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What Makes for an Effective Treatment?

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This volume provides an overview of recent advances in cognitive-behavioral treatments of behavioral and emotional difficulties experienced by youth. Even a cursory review of recent book titles and issues of journals in the fields of child psychiatry and clinical child psychology indicates that cognitive-behavioral approaches have generated considerable clinical and empirical attention over the past several years (Carr, 2000; Friedberg & McClure, 2002; Graham, 1998; Hibbs & Jensen, 1996; Kendall, 2000). Cognitive-behavioral therapy has been successfully applied to a wide range of clinical problems experienced by youth, including depression, anxiety, anger and aggression, eating disorders, learning problems, and autism. Given the breadth of this literature, and the speed with which it has advanced, this seemed an opportune time to review recent empirical, conceptual, and clinical work on cognitive-behavioral psychotherapy with children and adolescents and to describe how these approaches might be used in practice.

Epidemiological research indicates that a significant percentage of youth experience disabling behavioral and emotional difficulties. Although estimates vary depending on the nature of the sample and the methodologies employed, prevalence studies suggest that between 15 and 22% of youth will experience significant adaptive difficulties at some time (Costello, 1989; McCracken, 1992). Unfortunately, the majority of these individuals do not receive effective treatment. This is of particular concern insofar as longitudinal studies indicate that behavioral and emotional difficulties

among youth are often recurrent, and can be associated with a significantly increased risk of psychopathology during adulthood (Robins & Rutter, 1990). With these concerns in mind, it becomes important to develop efficient, cost-effective treatments, and to make them available to children and families. It also becomes important to understand factors associated with vulnerability for psychopathology so that effective prevention programs can be developed and implemented.

COGNITIVE-BEHAVIORAL THERAPY WITH YOUTH

Morris and Kratochwill (1991) observed that the child mental health literature is relatively young, and can be traced only to the early 20th century. The use of psychotherapy for treating children and adolescents dates to Freud's (1905/1953) treatment of Dora, an 18-year-old girl suffering from low spirits, headaches, nervous coughing, and social withdrawal. This case is of interest in that Freud's concern was not with Dora's developmental status or the social context in which her concerns arose. Rather, he was interested in elaborating upon his dynamic drive/structure model and in understanding the ways in which this may be expressed through dream content. The importance of adopting a developmental perspective for understanding and treating youth was not recognized until a number of years later. Developmentally and socially focused psychoanalysts during the 1920s and 1930s (including Anna Freud, Harry Stack Sullivan, and Melanie Klein) and those who viewed psychopathology as related to a lack of self-esteem (such as Sandor Rado, Otto Fenichel, and Edward Bibring) anticipated many of the issues confronting cognitive therapy today. The mental hygiene movement and the establishment of child guidance centers during the 1920s contributed to an increased concern for children's emotional development and an awareness of their mental health needs. Although child guidance programs provided clinical services to children and their families, they were not developed with the goal of supporting empirical research into the development of psychopathology or its treatment. The recognition of the value of adopting an objective, empirical approach for assessing, conceptualizing, and treating childhood emotional disorders did not begin to emerge until more recently. Cognitive-behavioral therapy deserves praise, then, for its concern with factors that place individuals at risk for developing behavioral and emotional problems, for its attention to the role of the family and social environment in the development and maintenance of these difficulties, for its attention to tacit beliefs about the self and how these may influence behavioral and emotional adjustment, and for its emphasis on empirically testing models of psychopathology and the effectiveness of interventions derived from them.

Cognitive therapy is founded upon the assumption that behavior is

adaptive and that there is an interaction between an individual's thoughts, feelings, and behaviors (Dobson & Dozois, 2001; Freeman & Reinecke, 1995). A major emphasis in cognitive-behavioral therapy with youth is on understanding the development of an individual's behavioral repertoire and the accompanying cognitive and perceptual processes. Cognitions are viewed as an organized set of beliefs, attitudes, memories and expectations, along with a set of strategies for using this body of knowledge in an adaptive manner. As Kendall and Dobson (1993) note, "Cognition is not a singular or unitary concept, but is rather a general term that refers to a complex system" (p. 9). Cognitions refer to one's current thoughts or self-statements, as well as perceptions, memories, appraisals, attributions, tacit beliefs or schemas, attitudes, goals, standards, values, expectations, and images. It can be useful to attend to each of these variables when conceptualizing and treating behavioral and emotional difficulties among youth. The term "cognition" refers not only to cognitive "contents," but also to the ways information is represented in memory and the mediational or control processes by which the information is processed or used.

Cognitions, as such, may be viewed as a set of complex skills (Weimer, 1977) that incorporate problem-solving or coping strategies, communication and linguistically based knowledge, interpersonal skills, and affect regulation capacities. This notion, that cognitions and cognitive processes may be viewed as skills, is conceptually important. It allows us to understand the development and use of these processes and capacities as we would other capacities acquired during childhood (Fogel, 1993; Vygotsky, 1962). It provides a point of contact between the cognitive therapy and developmental psychology literatures. From this perspective, all cognitive development (including the development of maladaptive beliefs and processes) occurs in a social context. It is impossible, then, to draw a line between the cognitive and the social. Cognitive contents and processes are acquired, maintained, and function in social contexts. They are modeled and reinforced by parents and others in the child's community, and serve an adaptive function in organizing and regulating the child's responses to stressful life events. This perspective is consistent with the clinical observation that it can be quite difficult, in practice, to conceptualize and treat clinical problems experienced by children and adolescents without attending to their home environment and peer group. One rarely anticipates that children or adolescents would demonstrate substantially similar behavioral or emotional reactions if there were significant changes in their home environment or social network.

One of the fundamental assumptions of cognitive-behavioral therapy is that cognitions influence emotions and behavior. Children and adolescents, like adults, are believed to respond to cognitive representations of events, rather than to the events themselves. This is an important assumption in that it designates cognitive change as a prerequisite to behavioral

and emotional improvement. This is not to say, however, that cognitive factors are necessary or sufficient causes of psychopathology. No single factor appears to "cause" psychopathology in childhood. Rather, research suggests that behavior and adaptation are multiply determined (Rutter, 1989), and that a number of factors interact in contributing to the emergence of behavioral and emotional problems. Biological, genetic, social, cognitive, and environmental factors reciprocally influence one another in placing children at risk for developing behavioral and emotional problems. In a similar manner, there appears to be a range of interpersonal, cognitive and social factors that serve a protective function and ameliorate these risks. As a consequence, some children, when exposed to stressful life events, experience only mild distress, whereas others experience relatively severe adjustment problems. The concept of multifinality, borrowed from the field of developmental psychopathology, captures this notion. Put simply, it refers to the fact that children born with similar conditions, or who are exposed to similar experiences, may demonstrate markedly different outcomes later in life. Our goal is to identify factors that may account for these different outcomes. Our challenge, as clinicians and researchers, is to attempt to understand the ways in which cognitive, biological, and environmental factors interact over time in mediating the emergence of psychopathology during childhood. This task is complicated by the fact that different factors appear to be more or less important at different stages of development, and that specific etiological factors may differ from one form of psychopathology to another. Although we are not suggesting that cognitive factors "cause" psychopathology among youth, strong evidence suggests that there are cognitive and behavioral differences between children who manifest difficulties in adaptation and those who do not (Kendall & MacDonald, 1993). It is these cognitive and behavioral factors that become the focus of our clinical interventions.

Emotional and behavioral responses to events in one's day-to-day life are a influenced by how these events are perceived, the recollection of similar events in the past, attributions that are made about the causes of the event, and the ways in which the events affect one's self-perceptions and the pursuit of one's goals. These cognitive processes are believed to be influenced, in turn, by underlying beliefs that individuals maintain about themselves, the world, and their future. These tacit beliefs or schemas are actively constructed over the course of development, and might be thought of as "lenses" or "templates" guiding the perception, processing, recollection, interpretation, and analysis of incoming information. When children's behavioral or emotional responses to an event are maladaptive—that is, they are inappropriate given the nature or severity of the event or significantly impair the child's social or academic adjustment—it is presumed that they may lack more appropriate cognitive or behavioral skills, or that their beliefs (cognitive contents) or problem-solving capacities (cognitive processes) are in some way disturbed. The latter difficulties may reflect cognitive deficiencies or distortions (Kendall, 2000). "Cognitive deficiencies" refer to the lack of effective cognitive processing, as might be demonstrated by an inattentive child who approaches problems in an impulsive, nonreflective manner. "Cognitive distortions," in turn, refer to beliefs and attitudes founded on irrational or "distorted" logic, as might be manifested by a depressed teenager who systematically minimizes his or her abilities, and who selectively dismisses or overlooks support provided by others. With this in mind, cognitive-behavioral therapists endeavor to assist children and adolescents by facilitating the acquisition of new cognitive and behavioral skills, and by providing children with experiences that will facilitate cognitive change.

COGNITIVE-BEHAVIORAL THERAPY IN PRACTICE

Therapy most often begins with a careful assessment of factors contributing to the child's behavioral and emotional difficulties. This typically involves collection of objective and subjective reports from the child, caregivers, and school officials. When possible, it is desirable to augment these data with direct behavioral observation. Assessments are made not only of the child's mood and behavior, but also of the full range of cognitive, social, and environmental factors that may underlie and maintain his or her distress. An outline of this assessment strategy is presented in Table 1.1.

This assessment is followed by the introduction of interventions

TABLE 1.1. Cognitive-Behavioral Assessment Strategy

Source	Domain	Respondent
Objective measures	Emotion	Child
Subjective report	Behavior	Caregiver(s)
Behavioral observation	Social adjustment	Teacher(s)
	Academic adjustment	Clinician
	Environmental stressors/supports	
	Cognition	
	Automatic thoughts	
	Schemas	
	Problem solving	
	Self-concept	
	Attributions	
	Expectations	
	Goals, standards, and values	
	Memories	
	Cognitive distortions/bias	

designed to increase behavioral competence, as well as techniques designed to correct maladaptive beliefs or cognitions. As in the practice of cognitive-behavioral therapy with adults, cognitive-behavioral therapy with children is (1) active, (2) structured, (3) problem-oriented, (4) collaborative, and (5) strategic. It is based upon a cognitive-behavioral formulation of factors maintaining the individual's difficulties. An outline of a standard course of cognitive-behavioral therapy is presented in Table 1.2.

Ellis (1962) and Beck (1976) are often credited with introducing the concept of "cognitive restructuring" to the clinical literature. This term refers to the use of Socratic questioning or rational disputation to modify maladaptive or "distorted" thoughts. This approach was subsequently refined (Kendall & Hollon, 1979; Meichenbaum, 1977), and then applied to the treatment of depression and anxiety experienced by children and adolescents. Other cognitive interventions include exercises in social perspective taking, rational problem solving, guided imagery, relaxation training,

TABLE 1.2. Outline of Standard Course of Cognitive-Behavioral Therapy

1. Therapist elicits information regarding the development of specific symptoms, as well as situational determinants and temporal course. Objective and subjective data are collected (preferably from multiple informants) regarding the nature of the presenting problem.
2. A goal list is developed with the child and the parents or other caregiver. Cognitive-behavioral formulation and treatment recommendations are shared with the child and his or her parents.
3. Underlying beliefs, attitudes, assumptions, expectations, attributions, goals, and self-statements or automatic thoughts are identified. Patients learn to monitor negative or maladaptive thoughts and emotions. Attempts at self-monitoring are rewarded.
4. Specific behavioral and interpersonal skills deficits are identified.
5. Medical, social, and environmental factors maintaining the symptoms are identified. The latter may include stressful life events (both major and minor, short-term and chronic) or the modeling and reinforcement of the symptoms by others in the child's life.
6. Cognitive and behavioral interventions are selected and introduced based upon the specific needs of the child.
7. Homework is assigned. The patient practices the cognitive or behavioral skills during the session. Attempts are made to ensure that the interventions are clearly understood, that the child is motivated to attempt the assignment, and that they expect the intervention to be helpful. Factors that may interfere with the successful completion of the homework assignment are identified and addressed.
8. Effectiveness of the intervention is evaluated through objective ratings, behavioral observations, and subjective reports.
9. Relapse prevention interventions are introduced. Follow-up or booster sessions are scheduled.

and the use of adaptive self-statements. These interventions (and others) may be introduced based on the specific needs of the child. Cognitive-behavioral interventions have also been developed to remediate cognitive deficiencies. These take the form of techniques introduced to facilitate the development of reflective thought, effective problem solving, and self-regulation.

As noted, virtually all of these interventions—including cognitive restructuring, enhancement of self-control skills, and social problem-solving techniques—were initially developed for treating emotional disorders among adults and are based on rationalist models of human adaptation (Mahoney & Nezworski, 1985). These techniques must be adapted for use with children and adolescents in that children often lack the social, linguistic, and cognitive sophistication to benefit from these techniques if they are introduced in an unmodified form. School-age children, for example, are often unable to discriminate and label emotional states or to readily identify their thoughts and concerns. Young children appear, as well, to be less able than adults to recall emotions apart from the environmental events that generated them. The use of rational disputation and Dysfunctional Thought Records (DTRs)—staples of cognitive-behavioral therapy with older adolescents and adults—are, as a consequence, not feasible with this population. With this in mind, we must simplify our interventions such that they are commensurate with the abilities of our patients, or assist children in developing the requisite skills so that they may benefit from these techniques.

Cognitive-behavioral therapy with children and adolescents requires more, however, than the modification of techniques developed for use with adults for this younger population. Rather, it requires that we recast cognitive-behavioral theories of psychopathology and psychotherapy in developmental terms.

THE IMPORTANCE OF MAINTAINING A DEVELOPMENTAL PERSPECTIVE

Rationally based models of psychotherapy have been criticized as being insensitive to developmental issues and tasks faced by children and adolescents. Moreover, it has been suggested that they do not attend to the self-organizing, constructive processes of child development (Mahoney & Nezworski, 1985). These criticisms are, in some ways, reasonable. Tacit beliefs regarding the reliability of relationships ("working models" in the attachment literature), personal security, and the stability of the family, for example, are of critical importance to school-age children, but are rarely explored in the cognitive therapy literature. Moreover, these factors are rarely incorporated into cognitive-behavioral conceptualizations of childhood emotional disorders. In a similar manner, the developmental tasks of

adolescence—the establishment of an adult identity, developing a sense of autonomy from one's family, developing vocational goals, and stabilization of self-concept—have not received a great deal of attention from cognitive-behavioral researchers or clinicians. It is worth noting, however, that relationships between early attachment, adult attachment style, and interpersonal schemas have received an increasing amount of attention since we prepared the first edition of this book (Ingram, Miranda, & Segal, 1998; Randolph & Dykman, 1998; Reinecke & Rogers, 2001; Roberts, Gotlib, & Kassel, 1996; Whisman & McGarvey, 1995). It is worth acknowledging, as well, that recently developed approaches for treating depressed adults (Gotlib & Hammen, 1992) and youth (Curry & Reinecke, Chapter 5, this volume) explicitly attend to attachment security and its relationship to mood and adjustment.

There are a number of reasons why it may be important to adopt a developmental perspective when developing cognitive-behavioral models for treatment of youth. Childhood and adolescence are characterized by dramatic changes in social, cognitive, behavioral, affective, and physical abilities. Competencies developed in each of these domains serve as the foundation for effective functioning as an adult. Not surprisingly, failures in the development of these skills and competencies can place the child at risk for later behavioral and emotional problems. Childhood and adolescence can be viewed, then, as critical periods for the acquisition of adaptive skills and as a period when an individual's developmental trajectory can more readily be influenced.

Second, changes in cognitive, social, and affective competencies during childhood and adolescence influence the nature and frequency of behavioral, emotional, and social problems experienced. Important changes have been observed, for example, in the rates, symptom patterns, gender distribution, and course of behavioral and emotional difficulties over the course of development. Developmental changes also influence the ways in which we think about the adaptiveness (or maladaptiveness) of certain forms of behavior. Various fears (e.g., the dark, being left by a parent), for example, are relatively common during early childhood (and are seen as normal), but may be indicative of clinically significant anxiety at a later age. Similarly, heightened sensitivity to social rejection is relatively common among adolescents, and may serve an adaptive developmental function during this period. It may, however, be indicative of a clinically significant difficulty at another age. Any comprehensive model of child psychopathology must account for these developmental differences.

Third, it is important to attend to transactional relationships between cognitive and socioenvironmental risk and protective factors (Reinecke & DuBois, 2001). As we have noted, human behavior is multiply determined. Although something of a truism, this simple concept is often overlooked in the development of treatment strategies for children. A range of biological,

social, cognitive, and environmental factors are associated with risk for psychopathology during childhood and adolescence (Cicchetti & Cohen, 1995; Lenzenweger & Haugaard, 1996). Any comprehensive treatment cognitive-behavioral model must, as a consequence, attend to the full range of factors associated with vulnerability for psychopathology among youth and to the ways in which these factors interact over time.

With this in mind, adaptation during childhood and adolescence, and the acquisition of skills necessary for effective functioning as an adult, can best be viewed from a developmental-systems perspective (Mash & Dozois, 2003; Rutter, 1986). This viewpoint offers a useful paradigm for understanding risk for psychopathology within a broader framework of normative developmental processes (Cicchetti & Schneider-Rosen, 1986; Garber, Braafladt, & Zeman, 1991; Holmbeck et al., 2000). Emotional and behavioral development are influenced by a range of factors that cut across multiple systems that are both internal and external to the child (Mash & Dozois, 2003). Moreover, children develop in a number of contexts. Their behavioral and emotional adaptation, as well as the acquisition of affective, cognitive, social, and vocational skills, are influenced by their family, peers, school, and community. A developmental-systems perspective can be useful in allowing for an integrative and systematic understanding of the effects of individual-level characteristics of the child or adolescent and those that are socially or environmentally based (Reinecke & DuBois, 2001). Whereas an emphasis has been placed during recent years on understanding factors associated with cognitive vulnerability for psychopathology (Ingram et al., 1998; Ingram & Price, 2001), a developmental-systems perspective also directs attention toward factors that promote healthy functioning. Comprehensive cognitive-behavioral models should attend to moderator variables that serve to insulate or protect individuals from developing behavioral and emotional problems (Anthony & Cohler, 1987; Cicchetti & Garmezy, 1993; Compas, Hinden, & Gerhardt, 1995). These variables—referred to by such terms as invulnerability, resilience, competence, and protective factors—may play a particularly important role in the development of prevention programs.

In sum, a developmental psychopathology perspective allows us to address a number of important issues and observations that have not been addressed in the cognitive-behavioral treatment literature. Moreover, it highlights the importance of examining multiple interacting risk and protective factors during specific stages of life, as well as the manner in which they may be manifest in both internal and external sources of risk and resilience.

Insofar as emotional adaptation during childhood and adolescence is influenced by a range of social, environmental, biological, and cognitive factors, our understanding of psychopathology and treatment will be advanced if we attend to the ways in which these factors interact over time. As cognitive, social, behavioral, and affective skill acquisition occurs in a

developmental context, an emphasis should be placed on understanding normative development and the ways in which deviations from normal developmental processes influence adjustment.

Although robust evidence suggests that cognitive-behavioral interventions can be effective for treating affective and anxiety disorders among adults (including clinical depression, obsessive–compulsive disorder, panic, generalized anxiety disorder, and social anxiety), it is necessary to modify both our models and techniques before these approaches can be applied with youth. How can we know whether our models and interventions are "developmentally appropriate"? A few simple questions provide the answer:

- Does the model or intervention attend to age-related differences in the cognitive, behavioral, social, or emotional competencies of the child or adolescent?
- Does the model or intervention attend to the contexts in which the child or adolescent is functioning?
- Could the study be conducted with adults using the same design and measures? Could the same intervention be used with adults without modification?
- Does the model or intervention attend to vulnerability or protective factors?
- Are the constructs, variables, and measures used in the study relevant to understanding child development?

Research in developmental psychopathology provides a range of tools and constructs for understanding emotional and behavioral difficulties experienced by youth. These concepts—including developmental trajectories, multifinality, developmental tasks, and resilience—can provide useful insights into vulnerability for psychopathology among youth and may allow for the development of more effective treatments. This paradigm directs us, for example, to attend to the timing of stressful life events, the impact of multiple, concurrent traumatic events, and the long-term effects of stressful life events on adjustment. Similarly, it guides us to attend to the developmental needs and tasks of the child or adolescent (e.g., development of affect regulation skills, affiliation with peer group, autonomy from parents), the resources available in the family or environment to address these needs, and the ways in which these affect the child's mood and adjustment. Finally, it encourages us to consider the ways in which cognitive and socioenvironmental factors interact over time in contributing to risk for psychopathology. This perspective is not far removed, then, from contemporary cognitive diathesis–stress models of psychopathology (Clark & Beck, 1999; Gotlib & Hammen, 1992). Although important advances have been made during recent years in understanding cognitive vulnerability for psychopathology (Ingram & Price, 2001; Reinecke & Clark, 2003), the field of cognitive-behavioral therapy has not fully incorporated the broad range of developmental psychopathology findings and principles into its techniques and models.

Cognitive therapy is based on the assumption that behavioral and emotional difficulties stem from the activation of maladaptive beliefs, from the use of biased information-processing strategies, or from a lack of effective behavioral skills. Clinical work with children and adolescents requires that we attend to how these cognitive contents and processes develop, the social contexts in which they function, and their implications for functioning later in life. It is possible, from a developmental perspective, to view behavioral and emotional difficulties experienced by youth as stemming, at least in part, from failures in the management of normative developmental tasks, or from breakdowns in the development of essential competencies (including affect regulation, rational problem solving, and social skills).

FUTURE DIRECTIONS

Cognitive-behavioral therapy with children and adolescents has developed rapidly during the past 10–15 years. The models are compelling, and many of the interventions derived from these approaches have received empirical support. Our understanding of vulnerability for psychopathology, processes of change, treatment effectiveness, and prevention of psychopathology are growing quickly, and will be facilitated by an ever-closer integration of findings and approaches from the cognitive-behavioral therapy, developmental psychology, and developmental psychopathology literatures.

In order to address developmentally oriented questions, developmentally oriented research designs must be used. We would suggest that future research with children and adolescents should, whenever possible and appropriate, use longitudinal (rather than cross-sectional) designs. In this way developmental trajectories (for both clinical and nonclinical populations) can be followed such that causal relationships between cognitive, social, environmental, and biological variables can be better understood. Second, research designs should attend to both risk and resilience factors, and to the contexts in which development occurs. Particular attention should be given to identifying moderator and mediator variables, and to using statistical techniques that are appropriate for delineating their relationships with outcome variables. Third, it will be useful to examine adaptation at developmentally important transition points (e.g., puberty, transition to early adolescence, transition from adolescence to early adulthood), and the ways in which cognitive-behavioral psychotherapy influences psychosocial adjustment at these times. Finally, we would suggest using a broader range of outcome variables in studies of therapeutic outcome and process. Relatively

few studies, for example, have examined the development of schemas among children and adolescents, the stability of tacit beliefs over time and how they are influenced by the beliefs and attitudes of parents and peers, their relationships to broader indices of adaptation (most studies focus solely on their relationship to measures of mood, such as the Beck Depression Inventory), or their implications for adjustment during adulthood. Follow-up studies are critically important, not only to document the stability of therapeutic gains, but also to clarify the effects of our interventions on broader indicators of social and emotional functioning.

The Effectiveness of Cognitive-Behavioral Psychotherapy with Youth

Research completed over the past 20 years on the effectiveness of cognitive-behavioral treatments for behavioral and emotional difficulties among youth has been substantial and, for the most part, positive. Although the volume of this literature is modest in comparison with work completed on the treatment of adult disorders, it is nonetheless impressive and a number of tentative conclusions can be drawn. First, cognitive-behavioral interventions appear to do some good, at least for some problems and under some conditions. Controlled outcome studies suggest that cognitive-behavioral therapy is superior to no-treatment and to placebo controls for treating a range of affective, anxiety, and behavioral disorders among youth. The effect sizes observed in these studies are comparable to those observed in outcome research with adults, and gains often are maintained over time (Reinecke, Ryan, & DuBois, 1998; Weisz & Weiss, 1993). It is worth acknowledging, however, that the number of controlled outcome studies completed is relatively small, most have employed nonclinical samples, few have included viable alternative forms of treatment as a control, and few have examined the stability of treatment gains for more than a few weeks or months. Moreover, specific interventions may be more effective at different ages, and few dismantling studies have been completed examining which components of the treatment protocols are most closely associated with clinical improvement. Second, cognitively based interventions may be effective, at least in the short term, for preventing some forms of affective, anxiety, and behavioral disorders. Finally, cognitive-behavioral interventions appear to be effective in alleviating both internalizing and externalizing difficulties. A caveat is in order here, as well, in that cognitive-behavioral therapy does not appear to be indicated as a primary form of treatment for attention-deficit/hyperactivity disorder. It may, however, serve as a useful adjunct for other interventions.

What are the characteristics of effective forms of psychotherapy with youth? It is difficult, based upon a review of the empirical literature, to draw firm conclusions. Empirically supported forms of psychotherapy appear, however, to share a number of characteristics. They tend, for example, to be active and problem-focused, rather than nondirective and primarily supportive in nature. Second, they tend to emphasize the development of a parsimonious treatment rationale and to share this with the patient and his or her family. This serves at least three purposes: It provides a shared vocabulary for the therapist and the family to understand the child's difficulties; it allows for the development of specific treatment recommendations; and, as a consequence, it leads the child and caregivers to feel understood and provides them with a sense of hope. This is not a minor contribution insofar as the family often views the child's difficulties as inexplicable and feels powerless to rectify them. Third, effective treatments encourage action. They assist the child to develop specific adaptive skills, and support the child's caregivers and school officials in their efforts to alleviate stressors in the child's life, provide reliable and consistent support, and reinforce the child's adaptive efforts. Effective forms of psychotherapy also tend, as a group, to encourage the child (or parents) to monitor moods and behavior and to modify these efforts on the basis of feedback about which techniques have been most useful. Empirically supported treatment programs tend to include a psychoeducational component, and attempt to develop specific cognitive and behavioral skills. They tend, as well, to attend to the family or community context in which the child is developing. Finally, effective psychosocial interventions typically attend to the generalizability of treatment gains and take steps to prevent recurrence or relapse.

As the astute reader will note, many of these characteristics also describe other, noncognitive, forms of empirically supported psychotherapy (such as Interpersonal Psychotherapy; Mufson, Moreau, Weissman, & Klerman, 1993). We mention this as the processes of therapeutic change in psychotherapy with youth are not well understood. Alternative forms of psychotherapy may, in practice, be similar. Moreover, there may be multiple pathways to change. The mechanisms of change in short-term psychodynamic psychotherapy, for example, may differ from those in cognitive-behavioral therapy. Pathways to change in alternative forms of psychotherapy may or may not be similar. Finally, it is worth noting that controversies exist regarding the relative importance of nonspecific (e.g., trusting therapeutic rapport, warmth, genuineness) and theory-specific technical factors for therapeutic improvement, and the impact of patient, therapist, family, and community variables on short- and long-term outcome.

Looking Forward

This volume includes chapters addressing several of these issues and concerns. Anastopoulos and Gerrard (Chapter 2), for example, directly address

the fact that there is limited evidence for the efficacy of cognitive-behavioral therapy as a primary treatment of attention-deficit/hyperactivity disorder. They propose that it may be necessary to reconceptualize this disorder, and direct our attention to understanding factors associated with failures in the development of inhibitory controls among youth. Along similar lines, Curry and Reinecke (Chapter 5) propose a "modularized" treatment approach for adolescent depression based upon findings in the cognitive therapy and developmental psychopathology literatures. They propose that interventions can be tailored to the needs of individual patients based upon an understanding of specific cognitive and behavioral deficits maintaining their dysphoria. They suggest that attention should be paid to attachment style and the development of affect regulation skills, and have incorporated intervention strategies to address these issues into their program.

Several of our contributors borrow from the adult psychotherapy literature in developing treatment programs for children and adolescents. Bowers, Evans, LeGrange, and Andersen (Chapter 10), for example, describe how empirically supported treatment protocols developed by Fairburn for treating eating disorders among adults may be adapted for work with adolescents. They explicitly attend to developmental differences that may influence the nature and course of treatment. Albano (Chapter 6) proposes an innovative, integrated cognitive-behavioral program for treating social anxiety among youth, what has been referred to as the "neglected anxiety disorder," and Heflin and Deblinger (Chapter 9) describe the ways in which cognitive and behavioral principles can inform the treatment of posttraumatic stress disorder among youth.

Programmatic research plays a particularly important role in the development of cognitive-behavioral models and treatment programs. Extended and intensive lines of investigation allow models to be put to the test and facilitate the refinement of clinical techniques. Programmatic research into the psychopathology of externalizing behavior problems and anxiety serve as the basis for treatment programs for oppositional defiant disorder (Pardini & Lochman, Chapter 3) and obsessive–compulsive disorder (Franklin, Rynn, Foa, & March, Chapter 7).

This volume also includes several chapters applying cognitive-behavioral therapy to "nontraditional" problems. Patterson and O'Connell (Chapter 4), for example, describe a cognitive-behavioral approach for understanding and treating chemical dependence among adolescents, Bradley-Klug and Shapiro (Chapter 11) describe procedures for assisting youth with academic problems or learning disabilities, and Beebe and Risi (Chapter 14) propose that cognitive-behavioral principles can be used in developing treatment programs for high functioning autistic youth. Freeman and Rigby (Chapter 16) address a highly controversial issue—the diagnosis and treatment of personality disorders among youth. They suggest that developmental precursors of personality disorders can be identified among children and adolescents, and that cognitive-behavioral interventions may be useful in addressing these potentially serious clinical problems. These are challenging clinical concerns, and press the bounds of cognitive-behavioral practice with youth.

Several of our contributors attempt to redefine cognitive-behavioral models of psychopathology. Shirk, Burwell, and Harter (Chapter 8), for example, discuss the relationship of self-concept to psychopathology among youth, and outline how insights from research on self-esteem can inform and enhance cognitive-behavioral therapy. This is particularly important given the fact that self-concept is typically viewed as a dependent variable in cognitive-behavioral research, and the central importance of the self-schema in cognitive models of vulnerability to psychopathology. Along similar lines, DuBois (Chapter 15) elaborates upon his quadripartite model of social competence and describes how it may be applied in treating children and adolescents. These approaches are noteworthy in that they draw heavily on work in developmental psychology and developmental psychopathology, and attend to factors associated with resilience and positive adaptation among youth.

Finally, several of our contributors have developed treatment programs that touch upon and invigorate older lines of clinical practice. Epstein and Schlesinger (Chapter 12), for example, provide a comprehensive, systematic, and scholarly discussion of the ways that cognitive-behavioral approaches can be applied in family therapy; and Knell and Ruma (Chapter 13) discuss how traditional play therapy techniques can be incorporated into effective cognitive-behavioral treatment programs for school-age children.

CONCLUSION

Cognitive-behavioral therapy with children and adolescents is promising in that it explicitly recognizes the importance of cognitive, behavioral, affective, and social factors in the etiology and maintenance of behavioral and emotional disorders. It is consistent with contemporary integrationist and constructivist models of behavior change, and maintains the objective, empirical focus that is the hallmark of cognitive therapy with adults. Cognitive-behavioral therapy with children and adolescents is fundamentally similar, both in theory and in practice, to cognitive therapy with adults. It challenges these models, however, by requiring us to carefully attend to the interpersonal contexts in which children's beliefs, attitudes, competencies, and skills develop, as well as developmental factors associated with behavioral and emotional change and adaptation.

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