An imaginative group of articles have been published in the past several years describing a rich array of brief clinical interventions designed to be of help to children and adolescents. A small number of these interventions have been rigorously evaluated, but those whose outcomes have been studied have demonstrated very promising results. In fact, the last decade has witnessed a significant increase in published reports of brief psychotherapy with children and adolescents, including a number of both controlled and uncontrolled treatment outcome studies. The principal difference between these two types of outcome studies depends on whether data from some comparison group or groups have been collected and contrasted with the results of the index treatment under investigation. [Brief Treatment and Crisis Intervention 2:261–273 (2002)]

KEY WORDS: brief child therapy, brief adolescent therapy, school problems, physical illness, sexual abuse, behavior disorders, attention deficit and hyperactivity disorder, parental illness, parental death.

The last decade has witnessed a significant increase in published reports of brief psychotherapy with children and adolescents, including a number of both controlled and uncontrolled treatment outcome studies. The principal difference between these two types of outcome studies depends on whether data from some comparison group or groups have been collected and contrasted with the results of the index treatment under investigation. Controlled treatment outcome studies include comparison data from groups of clients (often randomly selected) that differ in either the type or duration of treatment, or serve as untreated controls.

Some recent reviews offer more complex categorizations of clinical outcome studies. Nathan and Gorman (1998), for example, identify six types of outcome studies ranging from the most rigorous (prospective clinical trials involving comparison groups, random assignment, blind assessments, specified exclusion and inclusion criteria, state-of-the-art diagnostic methods, adequate sample size, and clearly described statistical methods) to moderately rigorous (for example, case-control studies in which retrospective data are collected and analyzed in or-
der to obtain pilot data that will help determine whether a specific treatment merits a more rigorous evaluation, to the least rigorous (case studies, essays, and clinical opinion papers).

A number of clinical reports have recently appeared that describe, often in considerable detail, a wide variety of approaches to the brief treatment of children and adolescents. Among these are comprehensive overviews (Dwivedi, 2000; Ghuman & Sarles, 1998; Prout & Brown, 1999; Russ & Ollendick, 1999; Snyder, 2000), as well as specific studies of brief group therapy (Leon & Dziegielewski, 1996; Toren et al., 2000), short-term play therapy (Kaduson & Schaefer, 2000; Landreth, 2001), brief cognitive-behavioral therapy (Orbach, 1999; Toren et al., 2000), brief solution-focused therapy (Corcoran & Stephen- son, 2000; Davis & Osborn, 2000; Thompson & Littrell, 1998), brief psychodynamic psychotherapy (Brunstetter, 1998; Lanyado & Horne, 1999; Shefler, 2000; Warren & Messer, 1999), and brief interpersonal psychotherapy (Fom- bonne, 1998; Mufson & Moreau, 1998). In addition, there are reports of a variety of brief therapy approaches in the treatment of conduct disorders (Kazdin, 1998), loss of hope (Snyder, 2000), mild traumatic brain injury (Miller & Mittenberg, 1998), and first episode psychosis (McGorry & Edwards, 1998).

The Kazdin review is particularly noteworthy. While the review is not limited to planned short-term psychotherapeutic approaches, in fact most of the treatments that were reviewed were brief and time-limited. Within this treatment context Kazdin found that as of the early to mid-1990s, rigorous outcome studies of four treatment approaches in working with young people with conduct disorders and their families were sufficiently promising to justify continued examination. These treatments include cognitive problem-solving skills training, parent management training, functional family therapy, and multisystemic therapy. In all four cases rigorous randomized clinical trials yielded very favorable results.

### Uncontrolled Treatment Outcome Studies

In this group of studies outcome data were collected and analyzed across time, but no comparison groups were identified and assessed in the process of evaluating the effects of the intervention program.

### Outpatient Studies

A number of studies have examined treatment effectiveness in specific diagnostic groups. Corder, Haizlip, and DeBoer (1990) have developed a group program designed to foster mastery skills in a sample of 6- to 8-year-old sexually abused children. Groups comprised eight girls and met for 20 sessions over a 5-month period for 1 hour per session. A number of innovative psychoeducational techniques were designed to help the children strengthen their intellectualization defenses, explore their feelings, engage in cognitive relabeling, and enhance their self-esteem. Success of the program was assessed by means of interviews with parents, teachers, and social workers. The authors noted that virtually without exception, members of the therapy groups were reported as having a decrease in symptoms . . . fewer sleep disturbances, more compliance at home and at school . . . , and more assertive verbalization at appropriate times. . . . Parents felt that the children were more verbal about their experience and more comfortable about discussing it with their mothers. (p. 249)

In addition, the children expressed positive feelings about being in the group and sadness
when the group ended. They felt better about knowing that they were not the only ones with these experiences and they felt far less guilt about the events that had occurred. They also felt better about learning how to keep themselves safer in the future.

Lokshin, Lindgren, Weinberger, and Kovach (1991) treated a total of nine children with symptoms of habit cough (harsh loud nonproductive barking coughs occurring several times per minute during waking hours) using a form of behavior therapy plus a distracter consisting of a diluted topical anesthetic. All cases had been originally and incorrectly diagnosed as asthma; five of the nine children had previously been hospitalized.

In all but one case the treatment episode was concluded in one 15-minute session. That one patient required a second session 9 days after the original session. Follow-up interviews conducted by telephone with seven of the nine cases (the other two cases could not be located) between 3 and 4 years after the treatment revealed that 6 were completely asymptomatic and the seventh continued to have minor self-controllable symptoms.

Klein, Koplewicz, and Kanner (1992) undertook a study to determine if children with separation anxiety who were unresponsive to a 4-week intensive behaviorally oriented psychotherapeutic intervention would profit from a supplementary 6-week course of treatment with imipramine, a tricyclic medication that had previously been found to be effective with adults in reducing panic attacks associated with agoraphobia. Separation anxiety disorder is manifested by a variety of symptoms usually including difficulty in sleeping alone, going out alone, and staying home alone or with unfamiliar adults, physical complaints in anticipation of or during separation, and unwillingness or resistance to go to school.

While the principal purpose of this study was to test the effectiveness of imipramine (which, incidentally, was found to have no benefits when contrasted with control-group children unresponsive to the behavioral intervention who were given a placebo), it is instructive to examine the response of the 45 children ages 6–16 who began the study by being assigned to the brief psychotherapy intervention. Of this group, 24 (43%) were not entered into the drug study because their symptom reduction was of sufficient magnitude as to judge them no longer diagnosable as suffering from separation anxiety, although many had continuing milder difficulties.

Gardano (1994) reported on a 16-session weekly therapy model for six early adolescent girls with adjustment problems making use of “creative video therapy” (p. 99). Her efforts to promote socialization skills included three steps—(a) initial open-ended therapy sessions, (b) the creation of a videotape based on the girls’ own ideas, and (c) discussions about the themes in the tapes. Two months after the ending of the program the group participants had a follow-up group session and the parents were contacted for a family session or by phone. Most girls, as well as their parents, reported improvement in their social relationships and self-esteem.

Cocciarella, Wood, and Low (1995) provided a seven-session behaviorally oriented therapy program for seven children with attention deficit hyperactivity disorders (ADHD). The 90-minute sessions reinforced appropriate behaviors, punished negative behaviors, and provided skill training. In addition, parents met separately to discuss problems or successes with the program, practice behavior management strategies, and learn more about ADHD. Significant decreases were found on the Attention Deficit Disorder Evaluation Scale in impulsivity at home and school. The authors, noting the very small sample size and heterogeneity of the population, urge a replication of the study on a larger sample of children.
March, Amaya-Jackson, Murray, and Schulte (1998) described the results of their 18-session weekly cognitive-behavioral group treatment program for a total of 14 children aged 10–15 who suffered from single-incident posttraumatic stress disorders. These incidents included car accidents, severe illness, fires, gunshot injury, or accidental death of a loved one. Diagnosis was determined by scores on standardized assessment instruments and a variety of outcome measures were collected initially, immediately after treatment, and at a 6-month follow-up.

The treatment protocol included anxiety management training, interpersonal problem solving, anger management, positive self-talk, cognitive training, graded in-vivo exposure, and relapse prevention. A 40% reduction in symptoms was found after treatment with a further equal-sized reduction at follow-up. Outcome measures all indicated significant improvement following treatment with additional improvement between the end of treatment and the follow-up assessment.

Kastner (1998) reported on the group treatment of two groups of a total of 11 adolescent boys with excessively aggressive behavior. The boys averaged 14 years of age and were equally divided between white and African American. Data were collected both before and after the completion of the 10-week program from the boys themselves as well as from their parents. Each session was divided into two parts—an initial portion devoted to the unstructured discussion of important personal and interpersonal problems, and a second portion that involved discussion and role-playing activities related to specific introduced topics—social events that elicit anger, reactions to anger, consequences of aggressive behavior, and alternative prosocial behaviors.

Complete data were available on only 4 of the 11 boys. While no significant differences between pre- and posttreatment scores were found, all scores, including those obtained from the parents, suggested that there was a decrease in aggressive behavior as well as in socially withdrawn behavior, somatic complaints, anxiety, and depression.

Other studies have examined the effectiveness of specific treatment methods. Eisenberg and Wahrman (1994; see also Eisenberg & Wahrman, 1991) interviewed 42 families who had been treated by brief strategic therapy (averaging 5 sessions) in a community mental health clinic between 1987 and 1991 in a follow-up study conducted 6 to 18 months after the completion of the treatment episode. A total of 40 out of the 42 families reported that their complaints were either partially or completely resolved. Nearly two-thirds of the families reported that additional positive changes occurred after termination of the treatment episode, and most were satisfied with the treatment.

Lee (1997) studied the usefulness of solution-focused brief family therapy. Rather than focusing on the history of family problems, clients were helped to find solutions to their problems using as few sessions as were needed. In that process many of the traditional solution-focused techniques were used—exception questions, outcome questions, coping questions, scaling questions, and relationship questions.

A total of 59 children, aged 4 to 17 (mean age = 10.9 years), and their families were included in the study. The most commonly reported problems were family related, school related, behavioral problems at home, or emotional regulation. Most families received team therapy (one therapist in the room with the family and one or more therapists behind a one-way mirror). A few families received individual therapy without observers. Treatment episodes averaged 4 months in duration during which time families were seen an average of 5.5 sessions.

Six months after concluding therapy families were contacted by an interviewer who had no
prior connection with them in order to assess their reactions to the treatment they received. The most commonly reported treatment goals were: (a) improved family relationship, (b) improved children’s behavior at home, (c) self-development in parents, (d) improvement in parents’ marital situation, and (e) improvement in children’s coping. A total of 65% of these goals were reported as being met, ranging from 56% for improved family relationship to 80% for improved emotional regulation and school functioning of the children. The therapy approach used in this study was found to work equally well with all types of clients. Families reported that the most helpful aspects of the treatment program were the sense of being supported and validated by the therapist. The least helpful aspects of the treatment approach were the sense that the therapist was too positive or too rigid, artificial, or inflexible.

**Inpatient Studies**

Recent overviews of inpatient treatment programs for children and adolescents can be found in Brunstetter (1998) and Ramsden (1999).

Three recent uncontrolled studies of inpatient services for children have been reported in the literature. Bradley and Clark (1993) reported on their follow-up study of a heterogeneous group of 56 children aged 4–16 treated in a 10-bed child psychiatric inpatient unit for an average of 42 days. Most common diagnoses included conduct disorders, adjustment disorder with depressed moods, and adjustment disorder with mixed disturbance of emotions and conduct. Follow-up assessments took place about 1 year after discharge. The treatment program included individualized treatment planning, individual, group- and family-based interventions, and psychotropic medications where indicated. Outcome evaluations were based on a consumer satisfaction questionnaire and treatment outcome reports completed by the parents and the therapists.

Treatment outcome measures indicated a relatively high level of satisfaction with the treatment on the part of parents and therapists, although there was only modest agreement between therapists and parents on their levels of satisfaction. The most helpful components of the treatment program were judged to be the parent training, particularly the teaching of behavior management strategies, and the support and consistency of the ward staff and treatment team.

Sourander, Helenius, and Piha (1996) collected outcome and follow-up data from 50 children and preadolescents consecutively admitted to a child psychiatric inpatient treatment program. Most children were diagnosed as having disruptive behavior problems and difficulties in the school environment. Follow-up measures were collected at discharge, and 5 months and 1 year after discharge, using the Children’s Global Assessment Scale (CGAS). Average length of stay on the unit was 33 days. Average age of the children was 10 years with a range of 3.5 to 15 years. More than 80% of the patients were boys. Treatments included milieu therapy, dyadic nurse relationship therapy, behavioral interventions, and a family-oriented therapy. Very little medication was used in this setting.

Greatest improvement occurred between admission and discharge. There was some continued improvement throughout the follow-up period except for children diagnosed as having a significant conduct disorder. This group exhibited no further improvement, and indeed showed some evidence of deterioration.

Mikkelsen, Bereika, and McKenzie (1993) have described a brief residential treatment program for children that represents an alternative to traditional psychiatric hospitalization. The program is based upon trained mentors who make their own homes available for children in
need of more intensive care than can ordinarily be provided in outpatient settings. Mentors, who typically are married women averaging 40 years old, work in collaboration with a multidisciplinary treatment team. The first 112 patients whose experiences were analyzed ranged in age from 4 to 22, with an average age of 12.6 years. Patients were most commonly suicidal or were involved with severe substance abuse or displayed inadequately controlled impulsive and aggressive behavior.

A treatment plan is developed by the clinical team in collaboration with the children and their parents. The mentor is responsible for the implementation of the treatment plan and receives supervision by the professional staff who also monitor the progress of the patient by means of frequent visits to the residential facility. Mentors provide training to the parents when they visit the facility. Average length of time spent in the mentors’ home was 16 days. At discharge more than 70% of the children were returned to their families or to a relative. Most of the remaining children required long-term specialized foster care.

Structured follow-up telephone interviews conducted 3 months after discharge revealed that subsequent psychiatric hospitalization was very infrequent, and that more than 60% of the children were still living at home. This figure is slightly lower than is typically reported following discharge from inpatient psychiatric facilities. The treatment program is well accepted by the children and their families, and the cost is about one-fifth that for hospitalizations of similar duration.

**Controlled Treatment Outcome Studies**

Controlled outcome studies published since 1990 all share the systematic collection of outcome data from at least two groups—a sample of patients who participated in some brief intervention program under study and a comparison or control sample of similar clients who were treated in a different manner or who were untreated. Statistical analyses of differences between the groups on a variety of dependent measures provide information regarding the effectiveness of the program being evaluated.

Kirkby and Smyrnios (1990) reviewed nine controlled outcomes studies conducted prior to 1990 contrasting brief family therapy with some alternative treatment. While all studies they reviewed suggested that childhood problems could be treated successfully with brief family therapy techniques, methodological problems were identified in most of the investigations. Among these were failure to specify therapeutic techniques that were used and to establish competence equivalency of therapists, confounding of therapeutic outcome variables, and deficiencies in the use of control groups. Accordingly, Kirkby and Smyrnios urge readers to treat these results as tentative and to use established guidelines in designing outcome studies in the future (see, for example, Foa & Meadows, 1997, pp. 453–455; Kaminer, Blitz, Burleson, Kadden, & Rounsaville, 1998; Nathan & Gorman, 1998, pp. ix–xi, 3–25).

Cramer et al. (1990) contrasted two forms of brief (maximum of 10 sessions) psychotherapy—psychodynamic and noninterpretive interactional guidance—in a sample of 38 mothers and their young children with functional and behavioral disturbances. Assessments, based both on self-reports and behavioral data, were undertaken before treatment, and 1 week and 6 months after treatment. While no differences were found in outcomes between the two treatments, both resulted in reductions or removal of symptoms, increases in cooperativeness among infants, decreases in intrusiveness among mothers, and increases in harmoniousness in mother-child interactions. These improvements were durable and in some cases increased after the termination of the brief therapy.
Szapocznik, Kurtines, Santisteban, and Rio (1990) have described their psychotherapy research program evaluating brief treatment for Cuban problem children and adolescents. One component of their research program was the effort to contrast the results of structural family therapy, individual psychodynamic child therapy, and a recreational activity control group. A total of 102 6–12-year-old Hispanic boys were randomly assigned to the three intervention conditions with outcome assessments conducted pretherapy, posttherapy, and 1 year following treatment termination.

Retention rate was significantly higher in each of the two treatment conditions than in the recreational control group. The two treatment conditions were equivalent in reducing behavior and emotional problems. Family therapy was superior to individual child therapy in protecting family integrity. While psychodynamic individual therapy brought about symptom reduction and improved child functioning, it also resulted in undesirable deterioration of family functioning.

Weisz, Walter, Weiss, Fernandez, and Mikow (1990) contrasted arrest rates for the 2-year period following discharge from two intervention programs that differed in duration. Participants in the program were emotionally disturbed assaultive adolescents (primarily males) who averaged 16–18 years old. The subjects in the short treatment group consisted of 21 individuals who had received services for 90 days or less; the long treatment group consisted of 147 individuals who received services for 1 year or more. The short-term group was in treatment for an average of 26 days; the long-term group was in treatment for nearly 900 days.

Examination of arrest data subsequent to discharge from the treatment program revealed that about 65% survived 2 years without being arrested—67% of the short-term patients survived as contrasted with 63% of the long-term patients—a nonsignificant difference. Subsequent analyses of the data examining carefully selected subsamples, for example, only those deemed to have been properly served, or contrasting the short-term group with the longest served of the long-term group, also failed to yield significant differences between the two groups.

Finney, Riley, and Cataldo (1991) examined the effects of brief targeted individual therapy on medical care utilization on a sample of 93 children ages 1–15 who, along with their parents, were members of a health maintenance organization. The children had common behavior, toilet, school, and psychosomatic difficulties. The individualized treatment was provided in between one and six 50-minute visits by the staff of the psychological consultation service attached to the primary care component of the HMO, making use of problem-specific behavioral protocols.

Treatment outcome and behavior checklist ratings completed by parents between 3 and 6 months after termination indicated improvement or resolution of the presenting problems for about three-quarters of the children in the treated sample and generally high satisfaction with the consultation service. Children’s use of medical services during the year following treatment decreased, while in a matched sample of untreated children in the same HMO, use of medical services was unchanged.

The authors note that their results parallel those found with adult patients—the cost of psychological services is offset by subsequent cost reductions in the provision of medical care. These findings underline the potential benefits of integrating general health and mental health services in the same health care setting.

Smyrnios and Kirkby (1993) randomly assigned 30 children and their parents to either time-unlimited or time-limited (12 sessions) psychodynamically oriented treatment or to a minimal-contact intervention group. Children and parents were seen in individual therapy by
different clinicians. Children were between the ages of 5 and 9 and all were diagnosed as in need of treatment because of disturbances of emotions specific to childhood. Assessments were made immediately before the first interview, within 24 hours after the last session of therapy, and 4 years after the termination of the therapy episode. Four instruments were used—the Target Complaints Scales, the van der Veen Family Concept Inventory, Goal Attainment Scales, and the Social Adjustment Guides completed by the child’s schoolteacher.

Children in the time-unlimited therapy group had more than twice as many therapy sessions as did those in the time-limited therapy group—28 versus 11 sessions. Parents in the time-unlimited therapy group also had more therapy sessions than those in the time-limited therapy group—10 versus 6 sessions. Children and parents in the minimal contact intervention group received, on average, two assessment interviews, a feedback session, and a follow-up interview 12 weeks after the feedback session. Thus, this group is properly called a minimal contact group; it is not an untreated control group.

All groups showed significant improvements on the Target Complaints Scales and Goal Attainment Scales. Wherever significant differences were found among the three treatment conditions, outcome measures favored the minimal-contact intervention group. The authors’ conclusions merit review:

Despite receiving the least amount of treatment, clients from the minimal-contact control group showed no less improvements on most measures and showed significantly improved family functioning than did the other groups. The cost of providing time-unlimited therapy to all 30 families of the present study would have been approximately 2.5 times greater than the cost of treating the same families by the minimal-contact procedure. . . .

Clearly, this finding raises important possibilities for the provision of child and family clinical services. . . . For many clients it might be more appropriate to provide them with suitable problem-focused, goal-oriented assessments and feedback rather than to place them on waiting lists with the expectation of lengthy therapy. (p. 1026)

Weiner, Kuppermintz, and Guttmann (1994) undertook a short-term prevention and treatment intervention program for disadvantaged families with young children—a program designed to improve relationships between parents and children—by means of videotaping family members interacting with each other and providing immediate feedback based on these videotapes. Families met in their homes with the therapist (a child welfare worker) weekly for 3 to 4 months. Each session lasted about 1 1/2 hours and included a videotaping of the family. At the first session the family viewed part of the tape just made; subsequently, each family viewed portions of the tapes made during the previous meeting.

A number of specific positive interactions were encouraged. These included: (a) naming with approval (parents provide a verbal description of what is taking place in the family), (b) taking turns (making sure that every family member is attended to), (c) strengthening the weak link in the family (making sure that the family members who are passive or especially quiet are given the opportunity to be more assertive and participate in the family interaction), and (d) following (commenting on some aspect of what children are saying or doing in the family interaction). In addition, other positive interactions were encouraged. These included: (e) saying “yes” (giving guidance to children in a positive way rather than by criticizing), (f) supporting initiative (encouraging children’s attempts to learn or to try out new behaviors), (g) taking the lead (providing guidance for children regarding what is expected of
them), and (h) sharing pleasant moments (exhibiting the ability to relax and share pleasures with children whenever opportunities present themselves).

Rating scales were developed for these eight interactional attributes and were completed by trained observers at the start and conclusion of the program and again 6 months later. An untreated sample of disadvantaged families was evaluated using the same rating scales. The scales were completed twice for the control families separated by an interval of 3 to 6 months. Dramatic increases in positive interactions were found between the beginning and end of the intervention program, increases that were sustained when the families were assessed 6 months later. In contrast, control families showed little change from the first to second assessment. Improvements in family interactions in the treated group were particularly significant among young (under age 34) mothers.

Jordan and Quinn (1994) contrasted the outcomes of two forms of brief family psychotherapy in a sample of 15 individuals, 10 couples and 2 families treated by 13 therapists to whom the clients were randomly assigned. The clients presented a variety of marriage and family issues. This study focused on the initial treatment session during which time the therapists’ principal task was to help patients develop a clear and concrete treatment goal. Assessments were made during the second treatment session by use of self-report questionnaires that provided measures of personal attachment, goal identification, problem improvement optimism, client’s ability to improve, perceived problem improvement, outcome expectancy, session depth, smoothness, positivity, and arousal. The two forms of brief family psychotherapy that were contrasted were problem-focused (identifying what happens in the family when the problem comes up) and solution-focused (identifying what happens in the family that the clients want to continue to have happen).

While no overall difference in outcome was found between the two approaches to brief family psychotherapy, a number of components of that overall difference were significantly different in the two groups. The solution-focused approach resulted in significantly greater perceived improvement and session depth, smoothness, and positivity than did the problem-focused approach.

Tonkins and Lambert (1996) examined outcomes in two contrasted groups of children aged 7–11 who had lost a parent or a sibling within the previous year—10 children treated in an 8-week bereavement group and a waiting-list control group of 6 children followed for 8 weeks and then treated.

Children in the intervention group were assessed at the start and conclusion of the group; children in the control group were assessed when they were enrolled in the control condition, when they started the group, and when the group ended. A variety of test instruments were employed, completed by the child, the parent, a teacher, and the therapist. A number of the assessment procedures were especially developed for this project; others consisted of well-standardized instruments including the Children’s Depression Inventory and the Child Behavior Checklist Parent Form and Teacher Form.

The treatment program was based on a carefully thought-out topical outline that included such issues as general discussion of how the deceased died and the child’s involvement at the time of death, positive memories of the deceased, changes in the self since the death, things the children miss about the deceased, discussion of sadness, fears, anger, and guilt, forgiving the self, discussing unfinished business with the deceased, and examination of both the positive and negative ways that the death impacted the children’s lives.

In spite of the small number of cases in this study, dramatic evidence of the program’s effectiveness was found. Members of the treated
group had a significantly greater decrease in sadness, anger, withdrawal, guilt, anxiety, loneliness, helplessness, and depression than did the members of the control group. Parents of the children judged the group treatment program to be very effective and parents and teachers both reported a substantial decrease in children’s behavioral disturbances.

Pfiffner and McBurnett (1997) investigated the effectiveness of a social skills training program for children with attention deficit disorder. A total of 27 children (ages 8–10) meeting the diagnostic criteria were randomly assigned to one of three groups—social skills training with parent-mediated generalization training designed to assist in the transfer of learned skills to the home and school setting, child-only social skills training, or a wait-list control group. Treatment consisted of eight group sessions.

Each session concentrated on one social skill module and involved brief didactic instruction, symbolic and in vivo modeling, role playing, and behavioral rehearsal. A total of six modules were included: good sportsmanship, accepting consequences, assertiveness, ignoring provocation, problem solving, and recognizing and dealing with feelings.

Outcome assessments were based on both parent-reported and teacher-reported measures of social skills and disruptive behavior, and were collected initially, posttreatment, and 3–4 months after the posttreatment assessment. Treatment groups showed significant improvement in both parent-rated and teacher-rated social skills and disruptive behavior when contrasted with the wait-list control group, but ratings did not differ substantially between the two treatment groups.

Brent et al. (1998) randomly assigned 107 adolescents aged 13–18 with major depression to 12–16 sessions of either cognitive-behavioral therapy, systemic-behavioral family therapy, or nondirective supportive psychotherapy. Outcome assessments took place during and immediately after the conclusion of treatment. Failure to achieve remission was generally predictable by higher initial levels of self-reported depression and hopelessness and by the presence of initial comorbid anxiety disorder and cognitive distortion. Cognitive-behavioral treatment results were robust and superior to either of the two other treatment modalities.

**Concluding Comments**

The controlled outcome evaluation studies of brief psychotherapy with children and adolescents published since 1990 have generally demonstrated significant and positive program effects. This finding is particularly important given the equivocal outcome findings of traditional child psychotherapy (Weiss, Catron, Harris, & Phung, 1999). Brief interventions that have been evaluated appear to be superior to no intervention at all and as effective as time-unlimited interventions. There is no consistent evidence that any specific brief intervention is superior to any other, whether in general or for any particular diagnostic or demographic group. Time-limited group treatment with children and adolescents seems to be particularly useful and its effectiveness may be underestimated in clinical practice (Lomonaco, Scheidlinger, & Aronsen, 1998).

One area of controlled treatment outcome research that is currently in need of expansion is the treatment of depression among adolescents. Moreau, Mufson, Weissman, and Klerman (1991; see also Moreau & Mufson, 1977) have noted that depression in this group is quite common and that pharmacotherapy has not been found to be helpful. Moreau et al. (1991) have developed a modification of interpersonal psychotherapy for depressed adolescents based upon the original interpersonal psychotherapy developed for adults. They have reviewed the epidemiology, morbidity, and course of adoles-
cent depression, and have outlined the rationale for the modified interpersonal psychotherapy in terms of goals, and the phases of the treatment (see also Mufson & Moreau, 1998).

Corroborative studies are needed, and efforts to identify moderating factors that may potentiate treatment effects with children and adolescents must be undertaken. At the moment, however, the most persuasive general conclusion that can be drawn is that those brief approaches that have been empirically evaluated appear to be indistinguishable in their results from every time-unlimited approach with which they have been compared. Included in this group of studies are efforts to reduce a wide variety of more common individual and family psychological difficulties related to children and adolescents, but also less frequent sources of psychological discomfort including assaultive behavior, adverse consequences of parental loss, as well as excessive use of medical care.

Under these circumstances, and in the absence of evidence to the contrary, mental health professionals should continue to play an active role in determining the duration of psychotherapy. It is as important to avoid overtreatment as it is to avoid undertreatment. Fisch has put this idea very succinctly—“How long or short therapy is . . . depends on whether the therapist knows when to stop” (1994, p. 131).

References


