A Modular, Transdiagnostic Approach to Treating Severe Irritability in Children and Adolescents

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KEYWORDS

- Irritability • Mood dysregulation • Oppositional • Behavioral parent training (BPT)
- Cognitive-behavioral therapy (CBT) • Modular • Transdiagnostic
- Children and adolescents

KEY POINTS

- Severe irritability often occurs in youth externalizing and internalizing problems, for which behavioral parent training and cognitive-behavioral therapy are recommended treatments.
- MATCH is a modular intervention for delivering evidence-based behavioral parent training/cognitive-behavioral treatment strategies to youth with anxiety, depression, trauma, and/or conduct problems.
- MATCH may be effective in the treatment of severely irritable youth, with strengths including its flexible, transdiagnostic, and personalized format.
- We offer strategies for personalized treatment of youth irritability with MATCH, emphasizing behavioral parent training as the first-line approach and cognitive-behavioral treatment elements as complementary or alternative approaches.

Research has demonstrated the clinical and developmental importance of irritability in children and adolescents (herein "youth").[1–4] Conceptualized as an increased proneness to anger, irritability is a common emotional experience with various manifestations moderated by development. In its most severe forms, irritability crosses into psychopathology. Chronic and developmentally inappropriate irritability (eg, severe temper outbursts, persistent angry/irritable mood) can be significantly impairing and warrant clinical attention. Evidence to guide care for severe irritability in youths is limited, although research in this area is rapidly advancing. The best available

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Abbreviations	
BPT	Behavioral parent training
CBT	Cognitive-behavioral therapy
EST	Empirically supported treatment

evidence supports using behavioral parent training (BPT) with a primary caregiver (herein "parent") and/or cognitive-behavioral therapy (CBT) with the youth directly.[3,5,6] Beyond these general recommendations, specific guidance concerning which techniques to use, how, when, and with whom is lacking.

This article aims to provide clinicians with practical information for treating severe irritability in youth. In doing so, we focus on the Modular Approach to Therapy with Children with Anxiety, Depression, Trauma, and Conduct Problems (MATCH)[7] as one transdiagnostic intervention that can be used to personalize BPT/CBT for irritability and related problems. Although we focus on MATCH, we acknowledge other youth psychotherapies that similarly adopt modular transdiagnostic frameworks and derive from BPT/CBT research and theory. Notable examples include FIRST (Feeling Calm, Increasing Motivation, Repairing Thoughts, Solving Problems, Trying the Opposite)[8]; the Unified Protocol for Children and Adolescents[9] (UP-C/A), and its recent extension to irritability/anger[10]; Brief Intervention Strategy for School Clinicians (BRISC)[11]; and Common Elements Treatment Approach for Youth (CETA-Y).[12] A cursory review of these programs reveals many common "active ingredients" targeting changes in thoughts, behaviors, and parenting practices. What is novel about MATCH and these other examples is that they present evidence-based techniques in a modular format for personalized transdiagnostic treatment of youth emotional and behavioral problems, including severe irritability.

WHY TRANSDIAGNOSTIC?

Irritability is usefully conceptualized as a transdiagnostic phenomenon for several reasons. First, irritability is a central feature in more than a dozen diagnostic categories (eg, oppositional defiant disorder, depression, anxiety disorder, post-traumatic stress disorder, borderline personality disorder) and an associated feature of many more (eg, autism spectrum disorder, attention-deficit/hyperactivity disorder, conduct disorder). Thus, the mere occurrence of irritability as part of the presentation entails numerous differential diagnostic considerations to clarify the nature of the problem.[3] Second, when the presentation is clearly defined by severe, chronic irritability (eg, disruptive mood dysregulation disorder or oppositional defiant disorder with chronic irritability/anger), this is typically accompanied by 2 to 3 other diagnoses such as attention-deficit/hyperactivity disorder, depression, anxiety, and conduct disorder.[1] Given so many potential treatment targets, a transdiagnostic framework can help the clinician to identify and prioritize co-occurring problems. Third, although severe irritability largely falls in the externalizing spectrum (eg, as a dimension of oppositional defiant disorder[1,13] or by comorbidity[14,15]), irritable youth are also at increased risk for depression, anxiety, suicidality, and other social, behavioral, and functional problems.[1,2,4] So, even in the rare case of a youth with severe irritability but no co-occurring disorders, it remains important to consider internalizing and externalizing problems as potential developmental precursors and outcomes. Finally, although these considerations are specifically relevant for severe irritability, they also generalize to other emotional and behavioral conditions common among treatment-referred

youth. This factor underscores the practical usefulness of transdiagnostic approaches for both broad and targeted applications.

OVERVIEW OF A MODULAR APPROACH TO YOUTH COGNITIVE BEHAVIORAL THERAPY AND BEHAVIORAL PARENT TRAINING

MATCH[7] is a modular, transdiagnostic, evidence-based youth psychotherapy. Rather than offering yet another new treatment, MATCH offers a menu of treatment techniques ("practice elements," in MATCH terminology) from empirically supported treatments (ESTs) for anxiety,[16] depression[17] and trauma (all CBT-based) and conduct[18] (BPT). These 4 areas, or "protocols," collectively house 33 brief "modules," each describing a CBT/BPT practice element and how to deliver it. **Fig. 1** illustrates this framework with 17 irritability-relevant modules (eg, Praise, Practicing, and Problem-Solving) from 3 protocols (Conduct, Anxiety, and Depression, respectively). Although this wide array of elements offers intuitive appeal for transdiagnostic flexibility (eg, praise could help with depression, or problem solving with anxiety), MATCH should not be used as an a-la-carte menu of treatment strategies; this practice would dilute its effectiveness. To promote personalization while retaining EST fidelity, MATCH guides clinicians to first select which of the 4 MATCH protocols best captures the core problem. From there, MATCH provides further personalization and decision-making guidance (discussed elsewhere in this article).

MATCH was designed to address common barriers faced by clinicians trying to implement ESTs in everyday settings. Many ESTs were developed for 1 problem or disorder, but in community clinics comorbidity is the norm. Moreover, there is often

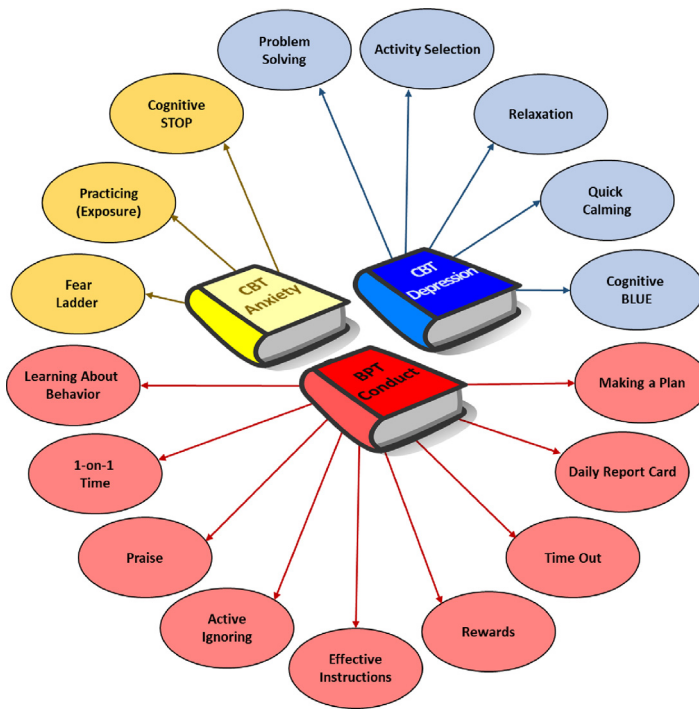

Fig. 1. Selected irritability-relevant modules illustrating the structure of MATCH.

heterogeneity, with the same problem presenting differently across patients, and flux, with problems changing over treatment. To address comorbidity, MATCH was designed for the most common youth mental health concerns (internalizing, externalizing, trauma), covering approximately 75% of outpatient youth mental health referrals. Fluctuations in problems during treatment can be managed via flowchart recommendations, such as addressing sources of treatment "interference" (eg, low motivation) using targeted practice elements (eg, rewards), or shifting to a new protocol (eg, from BPT to CBT-depression) if new problems arise or become primary. For clinics and clinicians, learning MATCH is simpler than learning 4 distinct interventions, and the flexible delivery of MATCH mirrors the way ESTs are administered in the real world.

Effectiveness of MATCH

Evidence for MATCH's effectiveness generally falls into 2 buckets. The first bucket consists of decades of youth psychotherapy research[19–21] demonstrating the efficacy and effectiveness of the ESTs[16–18] from which MATCH is derived. The second and more direct bucket includes trials of MATCH. In the initial randomized effectiveness trial,[22,23] 174 treatment-referred youths ages 7 to 13 years were assigned randomly to receive either standard manualized treatments[16–18] (CBT-Depression, CBT-Anxiety, BPT-Conduct), a modular version of them (MATCH), or usual care. MATCH consistently outperformed usual care and was equally or more effective than the standard treatments in decreasing internalizing, externalizing, total, and top problems, as well as number of diagnoses, over various measurement schedules.[22,23] Moreover, clinicians tended to prefer MATCH, suggesting it showed an optimal balance between responsiveness and effectiveness.[24] More recently, Chorpita and colleagues[25] again found MATCH to outperform a usual care condition composed of community-implemented EBTs. In sum, the evidence base for MATCH largely supports its effectiveness and acceptability in community youth mental health settings.

Preliminary Effectiveness of MATCH for Irritability

As noted, BPT and CBT are considered first-line treatments for irritability, but there is limited guidance regarding how to administer these techniques.[3,5,6] MATCH was designed to provide such guidance. Potential challenges in working with severely irritable youths include heterogeneity, comorbidity, difficult differential assessment, problems shifting over time, and variability across perspectives and settings.[1,3] MATCH was designed with these considerations in mind. Common comorbidities of irritability include anxiety and depression.[1,4] MATCH offers some of the best-supported techniques for these problems (eg, exposure ["practicing"], behavioral activation ["activity selection"]; **Fig. 1**), organized in a modular transdiagnostic framework rather than in separate disorder-specific interventions. Thus, if BPT/CBT techniques are appropriate for severely irritable youth, MATCH could be an appropriate vehicle for delivering them.

This reasoning prompted a recent reanalysis[26] of the original MATCH effectiveness data[22,23] to investigate its effects on severe irritability. Using empirically based cutoffs, the authors[26] identified a subsample of 81 youths with high irritability and impairment who had been randomly and evenly distributed across conditions at baseline. Severely irritable youths who received MATCH improved faster on all outcomes—especially by youth report—than those in other conditions, with medium to large effect sizes. From before to after the treatment, all 3 conditions showed significant reductions in youths' total number of mental health diagnoses (derived via structured diagnostic interviews); however, only MATCH significantly outperformed usual care on this metric, predicting

1.0 fewer diagnoses than usual care after treatment. Finally, MATCH's original effectiveness results[22,23] were not moderated by baseline irritability. In sum, BPT/CBT techniques were effective in reducing irritability in community-referred youths generally and, among severely irritability youth specifically, these effects were most pronounced when delivered via MATCH.

Clinical Application of MATCH to Youth Irritability

Although it is possible that various irritability-specific CBT/BPT techniques could be compiled into a new modular program targeting irritability, such an approach would be limited because it does not build on decades of research on the understanding and treatment of youth psychopathology. The clinical science of irritability is in its infancy, whereas the evidence base for treating other youth emotional and behavioral problems is much farther along. The modular approach draws from a comprehensive distillation of EST techniques for specific problems.[19,20,27] To develop an irritability-specific adaptation of MATCH or a MATCH-like treatment for irritability, it would need to be integrated into this framework and pass a certain threshold of empirical support. In our view, the evidence base for youth irritability treatment is not yet mature enough for this method. Rather, a more feasible and efficient approach is to take EST elements—already well-established and usefully arranged in MATCH—and apply them to irritability as it manifests across the landscape of youth psychopathology. From an evidence-based practice perspective,[28,29] there is never any single approach that is optimally effective for all clinicians with all patients with a given commonality. Nowhere does there exist an evidence base of randomized trials involving you and your patient to guide your clinical decision-making. Instead, best practice exists at the intersection of patient characteristics, clinician expertise, and the best available evidence.

So, where does the best available evidence lead? Generally, some form of BPT, such as MATCH-Conduct, is indicated. Although irritability does occur in anxiety, depression, and other disorders, most manifestations of severe irritability (eg, losing temper, angry/aggressive outbursts) are, by definition, disruptive behaviors. Thus, most presentations predominantly characterized by severe irritability fit this pattern and should probably receive the indicated treatment, BPT.[30–32] For example, in the MATCH irritability reanalysis,[26] 57% of the youths with severe irritability were identified by experts as being appropriate for MATCH-Conduct/BPT as a first-line treatment, as compared with anxiety (26%) and depression (17%). Finally, irritable, angry, and aggressive youths are not always the most motivated psychotherapy participants, but parents tend to be the ones bringing them to treatment and could serve as the agents of change in a youth's social environment.

Behavioral Parent Training (Conduct Protocol)

Evidence for BPT has accumulated over more than 50 years. Dating back to the work of Constance Hanf, Gerald Patterson, and others from the 1960s on,[30,33] various BPT programs have been developed, which—despite variations across settings, populations, and decades—contain essentially the same core intervention components. Thus, meta-analytic and systematic reviews[21,30–32] supporting BPT's effectiveness have broad generalizability. One example of a BPT protocol is Barkley's[18] Defiant Children, which was designed for general youth and family therapy settings and served as the basis for the Conduct protocol in MATCH.

The key premise in BPT is that child behavior problems are maintained by an interplay among child factors, parent factors, parent–child interactions, and other stressors. Treatment involves working with the parent to reverse dysfunctional

interactional patterns that have emerged in their relationship, such as coercive cycles. It is up to the parent, working with the therapist as a coach, to enact behavior changes that might reverse those patterns. In MATCH, BPT (ie, the Conduct protocol) begins with engagement building (Engaging Parents) and psychoeducation (Learning About Behavior), followed by 2 major treatment phases. First comes child-directed activities, including special play time between parent and child (One-on-One Time). Positive reinforcement techniques promote behavior change through the skillful application of positive attention (Praise, Rewards). Parental attention is also selectively withdrawn (Active Ignoring) for minor misbehavior. Collectively, these techniques strengthen the parent–child relationship and make the parent's attention even more valuable to the child.

With this foundation in place, BPT shifts to the next phase: parent-directed activities. Core elements include training in giving effective directives (Instructions), a well-specified Time-Out protocol, and Making a Plan for managing behavior on the go. If needed, there is a Daily Report Card for problem behaviors at school. The goal of this second phase is to teach parents to be more consistent, clear, and effective in their requests and consequences, and for children to learn to comply with those requests more often and more quickly. The ultimate goal for the child is to modify their behavior to be more adaptive, understanding the links to the consequences in their environment. Last, treatment gains are reviewed and consolidated (Looking Ahead), with additional support later, if needed (Booster).

These 12 MATCH BPT modules are listed in **Table 1** along with special considerations for severely irritable youth. Importantly, this BPT protocol it is not a fixed, linear, session-by-session sequence, nor does every module need to be given (eg, Daily Report Card is only given when applicable to behavior problems at school). Rather, these elements are organized via flexible flowcharts that help clinicians personalize treatment. **Fig. 2** presents our conceptualization of modular BPT/CBT treatment for youth irritability, embedded in a MATCH-style flowchart framework. As shown, effective treatment must first begin with an accurate assessment to identify the problem(s) to be addressed. Irritability symptoms could reflect an underlying problem of anxiety, depression, or trauma—in which case, the corresponding MATCH protocol would be indicated. Alternatively, the assessment could reveal some other problem (eg, bipolar disorder) for which MATCH is not appropriate as a standalone treatment. But, in general, BPT is likely to be an important part of intervention, often as the first-line treatment.

When following the standard BPT sequence in MATCH, personalization questions arise (see **Fig. 2**, diamonds): Is the family able to proceed with BPT? If there is interference, what is the problem? The flowchart suggests which modules might help with different types of interference. For example, if an irritable-depressed mood is interfering with the parents' ability to engage the youth, the clinician might administer Problem Solving and/or Activity Selection to help improve mood first, and then resume with BPT. If there is a preference/possibility for individual youth-focused work, it may be possible for 2 clinicians to work together, or for 1 clinician to have separate parent and youth appointments regularly or on alternating weeks. It might be doubly beneficial for a youth to work through an anger exposure hierarchy[5] (Fear Ladder and Practicing) while their parent is acquiring positive parenting skills through BPT. However, this kind of dual approach is not standard and might be advisable only in certain circumstances (eg, if there is a basic level of engagement from all parties).

In delivering BPT for severely irritable youth, clinicians should recognize that reward processes are likely to be influential and motivating, but may come with more difficulty learning and changing behaviors, as compared with nonirritable youth[2] (see **Table 1**).

Table 1
BPT techniques and considerations for severe irritability

Module	Goal	Considerations for Severe Irritability
Engaging parents	Establish relationship and treatment plan	BPT involves working with parents to implement techniques themselves, with the clinician occupying a "coach" role. With older youth and/or severely irritable mood, greater involvement from the youth may be warranted, but the parent BPT sequence is still essential. Building rapport and setting expectations at the outset is key.
Learning about behavior	Help parent to understand the factors that may maintain youth misbehavior	Psychoeducation centers on how child and parent factors, consequences, and stressors affect the youth's irritable moods or aggressive outbursts. It may be helpful to normalize strong emotions commonly experienced by children and parents alike, but noting developmental differences (eg, tantrums vs moodiness). This can help parents realize that disruptive behaviors could reflect frustration and dysregulation, not just "acting out."
One-on-one time	Increase positive parent–child interactions, strengthen bond	Parents may have come to know youths' chronic irritability as aversive. Positive interactions, as in one-on-one time, are key to reversing this cycle. It is important to ensure parents can differentiate minor misbehavior vs aggressive outbursts, and how to respond differently to each (active ignoring vs end one-on-one time).
Praise	Teach parents to give child praise effectively	Emphasize the need for frequent labeled praise for good or "just okay" behavior. Praise is especially effective when it is immediate, specific, enthusiastic, and incremental. Attend to the "positive opposites" of target problems when possible (eg, praising putting 1 toy away [positive opposite] rather than criticizing leaving a mess of toys [target problem]). The power of attention may be less apparent for irritable mood, but it is still there; ask parent, "Do these difficulties occur more or less often when others are around?"
Active ignoring	Teach parents to remove attention from minor misbehavior to avoid inadvertently reinforcing it	Even in severely irritable youth, some behaviors are attention-seeking in nature and minor enough to be be actively ignored (aggression being an exception). Extinction bursts can be more severe with irritable youths, as they may take longer to learn from ignoring. Initially, parents should select behaviors they are willing and able to ignore (failing to do so can backfire). Most effective with praise and one-on-one time already in place.

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Table 1
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Module	Goal	Considerations for Severe Irritability
Giving effective instructions	Teach parents to give instructions effectively	Common triggers of irritable behaviors include unexpected and unclear demands; effective instructions can reverse this. Parents and youth may be more successful when instructions are first given for trivial tasks before working up to more challenging requests. Extra practice may be needed with irritable youths, and youth preparation can be helpful.
Rewards	Help parent use rewards to increase positive behaviors	Irritable youths are responsive to rewards but may take longer to change behavior. With parents, involve youth in identifying range of potential rewards. Use easy criteria to ensure some success. Consider rewarding skill use and more socially appropriate expressions of emotion (eg, as verbalizing feeling angry).
Time-out	Help parent to decrease target behaviors by briefly removing reinforcement	Willful disobedience and aggression are good candidate behaviors for time-out. Use clinical judgment regarding its fit for the clinical presentation, youth age, and parent willingness. For older youths, consider framing as a "cool-down" (or similar), issue-able by youth or parent. Time-out may be inappropriate for severe aggression; safety is paramount.
Making a plan	Plan ahead to prevent and address behavior problems	Tantrums are often more likely to occur in public settings (eg, the supermarket), where parents often feel less equipped to manage them. Developing a plan for "high-risk" situations helps with maintaining and generalizing skills and gains.
Daily report card	Linking school behavior to home rewards	Applicable if the target mood and behavior problems occur at school. The teacher's perspective on the youth's problems may differ from parents. Prioritize a small, manageable set of problems that are impairing at school.
Looking ahead	Review, plan, and conclude BPT	Irritable/aggressive behaviors can recur or persist over time. As treatment ends, review skills, progress, and plan ahead for high-risk situations.
Booster session	Follow-up support after BPT	If irritable behavior problems do recur, acute challenges arise, or skills fade, call upon this session to review and consolidate skills.

Note. BPT Adapted from Chorpita and Weisz[7] (Copyright 2009, Practicewise). Table developed for this article.

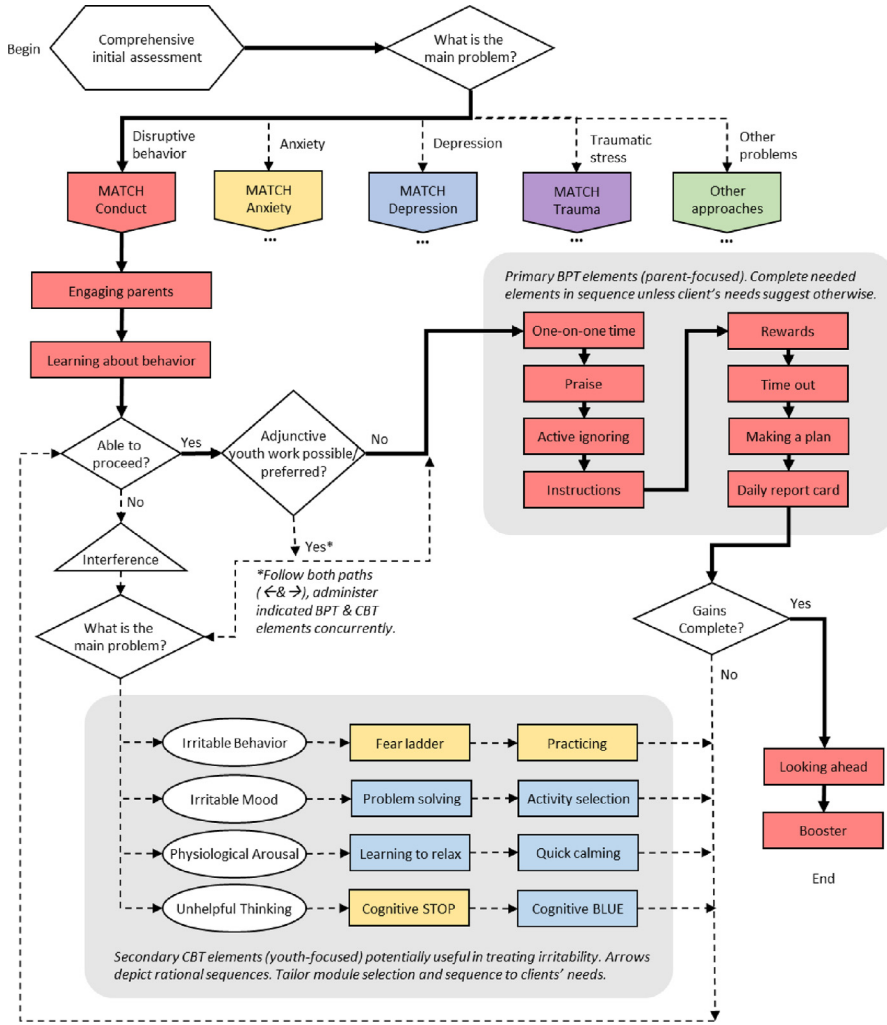

Fig. 2. MATCH-style flowchart conceptualizing youth irritability treatment in a modular framework. Bold: standard MATCH-conduct sequence; Dashed: alternative and adjunctive approaches potentially helpful for irritability when standard parent-focused treatment alone is not optimal; Ellipses: alternative approaches not presented here. (*Adapted from* Chorpita and Weisz[7] (Copyright 2009, PracticeWise). Figure developed for this article.)

Thus, personalizing for irritability could include allowing for more time and practice. Families are likely aware that certain circumstances can trigger angry, aggressive outbursts, and these patterns should be identified early in treatment. Later, when parent-directed strategies (eg, Instructions, Time-Out) are introduced, it is advisable to start small and work up to the more upsetting circumstances.[5] For example, if homework is a daily struggle leading to severe outbursts, the parent might start with more trivial and easily followed instructions (eg, please pass the salt) and later work up to homework directives after some initial success has been achieved. This graded approach may help to increase the parent's confidence so they feel better able to implement skills

consistently. Similarly, it is likely helpful to bring the youth into this process, giving them advance notice and possibly equipping them with emotion regulation skills to help cope (eg, Quick Calming).

Finally, regular assessments should be given to monitor progress, allowing the clinician to see whether the youth is responding and make treatment personalization decisions accordingly. We recommend giving brief parent and youth report measures of current problem severity. First, idiographic measures, such as the Top Problems,[34] help to monitor the problems identified by families as their biggest concerns for treatment. Second, various nomothetic measures can be used to obtain a quick snapshot of severity in specific domains such as internalizing and externalizing problems,[35] irritability,[36] or anger.[37]

Tips, Tricks, and Tweaks in Using MATCH for Irritability

Although BPT is generally the first-line treatment, many CBT elements in MATCH may also be helpful for teaching youths skills to manage their irritability and anger directly. This work could be done as a complementary or alternative strategy to BPT (see **Fig. 2**). We highlight elements that, based on evidence and experience, might be beneficial. Still, we emphasize that these applications of MATCH were not explicitly designed for irritability, and therefore should be used with careful clinical judgment.

1. Cognitive-Behavioral Psychoeducation (Learning About [Behavior, Depression, Anxiety]). Potentially helpful psychoeducation elements include: (a) the 3-component CBT model of thoughts (eg, "he meant to do that"), feelings (eg, irritability, anger, somatic arousal), and behaviors (eg, aggression); (b) the metaphor of developing a toolbox of skills, to have the right tool for different situations; (c) the importance of practicing new skills (eg, graded exposure to irritability triggers, mood-enhancing activities); and (d) a feelings thermometer to measure anger and irritability in general, when irritated, and when using skills.
2. Calming Techniques (Learning to Relax, Quick Calming). Techniques, such as deep breathing with visual imagery (Quick Calming) and progressive muscle relaxation (Learning to Relax) can help youths to manage strong emotions. Given that youths with irritability may have difficulty tolerating frustration and inhibiting impulsive actions, learning to recognize the physiologic cues of irritability and using self-calming in these moments can put a space between impulse and action. The clinician might teach the youth calming strategies to use on a regular basis (eg, before bed) to help regulate physiologic arousal at baseline and when emotions escalate.
3. Problem Solving. Irritable youths may respond to challenging situations in ways that make their problems worse. This module teaches a systematic approach to identifying the problem, generating possible solutions, evaluating them, picking one to try, evaluating its success, and trying alternatives if needed. Problem solving involves exploring a full range of possible solutions—including maladaptive ones—that may seem to be viable to the youth to foster objective evaluation. For example, a child who is asked to stop playing videogames might hit their caregiver as an immediate solution. In this case, the problem would be the strong unpleasant emotion the child feels. Hitting would be one possible solution; other solutions could include self-calming, verbally expressing frustration, refusing to comply, and requesting more time.
4. Behavioral Activation (Activity Selection). Considering that irritability is often part of youth depression, behavioral activation may be advisable for irritable/depressed mood. When youths feel sad or depressed, they may withdraw from activities they used to enjoy, which can exacerbate the problem. Behavioral activation

reverses this cycle by promoting engagement in enjoyable and meaningful activities that can be positively reinforcing (eg, an activity that is fun, involves social interaction, provides a sense of accomplishment, or helps someone else). It is important to convey that instead of waiting to feel less irritable or angry before doing something, youths should start doing something to feel better. It can be helpful to allow them to "fake it 'til you make it," because this skill can have a cumulative rather than an immediate effect.

5. Addressing Unhelpful Thoughts (Cognitive STOP, Cognitive BLUE). Youths with irritability may perceive ambiguous situations as threatening or hostile, and then act according to these assumptions. Through cognitive restructuring, youths can learn to identify biased interpretations, evaluate the evidence for and against them, and develop more realistic or helpful interpretations. For example, when asked to put their phone away in class, a student might think, "this is unfair, the teacher is targeting me." In turn, this could lead to the behavior of storming out of class, resulting in disciplinary action. By gathering evidence via Socratic questioning (What's the evidence the teacher is targeting you? Have they ever asked other students to put away their phones?), the clinician might help the student to arrive at the more likely or helpful alternative thought—for example, "The teacher does not allow phones in class"—leading to more adaptive behavior.
6. Graded Exposure (Fear Ladder, Practicing). In anxiety treatment, exposure involves a gradual, step-by-step approach to entering anxiety-provoking situations. Doing so allows the youth to learn that the aversive outcome does not occur or is not as bad as anticipated and that they can handle their strong emotions by staying in the situation rather than avoiding it. Irritability exposure treatment[5] follows the same model but with anger-provoking (not anxiety-provoking) situations. Youths are asked to tolerate strong feelings of anger without acting on them in unhelpful or disruptive ways. First, the clinician helps the youth to identify triggering situations and rate, on a 0 to 10 feelings thermometer, how hard it would be to tolerate emotions rather than act (Fear Ladder, reframed as an anger ladder or similar). Before starting exposure, consider teaching the youth coping strategies (eg, Cognitive STOP) or alternative responses rehearsed outside of the triggering moment.

Here, we have summarized 6 core anxiety/depression CBT strategies relevant to youth irritability. Of course, attention should be given to rapport-building and goal setting at the outset (Getting Acquainted, etc) and to maintaining gains and preventing relapse at the end (eg, Plans for Coping, Wrap Up, Maintenance). Because the youth will continue to experience irritability after treatment ends, it is important to review the need for continued practice, discuss difficulties that might arise, identify what skills could be most helpful, and emphasize persistence in the face of challenges.

SUMMARY AND CAVEATS

Decades of youth psychotherapy research have yielded core techniques that are effective for irritability-related problems in youth. These techniques include BPT for disruptive behavior and CBT for anxiety, depression, and traumatic stress. Rather than developing yet another treatment, MATCH put these effective strategies into a format that clinicians can readily apply to youths presenting with comorbid, heterogeneous, and shifting problems. We have adopted this same philosophy in presenting MATCH as a viable treatment for severe irritability. In addition to the direct and indirect evidence for MATCH, recent evidence suggests that MATCH—in its standard format, without adaptations for irritability—was more effective than usual care and linear ESTs in the treatment of youth with severe irritability. For this and the other reasons

presented in this article, we view MATCH as a potentially ideal first-line treatment recommendation for clinically referred youths with severe irritability.

However, this viewpoint must be accompanied by an important caveat: MATCH has not been developed, adapted, or tested specifically as a treatment for youths referred for severe irritability. The recommendations presented in this article are based on the available evidence and our experience as clinicians and trainers, but further research is clearly needed. Several other modular programs[8–12] were noted that could offer similar promise. Additionally, irritability-specific programs (some in this volume) are beginning to show evidence for effectiveness from dialectical behavior therapy,[38] interpersonal psychotherapy,[39] and behavioral/cognitive-behavioral approaches.[5,6,40,41] Such interventions may eventually be known as gold-standard EBTs for youth with severe irritability. Unfortunately, this kind of progress often takes years. In the meantime, MATCH can be used broadly today, with evidence of benefits for addressing irritability and related problems in youth.

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DISCLOSURE

The authors have nothing to disclose.

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