

# Psychotherapy for Children and Adolescents

*Evidence-Based Treatments and Case Examples*

By

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## 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 Now a fourth grader, he is shy and withdrawn at recess, certain that he will do something “dumb” and suffer ridicule.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

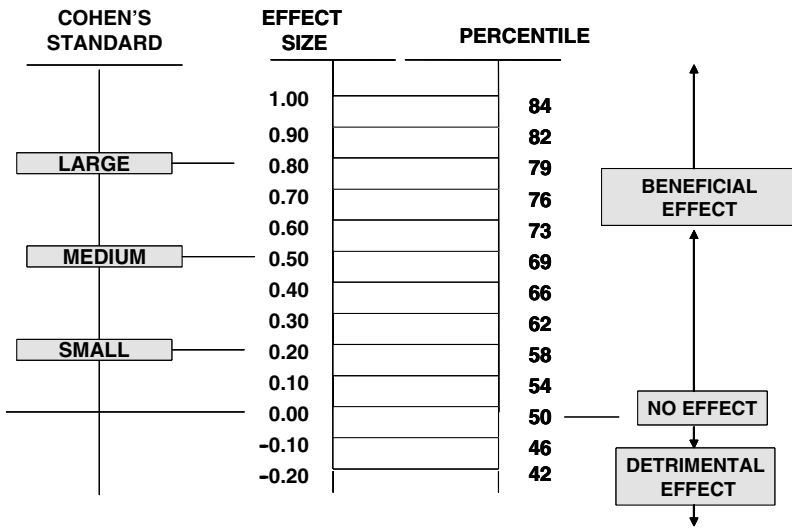


FIGURE 1.1. Guide to interpreting effect size statistics. Each effect size value corresponds to a particular posttreatment percentile for the average treated individual relative to the control group. From Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 688–701. Copyright 1995 by the American Psychological Association. Reprinted with permission.

control group. Finally, as an aid to interpretation, many researchers follow Cohen’s (1988) guidelines suggesting that an ES of 0.20 may be considered a small effect, 0.50 a medium effect, and 0.80 a large effect.

Effect size values are the building blocks of a technique called *meta-analysis*, which is used to pool the findings of multiple studies and thus gauge the average impact of treatment. The meta-analyst first computes an effect size for each relevant outcome measure used in a study, then averages them all to compute a single mean effect size for the study, then does the same for all other studies in the collection. This makes it possible to compute an overall effect size mean for the entire collection of studies (Mann, 1990; Smith et al., 1980) or to compare subgroups of studies that differ in potentially important ways.

### How Well Does Psychotherapy Work with Children and Adolescents?

The effect size metric is sometimes used to address a rather global question: How well does psychotherapy work with children and adolescents? The question is clearly too broad to be answered in a fully satisfying way. So many different forms of therapy are provided, at such varying duration, by so many different therapists, and for such a broad array of problems,

among youth who differ so widely in age, gender, and sociocultural and personality characteristics, that a single answer to the question of how well therapy works must certainly overlook many important group differences (see Paul, 1967). On the other hand, it seems useful to assess, from time to time, what the average impact of psychotherapy is across variations in treatments, durations, therapists, problems, and treated youth, to assess whether efforts to treat young people are generally helping or not. Here we will use meta-analytic findings to address that general question. We will take two different looks at the evidence base.

*Clinically Derived Treatment in Usual Clinical Care.* The millions of youth treated with psychotherapy in clinics, schools, and other service settings each year receive a remarkable variety of different treatments. The blend of 551 named treatments and the great variety of eclectic mixtures used by most therapists make it difficult to describe what psychotherapy looks like in usual clinical care. Indeed, the wide array of treatments across therapists and treated youngsters may be about as numerous as the number of youths who receive treatment in a year. However, the mix of treatment procedures often includes some relatively common elements, such as (a) talking or playing with the child, and talking with the parent; (b) establishing a warm, accepting relationship in which the child is encouraged to express thoughts and feelings; (c) listening reflectively and being empathic; and (d) responding to the issues the child brings to each session. Of course, any list of content and procedural examples will miss what many therapists do in their practice since the range is potentially infinite. A common denominator of many procedures used in usual clinical care is that they are fashioned by individual therapists based on their clinical training, supervision, experience, and judgment, and usually not based primarily on the findings of research.

The general approach outlined here and the four illustrative features have considerable intuitive appeal. Indeed, they are quite close to what I and many others were taught to do in our graduate and professional training. These elements certainly may contribute to a good relationship and a strong working alliance with children and parents, especially when used by empathic, charismatic practitioners. A key question is whether approaches that are primarily clinically guided are sufficient to generate significant measurable benefit, on average, when applied by a variety of clinicians across a variety of practice settings. Answering that question is rather difficult, because there has been so little research on clinically derived usual care as provided in clinical service settings and programs. Some relevant research can be found, however, and we turn to it now.

*Effects of Child and Adolescent Psychotherapy: I. Tests of Clinically Guided Care in Usual Practice.* My research team has searched for studies that fairly represent usual clinical care of children and teens. We have

looked for studies that involved (1) clinically referred youngsters (not recruited analog cases); (2) treatment in service-oriented clinics, schools, or programs (not university labs); (3) treatment by practicing clinicians (not researchers or research assistants); (4) intervention procedures that were part of the usual services of the clinic, program, or practitioner; and (5) study designs in which a group receiving the usual care procedures was compared to a group receiving some form of placebo, waitlist, minimal-treatment or no-treatment condition. Thus far, we have found 14 group comparisons (in 13 published articles) that appear to satisfy these criteria. The comparisons span a broad range of methodological rigor; for example, only six involved random assignment of youngsters to usual care versus control conditions. The effect size estimates for each of the 14 comparisons are shown in Figure 1.2. The horizontal arrow in the figure shows that the mean effect size, averaging across all 14 comparisons, was slightly below 0, indicating no effect. The exact mean was  $-0.03$ ; means for the nonrandom studies ( $-0.4$ ) and the random assignment studies ( $-0.08$ ) were not significantly different ( $p = 0.44$ ). As the figure shows, the state of the evidence on clinically guided usual care is not very encouraging. It is certainly possible that more favorable evidence will emerge in the future; however, the studies we have found thus far provide little evidence of benefit from usual care in the forms and contexts in which it has been tested to date.

Do the effects of usual care improve if multiple treatments are used concurrently? With this idea in mind, some have linked individual forms of clinically guided care together into what are called systems of care, sometimes providing a menu of mental health services and a case manager to help connect children to the various services (see Stroul & Friedman, 1986). The evidence to date is generally not very encouraging on this front either. In one assessment (Bickman, 1996; Bickman et al., 1995), the U.S. Army spent \$80 million to provide an extensive continuum of mental health care for children in the Fort Bragg (North Carolina) catchment area, and to test its cost effectiveness relative to the more typical fragmented services in a matched comparison site. The Fort Bragg program apparently did produce well-integrated services. It was judged by the American Psychological Association's section on Child Clinical Psychology and the Division of Child, Youth, and Family Services Joint Task Force to be "the most comprehensive program to date, integrating many of the approaches demonstrated by other service programs . . . flexibly constructed, yet comprehensive, [with] services available to be adapted to meet the needs of children and their families rather than a simplistic application of a single approach . . ." (Roberts, 1994, p. 215). The program was expensive, but it did produce better access to treatment and higher levels of client satisfaction than the comparison site (Bickman et al., 1995). Unfortunately, though, children's mental health and everyday functioning at home and school did not improve any more at Fort Bragg than at the comparison site.

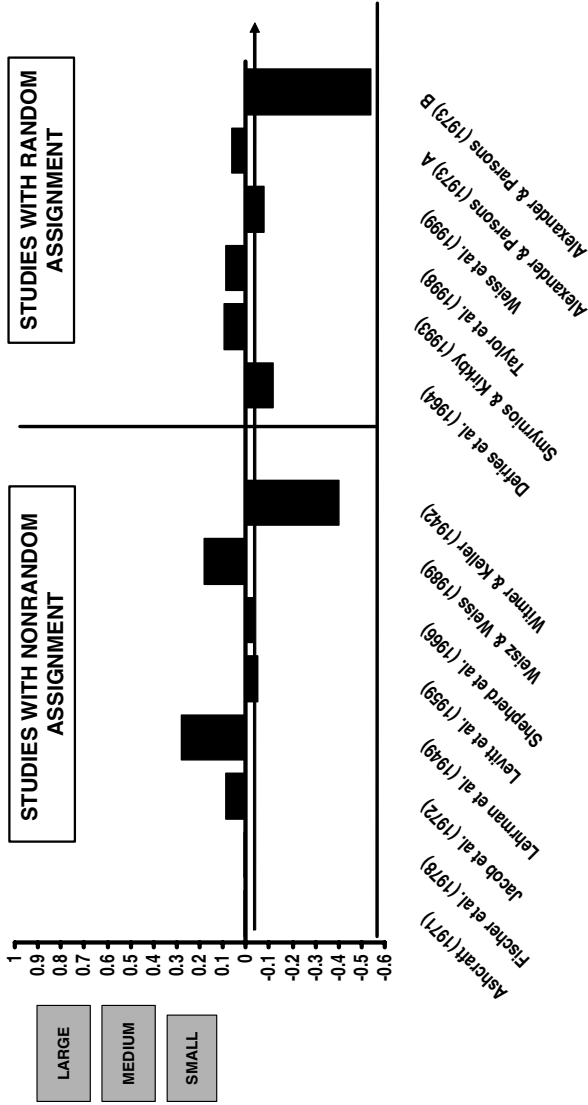


FIGURE 1.2. Clinically derived treatment studies. Estimated effect sizes for 14 comparisons of clinically derived child and adolescent treatment with control conditions. Horizontal arrow shows mean effect size averaging across the comparisons.



In a study with stronger experimental design (including random assignment of children to system-of-care vs. control group), Bickman, Summerfelt et al. (1997) and Bickman et al. (1999) found a pattern very similar to the Fort Bragg results. Studying a mature system of care in Stark County, Ohio, over a two-year period, the Bickman group again found that assignment to the system produced better access to care and larger doses of intervention. However, as in the case of Fort Bragg, there were no reliable differences between system-of-care youth and control group youth in either mental health outcomes or daily functioning at home and school.

Similar discouraging findings have emerged from other studies designed to combine usual clinical services and improve their delivery (Evans et al., 1994; Lehman et al., 1994; Weisz, Walter et al., 1990). Certainly, a number of alternative interpretations of these null findings may be plausible, but one interpretation that must be considered is this: The various treatments that are linked and coordinated within these continua of care simply may not be very effective, individually or in combination (Weisz, Han, & Valeri, 1997). There is no indication that the individual interventions that were combined in these studies had previously been tested and shown to work. Thus, it is possible that the various interventions are simply not effective. It is possible that organizing interventions into coordinated systems is a good idea in principle, but that it may work well only if the specific interventions that are organized and coordinated have beneficial effects.

To summarize findings on clinically guided treatment of youth in usual clinical care: (1) most available evidence on these treatments does not show beneficial effects, and (2) studies on the effects of integrating usual care procedures into systems of care also show little evidence of benefit. To be clear, it seems quite likely that there are individual therapists who use their own distinctive treatment procedures to good effect, and that there are treatment settings and programs where the prevailing forms of care do help children.<sup>1</sup> Moreover, organizing individual services into systems of care may be a good idea in principle, but the impact of any given system

<sup>1</sup> As one possible example, a recent article by Angold, Costello, Burns, Erkanli, and Farmer (2000) reported that naturally occurring outpatient mental health care in one region of North Carolina showed a positive dose-effect relationship (i.e., more sessions associated with greater symptom reduction), and apparently greater symptom reduction overall for treated youth than for a control group. However, the finding is difficult to interpret with confidence because (a) the interventions used included medication; (b) the control group consisted of youths from the community who had not been identified as needing treatment, had not been referred, and showed significantly lower symptom and impairment levels at the time of their first assessment than treated youth; and (c) real improvement was not seen in the treated youth who had fewer than eight sessions – our experience suggests that this tends to be a high percentage of treated youth in most outpatient settings. Moreover, the dose-effect finding reported by Angold et al. conflicts with Salzer, Bickman, and Lambert's (1999) findings of a null relationship between dose and effect with children, and Salzer et al. may have done a more thorough job of controlling for factors that could produce a spurious dose-effect association.

may depend on the effectiveness of its individual services. The question of interest here is how well clinically guided youth treatment in usual care seems to work, whether the treatments are provided one at a time or combined into systems. Most evidence to date has not been very encouraging.

***Effects of Child and Adolescent Psychotherapy: II. Broad-Based Meta-Analyses.*** Now we take a different look at the effects of youth psychotherapy as found in the broader research literature not confined to studies of usual care. That broader literature appears to include more than 1,500 group comparison studies (Durlak et al., 1995; Kazdin, 2000a), and more than 350 of these have met methodological requirements for inclusion in major meta-analyses. The treatments employed in these studies differ from one another in many ways, but some relatively common characteristics can be identified. First, the vast majority of the treatments tested in these studies do not represent the usual procedures of clinical practice settings. Most follow rather structured procedures with a specific agenda for the therapy process; therapists are usually guided by treatment manuals or procedural outlines that direct and constrain their actions to some degree. The treatments frequently involve training youngsters in specific skills for coping with their problems, procedures such as systematic problem solving, muscle relaxation, or thought monitoring. In addition, homework or practice assignments are frequently given to treated youngsters and/or their parents. In general, the procedures are structured in orderly ways consistent with what one might expect of researchers planning to submit their studies for peer review. An interesting possibility to consider is that such structure and orderliness may actually enhance the impact of treatment.

For a look at the state of the evidence on these treatments, we will focus on four published meta-analyses that have been particularly broad in their inclusion criteria, encompassing studies of diverse youth problems and disorders, and a variety of different treatments. These four meta-analyses appear to provide a particularly representative cross section of youth treatment outcome research. First we describe the procedures and the findings.

In the earliest of these meta-analyses, Casey and Berman (1985) surveyed outcome studies published between 1952 and 1983. The focus was on child samples – that is, studies whose samples averaged 12 years of age or younger. The mean effect size, averaging across the multiple outcome measures used in the various treatment-control comparisons, was 0.71; the average treated child scored better after treatment than 76% of control group children.

In a second meta-analysis, Weisz, Weiss et al. (1987) included outcome studies published between 1952 and 1983. Mean ages of the samples in these studies ranged from age 4 to 18. The mean effect size was 0.79; following treatment, the average treated child was at the 79th percentile of control group peers.

In the third meta-analysis, Kazdin, Bass et al. (1990b) included studies published between 1970 and 1988. Mean ages across the studies ranged from 4 to 18 years. For the subset of studies that compared treatment groups and no-treatment control groups, the mean effect size was 0.88; the average treated child scored better after treatment than 81% of the no-treatment comparison group. For studies in the Kazdin et al. collection that involved comparison of treatment groups to active control groups (e.g., those receiving a placebo treatment not expected to be effective), the mean effect size was somewhat lower, at 0.77; the average treated child was functioning better after treatment than 78% of the control group.

The fourth meta-analysis, carried out by Weisz, Weiss et al. (1995c), included studies published between 1967 and 1993. Mean ages of the samples ranged from 2 to 18 years. Weisz et al. reported a mean ES of 0.71; after treatment, the average treated child was functioning better than 76% of control group children.

The findings of these four broad meta-analyses are shown graphically in Figure 1.3. For comparison, the two bars at the left of the figure show

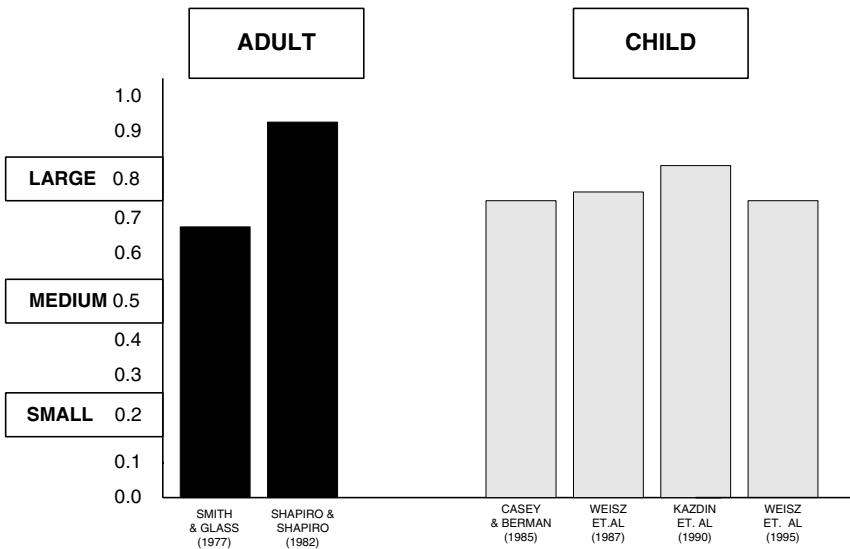


FIGURE 1.3. Mean effect sizes found in meta-analyses of psychotherapy outcome studies in the predominantly adult meta-analysis by Smith and Glass (1977), in the exclusively adult meta-analysis by Shapiro and Shapiro (1982), and in four broad-based meta-analyses of psychotherapy outcome studies with children and adolescents. [From Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology*, 63, 688–701. Copyright 1995 by the American Psychological Association. Reprinted with permission.]

the mean effect sizes found in two widely cited meta-analyses with older groups. One is Smith and Glass's (1977) analysis of primarily adult psychotherapy outcome studies; the other is Shapiro and Shapiro's (1982) analysis of exclusively adult outcome studies. The four bars at the right show effect size means from the four child and adolescent meta-analyses just described (Casey & Berman, 1985; Kazdin et al., 1990b; Weisz et al., 1987, 1995b). As the figure shows, mean effect size values were quite consistent from one child-adolescent meta-analysis to the next, and quite positive; means ranged from 0.71 to 0.84 (0.84 is an estimated overall mean for Kazdin et al., 1990b), near the threshold of 0.80 sometimes used to indicate a large effect (see Cohen, 1988). The means fell within the range shown for adult studies, suggesting that the effects of youth treatment may not differ much from the effects of adult treatment.

Two other meta-analytic findings warrant attention. First, we have found (in Weisz et al., 1987 and 1995b) that effects measured immediately after treatment are quite similar to effects measured at follow-up assessments, which average five to six months after treatment termination. Thus, treatment benefits appear to be durable, at least within typical follow-up time frames, and in studies whose authors were thorough enough to include follow-up assessments.

A second finding (Weisz et al., 1995b) concerns the specificity of treatment effects. Frank (1973) and others have proposed that psychotherapy has general, nonspecific effects, helping people with diverse problems in such broad, general ways as promoting a feeling of being understood or inducing an expectancy of relief. An alternative view is that therapies help in specific ways, having their strongest influence on the specific problems they are designed to address. Prompted by this debate, we tested (in Weisz et al., 1995b) whether effect sizes were larger for the specific problem domains targeted by a treatment than for other, more incidental domains; for example, did treatments for anxiety produce bigger changes in anxiety levels than in related but more peripheral problems such as depression? Across multiple comparisons like these, analyses showed that effect size means were about twice as large for the specific problems addressed in treatment as for related problems that were not specifically addressed (Weisz et al., 1995c, p. 460). This suggests that these tested psychotherapies do not merely produce global, nonspecific good feelings that influenced diverse outcomes equally, but instead, that the treatments had rather precise, focused effects consistent with the specific aims of the therapy.

Complementing the broad-based analyses just described, some meta-analysts have addressed rather specific questions by focusing on select subsets of outcome studies. Meta-analyses focused specifically on cognitive-behavioral therapy (CBT) (described later in this book) have found substantial positive effects on impulsivity (Baer & Nietzel, 1991), on depression (Lewinsohn & Clarke, 1999; Reinecke et al., 1998a,b), and