THIRD EDITION

CHILD AND ADOLESCENT THERAPY

SCIENCE AND ART

JEREMY P. SHAPIRO

WILEY

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Preface

The Therapist's Challenge

The purpose of this book is to equip readers with the knowledge and skills to provide effective psychotherapy to children and adolescents. I aim to provide an understanding of the major theoretical approaches, knowledge about the findings of outcome research, training in a variety of therapeutic techniques, and lots of good words to say to young people and their parents. This is an academic text and a how-to book in which intellectual rigor and practical application are viewed as equally important, complementary objectives. The goal is to articulate the knowledge base and thought processes of skilled therapists making scientifically and clinically well-informed decisions about what to do when. Thus, the book is about theory, etiology, change agents, technique, meta-analysis—and what to say to the kid.

When our field was young at the beginning of the 20th century, psychotherapy was called "the talking cure," and this description is still accurate. Therapy is not alone in its purposeful use of conversation, and people have sought help by talking to trusted relatives, friends, and clergy for far longer than counseling has existed. But therapy is also a professional service, and to justify the remuneration we receive, counselors should be able to provide forms of help that laypeople cannot reliably offer. There needs to be something different about our talk.

Psychotherapy fulfills a distinctive and rather remarkable function in our society. When something goes wrong with our cars, we go to automobile mechanics to fix them. When something goes wrong with our bodies, we go to physicians for treatment. When something goes wrong with our emotions or behavior, society recognizes psychotherapists as the people to call for help with these central aspects of self.

The trust that parents and children demonstrate by coming to us for help imposes an important responsibility. They are generally willing, just moments after meeting a stranger, to disclose important, painful, and, perhaps, embarrassing aspects of their lives, sometimes revealing things they have never told anyone before. They do this because the stranger sitting in front of them has a license indicating her commitment and ability to respond helpfully to this type of disclosure. It is an honor and a privilege to work with children and families on the most personal aspects of their lives, and, to be worthy of this trust, we must do our best not to let our clients down.

Language is the main tool of the therapy trade. Although play and artistic activities sometimes supplement verbal communication with children, and our talk often refers to actions, for the most part the work of therapy consists of a search for good words. Physicians have their laboratory tests, radiological devices, medicines, and surgical instruments—we have our words. At first, this might be an intimidating thought, because we are up against a lot. The causes of mental health problems include genetic vulnerabilities, neurobiological dysfunction, poverty, racism, family discord, trauma, maladaptive learning histories, and so forth. By the time a child becomes a therapy client, factors like these may have operated in his life day after day, month after month, for years. Confronted with forces like these, words might not seem like much.

When I was a graduate student in my first clinical placement, a client with severe problems resisted my invitation to therapy on the grounds that, "I don't see how talking about it will help." I did not have an adequate response. In fact, I was frightened that the young man might be right, and talking about his unhappy life would do nothing to make it better.

I panicked prematurely. As discussed in the outcome research sections of the chapters to follow, psychotherapy is usually an effective means of treating emotional and behavioral problems. During the past 100 years or so, clinicians and researchers have developed a number of methods that, for most clients, are at least moderately helpful. In a sense, this book represents a long, detailed response to my fear that therapy (i.e., mere talk) might be too weak and vague an activity to overcome the causes of mental health problems. The therapist's challenge is a daunting one, but most of the time it can be met. Talking about problems—in certain, specific ways—really can help. The chapters that follow describe these ways.

The website associated with this book includes a number of forms and handouts that therapists can use with clients. The forms can be printed out as they are, or you can modify the documents to customize them for particular clients. The web address is http://www.wiley.com/college/shapiro.

Acknowledgments

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On a more personal level, I want to express deep gratitude and appreciation to my wife, Nancy Winkelman, who provided endless patience and support during the long process of writing the book. I also want to honor the memory of my parents, Felicia and Jack, who were the source of my energy for learning and thinking that culminated in this book.

Abbreviations Used in Multiple Chapters

ACT:	Acceptance and Commitment Therapy
AHDH:	Attention Deficit Hyperactivity Disorder
APA:	American Psychological Association
CBCL:	Child Behavior Checklist
CBT:	Cognitive-Behavioral Therapy
DBT:	Dialectical Behavior Therapy
DSM-5-TR:	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Training Revision
EBP:	Evidence-Based Psychotherapy
ES:	Effect Size
HPA Axis:	Hypothalamic-Pituitary-Adrenal Axis
IFS:	Internal Family Systems
JCCAP:	Journal of Clinical Child and Adolescent Psychology
ODD:	Oppositional Defiant Disorder
PTSD:	Posttraumatic Stress Disorder
RCT:	Randomized Controlled Trial
TAU:	Treatment as Usual

Introduction: Integrating Science and Art in Therapy

The purpose of this Introduction is to explain how to use this book as a guide for conducting psychotherapy with children and adolescents. To fulfill this purpose, a larger issue must be addressed: The relationship between books about therapy and therapy as it is practiced in the "real world." This relationship is not simple; there are discrepancies between the two.

I want to minimize these discrepancies, but they cannot be reduced to zero, because for textbooks to be useful to readers, they must be simpler and more coherent than the realities they describe. (This is true in all fields, not just ours.) If you understand the differences between this book and the reality of psychotherapy, you will not be misled by the ways I have simplified and organized the presentation for the sake of accessibility.

Our field is organized mostly in terms of theoretical orientations: behavioral, psychodynamic, and so forth. The way to learn how to do therapy is to learn these treatment approaches, and that is how Part I of this book, *The Tools of the Therapist*, is organized. The major approaches each have their own chapter, and they are presented as distinct, separate, and self-contained. However, this method of presentation is a teaching strategy more than a reflection of how therapists actually work. Some practitioners adhere to a single theoretical orientation, but most are eclectic, drawing on techniques from multiple theories (Tasca et al., 2015; Thoma & Cecero, 2009). Eclecticism would make no sense if one or two therapeutic approaches stood head and shoulders above the rest, but as discussed ahead, this is not the case.

For ease of communication, this book has many sentences taking the form, "Cognitive therapists do this," and "Solution-focused counselors believe that," as if these terms referred to different groups of people. To some extent they do, but mostly these terms refer to clinicians using particular strategies at certain points in time. In other words, one can be a systems-oriented therapist at the beginning of a session, a behaviorist in the middle, and a narrative therapist at the end; there is no contradiction in this. Theoretical orientations can be like hats we put on and take off at different points in our sessions, hopefully determined by client needs and therapeutic opportunities. Also, therapeutic approaches can be blended by working multiple change processes at the same time. Nonetheless, Part I does not present the major theories this way but, for ease of comprehension, describes them in their pure forms, unmixed with other theories.

Theoretical orientations are the primary colors of psychotherapy. Just as painters mix a few primary colors to create every possible hue, clinicians mix treatment approaches to create the variety of technique combinations we provide to clients. Part I of this book presents these therapeutic primary colors, and in Part II we do some mixing, matching, and blending.

Part II, *The Needs of Clients*, is organized mostly in terms of diagnostic categories—another simplification. Many medical diagnoses are objective and definite, with clear boundaries between them, and they usually provide information about **etiology**—factors causing or maintaining disorders—which is what we really want to know. However, this is

generally not the case in the mental health field. When our diagnoses are examined empirically, the boundaries between them turn out to be poorly defined, in that many clients have symptoms of multiple diagnoses, there is much heterogeneity within diagnoses, and clients can have the same symptoms for different reasons, so diagnosis provides little information about etiology (Essau & de la Torre-Luque, 2019; Kotov et al., 2017). Nonetheless, we need shorthand terms to convey information quickly, if roughly, and diagnoses fulfill this function.

The Power and Limitations of Outcome Research

One central goal of this book is to help readers combine knowledge of research findings with clinical reasoning to plan therapy and, on a micro level, decide what to say next. But first, it is worth asking why the development of this difficult skill is even necessary—wouldn't it be more reliable simply to use outcome research to plan therapy with each client?

In general, scientific research is the most reliable known method of producing knowledge about the natural world, which includes human beings, our problems, and ways to alleviate them. Nonetheless, therapy outcome research, in its current stage of development, has some major limitations as a basis for treatment planning. We need to understand the weaknesses of the outcome research literature to make good use of its strengths. There are some things it can tell us, and some it cannot.

The first task of outcome research was to answer the question of whether, overall, psychotherapy is helpful to people with mental health problems. The answer to this question might seem obvious now, but during most of our field's history, it was not, and there was real controversy about whether our endeavor had any value at all. Eventually, researchers worked out the methodological problems that needed to be overcome to demonstrate conclusively that, on the whole, the answer to this question is yes—therapy "works."

More accurately, the answer is mostly yes. To summarize a huge body of research in one sentence, it would be fair to say that, for most diagnoses and both children and adults, in most outcome studies the treatment that works best is associated with improvement in approximately 75% of clients, with waitlist and no-treatment control groups showing improvement in about one-third of their cases, just because some people with mental health problems get better with the passage of time (Roth & Fonagy, 2006; Wampold & Imel, 2015). This difference between three-quarters and one-third means therapy is definitely valuable, overall.

But what about the approximately one-quarter of clients who got the winning intervention but did not show improvement? They do not change the conclusion of the research, but to clinicians, they are a big deal, an unsolved problem, and a significant part of our practices. These clients cannot be sent home with the statement so often found at the end of journal articles: "Future research is needed. . .."

Also, the 75% are not all fully recovered—far from it. The amount of benefit varies widely, and many clients who achieve some improvement still have serious difficulties after therapy is completed (Cohen, Delgadillo, & DeRubeis, 2021; Ng, Schleider, Horn, & Weisz, 2021). For these reasons, knowing the best treatment for most members of a diagnostic group (a research question) does not necessarily tell us the best treatment for the client sitting in front of us (a clinical question).

What Works for Whom?

There have been great hopes and what seemed like reasonable expectations that outcome research could guide clinical practice by answering Gordon Paul's (1967) classic question: What works for whom? Our field has addressed this question by identifying therapies that, in multiple studies, have achieved more improvement for clients than what was found in control groups. These interventions are called **Evidence-Based Psychotherapies** (EBPs). The thousands of studies conducted since 1967 have identified many EBPs and have definitely begun to answer Paul's question—but the answers are far from complete.

Research has found that, overall, and with some notable exceptions, the major therapeutic approaches are similar in effectiveness (Prochaska & Norcross, 2018; Wampold & Imel, 2015). This book will focus on the exceptions, but that does not negate the rough equivalence.

Even when an outcome study finds one therapy superior to another, there is always substantial overlap in the outcomes of the two groups. It is generally the case that a significant minority of the clients who got the winning therapy did not get better, and a majority of the clients who got the losing therapy did improve (e.g., 75% improved in one group and 60% in the other). Significant group effects do not guarantee that the client sitting in front of you would get the maximum benefit from the therapy that was effective for most young people in the studies. If your client differs from the study samples in some way, it is possible she would respond better to interventions that were less effective for the groups as a whole. Therefore, knowledge about outcome research should be the beginning, not the end, of treatment planning.

Another general finding is that, again with exceptions, most therapeutic strategies that are effective with one disorder are also effective with many others, at least within the broad categories of emotional versus behavioral disturbances. As examples, Dialectical Behavior Therapy, Acceptance and Commitment Therapy, and cognitive-behavioral training in psychosocial skills have all been shown to reduce the symptoms of just about every diagnosis with which they have been tested. This does not mean these interventions help everyone (as discussed, about 75%); it means there is not a strong relationship between diagnosis and the type of therapy most likely to help. It may be more important to identify the etiological processes causing or maintaining disturbances, because therapeutic techniques usually target these processes.

The original vision of a research-based answer to Paul's (1967) question was, in essence, a grid. The idea was that, once the necessary outcome research was done, diagnoses could be listed in rows, EBPs could be listed in columns, and there would be one or a few intersections for each, indicating what works for whom. If such a grid existed, assessment could consist simply of diagnosis and treatment planning could be accomplished by reading along the appropriate row until an EBP for that disorder is reached.

Things have not worked out this way, for the reasons described: Diagnostic groups are actually heterogeneous, client problems cross-cut diagnoses to a substantial degree, EBPs do not work for nearly all the clients in any diagnostic group, and many EBPs are effective treatments for many diagnoses. The reality is much more complicated and messy than a grid.

That is why this book is so long! (It is one of the reasons, anyway.) The material on treatment planning certainly starts with diagnosis and outcome research, which are our foundation, and then discusses clinical observations, etiologies, change processes, and client preferences, all of which must be woven together to produce our best guesses about what would work for whom. It sounds harder than it is, although it is certainly not easy.

While the major therapeutic approaches generally have similar overall or *average* effects, they also have widely varying *individual* effects on clients (Cohen et al., 2021). As an illustration, let's say a very small study provided two kinds of therapy to two groups of three clients each, and in both groups, there were identical reductions in depression scores of 0, 5, and 10 points. Both treatments produced the same average reduction of five points, and yet different individuals had very different responses to the same interventions. This is a valid illustration in that practically all studies include clients who recover completely, improve somewhat, show no change, and deteriorate during therapy.

It would be extremely useful to know how clients would respond to different interventions in advance, without trying techniques to see what happens. In statistics, variables that predict different responses to the same treatment are called **moderator variables**. (This term has nothing to do with "moderation" in the usual sense.) For example, if a treatment were helpful to girls but not boys, gender would be the moderator variable. Efforts to answer the question of what works for whom consist, in large part, of a search for moderators.

Unfortunately, thus far, this search has not found much. The *Journal of Clinical Child and Adolescent Psychology* (JCCAP) devoted a special issue to research on moderator variables. In their introduction, Mullarkey and Schleider (2021) provided an honest assessment of this research by stating that, while significant results have been obtained here and there, no reliable moderators of outcome for any disorder have been identified. They came to the "sobering" conclusion that a large body of research has not yet provided a basis for personalizing therapy for young clients. As discussed previously, even diagnosis is not much of a moderator.

Researchers are well aware that they have a long way to go before fulfilling their promise to clinicians, and they are working on new tools to produce more useful guidance. The new information technologies of machine learning and artificial intelligence are being applied to the goal of personalizing therapy (Aafjes-van Doorn, Kamsteeg, Bate, and Aafjes 2020; Schwartz et al., 2021). However, as of now, no new method has provided a clinically useful tool, and the achievement of this goal might be many years in the future (Cohen et al., 2021; Ng et al., 2021).

This is why clinical reasoning is a vital aspect of therapy planning and will remain so until the data that outperform it finally arrive. In the meantime, research and clinical reasoning should be viewed as complementary, not opposing, tools for planning. This complementarity is based on the reality that research is about groups, while clinical judgment is about individuals.

Modular Treatments

Research itself is beginning to incorporate some room for clinical judgment in its development of **modular treatments**. John Weisz and colleagues (Chorpita & Weisz, 2009; Weisz & Bearman, 2020; Venturo-Conerly, Fitzpatrick, & Weisz, 2023) have been leaders in this new approach to child therapy, as have Hofmann, Hayes, and Lorscheid (2021) in work with adults. The key is to break both interventions and diagnoses down into smaller units. Therapies are broken down into techniques or modules. Diagnoses are broken down into the smaller unit of problems. Decisions about which modules to use and when to use them are made by therapists on the basis of clinical judgment.

The *Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems* (MATCH; Chorpita & Weisz, 2009) is a menu of empirically validated cognitive-behavioral techniques from which clinicians choose to create individualized treatment packages. In studies by Weisz et al. (2012, 2013), MATCH produced better outcomes than treatment as usual both posttreatment and at two-year follow-up, with effect sizes about twice as large as those usually found in comparisons of manualized, validated therapies to treatment as usual.

The FIRST program (Weisz & Bearman, 2020) is a similar, transdiagnostic menu of empirically validated, cognitive-behavioral techniques that fit into the categories of **F**eeling calm, **I**ncreasing motivation, **R**epairing thoughts, **S**olving problems, and **T**rying the opposite. In a series of studies using pre/posttreatment, within-client designs, FIRST produced strongly positive results, with effect sizes much larger than those typical in outcome studies (Cho, Bearman, Woo, Weisz, & Hawley, 2021; Weisz, Bearman, Santucci, & Jensen-Doss, 2017).

MATCH and FIRST both involve clinical judgment, in that therapists choose techniques from menus. However, their scope of clinical reasoning is limited—the menus are not broad—in that they include only cognitive-behavioral techniques. This is not because only these techniques have been empirically validated.

Integrating Outcome Research and Clinical Reasoning

Outcome research is not difficult to define: Generally, it involves measuring client functioning before and after a treatment and then comparing the difference to change in a control group over the same period of time. (Chapter 2 provides more explanation of research methods.)

Clinical reasoning is harder to define. Unless a therapist simply chooses an EBP on the basis of a client's diagnosis, almost anything he thinks about while deciding what to do is clinical reasoning. Empirical findings should be included whenever possible, but this can occur in a more wide-ranging, flexible way than moving directly from diagnosis to outcome study to treatment plan. Also, clinical judgment extends beyond scientific findings to include past clinical experience, theory, personal experience, and intuition.

Because scientific research has a level of reliability that no one's intuition, experience, or reasoning can approach, we can be confident that empirical findings mean what it seems like they mean. (This is called "internal validity.") On the other hand, a counselor in a room with a youth has a different kind of advantage: She knows her observations are directly relevant to her client ("external validity"). Outcome studies are not necessarily relevant to her client because he might differ from the samples in outcome studies in important ways, even if his diagnosis is the same. Outcome research and clinical reasoning involve different kinds of information, and the differences are complementary, so the combination is optimal.

This book's emphasis on the integration of outcome research and clinical reasoning is consistent with the consensus of the psychotherapy field. The Practice Directorate Guidelines of the American Psychological Association (APA, 2023) define evidence-based practice as the integration of, (1) the best available research with, (2) clinical expertise in the context of, (3) patient characteristics, culture, and preferences. Other mental health professional associations have similar guidelines.

Much clinical reasoning is about *which* outcome studies are most relevant to a client's needs and strengths, particularly in the common situation in which multiple interventions have been found to be effective with the client's diagnosis (Cohen et al., 2021; Ng et al., 2021). Also, non-clinical research in areas like social, cognitive, developmental, and positive psychology, and in the social sciences in general, provide innumerable insights into patterns and processes in clients' lives, and these insights can help us plan therapy.

Most of the time, clinical considerations should just fill in the details of research-based frameworks and guide the implementation of EBPs. There are also times, however, when clinical considerations should outweigh research findings (APA, 2023).

Clinical reasoning sometimes generates units of intervention much smaller than the strategies studied in outcome research. These consist of therapist statements, ranging from one sentence to a couple paragraphs in length, that address a client issue much smaller than a disorder or even a symptom. These micro-interventions will probably never be evaluated in an outcome study because their scale is too small—some are just good lines to use in certain situations—so clinical judgment is their only possible basis of implementation. These little bits of therapy can be useful because, when they hit a nail on the head, their value becomes apparent even without a supportive study.

One big difference between outcome research and clinical reasoning is the role played by etiology. In outcome studies, client samples are generally defined by diagnosis, and diagnosis is defined by symptom patterns, not etiology (American Psychiatric Association, 2022). In contrast, clinicians frequently wonder *why* clients show their patterns of emotion and behavior. Counselor responses are based largely on their hypotheses about etiology, because this is what theories of psychotherapy are largely about (Hofmann, Hayes and Lorscheid, 2021; Mullarkey & Schleider, 2021). For example, if a child was depressed because he was unable to make friends, the therapist would probably provide social skills training, while if a popular youth was depressed because of self-critical thoughts, the counselor would probably respond with cognitive therapy.

Treatment planning can involve a three-part sequence. Therapists: (1) discern patterns, (2) try to figure out what is causing or maintaining those patterns, and (3) choose techniques to address those etiological factors.

Different theories provide different patterns to look for and different links between etiologies and interventions. In a sense, we are looking for something broken that we know how to fix. This (not diagnosis) is the most important purpose of assessment.

In the past, partisans of the different theoretical orientations argued vehemently that their approach was superior to the others, and this sometimes happens today, although less frequently. Over time, our field is moving toward a consensus that the different theories describe different psychological processes, etiologies, and change agents, which vary in their degree of relevance to different clients. The existence of one etiology or change process is not an argument against the existence of other etiologies or change processes. For example, the existence of operant conditioning is not an argument against the existence of unconscious defenses, and evidence for the efficacy of reinforcement is not evidence against the efficacy of insight. If so, arguing about whether behavioral, mindfulness-based, or psychodynamic therapy is best makes as much sense as arguing about whether orthopedics, cardiology, or neurology is best—that is, it makes no sense at all. The different approaches to medicine and therapy target different processes and systems, and they all offer value to patients suffering from dysfunction in the processes and systems they treat.

Guidelines for personalized, assessment-based therapy planning can be complicated and sophisticated, with many checklists and flowcharts (e.g., Hofmann et al., 2021). On the other hand, in the midst of clinical work, these decisions often seem straightforward. Some children and families show the etiological patterns of particular theories so clearly that the appropriate therapeutic response seems obvious. I would describe my experience of this process as like responding to clients in the language with which they address me. When they present patterns described by family systems theory, I respond with systemic techniques; when they present patterns described by cognitive theory, I respond with those strategies, and so forth.

While researchers strive to be rigorous, clinicians are more concerned about being pragmatic. Of course we should be thoughtful about which techniques we try, but if our first attempts are unsuccessful, we can make use of a wonderful freedom: If one thing does not work, we can try something else!

About the Companion Website

Child and Adolescent Therapy: Science and Art is accompanied by a companion website.

www.wiley.com/go/shapiro/childandadolescenttherapy3e

The website includes:

- PowerPoints

PART I

THE TOOLS OF THE THERAPIST