Therapeutic Alliance & Psychotherapeutic Intervention in Youth Mental Health:

A Selected Bibliography

The Evidence Base for:

Direct Therapeutic Intervention with Young People
Arnow, B. A., et al. (2013). "The Relationship Between the Therapeutic Alliance and Treatment Outcome in Two Distinct Psychotherapies for Chronic Depression."

Objective: This study tested whether the quality of the patient-rated working alliance, measured early in treatment, predicted subsequent symptom reduction in chronically depressed patients. Secondarily, the study assessed whether the relationship between early alliance and response to treatment differed between patients receiving cognitive behavioral analysis system of psychotherapy (CBASP) vs. brief supportive psychotherapy (BSP). Method: 395 adults (57% female; Mage = 46; 91% Caucasian) who met criteria for chronic depression and did not fully remit during a 12-week algorithm-based, open-label pharmacotherapy trial were randomized to receive either 16–20 sessions of CBASP or BSP in addition to continued, algorithm-based antidepressant medication. Of these, 224 patients completed the Working Alliance Inventory-Short Form at Weeks 2 or 4 of treatment. Blind raters assessed depressive symptoms at 2-week intervals across treatment using the Hamilton Rating Scale for Depression. Linear mixed models tested the association between early alliance and subsequent symptom ratings while accounting for early symptom change. Results: A more positive early working alliance was associated with lower subsequent symptom ratings in both the CBASP and BSP, F(1, 1236) = 62.48, p < .001. In addition, the interaction between alliance and psychotherapy type was significant, such that alliance quality was more strongly associated with symptom ratings among those in the CBASP treatment group, F(1, 1234) = 8.31, p = .004. Conclusions: The results support the role of the therapeutic alliance as a predictor of outcome across dissimilar treatments for chronic depression. Contrary to expectations, the therapeutic alliance was more strongly related to outcome in CBASP, the more directive of the 2 therapies.


Background: There has been a considerable increase in the need for psychiatric services for adolescents. Primary health care practitioners have a major role in detecting, screening and helping these adolescents. An intervention entitled SCREEN is described in this article. The SCREEN intervention was developed to help practitioners to detect and screen adolescent needs, to care for adolescents at the primary health care level and to facilitate the referral of adolescents to secondary care services in collaboration between primary and secondary health care. Secondly, the article presents the background and clinical characteristics of youths seeking help from the SCREEN services, and compares the background factors and clinical characteristics of those patients referred and not referred to secondary care services. Methods: The SCREEN intervention consisted of 1 to 5 sessions, including assessment by a semi-structured anamnesis interview, the structured Global Assessment Scale, and by a structured priority rating scale, as well as a brief intervention for each adolescent's chosen problem. Parents took part in the assessment in 39% of cases involving girls and 50% involving boys. During 34 months, 2071 adolescents (69% females) entered the intervention and 70% completed it. The mean age was 17.1 years for boys and 17.3 years for girls. Results: For 69% of adolescents, this was the first contact with psychiatric services. The most common reasons for seeking services were
depressive symptoms (31%). Self-harming behaviour had occurred in 25% of girls and 16% of boys. The intervention was sufficient for 37% of those who completed it. Psychosocial functioning improved during the intervention. Factors associated with referral for further treatment were female gender, anxiety as the main complaint, previous psychiatric treatment, self-harming behaviour, a previous need for child welfare services, poor psychosocial functioning and a high score in the priority rating scale. Conclusions: A brief intervention carried out by a team including professionals from both primary and secondary level services was sufficient for a considerable proportion of adolescents seeking help for their psychiatric problems. Referral practices and counselling in special level services can be standardized. In the future, it will be important to develop and assess psychiatric services for adolescents using randomised controlled trials.


Background: Adolescents in need of hospitalization often present with chronic and severe forms of psychopathology, placing the adolescent or someone else in danger. Extant research is limited related to the relationship of client symptoms and diagnoses to therapeutic goal attainment. Aims: The purpose of this study was to evaluate the relationship between therapeutic goal attainment to symptomatology for adolescents in acute care psychiatric hospitalization. Method: Four canonical correlations were conducted utilizing the set of subscales for the Goal Attainment Scale of Stabilization (GASS) with each set of subscales for the (a) Suicide Probability Scale (SPS), (b) Target Symptom Rating (TSR), (c) Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A), and (d) Millon Adolescent Clinical Inventory (MACI). Results: A statistically significant relationship was found between GASS subscales and the TSR subscales. The first canonical root was significant, λ = 0.89, F(4, 232) = 3.55, p = 0.008, accounting for 11% (rc = 0.33) of the overlapping variance. Conclusions: Psychiatric symptoms appear to contribute to therapeutic goal attainment. For counselors working with adolescents in crisis residence, familiarity with client issues that promote or inhibit therapeutic progress may be helpful.


This research examined goal attainment as it related to client stability in the process of counseling adolescents admitted to a crisis residence. Data were collected from licensed master’s-level clinicians treating adolescent clients admitted to an acute care psychiatric program at 1 of 2 hospitals located in the mid-South. There was a statistically significant relationship between the goal-attainment model and client stability, as defined by symptom manifestation.


Treatment can be usefully defined as a unique, planned, goal directed, temporally structured, multidimensional change process, which may be phase structured, of necessary quality, appropriateness, and conditions (endogenous and exogenous), implemented under conditions of uncertainty, which is bounded (culture, place, time, etc.), which can be (un)successful (partially and/or totally), as well as being associated with iatrogenic harm and can be categorized into professional-based, tradition-based, mutual-help based (AA,NA, etc.) and self-
help ("natural recovery") models. Whether or not a treatment technique is indicated or contraindicated, and its selection underpinnings (theory-based, empirically-based, “principle of faith-based, tradition-based, budget-based, etc.) continues to be a generic and key treatment issue. In the West, with the relatively new ideology of “harm reduction” and the even newer quality of life (QOL) and “wellness” treatment-driven models, there are now new sets of goals in addition to those derived from/associated with the older tradition of abstinence-driven models. Conflict-resolution models may stimulate an additional option for intervention. Treatment is implemented in a range of environments; ambulatory as well as within institutions which can also include controlled environments such as jails, prisons, and military camps. Treatment includes a spectrum of clinician–caregiver–patient relationships representing various forms of decision-making traditions/models: (1) the hierarchical model in which the clinician-treatment agent makes the decision(s) and the recipient is compliant and relatively passive, (2) shared decision making, which facilitates the collaboration between clinician and client(s)/patient(s) in which both are active, and (3) the “informed model” in which the patient makes the decision(s). Within this planned change process, relatively recently in various parts of the world, active substance users who are not in “treatment,” as well as those users who are in treatment, have become social change agents, active advocates, and peer health counselors...which represent just a sampling of their new labels. There are no unique models or techniques used with substance users—of whatever types and heterogeneities—which are not also used with nonsubstance users.


The formation of a therapeutic alliance is considered a central issue in therapy, and particularly crucial and challenging in work with adolescents. The relational and technical components of the therapeutic alliance were examined from the perspective of the adolescent client. 40 emotionally disturbed adolescent girls, aged 13 to 16 years, received brief supportive psychotherapy in the school setting. The alliance was assessed at sessions 3, 6 and 9, and outcome was evaluated on measures of internalizing problems, self-esteem, adjustment and client satisfaction. The results indicated the stability of the alliance between sessions 3 and 6, followed by significant linear increases between sessions 6 and 9. The strength of the alliance was most consistently related to reductions in internalising problems and client estimates of change. The implications for training and clinical practice with adolescent clients are discussed and future research avenues outlined.


Abstract: For some time now, the therapeutic alliance has served as a clinically significant "common factor" in positive outcomes for adult clients in most all types of psychotherapy. Yet among adolescents, the alliance has garnered interest among clinicians and researchers only relatively recently, particularly in cases of "high-risk" adolescents—teens who need mental health treatment services for a variety of disorders peculiar to this age group (e.g., anxiety disorders, depression, externalizing/disruptive behavioral disorders, etc.) but do not have access to these services or drop out of treatment prematurely. The more recent interest in the alliance with adolescents appears to be driven by myriad forces: interested researchers, frustrated clinicians, concerned parents, and policymakers engaged in healthcare reform. Elusive alliance examines the conceptual, theoretical, and empirical bases of these myriad forces, presenting some of the highly promising work that has been accomplished over the past two decades on
engaging high-risk adolescents in psychotherapy. By getting a picture of the current state of the field while also getting an in-depth analysis of a few specific programs of research supported by evidence examining adolescent engagement, researchers and clinicians alike will be able to establish a more robust knowledge base that serves to advance future treatment process research on how to engage the challenging and underserved population of high-risk adolescents. Beyond the practical appeal to researchers and clinicians, this book will be of vital interest to scholars, practitioners, and policymakers at all levels who are involved in making mental health service delivery for youth more accessible and more cost-effective.


The authors present a new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy—the Collaborative Interaction Scale (CIS)—and discuss the structure and theoretical background of the scale and the rating procedure. To assess interrater reliability, three raters independently evaluated 32 psychotherapy sessions (2,984 patient utterances and 2,984 therapist utterances) using the CIS, which demonstrated good interrater reliability (average $\kappa=.66$–.81). In evaluating the relationship between therapist interventions and patient alliance rupture and collaborative processes, the authors found significant correlations between therapist negative interventions and patient alliance ruptures and among therapist positive interventions, patient collaborative processes, and indirect rupture markers. Results indicate that the CIS is a reliable rating system, useful in both empirical research and clinical assessments.


Suicidal behavior is developmentally mediated, but the degree to which interventions for suicidal behaviors have been developmentally tailored has varied widely. Published controlled studies of psychosocial treatment interventions for reducing adolescent suicidal behavior are reviewed, with a particular emphasis on the developmental nuances of these interventions. In addition, developmental considerations important in the treatment of suicidal adolescents are discussed. There are insufficient data available from controlled trials to recommend one intervention over another for the treatment of suicidal youth, but interventions that are sensitive to the multiple developmental contexts have potential for greater effectiveness in reducing adolescent suicidal behavior.


This instructive manual presents a pragmatic and clinically proven approach to the prevention and treatment of undergraduate alcohol abuse. The BASICS model is a nonconfrontational, harm reduction approach that helps students reduce their alcohol consumption and decrease the behavioral and health risks associated with heavy drinking. Including numerous reproducible handouts and assessment forms, the book takes readers step-by-step through conducting BASICS assessment and feedback sessions. Special topics covered include the use of DSM-IV criteria to evaluate alcohol abuse, ways to counter student defensiveness about drinking, and obtaining additional treatment for students with severe alcohol dependency

The purpose of this review was to provide an evidence-based review of the effectiveness of mental health promotion, prevention and early intervention programmes for children, adolescents and adults. Studies were considered if they aimed either (a) to prevent the development of mental health conditions relating to alcohol and drug disorders, conduct disorder, eating disorders, mood and/or anxiety, or (b) to intervene in the early stages of a mental health condition to alter its development or pathway.


This guide has two main aims: To clarify for clinicians and managers, the range of child and youth mental health and addiction disorders that would be expected to be seen in primary, secondary and tertiary services, and the expected prevalence of these disorders. To identify the range of age-appropriate therapeutic skills/interventions that are needed to work effectively with children, young people and their family/whānau.


Used meta-analysis to review 177 primary prevention programs designed to prevent behavioral and social problems in children and adolescents. Findings provide empirical support for further research and practice in primary prevention. Most categories of programs produced outcomes similar to or higher in magnitude than those obtained by many other established preventive and treatment interventions in the social sciences and medicine. Programs modifying the school environment, individually focused mental health promotion efforts, and attempts to help children negotiate stressful transitions yield significant mean effects ranging from 0.24 to 0.93. In practical terms, the average participant in a primary prevention program surpasses the performance of between 59% to 82% of those in a control group, and outcomes reflect an 8% to 46% difference in success rates favoring prevention groups. Most categories of programs had the dual benefit of significantly reducing problems and significantly increasing competencies. Priorities for future research include clearer specification of intervention procedures and program goals, assessment of program implementation, more follow-up studies, and determining how characteristics of the intervention and participants relate to different outcomes.


Objectives: Investigate effect of baseline motivation for change on treatment fidelity, therapeutic alliance, treatment dose, and treatment outcome in a randomized controlled trial of family therapy for youth with poorly controlled diabetes. Methods: Seventy-four adolescents and caregivers completed measures of motivation for change. Measures of fidelity, alliance, dose, and youth health status were collected. Structural equation modeling was used to test the direct and indirect effects of motivation on treatment outcomes. Results: Parent motivation was significantly related to alliance and fidelity. Only alliance was significantly related to posttreatment metabolic control. In adolescent models, only motivation was significantly
related to alliance. In both models, motivation had a significant indirect effect on metabolic control through alliance. Conclusions: Findings demonstrate the importance of parent and youth initial motivational status and treatment alliance to treatment outcome among youth with poorly controlled diabetes. Additional research on treatment techniques that promote motivation for change is needed.


Brief interventions, including MI, have begun to accumulate empirical support as efficacious approaches to treating a wide range of behavioral, developmental, and social disturbances in children and adolescents within pediatric settings. Specifically, BIs in pediatric care have targeted educational and media-based interventions, MI-based prevention and intervention of health risk behaviors, procedural pain control, and adherence to treatment recommendations. In spite of recent advances, future research must reflect the complexity of health-related behaviors and their relationship to individual and contextual systems at various levels of analysis over time. In BI outcome research attending to the predictive value of individual (eg, comorbid conditions, developmental level) and contextual (eg, peer influences, family conflict) characteristics and the bidirectional dynamics between them (eg, parental modeling of health risk behavior) is needed. In this way, interventions best matched to patient characteristics and current health-related issues may be identified. Although support is amassing for BI efficacy with a variety of health-related issues, effectiveness has not yet been adequately addressed. Larger and more diverse samples, more detailed descriptions of intervention approaches, and greater methodological rigor are needed to demonstrate the generalizability of BI. In addition, some studies have begun to compare the relative efficacy of different forms of BI. Continued effort in this direction is needed to identify the relative efficacy of various approaches for various health-related issues and for various types of patients. In addition, BI outcome research must evaluate the ways in which parental involvement may optimize health-related outcomes. Identifying the most beneficial way to involve parents with respect to health-related intervention target, developmental level, nature of parent-child relationship, and the type of proposed treatment would represent significant progress.


Background: Among adolescents, substance abuse often occurs in conjunction with risk-taking behaviors. Aims: This review explores the nature and etiology of concomitant risk-taking behaviors, addressing behavioral, genetic, temperamental, and family factors that accompany adolescent substance use. Method: A literature review was conducted to determine the breadth of factors that contribute to adolescent substance abuse and correlated risk-taking behaviors, and to identify relevant evidence-based treatments. Results: The literature review revealed that among adolescents, substance abuse occurs as part of a cluster of problems and risk-taking behaviors. Predisposing factors include temperament, genetics, neurobehavioral disinhibition, social competencies, parenting, abuse/neglect, and peer behaviors. Various interventions, including individual therapies, parent training, and family therapies comprise the empirically-supported treatments for these co-occurring behaviors. Conclusions: The literature indicates that adolescents being seen for substance-related problems should be evaluated for engagement in other risk-taking behaviors, and school, peer, and social functioning. In addition,
the data support that family, versus individual, interventions should be the norm for substance-abusing adolescents.


The patterns of growth and development of the therapeutic alliance over the course of therapy have been of continued interest to psychotherapy researchers. The purpose of this study was to investigate whether a simple institutional metacommunication intervention with clients had an effect on the development of the alliance. This adjunctive instruction involved inviting therapy clients to take a proactive role in their treatment by encouraging feedback to their therapist about various aspects of the therapy process. In this randomized controlled study (N = 94), clients were assigned to 1 of 2 conditions: (a) an institutional adjunctive instruction condition in which patients were contacted by clinic personnel at the beginning of the remediation phase (Session 5) and encouraged to take a proactive role in their treatment and (b) a control condition that contained no institutional adjunctive instruction. Between-condition differences in the alliance were tested, controlling for baseline influences and the early therapeutic alliance. Clients' postsession reports from Sessions 1 to 24 indicated that the adjunctive instruction increased the alliance over the course of therapy vis-à-vis the control condition. The adjunctive instruction appeared to have fostered clients' evaluation of their therapists' interest in their welfare. The results indicate that interventions, even brief or subtle, can produce lasting benefits in the alliance when targeted at specific psychological processes. Systematic metacommunication from the institutional level appeared to reinforce clients' therapeutic alliance with their therapists in individual treatment.


Aim: This study evaluates the relationship of the alliance with youths affected by mental disorders aged 6 to 18 years and the collaboration between their parents and the clinician with the aim to analyse the relation of these variables with therapeutic compliance and clinical outcome. Methods: The sample consisted of 84 males and 37 females ranging 6-18 years of age. They were split into two categories on the basis of age: = 11 years and > 11 years. Patient alliance and Collaboration with parents were considered and evaluated in the diagnostic process, using the WAI (Working Alliance Inventory). Data about patients' therapeutic compliance and clinical outcome were collected during a follow-up visit six months later. Results: "Therapeutic compliance" appears to be a crucial variable in influencing the outcome of psychotherapy. In groups of different ages "collaboration with parents" and "patients' alliance", respectively, influence compliance. Conclusions: This pilot study shows that therapeutic compliance is the most predictive element of positive outcome. If compliance is the element common to all patients aged 6 to 18, factors influencing compliance in under-11s and over-11s are different.


Objective: To review critically the past 10 years of research on youth suicide. Method: Research literature on youth suicide was reviewed following a systematic search of PsycINFO and Medline. The search for school-based suicide prevention programs was expanded using two education databases:ERIC and Education Full Text. Finally, manual reviews of articles' reference
lists identified additional studies. The review focuses on epidemiology, risk factors, prevention strategies, and treatment protocols. Results: There has been a dramatic decrease in the youth suicide rate during the past decade. Although a number of factors have been posited for the decline, one of the more plausible ones appears to be the increase in antidepressants being prescribed for adolescents during this period. Youth psychiatric disorder, a family history of suicide and psychopathology, stressful life events, and access to firearms are key risk factors for youth suicide. Exciting new findings have emerged on the biology of suicide in adults, but, while encouraging, these are yet to be replicated in youths. Promising prevention strategies, including school-based skills training for students, screening for at-risk youths, education of primary care physicians, media education, and lethal-means restriction, need continuing evaluation studies. Dialectical behavior therapy, cognitive-behavioral therapy, and treatment with antidepressants have been identified as promising treatments but have not yet been tested in a randomized clinical trial of youth suicide. Conclusions: While tremendous strides have been made in our understanding of who is at risk for suicide, it is incumbent upon future research efforts to focus on the development and evaluation of empirically based suicide prevention and treatment protocols.


Background: Along with all other branches of medicine, child and adolescent psychiatry is faced with the need to consider its evidence base and justify its activities accordingly. Aims: To consider critically the use of the term ‘evidence’, to suggest limits to the value of conventionally defined evidence and to point to possible ways forward to bridge the gap between research findings and clinical practice. Method: A review of the literature relating to the use of evidence-based methods. Results: The term ‘evidence’ needs to be used more widely than is conventionally the case. Substantial evidence exists from controlled trials, but there are barriers to its use. Conclusions: A move away from nonvalidated methods of intervention is both desirable and feasible. The use of qualitative methods of enquiry, both in situations where controlled trials are unlikely to be feasible and as adjuncts to quantitative methods, should be considered more seriously.


Background: Uncertainties exist about the prevalence and comorbidity of substance use disorders and independent mood and anxiety disorders. Objective: To present nationally representative data on the prevalence and comorbidity of DSM-IV alcohol and drug use disorders and independent mood and anxiety disorders (including only those that are not substance induced and that are not due to a general medical condition). Main Outcome: Measures Prevalence and associations of substance use disorders and independent mood and anxiety disorders. Results: The prevalences of 12-month DSM-IV independent mood and anxiety disorders in the US population were 9.21% (95% confidence interval [CI], 8.78%-9.64%) and 11.08% (95% CI, 10.43%-11.73%), respectively. The rate of substance use disorders was 9.35% (95% CI, 8.86%-9.84%). Only a few individuals with mood or anxiety disorders were classified as having only substance-induced disorders. Associations between most substance use disorders and independent mood and anxiety disorders were positive and significant (P<.05). Conclusions: Substance use disorders and mood and anxiety disorders that develop independently of
intoxication and withdrawal are among the most prevalent psychiatric disorders in the United States. Associations between most substance use disorders and independent mood and anxiety disorders were overwhelmingly positive and significant, suggesting that treatment for a comorbid mood or anxiety disorder should not be withheld from individuals with substance use disorders.


There is a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged racial and ethnic groups. Many previous authors have advocated that traditional mental health treatments be modified to better match clients' cultural contexts. Numerous studies evaluating culturally adapted interventions have appeared, and the present study used meta-analytic methodology to summarize these data. Across 76 studies the resulting random effects weighted average effect size was $d = .45$, indicating a moderately strong benefit of culturally adapted interventions. Interventions targeted to a specific cultural group were four times more effective than interventions provided to groups consisting of clients from a variety of cultural backgrounds. Interventions conducted in clients' native language (if other than English) were twice as effective as interventions conducted in English. Recommendations are provided for improving the study of outcomes associated with mental health interventions adapted to the cultural context of the client.


It is apparent from previous studies in clinical populations that there is a high comorbidity rate between alcoholism and other psychiatric diagnoses. However, this may simply be an expression of Berkson's bias (i.e., an increased tendency for persons with multiple diagnoses to seek and receive treatment and thus fall into study populations drawn from treatment sources). In this article, we use data from the Epidemiologic Catchment Area survey to examine the comorbidity between alcohol abuse and dependence, other substances of abuse and nonsubstance psychiatric disorders in a sample of approximately 20,000 persons drawn from the general population. We also examine the effect of comorbidity on psychiatric treatment. Every one of the psychiatric diagnoses we examined was more likely to occur in alcoholics than in nonalcoholics. Associations were particularly strong with antisocial personality disorder, other substance use and mania. The association between alcoholism and depressive disorders was positive but not very strong. The presence of other illnesses increased the likelihood of utilization of treatment services by alcoholics but did not increase the likelihood that drinking problems would be communicated to a doctor. The findings confirm prior studies of comorbidity in clinical samples and suggest the need for increased vigilance toward alcoholism by physicians.


There are few mental health issues of greater concern to the wider community than the management of young people with depressive disorders. Consequently, the new draft clinical practice guidelines from beyondblue: the national depression initiative are timely. The previous National Health and Medical Research Council Clinical practice guidelines: depression in young people were produced in 1997 and rescinded in 2004, and a variety of other international perspectives are now available.2,3 Internationally, the limitations of the clinical trial database,
such as small and non-representative or restricted trial samples, and exclusion of more severe cases or patients with suicidal ideation, are widely recognised. Hence, the authors rely very heavily on “good practice points” that are said to be “based on lower quality evidence, expert opinion and current good practice”.


Background: Although numerous efficacy studies in recent years have found internet-based interventions for depression to be effective, there has been scant consideration of therapeutic process factors in the online setting. In face-to-face therapy, the quality of the working alliance explains variance in treatment outcome. However, little is yet known about the impact of the working alliance in internet-based interventions, particularly as compared with face-to-face therapy. Methods: This study explored the working alliance between client and therapist in the middle and at the end of a cognitive-behavioral intervention for depression. The participants were randomized to an internet-based treatment group (n = 25) or face-to-face group (n = 28). Both groups received the same cognitive behavioral therapy over an 8-week timeframe. Participants completed the Beck Depression Inventory (BDI) post-treatment and the Working Alliance Inventory at mid- and post-treatment. Therapists completed the therapist version of the Working Alliance Inventory at post-treatment. Results: With the exception of therapists' ratings of the tasks subscale, which were significantly higher in the online group, the two groups' ratings of the working alliance did not differ significantly. Further, significant correlations were found between clients' ratings of the working alliance and therapy outcome at post-treatment in the online group and at both mid- and post-treatment in the face-to-face group. Correlation analysis revealed that the working alliance ratings did not significantly predict the BDI residual gain score in either group. Conclusions: Contrary to what might have been expected, the working alliance in the online group was comparable to that in the face-to-face group. However, the results showed no significant relations between the BDI residual gain score and the working alliance ratings in either group.


This article reports on a research synthesis of the relation between alliance and the outcomes of individual psychotherapy. Included were over 200 research reports based on 190 independent data sources, covering more than 14,000 treatments. Research involving 5 or more adult participants receiving genuine (as opposed to analogue) treatments, where the author(s) referred to one of the independent variables as “alliance,” “therapeutic alliance,” “helping alliance,” or “working alliance” were the inclusion criteria. All analyses were done using the assumptions of a random model. The overall aggregate relation between the alliance and treatment outcome (adjusted for sample size and non independence of outcome measures) was \( r = .275 \) \((k = 190)\); the 95% confidence interval for this value was .25–.30. The statistical probability associated with the aggregated relation between alliance and outcome is \( p < .0001 \). The data collected for this meta-analysis were quite variable (heterogeneous). Potential variables such as assessment perspectives (client, therapist, observer), publication source, types of assessment methods and time of assessment were explored.


Objectives: Limited data exist on outcomes of older adults receiving psychotherapy for depression in real-world settings. Acceptance and Commitment Therapy for depression (ACT-D)
offers potential utility for older individuals who may experience issues of loss, reduced control, and other life changes. The present article examines and compares outcomes of older and younger Veterans receiving ACT-D nationally in the U.S. Department of Veterans Affairs health care system. Method: Patient outcomes were assessed using the Beck Depression Inventory–Second Edition and the World Health Organization Quality of Life-BREF. Therapeutic alliance was assessed using the Working Alliance Inventory-Short Revised. Results: Six hundred fifty-five Veterans aged 18-64 and 76 Veterans aged 65+ received ACT-D. Seventy-eight percent of older and 67% of younger patients completed all sessions or finished early. Mean depression scores declined from 28.4 (SD = 11.4) to 17.5 (SD = 12.0) in the older group and 30.3 (SD = 10.6) to 19.1 (SD = 14.3) in the younger group. Within-group effect sizes were d = .95 and d = 1.06 for the two age groups, respectively. Quality of life and therapeutic alliance also increased during treatment. Conclusion: The findings suggest that ACT-D is an effective and acceptable treatment for older Veterans treated in routine clinical settings, including those with high levels of depression.


Despite a long tradition of client-centered approaches in addiction therapy, these approaches have not been broadly applied until the 90s of the last century, since treatment programs were predominantly based on behavior therapy. However, due to dissemination of and research on motivational interviewing (MI) over the last 20 years, client-centered therapy has become increasingly accepted in routine care of patients with substance use disorders. Originally, W. R. Miller and S. Rollnick did not establish MI as a brief intervention. Nevertheless, research on MI has mainly been performed within the context of brief interventions. As a consequence, empirically supported client-centered interventions that are based on long-term treatment are largely missing in addiction therapy. OLITA, the Outpatient Long-term Intensive Therapy for Alcoholics, may be one of few exceptions. OLITA is a comprehensive long-term treatment program that is fully compatible with the principles of MI and that combines elements of client-centered and behavior therapy. This review article presents a synopsis of the published literature on OLITA, focusing on aspects of therapeutic alliance and multiple psychotherapy. After a short introduction of the therapy program, we delineate how client-centered therapy is integrated in the context of therapist rotation. The most important data on process–outcome research in OLITA are summarized. Our results suggest that the therapeutic alliance is a major treatment factor that is strongly associated with the eight treatment processes of the TOPPS (Therapy Orientation by Process Prediction Score) that, in turn, is highly predictive of long-term alcohol abstinence. Based on experience of clinical care and training of OLITA therapists, we show in the practical part of this article how to implement therapist rotation and multiple psychotherapy, as well as how to apply communication and interaction skills to build a successful working alliance.


This study compared the effectiveness of a family psychoeducational intervention (FPEI) and a therapeutic alliance focused intervention (TAFI) for parents of daughters and sons with severe mental illness (SMI). A process-outcome model was used to compare the effectiveness of the two interventions and to evaluate how they achieved their outcomes. Extent of effectiveness was assessed in terms of the family burden (FB) of the parents and the quality of life (QoL) and psychiatric symptoms of the daughters and sons. This study did not uncover a difference in effectiveness between the two interventions. However, at post-treatment, the participants in
both interventions reported statistically significant less FB and attributed more QoL and less psychiatric symptoms to their daughters and sons than at pre-treatment. In addition, these pre- and post-treatment differences were mediated by specific mediating variables. These results are discussed in terms of the great psychotherapy debate (Wampold, 2001) as to the relative effectiveness of technique oriented interventions as compared to context oriented interventions.


Little is known about the contribution of technical and relational factors to child outcomes in cognitive behavioral therapy (CBT) for children with anxiety disorders. This study investigated the association between treatment adherence, the child-therapist alliance, and child clinical outcomes in manual-guided individual- and group-based CBT for youths diagnosed with anxiety disorders. Trained observers rated tapes of therapy sessions for treatment adherence and child-therapist alliance in a sample of 52 children (aged 8 to 12) with anxiety disorders. Self-reported child anxiety was assessed at pre-, mid-, and posttreatment; parent-reported child internalizing symptoms was assessed at pre- and posttreatment. The results showed high levels of treatment adherence and child-therapist alliance in both CBT programs. Neither treatment adherence nor child-therapist alliance predicted traditional measurements of child outcomes in the present study, but a relation between alliance and outcome was found using a more precise estimation of the true pre-post differences. Implications of these findings for expanding our understanding of how treatment processes relate to child outcome in CBT for children with anxiety disorders are discussed.


This randomized controlled trial evaluated the efficacy of a brief intervention designed to reduce the harmful consequences of heavy drinking among high-risk college students. Students screened for risk while in their senior year of high school (188 women and 160 men) were randomly assigned to receive an individualized motivational brief intervention in their freshman year of college or to a no-treatment control condition. A normative group selected from the entire screening pool provided a natural history comparison. Follow-up assessments over a 2-year period showed significant reductions in both drinking rates and harmful consequences, favoring students receiving the intervention. Although high-risk students continued to experience more alcohol problems than the natural history comparison group over the 2-year period, most showed a decline in problems over time, suggesting a developmental maturational effect.


The aim of this study was to evaluate the efficacy of a brief motivational enhancement therapy in reducing cannabis use and cannabis-related problems in a population of non-treatment-seeking adolescent cannabis users. In a randomized controlled trial, 40 young people (aged 14–19 years) were randomly assigned to either a two-session brief intervention or a 3-month delayed-treatment control condition. The intervention consisted of a detailed assessment and a session of motivational enhancement therapy. An additional optional discussion of skills for reducing or quitting cannabis use was offered if a participant was interested in discussing these
issues. Primary outcome measures were changes in days of cannabis use, mean quantity of cannabis used weekly, and number of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition dependence symptoms reported. Significantly greater reductions on these measures were found in the Adolescent Cannabis Check-up group at 3-month follow-up. Between-group effect sizes were moderate. The approach is acceptable to participants and merits further evaluation with this difficult to reach population.


In this column, we comment on the state of the science regarding psychotherapy for youths (including children and adolescents) with depression. We begin by discussing our recent meta-analysis of the youth depression clinical trials literature to illustrate how meta-analysis can be of use to clinicians. We consider how to interpret measures of effect size, introduce some cautionary notes, and discuss the Treatment of Adolescent Depression Study (TADS; TADS Team, 2004) as an example of factors that may contribute to effect size. Then, using a component profile, we describe the techniques most often used in the most successful treatments for youth depression. When combined, we suggest, meta-analysis and component profiling can shed light on the magnitude of treatment benefit and on the treatment techniques associated with that benefit.


Consumer, professional, legislative and regulatory organizations are increasingly calling for the development and adoption of evidence-based therapies, based on demands for quality services and expectations that outpouring of dollars and time are rewarded by beneficial outcomes. In child and adolescent mental health, growing public concerns over safety, in particular with psychotropic medications, and the recognition that psychiatric impairment is a major factor within other social service systems has further fueled the demand for empirically based interventions. Randomized, controlled trials (RCTs) with adequate sample sizes and defined study populations are the standard for characterizing an intervention as evidence-based (Cochrane Collaboration, 2002). A listing of all RCTs in child and adolescent psychiatry is beyond the scope of this commentary (for a review, see McClellan and Werry [2003]). This review will outline interventions with the best research support. Fortunately, although the literature remains limited, the number of well-conducted studies is increasing.


Despite mental disorders being the dominant health issue confronting young people, youth mental health is yet to be recognised as a discrete, unified program area; responsibility for young people’s mental health is currently split across multiple levels of government. Public specialist mental health services have followed a paediatric–adult split in service delivery, mirroring general and acute health care. The pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest. Young people need youth-friendly services that recognise and respond to their special cultural and developmental needs. At the primary and community level, headspace: the National Youth Mental Health Foundation, is a national response to this and aims to provide better access, engagement and enhanced multidisciplinary
care for young people across Australia. The specialist mental health service level should be complemented by youth-specific specialist mental health services for young people, aged 12–25 years, which would strengthen the existing system with a better targeted stream of care, providing access to integrated mental health, substance use, and vocational-recovery services. Alternative approaches to creating this capacity should be urgently developed and evaluated, and sustained reform informed by evidence as well as values.


Recognizing an urgent need for increased access to evidenced-based psychological treatments, public health authorities have recently allocated over $2 billion to better disseminate these interventions. In response, implementation of these programs has begun, some of it on a very large scale, with substantial implications for the science and profession of psychology. But methods to transport treatments to service delivery settings have developed independently without strong evidence for, or even a consensus on, best practices for accomplishing this task or for measuring successful outcomes of training. This article reviews current leading efforts at the national, state, and individual treatment developer levels to integrate evidence-based interventions into service delivery settings. Programs are reviewed in the context of the accumulated wisdom of dissemination and implementation science and of methods for assessment of outcomes for training efforts. Recommendations for future implementation strategies will derive from evaluating outcomes of training procedures and developing a consensus on necessary training elements to be used in these efforts.


The goal of this meta-analytic review was to provide a reliable estimate of the alliance–outcome relation in youth psychotherapy. Previous meta-analyses focused upon the alliance–outcome association in youth and adult psychotherapy have produced effect size (ES) estimates above r = .20. In the current study, meta-analytic methods were applied to the largest study sample collected (N = 38) to date in the youth psychotherapy field and the mean weighted ES estimate was r = .14, which is smaller than previous estimates. The child- and parent-therapist alliances were not differentially associated with outcomes. However, the alliance–outcome association did vary across theoretical (i.e., child age, problem type, referral source, and mode of treatment) and methodological (i.e., source and timing of alliance assessment; domain, technology, and source of outcome assessment; single vs. multiple informants) variables. Existing client-, therapist-, and observer-report alliance measures evidenced adequate reliability; however, substantial variability exists in how the alliance is conceptualized and measured. Though the magnitude of the ES estimate raises questions about the role that the alliance may play in youth psychotherapy, the findings also suggest that the extant literature represents a heterogeneous group of studies whose effects vary according to theoretical and methodological factors. Addressing existing knowledge and measurement gaps in the field may therefore lead to a more robust estimate of the alliance–outcome association in youth psychotherapy.


Background: Depression is common in young people, has a marked negative impact and is associated with self-harm and suicide. Preventing its onset would be an important advance in
public health. Objectives: To determine whether psychological or educational interventions, or both, are effective in preventing the onset of depressive disorder in children and adolescents. 

Search methods: The Cochrane Depression, Anxiety and Neurosis Review Group’s trials registers (CCDANCTR) were searched at the editorial base in July 2010. Update searches of MEDLINE, EMBASE, PsycINFO and ERIC were conducted by the authors in September 2009. Conference abstracts, reference lists of included studies and reviews were searched and experts in the field contacted. Selection criteria: Randomised controlled trials of psychological or educational prevention programmes, or both, compared with placebo, any comparison intervention, or no intervention for young people aged 5 to 19 years-old, who did not currently meet diagnostic criteria for depression or who were below the clinical range on standardised, validated, and reliable rating scales of depression, or both, were included. Data collection and analysis: Two authors independently assessed studies for inclusion and rated their quality. Sample sizes were adjusted to take account of cluster designs and multiple comparisons. We contacted study authors for additional information where needed. Main results: Fifty-three studies including 14,406 participants were included in the analysis. There were only six studies with clear allocation concealment, participants and assessors were mostly not blind to the intervention or blinding was unclear so that the overall risk of bias was moderately high. Sixteen studies including 3240 participants reported outcomes on depressive diagnosis. The risk of having a depressive disorder post-intervention was reduced immediately compared with no intervention (15 studies; 3115 participants risk difference (RD) -0.09; 95% confidence interval (CI) -0.14 to -0.05; P<0.0003), at three to nine months (14 studies; 1842 participants; RD -0.11; 95% CI -0.16 to -0.06) and at 12 months (10 studies; 1750 participants; RD -0.06; 95% CI -0.11 to -0.01). There was no evidence for continued efficacy at 24 months (eight studies; 2084 participant; RD -0.01; 95% CI -0.04 to 0.03) but limited evidence of efficacy at 36 months (two studies; 464 participants; RD -0.10; 95% CI -0.19 to -0.02). There was significant heterogeneity in all these findings. There was no evidence of efficacy in the few studies that compared intervention with placebo or attention controls. Authors’ conclusions: There is some evidence from this review that targeted and universal depression prevention programmes may prevent the onset of depressive disorders compared with no intervention. However, allocation concealment is unclear in most studies, and there is heterogeneity in the findings. The persistence of findings suggests that this is real and not a placebo effect.


This article represents the proceedings of a symposium at the 2004 Research Society on Alcoholism meeting in Vancouver, British Columbia, Canada, organized and chaired by Peter M. Monti and Fulton T. Crews. The presentations and presenters were (1) Introduction, by Peter M. Monti; (2) Adolescent Binge Drinking Causes Life-Long Changes in Brain, by Fulton T. Crews and Kim Nixon; (3) Functional Neuroimaging Studies in Human Adolescent Drinkers, by Susan F. Tapert; (4) Abnormal Emotional Reactivity as a Risk Factor for Alcoholism, by Robert Miranda, Jr.; (5) Alcohol-Induced Memory Impairments, Including Blackouts, and the Changing Adolescent Brain, by Aaron M. White and H. Scott Swartzwelder; and (6) Discussion, by Kenneth Sher.


This state-of-the-art book presents research-based practice guidelines that clinicians of any orientation can use to optimize the therapeutic alliance. Leading proponents of the major psychotherapeutic approaches explain just what a good alliance is, how to create it, and how to
recognize and repair alliance ruptures. Applications in individual, group, couple, and family therapy are explored; case examples vividly illustrate the concepts and techniques. Links between the quality of the alliance and client outcomes are elucidated. A section on training fills a major gap in the field, reviewing proven strategies for helping therapists to develop key relationship-building skills.


Self-injury is a dangerous and pervasive behavior problem among adolescents. Clinical trials testing the effectiveness of psychological treatments for this behavior problem among adolescents are lacking; however, several treatments have shown promise, such as those focused on teaching emotion regulation, distress tolerance, and interpersonal skills. The authors provide a case illustration of the use of dialectical behavior therapy, which is one of the most promising treatments for adolescent self-injury. They then discuss several important considerations in the treatment of self-injury, such as the use of strategies to increase treatment participation and the assessment of self-injury and related target behaviors over the course of treatment to determine its effectiveness and to manage risk of self-injury.


This article summarizes the proceedings of a symposium, chaired by Peter Monti and cochaired by Tracy O'Leary, that was presented at the 2001 RSA Meeting in Montreal, Quebec. The aim of this symposium was to present data on group- and individual-based interventions for adolescent alcohol and substance abuse, with a discussion of the implications of research findings bearing on developmental considerations when working with adolescents and young adults. Elizabeth J. D'Amico, PhD, reviewed recent findings on adolescents' choice of type of substance abuse treatment. Jennifer L. Maggs, PhD, presented a developmental perspective on this issue. Tracy O'Leary, PhD, presented data on enhancing motivational interviewing with the presence of a supportive peer for college students cited for alcohol infractions. Mary E. Larimer, PhD, presented 1-year follow-up results of the Greeks 2000 Project, a 5-year longitudinal study designed to evaluate the efficacy of an alcohol abuse prevention program provided to college students who were entering a pledge class (first year) of Greek houses. Barbara McCrady, PhD, a noted expert on the treatment of couples for substance abuse problems, served as discussant.


Purpose: To assess primary care providers’ rates of screening for emotional distress among adolescent patients. Methods: Secondary data analysis utilizing data from: (1) well visits in pediatric clinics within a managed care plan in California, and (2) the 2003 California Health Interview Survey (CHIS), a state population sample. The Pediatric clinic sample included 1089 adolescent patients, ages 13 to 17, who completed a survey about provider screening immediately upon exiting a well visit. The CHIS sample included 899 adolescents, ages 13 to 17, who had a routine physical exam within the past 3 months. As part of the survey, adolescents answered a question about whether they had talked with their provider about their emotions at the time of the exam. Logistic regressions, controlling for age, gender, race/ethnicity, and adolescent depressive symptoms were performed. Results: About one-third of adolescents reported a discussion of emotional health. Females were significantly more likely to be screened than males (36% vs. 30% in clinic; 37% vs. 26% in CHIS); as were older and Latino adolescents in
the clinic sample. Although 27% of teens endorsed emotional distress, distress was not a significant predictor of talking to a provider about emotions.


Approximately 10% of children and adolescents have mental health problems necessitating intervention, but well below 50% of these children receive needed services, and far fewer receive the quality of care required to effectively reduce their impairments. Although system reform is needed to improve service utilization and quality of care for all children, preschoolers, girls, individuals of minority status, and the uninsured are most at risk for being underserved. Factors contributing to poor service utilization can be classified into two broad sets: sociopolitical factors referring to issues related to funding and access, and cultural/familial factors including beliefs about mental health services, providers, and treatments. This article describes the help-seeking process and focuses on cultural and familial factors that contribute to movement through these stages, with a particular focus on variables that are amenable to change by practitioners in the school and community, including school psychologists. Guidelines for understanding and changing the help-seeking behavior of families, including suggestions for creating service options, providing family education, and offering individualized family services, are described.


This study evaluated the immediate postintervention effects of two brief suicide prevention protocols: a brief interview—Counselors CARE (C-CARE)—and C-CARE plus a 12-session Coping and Support Training (CAST) peer-group intervention. Subjects were students “at risk” of high school dropout and suicide potential in Grades 9–12 from seven high schools (N = 341). Students were assigned randomly to C-CARE plus CAST, C-CARE only, or “intervention as usual.” The predicted patterns of change were assessed using trend analyses on data available from three repeated measures. C-CARE and CAST led to increases in personal control, problem-solving coping, and perceived family support. Both C-CARE plus CAST and C-CARE only led to decreases in depression, and to enhanced self-esteem and family goals met. All three groups showed equivalent decreases in suicide risk behaviors, anger control problems, and family distress.


Objective: To determine the effectiveness of brief strategic family therapy (BSFT; an evidence-based family therapy) compared to treatment as usual (TAU) as provided in community-based adolescent outpatient drug abuse programs. Method: A randomized effectiveness trial in the National Drug Abuse Treatment Clinical Trials Network compared BSFT to TAU with a multiethnic sample of adolescents (213 Hispanic, 148 White, and 110 Black) referred for drug abuse treatment at 8 community treatment agencies nationwide. Randomization encompassed both adolescents’ families (n = 480) and the agency therapists (n = 49) who provided either TAU or BSFT services. The primary outcome was adolescent drug use, assessed monthly via adolescent self-report and urinalysis for up to 1 year post randomization. Secondary outcomes included treatment engagement (≥2 sessions), retention (≥8 sessions), and participants’ reports of family functioning 4, 8, and 12 months following randomization. Results: No overall differences between conditions were observed in the trajectories of self-reports of adolescent
drug use. However, the median number of days of self-reported drug use was significantly higher, $\chi^2(1) = 5.40, p < .02$, in TAU (Mdn = 3.5, interquartile range [IQR] = 11) than BSFT (Mdn = 2, IQR = 9) at the final observation point. BSFT was significantly more effective than TAU in engaging, $\chi^2(1) = 11.33, p < .001$, and retaining, $\chi^2(1) = 5.66, p < .02$, family members in treatment and in improving parent reports of family functioning, $\chi^2(2) = 9.10, p < .011$. Conclusions: We discuss challenges in treatment implementation in community settings and provide recommendations for further research.


Background: Although deliberate self-harm is prevalent among young people, many who engage in deliberate self-harm receive sub-optimal care. Although schools are a well placed setting to support young people who engage in self-harm there are no specific training packages designed to assist school welfare staff to support these young people. The current study aimed to design, deliver and evaluate a training course specifically for school staff. Methods: The study employed a longitudinal design. Two hundred and thirteen people participated in the training and evaluation. A questionnaire was administered at baseline, immediately after the training and at 6-month follow-up in order to determine if the training led to improvements in confidence when working with young people who self-harm, perceived skill, knowledge of, and attitudes towards people who self-harm. Results: Prior to the course, the majority of participants demonstrated relatively high levels of confidence, perceived skill and knowledge of self-harm and endorsed relatively positive attitudes towards people who engage in self-harm. Despite this, significant improvements were observed in terms of increased confidence, increased perceptions of skill along with increased knowledge of deliberate self-harm. These improvements were sustained over the follow-up period. Conclusion: The results demonstrated that the provision of specifically designed training can help school welfare staff to feel better equipped to support young people who are engaging in deliberate self-harm.


OBJECTIVE. Few investigations have assessed the primary care detection of adolescent posttraumatic emotional distress after an injury. We aimed to determine (1) the level of attachment to primary care providers (PCPs) and school providers among this group of high-risk adolescents, (2) the emotional status of this population postinjury, (3) continuity of care between trauma center and community care, and (4) PCPs' detection of emotional problems in adolescents after an injury. METHODS. This was a prospective cohort study of traumatically injured adolescents aged 12 to 18 who were admitted to a level I regional trauma center. Adolescents were screened for posttraumatic stress symptoms, depressive symptoms, and alcohol use on the surgical ward and 4 to 6 months postinjury. PCPs were contacted by telephone 4 to 6 months postinjury to assess follow-up care and the detection of emotional distress. RESULTS. In the surgical ward, 39.4% of the adolescent patients or their parents reported no identifiable source of regular medical care. Only 24.3% of the patients had visited a PCP during the 4 to 6 months after injury. At 4 to 6 months postinjury, 30% of the adolescents were experiencing high posttraumatic stress symptom levels, 11% were experiencing high depressive symptom levels, and 17% had high levels of alcohol use. PCPs did not detect any new emotional distress or problem drinking during postinjury office visits. CONCLUSIONS. Injured adolescents represent a high-risk pediatric population, a substantial number of whom develop
mental health problems postinjury. Furthermore, almost 40% of adolescents in our study reported no source of primary care. These results suggest that referrals from trauma centers to PCPs are necessary and that an increase in awareness of and screening for adolescent emotional distress postinjury during follow-up appointments and at school should be routine components of postinjury care.


Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk. This paper describes research on the components of SBIRT conducted during the past 25 years, including the development of screening tests, clinical trials of brief interventions and implementation research. Beginning in the 1980s, concerted efforts were made in the US and at the World Health Organization to provide an evidence base for alcohol screening and brief intervention in primary health care settings. With the development of reliable and accurate screening tests for alcohol, more than a hundred clinical trials were conducted to evaluate the efficacy and cost effectiveness of alcohol screening and brief intervention in primary care, emergency departments and trauma centers. With the accumulation of positive evidence, implementation research on alcohol SBI was begun in the 1990s, followed by trials of similar methods for other substances (e.g., illicit drugs, tobacco, prescription drugs) and by national demonstration programs in the US and other countries. The results of these efforts demonstrate the cumulative benefit of translational research on health care delivery systems and substance abuse policy. That SBIRT yields short-term improvements in individuals’ health is irrefutable; long-term effects on population health have not yet been demonstrated, but simulation models suggest that the benefits could be substantial.


This study reports data on the efficacy of Strategic Structural Systems Engagement (SSSE), which is designed to bring hard-to-reach families into treatment. The study also explores variables that may contribute to differential effectiveness. Participants were 193 Hispanic families, who were randomly assigned to either experimental or control conditions. Several important findings emerged. First, the overall results replicated earlier findings showing the superiority of SSSE: 81% of SSSE families, compared to 60% of control families, were successfully engaged, χ²(1, N=193)=7.5, p<.001. Second, SSSE interventions were more successful with non-Cuban Hispanics (97% successfully engaged) than with Cuban Hispanics (64% successfully engaged), χ²(1, N=51)=7.53, p=.006. Third, an analysis of intervention failure suggests a mechanism by which culture and ethnicity influence clinical processes (resistance to engagement) and may result in differential effectiveness.


One problem in conceptualizing the various explanatory factors in psychotherapy has been the lack of a common theoretical language by which to construe these various aspects of treatment. This article integrates a broad range of theoretical contributions within the wider context of a learning theory perspective of essential psychotherapeutic processes. A tripartite model of
psychotherapy is outlined that incorporates the contributions of the emotional learning that takes place in the therapeutic alliance, the cognitive aspects of the therapist's technical interventions that are intended to accelerate change, and the behavioral elements of relearning that take place in the patient's world beyond the consulting room.


Psychotherapy research in children and adolescents has generated several evidence-based interventions in recent years. At this point, we know much about what outcomes are produced by treatments but have little understanding what drives these changes. The need for individualization in assessment and therapy is not new but still in its infancy. Furthermore, treatments should be adapted to a patient’s developmental level to optimize treatment efficacy. Novel assessment methods and trial designs that take individual treatment needs and the context of problems into account seem promising to personalize evidence-based treatments and thereby facilitate their implementation into clinical practice.


Innovate and adapt are watchwords for substance abuse treatment programs in today's environment of legislative mandates, effective new interventions, and competition. Organizations are having to evolve—ready or not—and those that are ready have superior chances for success and survival. The Texas Christian University Organizational Readiness for Change (ORC) survey is a free instrument, with supporting materials, that substance abuse treatment programs use to assess organizational traits that can facilitate or hinder efforts at transition. This article presents organizational change as a three-stage process of adopting, implementing, and routinizing new procedures; describes the use of the ORC; and outlines a step-by-step procedure for clearing away potential obstacles before setting forth on the road to improved practices and outcomes.


Context: No randomized controlled studies have been conducted to date on the effectiveness of psychological interventions for children with symptoms of posttraumatic stress disorder (PTSD) that has resulted from personally witnessing or being personally exposed to violence. Objective: To evaluate the effectiveness of a collaboratively designed school-based intervention for reducing children's symptoms of PTSD and depression that has resulted from exposure to violence. Design: A randomized controlled trial conducted during the 2001-2002 academic year. Setting and Participants: Sixth-grade students at 2 large middle schools in Los Angeles who reported exposure to violence and had clinical levels of symptoms of PTSD. Students were randomly assigned to a 10-session standardized cognitive-behavioral therapy (the Cognitive-Behavioral Intervention for Trauma in Schools) early intervention group (n = 61) or to a wait-list delayed intervention comparison group (n = 65) conducted by trained school mental health clinicians. Main Outcome Measures: Students were assessed before the intervention and 3 months after the intervention on measures assessing child-reported symptoms of PTSD (Child PTSD Symptom Scale; range, 0-51 points) and depression (Child Depression Inventory; range, 0-52 points), parent-reported psychosocial dysfunction (Pediatric Symptom Checklist; range, 0-70 points), and teacher-reported classroom problems using the Teacher-Child Rating Scale (acting
out, shyness/anxiousness, and learning problems; range of subscales, 6-30 points). Results: Compared with the wait-list delayed intervention group (no intervention), after 3 months of intervention students who were randomly assigned to the early intervention group had significantly lower scores on symptoms of PTSD (8.9 vs 15.5, adjusted mean difference, −7.0; 95% confidence interval [CI], −10.8 to −3.2), depression (9.4 vs 12.7, adjusted mean difference, −3.4; 95% CI, −6.5 to −0.4), and psychosocial dysfunction (12.5 vs 16.5, adjusted mean difference, −6.4; 95% CI, −10.4 to −2.3). Adjusted mean differences between the 2 groups at 3 months did not show significant differences for teacher-reported classroom problems in acting out (−1.0; 95% CI, −2.5 to 0.5), shyness/anxiousness (0.1; 95% CI, −1.5 to 1.7), and learning (−1.1, 95% CI, −2.9 to 0.8). At 6 months, after both groups had received the intervention, the differences between the 2 groups were not significantly different for symptoms of PTSD and depression; showed similar ratings for psychosocial function; and teachers did not report significant differences in classroom behaviors. Conclusion: A standardized 10-session cognitive-behavioral group intervention can significantly decrease symptoms of PTSD and depression in students who are exposed to violence and can be effectively delivered on school campuses by trained school-based mental health clinicians.


In this depression prevention trial, 341 high-risk adolescents (mean age = 15.6 years, SD = 1.2) with elevated depressive symptoms were randomized to a brief group cognitive-behavioral (CB) intervention, group supportive-expressive intervention, bibliotherapy, or assessment-only control condition. CB participants showed significantly greater reductions in depressive symptoms than did supportive-expressive, bibliotherapy, and assessment-only participants at posttest, though only the difference compared with assessment controls was significant at 6-month follow-up. CB participants showed significantly greater improvements in social adjustment and reductions in substance use at posttest and 6-month follow-up than did participants in all 3 other conditions. Supportive-expressive and bibliotherapy participants showed greater reductions in depressive symptoms than did assessment-only controls at certain follow-up assessments but produced no effects for social adjustment and substance use. CB, supportive-expressive, and bibliotherapy participants showed a significantly lower risk for major depression onset over the 6-month follow-up than did assessment-only controls. The evidence that this brief CB intervention reduced risk for future depression onset and outperformed alternative interventions for certain ecologically important outcomes suggests that this intervention may have clinical utility.


The therapeutic alliance is a common factor in psychotherapy that is associated with positive treatment outcomes for adult, child, and adolescent clients receiving mental health services. Compared to research with adult therapy clients, little research has been conducted with adolescent clients examining factors associated with the therapeutic alliance. The current study investigated possible predictors of the therapeutic alliance with adolescent clients receiving outpatient services at two community mental health centers: the adolescent’s attachment to his or her parent, and the extent to which parents and adolescents agree regarding the adolescent’s presenting problems. Consistent with previous research, parent-adolescent agreement on presenting problems was low. Regression analyses indicated a significant main effect of
attachment such that stronger attachments of the clients to their parents predicted stronger alliances with the therapist, as well as a significant interaction between attachment and agreement on presenting problems. Implications of these findings for enhancing the quality of the alliance with adolescent clients are discussed.


Motivational interviewing (MI) is an effective method of promoting change in adults, but its efficacy with children and adolescents is in the early stages of evaluation. The brevity of the intervention, documented effectiveness in adult populations and emphasis on motivating behavioural change have encouraged some researchers to test MI in educational settings. However, the number and quality of studies of MI with children and adolescents are limited, and it remains unclear whether MI is developmentally appropriate for children. This conceptual paper reviews cognitive and neurodevelopmental evidence of children's and adolescents' cognitive and social–emotional readiness for mental tasks thought to drive behavioural change in MI. Owing to the social context of MI, we place this research in a developmental framework using the social information processing network model of Nelson, Leibenluft, McClure, and Pine (2005). Based on these findings, we recommend continued testing of MI with students in middle and high schools but caution against using MI with elementary school students.


Despite the efficacy of family-based interventions for improving outcomes for adolescent behavior problems such as substance use, engaging and retaining whole families in treatment is one of the greatest challenges therapists confront. This article illustrates how the Brief Strategic Family Therapy model, a family-based, empirically validated intervention designed to treat children and adolescents' problem behaviors, can be used to increase engagement, improve retention, and bring about positive outcomes for families. Research evidence for efficacy and effectiveness is also presented.


Recently, the field of mental health has incorporated a growing interest in strengths, resilience, and growth, psychological phenomena that may be associated with healthy adjustment trajectories and profitably integrated into strategies for clinical assessment and practice. This movement constitutes a significant shift from traditional deficit-oriented approaches. Addressing clinical practitioners, this article (a) provides a broad overview of these constructs and phenomena, (b) discusses their relevance for clinical assessment and intervention, and (c) describes selected strategies and approaches for conducting assessments that can guide intervention.


Comorbidity is most generally defined as the co-occurrence of two or more mental health problems. Comorbidity between drug and other psychological disorders has emerged as a major clinical, public health and research issue over the past few decades. The reasons for comorbidity are complex. Furthermore, comorbidity is often associated with poor treatment outcome, severe illness course, and high service utilisation. This presents a significant challenge with
respect to the identification, prevention and management of people with comorbid disorders. The unmet need for treatment within this group is considerable and the lack of research is unacceptable. This paper will give a brief overview of epidemiological research into comorbidity; and examine the reasons why comorbidity might occur.


**Aims:** To present a comprehensive review of the use of motivational enhancement and other brief interventions for substance use in adolescents. **Methods:** In this paper, we review the major theoretical foundations and influences of brief interventions (including motivational interviewing), consider developmental issues in its application for adolescents, discuss methodological issues in the design and implementation of brief interventions, including the assessment of treatment fidelity, evaluate and interpret the latest findings on brief interventions for adolescents and young people and discuss the issue of translating and exporting effective research into practice. **Findings:** Results from recent clinical trials using motivational interventions indicate that these approaches result in decreases in substance-related negative consequences and problems, decrements in substance use and increased treatment engagement, with results particularly strong for those with heavier substance use patterns and/or less motivation to change. **Conclusion:** While results are promising, more research is needed to examine the essential elements of motivational interventions, for whom they work best, and their impact on developmental transitions during adolescence.


The therapeutic alliance is deemed to be integral to psychotherapeutic interventions, yet little is known about the nature of its role in treatment for substance use disorders (SUD), especially among young people. We investigated baseline predictors of the therapeutic alliance measured midtreatment and tested whether the alliance influenced during-treatment changes in key process variables (psychological distress, motivation, self-efficacy, coping skills, and commitment to Alcoholics Anonymous/Narcotics Anonymous [AA/NA]) independent of these baseline influences. Young adults in residential treatment (N = 303; age 18–24 years) were assessed at intake, midtreatment, and discharge. Older age and higher baseline levels of motivation, self-efficacy, coping skills, and commitment to AA/NA predicted a stronger alliance. Independent of these influences, participants who developed a stronger alliance achieved greater reductions in distress during treatment. Findings clarify a role for alliance in promoting during-treatment changes through reducing distress.


Cannabis use adversely affects adolescents and interventions that are attractive to adolescents are needed. This trial compared the effects of a brief motivational intervention for cannabis use with a brief educational feedback control and a no-assessment control. Participants were randomized into one of three treatment conditions: Motivational Enhancement Therapy (MET), Educational Feedback Control (EFC), or Delayed Feedback Control (DFC). Those who were assigned to MET and EFC were administered a computerized baseline assessment immediately following randomization and completed assessments at the 3- and 12-month follow-up periods. Participants in the DFC condition were not assessed until the 3-month follow-up. Following the
completion of treatment sessions, all participants were offered up to four optional individual treatment sessions aimed at cessation of cannabis use. The research was conducted in high schools in Seattle, Washington. The participants included 310 self-referred adolescents who smoked cannabis regularly. The main outcome measures included days of cannabis use, associated negative consequences, and engagement in additional treatment. At the 3-month follow-up, participants in both the MET and EFC conditions reported significantly fewer days of cannabis use and negative consequences compared to those in the DFC. The frequency of cannabis use was less in MET relative to EFC at 3 months, but it did not translate to differences in negative consequences. Reductions in use and problems were sustained at 12 months, but there were no differences between MET and EFC interventions. Engagement in additional treatment was minimal and did not differ by condition. Brief interventions can attract adolescent cannabis users and have positive impacts on them, but the mechanisms of the effects are yet to be identified.


Context: Emergency department (ED) visits present an opportunity to deliver brief interventions to reduce violence and alcohol misuse among urban adolescents at risk of future injury.

Objective: To determine the efficacy of brief interventions addressing violence and alcohol use among adolescents presenting to an urban ED.

Design, Setting, and Participants: Between September 2006 and September 2009, 3338 patients aged 14 to 18 years presenting to a level I ED in Flint, Michigan, between 12 PM and 11 PM 7 days a week completed a computerized survey (43.5% male; 55.9% African American). Adolescents reporting past-year alcohol use and aggression were enrolled in a randomized controlled trial (SaferTeens). Intervention: All patients underwent a computerized baseline assessment and were randomized to a control group that received a brochure (n = 235) or a 35-minute brief intervention delivered by either a computer (n = 237) or therapist (n = 254) in the ED, with follow-up assessments at 3 and 6 months. Combining motivational interviewing with skills training, the brief intervention for violence and alcohol included review of goals, tailored feedback, decisional balance exercise, role plays, and referrals. Main Outcome Measures: Self-report measures included peer aggression and violence, violence consequences, alcohol use, binge drinking, and alcohol consequences. Results: About 25% (n = 829) of screened patients had positive results for both alcohol and violence; 726 were randomized. Compared with controls, participants in the therapist intervention showed self-reported reductions in the occurrence of peer aggression (therapist, −34.3%; control, −16.4%; relative risk [RR], 0.74; 95% confidence interval [CI], 0.61-0.90), experience of peer violence (therapist, −10.4%; control, +4.7%; RR, 0.70; 95% CI, 0.52-0.95), and violence consequences (therapist, −30.4%; control, −13.0%; RR, 0.76; 95% CI, 0.64-0.90) at 3 months. At 6 months, participants in the therapist intervention showed self-reported reductions in alcohol consequences (therapist, −32.2%; control, −17.7%; odds ratio, 0.56; 95% CI, 0.34-0.91) compared with controls; participants in the computer intervention also showed self-reported reductions in alcohol consequences (computer, −29.1%; control, −17.7%; odds ratio, 0.57; 95% CI, 0.34-0.95). Conclusion: Among adolescents identified in the ED with self-reported alcohol use and aggression, a brief intervention resulted in a decrease in the prevalence of self-reported aggression and alcohol consequences.

In the debate over evidence-based treatments (EBTs) for youth, one question is central: Do EBTs produce better outcomes than the usual interventions employed in clinical care? The authors addressed this question through a meta-analysis of 32 randomized trials that directly compared EBTs with usual care. EBTs outperformed usual care. Effects fell within the small to medium range at posttreatment, increasing somewhat at follow-up. EBT superiority was not reduced by high levels of youth severity or by inclusion of minority youths. The findings underscore a need for improved study designs and detailed treatment descriptions. In the future, the EBT versus usual care genre can inform the search for the most effective interventions and guide treatment selection in clinical care.


Wide-rangingly regarded as a premier text and clinical resource, this book presents exemplary treatment approaches for a broad range of social, emotional, and behavioral problems in children and adolescents. Concise chapters from leading authorities describe the conceptual underpinnings of each therapy, how interventions are delivered on a session-by-session basis, and what the research shows about treatment effectiveness. Contributors discuss recommended manuals and other clinical and training resources and provide details on how to obtain them.


Serious sequelae of youth depression, plus recent concerns over medication safety, prompt growing interest in the effects of youth psychotherapy. In previous meta-analyses, effect sizes (ESs) have averaged .99, well above conventional standards for a large effect and well above mean ES for other conditions. The authors applied rigorous analytic methods to the largest study sample to date and found a mean ES of .34, not superior but significantly inferior to mean ES for other conditions. Cognitive treatments (e.g., cognitive-behavioral therapy) fared no better than noncognitive approaches. Effects showed both generality (anxiety was reduced) and specificity (externalizing problems were not), plus short- but not long-term holding power. Youth depression treatments appear to produce effects that are significant but modest in their strength, breadth, and durability.


For decades, empirically tested youth interventions have prevented dysfunction by addressing risk and ameliorated dysfunction through treatment. The authors propose linking prevention and treatment within an integrated model. The model suggests a research agenda: Identify effective programs for a broadened array of problems and disorders, examine ethnicity and culture in relation to intervention adoption and impact, clarify conditions under which programs do and do not work, identify change mechanisms that account for effects, test interventions in real-world contexts, and make tested interventions accessible and effective in community and practice settings. Connecting the science and practice of prevention and treatment will be good for science, for practice, and for children, adolescents, and their families.


The need for cultural competence and the need for evidence-based practice in mental health services are major issues in contemporary discourse, especially in the psychological treatment of
people of color. Although these 2 paradigms are complementary in nature, there is little cross-fertilization in the psychological literature. The present article illustrates the complementary nature of these 2 paradigms. A main point of convergence is related to the development of culturally adapted interventions in the move from efficacy research to effectiveness studies. The implications of cultural adaptations of empirically supported treatments for mental health services in terms of research and practice with ethnic/racial minority populations are discussed.


Objective: To examine the relationship of depressive and disruptive disorders with patterns of mental health services utilization in a community sample of children and adolescents. Method: Data were from the NIMH Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. The sample consisted of 1,285 child (ages 9–17 years) and parent/guardian pairs. Data included child psychopathology (assessed by the Diagnostic Interview Schedule for Children), Impairment, child need and use of mental health services, and family socioeconomic status. Results: After adjusting for potential confounding factors, disruptive disorder was significantly associated with children's use of mental health services, but depressive disorder was not. For school-based services, no difference was found between the 2 types of disorders. Parents perceived greater need for mental health services for children with disruptive disorders than for those with depression. Conversely, depression was more related to children's perception of mental health service need than was disruptive disorder. Conclusions: The findings highlight the need for more effective ways to identify and refer depressed children to mental health professionals, the importance of improving school-based services to meet children's needs, and the necessity to better educate parents and teachers regarding the identification of psychiatric disorders, especially depression.