Commentary: A refresh for evidence based psychological therapies – reflections on Marchette and Weisz (2017)

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Is the introduction of evidence-based psychotherapy into mainstream child and adolescent mental health services (CAMHS) a breakthrough for a scientific approach to child mental health? Or are we still in the dark ages despite our best efforts to link evidence with practice (EBP)?

Marchette and Weisz (2017) review three treatment strategies that have the potential to establish a pattern of clinical practice that would allow the discoveries of a rigorous developmental science to inform the average practitioner's work with their routine caseloads. Their review suggests that this can be achieved in a manner that does justice to the concerns of children, young people and their families, at the same time as enabling us to claim that our clinical work is genuinely informed by our scientific understanding of mental disorder and its treatment.

What have been the barriers to implementing evidence-informed practice in CAMHS? Marchette and Weisz identify the key as the mismatch of evidence-based protocols focused on the diagnostic categories of ICD or DSM with the complex and heterogeneous presentations practitioners actually encounter. Their review highlights the problem of comorbidity, the need for flexibility and shifts in focus throughout the course of treatment and, perhaps most importantly, the impracticality of implementing an idealised model of care in the context of overwhelming caseloads and the large number of complicating contextual factors encountered in the consulting room.

Marchette and Weisz advocate a departure from focal linear treatment protocols designed for singular diagnoses and propose the adoption of one of a number of transdiagnostic approaches that enable clinicians simultaneously to address the needs of individuals and to provide the structured framework of manualised therapy which we know even experienced therapists require [1].

Transdiagnostic treatments offer a single protocol to address multiple diagnoses. Why is this necessary? The obvious reason, stressed by Marchette and Weisz, is the so-called comorbidity or more precisely co-occurrence of mental disorders. Practitioners hardly need reminding. Most clinical CAMHS surveys identify an average of 2-4 diagnoses in this population. Recent factor analytic approaches to understanding the hierarchical structure of psychopathology have confirmed the three well known transdiagnostic group or spectral factors: internalising, externalising and thought disorder e.g. [2]. The observation that these factors are themselves correlated has recently inspired a series of studies that have investigated both group-specific and general sources of covariance across all symptoms using bi-factor modelling techniques. This emerging body of literature has repeatedly identified a general distress factor, often dubbed 'the p-factor', which captures the degree to which individuals tend to experience any and all mental health disorders as comorbid. This finding has been replicated

across child and adolescent populations [3], including in longitudinal studies where the p-factor turned out to be the best predictor of persistent mental health problems [4]. The consistent difficulty in identifying substantial differences between well-structured but conceptually incompatible models of therapy for particular diagnoses has traditionally been attributed to 'common factors' between therapies. However, it may be more closely linked to the way that all effective therapies are called upon to address an underlying general distress factor, which may need to be approached differently given differences between patients at spectral or diagnostic level.

We believe that Marchette and Weisz's delineation of transdiagnostic therapeutic approaches should be considered against this backdrop. The effective dissemination of evidence-based practice can readily be seen to benefit from a strategy creating a unified model that addresses a dysfunction core to a range of specific manifestations – the approach adopted by Barlow and colleagues. Alternatively, addressing multiple forms of psychopathology by either focusing on core principles of change as Weisz suggests or selecting from therapeutic procedures commonly used for each as Chorpita has proposed appear to outperform traditional models of EBP in efficiency and effectiveness. The trans-diagnostic approach is likely to be efficacious and has consistently been demonstrated to be more suitable for clinical implementation than a mixture of focal therapies when applied to community clinical practice.

Is the effectiveness of the transdiagnostic approach simply due to the practical advantages? Marchette and Weisz are persuasive about these. They share (unusually for treatment developers) the invaluable lessons from implementation that could facilitate the dissemination and generalisation of the transdiagnostic approach. We rely on such lessons as we do not know which service design most effectively enables prompt assessment and intervention for the large numbers of children with mental health disorders, since RCTs to examine service designs have not been conducted [5]. One of the practical advantages of approaches such as MATCH and FIRST is that they inevitably initiate a "meta-dialogue" between patient and therapist, that is, talking about preferences and choices entailed in the therapy (its acceptability, effectiveness, etc.) in addition to talking in the therapy. This enhances the patient's agency and modelling and shapes a therapist–patient relationship based on genuine curiosity about the patient's experience of the therapist and the therapy. Further, as evidence of effectiveness is collected as part of the clinical process and decision making, outcomes, collected systematically, often session by session, can put youths in charge of their own treatment as well as ensuring compliance with the principles of evidence-based practice. Marchette and Weisz place training at the fulcrum of implementation. It is hard not to agree. It follows from what we understand about the epidemiology of childhood and adolescent mental disorders, and particularly the problem of comorbidity, that evidence-based psychotherapy services need to be organized around the competencies of clinical staff. A critical advantage of the approach advocated by Marchette and Weisz is that while high fidelity to focal protocols in principle enables us to know exactly what has been delivered and evaluated, it makes uptake by practicing clinicians in community settings difficult. This problem is compounded by the increasing

commercialization of manualized psychological interventions, which makes some evidence-based treatments prohibitively expensive for services to adopt.

The flexibility which models such as MATCH or FIRST offer at a pragmatic level also brings advantages in terms of enabling clinicians to adapt the common core of evidence-based intervention strategies to the idiosyncratic but more peripheral constellation of presenting problems that could distract and deflect a structured intervention from the core set of dysfunctions that create a general vulnerability. Part of the strength of such models when properly utilised is that they require careful assessment and attention to the particular individual manifestations of disorder in order to address the underlying general vulnerability as effectively as possible.

There is a further area of conceptual interest that is directly relevant to Marchette and Weisz's description of transdiagnostic interventions. If we assume that transdiagnostic interventions are more efficacious than focal ones, we are left with a so far unanswered question about why, beyond the pragmatic advantages, this might be the case. The scientific discoveries around the p-factor may be of help here. The advantage of the transdiagnostic approach could arise because it addresses a common underlying general factor of vulnerability that plays a causal role in the emergence of mental disorder. Can we offer some speculative considerations?

The nature of the p-factor could be a reflection of a single underlying source of vulnerability such as an executive system dysfunction. For example, an imaging study of the 1,600 Philadelphia Neuro-developmental Cohort [6] showed that overall psychopathology (p-factor) was strongly associated with a significant disturbance in the global pattern of diminished executive system recruitment. There were some less significant specific regional diminutions of executive system activation for behavioural, psychotic and emotional symptoms. This is in line with the popular general hypothesis that dimensions of psychiatric symptomatology are associated with both common and distinct deficits within the executive system. The brain areas showing diminished activation in executive function tasks associated with the p-factor (left and right frontal pole, anterior cingulate cortex, anterior insula, thalamus and precuneus) implicate the deactivation of the so-called salience or ventral attention networks that contributes to cognitive control and may have a particular role in error monitoring and maintaining task related attentional sets.

It is not inconceivable that transdiagnostic interventions pull for and share a common focus. The therapeutic principles of protocols such as FIRST 'distil the essence' of decades of CBT research, combining enhancing of self-regulation, generating alternative perspectives, enhancing systematic problem solving and behavioural activation. The implication here is that principle-guided trans-diagnostic treatments may be effective because, irrespective of content, a range of evidence-based components address self-control, self-regulation and executive control deficits linked to a brain area implicated in investigations of numerous mental disorders of childhood and adolescence. A similar argument could be advanced for the Unified and MATCH approaches. The obvious next step

is the combination of bi-factor analytic methods and neuroimaging studies in the evaluation of a range of transdiagnostic therapies.

The adoption of a transdiagnostic approach to intervention should not be mistaken for a license to eclecticism. It requires an ongoing serious commitment to research and methodological rigour. Marchette and Weisz acknowledge that rigorous implementation of a transdiagnostic modular approach will require adequately powered research to determine common mechanisms and processes across different classes of disorders, to identify appropriate training methods and to develop evidence-based strategies for assessment and the measurement of treatment adherence.

The demand for a reboot of psychological therapies is unequivocal simply because of the disappointing lack of progress in the outcomes achieved by the best evidence-based interventions [7]. As Martin Seligman (2013), a past president of the American Psychological Association, put it in The Washington Post, "I have found that drugs and therapy offer disappointingly little additional help for the mentally ill than they did 25 years ago—despite billions of dollars in funding." Elsewhere we expressed some concern that the rise of certain well-publicized, evidence-based interventions could stifle innovation [5]. EBP has enabled the elimination of many ineffective and some harmful practices from comprehensive CAMHS. There are effective therapies for most disorders. Training professionals to competency in administering evidence-based treatments is an ethical and social imperative. Yet effect sizes remain modest, suggesting that we are not quite there yet. We are concerned that the availability of therapies that work breeds complacency in funders of research, stifles innovation, and encourages accommodation to a suboptimal set of clinical outcomes. Marchette and Weisz's contribution obliges us to repudiate any smugness and focus on the interface of science and practice to identify ever better solutions for the families we support.

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