



[Updated 2015]

CH 3: Psychosocial interventions, treatment of emotional disorders. [Updated 2015]

SCOPING QUESTION: What is the effectiveness of psychosocial interventions, including caregiver skills training, for emotional disorders in children and adolescents?

BACKGROUND

Emotional (or internalizing) disorders are among the leading mental health-related causes of the global burden of disease in children below 10 years of age (Murray et al., 2010). Additionally, depression is the leading cause of illness and disability among youth. Emotional disorders form the largest group of mental disorders and are characterized by increased levels of anxiety, depression, fear and somatic symptoms (Goldberg et al., 2009).

The WHO mhGAP programme has existing guidance on caregiver skills training for emotional and behavioural disorders in children, which states that caregiver skills training should be considered for the treatment of emotional and behavioural disorders in children aged 0-7 years. The recommendation also states that these programmes should include the following features: Positive parent-child interactions and emotional communication; emphasis on the importance of time out and parenting consistency; discouragement of harsh punishments; and requiring parents to practice new skills with their children during parent training sessions. This kind of training can apply to all caregivers including parents and other family members or guardians who are raising a child or adolescent with an emotional disorder. The content should be culturally sensitive, but should not allow violation of children's basic human rights, according to internationally endorsed principles. Health care providers need additional training to be able to offer caregiver skills training.

Other well-studied interventions for emotional disorders include cognitive behavioural therapy (CBT) and interpersonal therapy (IPT). CBT is based on the idea that feelings are affected by thinking and behaviour. CBT typically has both a cognitive component (i.e., helping the person develop the ability to identify and challenge unrealistic negative thoughts) and a behavioural component. CBT is applied differently to different mental health problems and may be offered by trained and supervised non-specialized health workers. IPT is a psychological treatment designed to help a person identify and address problems in their relationships with family, friends, partners and other people. Trained and supervised non-specialized health workers may also offer IPT.

The current evidence profile will update the evidence and, if indicated, the recommendation, as well as provide guidance on appropriate psychosocial interventions other than caregiver skills training for children with emotional disorders. The current evidence profile provides an overview of the most recent meta-analyses examining the effectiveness of psychosocial interventions, including caregiver skills training for reducing symptoms in children and adolescents with emotional disorders. In addition, the evidence profile will also consider the effects of these interventions on secondary outcomes, such as school performance, family functioning, user and caregiver satisfaction, adverse effects and issues related to feasible implementation, if available.



[Updated 2015]

PART 1: EVIDENCE REVIEW

Population/ Intervention / Comparison / Outcome (PICO)

- **Population:** Children and adolescents with an identified emotional disorder
- **Interventions:** Psychosocial interventions, including caregiver skills training
- **Comparison:** Usual care or no treatment control
- **Outcomes:**
 - **Critical** – Symptom reduction, school performance, family functioning
 - **Important** – User and caregiver satisfaction, adverse effects of treatment

Search strategy

The meta-analyses included in the current review were identified using an electronic database search. This electronic search included the databases CINHAL, Cochrane Database, EMBASE, MEDLINE and PsychINFO. The search terms were developed to capture meta-analyses and systematic reviews examining psychosocial interventions for children with emotional disorders aged 0 – 18 years, including caregiver skills training interventions. Emotional disorders were defined in accordance with the ICD-10 (F93 – F94), with the resulting search terms including both specific disorders and reference to broader behaviours that are characteristic of emotional disorders, such as apprehension, depersonalizations or obsession. Boolean expressions were used within each database to capture relevant meta-analyses and systematic reviews.

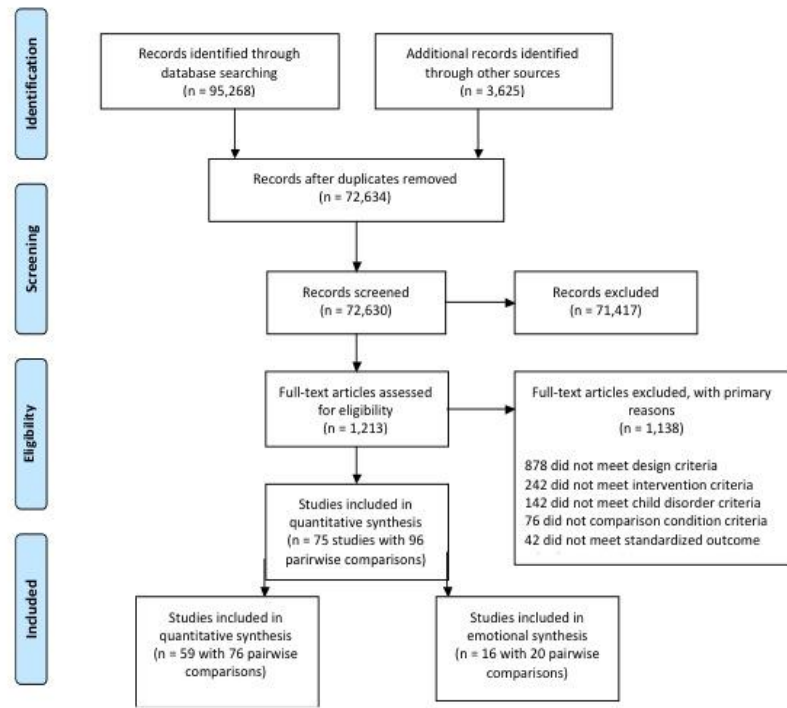
Each research database was searched with customized search terms. The generic search strategy included the following:

- (“depressive disorder” OR “anxiety disorder” OR “emotional dis*” OR “identity dis*” OR “overanxious dis*” OR “attachment dis*” OR “elective mutism” OR “selective mutism” OR “obsess*” OR “apprehensi*” OR “phobia” OR “depersonaliz*” OR “hypochondria*”) AND (“intervention” OR “therap*” OR “treatment*” OR “train*” OR “educat*” OR “program” OR “program” OR “counseling” OR “cognitive behavioral” OR “behavioral” OR “parent skills” OR “psychosocial” OR “psychotherapy”) AND (“child*” OR “youth” OR “student*” OR “adolescen*” OR “preschool” OR “school age*”) AND (“meta-analysis” OR “systematic review”)

The titles and abstracts for the returned citations were then reviewed and potentially relevant references retained for further examination to determine whether they would be included in the evidence profile. Meta-analyses were deemed eligible if they included studies examining the effects of a psychosocial intervention on the emotional outcomes of children aged 0 – 18 years. Psychosocial interventions were defined as any intervention that emphasizes psychological, behavioural or social factors rather than biological factors, such as pharmacotherapy. This criterion resulted in the exclusion of meta-analyses examining the effects of using psychosocial interventions as an adjunct to pharmacotherapies. Reviews including samples of students with additional risk factors (e.g., child abuse or disability characteristics) were not included in the present review. The primary outcome used in the meta-analysis needed to be drawn from a standardized post-test measure of behavioural functioning and represented

in a standardized mean difference (SMD) effect size. For meta-analyses reporting multiple outcomes, those based on broad domain scores (e.g., internalizing behaviour) were prioritized over those relating to specific constructs (e.g., depressive symptomology). Meta-analyses that aggregated measures of emotional constructs with behavioural constructs associated with the ICD-10 (F92 – F93) were not included in the review because these issues are dealt with separately in another portion of the document. However, the statistical summaries associated with each psychosocial intervention examined separately in a given review were included if applicable. The meta-analysis had to include studies that used prospective group designs such as randomized control trials (RCTs) or quasi-experimental designs with treatment as usual control groups. Finally, the meta-analysis had to be conducted within the past two years to ensure recommendations are based on the most recent research. The study selection process and results are summarized in Figure 1 below.

Figure 1. Study selection process and results



Included in GRADE tables or footnotes

- James AC, James G, Cowdrey FA, Soler A, Choke A (2013). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews*.6: CD004690. doi:10.1002/14651858.CD004690.pub3.
- Maggin DM, Johnson AH, Reichow B (2014). (Commissioned review)

Excluded from GRADE tables and footnotes

Review	Reason for Exclusion
Cox GR, Fisher CA, De Silva S, Phelan M, Akinwale OP, Simmons MB, et al. (2012). Interventions for preventing relapse and recurrence of a depressive disorder in children and adolescents. <i>Cochrane Database of Systematic Reviews</i> .11:CD007504. doi:10.1002/14651858.CD007504.pub2.	Includes pharmacotherapy as intervention and control conditions.
Hofmann SG, Asnaani A, Vonk IJ, Sawyer AT, Fang A (2012). The efficacy of cognitive behavioral therapy: a review of meta-analyses. <i>Cognitive Therapy and Research</i> .36(5):427-440. doi:10.1007/s10608-012-9476-1.	Both behavioural and emotional disorders were included.
Macdonald G, Higgins JPT, Ramchandani P, Valentine JC, Bronger LP, Klein P, O’Daniel R, Pickering M, Rademaker B, Richardson G, Taylor M (2012). Cognitive-behavioral interventions for children who have been sexually abused. <i>Cochrane Database of Systematic Reviews</i> . 5:CD001930. doi:10.1002/14651858.CD001930.pub3.	Population of interest was children with additive risk factor.
Malmberg L, Fenton M, Rathbone J (2012). Individual psychodynamic and psychoanalysis for schizophrenia and severe mental illness. <i>Cochrane Database of Systematic Reviews</i> .3: CD001360. doi:10.1002/14651858.CD001360.	Children were not the focus.
Parker B, Turner W (2013). Psychoanalytic/psychodynamic psychotherapy for children who have been sexually abused. <i>Cochrane Database of Systematic Reviews</i> .7:CD008162. doi:10.1002/14651858.CD008162.pub2.	Population of interest was children with additive risk factor.



[Updated 2015]

<p>Weisz JR, Kuppens S, Eckshtain D, Ugueto AM, Hawley KM, Jensen-Doss A (2013). Performance of evidence-based youth psychotherapies compared with usual clinical care: A multilevel meta-analysis. <i>Journal of the American Medical Association of Psychiatry</i>. 70(7):750-761. doi:10.1001/jamapsychiatry.2013.1176.</p>	<p>Both behavioural and emotional disorders were included.</p>
--	--

PICO Table

Population: Children and adolescents with emotional disorders					
Intervention	Comparison	Outcome	Systematic reviews used for GRADE	Justification for systematic review used	Relevant GRADE Table
Cognitive behavioural therapy	No treatment	Symptom reduction (condition remittance)	James et al. (2013)	The meta-analysis examined the effects of behavioural interventions and reported outcomes related to symptom reduction.	Table 1
		Symptom reduction	James et al. (2013)	The meta-analysis examined the effects of behavioural interventions and reported outcomes related to symptom reduction.	
		School performance	N/A		
		Family functioning (parenting skills)	N/A		
		Family functioning (parenting self-concept)	N/A		
		Family functioning (parent mental health)	N/A		
		User and caregiver satisfaction (attrition)	James et al. (2013)	The meta-analysis examined the effects of behavioural interventions and reported outcomes related to	



[Updated 2015]

				symptom reduction.	
		Adverse effects	N/A		
Caregiver skills training	No treatment or standard care	Symptom reduction (parent report)	Maggin et al. (not published)	The meta-analysis examined the effects of caregiver skills training programmes and reported outcomes related to symptom reduction.	Table 2
		Symptom reduction (child report)	Maggin et al. (not published)	The meta-analysis examined the effects of caregiver skills training programmes and reported outcomes related to symptom reduction.	
		School performance	N/A		
		Family functioning (parent skills)	Maggin et al. (not published)	The meta-analysis examined the effects of caregiver skills training programmes and reported outcomes related to symptom reduction.	
		Family functioning (parental mental health; stress)	Maggin et al. (not published)	The meta-analysis examined the effects of caregiver skills training programmes and reported outcomes related to symptom reduction.	
		User and caregiver satisfaction	N/A		
		Adverse effects	N/A		

Narrative description of the studies that went into analysis

The James et al. (2012)ⁱ review examined the following:

1. Whether CBT is an effective treatment for childhood and adolescent anxiety disorders in comparison with (a) wait-list controls; (b) active non-CBT treatments (i.e. psychological placebo, bibliotherapy and treatment as usual (TAU)); and (c) medication and the combination of medication and CBT versus placebo; and
2. The long-term effects of CBT.

Included in the analyses were 41 studies consisting of 1806 participants (age range 4-18 years). The studies involved children and adolescents with anxiety of mild to moderate severity, who attend university, community clinics and other school settings. For the primary outcome of remission of any anxiety diagnosis for CBT vs. waiting list controls, intention-to-treat (ITT) analyses with 26 studies and 1350 participants showed an odds ratio (OR) of 0.13 (95% confidence interval (CI) 0.09 to 0.19, $Z = 10.26$, $P < 0.0001$), but with evidence of moderate heterogeneity ($P = 0.04$, $I^2 = 33\%$). Moreover, the interventions were also found to lead to significant reductions in anxiety levels on standard measures (SMD -0.98 (95% CI -1.21 to -0.74)). The number needed to treat (NNT) was 6.0 (95% CI 7.5 to 4.6). No difference in outcome was noted between individual, group and family/parental formats. There were no secondary outcomes investigated in the review. ITT analyses revealed that CBT was no more effective than non-CBT active control treatments (six studies, 426 participants) or treatment as usual (TAU) in reducing anxiety diagnoses (two studies, 88 participants). The question whether CBT is superior to medication remains unclear, with only one study (Walkup, 2008) addressing this question. The few controlled follow-up studies ($n = 4$) indicate that treatment gains in the remission of anxiety diagnosis are not statistically significant.

There were no meta-analyses identified on the effects of caregiver skills training on emotional disorders for children and adolescents. As such, a systematic search for relevant studies was commissioned for this evidence profile (Maggin et al, unpublished data). The search identified 12 studies examining the effects of caregiver skills training on child emotional disorders that included 16 unique cohorts. All of these studies used an RCT with cohort response compared to passive controls, including waitlist and standard care. The disorders examined across the 16 cohorts included anxiety ($n = 11$), depression ($n = 2$), suicidality ($n = 1$) and internalizing problems broadly ($n = 3$). The mean age of the cohorts was 8.8 years and ranged from 3-16 years old. Moreover, the proportion of males included in the studies was 47%, with a range of 25-57%. A majority of the studies were conducted in high-income countries, including Australia ($n = 5$), Canada ($n = 1$), England ($n = 2$), Switzerland ($n = 1$) and the United States of America ($n = 2$). There was one study conducted in Hong Kong ($n = 1$). The interventions examined used parent-based psychoeducation ($n = 2$), family-based psychoeducation ($n = 2$), parent-delivered cognitive-behavioural interventions ($n = 4$), family-based cognitive behavioural interventions ($n = 3$) and play-based therapy ($n = 1$). There was a range of primary and secondary outcomes investigated across the studies, although only few studies reported findings for the secondary outcomes. Results for the primary outcome of reductions of symptoms in child emotional disorders indicated generally positive results across cohorts. Specifically, these positive effects (indicated by negative values representing symptom reduction) were found for parent reported outcomes on broad dimensions of emotional disorders ($n = 12$; SMD = -0.30; 95% CI = -0.51 to -0.09) and child reported



[Updated 2015]

outcomes ($n = 11$; SMD = $-.56$; 95% CI = -0.93 to -0.22). Results on secondary outcomes were showed positive effects found for parental stress ($n = 3$; SMD = $-.57$; 95% CI = -0.91 to -0.25).

GRADE Tables

Table 1. Cognitive behavioural therapy vs. controls for emotional disorders

Authors: D Maggin and C Servelli

Question: Is cognitive behavioural therapy effective for the treatment of emotional disorders in children and adolescents compared to controls?

Bibliography: James AC, James G, Cowdrey FA, Soler A, Choke A (2013). Cognitive behavioural therapy for anxiety disorders in children and adolescents. Cochrane Database of Systematic Reviews.6: CD004690. doi:10.1002/14651858.CD004690.pub3.

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Cognitive behavioral therapy	Control	Relative (95% CI)	Absolute		
Symptom reduction (condition remittance)												
26	Randomized trials	Serious ¹	No serious inconsistency	Serious ²	No serious imprecision	None	332/808 (41.1%)	455/542 (83.9%)	OR 0.13 (0.09 to 0.19)	730 fewer per 1000 (from 680 fewer to 764 fewer)	⊕⊕○○ LOW	CRITICAL
								0%		-		
Symptom reduction (better indicated by lower values)												
30	Randomized trials	Serious ¹	Serious ³	Serious ²	No serious imprecision	None	772	622	-	SMD 0.98 lower (0.74 to 1.21 lower)	⊕○○○ VERY LOW	CRITICAL
School performance												
0	No evidence available					None	-	-	-	-		IMPORTANT
								0%		-		
Caregiver functioning (parenting skills)												
0	No evidence available					None	-	-	-	-		IMPORTANT
								0%		-		
Caregiver functioning (mental health)												
0	No evidence available					None	-	-	-	-		IMPORTANT
								0%		-		
Family functioning												
0	No evidence available					None	-	-	-	-		IMPORTANT
								0%		-		

Caregiver satisfaction												
0	No evidence available					None	-	-	-	-		IMPORTANT
								0%		-		
Adverse effects												
26	Randomized trials	Serious ¹	No serious inconsistency	Serious ²	No serious imprecision	None	82/756 (10.8%)	56/541 (10.4%)	OR 0.93 (0.58 to 1.51)	7 fewer per 1000 (from 41 fewer to 45 more)	⊕⊕⊕ LOW	IMPORTANT
								0%		-		

¹ James et al. (2013) reported a low risk of bias for attrition, but the primary outcome variable was not masked.

² No studies conducted in low- and middle-income countries (LAMIC).

³ James et al. (2013) reported an I² value of approximately 70%, indicating high levels of heterogeneity.

Table 2. Caregiver skills training vs. controls for emotional disorders

Authors: D Maggin and C Servili

Question: Is caregiver skills training effective for treatment of emotional disorders in children and adolescents compared to controls?

Bibliography: Maggin DM, Johnson AH, Reichow B (2014). (Commissioned review)

Quality assessment							No. of patients		Effect		Quality	Importance
No. of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Caregiver skills training	Control	Relative (95% CI)	Absolute		
Symptom reduction (measured with parent report; better indicated by lower values)												
12	Randomized trials	Very serious ¹	Serious ²	No serious indirectness	No serious imprecision	None	362	354	-	SMD -0.28 lower (0.44 lower to 0.13 lower)	⊕⊕⊕ VERY LOW	CRITICAL
Symptom Reduction (measured with child self-report; better indicated by lower values)												
11	Randomized trials	Very serious ³	Serious ⁴	No serious indirectness	No serious imprecision	None	296	317	-	SMD -0.56 lower (0.93 lower to 0.22 lower)	⊕⊕⊕ VERY LOW	CRITICAL
School performance												
0	No evidence available					None	-	-	-	-		



[Updated 2015]

Family functioning (caregiver stress; better indicated by lower values)												
3	Randomized trials	Very serious ⁷	No serious inconsistency	No serious indirectness	Serious	None	402	328	-	SMD -0.58 lower (0.91 to 0.25 lower)	⊕○○○ VERY LOW	IMPORTANT
Family stress												
0	No evidence available					None			-	-		
Caregiver satisfaction												
0	No evidence available					None			-	-		
Adverse effects												
0	No evidence available					None			-	-		

¹ More than 30% of the trials did not use a masked outcome measure.

² The I² was 52% for the analysis.

³ More than 30% of the trials did not use a masked outcome.

⁴ The I² was 76% indicating high levels of variability.

⁵ More than 30% of trials used an unmasked outcome variable.

⁶ No explanation was provided.

⁷ More than 30% of trials used an unmasked outcome variable.

Results of the new meta-analysis

Figure 2. Outcome 1: Symptom reduction (child self-report)

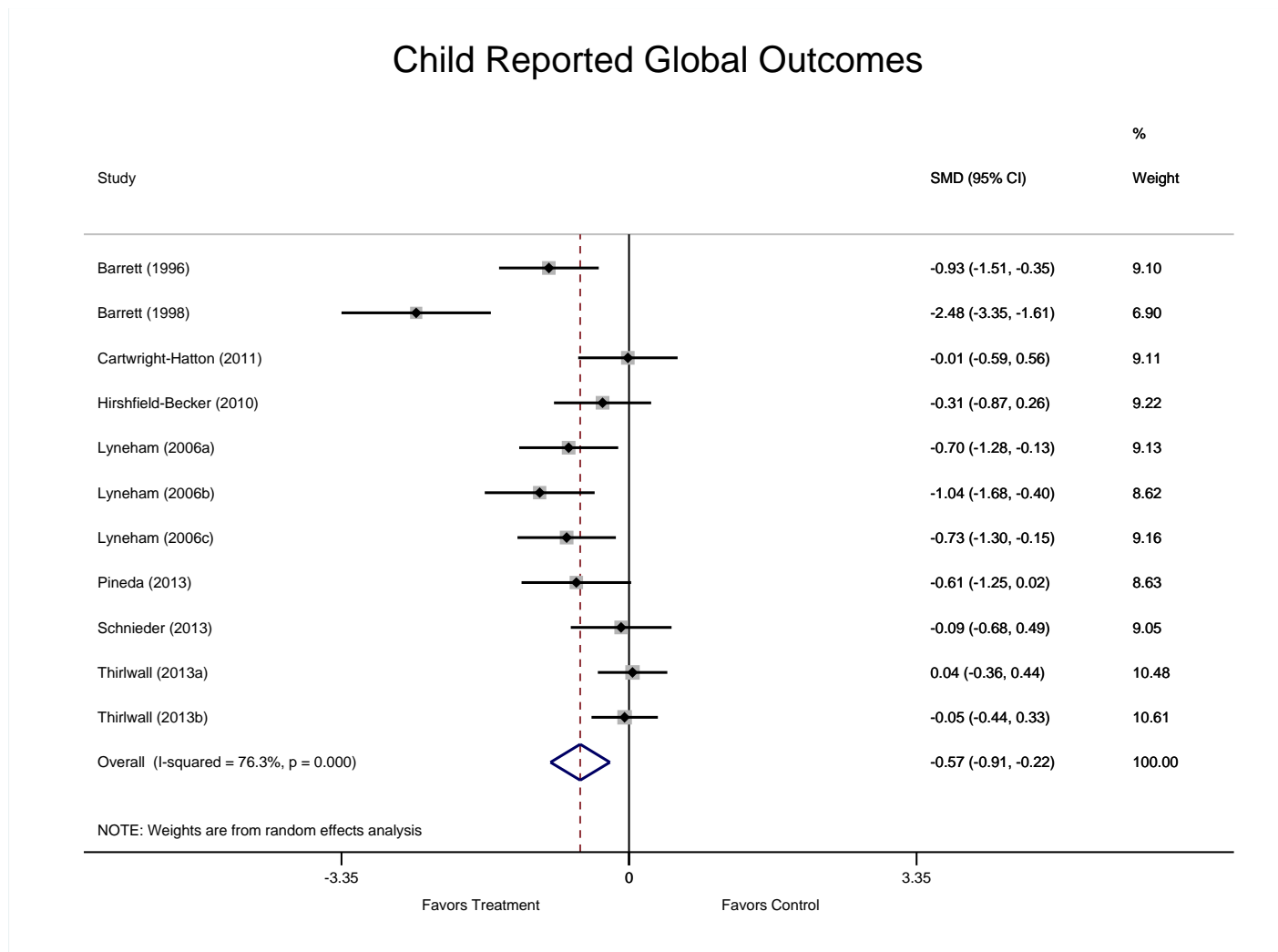
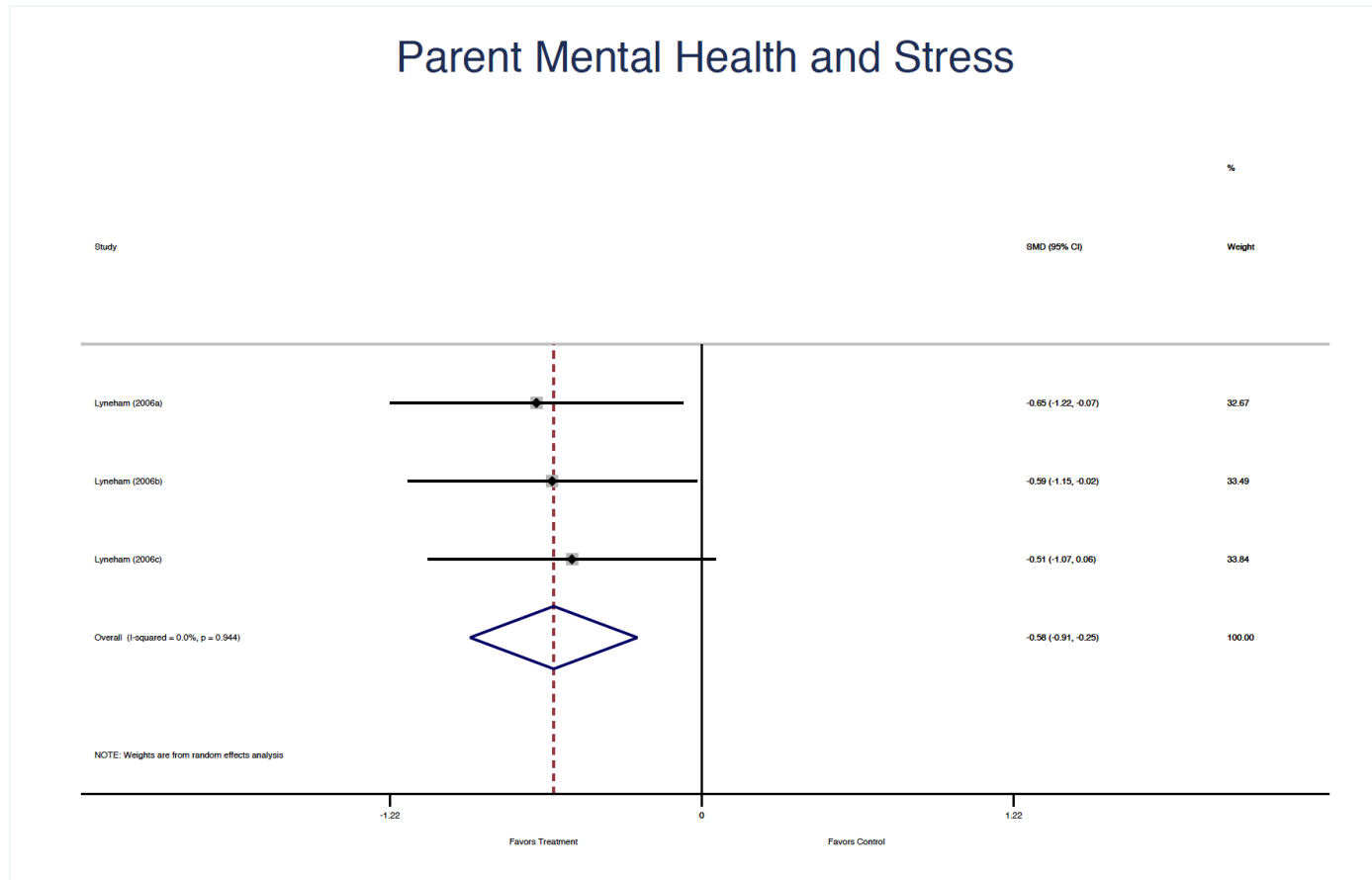


Figure 4. Outcome 3: Caregiver mental health and stress





[Updated 2015]

Additional evidence not mentioned in GRADE tables

Reynolds S, Wilson C, Austin J, Hooper L (2012). Effects of psychotherapy for anxiety in children and adolescents: A meta-analytic review. *Clinical Psychology Review*. 32(4):251-262. doi:10.1016/j.cpr.2012.01.005.

The Reynolds et al. (2012) review had the following aims:

1. Provide a comprehensive meta-analytic review of high quality randomized controlled trials of psychological treatments for anxiety disorders in children and adolescents and examine the effect size of cognitive behavioural treatments and other psychological treatments;
2. Compare the effectiveness of generic anxiety treatments with disorder-specific treatments for anxiety disorders;
3. Examine the effect of child age on effectiveness of treatment; and
4. Assess the effect of strategies of treatment delivery on outcome.

The review identified 55 RCTs in which children and/or adolescents with anxiety were treated using a psychological therapy. Study quality was assessed. Results indicated that the studies were of moderate quality. However, the authors noted that adverse effects were only considered in one study. Across all studies, 2434 children and young people were included in the treatment group and 1824 children and young people were included in the control group, with an age range of 2-18 years and a proportion of girls of 54%. The majority of studies ($n=33$) recruited children and young people with a specific anxiety disorder (16 post-traumatic stress disorder [PTSD], 7 social phobia, 5 obsessive compulsive disorder [OCD], 3 specific phobias and 2 school-related anxiety), with the rest of the studies recruiting children with a variety of anxiety disorders. Co-morbidity of anxiety disorders was typical.

There were 45 studies evaluating CBT, with the remaining seven studies evaluating eye movement desensitization and reprocessing (EMDR) ($n=3$), a psychosocial intervention ($n=1$), narrative therapy ($n=1$) and trauma specific psychotherapy ($n=2$). Quality ratings of the studies ranged from 19.5-43 (mean=29.9, SD=5.19), using a quality coding scheme developed specifically for evaluating anxiety and depression interventions. Results indicated that psychological interventions as a whole had a positive effect on child anxiety levels ($k = 39$; SMD = $-.76$; 95% CI= $-.55$ to $-.97$) and that cognitive-behavioural therapies, specifically, resulted in reduced levels of anxiety ($k = 34$; SMD = $-.77$; 95% CI = $-.55$ to -1.00). The effect size for psychological therapy (which was not a variant of CBT) was not significant. The effect size of psychological treatment for adolescents with anxiety was large and the effect size of treatment of children (i.e., less than 13 years of age) was small to medium. There were minimal differences in the effectiveness of treatment with- and without parental involvement. The effect size for group CBT was medium and the effect size for individual CBT was large. Treatments of 1-4 hours had a non-significant effect size. The effect size for treatments of 5-8 hours was small and statistically significant. The effect size for treatments of more than 9 hours was moderate to large.

Weisz JR, Kuppens S, Eckshtain D, Ugueto AM, Hawley KM, Jensen-Doss A (2013). Performance of evidence-based youth psychotherapies compared with usual clinical care: A multilevel meta-analysis. *Journal of the American Medical Association Psychiatry*. 70(7):750-761. doi:10.1001/jamapsychiatry.2013.1176.

Weisz et al. (2013) conducted a meta-analysis of 52 RCTs (including seven unpublished studies) of psychological interventions compared to standard care for emotional and behavioural disorders in over 5000 children, with a mean age of 12.6 years (SD = 2.8). Psychosocial treatments in this review included a broad array of psychological interventions, including CBT, individual psychotherapy and family therapy. Treatment length had a range of 8-76 weeks, with a mean of 30.9 weeks (SD = 18.7). There were 42 trials conducted in North America. The study locations for the other nine trials were not provided, but there was no mention of trials in LAMIC. The overall pooled mean across all studies was $d = 0.29$ (95% CI 0.19 to 0.38), which is a pooled estimate across both behavioural and emotional disorders. Subgroup analyses showed that 14 studies examined internalizing target problems (e.g., depression, anxiety) and the pooled effect size for just these studies was $d = 0.30$ (95% CI 0.13 to 0.48). Subgroup analyses did not show a significant difference between externalizing and internalizing conditions.

PART 2: FROM EVIDENCE TO RECOMMENDATIONS

Summary of evidence table

<u>Outcome</u>	Intervention	
	Behavioural and cognitive-behavioural therapies <i>(Number of studies, SMD or OR [95% CI], quality)</i>	Caregiver skills training <i>(Number of studies, SMD or OR [95% CI], quality)</i>
Symptom reduction	30 studies, SMD -0.98 (-1.21 to -0.74) In favour of behavioural and cognitive behavioural interventions, LOW quality	12 studies. SMD -0.30 (-0.51 to -0.09) In favour of caregiver skills training, VERY LOW quality
Condition remittance	26 studies, OR 0.13 (0.09 to 0.19) In favour of behavioural and cognitive behavioural	N/A



[Updated 2015]

	interventions, MODERATE quality	
Symptom reduction (child self-report)	N/A	11 studies, SMD -0.56 (-0.93 to -0.22) In favour of caregiver skills training, VERY LOW quality
School performance	N/A	N/A
Parenting skills	N/A	N/A
Parent mental health (stress)	N/A	8 studies, SMD 0.57 (95% CI 0.25 to 0.91) In favour of caregiver skills training, LOW quality
Family stress	N/A	N/A
Caregiver skills	N/A	N/A
User or caregiver satisfaction	N/A	N/A
Adverse effects	26 studies, OR 0.93 (0.58 to 1.51) No statistically significant difference, LOW quality	N/A

Evidence to recommendation table

Benefits	<p>For children with emotional disorders, there is low quality evidence that behavioural and cognitive behavioural interventions can lead to disorder remission, as well as very low quality evidence of symptom reduction. Evidence of benefit of psychosocial intervention for internalizing conditions was also shown in the Weisz et al. (2013) review; therefore, it is likely that this treatment is effective for more conditions than just anxiety, including depression. Weisz et al. (2013) also provides evidence for other types of psychosocial interventions other than CBT, including psychotherapy and family therapy.</p> <p>For children with emotional disorders whose caregivers receive caregiver skills training, there is very low quality evidence of symptom reduction, as reported by both parents and children. For caregivers of children with emotional disorders who participate in caregiver skills training programmes, there is low quality evidence of reduction in caregiver stress.</p>
-----------------	---



[Updated 2015]

Harms	None of the reviews provided examine potential harms, such as additional monetary, psychological or familial burdens associated with participation in cognitive-behavioural therapy, psychodynamic therapy or caregiver skills training programmes. Meta-analysis of James et al. (2013) reported even rates of attrition between treatment and control conditions, suggesting limited adverse events and treatment acceptability.
Summary of the quality of evidence	The quality of the evidence is low.

Value and preferences	
In favour	<p>Given the significant disease and disability burden of emotional disorders in children and adolescents and safety concerns over the use of pharmacological treatment in this population, making available effective psychological interventions is of paramount importance.</p> <p>Equipping children with skills to cope with stressful experiences and improving caregiving skills has value beyond the immediate reduction of children's emotional symptoms.</p> <p>Caregiver involvement has unique value, in that it may possibly address the ongoing environmental stressors (e.g., caregiver mental health) that play a role in the development and maintenance of symptoms among children with emotional disorders.</p>
Against	<p>CBTs are often complex and appear to be rooted most strongly in a particular individual-centred view of life.</p> <p>Participation in treatment programs labelled for children with emotional disorders may expose children and their families to stigma and discrimination.</p>



[Updated 2015]

Uncertainty or variability?	Cultural and family preferences vary in different settings and could affect participation in treatment programs because of potential stigmatization or discrimination
Feasibility (including resource use considerations)	<p>Psychological treatment is a human resource-intensive intervention because it requires substantial provider time, training and supervision. Psychological treatments are also diverse in their complexity. Nonetheless, there is evidence available supporting the effectiveness of relatively brief CBT treatment for reducing symptoms in children and adolescents with emotional disorders (between 5-8 hours) (Reynolds et al., 2012).</p> <p>Furthermore, based on the moderator analysis outlined in James et al. (2013), the format for delivery of the intervention (i.e., group vs. individual) does not appear to affect treatment outcome. The feasibility of providing behavioural interventions and caregiver skills training in primary health care settings depends on the availability of human resources for training and delivery of interventions, as well as on the availability of supportive supervision.</p> <p>There is some uncertainty as to whether younger children can benefit from CBT, which requires a minimum level of cognitive maturity to participate in the treatment. A recent study (Hirshfeld-Becker et al., 2010) found positive effects in children younger than 6 years. It is likely that children respond more to the behavioural elements of CBT, rather than to the cognitive elements, with parental involvement as a critical element.</p>
Uncertainty or variability?	Feasibility depends on local resources, as well as the choice and format of the psychosocial treatment offered.



[Updated 2015]

Recommendation and remarks

Recommendation

Psychological interventions, such as cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) for children and adolescents with emotional disorders, and caregiver skills training focused on their caregivers, may be offered for the treatment of emotional disorders.

Rationale: For children with emotional disorders, there is low quality evidence that behavioural and cognitive behavioural interventions can lead to symptom reduction and disorder remission. There were no adverse outcomes reported, in terms of additional psychological or familial burdens associated with participation in these interventions. Feasibility depends on local resources, as well as the choice and format of the psychosocial treatment offered.

Remarks

The choice of psychological intervention and how it is implemented should be based on the type of emotional problem(s) and the age and developmental stage of the child or adolescent. The child or adolescent's family should be involved in the intervention, whenever appropriate. The content should be culturally sensitive and should not allow violation of the child or adolescent's basic human rights according to internationally endorsed principles.

The social environment, family context, and other psychosocial and physical risk factors that may be contributing to or exacerbating the emotional disorder should be considered and addressed.



[Updated 2015]

Judgements about the strength of a recommendation

Factor	Decision
Quality of the evidence	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Low <input type="checkbox"/> Very low
Balance of benefits versus harms	<input checked="" type="checkbox"/> Benefits clearly outweigh harms <input type="checkbox"/> Benefits and harms are balanced <input type="checkbox"/> Potential harms clearly outweigh potential benefits
Values and preferences	<input type="checkbox"/> No major variability <input checked="" type="checkbox"/> Major variability
Resource use	<input type="checkbox"/> Less resource-intensive <input checked="" type="checkbox"/> More resource-intensive
Others (Acceptability/Feasibility/Equity/Accessibility)	<p>The provision of psychosocial treatments for emotional disorders in children and adolescents, while resource-intensive, generally has greater acceptability and less risk of harm than other forms of treatment, such as medications.</p> <p>There is greater equity in offering psychosocial treatments to children and adolescents, who may otherwise receive no treatment.</p>
Strength	CONDITIONAL



[Updated 2015]

OTHER REFERENCES

Goldberg DP, Krueger RF, Andrews G, Hobbs MJ (2009). Emotional disorders: cluster 4 of the proposed meta-structure for DSM-V and ICD-11. *Psychological Medicine*.39(12):2043-2059. doi:10.1017/S0033291709990298.

Hirshfeld-Becker DR, Masek B, Henin A, Blakely LR, Pollock-Wurman RA, McQuade J, DePetrillo L, Briesch J, Ollendick TH, Rosenblum JF, Biederman J (2010). Cognitive behavioral therapy for 4- to 7-year-old children with anxiety disorders: a randomized clinical trial. *Journal of Consulting and Clinical Psychology*.78(4):498-510. doi:10.1037/a0019055.

Murray CJ, Vos T, Lozano R, Naghavi M, Flaxman AD, Michaud C et al. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*.380(9859):2197-223. doi:[http://dx.doi.org/10.1016/S0140-6736\(12\)61689-4](http://dx.doi.org/10.1016/S0140-6736(12)61689-4).
