Preface

Cognitive-Behavioral Therapy in Youth

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Guest Editors

"I'm going to do CBT to that child."
"CBT is easy—all you have to do is read a manual with the family."
"You don't have to care about all that other stuff when you are doing CBT."

These phrases, or others like them, are uttered by clinicians in outpatient clinics, inpatient units, and psychiatry/psychology training programs around the country, demonstrating the common misperception that cognitive-behavioral therapy, or CBT, is "done" by a therapist "to" a patient. These beliefs often eliminate the notion of a therapeutic working relationship between a therapist and his or her patients and their families, which is essential to developing an understanding of the family system and structure in which the child's symptoms are thriving. Some mental health professionals feel that CBT is a robotic, "choose-your-own-adventure" style of therapy that is based solely on handouts and manuals.

The true practice of CBT is a far departure from a strictly manualized treatment. Dating back to the origins of CBT, practitioners and researchers have understood the importance of the therapeutic bond between clinicians and their patients. This bond fosters a therapeutic environment to tackle maladaptive cognitions and engage in exposure exercises in an effort to modify beliefs or behaviors causing intrapersonal and interpersonal conflicts.

This issue of the *Child and Adolescent Psychiatric Clinics of North America* was established to provide a comprehensive look at the history and practice of CBT in youth and its evidence base across multiple childhood disorders. An additional goal of this issue is to dispel the misunderstandings of the practice of CBT that abound in the community. We hope to demonstrate that CBT is a fluid process, not a rigid or inflexible style of therapy, focused on linking cognitions to thoughts and behaviors that may have become problematic over time. The authors who contributed to this issue are true leaders in the field of CBT in children and adolescents (albeit, not an exclusive list by any means).

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As you will see, some clinical disorders in youth, such as depression and anxiety, have a rich history of evidenced-based data backing CBT as a first-order treatment, whereas others, such as body dysmorphic disorder, have limited empirical data. Also included are areas that may be more problematic for some practitioners, including working with very young children and those with comorbid medical issues.

We end this issue by reviewing other areas of research, including more cognitive-based (less behavioral) therapy as well as acceptance and commitment therapy. Interwoven throughout the articles are summaries of general session structure, which may provide a helpful review for those reading this work. The articles also examine future avenues for CBT development in their respective areas.

We intend for this issue to be a stand-alone summary of the current data and practice of CBT in youth, which we hope will serve as an invaluable resource for the new trainee or experienced clinician alike. As stated in Harsh Trivedi's Foreword to this issue, you will not become an expert CBT clinician by reading this issue; however, we expect that you will leave with a thorough understanding of the evidence-based practice of CBT in youth across multiple spectrums. We are very grateful for all of the time and effort that went into this issue, from the incredible group of authors to the staff at *Child and Adolescent Psychiatric Clinics of North America* who made this all possible. We also send a warm thank you to Dr Harsh Trivedi, for allowing us to contribute to this journal.

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