Evidence-based psychosocial treatments for children and adolescents with disruptive behavior

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CRD summary
This review identified 16 evidence-based psychosocial treatments for child and adolescent disruptive behaviour based on established criteria: one was considered to be well-established and 15 to be probably efficacious. These conclusions are difficult to evaluate based on the presented information and may not be reliable.

Authors' objectives
To review evidence-based psychosocial treatments for children and adolescents with disruptive behaviour and update an earlier review.

Searching
MEDLINE and PsycINFO were searched from January 1996 (search terms reported). Relevant edited texts were scanned and additional searches were carried out for all treatments included in the original review (see Other Publications of Related Interest). Where additional treatments were identified, specific searches were carried out to check for earlier studies. The original review covered the literature up to 1995 by searching for studies identified via listings of empirical research collated by The Clinical Psychologist and examining four previous meta-analyses of various psychotherapy interventions for children covering studies published up to 1993. Handsearching and unspecified database searches were carried out to identify literature from 1993 to 1995. Only studies published in peer-reviewed journals were included (dissertations and book chapters were excluded).

Study selection
Prospective randomised controlled trials (RCTs) that compared any psychosocial intervention for children or adolescents with disruptive behaviour (as defined in the DSM-IV) with an appropriate control treatment or condition were eligible for inclusion. Studies had to report reliable measures of disruptive behaviour and meet other quality criteria (report specified sample characteristics, clearly describe statistical methods, clearly define treatment protocol or manual for the intervention and provide assurance of treatment fidelity).

The review identified 16 different treatments. Controls included no treatment, wait-list, systems family therapy, usual care, bibliotherapy, community services, relationship therapy and parent management training. Included studies reported outcomes using a mixture of direct observation, official records and report by parent, caregiver, peer, self or teacher. The age of participants ranged from 3 to 17 years.

The authors did not state how the papers were selected for the review, or how many reviewers performed the selection.

Assessment of study quality
Validity assessment formed part of the study selection process as described in Study Selection. The criteria were based on recommendations by Chambless to ensure that only well-conducted studies were considered. The authors did not report how the validity assessment was performed.

Data extraction
Included studies counted as providing supportive evidence if the paper reported superiority of the treatment on at least 50 per cent of the disruptive behaviour outcome measures. Post-treatment between group-effect sizes and p-values were extracted for each included study. The authors reported neither how the data were extracted for the review nor how many reviewers performed the data extraction.

Methods of synthesis
Studies were grouped according to the treatment they evaluated. The content of each intervention was described. Based on the available evidence each treatment was then judged to be well-established or probably efficacious according to task force classification criteria. To qualify for a well-established judgement a treatment was required to have been
evaluated favourably by at least two good between-group experiments comparing active intervention with placebo or another established treatment. Probably efficacious treatment was judged to have been met when two good between-group studies showed superiority of the active treatment in comparison with a wait-list control. Further subdivisions of this grading system are detailed in the original publication.

Results of the review
A total of 28 studies were included in this review (sample size ranged from six to 75 for participants completing target treatment). All included studies were prospective in design. Sixteen interventions were identified: one was judged to be well-established and the remaining 15 to be probably efficacious. Some treatments in the original review were reclassified.

Fifteen interventions were judged to be probably efficacious: Anger Control Training; Group Assertive Training (Counselor and Peer led); Helping the Noncompliant Child; Incredible Years (two versions); Multidimensional Treatment Foster Care; Multisystemic Therapy; Parent-Child Interaction Therapy; Problem-Solving Skills Training (three versions); Rational Emotive Mental Health Program; and Triple P (two versions). All were supported by two studies which met the criteria for well conducted and provided significant outcomes in favour of the active intervention.

The only intervention judged to be well-established was the Parent Management Training Oregon Model based on two studies conducted by independent research teams.

An additional six interventions were judged to be possible efficacious (lower level of evidence) and were supported by a single trial comparing the active treatment with a wait-list control.

Authors’ conclusions
This review identified 16 evidence-based psychosocial treatments for child and adolescent disruptive behaviour based on established criteria: one was considered to be well established and 15 to be probably efficacious.

CRD commentary
The original and updated review addressed a broad question. The searches from the original review were used as a basis for the update, but these had not been fully reported and so it was difficult to assess how comprehensive the original searches were. The updated search included several relevant sources. Unpublished studies were excluded explicitly, which is likely to have introduced publication bias. Only RCTs meeting minimum specified quality criteria were included. The review methodology was poorly reported, so reviewer-related error/bias could not be ruled out.

The country or setting of the studies was not reported or taken into account (presumably the cultural context could have implications for the effectiveness or implementation of particular interventions). With this kind of complex, broad review it can be difficult to separate out the active and control conditions. In at least one included study, the control condition appears to match one other active intervention, which could lead to confounding of the results.

The narrative synthesis may have been appropriate, but relatively few details of the primary studies' outcomes were reported and so findings reported in the review could not be verified. A more quantitative synthesis may have been more informative. In addition, the methods used to classify the evidence level of studies were only based on positive results. For example, four studies evaluated the intervention judged to be well-established but only two of the studies reported positive outcomes in over 50 per cent of measures and the other two studies reported positive outcome in less than 50 per cent of outcomes. In addition, sample sizes were small (for example, the two positive studies for the well-established intervention included 22 patients).

Lack of reporting of review methods, inadequate information about results data from individual studies, small sample sizes and a focus on studies reporting positive results mean that the authors’ conclusions may not be reliable.

Implications of the review for practice and research
Practice: The authors stated that this review provided support for parent-training programmes in young children and child-training approaches in older children. It was important once an intervention had been selected to maintain treatment integrity by following the relevant guidelines.

Research: The authors recommended that despite ethical and other problems with randomised controlled follow-up
studies in this area, continued assessment of disruptive behaviour over time after treatment was important to demonstrate the lasting effects of evidence-based psychosocial treatments. Replication studies for most interventions were needed and future studies should aim to compare active interventions.

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