SECTION A

GENERAL INTRODUCTION

1

Child and Adolescent Psychotherapies

The Lay of the Land

Sean

Nine-year-old Sean has been a worrier since early childhood. In the preschool years, he was afraid to be left alone in his room, and dropoffs at preschool were sheer trauma with Sean terrified of separation. Now a fourth grader, he is shy and withdrawn at recess, certain that he will do something "dumb" and suffer ridicule. When his teacher assigned an oral report, Sean was paralyzed by fear that he would make a fool of himself in front of the class. He trembled throughout the report, forgot his main points, and was mortified afterward. Fear robs Sean of peer connections as well. He avoids play dates, certain that other kids see him as "weird" or "a loser." He is also too afraid of separation to leave home for sleepovers. Recently, Sean has developed a fear of eating in the school cafeteria; he says his hands tremble, and other kids will see and mock him. So he looks for empty classrooms where he can eat hidden from view.

Megan

Thirteen-year-old Megan is both miserable and angry. She mopes around the house, snaps at her parents, and complains bitterly when asked to help with housework. She resents family rules and recently told her mother, "When I'm at home, I feel like a prisoner." For years, Megan has had an eye for dark clouds rather than silver linings. Her current bout with depression began when members of her clique began to exclude her. She lost confidence in herself and seemed adrift socially. Since then, her parents have heard her crying behind her locked bedroom door, and she has tearfully told her mother, "No one likes me anymore. I'm an outcast." Once a good student, Megan now lacks energy or motivation for schoolwork and her grades have dropped sharply. Her teacher and school counselor recently called her parents to express concern, and her little sister has been asking, "What's wrong with Megan?"

Kevin

Eleven-year-old Kevin zigs and zags through his house in an unpredictable course, leaving a path of destruction in his wake. Kevin is not malicious, but he is so scattered and impulsive that each day is a series of collisions, spills, scars on the wall, and broken objects. Simple daily routines such as teeth-brushing and hair care seem to elude Kevin, and he has major difficulty obeying his parents' instructions. Kevin's distractible, impulsive, disobedient style has a major impact at school. Unable to attend to his teacher or a class discussion for more than a few minutes, he fidgets at his desk and he blurts out inappropriate comments. His behavior also devastates peer relationships. Recently, when a group was discussing a favorite TV show, Kevin blurted out, "I'm getting a new bike for my birthday!" Two of the kids rolled their eyes, and the others smiled knowingly. His impulsive comments to peers (e.g., "You look like a monkey") have sparked fights. His poor concentration makes him error-prone in sports. Some of his little league teammates say Kevin is "from outer space." He is rarely invited for play dates or birthday parties, and when he wants to invite another child over, there is usually no one who wants to come.

Sal

Thirteen-year-old Sal has a reputation to protect: his own, as a bad dude. He gets in trouble at school almost every week, sometimes for disobeying a school rule, sometimes for getting into shoving matches or outright fights with other kids. He has been suspended three times, once for stealing money, once for hitting another child with a stick and drawing blood, and once for shouting profanity at a teacher who was disciplining him. Sal has a short fuse. He is quick to take offense, quick to assume that others mean him harm, and quick to strike out in fury. Understandably, most of Sal's peers at school actively avoid him, and his only friends are other youngsters with serious conduct problems; two of these youths have already been arrested and both are suspected of being gang members. At home, Sal is also disobedient, disruptive, and full of attitude. He insults and mocks his mother, refuses to lift a finger with household chores, and stays out as late as he wants. He and his uninvolved father maintain a sort of mutual ignoring relationship. In this climate, Sal is out of control and exploring ever-riskier behavior with his delinquent peers. The neighbors watch nervously, expecting to see Sal on the evening news, and not for anything good.

Young people like Sean, Megan, Kevin, and Sal can be found in homes and schools all around the world. For most such troubled children there are concerned parents and other caregivers, some at wit's end, knowing their children need help, but not sure where to turn. Eventually, many parents and youngsters make their way to mental health professionals who provide help in a variety of forms collectively labeled psychotherapy. Given the many forms that psychotherapy can take, how is one to decide

which approach will really help? It is that question to which this book is addressed.

Nature, Philosophical Roots, and Evolution of Child and Adolescent Psychotherapy

This book focuses on *psychotherapy*, an array of nonmedical interventions designed to relieve psychological distress, reduce maladaptive behavior, or enhance adaptive functioning through counseling, structured or unstructured interactions, training programs, or specific environmental changes. We will concentrate specifically on children and adolescents, sometimes referred to collectively as *children* or *youth*.

Tracking psychotherapy back to its origins is not easy. The tradition of helping by listening and discussing is certainly older than recorded history. When the process began to be a profession is debatable, but a case could be made for the era of the classical Greek philosophers, who used discourse to probe the life of the mind. Socrates (469–399 BCE) developed both a method and a thesis that are arguably precursors to some modern forms of psychotherapy (see Plato's *Apology*). His philosophical dialectic, later called the Socratic method, involved questioning others in ways designed to prompt examination of their beliefs and bring them closer to truth. His "midwife thesis," the notion that the philosopher's role was to deliver the truth that is already within others, much like the midwife delivers the baby that is within a mother, is not far from the view many modern therapists have of their role. By asking others to tell him what they thought rather than telling them what to think, Socrates sought to reach the rational soul or *psyche* of those he talked with. The term *psyche* denoted the mind, inner nature, and capacity for feeling, desire, and reasoning, and was a precursor to the word *psychology*. Finally, Socrates maintained that thought and outward behavior are closely connected (see Brettschneider, 2001), presaging a tenet of many modern therapies.

The ideas of other early Greeks and many who came after the Greek era have contributed to the evolution of psychotherapy. For example, Aristotle (384–322 BCE) emphasized the role of catharsis in tragic drama, comedy, and other arts in arousing and alleviating emotional states (*Poetics*, 350 BCE; *Politics* VIII, 350 BCE; see discussion in Kazdin & Weisz, 2003). Centuries of subsequent work in philosophy, religion, medicine, and other contemplative and healing traditions have opened up a panoply of practices encompassing meditation, expert directives, subtle suggestion, hypnosis, expectancy manipulation, and persuasion, all intended to alleviate distress or dysfunction in various forms or change unwanted behavior (Shapiro & Shapiro, 1998).

Formal designation of psychotherapy as a type of professional intervention and an area of study can be traced back about 100 years (Freedheim,

1992). Arguably, contemporary psychotherapy grows out of the work of Sigmund Freud (1856–1939) and his intellectual heirs. Early markers in the application to children were Freud's treatment of a boy known as Little Hans who was afraid of horses (and much more) by consulting with the boy's father, and Freud's psychoanalysis of his own daughter, Anna (1895–1982), who became a prominent child analyst in her own right beginning in the 1920s. Anna Freud and others such as Berta Bornstein continued to apply psychoanalytic precepts and methods to children and adolescents well into the latter half of the century. The acceleration of child psychotherapy through the century was propelled by other models and methods as well, including a radically different behavioral approach. Emblematic of this new approach, Mary Cover Jones (1924a,b) used modeling and *direct conditioning* to help two-year-old Peter overcome his fear of a white rabbit. The decades beyond saw a remarkable burgeoning of behavioral psychotherapies for children and adolescents, complementing the psychoanalytic and other treatments that took shape in other quarters. By the late twentieth century, child and adolescent psychotherapy had expanded remarkably in the variety of its forms and the extent of its reach.

Evolution of Research on Psychotherapy with Young People

With the growth of psychotherapy came a growing curiosity about its potential benefits. Although research on psychotherapy developed later and more slowly than the practice itself, studies began to accumulate. Eysenck (1952) reviewed studies of adult psychotherapy and concluded that the evidence did not show it to be effective. Complementing Eysenck's work, Levitt (1957, 1963) reviewed studies that included children or adolescents and concluded that the rate of improvement among children (67–73%) was about the same with or without treatment. This conclusion was reinforced by Eysenck (1960, 1966) in later reviews encompassing studies of therapy for children and adolescents as well as adults; Eysenck's interpretation of the findings was that they provided no firm evidence that treatment led to greater improvements than the mere passage of time (i.e., no treatment).

These early reviews were highly influential, but many of the studies they relied on were methodologically weak. Subsequent research has grown stronger, and much more plentiful. Indeed, by the year 2000, about 1500 treatment outcome studies of child and adolescent psychotherapy had been completed (Durlak et al., 1995; Kazdin, 2000a). The studies have grown increasingly sophisticated over the years, more and more meeting the standards of randomized clinical trials, what has been called the "methodological Esperanto" of all disciplines that test the effects of interventions (Kazdin & Weisz, 2003, p. 4).

Another important development is that research has shifted more and more from tests of unspecified "treatment" or generic "psychotherapy" to

tests of well-delineated therapies with specific treatment procedures described in detailed outlines or manuals. Of course, tests of therapy that are *not* manualized but rather done as a part of usual clinical care with therapists free to choose the methods they prefer, are potentially very useful in helping us understand whether usual care is beneficial (see Weisz et al., 1992; Weisz, Donenberg et al., 1995; and see later discussion under "Clinically Derived Treatment in Usual Clinical Care"). However, the now much more numerous studies in which treatment procedures are specified in advance and therapists follow those procedures make it possible to know, when results are published, *which specific intervention methods* worked and which did not. This, of course, is a major strength, bolstering prospects for both understanding and disseminating what works. In summary, as a consequence of several important trends over time, we are now in a position at the turn of the new century to pool and evaluate rapidly accumulating evidence on youth psychotherapies and their effects.

Forms, Scope, and Cost of Youth Psychotherapy

Just how many specific psychotherapies are practiced with children and adolescents? One recent count found 551 named therapies used with this age group (Kazdin, 2000b). The list includes familiar approaches such as play therapy and behavior modification, as well as less familiar treatments, some with intriguing names, such as "Alf group," "Barb technique," "blindfold treatment," "Let's pretend hospital," "pal program," "paraverbal therapy," "release therapy," and "Zaraleya psychoenergetic technique." Even the number 551 greatly understates the array of approaches used with young people, because few therapists limit themselves to one specific treatment approach. Instead, most therapists use eclectic mixtures of treatment methods, fashioned from their own previous clinical work, clinical supervision, and other learning experiences, and the mixtures differ from case to case. The resulting combination of adherence to specific treatments and clinically guided eclecticism means that a virtually countless array of specific psychotherapies is practiced. Moreover, any two therapists chosen at random may well have markedly different views as to what treatment is needed for any specific child, such as the four introduced at the beginning of this chapter.

Like most labor-intensive activities, psychotherapy for young people costs money. In the United States alone, the most recent figures available indicate that about 6% of youth under age 18 receive mental health care each year, at an annual cost of $11.75 billion (Sturm et al., 2000). About 10% of this cost is explicitly for medication, but most is for psychotherapy. Outpatient care accounts for about twice as much of the cost as inpatient (67% vs. 33%). And costs increase sharply with age, from 7% of the total at ages 1–5, to 34% at ages 6–11, to 59% for adolescents ages 12–17.

Problems Addressed in Psychotherapy with Children and Adolescents

Psychotherapy is used to address diverse problems and disorders that cause emotional distress, interfere with daily living, undermine development of adaptive skills, or threaten the well-being of others. Many of the problems addressed with children and adolescents fit within two broad groupings, or *syndromes*: *internalizing* (e.g., sadness, fears, shyness) and *externalizing* (e.g., temper tantrums, disobedience, fighting, stealing; Achenbach, 1991). Problems within both syndromes are frequent reasons for referral to clinics. North American youngsters are more likely to be referred for externalizing rather than internalizing problems, but not all cultures show such a strong tilt toward externalizing (see Weisz, Suwanlert et al., 1987; Weisz & Weiss, 1991). Problems that undermine school performance also generate many treatment referrals (see Burns et al., 1995; Bussing et al., 1998; Leaf et al., 1996; Weisz, McCarty et al., 1997). These include internalizing problems such as fears that prevent school attendance, externalizing problems such as disrupting class or disobeying teachers, and other problems that do not fall neatly into either category, such as serious difficulty paying attention in class.

Another way to describe the targets of treatment is to focus on categorical diagnoses within the formal Diagnostic and Statistical Manual of Mental Disorders tradition (American Psychiatric Association, 1987, 1994, 2000). Recent evidence (e.g., Jensen & Weisz, 2002) suggests that four clusters of disorders account for a very high percentage of youth referrals:

- **Anxiety Disorders** (Social Phobia, Separation Anxiety Disorder, Generalized Anxiety Disorder, and others)
- **Depressive Disorders** (i.e., Dysthymic Disorder, Major Depressive Disorder)
- **Attention Deficit/Hyperactivity Disorder** (ADHD)
- **Conduct-related Disorders** (i.e., Oppositional Defiant Disorder, Conduct Disorder)

In this book, we will concentrate on treatments for disorders and related referral problems associated with these four clusters.

Youth versus Adult Psychotherapy: Social, Developmental, and Cultural Factors

Although psychotherapy with children and adolescents bears obvious similarities to work with adults, some important differences warrant emphasis. First, because children rarely perceive themselves as disturbed or as candidates for therapy, most referrals for treatment up until late adolescence tend to be made by parents, teachers, or other adults. These adults may

thus be construed as clients in the sense that they commission the therapy, pay for it, and identify some or all of the goals. The child may or may not participate in identifying target problems or setting treatment goals, and even when he or she does participate, adult input may be weighted more heavily (Hawley & Weisz, 2002). With therapy commissioned by adults and goals shaped mostly by adults, it makes sense that children often enter the process with little motivation for treatment or personal change, or with objectives that differ from those of the adults involved.

Given marked developmental differences in the self-awareness, psychological mindedness, and expressive ability of their clientele, child therapists must often rely on adults for information about the youngsters they treat, and this can present problems of several types. First, parents' and teachers' reports may be inaccurate, based on distorted samples of child behavior, influenced by their own adult agendas, calculated to conceal their own failings as parents (including neglect or abuse), or even influenced by their own pathologies (see e.g., Goodman et al., 1994); and levels of agreement among different adults reporting on the same child tend to be low (Achenbach et al., 1989; Yeh & Weisz, 2001). In addition, adults' reports of child behavior, identification of referral concerns, and views on the acceptable process and outcome of therapy are all apt to reflect beliefs, values, practices, and social ideals of the adults' cultural reference group (see Weisz, McCarty et al., 1997).

Finally, children tend to be captives of their externally engineered environments to a much greater extent than are adults. One consequence may be that the pathology the child therapist treats may reside as much in a chaotic or disturbed environment from which the child cannot escape as in the child himself or herself. This may limit the impact of interventions involving the child as solo or primary participant. It may also argue for involvement of parents, teachers, or others from the child's social context, but such significant others are not always willing or cooperative. So, in a number of ways, the youth therapist faces challenges that are rather different from those the adult therapist confronts.

Outcomes of Youth Psychotherapy: Who Cares?

Many individuals and interest groups have a stake in the outcome of youth psychotherapy. As the focus of the intervention, the treated youth is a major stakeholder. In addition, parents and other family members who seek treatment for the youngster, and frequently for the family, are also invested in psychotherapy. Teachers' interests as well may include both concern for the treated youth and for the classroom of which that youth is a part. Those who finance the treatment – including family members, government agencies, insurance carriers, and others – have a clear stake. Finally, the therapists, clinical staff, administrators, and others in the provider community

have a clear interest in the outcomes of the care in which they invest their careers. All these parties to the process of treatment have a clear stake in the question, "How effective is youth psychotherapy?"

How Are the Effects of Child and Adolescent Psychotherapy Assessed?

Questions about effects of youth psychotherapy are answered using several different methods. The most widely accepted approach involves *group comparison* designs: outcomes for a group who received a target treatment are compared with outcomes for others who received either an alternative treatment or some kind of inert control condition (e.g., placement on a waiting list). A particularly strong form of the group comparison study is the *randomized clinical trial*; here, the participants' group membership (e.g., treatment vs. control group) is determined randomly, say, by a coin toss. Such trials constitute most of the evidence discussed in this chapter. We will also review some evidence from *within-group* or *within-subject* designs, in which all study participants receive treatment. In most of these designs (reviewed in Kazdin, 1998; Kratochwill & Levin, 1992), treatments are alternately applied and withdrawn, or switched (i.e., from one treatment to another), and treatment effects are inferred from differences in behavior across the various conditions. Such approaches might be used, for example, when an entire classroom is the target of an intervention (e.g., Wurtele & Drabman, 1984), or when treated conditions are so rare that only one or two children will be treated (e.g., McGrath et al., 1988; Tarnowski et al., 1987).

Specific findings from within-group and within-subject studies will be described in later chapters of this book when relevant to particular treatment programs. However, for our overview of treatment outcome evidence, we will focus on group comparison studies, which have been reviewed much more thoroughly, and which arguably yield the strongest inferences about treatment impact.

The common currency for these inferences is the *effect size*, an index of the magnitude and direction of treatment effects. In group comparison studies, the effect size (ES) for any specific outcome measure is the posttreatment difference between the mean for that measure in the treatment group and the mean in the control group, divided by the standard deviation of the measure (for different ways of doing this computation, see Cohen, 1988; Weisz, Weiss et al., 1995c). Figure 1.1 is a guide to interpreting ES values. As the figure shows, positive ES values indicate treatment benefit, zero indicates no effect, and negative values indicate a harmful effect. As is also shown in the figure, each ES value corresponds to a percentile standing of the average treated child on the outcome measure if that child were placed in the control group after treatment; for example, an ES of 0.90 indicates that the average treated child scored better after treatment than 82% of the