by qualified practitioners in schools. Counsellors offer troubled and/or distressed children and young people an opportunity to talk about their difficulties, within a relationship of agreed confidentiality.”

Scoping study: definition of terms

This study is a systematic scoping review, whose aim is to map rapidly the key concepts underpinning the research area and the main sources and types of evidence available. Statistical methods were not used, nor were the studies in meta-analyses reanalysed. Instead a narrative approach was adopted to describe the extent and nature of the literature. Systematic methods were used to review the evidence, as described in the methodology section. Judgements about the quality of studies were made when deciding which should be included in the review and the quality of included studies was also appraised and reported on. Two broad categories of study were included in the review: new studies published since 2003 and systematic reviews published post-2003, which may have included pre-2003 studies.

The nature of the evidence

Studies that fell into any of the following domains, as categorised in the 2004 review, were included in the update:

1. The evidence from systematic reviews and meta-analyses.
2. The evidence from controlled trials, including randomised control trials (RCTs) and controlled before and after studies (CBAs) that did not use randomisation.
3. Supporting evidence from cohort studies, case studies, observational and exploratory studies, and methodological papers that raise issues for future research in this field.

Review methods

- Bibliographic databases searched using CSA Illumina, which provides access to more than 100 databases
- 517 papers identified through Illumina
- 513 records identified after duplicates removed
- 317 excluded after screening
- 196 records further screened and 53 excluded after reading abstracts
- 143 full text articles assessed for eligibility
- 41 excluded
- 102 full text articles included in the review
- Additional 12 papers identified through other sources
- 114 included in the final synthesis

Findings

Which types of interventions work?

Cognitive behavioural therapy

Cognitive behavioural therapies (CBT) were found to be effective for anxiety and behavioural and conduct problems. There is less evidence of the effectiveness of CBT for children as opposed to adolescents, and for depression as opposed to anxiety. More studies investigated CBT than any other therapeutic intervention (36 per cent of total interventions). There is a need for further research to investigate the long-term effects of CBT interventions and to explore differential responses to CBT in children and adolescents with anxiety and depression.

Psychodynamic therapy

Unlike CBT studies, which have been carried out predominantly in the US, studies using psychodynamic therapies have a much wider geographical spread. Psychodynamic interventions are effective for a variety of presenting problems, including mood disorders such as depression. There is a small amount of evidence to support the construct of a 'sleeper effect' for psychodynamic therapy, which refers to how symptomatic recovery can be greater at six-month follow-up than at the end of therapy. There is a need for further research in this area.

Play therapy

The number of studies investigating play therapy has grown from just two in the 2004 review to 14 in this update. One of these is a systematic review of 93 studies, marking the growth in the evidence base for this type of therapy. As a therapeutic intervention, play therapy is highly effective for a variety of presenting problems, particularly anxiety and behaviour/conduct problems; for a range of young populations, but particularly primary-aged children; and in a number of settings, particularly clinics and schools.

Humanistic therapies and interpersonal psychotherapy

As evidenced by a number of studies, humanistic therapies are effective in school settings. Interpersonal psychotherapy (IPT) was found to be beneficial for children and adolescents with depression, particularly when presenting problems involved relational issues rooted in conflict.

Non-specific factors

Beyond specific therapeutic approaches certain therapist behaviours and practices were found to be associated with outcome. Therapists' behaviour in the first stages of treatment was associated with young people's subsequent engagement in their therapy. Other factors positively associated with outcomes were paying attention to the client's level of motivation, less structuring of the therapy and paying attention to the young person's experiences. Therapists' selection of an appropriate treatment strategy was also important, along with offering choice to clients and being sensitive to gender and cultural issues.

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For which types of problems?

Depression
In the case of depression, psychological therapy was generally found to be beneficial and more effective than either no treatment or treatment as usual. A range of therapeutic approaches emerged as effective in the treatment of adolescent depression, including CBT, IPT, psychodynamic and family therapies. Treatments were effective in the short term (up to six months) and there was little discernible difference in outcomes between therapeutic approaches.

Anxiety
As in the 2004 review, CBT emerged as an effective therapy for anxious children and adolescents. Little evidence was found for the effectiveness of other approaches in the treatment of this problem. Since 2004, the amount of research in this area has grown steadily, providing a more detailed understanding of the active processes involved in CBT interventions. Evidence has also been accumulating for the effectiveness of IPT in reducing anxiety in young people who are also suffering from depression.

Post-traumatic stress disorder
Most of the therapeutic interventions for PTSD involved short-term CBT-based therapies (including re-exposure interventions, psycho-education, Emotion Recognition and Expression, or Eye Movement Desensitization and Reprocessing (EMDR). Parental involvement in the therapy was important for the success of CBT interventions, with the exception of cases where there were especially negative family circumstances or where parents may be perpetrators of abuse.

Behaviour and conduct disorders
Similar to the 2004 review, the majority of studies investigating behaviour and conduct disorders employed CBT interventions that were found to be effective. Conduct disorders were sometimes associated with PTSD. Other effective interventions included Behavioural Parent Training (BPT) for both pre-school and school-aged children, which was less effective with adolescents than with younger children. More generic work with parents to help young people with conduct disorders also had evidence of effectiveness. Some interventions had detrimental effects where following the intervention, levels of antisocial behaviour actually increased. Such programmes, based on a ‘get tough’ approach, were not appropriate for the developmental stage of the child and ignored the powerful influences of the psychosocial context (eg peer pressure).

Learning difficulties and school-related problems
Counselling interventions are reasonably well established in UK and US schools, although defined differently in the two countries. A dearth of research into the counselling of children with learning difficulties persists. The small amount of research available suggests that treating learning difficulties and school-related problems in school settings may have some advantages over treatment in mental health clinics. Additionally, a comparative study found humanistic therapy more effective than CBT for children with learning difficulties.

Children affected by medical conditions
There is a lack of evidence relating to psychological therapy for children affected by medical conditions or for children with parents experiencing serious health issues. More research is needed in this area.

Self-harm
More research is also needed in relation to self-harm in children and young people. The current evidence is inconclusive, and this has consistently been identified by reviews and by a national enquiry as an under-researched area.

Children and young people with eating disorders
There is a stronger evidence base regarding interventions for young people with eating disorders. Family therapy and CBT, including guided self-care, exhibited the most positive results. Other therapies, including IPT, yielded more modest improvements in depressive symptoms and eating behaviours in the treatment of bulimia nervosa. In the case of anorexia nervosa, the importance of an empathic engagement and a therapeutic relationship that can be maintained over time, were emphasised. Further research into the effectiveness of psychological therapies for people with eating disorders is recommended.

Neglect and physical, emotional and sexual abuse
Few studies looked into the effectiveness of counselling specifically for abuse. Within these studies, results pointed towards group treatment being generally beneficial for young people, as it normalised their experiences, with the exception of children with poor social skills who ran the risk of further

rejection. Re-traumatisation in therapy was a risk for children suffering from PTSD. This tended to be avoided by allowing the child a greater sense of control in the session. As discussed above (PTSD section), parental participation only presented benefits when the family was not part of the problem-causing circumstances.

For whom?

Key factors that moderate the effectiveness of therapeutic approaches in the treatment of children and young people, across a range of problems, were race, gender, ethnicity, the child-therapist alliance, and parental involvement. All had an impact on the outcomes of specific interventions. Race and gender matching impacted on client retention and motivation, especially among particular ethnic groups. The need for therapists to be trained to work with difference and diversity was highlighted. Studies indicated that the child-therapist alliance was an important factor but not as significant as the intervention itself and the child's adherence to treatment. Parental involvement was generally beneficial in work with younger children, particularly in the case of play therapy. However, the benefits were less evident with CBT interventions.

Implications for practice and further research

Future research needs to be rigorous and transparent, and capture the complexity of routine practice with this client group. To address this, a wider range of research methodologies is recommended. Attention also needs to be paid to the transfer of research findings into clinical settings to ensure the best outcomes for clients. There is a need for research to address the relationship between age and treatment outcome. This should focus on how treatment approaches can be adapted to the different developmental stages of adolescence and preadolescence. Additionally, research into the long-term impact of interventions with children and young people is recommended. The relative absence of research relating to certain disorders is noteworthy, particularly self-harm and eating disorders, and further research is needed in these areas.

Methodological issues

Methodological discussions were evident in a number of papers included in the review, with particular reference to the evidence-based practice model. Questions regarding the generalisation of experimental research findings to routine practice settings are raised, along with the difficulty of transferring treatments delivered in controlled experiments into routine practice. Likewise, the need to study therapy in routine practice while maintaining methodological rigour is highlighted. More research comparing therapies with usual care (as opposed to no treatment) is recommended, along with the need for improved study designs and richer, more detailed, descriptions of interventions.

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Introduction

This systematic scoping review was commissioned by BACP to contribute to the evidence base for counselling and psychotherapy with children and young people. The review aims to be readable and rigorous, to inform practice, and to reconsider the evidence. It updates the Harris and Pattison (2004) review which asked: Is counselling and psychotherapy effective for children and young people? That work aimed to provide a transparent, replicable and comprehensive review of the research evidence into the effects of counselling and psychotherapy for children and young people, and this review shares that aim. The original review together with this update gives an overview of research between 1980 and early 2011. Both aim to identify the effects of interventions and draw out implications for policy and practice, as well as evaluating methodological issues and identifying priorities for future research.

Nature of the review

The review takes a systematic approach to the process of reviewing the literature on counselling and psychotherapy with children and young people. Details of the review process are in Section 3, Methodology. Because this was an update, the processes used in the 2004 study were mirrored. This had strengths and limitations, but made it possible to see how the field has developed. Similar definitions have been used in this update as in the original review. The 2004 Harris and Pattison review drew on the BACP definition of counselling:

> "Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' for counselling." (Harris and Pattison, 2004)

This definition is a broad one, largely applicable to work with adults. The situation is different for children and young people, as they are often referred by adults rather than self-referring, and this has been acknowledged in this review.

This study takes on board the updated (2012) BACP definition of counselling, particularly in relation to counselling in schools:

- "Counselling and psychotherapy are umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance their wellbeing.
- Counselling can be an effective early intervention strategy for children and young people who have emotional, behavioural or social difficulties, with the aim of alleviating, lessening or preventing these problems from becoming more complex, costly and requiring referral to specialist services.
- School-based counselling is a professional activity delivered by qualified practitioners in schools. Counsellors offer troubled and/or distressed children and young people an opportunity to talk about their difficulties, within a relationship of agreed confidentiality."

A recent report on counselling in Wales (Philips and Smith, 2011) differentiates between the use of counselling and psychotherapy with children and young people, and the application of counselling skills; this review focuses on the former and excludes the latter. The original 2004 review argued that there is little to differentiate counselling from psychotherapy and that they are part of a continuum. We held to this definition.

In addressing the overall question – Is counselling and psychotherapy effective for children and young people? – three sub questions were identified:

1. Which types of counselling and psychotherapy interventions work?
2. For which presenting problems?
3. For whom?

Which types of counselling and psychotherapy intervention work?

The original categorisation of four groups of counselling and psychotherapy approaches was adopted: cognitive behavioural; psychoanalytic; humanistic and interpersonal psychotherapy (IPT); and play/creative therapies. We recognise that humanistic and IPT are very different forms of practice. However, due to the relatively small amount of research into these two therapies, they were combined as a matter of convenience. Table 1 shows the number of studies examining the various interventions.

Table 1: Therapeutic interventions reviewed

Intervention	Frequency
CBT	49
Humanistic therapies and IPT	10
Play/creative therapies	19
Psychodynamic therapies	10
Other (inc. EBT[1] not otherwise classified)[2]	50
Total	138[3]

When interpreting the findings of this review it is important to bear in mind that no evidence of effectiveness is not the same as evidence of ineffectiveness, and that therapeutic approaches other than those reviewed here may in future prove effective.

For which presenting problems?
Evidence on the effectiveness of particular approaches is considered in relation to particular presenting problems (see Table 2).

Table 2: Presenting problems in reviewed literature

Presenting problem	Frequency
Anxiety	23
Depression	13
PTSD	10
School-related issues	5
Learning difficulties	7
Eating disorders	8
Medical conditions	3
Behaviour and conduct issues	10
Self-harm	1
Abuse	5
Other (the term counselling/psychotherapy is used but the problem is unspecified)	27
Total	112

For whom?
The effectiveness of interventions for particular groups was also examined in the review. In particular, issues of age, race, ethnicity, and groups with learning difficulties formed part of the analysis. The importance of developmental issues when working with children and young people was also examined.

Challenges
There were several challenges in conducting this update. First, the large number of papers included in the review made significant demands on resources. Second, resource limitations meant that only a limited grey search was undertaken. Authors adopted a flexible and inclusive approach to hierarchy of evidence, including both quantitative and qualitative studies. This produced challenges in synthesising the data. Third, participant ages were not always clear from the studies, making it difficult to define whether they were focused on children and young people.

1 EBT = evidence-based treatment/therapy

2 Studies that evaluate a number of therapies are only counted once, in the ‘Other’ therapies class to avoid assigning disproportionate weight to these therapies in the evidence synthesis

3 The 112 included papers covered a total of 138 interventions

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The original 2004 study did not include family or filial therapy but acknowledged this was a contentious issue. This update includes family and filial therapy where it was part of a comparative study. The update also investigated the involvement of parents and carers in therapy but 'family therapy' was not used as a search term. The 2004 review noted that psycho-educational approaches and peer involvement in therapy, including peer counselling, were significant areas not included in the review. The update is consistent with this approach, although in some cases psycho-education has been included as part of the CBT literature.

Overview of the reviewed papers
An overview of the included papers is presented here with a more detailed analysis in subsequent sections of the report. The distribution of approaches, types of presenting problems, and types of study are shown in Figures 1, 2 and 3.

Figure 1: Therapeutic approaches in reviewed literature

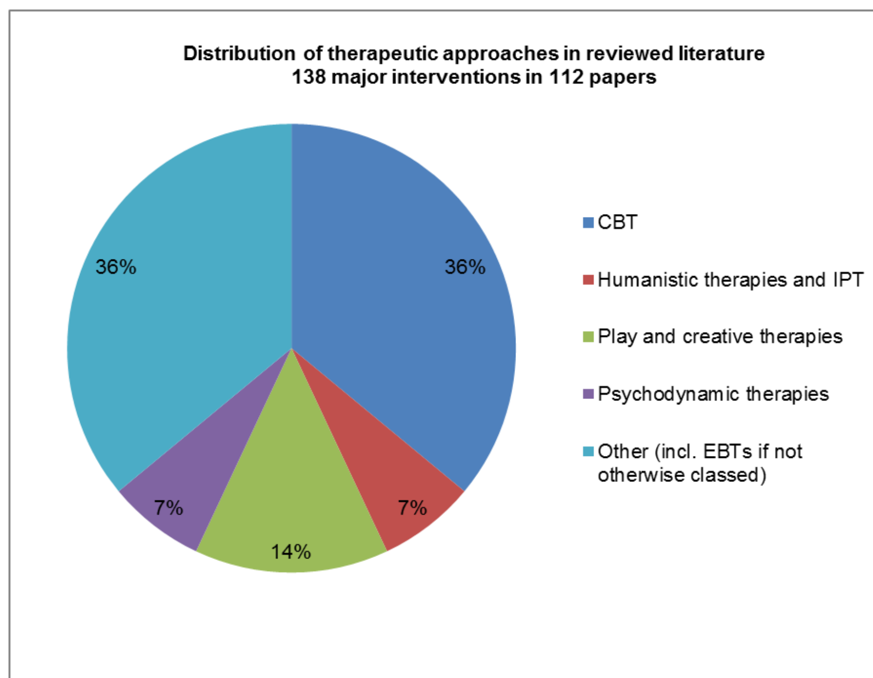


Figure 2: Types of study in reviewed literature

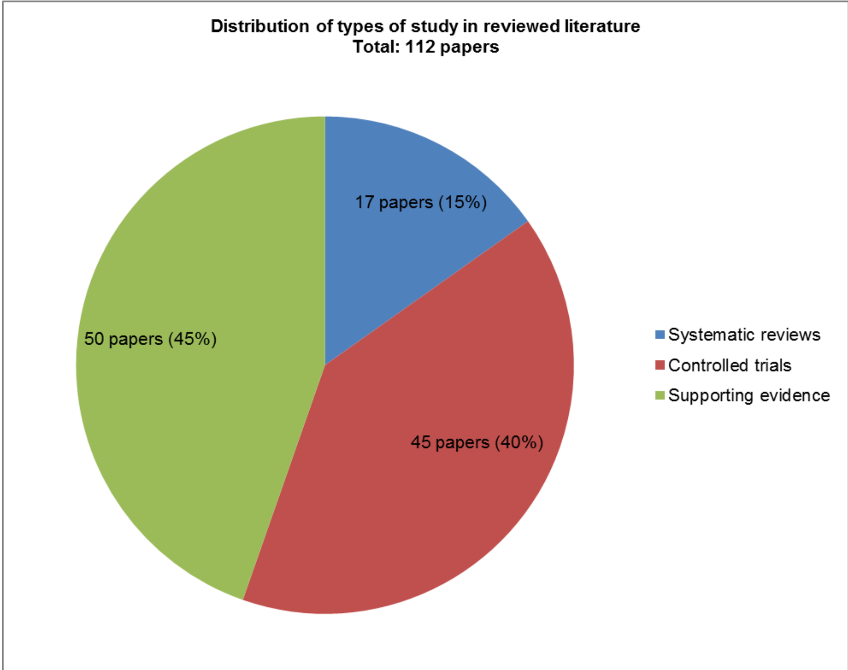
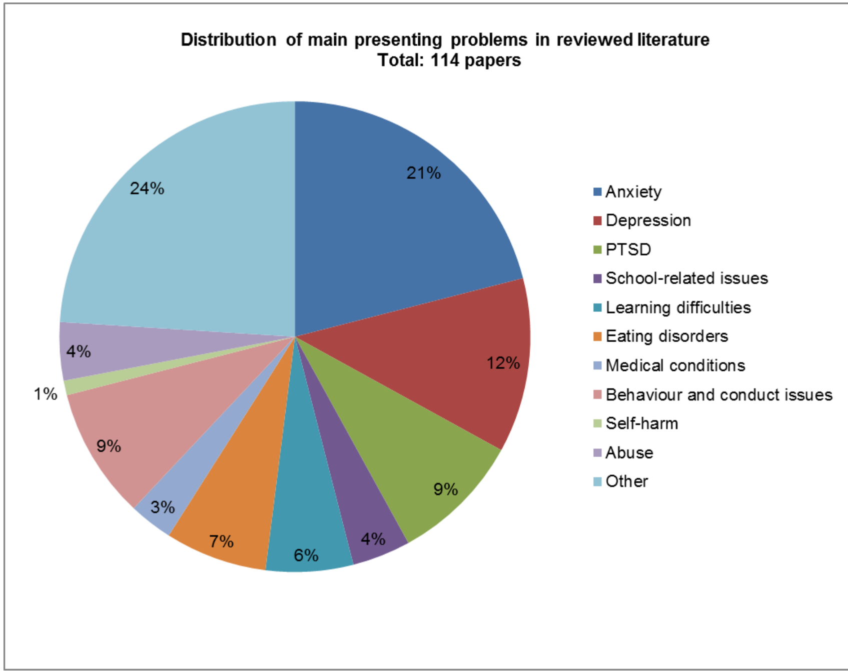


Figure 3: Main presenting problems in reviewed literature



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Methodology

This section details the general approach taken in the review, search methods, the inclusion and exclusion criteria, and the three-stage process of excluding papers. The lists of included and excluded papers are included in Appendix 1.

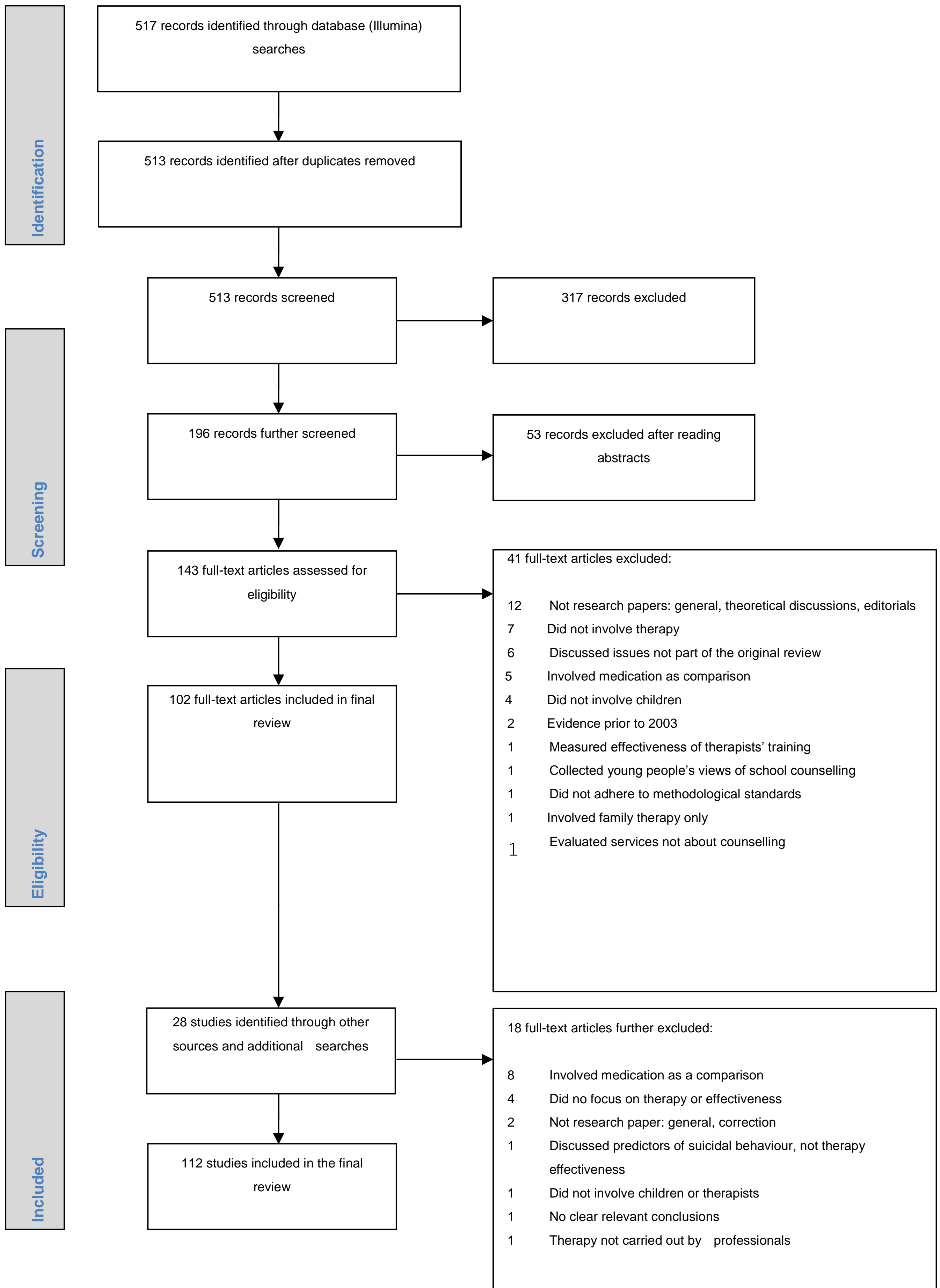
Scoping study: definition of terms

This study is a systematic scoping review. Arksey and O'Malley (2005) observe that definitions of scoping studies are few and far between, noting that scoping studies "aim to map *rapidly* the key concepts underpinning a research area and the main sources and types of evidence available" (Mays *et al*, 2001). The NHS Centre for Reviews and Dissemination (2001) defines a systematic review as:

> "A review of the evidence of clearly formulated questions that uses systematic and explicit methods to identify, select and critically appraise relevant primary research, and to extract and analyse data from the studies that are included in the review. Statistical methods (meta-analysis) may or may not be used."

In this scoping study statistical methods were not used nor were the studies included in systematic reviews reanalysed. However, systematic methods were used to review the evidence. Judgements about the quality of studies were made when deciding which should be included in the review and the quality of included studies was also appraised and reported on. This is discussed further in sections 3.3 and 3.4 below. A three-stage process of searching and excluding studies was used, as shown in Figure 4, and is discussed below. This update of the 2004 review searched for studies published between 2003 and 2011, creating two broad categories: new studies published since 2003; and systematic reviews including numerous studies, some of which may have been published before 2003.

Figure 4: Search and identification process



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Search strategy

The same search strategy as used in the original 2004 study was used in this update. This was important in order to maintain consistency with the original report, but means that inevitably some areas of evidence may have been left out.

The initial list of search terms related to:

- the child and adolescent population, ie child, adolescent, youth, children adolescence and young people
- counselling and psychotherapy counselling, ie counselling, psychotherapy, therapy and children
- terms for outcomes and effectiveness, ie reviews, meta-reviews, effectiveness and outcomes.

This screening was carried out using record titles and abstracts (where available) to ensure the search results conformed to the search parameters and was relevant for answering the scoping study questions.

Bibliographic databases were searched. CSA Illumina was used, providing access to more than 100 databases including: ComDisDome, IBSS (International Bibliography of the Social Sciences), CSA Social Services Abstracts, ERIC, BEI, PAIS International, PsychARTICLES, PsychBOOKS, PsychINFO, and Web of Knowledge.

The grey literature was searched only within PAIS International which includes citations to journal articles, books, government documents, statistical directories, grey literature, research reports, conference reports, publications of international agencies, microfiche and internet material from more than 120 countries. Newspapers and newsletters are not indexed. Internet searches were used to find additional papers.

Inclusion and exclusion criteria

The same position was adopted as in the Department of Health Evidence-Based Clinical Practice Guideline on Treatment Choice in Psychological Therapies and Counselling (2001):

> "The guideline only considers the choice of psychological therapy and does not consider pharmacological treatments. No evidence has been reviewed on their effectiveness or the comparative effectiveness of medication and psychological therapy. This means that recommendations for a psychological therapy do not imply that a pharmacological treatment is not indicated. In general, prescribed medication is not a contra-indication for psychological therapy (or vice versa), and separate consideration will need to be given to pharmacological treatments. Nor is the combination of psychological and pharmacological treatments considered here. The research evidence on the relative merits of either form of therapy or combination therapies will be most appropriately considered in condition-specific guidelines, such as the forthcoming NICE guideline on treatments for depression."

Therefore the following types of treatment and therapy were excluded from this study, as they had been excluded from the 2004 study:

- pharmacological treatments
- psychiatric inpatient settings
- online counselling
- telephone counselling
- peer counselling
- social skills training
- behaviour therapy, although CBT is included
- filial therapy, except where a comparative analysis is made with the effects of individual or group therapy for the child or young person
- family therapy, except where a comparative analysis is made with the effects of individual or group therapy for the child or young person
- psycho-education programmes, except where they form part of a comparison or as part of CBT.

As in the original review, the following criteria were used for inclusion:

- work published between 2003 and beginning of 2011
- children and young people aged three to 19
- individual and group therapy
- work by trained therapists
- in English.

The review articles and meta-analyses were evaluated using the same quality criteria as the original review, which were those suggested by Oxman and Guyatt (1988):

- Were the questions and methods stated clearly?
- Were comprehensive search methods used to locate relevant studies?
- Were explicit methods used to determine which articles were to be included in the review?
- Was the validity of the primary studies assessed?
- Was the assessment of the primary studies reproducible and free from bias?
- Was variation in the findings of the relevant studies analysed?
- Were the findings of the primary studies combined appropriately?
- Were the reviewers' conclusions supported by the data cited?

The approach to judgements about quality taken in this update had three elements. First, information pertaining to the quality of each study is presented; second, descriptions of the study are given alongside; third, a summary section describes information about quality and assesses the overall quality of the literature.

In addition to systematic reviews, meta-analyses and controlled trials, other studies of supporting evidence were included (see Figures 1 to 3). Information on the design of each study is provided in a summary to enable quality judgements to be made. The data were presented in the traditional hierarchy of evidence: systematic reviews and meta-analyses first, then controlled trials (with or without randomisation), with supporting evidence at the end. Studies were excluded if the design was unclear.

The process of selection

Record cards based on a template were kept of each article included in the search (see Appendix 1). Figure 4, the PRISMA chart, shows how many papers were identified at each stage of the review. The first screening was undertaken using abstracts. All the authors read all the abstracts and 317 papers were eliminated. Looking again at abstracts and scanning the articles further screened the remaining 196 papers. A further 53 papers were excluded, leaving 143 articles at this stage. Full texts were obtained and screened and a further 41 papers excluded. A further 28 articles were identified through discussions with subject experts and 18 of these were excluded. This resulted in a total of 112 included papers. The full list of papers, which comprises the included and excluded list, is in Appendix 1, as is the template.

Presentation of the evidence

The evidence is presented in the following order within each section:

1. evidence from systematic reviews and meta analyses
2. evidence from controlled trials: randomised control trials (RCTs) and controlled before and after studies (CBAs)
3. supporting evidence: cohort studies, case studies, exploratory studies, and supplementary papers including methodological papers that added significant methodological material.

Tables are presented within each section of the review detailing the studies, including outcomes such as effect sizes. The original review notes there are different ways to calculate effect size but generally "effect sizes of 0.2 are considered small, 0.5 as medium and 0.8 or over as large" (Harris and Pattison, 2004).

Throughout the review, the following abbreviations are used consistently. Further abbreviations are explained if and when they occur.

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Table 4: Abbreviations used in table presentations of research evidence

ADHD – attention deficit hyperactivity disorder	ICPP – individual child psychoanalytic psychotherapy
AFT – adolescent focused therapy	IPSRT – interpersonal and social rhythm therapy
AMT – anxiety management training	IPT – interpersonal psychotherapy
BPT – behavioural parent training	IPT-A – interpersonal psychotherapy for depressed adolescents
CAMHS – child and adolescent mental health service	IPT-A-IN – intensive interpersonal psychotherapy for depressed adolescents with suicidal risk
CAMHS AIM – child and adolescent mental health service adolescent intensive management	LS – life skills
CANS – child and adolescent needs and strengths scale	MDFT – multidimensional family therapy
CAT – cognitive analytic therapy	NA – not applicable
CBA – controlled before and after study	NT – no treatment
CBS – client behaviour system	OCD – obsessive compulsive disorder
CBT – cognitive behavioural therapy	PBE – practice-based evidence
CCBT – computerised cognitive behavioural therapy	PE-A – prolonged exposure therapy for adolescents
CESA – computer education support attention	PMT – parental management training
CPI – coping power intervention	PSST – problem-solving skills training
CPP – child-parent psychotherapy	PTSD – post-traumatic stress disorder
CWD – coping with depression	RCT – randomised controlled trial
CWD-A – coping with depression course for adolescents	SAD – separation anxiety disorder
DBT – dialectical behaviour therapy	SBA – simple before and after study
EBT – evidence-based treatment/therapy	SET – successive efficacy trial
ECT – electroconvulsive therapy	SO – significant other
EMDR – eye movement desensitization and reprocessing	SP – social phobia
ES – effect size	SPARCS – structured psychotherapy for adolescents responding to chronic stress
FBT – family based treatment	SRIS – self-reflection and insight scale
FESA – family education support attention	SSRI – selective serotonin reuptake inhibitor
FST – family systems therapy	TAU – treatment as usual
GAD – general anxiety disorder	TF-CBT – trauma-focused cognitive behavioural therapy
GCC – good clinical care	TORDIA – treatment of resistant depression in adolescents
HSS – helping skills system	

Findings

Which types of counselling interventions work?

The interventions are grouped under the four main headings of cognitive-behavioural therapy, psychodynamic therapy, humanistic and interpersonal psychotherapy, and the play/creative therapies.

Effectiveness of cognitive behavioural therapy

Background

In April 2008 the National Institute for Health and Clinical Excellence (NICE) issued guidelines for commissioning psychological therapies for common mental health problems. Based on the available evidence, the guidelines report cognitive behavioural therapy (CBT) as an effective intervention for people with depression, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and anxiety. The guidelines state that "the purpose of therapy is to reduce distress or unwanted behaviour by undoing previous learning or by providing new, more adaptive learning experiences" (NICE, 2008). The report points out that CBT can be delivered by trained therapists from a number of disciplines, and also interactively via a computer (CCBT). In addition, it states that the length of therapy might vary among individuals and conditions. An earlier guideline for implementing CBT for children (NICE, 2005) says: "When assessing a child or young person with depression, healthcare professionals should routinely consider, and record in the patient's notes, potential comorbidities, and the social, educational and family context for the patient and family members, including the quality of interpersonal relationships, both between the patient and other family members, and with their friends and peers." The guideline also stipulates the importance of the intervention being delivered by trained therapists: "Psychological therapies used in the treatment of children and young people should be provided by therapists who are also trained child and adolescent mental healthcare professionals".

The majority of studies (n=26) included in this review include CBT in therapeutic treatment for children and young people. The terminology sometimes differs – for example, some studies refer to a 'behaviour change programme' or 'psycho-education' – but they are underpinned by CBT. In this review, behaviour change, behaviourism and psycho-education are incorporated under the CBT heading.

The 2004 review – summary of evidence

The 2004 review concluded that CBT is an effective treatment for behavioural and conduct problems, anxiety, depression, medical illness, school-related issues, self-harm, and sexual abuse.

The 2012 review – summary of evidence

Clinical guidelines and more recent systematic reviews have established that CBT has the potential to play an important role in improving the mental health of children and adolescents. Many of the papers in this review reflect the NICE conclusion that CBT is an effective treatment for children with a wide range of problems, but especially behaviour and conduct disorders, PTSD and anxiety, but it is less effective for depression. CBT tends to be a short-term (less than 12 weeks) treatment and there is little evidence to indicate the effectiveness of longer treatment, or to establish its long-term effects. Further research is needed in this area.

Table 5: Overview of research evidence: CBT

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample*	Findings
Brown *et al*	2008	Children and adolescents	Psychosocial, psycho-pharmacological and combined interventions	Individual and group	Meta-analysis (book chapter)	NA	The analysis reveals that contingency management interventions implemented at home and school have resulted in moderate to large effect sizes for reduction in conduct problems, while CBT and multi-systemic therapies had moderate effects.
Carroll *et al*	2009	Adolescents, male and female	CBT, FBT, school-based interventions	Individual and group and family	Meta-analysis (report chapter)	488	While family interventions appear ineffective and school-based programmes overlook significant groups of at-risk adolescents, CBT therapies are effective in the treatment of young offenders, particularly in one-to-one settings.
Chu and Harrison	2010	Age: 6-18, exhibiting depression, SAD, GAD or social phobia, male and female	CBT and behavioural therapy	Individual and family	Meta-analysis	28	CBT produced reliable, moderate effects for anxiety, depression and general functioning outcomes. CBT was equally effective in producing symptom change in anxiety and in depression studies, but produced comparatively greater behavioural and coping change in anxiety samples. The study suggests that CBT might work through different mechanisms in young people and adults. Cognitive processes may be more central to change in CBT for children and adolescents. Intervention length affected outcomes, with longer sessions having a greater effect than short ones.
Feeny *et al*	2004	Age: 3-17, with PTSD, male and female	CBT	Group and family	Meta-analysis	13	Variants of CBT are effective in treating children and adolescents with PTSD: EMDR was effective for children who had been exposed to natural disasters; CPPs were effective in treating sexual abuse-related PTSD, especially when the child was treated both alone *and* with parents; TF-CBT was better at improving PTSD symptoms than child-centred therapies; AMT was generally effective; group-delivered CBT was highly effective, even at 18-month follow-up. Research is needed to further consolidate the scientific base of clinical practice with PTSD children and adolescents.
Lang *et al*	2010	Age: 3-21, with PTSD, male and female	TF-CBT	Individual and with carer	Meta-analysis	7	TF-CBT was successful and highly effective at reducing PTSD symptoms, though less effective for long-term effects of anxiety. There was ample

							evidence that caregiver involvement was beneficial, but CBT was effective even when this was not possible.
McCart *et al*	2006	Age: 6-18, with antisocial behaviour, male and female	CBT and BPT	Individual and group	Meta-analysis	71	In addressing youths' antisocial behaviour, BPT was more effective for pre-school and school-aged children, while CBT had a stronger positive effect for adolescents. The intervention setting was important, with clinical BPT yielding better results than clinical CBT, which in turn was better than both treatments in non-clinical settings. Across treatments, the overall mean effect size was 0.4, in the small to medium range.
Varchol and Cooper	2009	Adolescents with eating disorders	FBT, CBT, DBT, psychotherapy	Individual and family	Meta-analysis	NA	FBT and supportive psychotherapy appear promising for adolescents with anorexia, with CBT and FBT among the most favoured modalities. DBT and IPT may be applicable to bulimia and binge eating. Family involvement is important in limiting dropout and improving outcomes, with professionals integrating modalities to address each child's needs.
Vickerman and Margolin	2007	Age: 3-16, who had been exposed to family violence, male and female	CBT and CCP	Individual and family	Meta-analysis	8	Both psycho-education and CBT are generally effective in the treatment of family violence-related PTSD, but the benefit of different modalities and CBT variations varies according to age. Parental involvement in the therapies is important and group treatment could be counterproductive for children with poor social skills.
Wethington *et al*	2008	Adolescents under 21, male and female	CBT, play, art, psychodynamic and pharmacological therapies	Individual vs group	Meta-analysis	21	Individual CBT was effective at reducing psychological harm in adolescents who had had traumatic experiences. There was insufficient evidence to draw definitive conclusions about play, art, psychodynamic and pharmacological treatments.

<u>Controlled trials</u>

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample*	Findings
Bodden *et al*	2008	Age: 8-18, 59% female	CBT	Individual and family	CBA	128	CBT was more efficacious than the 2-3 month waiting list. Child CBT was superior to family CBT at post-treatment, but similar at follow-up. Both treatments were more beneficial for younger children than older children at post-treatment and at follow-up.
Calear *et al*	2009	Age: 12-17, male and female	Self-directed online CBT (MoodGym)	Individual	RCT	1477	Compared to the control group, the MoodGym group exhibited significant improvements in anxiety

							symptoms immediately after the programme and at 6-month follow-up. Depression symptoms were less positively affected; the authors suggest face-to-face therapy might be needed for treating depression.
Carpentier *et al*	2006	Age: 5-12, exhibiting sexual behaviour problems, male and female	CBT vs play therapy	Group	RCT	135	Across all conditions, treatment was beneficial for children with sexual behaviour problems. Ten years after the interventions, the CBT group exhibited a significantly lower incidence of sexual offences than the play therapy group, with the CBT group outcomes not significantly different to those of a group of children treated in the same clinic for behaviour problems of a non-sexual nature.
Gowers *et al*	2007	Age: 12-18, with anorexia nervosa, 92% female	Supportive therapy or CBT and FBT in inpatient, specialist outpatient, and general CAMHS	Individual and family	RCT	167	In the comparison between inpatient, specialist outpatient, and general CAMHS, first-line inpatient psychiatric treatment does not provide advantages over outpatient management. Outpatient treatment failures do very poorly on transfer to inpatient facilities. Patient cooperation was a key factor.
Hlastala *et al*	2010	Mean age: 16.5, previously diagnosed with bipolar disorder, 50% female	IPSRT	Individual	Open trial	12 (11 fully treated)	Adolescent-specific IPSRT had positive effects, reducing manic-depressive and general psychiatric symptoms. Participant satisfaction with the intervention was high and they reported a better understanding of their disorder and symptoms after treatment.
Hogue *et al*	2008	Age: 13-17, exhibiting drug abuse, oppositional conduct or mood disorders, 19% female	CBT and MDFT	Individual and family	RCT	136	CBT and MDFT both appeared effective in reducing substance abuse but greater adherence to therapy increased success in both samples at follow-up after 6 months. Therapist competence appeared not to influence results.
Kaufman *et al*	2005	Age: 13-17, with comorbid major depression and conduct disorder, male and female	CBT (CWD-A) vs LS	Group	RCT	93	The study detected no significant differences between the interventions in terms of longstanding alleviation of depression symptoms, but CWD-A was more effective at reducing automatic destructive thinking. Suggests that a more intensive CBT treatment would have yielded better results.
Kendall *et al*	2008	Age: 7-14, 44% female	CBT vs FESA	Individual and family	RCT	161	Treatment gains observed for all conditions, but child and family CBT superior to FESA. If present, gains were maintained at 1-year follow-

							up.
Khanna and Kendall	2010	Age: 7-13, 32% female	CBT (individual; computer; CESA)	Individual	RCT (comp.)	45	Individual CBT and computer CBT resulted in better gains than CESA at post-treatment, with gains maintained at follow-up. All treatments rated acceptable by children and parents, but CESA rated lowest.
Layne *et al*	2008	Age: 13-19, exposed to war, 63% female	School-based psychotherapy	Group	RCT	127	This school-based multi-tier group mental health intervention with Bosnian adolescents was effective at reducing war trauma symptoms. Psycho-education alone was effective, but more so when combined with the treatment. Generally, these programmes were similar in effectiveness to community-based interventions.
Liddle *et al*	2008	Age: 12-17, drug users, 19% female	CBT and MDFT	Individual and family	RCT	224	CBT and MDFT groups both showed significant reduction in substance abuse during treatment, but youth receiving MDFT retained their treatment gains significantly better at 6- and 12-month follow-up compared with those receiving CBT.
Ollendick *et al*	2009	Age: 7-16, with various phobias; female only in Sweden, male and female in US	CBT	Individual (parents involved in pre-treatment sessions)	RCT	196	Participants receiving one-session CBT and education support therapy had better results than those on waiting list, but not on self-reported measures. Results were maintained at follow-up.
Ollendick *et al*	2010	Age: 7-16, with various phobias, 42% female	CBT (brief)	Individual	RCT (analysis of previous data)	100	The presence of comorbid phobias or anxiety disorders did not affect treatment results. Phobia-specific treatments also mitigated co-occurring conditions.
Podell *et al*	2010	Age: 9-13; 7-14, male and female	CBT	Individual and family	RCT	NA	The Coping Cat Program is described, together with the FEAR plan, which provides children with a framework to recall their skills. Three RCT studies to evaluate the program show positive outcomes for children.
Rossello *et al*	2008	Age: 12-18, 55% female	CBT/IPT	Individual vs group	RCT	112	All treatments were effective in reducing symptoms of depression, but CBT had stronger effects and was more effective in improving self-concept and social adaptation, despite initial hypotheses arguing in favour of IPT because of cultural relevance for the adolescents.
Schmidt *et al*	2009	Age: 13-20, with bulimia or eating disorders, 95.5% female	CBT guided self-care or FBT	Individual and family therapy	RCT	85	Of the 85 study participants, 41 were assigned to FBT and 44 to CBT guided self-care. Compared with family therapy, CBT guided self-care had the slight advantage of a more rapid

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							reduction in bingeing, lower cost, and greater acceptability for adolescents with bulimia or an unspecified eating disorder.
Shooshtary *et al*	2008	Age: 11-20, exposed to the 2004 Iran earthquake, male and female	CBT	Group	CBA	168	Four months after the earthquake, participants took part in four weekly CBT sessions, which were effective at reducing self-reported PTSD symptoms.
Silverman *et al*	2009	Age: 7-16, 57% female	CBT	Group (child and mother)	RCT	119	Anxiety was reduced for both active and minimal parent involvement CBT. Youth-to-parent influence with regard to anxiety was stronger than customary.
Southam-Gerow *et al*	2010	Age: 8-15, exhibiting anxiety, 56% female	CBT vs a variety of therapeutic methods	Individual	RCT	48	Young people in the usual care group received significantly more mental health services than those in the CBT group, but no significant differences were observed between the two on outcome measures. Newly trained, supervised practitioners could administer CBT with the same level of success as the trained therapists working in community care clinics with a mix of interventions.
Spence *et al*	2006	Age: 7-14, exhibiting depression, 42% female	CBT (clinic-based, partially internet-based and waiting list control)	Individual and group	RCT	72	Significant improvements in anxiety symptoms were observed at post-treatment and 12-month follow-up, without overall differences between the clinic or clinic-internet therapies. Neither gender nor age influenced outcomes. Internet-delivered CBT was effective when combined with face-to-face group therapy.
Suveg *et al*	2009	Age: 7-14, 44% female	CBT and FESA	Individual and family	RCT	161	Treatment gains observed for all conditions and maintained at 1-year follow-up. Gender and age had no effect on treatment results.
Wood	2006	Age: 6-13, male and female	CBT	Individual	RCT	40	Reductions in anxiety may lead to improved school performance and social functioning.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Chu and Kendall	2009	Age: 8-14, 41% female	CBT (Coping Cat)	Individual	Analysis of practice	63	Therapist flexibility was related to later increases in child engagement, which was associated with clinical improvement. Therapists adapted to fit the interests of the child, but a mediation model of flexibility effects on treatment outcome was not supported.
Creed and Kendall	2005	Age: 7-13, 39% female	CBT	Individual	Behaviour study	56	Therapeutic alliance with children, as coded for 11

							therapist behaviours, was positively predicted by 'collaboration' and 'not being overly formal' and negatively predicted by 'finding common ground' and 'pushing the child to talk'. Child, therapist and observer perceptions of the sessions concurred.
Faust and Katchen	2004	Children and adolescents with experiences of trauma, male and female	CBT vs FST	Individual and family	Literature review	NA	CBT is effective for treating youth with PTSD; integrating it with family therapies increases recovery. Individual CBT can directly reduce trauma symptoms, as well as increase individual coping resources. FST can help parents understand the trauma that their child is experiencing.
Gowers and Bryant-Waugh	2004	Age: 8-18, male and female	CBT, IPT, FBT, multiple family group therapy, nutritional counselling, DBT, CAT	Individual and family	Literature review	NA	Reviews the evidence prior to 2004 on physical management, psychological therapies, and service issues. Concludes that certain therapies are effective but evidence base poor. FBT, IPT and CBT most favoured.
Hogue *et al*	2004	Mean age: 15.2, exhibiting drug and alcohol abuse, 33% female	CBT or MDFT	Individual and group	Observation study	51	From observations of therapy sessions with substance-abusing adolescents, a family focus in the therapy predicts improvement in drug use at post-treatment, for both individual and family therapy conditions.
Jungbluth and Shirk	2009	Age: 14-18, male and female	CBT	Individual	Behaviour study	42	Higher levels of attending to adolescents' experience, greater exploration of motivation and lower levels of structuring (as identified from female therapists' behaviour) were associated with greater involvement in core tasks of adolescents. The latter two behaviours predicated the youths' involvement in the subsequent session.
Kennard *et al*	2009	Age: 12-18, with major depressive disorder and SSRI resistant, male and female	CBT component of intervention	Individual	Secondary analysis	334	Youths in TORDIA with major depressive disorder who had failed to respond to an adequate course of SSRI medication were randomised to a medication switch (to an alternative SSRI or to venlafaxine, an SNRI) with or without 12 weeks of adjunctive CBT. Participants who had more than 9 CBT sessions were 2.5 times more likely to have adequate treatment response than those who had 9 or fewer sessions. CBT participants who received problem-solving and social skills treatment components, controlling for number of sessions and other confounding variables, were, respectively, 2.3 and 2.6 times more likely to have a positive response.

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Little *et al*	2009	Children and adolescents with experiences of trauma, generally, male and female	CBT, behavioural and psycho-education therapies	Individual and family	Literature review	NA	This paper presents a TF-CBT intervention (that includes psycho-education, parenting skills training, relaxation, affective modulation, cognitive coping and processing, trauma narrative, in vivo mastery of trauma reminders, child-parent sessions and the enhancement of future safety and development) and deems it an effective therapeutic technique in addressing trauma-related issues in children.
Rosenberg *et al*	2011	Age: 14-18, with PTSD, 9 female and 3 male	CBT	Individual	Case study	12 (9 fully treated)	12 adolescents with PTSD took part in a manualised cognitive restructuring programme and exhibited significant improvement of PTSD and depression symptoms. Gains were maintained at 3-month follow-up.
Salloum	2010	NA	CBT	Individual and group	Literature review	NA	Minimal therapist-assisted CBT may be the first step in a stepped-care approach, providing more access to treatment for children. Further research needs to develop these interventions and evaluate the results.
Sauter *et al*	2010	Age: 9-18, male and female	CBT (SRIS)	Individual and group	Two evaluation studies on SRIS	138 and 215	Considering that the success of CBT is dependent on participants' abilities to identify and discriminate their own thoughts, feelings and behaviours, this study pinpoints language as being essential in terms of measurement. Girls were significantly more able than boys to self-reflect, but there were no gender differences on the insight scale. Self-reflection improved with age and was more apparent in adolescence. Thus SRIS for Youth was more relevant for adolescents than for younger children.
Shechtman and Pastor	2005	Age: 7-11, with learning disabilities, male and female	Humanistic therapy, group CBT	Group	Comparison study	200	Humanistic therapy was more effective than CBT on most measures. Both treatments were more effective when academic assistance was also offered to the children, but on their own were more effective than solely academic assistance. Treatment gains generally retained at follow-up, but effect sizes were low.
Silovsky *et al*	2007	Age: 3-7, exhibiting sexual behaviour problems, male and female	CBT	Group	SBA	85	A significant improvement following the 12-week course of treatment was observed in children's sexual behaviour problems, with female and older children exhibiting highest benefits.

Simard and Nielsen	2009	Age: 6-11, with nightmares, male and female	CBT (drawing therapy)	Group (dyad: mother and child)	SBA	32	A reduction in nightmare occurrence, distress and anxiety were associated with the treatment.
Sperry *et al*	2009	Young people with eating disorders, male and female	CBT and FBT	Individual and family	Literature review	NA	Research concerning the types of therapies effective for treating young people with eating disorders is underdeveloped, with few RCTs, despite general evidence that FBT and CBT are effective.
Tompson and Dingman Boger	2009	Children and adolescents, male and female	CBT, IPT, social skills conditioning, FBT, medication	Individual and group	Literature review	32	Though advances in understanding and treating youth depression have been made, treatments still have limited efficacy, and studies still focus on short-term evidence and on symptomatic as opposed to functional outcomes. Most clinical trials do not focus enough on young children and youths with developmental and mental health issues. CBT is effective, though less so in community settings, but still more effective than other treatments in community mental health centres.
Wilson *et al*	2007	Adolescents with anorexia nervosa and bulimia nervosa	FBT, CBT, nutritional therapy	Individual and family	Literature review	NA	Reviews progress in the development and evaluation of EBTs for eating disorders over the past 25 years. CBT is the treatment of choice for bulimia nervosa and binge-eating disorder, and existing evidence supports the use of a specific form of FBT for adolescents with anorexia nervosa.
Wood *et al*	2008	NA	CBT	Individual	Literature review	NA	The paper discusses 10 principles of culturally adapted CBT interventions that would be more effective with Mexican-American students than current interventions.

*Sample refers here and in all following evidence tables to the number of individual studies in the case of reviews and meta-analyses, and to the number of participants in other studies.

Commentary on the research on CBT

There are significantly more studies exploring the effectiveness of CBT than any other intervention. Overall results indicate outcomes for CBT to be positive. However, few longer-term follow-up studies have been carried out.

The evidence suggests CBT is more successful in treating anxiety than depression in children and young people. Chu and Harrison (2010) carried out a meta-analysis of 28 studies in the US on the effectiveness of CBT for treating anxiety and depression with children and young people aged six to 18 years. Participants were followed up six and 12 months after treatment. Positive outcomes were recorded within all these studies but there was less success in treating depressive symptoms. In another US study (Kaufman *et al*, 2005) two forms of treatment were compared: CBT and life skills (LS) tutoring (eg learning how to fill in forms, or renting an apartment). No difference was detected between the two interventions in terms of longstanding alleviation of symptoms of depression although CBT had a positive effect on automatic destructive thinking.

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CBT may be more effective for adolescents than for younger children. A meta-analysis of 71 studies compared CBT with behavioural parent training (BPT) for children and adolescents (McCart *et al*, 2006). The findings showed that BPT was more effective than CBT for preschool and school age children up to 12 years who were more dependent on their parents, but who also needed to have reached the developmental stage of adolescence for the more abstract cognitive skills that are emphasised in CBT to be effective, eg self-reflection, consequential thinking, consideration of future outcomes and consequences etc. In a meta-analysis (n=488), CBT was found to be the most effective therapy for adolescents at risk (Carroll *et al*, 2009).

A comparison of two studies (study 1, n=138; study 2, n=215) undertaken in the Netherlands assessed the effect of CBT with children who have capacity for self-reflection and insight (SRIS) (Sauter *et al*, 2010). For children and adolescents aged nine to 18, the success of CBT was dependent on the child's ability to identify and discriminate their own thoughts, feelings and behaviours, and to objectively identify causal relations between them. Without the ability to express themselves adequately through language, younger children struggled to benefit from CBT.

Although CBT has been found to increase social skills and problem-solving skills (Kennard *et al*, 2009), it is not necessarily more effective when compared to other types of therapy. For example, in a study (n=334) that compared CBT with usual care in the community (which included individual and group therapy) for children aged eight to 15 with anxiety, CBT did not have better outcomes than usual community care (Kennard *et al*, 2009). However, it is important to note that such comparisons are few in the papers included in this review.

There is a lack of research assessing the long-term impact of CBT. However, an RCT that followed 135 children aged five to 12 with sexual behaviour problems, comparing 12 sessions of CBT with a play therapy group, and including a 10-year follow-up, indicated significant improvements in behaviour in the CBT group. Short-term education treatments, such as relearning (teaching children rules and giving them boundaries) seemed to be effective. The findings support the effectiveness of short-term CBT with children and their caregivers. Compared to the play therapy conditions, where future offences of a sexual nature occurred in 10 per cent of cases, the CBT intervention resulted in a significantly lower occurrence rate of two per cent (Carpentier *et al*, 2006). Therefore, given the important reduction in symptoms associated with either intervention, the results cast doubt on the assumption that children with sexual behaviour problems are likely to go on to become sex offenders.

Computer-assisted CBT

There is a growing interest in computer-based programmes, and these appear to be particularly effective if combined with face-to-face therapy. In countries such as Australia, where large distances mean not all children have ready access to face-to-face therapy, the effectiveness of computer-based interventions is important. Spence *et al* (2006) compared the effectiveness of face-to-face and computer-based CBT for anxiety in 72 children aged seven to 14. One sample was given CBT in a clinic with group therapy for seven to 10-year-olds and 11-14 year-olds; this was offered as 10 child sessions and six parent sessions (both weekly for one hour, in consecutive weeks) plus a booster at one and three months post-treatment. The other sample was given a mix of face-to-face CBT, as described above, but with only half the sessions face-to-face, the remainder being delivered via the internet. In the 12-month post-treatment follow-up, the efficacy of the work was the same for the group receiving half their treatment via the internet, and there were no significant differences in outcomes by age or gender.

Research has indicated that internet-based programmes alone are less effective in reducing symptoms of depression than anxiety. Calear *et al* (2009) investigated the effectiveness of an online self-directed CBT programme, 'MoodGym', in preventing and reducing the symptoms of anxiety and depression in 1,477 students aged 12 to 17 across 30 schools in Australia. Immediately after the programme, and in a six-month follow-up, participants were found to have significantly lower levels of anxiety than those in the control group. However, the effects of MoodGym were less successful on levels of depressive symptoms at post-intervention and in six-month follow-up, perhaps indicating the need for face-to-face therapy for depression.

In contrast, a meta-analysis of several different treatments for adolescents who indulge in risky behaviour (Carroll *et al*, 2009) showed that interactive multimedia-based programmes prompted opportunities for change particularly in exploring and establishing a specific social identity. The paper cites the 'Mindfields' programme, which is based on 15 years of research with children at risk. The

programme encourages young people to focus on choices on a day-to-day basis, and it provides feedback and discussion about the impact these choices will have on their social identity.

Psycho-education (as a component of CBT)

Several studies referred to psycho-education as part of CBT. NICE (2006) defines psycho-education as “any structured group or individual programme that addresses an illness from a multi-dimensional viewpoint, including familial, social, biological and pharmacological perspectives, as well as providing service users and carers with information, support and management strategies”. Psycho-education was found to be effective in helping children and young people understand their condition, and also to help parents. Several studies included a review of the effectiveness of psycho-education alongside other CBT interventions. One study (Hlastala *et al*, 2010) looking at the treatment of young people with bipolar disorder began with a programme of psycho-education to encourage young people to keep taking necessary medication. This was followed with a programme of interpersonal and social rhythm therapy (ISRT). The findings indicate proven and continual improvement in the bipolar symptoms, with significant improvement in manic incidents as well as depressive symptoms. Adolescents taking part in the programme reported extreme satisfaction.

Psycho-education was found to be effective as part of CBT therapy for post-traumatic stress disorder (PTSD). Practitioners used psycho-education to help young people with PTSD understand their condition (Feeny *et al*, 2004). A literature review of studies that had used trauma-focused CBT (Little *et al*, 2009) concluded that psycho-education should be an initial component for children with PTSD, and should continue throughout therapy for both children and parents. This included information about trauma, its effects and its treatment.

CBT is an effective form of treatment for common mental health disorders in children and adolescents, and is recommended by NICE. However, the evidence reviewed here suggests that CBT may be less effective for young children than for adolescents, and less effective for treating depression than anxiety. More research is needed on the effectiveness of CBT for the age and developmental stage of the child, and for its effectiveness as a treatment for depression. The length of treatment of CBT tends to be short (less than 12 weeks), and the long-term benefits should be assessed. While some studies follow-up after six or 12 months, a longer-term follow-up would be beneficial in assessing the effectiveness of CBT.

Note: Papers that specifically relate to CBT for anxiety and depression are discussed in full in Section 4.2.2.

Effectiveness of psychodynamic therapy

The term psychodynamic therapy covers a range of therapies with a psychoanalytic or psychodynamic basis. Although it is an integrative form of therapy, cognitive analytical therapy (CAT) is included in this section.

The 2004 review – summary of evidence

It was reported that psychodynamic therapies were effective for a range of mild to moderate rather than severe behavioural problems. There was some evidence of effectiveness for emotional disorders. However, one study contradicted this and reported no improvement in children suffering from depression.

The 2012 review – summary of evidence

Overall, the evidence points to psychodynamic therapies being effective for a range of presenting problems. The updated findings are similar to those of the original review but there is new evidence as to this therapy’s effectiveness for emotional disorders, including depression.

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Table 6: Overview of research evidence: psychodynamic therapies

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Midgley and Kennedy	2011	Children and adolescents, male and female	Psychodynamic or psychoanalytic psychotherapy	Individual	Systematic review	34	There is growing evidence that these therapies are effective for children, for a variety of disorders, but mostly for emotional and internalising disorders, as well as for abuse and trauma. There is some indication that psychodynamic interventions may affect participants in a different manner (eg, slower but more resilience-building effects in the treatment of depression). Younger children appear to benefit more from these treatments.
Wethington *et al*	2008	Adolescents under 21, male and female	CBT, play, art, psychodynamic and pharmacologic therapies	Individual vs group	Meta-analysis	21	Individual CBT was effective at reducing psychological harm in adolescents who had had traumatic experiences. There was insufficient evidence to draw definitive conclusions about play, art, psychodynamic and pharmacological treatments.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Chanen *et al*	2008	Age: 15-18, with borderline personality disorders, male and female	CAT and manualised GCC	Individual	RCT	86	After treatment, the CAT and GCC groups both showed improvements. The rate was higher for the CAT group for externalising and internalising pathologies, and moderately higher for the GCC for general functioning. At the 24-month follow-up, the CAT group retained the differences in externalising psychopathologies.
Gilboa-Schechtman *et al*	2010	Age: 12-18, with PTSD, male and female	Comparison of PE-A and dynamic therapy	Individual	RCT	38	Both treatments resulted in decreased PTSD and depressive symptoms and increased functioning. PE-A had a greater impact on symptoms and global functioning. After treatment more patients in the PE-A group no longer met the diagnostic criteria for PTSD (68.4% vs 36.8%). Treatment gains were maintained in both groups at 6- and 17-month follow-up.
Kronmueller *et al*	2010	Age: 6-18, 60% female	Short-term psychodynamic psychotherapy and long-term psychoanalytical therapy	Individual	RCT	71	Both short-term and long-term therapies proved effective, yielding effect sizes comparable to those of CBT studies. This study found the longer-term treatment to be more effective.
Lock *et al*	2010	Age: 12-18, with anorexia nervosa	Comparison of FBT and AFT	Family vs individual	RCT	121	Both treatments led to considerable improvement and were similarly effective in producing full remission at end of treatment. FBT was more effective in facilitating full

							remission at both follow-up points.
Trowell *et al*	2007	Age: 9-15, male and female	Comparison of individual psychodynamic therapy with family therapy	Individual vs family	RCT	72	In both treatment groups changes were persistent. There was ongoing improvement and an overall reduction in comorbid symptoms. At 6-month follow-up 100% of cases in the individual therapy group and 81% of cases in the family therapy group were no longer clinically depressed.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Deakin and Nunes	2009	Age: 6-10, male and female	Psychoanalytic therapy	Individual	SBA	23	A reduction in anxious and depressive symptoms as well as school-related symptoms was observed in those receiving therapy. An improvement in interpersonal relationships was also noted. ICPP was deemed effective mostly with girls who present with internalising disorders such as anxiety and depression, while boys were less likely to complete the 12 months of treatment.
Di Riso *et al*	2009	One 12-year-old male with obsessive-compulsive symptoms and very high levels of anxiety	Psychodynamic therapy with some CBT interventions	Individual	Case study	1	A 2-year course of therapy with the participant was recorded and showed the therapy to be effective in reducing his symptoms. The participant's therapeutic relationships were deemed to be significant throughout the treatment.
Tonge *et al*	2009	Age: 12-18, previously diagnosed with severe mental illnesses, male and female	Psychoanalytic therapy	Individual	Naturalistic longitudinal study	80 (40 control group and 18 fully treated)	At 12 months psychotherapy was associated with a greater reduction in depressive, social and attention problems than treatment as usual, alone, if these issues had initially been in the clinical range.

Commentary on the research on psychodynamic therapies

Midgley and Kennedy (2011) reviewed 34 studies and found growing evidence for the efficacy of psychodynamic psychotherapy for a variety of presenting problems. The review aimed to evaluate all the research evidence on psychodynamic therapy over the entire lifespan of a large number of databases as well as engaging in a comprehensive hand search. In particular, they found this therapy to be effective for internalising disorders as well as for abuse and trauma. This contrasts with the findings of Wethington *et al* (2008) who noted that was there was insufficient evidence to be able to judge the efficacy of psychodynamic approaches to trauma in their analysis of 21 studies. This latter review focused on a variety of interventions for traumatised children.

In a pilot RCT (n=38) in Israel, Gilboa-Schechtmann *et al* (2010) examined the efficacy and maintenance of a developmentally adapted prolonged exposure therapy for adolescents (PE-A). This was compared with an active control, time-limited dynamic therapy for decreasing post-traumatic and depressive symptoms in adolescents who had experienced single event traumas. Both treatments resulted in decreased PTSD and depressive symptoms, and increased functioning. PE-A was reported to have a greater impact on symptoms and global functioning, and after treatment more patients in the

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PE-A group no longer met the diagnostic criteria for PTSD (68.4 per cent vs 36.8 per cent). Treatment gains were maintained in both groups at both six- and 17-month follow-up.

Another RCT (Trowell *et al*, 2007), with a focus on depression, compared individual psychodynamic psychotherapy with family therapy, with 72 children aged nine to 15. Significant reductions were found in clinical symptoms for both individual and family therapy: 74.3 per cent of the children were no longer clinically depressed following individual therapy and 75.7 per cent were no longer clinically depressed following family therapy. In both treatment groups changes were persistent, there was ongoing improvement and an overall reduction in comorbid symptoms. At six-month follow-up, 100 per cent of cases in the individual therapy group and 81 per cent of cases in the family therapy group were no longer clinically depressed. Midgley and Kennedy (2011) suggest this is a sleeper effect, ie an ongoing response to therapy after completion.

Lock *et al* (2010) undertook a similar comparison study focusing on adolescents with anorexia nervosa in the US. This RCT (n=121) compared a family based treatment (FBT) with an individual therapy derived from a psychodynamic approach. Adolescents aged 12-18 meeting DSM IV diagnostic criteria excluding the amenorrhea (abnormal absence of menstruation) requirement were assessed at baseline, end of treatment, and six-month and 12-month follow-up post-treatment. There were no differences in full remission between treatments at end of treatment. However, at both the six- and 12-month follow-up, FBT was statistically superior to adolescent-focused individual therapy (AFT). FBT was significantly superior for partial remission at end of treatment but not at follow-up. In addition, body mass index percentile at end of treatment was significantly superior for FBT, but this effect was not found at follow-up. Participants in FBT also had greater changes in Eating Disorder Examination score at end of treatment than those in AFT, but there were no differences at follow-up. Although both treatments led to considerable improvement and were similarly effective in producing full remission at end of treatment, FBT was more effective in facilitating full remission at both follow-up points.

An RCT comparing cognitive analytic therapy (CAT) with good clinical care for adolescents with borderline personality disorder in Australia found both treatments were effective in reducing externalising pathology. There was some evidence that patients allocated to CAT improved more quickly (Chanen *et al*, 2008).

The Heidelberg study (Kronmuller *et al*, 2010) (n=71) examined the efficacy of short-term psychodynamic treatment and the effectiveness of long-term psychoanalysis for children and adolescents (mean age 11.3) with a range of presenting problems. Both short-term and long-term therapies proved to be effective yielding effect sizes comparable to those of CBT studies. This study found the longer-term treatment to be more effective.

Tonge *et al* (2009), in Australia and New Zealand, examined the effectiveness of individual psychodynamic psychotherapy for 33 adolescents with serious and complex mental illness in a 12-month naturalistic follow-up study. At 12 months, psychotherapy was associated with a greater reduction in depressive, social and attention problems. There was no effect on participant overall functioning or family functioning. The authors conclude that psychodynamic psychotherapy is an effective addition to child and adolescent mental health services.

Deakin and Nunes (2009) evaluated the outcome of psychodynamic psychotherapy for 23 children in Brazil, compared with a control group who received no intervention. Those receiving therapy were observed to have reduced anxious and depressive symptoms. An improvement in interpersonal relationships was also noted. This paper suggests that ICPP is mostly effective with females who present with internalising disorders such as anxiety and depression. There is a moderate effect size of 0.7 for females. The same positive effect was not seen in boys and they were less likely to complete the 12 months of treatment.

Di Riso *et al*, (2009) offered a single case study of an anxious early adolescent boy, in Italy. While predominantly psychodynamic, the therapy included elements of CBT and the paper reported changes in the boy's functioning. This was measured with Exner's Rorschach Comprehensive System and the Collaborative Interactive Scale.

The findings in this area, as in other sections of this review, suggest the need for future research to be more nuanced and move beyond questioning efficacy to exploring "what makes therapy optimally effective and how research can be translated into the real world of clinical practice" (Midgley and Kennedy, 2011). The findings of some trials were mixed, without a clear consensus for the superiority of psychodynamic therapy. There is evidence to support the suggestion of a sleeper effect for

psychodynamic therapy, where clients continue to recover post-therapy. The research in this area is more geographically diverse, contrasting with CBT research, which is mainly US-based.

Effectiveness of humanistic and interpersonal psychotherapy

Background

This section includes papers reporting on person-centred/humanistic therapy and interpersonal psychotherapy (IPT). Whereas person-centred/humanistic therapy emphasises the quality of the therapeutic relationship and the client's subjective experience (Rogers, 1951), IPT is a pragmatic, time-limited and focused approach, integrating a range of modalities and focusing on the client's interpersonal relationships (Mufson *et al*, 2004). IPT is most commonly used to treat depression.

The 2004 review – summary of evidence

There were nine papers reporting the use of humanistic therapies and two on IPT. Some reporting a humanistic approach involved a combination of CBT, psychodynamic and client-centred therapies. All but one found these interventions to be effective.

The 2012 review – summary of evidence

One paper investigated person-centred and one humanistic therapy. Four studies reported the effectiveness of IPT. Person-centred therapy was effective in a review of counselling in UK secondary schools and IPT was effective for depression.

Table 7: Overview of research evidence: humanistic and interpersonal therapies

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Gunlicks-Stoessel *et al*	2010	Age: 12-18, 84% female	IPT-A vs treatment as usual (TAU)	Individual	RCT	63	The benefits of IPT-A were greater than TAU for depressed adolescents; the difference was most dramatic for adolescents with high levels of maternal and social conflict. Across treatments, this group also showed slower reductions in depression.
Rossello *et al*	2008	Age: 12-18, 55% female	CBT/IPT	Individual vs group	RCT	112	All treatments were effective in reducing symptoms of depression, but CBT had stronger effects and was also more effective in improving self-concept and social adaptation, despite initial hypotheses arguing in favour of IPT because of cultural relevance for the adolescents.
Tang *et al*	2009	Age: 12-18, with depression and suicidal risk, male and female	School-based IPT-A-IN vs TAU	Individual	One school RCT	73	Compared to TAU, the programme of IPT-A-IN was more effective at reducing severity of depression, suicidal risk, anxiety and hopelessness.
Young *et al*	2006	Age: 12-18, exhibiting depression and comorbid anxiety, male and female	IPT	Individual	RCT	63	Depressed adolescents with comorbid anxiety entered treatment with more severe symptoms of depression. Both anxious and non-anxious youth had similar levels of functioning at post-treatment, while depression proved more difficult to treat.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Cooper	2009	Mean age: 13.86, 56% female	Person-centred therapy	Individual	Literature review	30	School-based counselling appears to be of considerable benefit to young people in the UK, with participants exhibiting large improvements in mental health (mean weighted ES=0.81). Young people and teachers both rated counselling as being generally helpful.
Shechtman and Pastor	2005	Age: 7-11, with learning disabilities, male and female	Humanistic therapy, group CBT	Group	Comparison study	200	The humanistic therapy was seen to be more effective than CBT on most measures. Both treatments were more effective when academic assistance was also offered to the children, but on their own were more effective than solely academic assistance. Treatment gains were generally retained at follow-up, though effect sizes were low.
Tompson and Dingman Boger	2009	Children and adolescents, male and female	CBT, IPT, social skills conditioning, FBT, medication	Individual and group	Review	32	Though advances in understanding and treating youth depression have been made, treatments still have only limited efficacy, and studies still focus mostly on short-term evidence and symptomatic as opposed to functional outcomes. Most clinical trials to date do not focus enough on young children and on youths with developmental and mental health issues.

Commentary on the research on humanistic and interpersonal therapies

All the IPT studies were with children and young people suffering from depression. IPT emerged as an effective intervention for depression (Gunlicks-Stoessel, 2010), particularly where the presenting problem involves relational issues, and in other mental health conditions that are rooted in conflict (Rossello *et al*, 2008). The focus on improving relational skills is seen as an important factor. However, a comparison study found that CBT had a stronger effect than IPT (Rossello *et al*, 2008).

A comprehensive review of counselling in UK secondary schools (Cooper, 2009), where typically the counselling services were offering person-centred counselling, found large improvements in mental health (effect size 0.81). This was an analysis of 30 studies.

Effectiveness of play/creative therapies

The 2004 review – summary of evidence

Two papers reported the effectiveness of play therapy. They indicated that it was effective in improving psychological symptoms of sexual abuse, in reducing anxiety, and in improving self-esteem and cognitive skills in school children.

The 2012 review – summary of evidence

Since the original review there has been an increase in the number of studies on the effectiveness of play therapy. These all suggest that play therapy is an effective intervention for a range of child populations, settings and presenting problems.

Table 8: Overview of research evidence: play therapy

Systematic review

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Bratton *et al*	2005	Children, male and female	Humanistic non-directive and non-humanistic directive therapies	Individual, group and family	Meta-analysis	93	Across the studies, a positive large treatment effect of play therapy with children was observed. Effects were stronger for humanistic treatments and strongest for the therapies that included parents. Age, gender and the problems children came to therapy with did not influence the effectiveness of therapies.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Danger and Landreth	2005	Age: 4-6, with speech difficulties, male and female	Child-centred play therapy	Group	Controlled trial	21	Child-centred play therapy was effective at improving receptive and expressive language skills of children with speech difficulties, but the group intervention had mixed effects on children's anxiety levels.
Dougherty and Ray	2007	Age: 3-8, 42% female	Play therapy	Individual	Controlled trial	24	The impact of child-centred play therapy was different for children at different developmental stages, on the basis of parents' responses to the Parenting Stress Index.
Ray *et al*	2009	Age: 2-11, with aggression issues, 24% female	Play therapy	Individual	Controlled trial	42	A 14-session child-centred play therapy intervention yielded moderate decreases in aggressive behaviour for participating children. Across the control and treatment group teachers reported significant improvements over time.
Ray *et al*	2007	Age: 5-11, with ADHD, 20% female	Child-centred play therapy (and reading mentoring)	Individual	RCT	60	Both the play therapy and the reading-mentoring group exhibited significant positive changes in ADHD symptoms over time, with the play therapy group also exhibiting improvements significantly larger on emotional ability and anxiety/withdrawal scales.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Baggerly and Jenkins	2009	Age: 5-12, homeless children, 50% female	Child-centred play therapy	Individual	SBA	36	A play therapy intervention with homeless school children was effective in improving the internalisation of controls and self-limiting features, as well as in unsupported development.
Frick-Helms and Drewes	2010	Children, male and female	Play therapy	NA	Editorial	NA	This introduction to a special issue journal on play therapy research identifies the need to consolidate research-

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							based evidence surrounding play therapy and to inform practitioners and researchers of ongoing efforts.
Garza and Bratton	2005	Age: 5-11, with behavioural problems, 42% female	Child-centred play therapy	Individual	Randomised comparison study	29	Parents reported that the child-centred play therapy had a large treatment effect on externalising problem behaviours and a moderate effect on internalising behaviours, when measured against the curriculum-based group. Parent, teacher and therapist observations support these findings.
Muro *et al*	2006	Age: 4-11, with behavioural and emotional difficulties, 26% female	Child-centred play therapy	Individual	Exploratory study	23	Children participating in a 32-session child-centred play therapy intervention exhibited statistically significant and steady improvements (measured on the Total Problems scale).
Paone and Douma	2009	One 7-year-old male, previously diagnosed with intermittent explosive disorder	Child-centred play therapy	Individual	Case study	1	The participant took part in a 16-session play therapy intervention, where he was able to express his thoughts and feelings in a personal manner and a safe environment. Parental involvement and the duration of the therapy appeared to enhance its effectiveness.
Phillips	2010	Children, male and female	Play therapy	NA	Literature review	NA	The review finds that there is limited research-based evidence around play therapy, identifies that the most convincing results concern its effectiveness with children facing medical procedures, and suggests a series of methodological points that would improve the quality of play therapy research.
Reddy *et al*	2005		Play therapy		Book		This book presents evidence-based play interventions for scholars and practitioners for a variety of child populations and settings.
Schaefer and Mattei	2005	Age: 2-9, with aggressive symptoms, male and female	Play therapy	Individual and group	Literature review	NA	Encouraging children to release aggression in play found they are likely to maintain this behaviour or actually increase it – it appears that adults condoning such behaviour discourage children from learning socialised inhibitions. A better strategy would be to teach children more appropriate ways to respond when angry (eg conflict resolution skills, understanding others' motives, and relaxation).
Urquiza	2010	Children , male and female	Play therapy	NA	Methodological paper	NA	This paper discusses methodological issues in play therapy research. It suggests there is limited

							exposure of research on the topic for those outside it and exhorts play therapists to publish more widely in journals with greater impact. A case is also made for the standardisation of the assessment and evaluation measures used by play therapists.

Commentary on the research on play therapy

In a meta-analytic review of 93 controlled outcome studies, Bratton *et al* (2005) report the overall treatment effect for play therapy interventions as 0.80 standard deviations. Effect size measured in this way provides a standard measure of comparison across practice. An effect size of 0.8 is a large effect. Interestingly, the authors included the term ‘play in therapy’ in their search terms thus capturing studies beyond those rooted in traditional play therapy. Effects were more positive for humanistic than non-humanistic (including CBT) treatments and the review found that including parents in play therapy produces the largest positive effects. Play therapy was equally effective in relation to variables such as age, gender and presenting issue. Papers by Schaefer and Mattei (2005), Danger and Landreth (2005), and Paone and Douma (2009) demonstrate that play therapy is effective for younger children.

Reddy *et al* (2005) cite the Bratton *et al* (2005) meta-analysis as providing evidence for the clinical utility and efficacy of play therapy. Their book sought to provide empirical evidence for play therapy to scholars and practitioners.

Specifically, in the US, play therapy has been shown to be effective with aggressive children (Ray *et al*, 2009), with children exhibiting symptoms of ADHD (Ray *et al*, 2007), and for child victims of sexual abuse (Reyes *et al*, 2005). A pilot project with homeless children demonstrated play therapy’s effectiveness (Baggerley and Jenkins, 2009) and reported a positive impact on their emotional, behavioural and social development within the classroom.

In a small US comparison study (n=23) Dougherty and Ray (2007) compared the impact of client-centred play therapy for children at two developmental stages: Piaget’s preoperational and concrete operations stages. Both groups benefited from the therapy as measured by the Parent Stress Index. However, the data is limited as it reported only on parental responses, with no narrative element to incorporate the views of the children or therapists.

Garza and Bratton (2005) conducted a study in the US, comparing play therapy with a curriculum-based group in Hispanic children (n=29). A large treatment effect (.79) on externalising problem behaviours and a moderate effect (.58) on internalising behaviours were reported. Parent, teacher and therapist observations supported these findings. The authors suggest that comparing child-centred play therapy with no treatment would produce even larger treatment effects. Another school-based study in the US, examining the effects of long-term (32 sessions), child-centred play therapy across 23 children, reported improvements in emotional and behavioural difficulties (Muro *et al*, 2006).

The play therapy literature discusses some interesting methodological issues. Philips (2010) acknowledged the contribution of Bratton *et al* (2005) but still claimed that a credible body of evidence for play therapy does not exist. One piece of evidence for this is that play therapy research is not cited in key child and adolescent psychology journals and handbooks. He also asserted that play therapy research does not measure up to a hierarchy of evidence that puts RCTs at the top. Frick-Helms and Drewes (2010) and Urquiza (2010) also cited the Bratton *et al* review and Urquiza made the important point that play therapy research published in play therapy journals only reaches a limited audience of play therapists and not clinicians from other modalities.

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For which presenting problem?

Conduct and behaviour disorders

Background

There is evidence that the incidence of conduct disorders and emotional problems has been increasing, and that these typically affect around 10 per cent (and sometimes more) of the adolescent population (Gray *et al*, 2011). The Office for National Statistics found that conduct disorder was prevalent in 7.5 per cent of boys and 3.9 per cent of girls (Green *et al*, 2005). Research by the Sainsbury Centre for Mental Health (Richards and Abbott, 2009) suggests that conduct disorder is the most common form of mental health problem and that effective early treatment can lead to savings of up to £150,000 per child. The report found a particularly strong link between conduct disorder in childhood and subsequent criminal activity. The report defines 'conduct problems' as a range of oppositional or antisocial behaviour such as disobedience, lying, fighting and stealing. 'Conduct disorder' is defined as a more severe psychiatric condition that is likely to impair a child's own functioning as well as causing significant distress to others (NICE, 2007). The Cambridge Centre for Delinquent Behaviour (Farringdon *et al*, 2006), a study that has been tracking a sample of 411 boys born in inner London in 1953, found that 90 per cent of prolific adolescent offenders had a conduct disorder at age eight. The original (2004) review (see below) found similar evidence of the prevalence of conduct disorder among children and adolescents, and there is some evidence that the increase in the number of children diagnosed with the condition has risen less sharply since the original review (Gray *et al*, 2011).

The 2004 review – summary of evidence

The review states that children with behaviour problems "present a specific set of challenges for the counsellor due to their symptoms (eg defiance, aggression), their prevalence (Robins, 1999), and their association with a range of socially unacceptable outcomes during adolescence and beyond (eg school exclusion, unemployment, criminal activity, substance use and abuse) (Caspi *et al*, 1990)." It suggests that "it is incumbent upon counsellors and psychotherapists working with young children to engage in research and contribute to our understanding of key factors and therapeutic strategies that are effective in combating difficult behaviour" (Harris and Pattison, 2004).

The 2004 review found four reviews of counselling and psychotherapy on behavioural and conduct problems, of which three focused on CBT.

The 2012 review – summary of evidence

As in 2004, the updated review included many studies of CBT-based treatment for behaviour and conduct disorders. CBT appears to be effective in helping children and young people address their behaviour and the underlying triggers that might prompt conduct disorders. The inclusion of parents in treatment appears to be especially effective.

Table 9: Overview of research evidence: behaviour, conduct and behaviour change

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Brown *et al*	2008	Children and adolescents, male and female	Psychosocial, psycho-pharmacological and combined interventions	Individual and group	Meta-analysis	NA	Contingency management interventions implemented at home and school have resulted in moderate to large effect sizes for reduction in conduct problems, while CBT and multi-systemic therapies had moderate effects.
Brown *et al*	2008	Children and adolescents, male and female	Psychosocial, psycho-pharmacological and combined interventions	Individual and group	Meta-analysis	NA	The evidence base of treatment effectiveness is uneven across disorders, with most research focusing on ADHD, depression and anxiety. For these, and for oppositional defiant disorder,

							autism, OCD, PTSD and some eating disorders, the use of psychosocial treatments is supported as a first-line intervention.
McCart *et al*	2006	Age: 6-18, with antisocial behaviour, male and female	CBT and BPT	Individual and group	Meta-analysis	71	In addressing youths' antisocial behaviour, BPT was more effective for pre-school and school-aged children, while CBT had a stronger positive effect for adolescents. The intervention setting was important, with clinical BPT yielding better results than clinical CBT, which in turn was better than both treatments in non-clinical settings. Across treatments, the overall mean effect size was 0.4, in the small to medium range.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Kaufman *et al*	2005	Age: 13-17, with comorbid major depression and conduct disorder, male and female	CBT (CWD-A) vs LS	Group	RCT	93	No significant differences were detected between the two interventions in terms of longstanding alleviation of depression symptoms, although CWD-A was more effective at reducing automatic destructive thinking. A more intensive CBT treatment would have yielded better results.
Liddle *et al*	2008	Age: 12-17, drug users, 19% female	CBT and MDFT	Individual and family	RCT	224	While CBT and MDFT groups both showed significant reduction in substance abuse during treatment, youth receiving MDFT retained their treatment gains significantly better at 6- and 12-month follow-up compared with those receiving CBT.
Lochman and Wells	2004	Preadolescent males	CPI (child vs parent focus)	Individual and group	RCT	183	CPI produced lower rates of covert delinquent behaviour and of parent-related substance use at the 1-year follow-up than the control group and had a significant impact on boys' behaviour. A preventative intervention delivered to high-risk, adolescent, aggressive and disruptive children at the time of transition to middle schools can prevent certain antisocial problem behaviours, and the effects appear to be sustained in the 1-year follow-up.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Carroll *et al*	2009	At-risk young people, male and female	A variety of interventions	Individual and group	Literature review	NA	Generally, family based programmes are relatively ineffective for youths disengaged with their families or with limited personal resources. School interventions may fail to

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							account for suspended, excluded, truant youths. CBT is effective for juvenile offenders, with one-to-one treatments most beneficial. Interactive multimedia-based programmes have significant potential for youths with risky behaviours.
Hogue *et al*	2006	Adolescents with acute substance abuse issues, age not specified, 19% female	CBT or MDFT	Individual and family	Comparison study	100	An early parent-therapist alliance was important and effective, and more effective than the child-therapist alliance. Alliance did not influence treatment retention or behaviour at 6-month follow-up. In MDFT, both child and parent alliance were significant predictors of outcomes.
Kazdin *et al*	2005	Age: 3-14, with oppositional, aggressive and antisocial behaviour, 25% female	CBT	Individual and group	Case study	185	The more positive the child-therapist and parent-therapist alliances during treatment, the greater the therapeutic changes of the children, the fewer perceived barriers to participation in treatment, and the more acceptable parents and children view the treatment techniques. If a poor alliance is apparent, strategies could be used to enhance it and augment therapeutic change.
Kazdin and Whitley	2006	Age: 3-14, with oppositional defiant or conduct disorders, 24% female	PMT or PSST	Individual and family	Comparative study	315	The study sought to establish whether effectiveness of interventions could be measured in children with comorbidity. Comorbidity was associated with greater therapeutic change. Parental encouragement and help increased treatment effectiveness.
Shechtman	2004	Age: 8-12, aggressive males	Behavioural therapy using bibliotherapy and psychotherapy (CBS and HSS)	Individual and group	Comparative study	51 boys and their 51 therapists	Aggression decreased over course of treatment; insight and change increased, and so did cognitive exploration in the treatment group. The 10 sessions might have been insufficient to elicit long-term behaviour change. CBS assessment indicated that overall resistance decreased over the course of treatment, and insight and change increased. HSS indicated that interpretation from the therapist was unrelated to client behaviour, whereas challenge appeared to be destructive, although group treatment appeared to

							handle challenge better than did individual treatment.

Commentary on the research on conduct and behaviour disorders

The updated review found 11 studies of counselling and psychotherapy focusing chiefly on conduct and behaviour disorders. Like the 2004 review, many of these derive from CBT, and some studies indicate a link between conduct disorder and PTSD (Kazdin and Whitley, 2006; Lochman and Wells, 2004; Kaufman *et al*, 2005). In addition, six studies reported on behaviour change programmes as an intervention for conduct disorders. Behaviour change programmes are becoming a common form of treatment for behaviour disorders, although descriptions of interventions are sometimes unclear, with behaviour change programmes in some cases being conflated with CBT (considered separately in 4.1.1).

Stand-alone behaviour change programmes run by leaders with no therapeutic training (such as teachers) have been excluded from the updated review. However, multi-modal interventions – including, for example, individual CBT, school-based behaviour modification programmes run by teachers, and home-based behaviour modification programmes involving parental training – have been included in the review. Such programmes are rated highly in producing significant improvements in compliance and concomitant reduction in aggression and disruptive behaviour with children, but these effects are less pronounced in adolescents (Brown *et al*, 2008a). This is supported by a comprehensive review by the same authors of effective treatment for conduct disorders (Brown *et al*, 2008b). This latter review concludes that there are two forms of conduct disorder, one beginning in childhood and the other in adolescence. Childhood-onset conduct disorder, it is argued, is more serious in terms of severity of antisocial behaviour. The review also says that children and adolescents with conduct disorders are at a higher than average risk for ADHD, family and social relationship difficulties, academic underachievement, delinquency, and eventual prison placement as adults.

There are indications that interventions involving parents can be beneficial for children involved in risky behaviour. For example, one study (Kazdin *et al*, 2005) included 185 children aged three to 14 who had been referred for oppositional, aggressive and antisocial behaviour. Children received CBT by trained therapists as well as learning behavioural techniques. Parents were seen separately from their children by therapists for PMT. They were also provided with help for 'adaptive parenting' in the home. The intervention was effective, particularly when the child-therapist and parent-therapist alliances were strong.

A meta-analysis by McCart *et al* (2006) compared 30 BPT studies with 41 CBT studies for youth with antisocial behaviour. For pre-school and school-aged children, BPT had a stronger effect; for adolescents, CBT had a stronger effect. Another meta-analysis (Carroll *et al*, 2009) looked at a wider range of treatments for young people at risk, including family, school interventions, CBT, wilderness programmes, boot camps and interactive multimedia programmes. The review points out that many such programmes are based on a 'get tough' approach: they are not informed by the developmental stage of the child and ignore the powerful influences of psychosocial context (eg peer pressure). It suggests that there is evidence that some interventions actually increase the levels of antisocial behaviour and risk for negative life outcomes. It argues that FBT can be ineffective for adolescents who are disengaged from their families and that school-based interventions fail to take into account the many young people who have abandoned school, or who have been suspended or excluded. Individual CBT did appear to be effective, however, and interactive multimedia programmes such as 'Mindfield' appeared beneficial.

In contrast, a study by Liddle *et al* (2008) indicated that therapy that involves parents is more effective than individual CBT alone. The paper compared six months of individual CBT with MDFT for treating adolescent drug abuse. The study looked at 224 young people aged 12-17 and efficacy was measured six and 12 months after therapy ended. In the CBT arm of the trial, adolescents' parents attended the first two sessions to support their child's participation in the treatment. MDFT sessions were delivered to the child and their family once a week for six months. While both showed significant reduction in substance abuse, those adolescents receiving MDFT retained their treatment gains significantly better at six- and 12-month follow-up compared with those receiving individual CBT.

One study (Shechtman, 2004) with children aged eight to 12 displaying aggressive behaviour used behaviour change techniques with bibliotherapy (the use of stories, poems and films for therapeutic purposes). The study indicated that behaviour change could occur when the child learns to express

itself and the process of affect regulation is achieved. The findings show that behaviour change is linked to the facilitation of insight and exploration on the part of the therapist and especially in a group setting, but questions the length of treatment, which was short term (10 weeks), and the impact on long-term behaviour change.

CBT was the dominant therapeutic approach for conduct and behaviour disorders and it appears to be effective, especially combined with other interventions. However, more research is needed on the long-term effect of CBT for conduct disorders.

Emotional problems

Anxiety

Background and definition of terms

Anxiety disorders are highly prevalent in children and young people. Estimates of the prevalence of anxiety disorders in the UK and USA for children aged between two and 18 vary from 10 to 15 per cent (Silverman and Field, 2011).

Anxiety disorders include:

- separation anxiety disorder
- generalised anxiety disorder
- social phobia
- panic disorder
- obsessive compulsive disorder
- specific phobias
- post-traumatic stress disorder (PTSD)
- anxiety disorder not specified.

(Silverman and Field, 2011)

The 2004 review – summary of evidence

Harris and Pattison (2004) reported anxiety disorders as being one of the commonest categories of problems among children and young people, with prevalence rates ranging from six to 15 per cent. Overall, counselling and psychotherapy was seen to be effective for a range of anxiety disorders. Psychoanalysis was effective across the age range and children under 11 experienced greater improvements. Seven (out of 15) papers referred to CBT, which was effective for a range of problems. It was superior to no treatment in the short and medium term, and group CBT was also effective.

The 2012 review – summary of evidence

The update yielded 17 new papers that focus on children and young people suffering from anxiety, including two articles on youth phobia. Three more papers focus on depression with comorbid anxiety and are included here. A further set of papers was found that dealt solely with PTSD, and these are discussed in the next section.

A key theme that emerged from the literature is the emphasis on research into CBT for child and youth anxiety. All the research papers focusing specifically on child or youth anxiety use CBT or a variation of CBT. Variations of CBT include research by Khanna and Kendall (2010), which reported on an RCT focusing on computer-assisted CBT for child anxiety (see section 4.1.1 on the effectiveness of CBT). The only meta-analysis (Chu and Harrison, 2010) focused on both anxiety and depression.

All the papers found CBT effective as a treatment for child and adolescent anxiety. Most of the articles report on robust RCT studies; however, an evolving body of knowledge is now moving beyond merely establishing the efficacy of CBT. Many papers in this section go further and begin to explore differential outcomes, parental involvement in therapy, race issues, comorbidity, follow-up studies and flexibility.

Table 10: Overview of research evidence: anxiety

Systematic review

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Chu and Harrison	2010	Age: 6-18, exhibiting depression, SAD, GAD or social phobia, male and female	CBT and behavioural therapy	Individual and family	Meta-analysis	28	CBT produced reliable moderate effects for anxiety, depression and general functioning outcomes. CBT was equally effective in producing symptom change in both anxiety and depression studies, but produced comparatively greater behavioural and coping change in anxiety samples. The study suggests that CBT potentially works through different mechanisms in youth and adults. Cognitive processes may be more central to change in CBT for children and adolescents. The length of interventions affected outcomes, with longer sessions having a greater effect than short ones.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Bodden *et al*	2008	Age: 8-18, 59% female	CBT	Individual and family	CBA	128	CBT was more efficacious than the 2-3 month waiting list. Child CBT was superior to family CBT at post-treatment, but similar at follow-up. Both were more beneficial for younger children than older children at post-treatment but at follow-up they were equally effective.
Crawley *et al*	2008	Age: 7-17, with SP, SAD or GAD, male and female	CBT (Coping Cat)	Individual	RCT (n= 110) or treatment as outpatient (n=56)	166	SP children differed significantly from SAD and GAD children on a number of measures. SP children responded favourably to treatment, but less so than SAD or GAD groups. Comorbid affective disorders contributed to different treatment outcomes. Socially phobic children responded favourably to treatment.
Kendall *et al*	2004	Age: 15-22, 9-13, at time of treatment, 38% female	CBT	Individual	Initial RCT and follow-up	86	The majority maintained their initial treatment gains. There were beneficial effects on the sequelae of the disorder. Successful treatments were associated with less substance misuse.
Kendall *et al*	2008	Age: 7-14, 44% female	CBT, FESA	Individual and family	RCT	161	Treatment gains observed for all conditions, but child and family CBT superior to FESA. If present, gains maintained at 1-year follow-up.
Khanna and Kendall	2010	Age: 7-13, 32% female	CBT (individual; computer; CESA)	Individual	RCT (comp.)	45	Individual CBT and computer CBT resulted in better gains than CESA at post-treatment, with gains maintained at follow-up. Children and parents rated all treatments acceptable, but CESA was rated lowest.
Ollendick *et al*	2009	Age: 7-16, with various phobias; female only in Sweden,	CBT	Individual (parents involved in pre-treatment	RCT	196	Participants receiving one-session CBT and education support therapy had better results than those on waiting list, but not on self-reported measures. Results

		male and female in the US		sessions)			were maintained at follow-up.
Ollendick *et al*	2010	Age: 7-16, with various phobias, 42% female	CBT (brief)	Individual	RCT (analysis of previous data)	100	The presence of comorbid phobias or anxiety disorders did not affect treatment results. Phobia-specific treatments also mitigated co-occurring conditions.
Silverman *et al*	2009	Age: 7-16, 57% female	CBT	Group (child and mother)	RCT	119	Anxiety was reduced for both active parent involvement CBT and minimal parent involvement CBT. Youth-to-parent influence with regard to anxiety appeared to be stronger than customary.
Southam-Gerow *et al*	2010	Age: 8-15, exhibiting anxiety, 56% female	CBT vs a variety of therapeutic methods	Individual	RCT		Young people in the usual care group received significantly more mental health services than youth in the CBT group, but no significant differences were observed between the two groups on outcome measures. CBT could be administered with the same level of success by newly trained and supervised practitioners as by highly trained therapists working in community care clinics with a mix of interventions.
Spence *et al*	2006	Age: 7-14, exhibiting depression, 42% female	CBT (clinic-based, partially internet-based, and waiting list control)	Individual and group	RCT	72	Significant improvements in anxiety symptoms were observed at post-treatment and 12-month follow-up, without overall differences between the clinic or clinic-internet therapies. Neither gender nor age appears to influence outcomes. Internet-delivered CBT was effective when combined with some face-to-face group therapy.
Suveg *et al*	2009	Age: 7-14, 44% female	CBT, FESA	Individual and family	RCT	161	Treatment gains observed for all conditions and maintained at 1-year follow-up. Gender and age had no effects on treatment results.
Wood	2006	Age: 6-13, male and female	CBT	Individual	RCT	40	Reductions in anxiety might lead to improved school performance and social functioning.
Young *et al*	2006	Age: 12-18, exhibiting depression and comorbid anxiety, male and female	IPT	Individual	RCT	63	Depressed adolescents with comorbid anxiety entered treatment with more severe symptoms of depression. Both anxious and non-anxious youth had similar levels of functioning at post-treatment, while depression proved more difficult to treat.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Chu and Kendall	2009	Age: 8-14, 41% female	CBT (Coping Cat)	Individual	Analysis of practice	63	Therapist flexibility was related to later increases in child engagement, which was associated with clinical improvement. Therapists adapted to fit the interests of the child, but a mediation model of flexibility effects on treatment outcome was not supported.

Creed and Kendall	2005	Age: 7-13, 39% female	CBT	Individual	Behaviour study	56	Therapeutic alliance with children, as coded for 11 therapist behaviours, was positively predicted by ‘collaboration’ and ‘not being overly formal’ and negatively predicted by ‘finding common ground’ and ‘pushing the child to talk’. Children’s, therapists’ and observers’ perceptions of the sessions concurred.
Podell *et al*	2010	Age: 9-13; 7-14, male and female	CBT	Individual and family	Interventio n description	NA	The Coping Cat Program is described, together with the FEAR plan, which provides children with a framework to recall their skills. 3 RCT studies conducted to evaluate the program show positive outcomes for children.
Salloum	2010	NA	CBT	Individual, group	Literature review	NA	Minimal therapist-assisted CBT may be the first step in a stepped-care approach, providing more access to treatment for children, but further research is required to develop these interventions and evaluate their results.
Simard and Nielsen	2009	Age: 6-11, with nightmares, male and female	CBT (drawing therapy)	Group (dyad: mother and child)	SBA	32	A reduction in nightmare occurrence, distress and anxiety were associated with the treatment.
Wood *et al*	2008	NA	CBT	Individual	Literature review	NA	The paper discusses 10 principles of culturally adapted CBT interventions that would be more effective with Mexican-American students than current interventions.

Commentary on the research on anxiety

A number of themes emerged in the anxiety evidence. These include: parental involvement in therapy; comorbidity; CBT in conjunction with other interventions; flexibility in the use of manualised CBT; specific phobias; and therapeutic alliance. Many of these are discussed in a more general way in section 4.3.

Parental involvement in therapy for anxiety

In a study of 128 children Bodden (2008) compared child CBT with family CBT in a controlled before and after study. Child CBT was more efficacious than family CBT at post-treatment but at follow-up they were equally efficacious. Generally, if parents had anxiety disorders, both treatment outcomes were less positive at post-treatment and at three-month follow-up; however, some measures showed superior results for child CBT if parents had anxiety disorders. Both treatments were more beneficial for younger children than older children at post-treatment but not at follow-up. The authors conclude that family CBT is not superior to child CBT, and on some measures is actually inferior. This suggests that clinical intuition to include families, especially if there is parental anxiety, may not be best practice; individual therapy may be the best treatment in these cases. For parents with no anxiety disorder, family CBT does seem to be an alternative to child-focused CBT.

Silverman *et al* (2009) examined adolescent anxiety treatments involving parents in the US. They compared minimal parent involvement with active parent involvement (n=119). Anxiety was significantly reduced in both groups. The discussion suggests that the relative strength of youth to parent influence is somewhat stronger than parent to youth influence, as regards anxiety. The authors suggested that the dynamics of change are bi-directional and flow from youth to parents as well as from parents to youth.

Kendall *et al* (2008) studied 161 anxious children in the US and reported gains in anxiety reduction for individual child CBT, family CBT and FESA. Individual CBT and family CBT were superior to FESA in

terms of outcomes. Teacher reports were considered less biased towards recording positive outcomes than parental reports and these showed individual CBT to be more effective than family CBT. The study concluded that including parents is not essential to achieving positive gains, and treatment gains were maintained at one-year follow-up. Interestingly, when both parents had an anxiety disorder, family CBT outperformed individual CBT. Here, it is claimed that children with non-anxious mothers were significantly more likely to improve than children with anxious mothers. This contradicts the findings of Bodden *et al* (2008) discussed earlier. The issue of parental involvement in child therapy has also emerged as a key issue in other modalities, and is discussed in a later section.

Comorbidity with anxiety

The issue of comorbidity was evident in the childhood anxiety literature, anxiety often being comorbid with depression. Ollendicka *et al* (2010) conducted a study involving 196 young people in the US and Sweden with specific phobias. They investigated the impact of comorbidity on treatment outcomes and the impact of treatment on comorbid disorders. The findings were that the presence of comorbid disorders did not affect treatment outcome and that the clinical severity of comorbid phobias and other anxieties was reduced. Another US RCT (Suveg *et al*, 2009) evaluated secondary outcomes from a previous evaluation of child and family modalities treating anxiety disorders (Kendall *et al*, 2008) (n=161). They claimed secondary outcomes of improved associated symptoms, concluding that when treating youth with anxiety, therapists can also expect improvement in other symptoms, especially depression and externalising symptoms, and improvements in adaptive functioning. In addition, Wood (2006) suggested reduced anxiety might promote improved school performance and social functioning. A 7.4-year follow-up study (Kendall *et al*, 2004) (n=86), for child anxiety in the US treated with a 16-week CBT intervention, showed less substance use in the treated youth (now 15-22 years old) but no positive effect on mood disorder.

CBT in conjunction with other interventions

Two papers focusing on childhood anxiety demonstrate the efficacy of CBT employed in conjunction with other interventions such as computer assisted work, bibliotherapy and telephone therapy (Khanna and Kendall, 2010; Salloum, 2010). This is discussed in Section 4.1.

Flexibility in the use of manualised CBT

An interesting development has been the exploration of flexibility within manual-based CBT for anxious youth. Flexibility was defined as the therapist's attempts to adapt treatment to the child's needs. Kendall and Chu (2009) (n=63) in the US found that therapists do tend to adapt the manual to the interests of the child. There was a correlation between increased therapist flexibility and subsequent increased child engagement in the therapy, which was associated with clinical improvement. The authors declared that therapist flexibility does not directly predict treatment outcome but neither does it lead to unwanted treatment outcomes. In a later article Podell *et al* (2010) also recommended the flexible application of manualised treatments.

A further adaptation of manualised CBT for anxious youth has been to create culturally sensitive therapy. A study addressing CBT therapy with Mexican American students suggested that therapy is more effective when cultural factors are taken into account and when underlying principles for practice are explicit (Wood *et al*, 2008). This is discussed in Section 4.1.1.

Specific phobias

An RCT reporting on a one-session treatment of specific phobias in 196 young people compared two active treatments with a waiting list (Ollendick *et al*, 2009). The first treatment was an intensive CBT treatment incorporating participant modelling, exposure in vivo and reinforced practice, named OST. The second treatment was education and support. Overall, participants receiving both active treatments had more positive outcomes than those on the waiting list. However, these outcomes were not superior to the waiting list group on all measures, specifically the Behaviour Approach Test, self-report or parent report. Although the findings were mixed, overall one-session therapy was superior to education support therapy for specific phobias. The discussion compares the findings to two similar studies. Generally girls improved more than boys. The authors concluded that one-session therapy is efficient and effective in treating phobias in youth.

Another RCT examining phobias in school children compared children with primary social phobia to children with primary separation anxiety disorder and children with generalised anxiety disorder (n=166) (Crawley, 2008). These groups differed significantly on pre-treatment measures and on

treatment outcomes. Children with primary social phobia responded less favourably to treatment although there were some positive treatment gains. When the socially phobic youth with a comorbid affective disorder were taken out of the analyses there were insignificant differences in outcome. It is suggested that the added impairment of the comorbidity influences treatment response. It is further suggested that severe social phobia is more difficult to treat effectively than other anxiety disorders and that perhaps a longer time to build a therapeutic relationship is needed than may be allowed for in some CBT protocols.

Therapeutic alliance

Creed and Kendall (2005) in a US-based study (n=56) found that collaboration positively correlated with alliance as did 'not being overly formal'. 'Pushing the child to talk' and 'finding common ground' in terms of self-disclosing (eg 'I play hockey too') correlated negatively with a positive therapeutic alliance. Child, therapist and observer perceptions of the sessions concurred in this study.

Post-traumatic stress disorder

Background

The Royal College of Psychiatrists describes PTSD as a condition that can be triggered by a traumatic event that can feel overwhelming and frightening and from which it is difficult to recover. "The symptoms of PTSD can start immediately or after a delay of weeks or months. They usually appear within six months of the traumatic event." (RCPsych, 2010) Children can display symptoms of PTSD through upsetting dreams and nightmares and relive the experience through their play. They are likely to lose interest in activities that used to be enjoyable, and might complain of physical symptoms such as stomach ache or headache. The Royal College of Psychiatrists says there is evidence that EMDR, psychotherapy, behaviour therapy and antidepressants are all effective. NICE (2005) recommends CBT or TF-CBT for treating PTSD in children and young people. It suggests that medication is not effective for children, and that CBT is likely to be the best therapeutic intervention. "There is little evidence at the moment to show that other treatments (such as play therapy, art therapy and family therapy) can help young people with PTSD." (NICE, 2005)

The 2004 review – summary of evidence

The 2004 review did not consider PTSD separately but included it in the general description of emotional problems that included anxiety, bereavement and loss, OCD and depression. PTSD might be overlooked in children with behaviour and conduct disorders, and ADHD (Ford *et al*, 2000). Symptoms of PTSD are described as:

- re-experiencing, such as intrusive flashbacks, memories and dreams
- desensitisation of responsiveness, such as social withdrawal, dissociation, constricted play, reduced range of affect, and lack of a here-and-now focus
- increased arousal such as agitation, hyper-vigilance, startle response, sensitivity, increase in base body temperature, profound sleep disturbances and increase in heart rate and blood pressure
- new fears and aggressive behaviours in younger children.

(Harris and Pattison, 2004)

The 2004 review suggests that methodologically rigorous studies were beginning to emerge that addressed the treatment of PTSD although these focused primarily on the adult population; and that the effects of counselling children with PTSD were scarce but on the increase. The review cited four studies that looked at PTSD in children (Kaplan *et al*, 2001; March *et al*, 1998; Ovaert *et al*, 2003; Salloumi *et al*, 2001), concluding that there is little empirical evidence of the comparative efficacy of treatments for PTSD.

The 2012 review – summary of evidence

The updated review located nine studies on the effectiveness of counselling for children and young people with symptoms of PTSD.

Table 11: Overview of research evidence: Post-traumatic stress disorder

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Feeny *et al*	2004	Age: 3-17, with PTSD, male and female	CBT	Group and family	Meta-analysis	13	Different variants of CBT are effective in the treatment of children and adolescents with PTSD: EMDR was effective for children who had been exposed to natural disasters; Child-parent therapies were effective in treating sexual abuse-related PTSD, especially when the child was treated both alone *and* with parents; trauma-focused therapy was better at improving PTSD symptoms than child-centred therapies; AMT was generally an effective therapy; group-delivered CBT was highly effective, even at 18-month follow-up. There is a need for research to further consolidate the scientific base of clinical practice with PTSD children and adolescents.
Lang *et al*	2010	Age: 3-21, with PTSD, male and female	TF-CBT	Individual and with carer	Meta-analysis	7	TF-CBT was successful and highly effective at reducing PTSD symptoms, though it was less effective for long-term effects of anxiety. There was ample evidence that caregiver involvement was beneficial but CBT was effective even when this was not possible
Vickerman and Margolin	2007	Age: 3-16, who had been exposed to family violence, male and female	CBT and CPP	Individual and family	Meta-analysis	8	Psycho-education and CBT are generally effective in the treatment of family violence-related PTSD, but different age children benefit more from different modalities and variations of CBT. Parental involvement in therapy is important and group treatment could be counterproductive for children with poor social skills.

Controlled trials

Authors	Date	Population	Therapeutic Intervention	Individual or group	Study Design	Sample	Findings
Adúriz *et al*	2009	Children exposed to severe floods in Argentina, male and female	EMDR	Group	SBA	124	A one-session EMDR intervention proved effective in the mitigation of PTSD symptoms, both immediately after the intervention and at a 3-month follow-up, but with gender-based differences.
Gilboa-Schechtman *et al*	2010	Age: 12-18, with PTSD, male and female	Comparison of PE-A and dynamic therapy	Individual	RCT	38	Both treatments resulted in decreased PTSD and depressive symptoms and increased functioning. PE-A was reported to have a greater impact on symptoms and global functioning, and after treatment more patients in the PE-A group no longer met the diagnostic criteria for PTSD (68.4% vs 36.8%). Treatment gains were maintained in both groups at 6- and 17-month follow-up.
Layne *et al*	2008	Age: 13-19, exposed to war, 63%	School-based psychotherapy	Group	RCT	127	This school-based, multi-tier, group mental health intervention with Bosnian adolescents was

		female					effective at reducing war trauma symptoms. Psycho-education alone was effective, but more so when combined with the treatment. Generally, these programmes were seen as similarly effective to community-based interventions.
Shooshtary *et al*	2008	Age: 11-20, exposed to the 2004 Iran earthquake, male and female	CBT	Group	CBA	168	Four months after earthquake, participants took part in four weekly CBT sessions, which were found to be effective at reducing self-reported PTSD symptoms.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Faust and Katchen	2004	Children and adolescents with experiences of trauma, male and female	CBT vs FST	Individual and family	Literature review	NA	CBT is effective for treating youth with PTSD, but integrating it with family therapies appears to increase recovery. Individual CBT can directly reduce trauma symptoms and increase individual coping resources. FST can help parents understand the trauma that their child is experiencing.
Little and Akin-Little	2009	Children and adolescents with experiences of trauma, male and female	CBT, behavioural and psycho-education therapies	Individual and family	Literature review	NA	This paper presents a trauma-focused CBT intervention (that includes psycho-education, parenting skills training, relaxation, affective modulation, cognitive coping and processing, trauma narrative, in vivo mastery of trauma reminders, child-parent sessions and the enhancement of future safety and development) and deems it an effective therapeutic technique in addressing trauma-related issues in children.
Rosenberg *et al*	2011	Age: 14-18, with PTSD, 9 female and 3 male	CBT	Individual	Case study	12 (9 fully treated)	12 adolescents with PTSD took part in a manualised cognitive restructuring programme, with significant improvement in PTSD and depression symptoms, gains maintained at 3-month follow-up.
Weiner *et al*	2009	Age: 3-18, with traumatic stress symptoms, 55% female	EBT: CPP, TF-CBT, SPARCS	Individual and family	Comparison study	216	Differences were observed in the effectiveness of the three interventions for particular racial groups across the five dimensions of CANS. African-American youth showed improvements on all dimensions if in CPP or on three dimensions if in TF-CBT or SPARCS. White adolescents showed least progress, regardless of intervention, with no significant improvement on SPARCS.

Commentary on the research on PTSD

Most interventions for PTSD involve CBT or some form of short-term therapy such as EMDR. A US meta-analysis of seven reviews that looked at CBT as a treatment for children with PTSD found it highly effective in reducing symptoms, though less effective for the long-term effects of anxiety (Lang *et al*, 2010). The purpose of the review was to develop an algorithm to assist clinicians in determining whether a particular client is appropriate for TF-CBT. There was ample evidence to support caregiver involvement when possible but CBT was still effective when a caregiver was unavailable. Another US meta-analysis that looked at eight studies where CBT had been used for PTSD found that parental inclusion was particularly important for treatment success (Vickerman and Margolin, 2007). Various CBT forms were assessed – including re-exposure intervention, psycho-education, and emotion recognition and expression – and all were effective for the children aged three to 16. Some of these treatments lasted longer than the normal 12 weeks of CBT, some as long as a year.

A US meta-analysis by Feeny *et al* (2004) looked at 13 studies describing the treatment of PTSD in children. It pointed out that only two previous studies focused on therapies that did not include CBT for PTSD, both of which looked at treatment for sexually abused children. The study by Trowell *et al* (2002) used an RCT approach comparing psychotherapy with psycho-education; the study by Baker (1987) used a Rogerian model. Neither compared the therapeutic approach with an alternative therapy, although both showed improvements for the children treated (Feeny *et al*, 2004). Various types of short-term treatment were looked at in the Feeny *et al* (2004) meta-analysis and were found to be effective for PTSD in longer-term follow-up. These included imaginal and in vivo exposure (that helped clients confront traumatic events), EMDR, AMT and group CBT. Treatment that offered only group CBT, but which included a similar range of treatments such as in vivo exposure, is described in a study carried out in Iran four months after an earthquake with 135 adolescents aged 11-20 (Shooshtary *et al*, 2008). The intervention was effective at reducing self-reported PTSD symptoms, although follow-up was conducted only four weeks post-treatment. EMDR was also effective in the amelioration of symptoms of children who were exposed to severe floods in Argentina. Despite the lack of a control group in the study, the persistence of positive effects three months following the intervention was deemed by the authors (Adúriz *et al*, 2009) to be evidence towards the potential efficacy of such short-term therapies for the treatment of PTSD.

An RCT found that a school-based, multi-tier, group mental health intervention with Bosnian adolescents was effective in reducing war trauma symptoms (Layne *et al*, 2008). Psycho-education alone was effective, but more so when combined with other treatments; generally, these programmes were seen as similarly effective to community-based interventions. Weiner *et al* (2009) compared the effectiveness of interventions for particular cultural groups of children aged three to 18 (n=216) suffering from PTSD symptoms and found cultural differences in response to treatment.

Gilboa-Schechtmann *et al* (2010) conducted a pilot RCT study in Israel (n=38) that examined the efficacy and maintenance of a developmentally adapted PE-A, compared with an active control time-limited dynamic therapy for decreasing post-traumatic and depressive symptoms in adolescents of single event traumas. Both treatments resulted in decreased PTSD and depressive symptoms, and increased functioning. PE-A was reported to have a greater impact on symptoms and global functioning, and after treatment more patients in the PE-A group no longer met the diagnostic criteria for PTSD (68.4 per cent vs 36.8 per cent). Treatment gains were maintained in both groups at both six- and 17-month follow-up.

A number of small-scale studies provide supporting evidence for the effectiveness of psychological interventions with PTSD. For example, Rosenberg *et al* (2010) conducted a study in the US with nine adolescents who had experienced abuse. Following CBT including psycho-education, relaxation breathing and cognitive restructuring, adolescents reported a significant reduction in frequency and intensity of PTSD symptoms with significantly lower levels of depressive symptoms at end of session and at follow-up three months later. This study also showed the importance of parental participation except where there are chaotic family circumstances and where parents may be perpetrators of abuse.

Depression

Background

Depression in young people is "a significant, persistent and recurrent public health problem that undermines social and school functioning, generates severe family stress, and prompts significant use of mental health services" (Weisz *et al*, 2006a). Weisz *et al* (2006a) summarise the importance of this as an area for therapy, noting that it is significantly linked to adult psychiatric disorders, as well as drug use and suicide. The authors write in a US context and there may be cultural differences between the US and UK in terms of the reported incidence of depression and other related disorders: this is certainly true of schizophrenia as a diagnosis, with higher rates reported in the US than in the UK. Carr (2008), writing in Ireland, says that depression in young people is not rare and is more common in adolescents than children. The papers distinguish between pre-adolescent and adolescent onset and treatment. Mental health professionals relatively rarely diagnose depression prior to mid-adolescence, despite the fact that earlier onset depression may be more pernicious in its adverse psychological effects (Tompson and Dingman Boger, 2009). Weisz *et al*'s (2006a) meta-analysis examining treatment for depressed youth found that, excluding trials with mixed child and adolescent samples, the effect size for studies of children under 13 was not significantly different from the effect size for treatment of adolescents (0.41 versus 0.33). There is a need for a better understanding of the relationship between age and treatment outcome, particularly in relation to youth depression, and the part that developmental tasks play (Tompson and Dingman Boger, 2009). Comorbidity of depression, especially with anxiety, is common in adolescent diagnoses. Tompson and Dingman Boger (2009) quote a study by Lewinsohn *et al* (1998), which shows that more than half of US youth with a diagnosis of depression meet another criteria of an Axis 1 disorder, eg OCD.

Rates of depression in children and young people vary between 4.7 per cent for serious depression (Carr, 2008) and 20 per cent (Tompson and Dingman Boger, 2009). Since 2004, there has been an important increase in published evidence in this area, including three meta-analyses (Weisz *et al*, 2006a; Weisz *et al*, 2006b; Watanabe *et al*, 2007), three RCTs (Rosello *et al*, 2008; Gunlicks-Stoessel *et al*, 2010; Tang *et al*, 2009), and two major reviews (Carr, 2008; Tompson and Dingman Boger, 2009).

The 2004 review – summary of evidence

Four reviews of psychological therapies for depression were located and these demonstrated the significant short-term effect of CBT for depression, with inconclusive results in terms of the longer-term efficacy of therapy over waiting list controls. There was some evidence of a moderate effect for IPT, non-directive supportive therapy and personal growth groups, but no evidence for social skills training. Different models of therapy produced differential effects, eg enhanced personal control was associated with personal growth groups, and positive explanatory style with CBT.

The 2012 review – summary of evidence

The findings showed the effectiveness of CBT, interpersonal, psychodynamic and family therapies for depression in adolescents (Carr, 20008; Weisz *et al*, 2006a; Weisz *et al*, 2006b). The meta-analyses all showed that psychotherapy for adolescent depression is effective and significantly more effective than no intervention or than treatment as usual. There is some evidence for the combination of therapeutic approaches. There has been some growth in research on different types of intervention and comparisons between interventions. Studies show the short-term effectiveness of CBT and of other EBTs. Treatment length has been explored by Kennard *et al* (2009) in a secondary analysis of the TORDIA data (n=334), which found that youths who had more than nine CBT sessions were 2.5 times more likely to have adequate treatment response than those who had nine or fewer sessions. CBT participants receiving problem-solving and social skills treatment components, controlling for number of sessions and other confounding variables, were 2.3 and 2.6 times respectively more likely to have a positive response.

Weisz *et al*'s review (2006a) suggested effect sizes may be smaller than previously reported, "with evidence from 35 studies pointing to treatment effects that are significant, albeit markedly more modest than those reported in previous meta-analyses". Effects appear to last for the initial months following treatment but not at 12-month follow-up. More evidence is needed regarding long-term effects (Weisz *et al*, 2006a; Watanabe *et al*, 2007). The need to examine long-term impact and for studies to follow-up for a longer period is highlighted (Weisz, 2006a; Tompson and Dingman Boger, 2009). Other factors that may impact upon effectiveness, and that need to be taken into account when

considering interventions, include the number of sessions, attention to contextual factors such as the young person's cultural context, and the appropriateness of the approach for the presenting problem.

Table 12: Overview of research evidence: depression

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Watanabe *et al*	2007	Age: 6-18, male and female	Psychotherapy vs NT vs waiting list vs placebo vs TAU	Individual and group	Meta-analysis	27	Psychotherapy (especially CBT) was more effective than all other controls at post-treatment for depressed youths, particularly the 12-18 age group, and for moderate-to-severe symptoms. These effects were not evident at 6 months or longer after treatment.
Weisz *et al*	2006	Age: 3-18, male and female	EBTs (cognitive and non-cognitive)	Individual and group	Meta-analysis	32	EBTs were more effective (but not by much) than usual care approaches, with effects not reduced by the severity or ethnic distribution of young people (general ES=0.30)
Weisz *et al*	2006	Mean age: less than 19, male and female	Cognitive and non-cognitive treatments	Individual and group	Meta-analysis	35	No difference in effectiveness was identified between cognitive (inc CBT) and non-cognitive treatments (inc family therapies), with effects evident in the short term only. Effects of these therapies are modest, with general ES=0.34.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Gunlicks-Stoessel *et al*	2010	Age: 12-18, 84% female	IPT-A vs TAU	Individual	RCT	63	The benefits of IPT-A were greater than TAU for depressed adolescents; the difference was most dramatic for adolescents with high levels of maternal and social conflict. Across treatments, this group showed slower reductions in depression.
Kaufman *et al*	2005	Age: 13-17, with comorbid major depression and conduct disorder, male and female	CBT (CWD-A) vs LS	Group	RCT	93	No significant differences between the two interventions in terms of longstanding alleviation of depression symptoms, although CWD-A was more effective at reducing automatic destructive thinking. A more intensive CBT treatment might have yielded better results.
Rossello *et al*	2008	Age: 12-18, 55% female	CBT vs IPT	Individual vs group	RCT	112	All treatments were effective in reducing symptoms of depression, but CBT had stronger effects and was more effective in improving self-concept and social adaptation, despite initial hypothesis arguing in favour of IPT because of cultural relevance for the adolescents.
Tang *et al*	2009	Age: 12-18, with depression and suicidal risk, male and female	School-based IPT-A-IN vs TAU	Individual	One school RCT	73	Compared to TAU the IPT-A-IN programme was more effective at reducing severity of depression, suicidal risk, anxiety and hopelessness.

Trowell *et al*	2007	Age: 9-15, male and female	Individual psychodynamic therapy vs FBT	Individual vs family	RCT	72	In both treatment groups changes were persistent, there was ongoing improvement and an overall reduction in comorbid symptoms. At 6-month follow-up 100% of cases in the individual therapy group and 81% of cases in the family therapy group were no longer clinically depressed.
Young *et al*	2006	Age: 12-18, exhibiting depression and comorbid anxiety, male and female	IPT	Individual	RCT	63	Depressed adolescents with comorbid anxiety entered treatment with more severe symptoms of depression. Anxious and non-anxious youth had similar levels of functioning at post-treatment, while depression proved more difficult to treat.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Bradley *et al*	2010	Age: 15-21, 51% female	None	NA	Survey: preference for depression treatment	156	Adolescents showed higher preference for psychotherapy than antidepressants, which was predicted by greater severity of depression symptoms and general willingness to seek treatment.
Carr	2008	Children and adolescents, male and female	Reviewed: CBT, IPT, FBT, ECT, antidepressant medication	Individual and family	Literature review	NA	There is growing evidence for the effectiveness in treating depression of CBT, psychodynamic, IPT and FBT. Integrating family in CBT and psychodynamic therapies is beneficial, but approaches should be tailored to clients based on prior assessment. SSRIs seen as particularly effective for severe depression, but at the risk of increased suicidality.
Jungbluth and Shirk	2009	Age: 14-18, male and female	CBT	Individual	Behaviour study	42	Higher levels of attending to adolescents' experience, greater exploration of motivation and lower levels of structuring (as identified from female therapists' behaviour) were associated with greater involvement in core tasks of adolescents. The latter two behaviours predicated the youths' involvement in the subsequent session.
Kennard *et al*	2009	Age: 12-18, with major depressive disorder and SSRI resistant, male and female	CBT component of intervention	Individual	Secondary analysis	334	Youths in TORDIA with major depressive disorder who had failed to respond to an adequate course of SSRI medication were randomised to a medication switch (to an alternative SSRI or to venlafaxine, an SNRI) with or without 12 weeks of adjunctive CBT. Participants who had more than 9 CBT sessions were 2.5 times more likely to have adequate treatment response than those who had 9 or fewer sessions. CBT participants who received problem-solving and social skills treatment components, controlling for number of sessions and other

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							confounding variables, were 2.3 and 2.6 times respectively more likely to have a positive response.
Tompson and Dingman Boger	2009	Children and adolescents, male and female	CBT, IPT, social skills conditioning, FBT, medication	Individual and group	Literature review	32	Though advances in understanding and treating depression have been made, treatments still have only limited efficacy, and studies still focus mostly on short-term evidence and on symptomatic as opposed to functional outcomes. Most clinical trials to date do not focus enough on young children and on youths with developmental and mental health issues. CBT is an effective treatment, but less so in community settings, though it is still more effective than treatment in community mental health centres only.

Commentary on the research findings on depression

Three meta-analyses of the effectiveness of psychological therapies for children and young people were located (Weisz *et al*, 2006a; Weisz *et al*, 2006b; Watanabe *et al*, 2007). These found that cognitive (including CBT) and non-cognitive treatments (including family therapies) were effective in the short term, ie up to six months, and that there were no differences in effectiveness identified between the two. Effects of these therapies are modest, with general ES=0.34 (Weisz *et al*, 2006a). EBTs were more effective (but not by much) than usual care approaches, with effects not reduced by the severity of the depression (general ES=0.30). Psychotherapies (especially CBT) were more effective than all other controls at post-treatment for depressed youths, particularly the 12-18 age group, and for moderate-to-severe symptoms (Watanabe *et al*, 2007). These effects were not evident at six months after treatment. Carr's (2008) review reports a small amount of evidence of the long-term effectiveness of psychodynamic therapy at two-year follow-up.

There were five randomised controlled trials (Kaufman *et al*, 2005; Young *et al*, 2006; Rossello *et al*, 2008; Gunlicks-Stoessel *et al*, 2010; Trowell *et al*, 2007). Two were studies of depression comorbid with anxiety (Kaufman *et al*, 2005; Young *et al*, 2006). Rossello *et al* (2008) found that all treatments were effective in reducing symptoms of depression, but CBT had stronger effects and was also more effective in improving self-concept and social adaptation, despite an initial hypothesis arguing in favour of IPT. Gunlicks-Stoessel *et al* (2010) conducted an RCT confirming that IPT was more effective than TAU and that the difference was most dramatic for adolescents with high levels of maternal and social conflict. Across treatments, this group also showed slower reductions in depression. A study by Young *et al* (2006) looked at depressed adolescents with comorbid anxiety who entered treatment. Both anxious and non-anxious youth had similar levels of functioning at post-treatment, while depression proved more difficult to treat. In a study by Kaufman *et al* (2005), two psycho-education programmes were tested on depressed young people with comorbid conduct disorder. The studies detected no significant differences between the two interventions in terms of longstanding alleviation of depression symptoms, although CWD-A was more effective than LS at reducing automatic destructive thinking. It suggests that a more intensive CBT treatment would have yielded better results (Kaufman *et al*, 2005).

The two reviews of the evidence (Carr, 2008; Tompson and Dingman Boger, 2009) confirmed the short-term efficacy of psychodynamic, IPT, FBT, individual and group-based cognitive behavioural interventions. Tompson and Dingman Boger (2009) make the case for a refinement of research, ie to focus on functional rather than symptomatic outcomes and clinical trials to focus on young children and on youths with developmental and mental health issues. They also note the need to research the transfer from clinical trials to real world settings.

Bradley *et al* (2009) conducted a survey of adolescents (n=156) in one UK school, which showed higher preference for psychotherapy than for antidepressants. Greater severity of depression symptoms, perceived social support for the particular treatment modality, and general willingness to seek treatment predicted greater preference for psychotherapy than for antidepressants.

Characteristics of therapist behaviour in the first session and its relationship to subsequent client engagement were highlighted in one study of 42 therapists (Jungbluth and Shirk, 2009). Higher levels

of attending to adolescents' experience, greater exploration of motivation and lower levels of structuring (as identified from female therapists' behaviour) were associated with greater involvement of adolescents in core tasks. The latter two behaviours predicted the youths' involvement in subsequent sessions, having implications with regard to reducing dropout rates.

Two studies highlighted the issues related to specific groups of young people and specifically in relation to depression. In the US, Rossello *et al* (2008) noted that during adolescence Latinos have higher than average rates of depression. They found that CBT produced significantly greater decreases in depressive symptoms and improved self-concept than did IPT and argued that this relates to the cultural characteristics of these young people. Gunlicks-Stoessel *et al* (2010), in an 84.1 per cent Latino sample of girls with high conflict-related depression, reported that IPT-A was effective (n=63). These two studies suggest that the appropriateness of the approach for the presenting problem and cultural context of the young people need to be taken into account when considering effective interventions.

School-related issues and learning difficulties

Background

This section reports on counselling that takes place in school settings and on problems relating to school. These include:

- bullying
- behavioural difficulties
- emotional problems
- school refusal
- truancy
- academic failure.

The 2004 review – summary of evidence

A range of studies indicated that a variety of counselling approaches were effective for behavioural problems, school attendance, school refusing and anxiety in particular.

The 2012 review – summary of evidence

As in the 2004 review, it was found that school-based counselling was effective for a range of difficulties

Table 13: Overview of research evidence: school-related issues and learning difficulties

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Baskin *et al* (a)*	2010	Students aged 5-18, male and female	Psychotherapy	Individual	Meta-analysis	83	Psychotherapy was beneficial for US students (overall ES=0.46), regardless of age and more so in the case of ethnically diverse groups as regards academic outcomes.
Baskin *et al* (b)*	2010	Students aged 5-18, male and female	In-school counselling and psychotherapy	Individual and group	Meta-analysis	107	In-school psychotherapy and counselling had positive results (overall ES=0.45). Interventions were more effective with adolescents than with children (ES=0.59 vs ES=0.35), with

* Refer to the same review

							single-gender groups than mixed groups (female ES=0.54, male ES=0.51, mixed ES=0.33). Treatment modalities did not make significant differences in the interventions' effectiveness, but trained therapists had better outcomes than paraprofessionals or PhD students.
Zirkelback and Reese	2010	Children and young people, male and female	Psychotherapy	Individual and group	Meta-analysis	9	Psychotherapy interventions are generally effective for children and adolescents, but benefits appear to increase with age and in the case of individual therapies and behaviourally oriented treatments, with therapeutic alliance important across therapies.

<u>Controlled trial</u>

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Tang *et al*	2009	Age: 12-18, with depression and suicidal risk, male and female	School-based IPT-A-IN vs TAU	Individual	One school RCT	73	Compared to TAU, the IPT-A-IN programme was more effective at reducing severity of depression, suicidal risk, anxiety and hopelessness.

<u>Supporting evidence</u>

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Cooper	2009	Mean age: 13.86, 56% females	Person-centred therapy	Individual	Literature review	30	School-based counselling appears to be of considerable benefit to young people in the UK, with participants exhibiting large improvements in mental health (mean weighted ES=0.81). Young people and teachers rated it as being generally helpful.
Schuengel *et al*	2009	Age: 10-17, 50% female, with intellectual and physical disabilities	Behavioural therapy	Individual	Controlled multiple case study	6	Even for children with multiple disabilities and growing up without stable attachment, secure attachment behaviour could be stimulated. The children differentiated between a therapist offering psychotherapeutically sensitive and supportive mirroring and one who offered just positive attention; those in the former group appeared to cope better with the behavioural modification sessions. The integration of psychotherapy with behavioural therapy is an important illustration of the way in which the development of the therapeutic relationship and alliance, especially in terms of attachment, can help in behaviour modification.
Shechtman and Pastor	2005	Age: 7-11, with learning disabilities, male and female	Humanistic therapy, group CBT	Group	Comparison study	200	Humanistic therapy was more effective than CBT on most measures. Both were more effective when academic assistance was also offered to the children, but on their own were more effective than solely

							academic assistance. Treatment gains were generally retained at follow-up, though effect sizes were low.

Commentary on the research on school-related issues and learning difficulties

Cooper (2009) reviewed 30 studies of school-based counselling in UK secondary schools. This work concluded that school-based counselling, largely person centred, resulted in large improvements in mental health.

Some studies were located in school-based clinics in the US. Baskin *et al* (2010a) undertook a systematic exploration of the impact of psychotherapy upon youth academic performance in which 83 studies were examined. The review showed that psychotherapy impacted positively upon academic outputs between five and 18 years of age. This study notes the link between wellbeing and academic achievement.

Another paper examined data from 107 studies (Baskin *et al*, 2010b) and found counselling and psychotherapy to be effective. Interventions for adolescents outperformed those for children; treatment groups that were predominantly male or female did better than mixed gender groups; and licensed professionals outperformed paraprofessionals who, in turn, outperformed graduate students. The authors suggest that the flexibility of schools to offer multi-faceted interventions seemed to demonstrate an advantage of the school setting over mental health clinic settings.

Tang *et al* (2009) (discussed in section 4.2.2.3) evaluated the effects of IPT-A for depression in a schools setting (n=73) and found positive outcomes. Zirkelback *et al* (2010) conducted a meta-review of psychotherapy outcome research, which aimed to inform school-based mental health providers. This review found psychotherapy to be generally effective for children and young people, with benefits increasing with age.

Few studies have been carried out with children with learning difficulties. A study in the Netherlands included six children aged 10-17 with severe learning difficulties (Schuengel *et al*, 2009). Two clinical psychologists each delivered an integrative therapy with three clients in three sessions of one hour per week. The study showed that an integrative approach, that is first using psychotherapy and then behaviour modification, was highly effective. However, this was a very small-scale study and the findings cannot be generalised. A larger scale study (Shechtman and Pastor, 2005) compared humanistic group therapy with CBT group therapy including 200 children with learning disabilities in Israel. Both types of group therapy plus academic assistance were more effective than the group therapy alone on most measures and both types of group therapy alone were more effective than academic assistance alone. Humanistic group therapy was found to be more effective than CBT group therapy on most measures. The measures included self-report and teacher report, and covered behaviour, social acceptance and self-efficacy. The focus was on emotional release and the conclusion drawn is that relational emphasis is more effective than problem solving and information processing.

Self-harming practices

Background

Self-harm in the UK affects at least seven per cent of young people, in particular girls (Pryjmachuk and Trainor, 2010). Concern in this area has led to a national inquiry (National Inquiry into Self-Harm among Young People, 2006) and the publication of national guidelines for self-harm (NICE, 2004). Self-harm is defined as:

> "An act with a non-fatal outcome in which an individual deliberately did one or more of the following: initiated behaviour (for example, self-cutting, jumping from a height) which they intended to cause self-harm; ingested a substance in excess of the prescribed or generally recognised therapeutic dose; ingested a recreational or illicit drug that was an act that the person regarded as self-harm; ingested a non-ingestible substance or object." (Hawton *et al*, 2002, cited in Pryjmachuk and Trainor, 2010)

The 2004 review – summary of evidence

The 2004 review noted the two forms of self-injury: compulsive and impulsive. The importance of non-judgemental and compassionate attitudes was acknowledged as well as paying great attention to the relationship in therapy. The marked absence of research and evidence was noted.

The 2012 review – summary of evidence

This continues to be an under-researched area with just one paper located (Pryjmachuk and Trainor, 2010).

Table 14: Overview of research evidence: self-harming practices

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Pryjmachuk and Trainor	2010	English young people, male and female	A variety of therapies	Individual and group	Review	13	There is no definitive evidence as to the general effectiveness of therapies with young people who self-harm, and no indication as to which therapy might be more effective; but in the UK, nurses are in a very good position to initiate help for affected adolescents.

Commentary on the research on self-harming practices

Pryjmachuk and Trainor (2010) reviewed a variety of treatment modalities used in England with young people who self-harm, categorising them according to whether they were individual, family, group, or psychopharmacological therapies. They concluded that the overall picture regarding these interventions is unclear: some have no evidence base while others are supported by emerging evidence, although limitations in study design mean no definitive conclusions can be drawn. They argued for further research in this area, especially evaluating the effectiveness of interventions. In terms of implications for practice, they concluded that nurses should play a lead role in this area as they are often best placed to help young people who self-harm.

Eating disorders

Background and definition of terms

The original 2004 study categorised eating disorders as:

- obesity
- anorexia nervosa
- bulimia nervosa.

The update of the 2004 review has followed this categorisation. A distinction exists between the psychology of anorexia nervosa/bulimia nervosa and other eating problems such as obesity in that the former are characterised by overvaluation of weight and/or shape (Gowers and Bryant Waugh, 2004), which is not necessarily the case with the latter.

Estimates of the prevalence of anorexia nervosa are 0.48 per cent of female adolescents aged 15-19 (Harris and Pattison, 2004) and four to seven per cent for full or partial bulimia nervosa *(*Gowers and Bryant-Waugh, 2004). Anorexia nervosa can begin at around eight years of age, while full bulimia nervosa appears very rarely in those under 12. Typically, bulimia develops in adolescence, and individuals with a partial syndrome are at risk of developing the full syndrome. Without treatment, bulimia nervosa tends to persist into adulthood; it is associated with secondary physical and mental disorders and imposes a major burden on families.

The 2004 review – summary of evidence

The 2004 study concluded that family therapy was the most researched psychosocial therapy for anorexia nervosa in young people and that there was substantial evidence for its effectiveness.

The 2012 review – summary of evidence

The relative absence of research on therapeutic interventions for anorexia nervosa and bulimia nervosa in children and young people is noted in several papers (Wilson *et al*, 2007; Gowers *et al*, 2007; Varchol and Cooper, 2009; Sperry *et al*, 2009). Two approaches, FBT and CBT (including self-care formats), are the strategies that are receiving the most empirical evaluation and dissemination into practice, particularly the Maudsley approach (Gowers *et al*, 2007; Gowers and Bryant-Waugh, 2004; Wilson *et al*, 2007; Sperry *et al*, 2009; Varchol and Cooper, 2009; Schmidt, 2009). Distinctions are made between interventions appropriate for anorexia nervosa and those for bulimia nervosa. CBT and FBT appear to be the most favoured approaches for anorexia nervosa; DBT and IPT may be the most applicable to adolescent bulimia nervosa and binge eating (Sperry *et al*, 2009).

Table 15: Overview of research: eating disorders

Systematic review

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Varchol and Cooper	2009	Adolescents with eating disorders	FBT, CBT, dialectical approaches, psychotherapy	Individual and family	Meta-analysis	NA	FBT and supportive psychotherapy appear promising for adolescents with anorexia, with CBT and FBT among the most favoured modalities. DBT and IPT may be applicable to bulimia and binge eating. Family involvement is important in limiting dropout and improving outcomes, with professionals integrating modalities to address each child's needs.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Gowers *et al*	2007	Age: 12-18, with anorexia nervosa, 92% female	CBT, FBT, CAMHS	Individual and family	RCT	167	In the comparison between inpatient, specialist outpatient and general CAMHS, first-line inpatient psychiatric treatment does not provide advantages over outpatient management. Outpatient treatment failures do very poorly on transfer to inpatient facilities. Patient cooperation is a key factor.
Lock *et al*	2010	Age: 12-18, with anorexia nervosa	Comparison of FBT and individual treatment	Family vs individual	RCT	121	Although both treatments led to considerable improvement and were similarly effective in producing full remission at end of treatment, FBT was more effective in facilitating full remission at both follow-up points.
Schmidt *et al*	2009	Age: 13-20, with bulimia or eating disorders, 95.5% female	CBT guided self-care or FBT	Individual and family therapy	RCT	85	Of the 85 study participants, 41 were assigned to FBT and 44 to CBT guided self-care. Compared with FBT, CBT guided self-care has the slight advantage of offering a more rapid reduction of bingeing, lower cost, and greater acceptability for adolescents with bulimia or an unspecified eating disorder.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Gowers and Bryant-Waugh	2004	Age: 8-18	CBT, IPT, FBT, multiple family group therapy, nutritional counselling, DBT, CAT	Individual and family	Literature Review	NA	Reviews the evidence prior to 2004 on physical management, psychological therapies, and service issues. Concludes that certain therapies are effective but evidence base poor. FBT, IPT and CBT are most favoured.

Lock and Le Grange	2005	Adolescents with anorexia nervosa and bulimia nervosa	Maudsley family treatment approach	Individual and family	Literature review	NA	Family treatment, particularly as devised by researchers at the Maudsley Hospital, appears to be effective for adolescents with short-term AN. It may be an appropriate treatment for BN in the same age group, but evidence for this is scarce.
Sperry *et al*	2009	Young people with eating disorders	CBT and FBT	Individual and family	Literature review	NA	Research concerning the types of therapies effective for treating young people with eating disorders is underdeveloped, with few RCTs, despite general evidence that FBT and CBT are effective.
Wilson *et al*	2007	Adolescents with anorexia nervosa and bulimia nervosa	FBT, CBT, nutritional therapy	Individual and family	Literature review	NA	Reviews progress in the development and evaluation of EBTs for eating disorders over the past 25 years. CBT is the treatment of choice for bulimia nervosa and binge-eating disorder, and existing evidence supports the use of a specific form of family therapy for adolescents with anorexia nervosa.

Commentary on the research on eating disorders

The relative lack of research on effectiveness of therapeutic interventions for children and adolescents with eating disorders is one of the key factors focused upon in some of the studies reviewed (Gowers *et al*, 2007: Wilson *et al*, 2007). However, three RCTs, one meta-analysis and four literature reviews were located. The NICE Guidelines (2004) on eating disorders are based on a comprehensive review and they too identified treatment of adolescent eating disorders as a research priority (Gowers *et al*, 2007; Wilson *et al*, 2007). Conducting RCTs with eating disordered participants is sometimes difficult because of the distinctive features of the disorder, including its relative rarity, the presence of medical complications that sometimes require inpatient management, and the extended period of treatment necessary for full symptom remission in established cases. Ambivalent patient attitudes to recovery compound these challenges at every phase of research, making it more difficult to recruit samples, prevent attrition, and secure participation in follow-up assessments (Wilson *et al*, 2007).

Schmidt *et al* (2009) undertook an RCT in the UK, which compared FBT and CBT guided self-care with 85 adolescents with bulimia nervosa or an unspecified eating disorder. At six months, bingeing had undergone a significantly greater reduction in the guided self-care group than in the FBT group. However, this difference disappeared at 12 months. Gowers *et al*'s (2007) multi-centre RCT of 167 young people with anorexia nervosa in UK inpatient, specialist outpatient and general CAMHS suggested that there is still much uncertainty about effective treatment for this condition.

Lock *et al* (2010) undertook an RCT (n=121) that compared FBT with an individual therapy derived from a psychodynamic approach (AFT). Adolescents aged 12-18 meeting DSM IV diagnostic criteria for anorexia nervosa, excluding the amenorrhea requirement (abnormal absence of menstruation), were assessed at baseline, end of treatment, and at six and 12 months follow-up. There were no differences in full remission between treatments at end of treatment. FBT was significantly superior for partial remission at end of treatment but not at follow-up. However, at both the six- and 12-month follow-up, FBT was statistically superior to AFT. In addition, body mass index percentile at end of treatment was significantly superior for FBT, but this effect was not found at follow-up. Participants in FBT also had greater changes in Eating Disorder Examination score at end of treatment than those in AFT, but there were no differences at follow-up. Although both treatments led to considerable improvement and were similarly effective in producing full remission at end of treatment, FBT was more effective in facilitating full remission at both follow-up points.

The literature reviews (Wilson *et al*, 2007; Sperry *et al*, 2009; Lock *et al*, 2005; Gowers and Bryant-Waugh, 2004) and meta-analysis (Varchol and Cooper, 2009) confirmed the lack of a robust evidence base and the finding that FBT and CBT including guided self-care, in improving the specific symptoms and eating behaviours of bulimia nervosa and non-specific symptoms such as depression, were currently the most evidenced approaches. Other psychotherapies, including IPT, have yielded more modest findings (Gowers and Bryant-Waugh, 2004). The importance of a therapeutic relationship that

can be maintained over time, along with an empathic engagement, is emphasised in the treatment and management of anorexia nervosa (Gowers and Bryant-Waugh, 2007).

Neglect and physical, emotional and sexual abuse

Background

National policy for safeguarding children (DfE, 2011) identifies four types of abuse:

- physical abuse
- emotional abuse
- sexual abuse
- neglect.

The 2004 review – summary of evidence

This review looked at studies into counselling for sexual abuse. It pointed out that some children might be asymptomatic, leading to a misconception that they are dealing with abuse better than is the case. The review looked at eight studies that considered therapeutic treatment for sexual abuse, of which five included CBT.

The 2012 review – summary of evidence

Studies that specifically addressed childhood abuse or neglect were few, although there were many papers on PTSD (see section 4.2.2.2) that did not necessarily define the source of trauma for the child or young person. Seven studies were identified, and CBT appeared to be the most common form of treatment.

Table 16: Overview of research evidence: neglect and physical, emotional and sexual abuse

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Skowron and Reinemann	2005	Children, age unspecified, male and female	Psychological interventions	Individual, group and family	Meta-analysis	21	Psychological treatments for children who had experienced maltreatment were more effective at improving their symptoms than any control condition. Non-behavioural interventions yielded better results than behavioural therapies, with these effects not varying with treatment modality.
Vickerman and Margolin	2007	Age: 3-16, who had been exposed to family violence, male and female	CBT and CPP	Individual and family	Meta-analysis	8	Both psycho-education and CBT are generally effective in the treatment of family violence-related PTSD, but different aged children benefit more from different modalities and variations of CBT. Parental involvement in therapy is important and group treatment could be counterproductive for children with poor social skills.
Wethington *et al*	2008	Adolescents under 21, male and female	CBT, play, art, psychodynamic and pharmacological therapies	Individual vs group	Meta-analysis	21	Individual CBT was effective at reducing psychological harm in adolescents who had had traumatic experiences. There was insufficient evidence to draw definitive conclusions about play, art, psychodynamic and pharmacological treatments.

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Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Crenshaw and Hardy	2007	One 14-year-old male	Play therapy	Individual	Single case study	1	A case is made for the power of therapy and empathy in working with children who have been exposed to abuse, using a single case study of a 14-year-old boy.
Reyes and Asbrand	2005	Age: 8-16, who had been sexually abused, male and female	Play therapy	Individual	Longitud. study	43 (18 fully treated)	A six-month play therapy treatment was effective at decreasing trauma symptoms in sexually abused children, as well as anxiety, depression, PTSD and sexual distress.
Rosenberg *et al*	2011	Age: 14-18, with PTSD, 9 female and 3 male	CBT	Individual	Case study	12 (9 fully treated)	12 adolescents with PTSD took part in a manualised cognitive restructuring programme; significant improvements in PTSD and depression symptoms were maintained at 3-month follow-up.

Commentary on the research on neglect and physical, emotional and sexual abuse

Children who have experienced physical, sexual or emotional abuse are often treated for PTSD. A review by Vickerman and Margolin (2007) reviewed eight studies of children aged three to 16 with experience of family violence (either towards the child or between parents, but not sexual abuse). This review found that group treatment was effective in that it can normalise experiences but can be counter indicative for children with poor social skills because of risk of further rejection (Friedrich, 2002). It also found that a comprehensive assessment of the client by the therapist was very important before treatment begins.

Vickerman and Margolin (2007) point out that it is essential that re-traumatising does not occur for the child experiencing PTSD, and this is achieved in individual sessions by allowing the child to control the session and ultimately gain mastery over the experience. They argue that the child should be encouraged to develop a personal story and coping strategies so that future events (eg violence at home) can be dealt with. Psycho-education for violence and cognitive restructuring helps the child learn to view this, and their reaction, as a normal response to such a situation. They therefore learn that violence and abuse is unacceptable. Children also learn social problem-solving, social interaction skills, how to listen, instigate conversation, ask questions, be polite, and give compliments. In addition they learn safety planning, coping with violence and how to protect themselves.

There were relatively few studies of child victims of sexual abuse. Reyes and Asbrand (2005) (n=18) point out that many victims of sexual abuse have been abused at a very young age, before they can think abstractly or express themselves verbally. In this context, play therapy appeared to decrease trauma symptoms such as anxiety, depression, anger and dissociation.

In the study by Rosenberg *et al* (2010), children who had experienced abuse attended between 12 and 16 one-hour weekly sessions that included scripts, detailed handouts and worksheets, and a trouble-shooting guide for conducting cognitive restructuring. They were educated about the core symptoms of PTSD, relaxation breathing, and cognitive restructuring – ie identifying problematic thoughts and beliefs related to their traumatic experiences, evaluating their accuracy, and developing new, more helpful and realistic beliefs and action plans. Adolescents reported a significant reduction in frequency and intensity of PTSD symptoms with significantly lower levels of depressive symptoms at the end of session and at follow-up three months later. However, the sample was small (n=9). As other studies have shown, parental participation is effective but not where there are chaotic family circumstances and where parents may be perpetrators of abuse.

Other factors affecting effectiveness

Race, gender and culture

Commentary

A group of studies have explored issues of race, gender and culture and their relationship to effectiveness. A US clinical trial looked at the impact on the working alliance and retention of 600 adolescents, matched for gender and race. It showed that girls rated the therapeutic alliance higher than boys, and those matched with therapists on the basis of gender achieved earlier positive working alliance formation (Wintersteen *et al*, 2005). Gender matching contributed to higher retention rates. Adolescent boys were more likely to stay in therapy longer when matched with a male therapist. Matching therapists and clients on the basis of race did yield improved results, although Caucasian therapists treating ethnic minority clients had the lowest retention rates. This paper's findings support the case for training in multicultural aspects of counselling and gender competency. Three other papers also support this position.

Wood *et al* (2008) suggested a lack of cultural competence in therapeutic provision for Mexican American students. McCart *et al*'s (2006) meta-analysis also examined diversity and made the same argument that there was not enough research that highlights gender differences or ethnicity; for example, most studies appear to be of white male adolescents. Papers tended not to make distinctions between ages, many studies including children and young people between the relatively wide age range of six and 16. Rossello *et al* (2008) studied 112 Puerto Rican adolescents, 55.4 per cent of whom were female. They found that individual rather than group therapy, and CBT rather than IPT, were most effective with this population, despite their hypothesis that IPT would fit well with the interpersonal values of *personalismo* and *familismo* of the Latino culture. This paper is debated further in section 4.2.2.3 on depression.

Table 17: Overview of research evidence: race, gender and culture

Systematic review

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
McCart *et al*	2006	Age: 6-18, with antisocial behaviour, male and female	CBT and BPT	Individual and group	Meta-analysis	71	In addressing youths' antisocial behaviour, BPT was more effective for pre-school and school-aged children, while CBT had a stronger positive effect for adolescents. The intervention setting was important, clinical BPT yielding better results than clinical CBT, which in turn was better than both treatments in non-clinical settings. Across treatments, the overall mean effect size was 0.4, in the small to medium range.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Rossello *et al*	2008	Age: 12-18, 55% female	CBT/IPT	Individual vs group	RCT	112	All treatments effective in reducing symptoms of depression, but CBT had stronger effects and was also more effective in improving self-concept and social adaptation, despite initial hypotheses arguing in favour of IPT because of cultural relevance for the adolescents.
Wintersteen *et al*	2005	Mean age: 15.7; 14 therapists, 9 female	Behavioural and family therapies	Individual	Clinical trial	600	Girls reported a higher level of therapy alliance than boys, and gender-matched pairs reported higher early alliance, with boys' retention rates higher when in such pairs. Race matching did not yield improved results and Caucasian therapists treating minority clients had lowest retention rates.

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Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Wood *et al*	2008	NA	CBT	Individual	Literature review	NA	The paper discusses 10 principles of culturally adapted CBT interventions that would be more effective than current interventions with Mexican-American students.

Preferences of adolescents

Bradley *et al* (2009) conducted a survey of adolescents (n=156) in one UK school, which showed a higher preference for psychotherapy than antidepressants. Greater severity of depression symptoms, perceived social support for the particular treatment modality, and general willingness to seek treatment predicted greater preference for psychotherapy than for antidepressants. This paper is also discussed in the depression section (4.2.2.3).

Table 18: Overview of research evidence: preferences of adolescents

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Bradley *et al*	2010	Age: 15-21, 51% female	None	NA	Survey: preference for depression treatment	156	Adolescents showed higher preference for psychotherapy than antidepressants, which was predicted by greater severity of depression symptoms and general willingness to seek treatment.

The effectiveness of the child-therapist alliance

Summary

The original 2004 review discussed the therapeutic relationship and noted that "the wider literature on child and adolescent counselling highlights the important of the therapeutic relationship, yet few studies attend directly to this aspect" (Harris and Pattison, 2004). Therapeutic alliance and therapeutic relationship were not search terms in this review. The studies noted below explicitly discussed the alliance between therapist and client although it was not their original research focus.

Table 19: Overview of research evidence: the child-therapist alliance

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Barish	2004	Children and adolescents with emotional problems	Affect-centred approach to starting psychotherapy	Individual and family	Literature review	NA	Affect-centred approaches to beginning psychotherapy with children rely on two essential therapeutic attitudes: therapists' empathic recognition of children's distress and therapists' enthusiastic, affirming responsiveness to the children's interests and positive affects. These approaches are seen as a means of engagement and as an agent of change. Engaging the family helps improve or repair parent-child relationships.
Creed and Kendall	2005	Age: 7-13, 39% female	CBT	Individual	Behaviour study	56	Therapeutic alliance with children, as coded for 11 therapist behaviours, was positively predicted by

							'collaboration' and 'not being overly formal', and negatively predicted by 'finding common ground' and 'pushing the child to talk'. Child, therapist and observer perceptions of the sessions concurred.
Kazdin *et al*	2005	Age: 3-14, with oppositional, aggressive and antisocial behaviour, 25% female	CBT	Individual and group	Case study	185	The more positive the child-therapist and parent-therapist alliances during treatment, the greater the therapeutic changes of the children, the fewer perceived barriers to treatment participation, and the more acceptable parents and children view the treatment techniques. If a poor alliance is apparent, strategies can be used to enhance it and perhaps augment therapeutic change.
McLeod, and Weisz	2005	Age: 8-14, with anxiety or depressive disorders, 59% female	Eclectic integrative approach (inc. play therapy, psychodynamic therapy, CBT etc)	Individual	Case study	22	Strong observer-rated child-therapist alliance was associated with improvement in child-reported anxiety symptoms; strong parent-therapist alliance was associated with improvement in anxiety and depressive symptoms. A close child-therapist alliance might help promote positive youth outcomes from the child's perspective.

Commentary on the research on the child-therapist alliance

A US study by Kazdin *et al* (2005) looked at 185 children aged three to 14 who had been referred for oppositional, aggressive and antisocial behaviour. Children and parents received CBT and behavioural technique training from trained therapists. Measurements centred on the success of the working alliance between the therapist and parent and the therapist and child. Measures were completed before, during, and at the end of treatment, and rating included perceived therapeutic change, barriers to change, and acceptability of therapy. The study found that treatment was significantly more effective if the child-therapist and parent-therapist alliances were strong.

McLeod and Weisz (2005) carried out research with 22 children aged eight to 14 with anxiety or depressive symptoms in the US. Their purpose was to look at the child-therapist alliance, and measures being taken pre-treatment and 15 months later. The 20 therapists who worked with the children employed an eclectic mix of therapeutic practices, mostly favouring client-centred and psychodynamic therapy over CBT or behavioural therapy. Children's reported level of anxiety showed marked improvement if their alliance with the therapist was strong. If the parent-therapist alliance was strong, improvements in anxiety and depressive symptoms were also significantly improved. The authors concluded that strong child-therapist and parent-therapist alliances were associated with improvement in both the parent-reported and child-reported outcome measures.

Parental involvement in therapy

Commentary

Many papers have included the involvement of parents in therapy, and this appears to be an increasingly common factor in childhood therapeutic interventions. For example, Silverman *et al* (2009) in the US compared CBT with minimal parental involvement, with CBT with active parental involvement (n=119). Both treatments significantly reduced youth anxiety. This work emphasises the reciprocal influence between youth and parent anxiety. In a study of 128 children, Bodden *et al* (2008)

compared child-focused CBT with family CBT. It was found that child-focused CBT was more efficacious than family CBT at post-treatment. The authors concluded that including parents in the therapy was not essential to improvement of symptoms. Kendall *et al* (2008) studied 161 anxious children in the US and reported gains in anxiety reduction for individual child CBT, family CBT and FESA. The overall conclusion in this study was also that including parents was not essential to symptom reduction. The issue of whether or not parental anxiety impeded or supported the therapy was not resolved as these studies came to different conclusions. See section 4.2.2.1 on anxiety for a fuller discussion of the effects of parental anxiety on treatment of children and young people.

In the play therapy literature there is a consensus that including parents in the work is beneficial in improving presenting problems. For example, Paone and Douma (2009) showed in a single case study that parental involvement appeared to enhance the effectiveness of play therapy in treating intermittent explosive disorder[4]. Kazdin and Whitley (2006) indicated that parental encouragement and help increased effectiveness of treatment in their study of 315 children aged three to 14 showing severe disruptive behaviour. A large-scale study of 1,578 boys with aggressive behaviour showed parental involvement in therapy was effective both for the boys in terms of behaviour improvement and in moderating the substance abuse habits of parents (Lochman and Wells, 2004).

A meta-analysis of 76 studies showed that parental training in effective behaviour management strategies can prove successful in reducing aggressive and antisocial behaviour, especially for pre-adolescents (McCart *et al*, 2006). A study by Hogue *et al* (2006) reports similar findings with adolescents. The alliance between parent and therapist, in terms of helping parents support their adolescent children, appeared more effective than the client-therapist relationship alone. Hogue *et al* (2004) compared individual treatment to family treatment with substance-abusing adolescents. They found that parental involvement was more effective, concluding that family conflict, parent-child detachment, and deficient parenting skills are primary etiologic factors for adolescent substance abuse.

Vickerman and Margolin (2007) indicate that parents are important in a child's recovery. They argue that parents, even if they are perpetrators of violence, mostly want to 'do the best' for their child and this should not be underestimated. Parents are more likely to listen to messages about corporal punishment if the clinician recognises that the parent does 'want the best' and commends rather than condemns the parent. Many parents, the paper argues, need to learn to employ a 'time out' approach rather than use a potentially abusive strategy. Parents in such families are often highly stressed for a variety of reasons and learning to cope with stress and anxiety as well as anger management may be useful for them.

Table 20: Overview of research evidence: parental involvement

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Bratton *et al*	2005	Children	Humanistic non-directive and non-humanistic directive therapies	Individual, group and family	Meta-analysis	93	Across the studies a positive, large treatment effect of play therapy with children was observed. Effects were stronger for humanistic treatments and strongest for the therapies that included parents. Age, gender and the problems children came to therapy with did not influence the effectiveness of therapies.
McCart *et al*	2006	Age: 6-18, with antisocial behaviour, male and female	CBT and BPT	Individual and group	Meta-Analysis	71	In addressing youths' antisocial behaviour, BPT was more effective for pre-school and school-aged children, while CBT had a stronger positive effect for adolescents. The setting of the interventions was

[4] Intermittent explosive disorder (IED) is a behavioural disorder characterised by extreme expressions of anger, often to the point of uncontrollable rage, that are disproportionate to the situation at hand. It is currently categorised in the Diagnostic and Statistical Manual of Mental Disorders as an impulse control disorder.

							important, with clinical BPT yielding better results than clinical CBT, which in turn was better than both treatments in non-clinical settings. Across treatments, the overall mean effect size was 0.4, in the small to medium range.
Vickerman and Margolin	2007	Age: 3-16, who had been exposed to family violence, male and female	CBT and CPP	Individual and family	Meta-analysis	8	Both psycho-education and CBT are generally effective in the treatment of family violence-related PTSD, but different age children benefit more from different modalities and variations of CBT. Parental involvement in therapy is important and group treatment could be counterproductive for children with poor social skills.

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Bodden *et al*	2008	Age: 8-18, with clinical anxiety, 59% female	Child and family CBT	Individual and family	RCT	128	CBT was shown to be more efficacious than the 2-3 month waiting list control. Child CBT was superior to family CBT at post-treatment, but equally efficacious at follow-up. Both were less successful at these times if the parents exhibited anxiety disorders. Both were more beneficial for younger children at post-treatment but not follow-up.
Kendall *et al*	2008	Age: 7-14, 44% female	CBT, FESA	Individual and family	RCT	161	Treatment gains observed for all conditions, but child and family CBT superior to FESA. If present, gains were maintained at 1-year follow-up.
Lochman and Wells	2004	Preadolescent males	CPI (child vs parent focus)	Individual and group	RCT	183	CPI produced lower rates of covert delinquent behaviour and of parent-related substance use at the 1-year follow-up than the control group and appeared to have a significant impact on boys' behaviour. A preventative intervention delivered to high-risk, adolescent, aggressive and disruptive children at the time of transition to middle schools can prevent certain antisocial problem behaviours; the effects appear to be sustained at 1-year follow-up.
Silverman *et al*	2009	Age: 7-16, 57% female	CBT	Group (child and mother)	RCT	119	Anxiety was reduced for both active parent involvement CBT and minimal parent involvement CBT. Youth-to-parent influence with regard to anxiety appeared to be stronger than customary.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Hoffman *et al*	2006	Toddlers and pre-school children, mean age 32 months, 54% female	Circle of security (an attachment-based education and psycho-therapy protocol)	Child-parent dyad	Protocol development study	65 dyads	The circle of security protocol had a significant impact on the attachment/care-giving patterns of high-risk toddlers, emphasising the effectiveness for young children of work that includes parents.

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Hogue *et al*	2004	Adolescents exhibiting drug and alcohol abuse, mean age 15.2 years, 33% female	CBT and MDFT	Individual and group	Comparison study	51	A family focus (identified via an observational instrument investigating therapeutic foci and as opposed to an adolescent focus) was a significant predictor of post-treatment improvement in drug use, externalising and internalising symptoms of adolescents, regardless of whether the parents were involved in the therapy.
Hogue *et al*	2006	Adolescents with acute substance abuse issues age not specified, 19% female	CBT or MDFT	Individual and family	Comparison study	100	An early alliance between parent and therapist was important and effective, and appeared more effective than the alliance between child and therapist. Alliance did not influence treatment retention or behaviour at 6-month follow-up. In family therapy, both child and parent alliance were significant predictors of outcomes.
Kazdin and Whitley	2006	Age: 3-14, with oppositional defiant or conduct disorders, 24% female	PMT or PSST	Individual and family	Comparative study	315	The study sought to establish whether effectiveness of interventions could be measured in children with comorbidity. Comorbidity was associated with greater therapeutic change. Parental encouragement and help was shown to increase the effectiveness of treatments.
Paone and Douma	2009	One 7-year-old male, previously diagnosed with intermittent explosive disorder	Child-centred play therapy	Individual	Case study	1	The participant took part in a 16-session play therapy intervention, during which he was able to express his thoughts and feelings in a personal manner and a safe environment. Parental involvement and the duration of the therapy appeared to enhance its effectiveness.

Commentary on the research on parental involvement in therapy

The findings on play therapy research suggesting parental involvement is beneficial are in contrast to the CBT research findings where parental involvement was often not found to be beneficial with regard to symptom improvement. Play therapy traditionally has a younger client group and CBT an older one, which could account for the discrepancies in findings. Attachment-based interventions such as The Circle of Security (Hoffman *et al*, 2006), where therapy takes place in child-parent dyads, has been shown to be a promising intervention with regard to changing to a secure attachment classification.

Multi-systemic approaches

Commentary

Assan *et al* (2008) evaluated an intensive management team approach to working with adolescents in the Austin CAMHS Adolescent Intensive Management (AIM) team, a unique model of intensive outreach service with high-risk and difficult-to-engage adolescents (n=112), and described the profile of clients referred to it. The results showed that a 100 per cent retention rate of adolescents with complex social, emotional and mental health needs is possible in a flexible and multi-system approach to service provision. Clients referred to the CAMHS AIM team displayed a pattern of multiple risk factors and comorbidities. Low caseloads of eight to 10 clients per clinician allowed flexibility and a level of intensity to make any necessary changes in service provision to better suit the client's needs. The majority of clients showed improvement in functioning following intervention by the team. Further studies are required to measure functioning pre- and post-referral.

Table 21: Overview of research evidence: multi-systemic approaches

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Assan *et al*	2008	Age: 13-17, at referral, 66% female	Adolescent Intensive Management (AIM) at the Austin CAMHS, Australia	Individual group and family	Evaluation	112	CAMHS AIM is an intensive outreach service working with high-risk and difficult-to-engage adolescents; it uses a variety of approaches to address clients' difficulties (case management inc. therapy with parent, with the parent-adolescent dyad, family therapy; individual therapy, influenced by CBT and by a psychodynamic approach). Using clients' retrospective data, the retention rate over 12 months was 100% with a majority of clients showing improvement.

Comorbidity

Commentary

Comorbidity was a theme evident in the depression and anxiety literature. Comorbidity of depression, especially with anxiety, is a common feature of adolescent diagnoses. Tompson and Dingman Boger (2009) quote a study by Lewinsohn *et al* (1998), which shows that more than half of US youth with a diagnosis of depression meet another criteria of an Axis 1 disorder, such as social anxiety disorder.

Ollendick *et al* (2010) conducted a study involving 196 young people in the US and Sweden with specific phobias, and investigated the impact of comorbidity on treatment outcomes and the impact of treatment on comorbid disorders. They reported that the presence of comorbid disorders did not affect treatment outcome and that the clinical severity of comorbid phobias and other anxieties was reduced. Another US RCT (Suveg *et al*, 2009) evaluated secondary outcomes from a previous evaluation of child and family modalities treating anxiety disorders (Kendall *et al*, 2008) (n=161). They claimed secondary outcomes of improved associated symptoms. The authors concluded that when treating youth with anxiety, therapists could also expect improvement in other symptoms, especially depression, externalising symptoms and adaptive functioning. In addition, Wood (2006) suggested reduced anxiety might promote improved school performance and social functioning. A 7.4-year follow-up study (Kendall *et al*, 2008) for child anxiety in the US, treated with a 16-week CBT intervention, showed less substance use in the treated youth (now 15-22 years old) but no positive effect of treatment on mood disorder (n=86).

Table 22: Overview of research evidence: comorbidity

Controlled trials

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Kendall *et al*	2008	Age: 7-14, 44% female	CBT, FESA	Individual and family	RCT	161	Treatment gains observed for all conditions, but child and family CBT superior to FESA. If present, gains were maintained at 1-year follow-up.
Ollendick *et al*	2010	Age: 7-16, with various phobias, 42% female	CBT (brief)	Individual	RCT (analysis of previous data)	100	The presence of comorbid phobias or anxiety disorders did not affect treatment results. Phobia-specific treatments also mitigated co-occurring conditions.
Suveg *et al*	2009	Age: 7-14, 44% female	CBT, FESA	Individual and family	RCT	161	Treatment gains observed for all conditions and maintained at 1-year follow-up. Gender and age had no effects on treatment results.
Wood	2006	Age: 6-13, male and female	CBT	Individual	RCT	40	Reductions in anxiety may lead to improved school performance and social functioning.

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Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Tompson and Dingman Boger	2009	Children and adolescents, male and female	CBT, IPT, social skills conditioning, FBT, medication	Individual and group	Review	32	Though advances in understanding and treating youth depression have been made, treatments still have only limited efficacy, and studies still focus mostly on short-term evidence and on symptomatic as opposed to functional outcomes. More than 50% of youths diagnosed with depression present comorbid conditions, the impact of which is not yet fully understood. Most clinical trials to date do not focus enough on young children and on youths with developmental and mental health issues. CBT is an effective treatment, but less so in community settings, though CBT is still more effective than treatment in community mental health centres only.

For whom? Effectiveness for particular groups, ages and stages

Particular groups

It has already been mentioned that depression in Latino and Mexican adolescents is a particular difficulty with rates being higher than depression in Caucasian and African-American youth (Gunlicks-Stoessel *et al*, 2010). CBT was particularly well matched to the culture of young Latinos and this is significant because they are the largest minority group in the USA. Rossello *et al* (2008) report similar findings but they studied Puerto Rican girls. Wintersteen *et al* (2005) examined the specific question of whether the gender and racial match between therapist and patient contributes to worse alliances and treatment dropout. In a large randomised clinical trial, 600 adolescent substance abusers and their therapists were grouped according to matches and mismatches on both gender and race, and alliance ratings were collected from patients and therapists. Gender-matched dyads reported higher alliances and were more likely to complete treatment. Racial matching predicted greater retention but not patient-rated alliance. However, therapists in mismatched dyads rated significantly lower alliances. Results suggest that, although multicultural training remains critical, training emphasis should also be placed on understanding how gender and racial differences affect therapeutic processes.

Effectiveness at different ages and stages

Depression

The literature distinguishes between pre-adolescent and adolescent onset and treatment. Depression is relatively rare prior to adolescence but earlier onset depression may be more pernicious (Tompson and Dingman Boger, 2009). Weisz *et al* (2006a) in a meta-analysis found that:

> "excluding trials with mixed child and adolescent samples, the effect size for studies of youth under age 13 was not significantly different from the effect size for treatment of adolescents (0.41 vs 0.33). However, the effect size for the younger children (vs adolescents) was based on a very small number of trials (*n*=7) all of which were selected based on depressive symptoms vs diagnoses, which likely led to less severe depression in the child samples. Clearly, there is a need for a better understanding of the relationship between age and treatment outcome, particularly in relation to youth depression." (Tompson and Dingman Boger, 2009)

There is also the need, they argue, to take into account developmental tasks and the appropriateness of cognitive approaches for children who may not be able to generalise due to their cognitive development.

Play therapy

Evidence is developing as to the effectiveness of play therapy. A meta-analysis of 93 studies (Bratton *et al*, 2005) finds play therapy to be effective with younger children. Dougherty and Ray (2007) compared the impact of client-centred play therapy on children at two developmental stages. Although both groups benefited from the therapy, there were differences. Children in the preoperational developmental stage (younger than seven) did not show decreases in parent-child relationship stress whereas the older group did. These findings are tentative and the methodological issues in section 4.1.4 should be noted.

Effectiveness for children with learning disabilities

Two papers examining therapeutic work with children with learning disabilities compared humanistic group therapy with CBT group therapy (Schuengel *et al*, 2009; Shechtman and Pastor, 2005). Both humanistic and CBT group therapy with academic assistance were more effective than group therapy alone, and both were more effective than academic assistance alone. Humanistic group therapy was more effective than CBT group therapy on most measures. With a focus on emotional release, the authors conclude that the relational emphasis is more effective than problem solving and information processing. Schuengel *et al* (2009) carried out a study in the Netherlands with six children aged 10-17 with severe learning difficulties. The study showed that an integrative approach, that is first using psychotherapy and then behaviour modification, was highly effective. This was a very small sample but worth noting, given the paucity of research; the study was well documented and provides detailed evidence on the six participants.

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Methodological reflections

> "Evidence based treatment (EBT) is not just a fashionable phrase to describe empirically supported approaches for specific childhood disorders; it is fast becoming a practice mandate by market forces and centrepiece of policy recommendations (Bickman, 2005; Kazdin and Whiteley, 2006). At the same time, EBT has spurred some of the most spirited debates in the history of mental health." (Kelley *et al*, 2010)

The most important areas of enquiry emerging from this review have been the use of the EBT model of research, in particular, and debates into the methods and models of research in general. Dominant models of research are being questioned and there are calls to shift the focus towards practice. This section reports on the papers that debate these and other issues.

How can we use the research from EBTs?
It might be assumed that the process of seeking evidence to inform practice is a simple one, ie an examination of the results of an RCT points towards the optimum intervention. This approach has arisen from the need to know which interventions actually work but it is becoming increasingly questioned on a range of grounds (Kazdin, 2008; McArdle, 2007; Weisz and Simpson Gray, 2008; Weisz *et al*, 2006b). Weisz and Simpson Gray (2008) and McArdle (2007) argue that the model of EBT research is based upon one similar to: "the one that has guided medical and pharmaceutical research for years. That model – we will call it the successive efficacy trial (SET) model – may work reasonably well for biological interventions, but it may not be quite as well suited to the production of clinic-ready psychotherapies." (Weisz and Simpson Gray, 2008) This SET model, derived from medical-pharmaceutical research, means that from research conducted to date, "we know a good deal about the efficacy of our tested treatments; we know far less about their effectiveness" (Weisz and Simpson Gray, 2008). Similar arguments are made by McArdle, 2007; Kazdin, 2008; and Weisz *et al*, 2006b. Kelley *et al* (2010) argue that relying so heavily on this popular approach has resulted "in significant limitations in this knowledge base".

The second reason for questioning the usefulness of the EBT approach is that:

> "despite the replicated beneficial effects of several treatments for youth psychopathology, most of the tested treatment programmes noted above have not made their way into standard everyday clinical practice. The evidence available to us (Ho *et al*, 2007; Martin *et al*, 2007; McLeod, 2001; McLeod and Weisz, 2004) suggests that most everyday clinical practice continues to be characterised by interventions that do not rely on behavioural or cognitive behavioural principles and are not derived from the clinical trials literature." (Weisz and Simpson Gray, 2008)

Reasons given for this are the difficulties in transferring the knowledge gained from experimental research into clinical settings.

The final criticism is that EBTs have rarely been tested in comparison to usual care. When this has been undertaken (Weisz *et al*, 2006b) it was found that EBTs outperformed usual care but with smaller effect sizes than those previously claimed and that the findings underscored a need for improved study designs and more detailed treatment descriptions.

McArdle's (2007) critique of the 2005 NICE guidelines for depression, *Depression in children and young people: identification and management in primary, community and secondary care*, is an example of these general points. The guidelines recommend that CBT and IPT should be the treatments of choice for child or adolescent depression. McArdle argues that NICE goes beyond the evidence adduced and judges too much relevant data ineligible. This methodology may be appropriate in the field of biomedicine, where substantial data exist, but in counselling and psychotherapy where RCTs are comparatively rare and usually involve small sample sizes, NICE risks distorting practice. The author points out that child depression research cannot claim anything like the incontrovertible status of its biomedical counterpart. Also, while the strongest evidence is in support of CBT, the guideline states that "the overall evidence for [its]…effectiveness…is inconclusive". Nevertheless, apparently ignoring its own counsel, it firmly recommends that children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (individual CBT, IPT or shorter-term FBT) for at least three (and potentially six) months. Healthcare professionals who have been trained in the specific modality being offered should provide

these therapies. The CBT guidance is based on the largest data set and is the strongest of the psychotherapy recommendations. McArdle refers to three studies for support. In the largest cited trial, March *et al* (2004) compared CBT with fluoxetine and fluoxetine placebo. CBT alone was inferior to fluoxetine and equivalent to placebo. McArdle also cites evidence to show that the therapeutic alliance is the most important factor that has emerged from recent research.

Kazdin *et al* (2005) have also demonstrated that the quality of the treatment alliance, which transcends the different forms of therapy, predicts outcome. Recent reviews of child and adult therapy literature point to the crucial nature of these phenomena – engagement, empathy, therapeutic alliance, belief and hope (Jensen *et al*, 2005) – and the ability to 'read' people (Westen *et al*, 2004). A further analysis of the youth trial related to cannabis use (Shelef *et al*, 2005) emphasised the strength of the therapist alliance with the young person and parents and not, for instance, faithfulness to the therapy manual, as a predictor of outcome.

Baruch and Vrouvra's (2010) paper is an example of collecting data in a different form. They reported on the collection of routine outcome data from an ongoing audit at a voluntary sector psychotherapy service for young people aged 12 to 21 (n=1,608) in London offering weekly psychotherapy. The study used intake and follow-up data from an ongoing audit of the psychotherapy service that started in 1993. Measures and areas of interest include the Youth Self-Report form, a significant other (SO) version of the Teacher's Report Form, the Young Adult Self Report form, and the Young Adult Behaviour Checklist. Percentage returns at intake were 94 per cent (self), 66 per cent (SO) and 80 per cent (therapist), but became 35 per cent, 21 per cent and 38 per cent at three-month follow-up, and decreased further at six- and 12-month follow-up. At all time points, SO report rates were lower than self or therapist report rates. Young people who did not provide data at intake were more likely to have dropped out of treatment. Over the 15-year period of the audit, intake self-report data rates remained stable (about 94 per cent) whereas SO and especially therapist report rates increased. However, there was a reduction in self, SO and therapist report rates at three- and six-month follow-up. The authors concluded that collecting routine outcome data from young people based on a repeated follow-up design as opposed to post-treatment only is preferable in order to maximise data collection rates:

- treatment dropout significantly affects data collection
- the rate of self-report follow-up data is significantly higher than data collected from significant others
- multiple methods are needed to increase response rates for follow-up data, which has significant resource implications.

These criticisms and debates are also characterised by the argument for a new model of treatment development and testing (Weisz *et al*, 2006b; McArdle, 2007; Kazdin, 2008; Weisz and Simpson-Gray, 2008; Kelley *et al*, 2010), because "the ways most evidence-based psychotherapies for children have been developed and tested do not expose these therapies to the full array of factors present in everyday, real world clinical care" (Weisz and Simpson-Gray, 2008). The model being sought is one that is rooted in, reflects and informs practice in all its complexity, including young people with complex problems, often with comorbid conditions and living in challenging contexts. Weisz and Simpson-Gray (2008) argue for a "deployment-focused model of treatment" and Kelley *et al* (2010) for the PBE model. McArdle (2007) argues for the therapeutic alliance to be acknowledged as the key factor.

Kazdin (2008) makes a heartfelt plea for greater acknowledgement of other factors impacting on mental health provision. The diversity of clients, the range of settings in which treatments must be delivered, and the models of delivery ought to receive greater attention in developing evidence-based interventions:

> "The challenges facing us now include but greatly extend beyond developing effective interventions. We have a deeper appreciation of what is needed to reduce the burden of mental illness and the scope of impairment and disability. Major issues need to be addressed related to infrastructure and healthcare financing; mental health parity; discrimination, accessibility, and barriers to treatment; and training more professionals to deliver services where they are needed, among others. All of these are separate priorities that require solution. Yet, we have much to do within our own ranks and areas immediately under our control, all the while trying to alter the larger contextual influences that constrain our impact."

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Table 23: Overview of research evidence: methodological papers

Systematic reviews

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Reese *et al*	2010	School-age children and adolescents, male and female	School-based psychotherapy	Individual and group	Meta-analysis	65	Evidence from doctoral theses suggests that publication bias may not be as significant as previously thought: the effect sizes of the unpublished dissertations in the sample were actually larger than those of published work.
Weisz and Simpson-Gray	2008	Children, male and female	Various psychotherapies	NA	Meta-analytical review	298	The paper discusses the manner in which results are achieved in EBTs and how the effectiveness of treatments in these studies is presented, in terms of effect sizes. This is also related to the dissemination of results in the research and practitioner communities.
Weisz *et al*	2006	Age: 3-18, male and female	EBTs (cognitive and non-cognitive)	Individual and group	Meta-analysis	32	EBTs were found to be more effective (but not by much) than usual care approaches, with effects not reduced by the severity or ethnic distribution of young people (general ES=0.30).
Zirkelback and Reese	2010	Children and young people, male and female	General psychotherapy	Individual and group	Meta-analysis	9	Psychotherapy interventions are generally effective for children and adolescents. Benefits increase with age, and in individual therapies and behaviour-oriented treatments. The therapeutic alliance is important across therapies.

Supporting evidence

Authors	Date	Population	Therapeutic intervention	Individual or group	Study design	Sample	Findings
Baruch and Vrouvra	2010	Age: 12-21, in voluntary psychotherapy centre, 71.6% female	General psychotherapy	Individual	NA	1608	The paper reports on the problems of data collection from participants, their companions (significant others – SO) and therapists in a centre providing therapy to youths. The collection of routine outcome data was seen to be better suited for a repeated follow-up design, as opposed to post-treatment only. Dropout significantly affected collected data but self-reported data was still at a much higher rate than for any of the other stakeholders. Multiple methods of data collection may help increase the response rate.
Kazdin	2008	Children and adolescents, male and female	EBTs	NA	Critique of EBT	NA	Psychotherapy is effective for young people but not all of those in need access it. Availability, ethnic and cultural adaptation, treatment models and cost are all issues which, if addressed could lead to EBT having a higher impact.
Kelley	2010	Children and	Various psycho-	NA	Review	NA	The paper argues for the closer

et al		young people, male and female	therapies (EBT)		(book chapter)		examination of specific aspects of EBTs (control groups, allegiance effect, etc) with a view to ascertaining whether the common factors theory (whereby gains from therapies actually emerge from a variety of common factors such as having a warm close relationship with another person, instead of from the treatment itself) could account for treatment gains. It also argues for a shift in the direction of studies on therapy, moving 'from the laboratory to the field', thus yielding more practical contextualised results.
McArdle	2007	Children and adolescents, male and female	Critique of NICE recommendations	NA	Methodo-logical critique	NA	NICE work on clinical assessment or drugs trials methodologically not comparable to the work on mental health and as such distorts the findings and emerging practice recommendations, particularly in relation to CBT.
Westen *et al*	2004	Children and adolescents, male and female	General psychotherapy	Individual	Literature review	NA	This article provides a critical review of the assumptions and findings of studies used to establish psychotherapies as empirically supported. The findings from meta-analytic studies support a more nuanced view of treatment efficacy than simply validating certain treatment packages. The authors recommend a shift to theories of change that clinicians can integrate into empirically informed therapies.

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Conclusions and implications for further research

This review addresses one main research question: *Is counselling and psychotherapy effective for children and young people?* Overall the evidence indicates that a variety of counselling and psychotherapy interventions are effective for children and young people with a range of problems.

This final section examines the implications for research and practice by considering the three sub questions:

1. Which types of counselling and psychotherapy interventions work?
2. For which presenting problems?
3. For whom?

Which types of counselling and psychotherapy interventions work?

The main modalities of CBT, psychodynamic therapy, humanistic therapy and IPT, and play therapy were all found to be effective. However, the number of papers relating to each modality varied considerably, suggesting the need for further research in some modalities, such as psychodynamic and humanistic. There was a predominance of US studies within CBT and thus a need for further UK-based research.

The long-term impact of counselling and psychotherapy with children and young people needs to be examined. While some studies assess outcomes at six or 12 months, longer-term follow-up would be beneficial particularly in assessing the effectiveness of CBT. The relationship between long-term impact and type of intervention also merits further research. The evidence in this review on CBT, for example, questions its effectiveness for children compared to adolescents, and its effectiveness for treating depression compared to anxiety. More research is needed into the effectiveness of CBT and other therapies in relation to the age and developmental stage of the child. The possibility of a sleeper effect within psychodynamic therapy also warrants further investigation. The research reported here suggests that the effect of psychodynamic therapy would not necessarily show early on but may become evident at six months.

Practice-focused research

Difficulties in translating the findings from reviews and experimental studies into practice highlight the need for more practice-based research that is rigorous and transparent. Kazdin (2008) argues that current research into EBTs is neither addressing the needs of practitioners nor transferring quickly or easily enough into practice. A growth in rigorous case study research would provide useful insights into the complexity of practice and the responses of clients to therapy. Case studies need to be reported with greater detail and transparency in order to allow judgements about quality and rigour. The findings in the area of psychodynamic therapy, as in other sections of this review, suggest the need for future research to be more nuanced and to move beyond questioning efficacy to exploring "what makes therapy optimally effective and how research can be translated into the real world of clinical practice" (Midgley and Kennedy, 2011).

For which presenting problems?

The majority of papers reviewed related to CBT, which was found to be effective for conduct and behaviour disorders, and anxiety. In addition, counselling and psychotherapy in general was found to be effective for anxiety and depression. Further research is needed to examine the factors and processes involved in these effective interventions. Interventions that included engaging families and carers were significant in effectiveness, although assessment of the family's capacity to engage constructively is clearly important.

For whom?

There were studies that showed that race, gender culture and age continue to be factors in the outcomes of therapeutic interventions. Girls valued the therapeutic alliance more highly. Boys in certain ethnic groups valued the matching of the therapist on the grounds of culture and gender.

Under-researched areas

Some presenting problems appeared to have little research evidence, particularly self-harming practices, eating disorders, medical conditions and learning difficulties. Further research in these areas is recommended.

Kelley *et al* (2010) remind us of the words of the Dodo bird in Lewis Carroll's *Alice in Wonderland* (1865), that "everybody has won and all must have prizes". Saul Rosenzweig (1936) coined the phrase the 'Dodo bird verdict' to describe how when different approaches to counselling and psychotherapy are tested against each other the outcomes are not significantly different. This has led to an area of theorising where the factors common to the different approaches are seen as more potent than the different techniques peculiar to the various approaches. A particularly important common factor appears to be having a relationship with a therapist who is warm, respectful and friendly. Kelley *et al* (2010) conclude that:

> "the existing research is simply not sophisticated enough to answer questions related to the impact of client and clinician characteristics, relationship factors and the other ingredients of the therapeutic process that are common to a psychotherapy, regardless of treatment modality or model. These factors, as well as the characteristics of the intervention and the service setting, should inform future research on EBTs."

The evidence reviewed here supports Kelley *et al*'s conclusion.

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Appendices

Appendix 1. Final list of references, included and excluded papers

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Name:	BC/CM/CH	Literature list number:

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Title of paper	Title / Paper no. / Initials
Abstract	
Type of paper	
Country of origin	
Type of client (eg flood victims etc)	
Age of child	0-5 / 6-11 / 12+
Gender: boy/girl/both	
Ethnicity	
Type of practitioner (eg school counsellor/student counsellor etc)	
Type of therapy:	
Individual	
Group	
Both	
Therapeutic approach:	
CBT	
Behavioural	
Person centred	
Psychodynamic	
Play/art/music	
EMDR	
Other	
Presenting problem	
Parents/carers included?	
Counselling setting in study	
Potential categories to put this study in:	
Behaviour and conduct disorder	
Emotional problems	
Medical issues	
School related issues	
Self-harming issues	
Sexual abuse	
PTSD	
Short-term work (up to 15 sessions)	
Long-term work (15+ sessions)	
Online counselling?	
Types of intervention	
Outcome measures	
Nature of study's methodology eg case study, RCT Sample or no. of papers in meta-analysis	
Sample details	eg 1-20 / 21-50 / 51-100 / 101-200 / 201-300 / 301-500 501-1,000 / 1,001-3,000 / 3,001-5,000 / 5,000+
Research methods used	
Summary of findings	
Methodological queries or questions or reflections	
Confidence rating	Create 5-point scale Excellent = 1 / Very good = 2 / Satisfactory = 3 Not very good = 4 / Poor = 5
Personal commentary	
Summary of relevance to review goals	Create 5-point scale Excellent = 1 / Very good = 2 / Satisfactory = 3 Not very good = 4 / Poor = 5
Should this paper be excluded or included?	
Websites mentioned that were useful	

Template used to record reading of papers

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Appendix 2. Search terms used

Search terms used	Date
Children and CBT	30/12/10
Children and counselling	30/12/10
Children and psychotherapy	30/12/10
Children and drama therapy	4/1/11
Children and bibliotherapy	4/1/11
Children and psychodynamic	4/1/11
Children and humanistic/interpersonal	4/1/11
Children and humanistic	4/1/11
Children and interpersonal and outcomes	4/1/11
Children and interpersonal and impact	4/1/11
Children and interpersonal and effectiveness	4/1/11
(Publications)	4/1/11
Children and play therapy and outcomes	4/1/11
Children and play therapy and impact	4/1/11
Children and play therapy and effectiveness	4/1/11
Children and outdoor therapy	5/1/11
Children and cognitive therapy	5/1/11
Children and eco-therapy	5/1/11
Children and mindfulness	5/1/11
Children and art therapy	5/1/11
Early adolescents and counselling	5/1/11
Early adolescents and psychotherapy	5/1/11
Early adolescents and psychodynamic	5/1/11
Early adolescents and humanistic	5/1/11
Early adolescents and interpersonal	5/1/11
Youth and psychotherapy and outcomes	6/1/11
Youth and psychotherapy and impact	6/1/11
Youth and psychotherapy and effectiveness	6/1/11
Youth and counselling	6/1/11
Youth and psychodynamic	6/1/11
Youth and humanistic	6/1/11
Youth and interpersonal and outcomes	6/1/11
Youth and interpersonal and impact	6/1/11
Youth and interpersonal and effectiveness	6/1/11
Youth and play therapy	6/1/11
Youth and art therapy	6/1/11
Youth and drama therapy	6/1/11
Youth and bibliotherapy	6/1/11
Youth and CBT	6/1/11
Youth and cognitive therapy	6/1/11
Youth and outdoor therapy	6/1/11
Youth and eco-therapy	6/1/11
Youth and mindfulness	6/1/11
Early adolescents and play therapy	7/1/11
Early adolescents and art therapy	7/1/11
Early adolescents and drama therapy	7/1/11
Early adolescents and bibliotherapy	7/1/11
Early adolescents and CBT	7/1/11
Early adolescents and cognitive therapy	7/1/11
Early adolescents and outdoor therapy	7/1/11
Early adolescents and eco-therapy	7/1/11
Early adolescents and mindfulness	7/1/11
Adolescents and counselling	7/1/11
Adolescents and psychotherapy and outcomes	7/1/11
Adolescents and psychotherapy and impact	7/1/11

Adolescents and psychotherapy and effectiveness	7/1/11
Young people and counselling	7/1/11
Young people and psychotherapy	7/1/11
Young people and psychodynamic	7/1/11
Young people and humanistic	7/1/11
Young people and interpersonal and outcomes	7/1/11
Young people and play therapy	7/1/11
Young people and art therapy	7/1/11
Young people and drama therapy	7/1/11
Young people and bibliotherapy	7/1/11
Young people and CBT	7/1/11
Young people and cognitive therapy	7/1/11
Young people and outdoor therapy	7/1/11
Young people and eco-therapy	7/1/11
Young people and mindfulness	7/1/11
Adolescents and psychodynamic	7/1/11
Adolescents and humanistic	7/1/11
Adolescents and interpersonal and outcomes	7/1/11
Adolescents and interpersonal and impact	7/1/11
Adolescents and interpersonal and effectiveness	7/1/11
Adolescents and play therapy	7/1/11
Adolescents and art therapy	7/1/11
Adolescents and drama therapy	7/1/11
Adolescents and bibliotherapy	7/1/11
Adolescents and CBT	7/1/11
Adolescents and cognitive therapy and outcomes	7/1/11
Adolescents and cognitive therapy and impact	7/1/11
Adolescents and cognitive therapy and effectiveness	7/1/11
Adolescents and outdoor therapy	7/1/11
Adolescents and eco-therapy	7/1/11
Adolescents and mindfulness	7/1/11
Children and counselling and outcomes (since 2004)	10/1/11
Adolescents and psychotherapy and impact (since 2004)	11/1/11
Young people and psychodynamic and effectiveness (since 2004)	13/1/11
Youth and CBT and outcomes (since 2004)	16/1/11

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