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When Life gets in the Way: A systematic review of the assessment of life events in change over the course of counselling and psychotherapy for depression and anxiety in children and adolescents

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Abstract

This paper presents a conceptual and methodological review of the literature on life events that are intercurrent with (occur over) the course of psychotherapy for depression and anxiety in young people. Method. Life events were defined to include those that are chronic and severe, as well as minor, everyday occurrences. Study participants were children, or adolescents (5-18 years). No limits were placed on psychotherapy type, or study setting. Outcomes were restricted to internalising problems related to depression and anxiety. A three-part search strategy was used, involving searching: 1) bibliographic databases; 2) citations and review reference lists; and 3) contacting relevant scholars. An aggregative review methodology was undertaken to report on the conceptual and methodological nature of the literature. Results. This review included 42 studies. Intercurrent events varied in severity and chronicity. Events were most frequently measured using questionnaires. The same questionnaire was rarely used in more than one study and questionnaires were often adapted for use for the study's purpose/population. Events included in analyses tended to be analysed as a mediator of change in psychiatric symptomatology, or an outcome of therapy. Conclusions. Attention to intercurrent life events appears rare in psychotherapy research. This contributes to a systematic neglect of socioeconomic issues in psychotherapy research and arguably psychotherapy more generally. This neglect is exacerbated by a lack of agreed measures of life events, both intensive and routine in nature. Insights into methods of assessment and analysis of intercurrent events are provided and recommendations are made for corrective attention to such events.

Keywords: psychotherapy, life events, children, adolescents, depression, anxiety

It has been argued that sources of stress are social in origin, with experiences of life events arising out of social roles, defined by class, race, gender and age (Pearlin, 1989). This suggests multiple mechanisms contributing to the relationship between socioeconomic status (SES), stressful experiences and the sequelae of those experiences. A review (Baum, Garofalo, & Yali, 1999) concluded that SES is associated with both the frequency of stressful life events and stress responses. Indeed, a more recent review concluded that life events and other types of stressor are clearly related to SES (Lantz, House, Mero, & Williams, 2005). This association between SES and negative, or stressful events presents itself most starkly in accident-related mortality rates. In the UK, children and young people, aged 28 days to 15 years from the lowest socioeconomic bracket, had a mortality rate from accidents that was 4.4 times greater than those in the most advantaged class (Siegler, Al-Hamad, & Blane, 2010). This association also applies for less severe events, such as school suspension (Brady & Matthews, 2002). Various explanations for the relationship between lower SES and increased rates of stressful events have been posited, including an increased likelihood to be in an environment where one encounters such occurrences and decreased psychological and social resources to cope with such events, resulting in a heightened experience of subjective stress (Adler et al., 1994).

SES also has a well-established negative association with mental health. A recent review reported an association between various measures of poverty and common mental health disorders in 70% of the 115 included studies (Lund et al., 2010). These patterns seem to emerge before adulthood. Disadvantaged children and adolescents are two to three times more likely to develop mental health problems (Reiss, 2013). Further, research suggests low SES is related to symptoms of psychiatric disturbance in children and an increased probability of depression in adolescents (Bradley & Corwyn, 2002). Negative life events have been put forward as one mechanism for the relationship between lower SES and poorer health. Research has explored the mediating role of exposure to stressors in the relationship between SES and health inequalities (Pearlin, Schieman, Fazio, & Meersman, 2005). For instance, the Americans' Changing Lives study revealed socioeconomic inequalities in health are

produced by disparate exposure to negative life events (Lantz et al., 2005). A recent publication by the World Health Organisation highlights the link between SES and mental health and discusses this association in relation to the level, frequency and duration of stressful experiences that are disproportionately experienced by those lower down the social hierarchy (World Health Organization, 2014).

Two competing theories for this mediated relationship are the social selection and social causation hypotheses. Social selection theory suggests environmental factors influence the onset of psychiatric disorders, which contributes negatively to various facets of SES, including educational outcomes. Social causation theory suggests that adversities associated with lower SES, such as increased environmental stressors leads to the development of mental health problems (Johnson, Cohen, Dohrenwend, Link, & Brook, 1999). A longitudinal study of young people, aged one to ten years, indicated a more emphasised role of social causation in the association between SES and depression and anxiety, compared to social selection (Johnson et al., 1999). However, a recent review of mental health problems and socioeconomic inequalities in young people concluded that the theories of social selection and causation are not mutually exclusive and that together they create a cycle of socioeconomic deprivation and mental health problems (Reiss, 2013). The review emphasises a need to continue to explore the complex mechanisms by which SES influences mental health in young people.

Whilst the association between negative life events and psychological distress is relatively well-established, that between positive life events and mental health remains somewhat under-studied (Davidson, Shahar, Lawless, Sells, & Tondora, 2006). An interplay between positive events and adolescents' psychological distress has been reported, supporting both a direct-effect and a stress-buffering mechanistic relationship (Shahar & Priel, 2002). However, this area remains rife with inconsistencies and contradictory findings; from studies reporting the 'low-potency' of stress-buffering effects of positive life events (Reich & Zautra, 1981), to those that demonstrate an

association between positive events and elevated distress (Riskind, Kleiman, & Schafer, 2013).

Further, studies of the relationship between positively valenced, or desirable life events and SES are scarce. Indeed, one study that recognised the neglect of this issue and explored life events and their association with SES and ethnicity, was unable to examine the valence of life events and SES (Brady & Matthews, 2002), owing to the underassessment of positive events (authors used a scale with 5 positively valenced life event items; the Life Events Questionnaire – Adolescents (Garmezy & Tellegen, 1984)).

Impacts of antecedent life events are well recognised in many theories of psychotherapy and even central to some (broadly, “trauma” models) and individuals often seek help for distress caused by a traumatic event. A review of school-based counselling for adolescents identified a number of presenting issues for young people, including bereavement, bullying and academic issues (Cooper, 2009). Aside from life events and experiences triggering a period of depression and/or anxiety, life events may also occur over the period of psychotherapy and influence the course of treatment, but such events seem to have received much less attention in the psychotherapy and psychotherapy research literature. This paper will review the literature on life events occurring over the course of counselling and psychotherapeutic intervention for depression and anxiety in young people, with the aim of answering the following questions:

- i) How are life events conceptualised?
- ii) What methods are used to assess life events?
- iii) What, if any, statistical analyses are used to assess the impact of life events on change/outcomes?

1. Method

1.1 Registration. The review is registered with PROSPERO registration number CRD42017065850.

Methods of searching, inclusion criteria and analysis were specified in advance and documented online.

1.2 Eligibility criteria. Studies were included that met the following inclusion criteria. Clients were child, or adolescent participants (5-18 years). The focal intervention was psychotherapy (including counselling) working with the following definition: 'a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client's disorder, problem, or complaint; and it is adapted or individualised for the particular client and his or her disorder, problem or complaint' (Wampold, 2001, p.3). Participants had presented with problems of depression and/or anxiety and the studies reported on psychotherapeutic change i.e. including evaluations from at least two separate assessments. There was some assessment, or record of incidence of an intercurrent life event for participants. Studies reporting on non-psychological (e.g. solely pharmacological) therapies, or non-interpersonal psychotherapies (e.g. unguided self-help) were excluded. Studies were also excluded where the life events were wholly historic in nature (i.e. not intercurrent). Only studies reported in the English language were included and no time limit was placed on the year of publication, although only bibliographic records up to 01 May 2017 were searched.

1.3 Sources. A comprehensive search of electronic databases using both keywords and subject-headings was carried out, including PsycINFO (EBSCO) and Medline (PubMed). Forward and backward citation-chaining using Web of Science Cited Reference Search was carried out. Requests for un/published studies/materials were placed on online forums (ResearchGate) and email lists (see supplementary material 1). Scholars who had published more than one relevant article in the past decade were contacted.

1.4 Search. The strategies used for searching PsycINFO and Medline are provided in supplementary materials 2 and 3, respectively.

1.5 Study selection. Eligibility assessment (title/abstract screening and full text assessment) was performed by the first author. Where the first author was unsure whether a paper met eligibility criteria, the second author was consulted. Disagreements between reviewers were resolved by consensus.

1.6 Data collection. A data extraction sheet was developed by the first author, pilot-tested with five included studies and refined accordingly. The first author extracted data from the included studies. Studies were also imported into ATLAS.ti (ATLAS.ti, 1999) for analysis.

1.7 Data items. Information was extracted from each trial on: 1) characteristics of participants (e.g. age, socioeconomic status); 2) type of intervention (e.g. type of therapy, duration); 3) life events measured (e.g. nature of events, method of assessment); 4) data analysis (e.g. events as mediator of treatment).

1.9 Methods of analysis. A narrative synthesis of the findings was conducted, summarising key descriptive features of the studies. Adapted grounded theory methods were used to explore qualitative/narrative aspects of the publications using ATLAS.ti (ATLAS.ti, 1999) to collate notes. As anticipated, there was no scope for meta-analysis due to the heterogeneous nature of the outcomes, methods of assessment and study characteristics.

2. Results

2.1 Study selection. A total of 42 studies were selected for inclusion within this review (see figure 1).

The search of PsycINFO and Medline yielded the return of 2,140 records. These studies were combined with those identified from the forum post, the contacting of relevant scholars and posting in email circulars (n=17). After abstract screening and the removing of duplicates, 118

studies were retained. The full texts of these studies were examined in more detail, resulting in selection of 30 studies. A further 12 studies were selected through citation chaining and searching review reference lists.

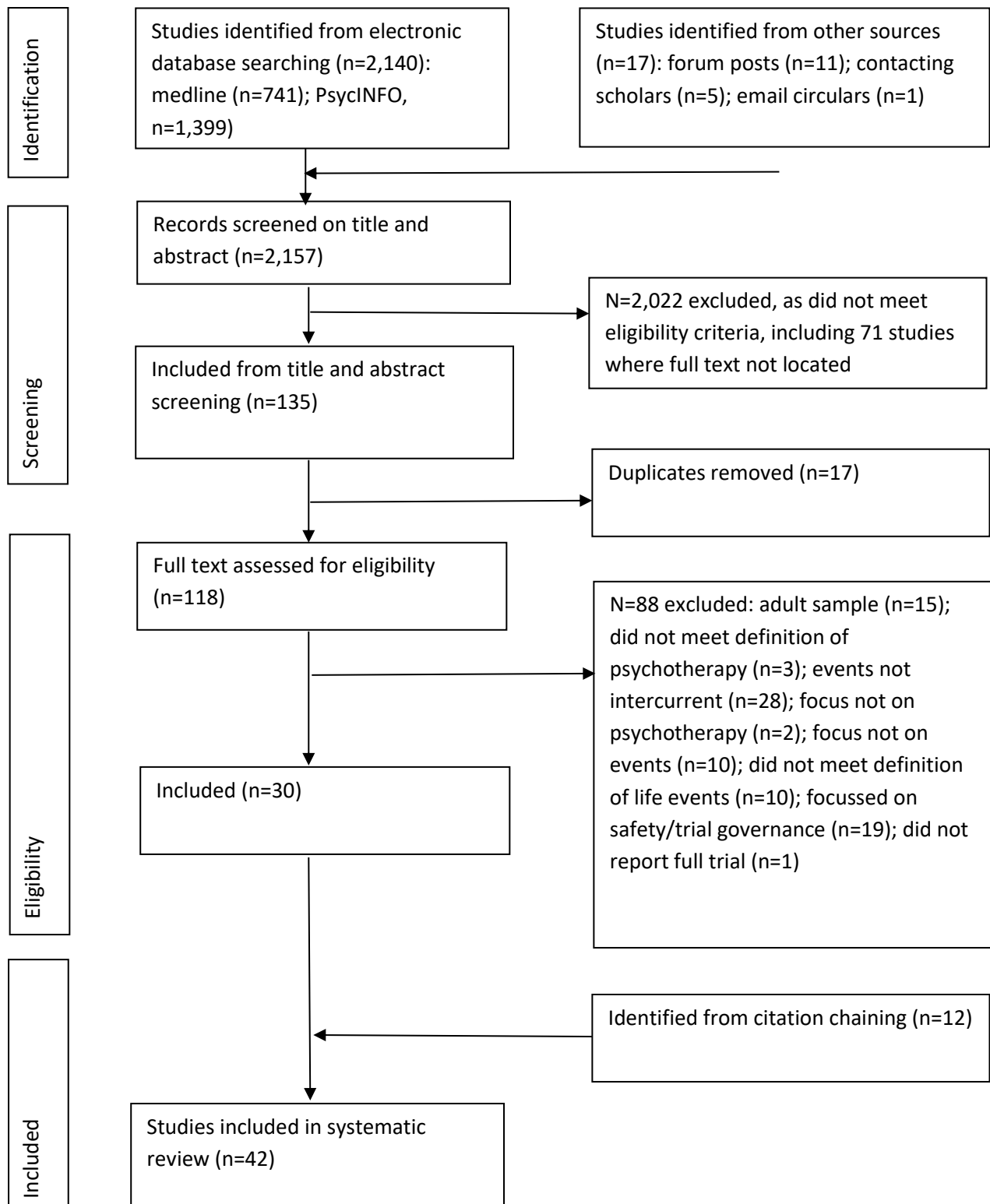


Figure 1. Flow diagram of study selection.

2.2 Study characteristics.

2.2.1 Design. Ten were case studies, 15 were randomised controlled trials (RCTs), 13 were uncontrolled longitudinal studies (case series) and 3 were qualitative studies. One study met the criteria of two trial types, including both a case study report and an uncontrolled longitudinal analysis of quantitative outcomes (O'Shea, Hodes, Down, & Bramley, 2000).

2.2.2 Participants. The studies involved 2,747 participants (n=41 studies). One trial (Rousseau & Machouf, 2005) did not report participant numbers. Participants ranged in age from 3-20 years. Participants' gender (38 studies) was 53.5% female. Ethnicity of participants was reported in 26 studies (61.9%) where methods of reporting varied, describing the ethnicity of the parents, the children/adolescents, and the population from which the sample was sourced. SES was reported in 26 (61.9%) studies. Methods of assessing and reporting SES varied widely, with reports of household income, employment status of parents, standardised scoring and generalised descriptions of the target populations.

2.2.3 Intervention. Details about the therapy were not included in two studies. The type of psychotherapy delivered in the remaining 40 studies varied widely (see supplementary materials 4-7 for details). In 23 studies (57.5%) interventions were reported that directly involved the young person's family member(s), and/or caregiver(s). For example, studies involved joint parent-child sessions (e.g. Chavira et al., 2014). This reflected the age of the participants and the importance of their caregivers in their environment, wellbeing and development. This range of foci meant that some studies reported events occurring within the family group, or domestic situation. In 27 (67.5%) studies, the presenting issues of participants were described as being in some way related to trauma, or negative events that either occurred prior to therapy, were anticipated to occur during therapy, or recruited participants considered to be at risk of experiencing negative events. For

example, interventions targeted youth who were exposed to intimate partner violence (IPV; n=1), who were anticipating medical procedures, such as chemotherapy (n=3) and who had recently suffered a parental bereavement (n=2). The shortest duration of therapy was two days (Dolgin, 2014), whilst the longest period of therapeutic intervention was 13-months (Ford & Nangle, 2015).

2.3 How are life events conceptualised in studies of psychotherapeutic change in children and adolescents with depression and/or anxiety?

Intercurrent events came in many forms. Events were often chronic in nature, such as residing in an area exposed to war and armed conflict and experiencing ongoing resource hardships. Other events were more acute, or discrete in nature, such as an anticipated limb amputation, or testifying against a perpetrator of abuse in court. Focal events were sometimes severe and traumatic such as being in contact with an abuse perpetrator, or less severe such as witnessing their parents arguing, whilst some studies reported on multiple events with a wide range of severity. Life events also varied in terms of their predictability and in the possible control participants had over the events. In two studies (Danielson, Feeny, Findling, & Youngstrom, 2004; Weintraub, 1990), the events were triggered by the therapist and impinged directly on the course of therapy (therapist becoming ill and carrying out sessions by phone, therapist moving out of state meaning maintenance phase of therapy not carried out). For details of life events assessed, please see supplementary materials 4-7.

2.4 What methods are used to assess life events in studies of psychotherapeutic change in children and adolescents with depression and/or anxiety?

Questionnaires constituted the most common method of assessing life events (n=22 studies used at least one questionnaire, n=53 questionnaires in total), but this was sometimes supplemented by interviews (n=3), or records such as hospital reports (n=3). The majority (n=10 studies) used just one measure, but there was a range of up to six measures per study. The majority of questionnaires were child/adolescent self-report (n=35 measures, including one measure with a sub-scale

supplemented by clinician observation). The number of child/adolescent report measures ranged from 0-3 measures per study. The remaining 18 questionnaires used parent/caregiver report. Per study, the number of parent/caregiver-report measures used ranged from 0-3 measures.

One striking finding was how little comparability there was between life event scores because of the diversity of measures used. Many questionnaire-based studies included at least one measure that was adapted from its original form (n=12 studies, n=24 questionnaires) or designed specifically for that trial (n=2 studies, n=3 questionnaires). Of the 24 adapted questionnaires, n=7 were adapted by combining items, sub-scales, or full scales from existing questionnaires, n=8 by including only certain items, or sub-scales from an existing measure, n=5 measures were adapted by altering the time frame and n=1 measure was adapted by including and omitting items as the researchers saw necessary. The types of adaptation were not specified for n=3 questionnaires. Of those measures that were not adapted, or designed for the study (n=26), three questionnaires were used twice (Alabama Parenting Questionnaire – child report; Alabama Parenting Questionnaire – parent report (Frick, 1991); Conflict Behaviour Questionnaire – child/adolescent report; (Robin & Foster, 1989)). A list of standardised and unadapted measures (n=23) used in the studies is provided in supplementary material 8.

Events were also assessed in unstandardised ways: in nine studies, they were recorded as having been spontaneously disclosed in the therapy and in 7 studies events were not assessed, as they were pre-determined, naturally occurring, or planned, such as the ongoing Iraq war, or planned hospitalisations.

2.5 What, if any, statistical analyses are used to assess the impact of life events on change/outcomes?

Twenty-eight studies (66.7%) reported using statistical analyses to assess life events and change over the course of therapy. Ten studies looked at intercurrent life events as mediators of change over the

course of psychotherapy. For example, one study examined parent-child conflict as a predictor of recovery from depression (Birmaher et al., 2000) and another explored the role of stress events in predicting change in symptoms of mania, depression and combined mood symptoms (Kim, Miklowitz, Biuckians, & Mullen, 2007).

Life events were also reported in terms of pre- to post- change over the course of therapy. For example from pre- to post-therapy young people reported changes in stressful family life events (Valdez, Mills, Barrueco, Leis, & Riley, 2011) and instances of teasing in the classroom and playground (Maddern, Cadogan, & Emerson, 2006). Events were analysed in some studies in terms of their influence on access and engagement in therapy (n=1; Chavira et al., 2014); and within a cost analysis (n=1; number of hospitalisations; Ellis, Saxe, & Twiss, 2011).

Case studies did not provide formal analyses of findings; the therapist and/or author frequently provided an account of the association between events during therapy and other outcomes. For example, one study provided details of increased anxiety, nightmares and conflict with others on the thirteenth week of therapy, which coincided with the patient's appearance in court (Ford & Nangle, 2015). In another case study, the therapist reflected on how the interruption to therapy, in the form of therapist illness and the consequent delivery of therapy by phone, gave rise to discussing and resolving patient issues related to a history of traumatic separations (Weintraub, 1990).

4. Discussion

This review found 42 studies reporting on life events experienced by participants during the course of psychotherapeutic intervention for depression and anxiety in children and adolescents.

Considering the number of studies that exist on counselling and psychotherapy for children and adolescents for depression and/or anxiety (to illustrate, a search PsycINFO for this area of psychotherapy using search terms in supplementary material 2 returned 21,708 records), those

studies that examine intercurrent life events constitute just a fraction: 0.2%. Many studies (n=19 studies excluded at full text screening) that were initially included in this review from bibliographic database searches were later screened out as their focus on life events was solely on adverse events in terms of trial governance. Whilst such adverse event reporting is vital in countering a bias to see psychotherapies are without negative impacts, the focus of this review was on those life events that may influence the course of psychotherapy and are often inextricably bound with an individual's socioeconomic circumstances.

Studies varied in how much they did discuss the definition and conceptualisation of life events. On reflection, we were surprised how little this was discussed. Studies reported a wide range of events, from severe, negative events, to more common daily events, such as witnessing parents arguing. Another facet of life events was chronicity, uniqueness and with that, predictability. Some events, such as medical procedures, come with varying but sometimes long and definite planning periods, whereas other events were more likely to repeat but, were not predictable. There is also a question of the degree of the protagonist's involvement in and control over events. A number of events lie complexly between the two extremes of no control, or total agency: accidents for example, are unpredictable in themselves but contributed to by voluntary intoxication, anger, etc. It was also noted that there were often complexities of family, educational or social contributions to events that may be only partially within the child or adolescent's choice to avoid, or escape.

Despite the paucity of information and methodological heterogeneity in the reporting of SES, it was apparent that many of the studies recruited participants from low SES backgrounds. For example, studies of events in therapy for newly resettled refugees describe resource hardships faced by such individuals (O'Shea et al., 2000) and preventative studies targeting 'at-risk' populations recruit young people from areas with elevated rates of violent crime, drug-use and sexually transmitted infections (Cooley-Strickland, Griffin, Darney, Otte, & Ko, 2011; Kerrigan et al., 2011). In such studies, the authors reasonably anticipate a relationship between negative events or stressors, and negative

impacts on mental health. In one study, authors reflect on the nature of the association between life events and SES, highlighting interventions in Zambia and Cambodia, where extensive poverty is found alongside limited mental health infrastructure and equally limited legal systems protecting children (Murray, Cohen, & Mannarino, 2013). The paper goes on to provide a striking example of how deprivation and life events can be positively associated describing situations in which a perpetrator of child abuse remains in the household with the child victim(s), as the perpetrator is the main breadwinner (Murray et al., 2013). Many of the interventions in these studies were psychosocial involving 'wraparound' support highly individualised to the needs of the patient. One such study reported on a multi-tiered intervention involving co-ordinated community systems to suit the diverse and multiple problems experienced by refugee youth. Treatment was tiered to provide young people with the appropriate interventions that were suited not only to their level of psychological distress, but also their degree of exposure to socioenvironmental stressors.

Many of the included treatments share a common feature in response to the occurrence of such an event, in that the young person's environment needs to be stabilised. Two papers describe youth receiving therapy for continuous trauma, whose situations are described as 'stably unstable' (Murray et al., 2013). These studies emphasise strategies that enable effective treatment during ongoing traumatic experiences, including prioritising patient safety early in treatment.

Questionnaires were the most frequently used method for assessing intercurrent life events. However, questionnaires were often adapted for individual studies, or designed specifically for the purpose of the study. Further, of the 23 standardised questionnaires that were utilised without amendment, only 3 questionnaires were used more than once. Such heterogeneity of assessment limits opportunities for comparisons across studies and severely limits this area of psychotherapy research.

Four of the studies discussed the difficulties in assessing life events, including the potential confounding of self-reports of life events with clinical status (Goodyer, Herbert, Tamplin, Secher, &

Pearson, 1997; Wilkinson, Dubicka, Kelvin, Roberts, & Goodyer, 2009). For instance, one study noted that retrospective collection of life event data risks those with continuing or recurrent depression reporting more adverse life events than those in remission (Wilkinson et al., 2009). Indeed, the current review attempted to avoid these confounding reports of life events, by omitting studies of those events that are 'internally-generated' and more likely confounded with clinical status. However, the scope of this review did not allow for an in-depth, item-by-item review of the measures used and may have included studies also reporting on such events. One study recommended assessing mediators of therapeutic change, such as life events, more frequently and over longer periods of follow-up in order to account for non-linear mediational change. Life events do appear to pose a unique challenge in terms of their assessment, in that possible intercurrent events are likely to be highly specific to different populations and cultures and can vary widely in terms of their severity and chronicity. Future studies and reviews of life events in therapy should aim to develop and collate both intensive research measures and measures suitable for routine clinical use. Whilst reviews of measures for adult life events exist (e.g. Dohrenwend, 2006), to our knowledge, no such reviews exist for children and adolescents.

Of the 42 studies included, just 28 reported using statistical analyses to explore intercurrent life events and the course of therapy. Ten of the included studies explored life events as mediators of treatment in an attempt to better understand the mechanisms by which outcomes are affected over the course of psychotherapy. Whilst there are many reasons for studying such mechanisms of change, including identifying common factors, optimising beneficial aspects of therapy and identifying moderators of treatment, the exploration of life events as mediators of change in psychotherapy offers two more specific lines of investigation (Kazdin, 2007). Firstly, through increasing our understanding of life events as mediators of treatment, treatments may be better translated from the clinic and into real-world settings and begin to take into account the contextual complexity involved in real world psychotherapy, particularly with clients from low SES settings. Secondly, the mediating effects of life events are of value beyond psychotherapy: everyday

experiences and occurrences are integral to one's sense of wellbeing, adjustment and navigation through the 'shoals of life' (Kazdin, 2007) and understanding more about how such events and experiences affect our psychological wellbeing could help develop resilience and preventative strategies which might be social rather than individual.

Whilst awareness of a young person's environmental circumstances seems to exist within psychotherapeutic practice, intercurrent life events appear vastly overlooked in psychotherapy research for young people with 0.2% of reports on change/outcomes in child/adolescent therapies in this review addressing these events. Given that life events are recognised as one mechanism for the association between SES and mental health (World Health Organization, 2014) this neglect of intercurrent life events in psychotherapy research may not only parallel a general neglect of socioeconomic circumstances (Smail, 1993, 2015), but also serve to further exacerbate it. Life events that are intercurrent with psychotherapeutic intervention may be a discomfoting area for therapists, due to the therapists' lack of control over such events and the challenges they face of delivering effective therapies in shifting patient circumstances. This discomfort may also explain the lack of agreed measures for assessing intercurrent events in therapy which further exacerbates the general neglect: further efforts must be made in this area. The study of intercurrent life events in psychotherapy research may help us to take into account the great contextual complexity that exists in therapy beyond the confines of the clinic and help us bridge to general psychosocial processes and possible interventions.

References

- Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., & Syme, S. L. (1994). Socioeconomic status and health: the challenge of the gradient. *American Psychologist*, 49(1), 15.
- ATLAS.ti. (1999). (Version Version 8.0). Berlin: Scientific Software Development.

- Baum, A., Garofolo, J. P., & Yali, A. M. (1999). Socioeconomic Status and Chronic Stress: Does Stress Account for SES Effects on Health? *Annals of the New York Academy of Sciences*, *896*(1), 131–144. <https://doi.org/10.1111/j.1749-6632.1999.tb08111.x>
- Birmaher, B., Brent, D. A., Kolko, D., Baugher, M., Bridge, J., Holder, D., ... Ulloa, R. E. (2000). Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Archives of General Psychiatry*, *57*(1), 29–36.
- Bradley, R. H., & Corwyn, R. F. (2002). Socioeconomic status and child development. *Annual Review of Psychology*, *53*(1), 371–399.
- Brady, S. S., & Matthews, K. A. (2002). The Influence of Socioeconomic Status and Ethnicity on Adolescents' Exposure to Stressful Life Events. *Journal of Pediatric Psychology*, *27*(7), 575–583. <https://doi.org/10.1093/jpepsy/27.7.575>
- Chavira, D. A., Drahota, A., Garland, A. F., Roesch, S., Garcia, M., & Stein, M. B. (2014). Feasibility of two modes of treatment delivery for child anxiety in primary care. *Behaviour Research and Therapy*, *60*, 60–66. <https://doi.org/10.1016/j.brat.2014.06.010>
- Cooley-Strickland, M. R., Griffin, R. S., Darney, D., Otte, K., & Ko, J. (2011). Urban African American youth exposed to community violence: A school-based anxiety preventive intervention efficacy study. *Journal of Prevention & Intervention in the Community*, *39*(2), 149–166. <https://doi.org/10.1080/10852352.2011.556573>
- Cooper, M. (2009). Counselling in UK secondary schools: A comprehensive review of audit and evaluation data. *Counselling and Psychotherapy Research*, *9*(3), 137–150.
- Danielson, C. K., Feeny, N. C., Findling, R. L., & Youngstrom, E. A. (2004). Psychosocial Treatment of Bipolar Disorders in Adolescents: A Proposed Cognitive-Behavioral Intervention. *Cognitive and Behavioral Practice*, *11*(3), 283–297. [https://doi.org/10.1016/S1077-7229\(04\)80043-9](https://doi.org/10.1016/S1077-7229(04)80043-9)
- Davidson, L., Shahar, G., Lawless, M. S., Sells, D., & Tondora, J. (2006). Play, Pleasure, and Other Positive Life Events: “Non-Specific” Factors in Recovery from Mental Illness? *Psychiatry: Interpersonal and Biological Processes*, *69*(2), 151–163.

- Dohrenwend, B. P. (2006). Inventorying stressful life events as risk factors for psychopathology: Toward resolution of the problem of intracategory variability. *Psychological Bulletin*, *132*(3), 477.
- Dolgin, R. (2014). Into the wild: A group wilderness intervention to build coping strategies in high school youth through collaboration and shared experience. *Journal of Creativity in Mental Health*, *9*(1), 83–98. <https://doi.org/10.1080/15401383.2013.864963>
- Ellis, B. H., Saxe, G. N., & Twiss, J. (2011). Trauma systems therapy: Intervening in the interaction between the social environment and a child's emotional regulation. In V. Ardino & V. Ardino (Eds.) (Eds.), *Post-traumatic syndromes in childhood and adolescence: A handbook of research and practice*. (pp. 373–390). Wiley-Blackwell. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2011-20396-019&site=ehost-live>
- Ford, H. A., & Nangle, D. W. (2015). Treatment guided by an online course: A single case evaluation of TF-CBT for an adolescent with chronic posttraumatic stress disorder. *Clinical Case Studies*, *14*(3), 227–243. <https://doi.org/10.1177/1534650114553464>
- Frick, P. (1991). *The Alabama Parenting Questionnaire*. Unpublished rating scale: University of Alabama.
- Garnezy, N., & Tellegen, A. (1984). Studies of stress-resistant children: Methods, variables, and preliminary findings. *Advances in Applied Developmental Psychology*, *1*, 231–287.
- Goodyer, I. M., Herbert, J., Tamplin, A., Secher, S. M., & Pearson, J. (1997). Short-term outcome of major depression: II. Life events, family dysfunction, and friendship difficulties as predictors of persistent disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(4), 474–480.
- Johnson, J. G., Cohen, P., Dohrenwend, B. P., Link, B. G., & Brook, J. S. (1999). A longitudinal investigation of social causation and social selection processes involved in the association

- between socioeconomic status and psychiatric disorders. *Journal of Abnormal Psychology*, 108(3), 490.
- Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annu. Rev. Clin. Psychol.*, 3, 1–27.
- Kerrigan, D., Johnson, K., Stewart, M., Magyari, T., Hutton, N., Ellen, J. M., & Sibinga, E. M. (2011). Perceptions, experiences, and shifts in perspective occurring among urban youth participating in a mindfulness-based stress reduction program. *Complementary Therapies in Clinical Practice*, 17(2), 96–101.
- Kim, E. Y., Miklowitz, D. J., Biuckians, A., & Mullen, K. (2007). Life stress and the course of early-onset bipolar disorder. *Journal of Affective Disorders*, 99(1–3), 37–44.
<https://doi.org/10.1016/j.jad.2006.08.022>
- Lantz, P. M., House, J. S., Mero, R. P., & Williams, D. R. (2005). Stress, Life Events, and Socioeconomic Disparities in Health: Results from the Americans' Changing Lives Study. *Journal of Health and Social Behavior*, 46(3), 274–288. <https://doi.org/10.1177/002214650504600305>
- Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., ... Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: a systematic review. *Social Science & Medicine*, 71(3), 517–528.
- Maddern, L. H., Cadogan, J. C., & Emerson, M. P. (2006). "Outlook": A Psychological Service for Children with a Different Appearance. *Clinical Child Psychology and Psychiatry*, 11(3), 431–443. <https://doi.org/10.1177/1359104506064987>
- Murray, L. K., Cohen, J. A., & Mannarino, A. P. (2013). Trauma-focused cognitive behavioral therapy for youth who experience continuous traumatic exposure. *Peace and Conflict: Journal of Peace Psychology*, 19(2), 180–195. <https://doi.org/10.1037/a0032533>
- O'shea, B., Hodes, M., Down, G., & Bramley, J. (2000). A school-based mental health service for refugee children. *Clinical Child Psychology and Psychiatry*, 5(2), 189–201.

- Pearlin, L. I. (1989). The Sociological Study of Stress. *Journal of Health and Social Behavior*, 30(3), 241–256. <https://doi.org/10.2307/2136956>
- Pearlin, L. I., Schieman, S., Fazio, E. M., & Meersman, S. C. (2005). Stress, Health, and the Life Course: Some Conceptual Perspectives. *Journal of Health and Social Behavior*, 46(2), 205–219. <https://doi.org/10.1177/002214650504600206>
- Reich, J. W., & Zautra, A. (1981). Life events and personal causation: Some relationships with satisfaction and distress. *Journal of Personality and Social Psychology*, 41(5), 1002.
- Reiss, F. (2013). Socioeconomic inequalities and mental health problems in children and adolescents: A systematic review. *Social Science & Medicine*, 90, 24–31. <https://doi.org/10.1016/j.socscimed.2013.04.026>
- Riskind, J. H., Kleiman, E. M., & Schafer, K. E. (2013). “Undoing” effects of positive affect: Does it buffer the effects of negative affect in predicting changes in depression? *Journal of Social and Clinical Psychology*, 32(4), 363–380.
- Robin, A. L., & Foster, S. L. (1989). Negotiating parent–adolescent conflict: A behavioral–family systems approach.
- Rousseau, C., & Machouf, A. (2005). A Preventive Pilot Project Addressing Multiethnic Tensions in the Wake of the Iraq War. *American Journal of Orthopsychiatry*, 75(4), 466–474. <https://doi.org/10.1037/0002-9432.75.4.466>
- Shahar, G., & Priel, B. (2002). Positive life events and adolescent emotional distress: In search of protective-interactive processes. *Journal of Social and Clinical Psychology*, 21(6), 645–668.
- Siegler, V., Al-Hamad, A., & Blane, D. (2010). Social inequalities in fatal childhood accidents and assaults: England and Wales, 2001–03. *Health Statistics Quarterly*, 48(1), 3–35.
- Smail, D. (1993). *The origins of unhappiness*. London: Constable.
- Smail, D. (2015). *Illusion and reality: The meaning of anxiety*. Karnac Books.

- Valdez, C. R., Mills, C. L., Barrueco, S., Leis, J., & Riley, A. W. (2011). A pilot study of a family-focused intervention for children and families affected by maternal depression. *Journal of Family Therapy, 33*(1), 3–19. <https://doi.org/10.1111/j.1467-6427.2010.00529.x>
- Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. L. Erlbaum Associates.
- Weintraub, C. G. (1990). Telephone sessions in the treatment of a child during the therapist's absence because of threatened miscarriage. *Clinical Social Work Journal, 18*(3), 227–241. <https://doi.org/10.1007/BF00755098>
- Wilkinson, P., Dubicka, B., Kelvin, R., Roberts, C., & Goodyer, I. (2009). Treated depression in adolescents: Predictors of outcome at 28 weeks. *The British Journal of Psychiatry, 194*(4), 334–341. <https://doi.org/10.1192/bjp.bp.108.052381>
- World Health Organization. (2014). *Social determinants of mental health*. World Health Organization.

Supplementary material 1. List of email circulars contacted as part of study identification.

1. EAPA (European Association of Psychological Assessment) members
2. Critical Psychiatry Network List
3. Discussion of theoretical and research issues in counselling
4. SITAR (Society for Interpersonal Theory and Research) members
5. SEPI (Society for the Exploration of Psychotherapy integration) members

Supplementary material 2. Search strategy used in PsycINFO (EBSCO).

#	Searches
1	psychotherap*
2	psycho-therap*
3	counsel*
4	exp/ psychotherapy (exp/ child psychotherapy, exp/ adolescent psychotherapy)
5	1 or 2 or 3 or 4
6	youth
7	child*
8	teen*
9	adolescen*
10	6 or 7 or 8 or 9
11	event
12	life-event
13	hassl*

14	stressor*
15	accident
16	trauma
17	experiences (events) (life experiences, life changes)
18	11 or 12 or 13 or 14 or 15 or 16
19	depress*
20	anxi*
21	mood
22	internalising
23	internalizing
24	depression (emotion) (inc major depression)
25	Anxiety (inc anxiety disorders)
26	19 or 20 or 21 or 22 or 23 or 24
27	5 and 10 and 18 and 26
28	Limit to English (language)
29	Filter childhood (birth – 12 years), school age (6-12 years) and adolescence (13-17 years)
30	Publication time limited to end of April 2017

Supplementary material 3. Search strategy used in Medline (PubMed).

#	Searches
1	psychotherap*
2	psycho-therap*
3	counsel*
4	"Psychotherapy"[Mesh]
5	1 or 2 or 3 or 4
6	youth
7	child
8	children
9	childhood
10	teen*

11	adolescen*
12	"Child"[Mesh]
13	"Adolescent"[Mesh]
14	6 or 7 or 8 or 9 or 10 or 11 or 12 or 13
15	event
16	life-event
17	hassl*
18	stressor*
19	accident
20	"Life Change Events"[Mesh]
21	15 or 16 or 17 or 18 or 19 or 20 or 21
22	depress*
23	anxi*
24	mood
25	internalising
26	internalizing
27	"Depression"[Mesh] OR "Depressive Disorder"[Mesh]
28	"Anxiety"[Mesh] OR "Anxiety Disorders"[Mesh]
29	23 or 24 or 25 or 26 or 27 or 28 or 29
30	5 and 14 and 22 and 30
31	Limit to humans
32	Limit to English (language)
33	Filter all child: birth – 18 years
34	Publication time limited to end of April 2017

Supplementary material 4. Case studies (n=11) included in review.

Source	No of participants	Age range (years)	Gender (% female)	Type of psychotherapy	Intercurrent life events
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Alexander 2017(1)	1	16	100.0%	Intensive psychotherapy	16th birthday, returning to school
Murray et al 2013(2)	8	6-15 (n=7)	37.5%	TF-CBT ^a	Witnessing domestic violence, sexual abuse, violence in neighbourhood, domestic abuse, involvement of child protection services, moving accommodation, community violence, continuous contact with rape perpetrator
Ford et al 2015(3)	1	16	100.0%	TF-CBT ^a	Sexual abuse perpetrator appealing case, application and acceptance to college, appearance in court in front of perpetrator, perpetrator not found guilty
Ruggiero et al 2007(4)	1	17	100.0%	BATD ^b	Pleasant activities, social activities with peers
Weintraub 1990(5)	1	11	0.0%	Not reported	Therapist illness (distance/telephone sessions) and patient holiday
Nurcombe et al 2002(6)	1	9	0.0%	Individual and marital therapy	Teasing
Slutsker et al 2010(7)	1	13	0.0%	CBT ^c plus biofeedback training	Return to school, vomiting
Atala & Carter 1992(8)	1	10	100.0%	Multi-component treatment with CBT ^c	Chemotherapy, hospitalisations, limb amputation
Runyon & Orvaschel 1999(9)	1	17	100.0%	CBT ^c	Required testing for HIV, enrolled in college, obtained driver's permit
Danielson et al 2004(10)	1	13	0.0%	Psychosocial intervention based on CBT ^c	Therapist moved out of state, pleasant activities
O'Shea et al 2000(11)	14	7-11	14.3%	Multiple treatment options including CBT ^c	Change of accommodation. Move from primary to secondary school. Visit to war museum. Permanent housing obtained

^a TF-CBT – Trauma Focused Cognitive Behavioural Therapy

^bBATD – Behavioural Activation Treatment for Depression

^cCBT – Cognitive Behavioural Therapy

Supplementary material 5. Randomised controlled trials (RCTs; n=15) included in review

Source	No of participants	Age range (years)	Gender (% female)	Type of psychotherapy	Intercurrent life events
Baron et al 2016(12)	154	11-15	59.7%	TRT ^a program	War stressor exposure
Chavira et al 2014(13)	48	8-13	61.9%	CBT ^b	Barriers to treatment: competing stressors and obstacles
Cooley-Strickland et al 2011(14)	93	8-12	48.4%	CBT ^b	Exposure to community violence, including victimisation and adverse life events
Sandler et al 2003(15)	244	8-16	46.0%	FBP ^c	Negative events, negative thoughts about stressful events and parental discipline
Kaufman et al 2005(16)	93	13-17	48.4%	CBT-CWD-A ^d	Instances of relaxation, pleasant activities, parental conflict
Thabet et al 2005(17)	111	9.15	45.9%	Crisis intervention group	Ongoing armed conflict in region, varying by area of residence
Wilkinson et al 2009(18)	192	11-17	73.4%	Routine psychosocial care, SSRIs ^e , CBT ^b	Recent episodic life events: personal disappointments to the self, physically dangerous events to self, physically dangerous events to others and permanent losses
Stice et al 2010(19)	341	Not reported	Not reported	CBT ^b group, a supportive expressive group, CBT ^b bibliotherapy, or control condition	Pleasant activities
Clarke et al 2016(20)	212	12-18	68.4%	CBT ^b	Pleasant events
Birmaher et al 2000(21)	107	13-18	75.7%	CBT, SBFT ^f , NST ^g	Parent child conflict
Swenson et al 2010(22)	86	10-17	55.8%	MST-CAN ^h	Parent child conflict, maltreatment (reabuse, out of home placement)
Shamseddeen et al 2011(23)	334	12-18	67.4%	Switching to second SSRI ^e combined with CBT ^b , switching to venlafaxine combined with CBT ^b	End of school and whether this coincided with the end of treatment. Family conflict.
Diamond et al 2002(24)	32	13-17	78.0%	ABFT ⁱ	Family conflict
Cohen et al 2011(25)	124	7-14	50.8%	TF-CBT ^j , usual care (child-centered therapy)	Contact with IPV perpetrator during treatment, trauma during treatment
Sandler et al 1992(26)	72	7-17	48.6%	FBP ^c	Stable positive events, negative events, discussion of grief-related issues

^aTRT – Teaching Recovery Techniques

^bCBT – Cognitive Behavioural Therapy

^cFBP – Family Bereavement Program

^dCBT-CWD-A – Cognitive Behavioural Therapy – Coping with Depression – for Adolescents

^eSSRIs - selective serotonin reuptake inhibitors

^fSBFT - Systemic Behavioural Family Therapy

^gNST - Nondirective Supportive Therapy

^hMST-CAN - Multi-systemic therapy for Child Abuse and Neglect

ⁱABFT - Attachment-based Family Therapy

^jTF-CBT – Trauma Focused Cognitive Behavioural Therapy

Supplementary material 6. Uncontrolled case series studies (n=13) included in review

Source	No of participants	Age range (years)	Gender (% female)	Type of psychotherapy	Intercurrent life events
Schaeffer et al 2013(27)	43	6-17	44.2%	MST-BSF ^a	Non-violent discipline, minor physical assault, psychological aggression, re-abuse and out-of-home placements
Högberg & Hällström 2008(28)	14	7-18	78.6%	Active multi-modal therapy	Trauma during treatment
Maddern et al 2006(29)	29	5-16	58.6%	CBT ^b plus parent support	Teasing
Szigethy et al 2004(30)	11	12-17	63.6%	CBT ^b	Illness severity and functioning, hospitalisations

Ellis et al 2013(31)	30	11-15	36.7%	Multi-tier mental health program (Project SHIFA)	Resource hardships, including housing, financial and interpersonal problems, discrimination, acculturative hassles
Valdez et al 2011(32)	16	9-16	Not reported	Family-focused intervention; multi-family group intervention	Stressful life events, parenting and family activities/routines.
Kim et al 2007(33)	38	13-17	52.6%	Family-focused psychoeducation and pharmacotherapy	Life stress (stressful events/episodic stress and chronic stress)
Kjellgren et al 2013(34)	25	6-14	40.0%	CPC-CBT ^c	Traumatic experiences, positive parenting, inconsistent parenting, corporal punishment, movement from home
Hains 1992(35)	8	15-17	25.0%	Stress inoculation training	Daily and major life stress events
Runyon et al 2009(36)	21	4-14	61.9%	CPC-CBT ^c	Positive parenting, inconsistent parenting and corporal punishment, violent and non-violent discipline.
Ellis et al 2012(37)	124	3-20	45.2%	TST ^d	Hospitalisation
Jay et al 1985(38)	5	3.5-7	6.0%	Behavioural management intervention	Medical procedure
Goodyer et al 1997(39)	78	8-16	Not reported	Not assessed	Recent life events (events relating to danger, disappointment, and loss).

^aMST-BSF - Multi-Systemic Therapy - Building Stronger Families

^bCBT – Cognitive Behavioural Therapy

^cCPC-CBT - Combined Parent-Child Cognitive Behavioural Therapy for Families at Risk for Child Physical Abuse

^dTST - Trauma Systems Therapy

^eDBT – Dialectical Behaviour Therapy

Supplementary material 7. Qualitative studies (n=2) included in the review.

Source	No of participants	Age range (years)	Gender (% female)	Type of psychotherapy	Intercurrent life events
Dolgin 2014(40)	21	15-17	61.9%	Wilderness-based therapy	Stressors (common familial (parents arguing) and social (bullying) issues)
Kerrigan et al 2011(41)	10	13-19	80.0%	Mindfulness-based stress reduction program	Ongoing external stressors (school-related academic issues, friend and family dynamics, finishing school, verbal conflicts)
Rousseau & Machouf 2005(42)	Not reported	11-12	Not reported	Preventative project addressing multi-ethnic tensions	War in Iraq launched 3 weeks after project started. Possible increases in schoolyard violence and rumours of bombs in the school.

Supplementary material 8. Standardised outcome measures used.

1. Acculturative Hassles Inventory (43)
2. Alabama Parenting Questionnaire - child report (44)
3. Alabama Parenting Questionnaire - parent report (44)
4. Areas of change questionnaire – child report (ACQ; 46)
5. Areas of change questionnaire – parent report (ACQ; 46)
6. Barriers to Treatment Participation Scales (46)
7. Child Behaviour Checklist (CBCL; 48)
8. Conflict Behaviour Questionnaire – child report (CBQ-A; 49)
9. Conflict behaviour questionnaire – parent report (CBQ; 49)
10. Conflict Tactics Scale – parent report (CTS; 50)
11. Conflict Tactics Scale – child report (CTS; 50)
12. Clinical Score of Kozarek (CSK; 51)
13. Daily Activity Log – Form 1 (DAL; 52)
14. Everyday Discrimination Scale (EDD; 53)
15. Exposure to war stressors questionnaire (EWSQ; 54)
16. Family Times and Routines Index – child report (54)
17. Family Times and Routines Index – parent report (54)

18. McMaster family assessment device – child report (FAD; 56)
19. McMaster family assessment device – parent report (FAD; 56)
20. Multicultural Events Schedule for Adolescents (MESA; 57)
21. Paediatric Crohn’s Disease Activity Index (PCDAI; 58)
22. Report of Parenting Behavior Inventory – child report (58)
23. Report of Parenting Behavior Inventory – parent report (58)

1. Alexander L. Clinical commentary on Greta: I. *J Child Psychother.* 2017 Jan;43(1):115–21.
2. Murray LK, Cohen JA, Mannarino AP. Trauma-focused cognitive behavioral therapy for youth who experience continuous traumatic exposure. *Peace Confl J Peace Psychol.* 2013 May;19(2):180–95.
3. Ford HA, Nangle DW. Treatment guided by an online course: A single case evaluation of TF-CBT for an adolescent with chronic posttraumatic stress disorder. *Clin Case Stud.* 2015 Jun;14(3):227–43.
4. Ruggiero KJ, Morris TL, Hopko DR, Lejuez CW. Application of Behavioral Activation Treatment for Depression to an Adolescent With a History of Child Maltreatment. *Clin Case Stud.* 2007 Feb;6(1):64–78.
5. Weintraub CG. Telephone sessions in the treatment of a child during the therapist’s absence because of threatened miscarriage. *Clin Soc Work J.* 1990;18(3):227–41.
6. Nurcombe B, Drell MJ, Leonard HL, McDermott JF. Clinical problem solving: The case of Matthew, part III. *J Am Acad Child Adolesc Psychiatry.* 2002 Mar;41(3):344–53.

7. Slutsker B, Konichezky A, Gothelf D. Breaking the cycle: Cognitive behavioral therapy and biofeedback training in a case of cyclic vomiting syndrome. *Psychol Health Med*. 2010 Dec;15(6):625–31.
8. Atala KD, Carter BD. Pediatric limb amputation: Aspects of coping and psychotherapeutic intervention. *Child Psychiatry Hum Dev*. 1992;23(2):117–30.
9. Runyon MK, Orvaschel H. Cognitive-behavioral treatment for adolescent depression complicated by childhood trauma: A case illustration. *Clin Child Psychol Psychiatry*. 1999 Oct;4(4):493–504.
10. Danielson CK, Feeny NC, Findling RL, Youngstrom EA. Psychosocial Treatment of Bipolar Disorders in Adolescents: A Proposed Cognitive-Behavioral Intervention. *Cogn Behav Pract*. 2004;11(3):283–97.
11. O’Shea G, Spence SH, Donovan CL. Interpersonal factors associated with depression in adolescents: Are these consistent with theories underpinning interpersonal psychotherapy? *Clin Psychol Psychother*. 2014 Nov;21(6):548–58.
12. Barron I, Abdallah G, Heltne U. Randomized control trial of Teaching Recovery Techniques in rural occupied Palestine: Effect on adolescent dissociation. *J Aggress Maltreatment Trauma*. 2016 Oct;25(9):955–73.
13. Chavira DA, Drahota A, Garland AF, Roesch S, Garcia M, Stein MB. Feasibility of two modes of treatment delivery for child anxiety in primary care. *Behav Res Ther*. 2014 Sep;60:60–6.
14. Cooley-Strickland MR, Griffin RS, Darney D, Otte K, Ko J. Urban African American youth exposed to community violence: A school-based anxiety preventive intervention efficacy study. *J Prev Interv Community*. 2011 Apr;39(2):149–66.

15. Sandler IN, Ayers TS, Wolchik SA, Tein J-Y, Kwok O-M, Haine RA, et al. The Family Bereavement Program: Efficacy evaluation of a theory-based prevention program for parentally bereaved children and adolescents. *J Consult Clin Psychol*. 2003 Jun;71(3):587–600.
16. Kaufman NK, Rohde P, Seeley JR, Clarke GN, Stice E. Potential Mediators of Cognitive-Behavioral Therapy for Adolescents With Comorbid Major Depression and Conduct Disorder. *J Consult Clin Psychol*. 2005 Feb;73(1):38–46.
17. Thabet AA, Vostanis P, Karim K. Group crisis intervention for children during ongoing war conflict. *Eur Child Adolesc Psychiatry*. 2005 Aug;14(5):262–9.
18. Wilkinson P, Dubicka B, Kelvin R, Roberts C, Goodyer I. Treated depression in adolescents: Predictors of outcome at 28 weeks. *Br J Psychiatry*. 2009 Apr;194(4):334–41.
19. Stice E, Rohde P, Seeley JR, Gau JM. Testing mediators of intervention effects in randomized controlled trials: An evaluation of three depression prevention programs. *J Consult Clin Psychol*. 2010 Apr;78(2):273–80.
20. Clarke G, DeBar LL, Pearson JA, Dickerson JF, Lynch FL, Gullion CM, et al. Cognitive behavioral therapy in primary care for youth declining antidepressants: A randomized trial. *Pediatrics*. 2016 May;137(5):1–13.
21. Birmaher B, Brent DA, Kolko D, Baugher M, Bridge J, Holder D, et al. Clinical outcome after short-term psychotherapy for adolescents with major depressive disorder. *Arch Gen Psychiatry*. 2000;57(1):29–36.
22. Swenson CC, Schaeffer CM, Henggeler SW, Faldowski R, Mayhew AM. Multisystemic Therapy for Child Abuse and Neglect: a randomized effectiveness trial. *J Fam Psychol*. 2010;24(4):497.

23. Shamseddeen W, Clarke G, Wagner KD, Ryan ND, Birmaher B, Emslie G, et al. Treatment-Resistant Depressed Youth Show a Higher Response Rate if Treatment Ends During Summer School Break. *J Am Acad Child Adolesc Psychiatry*. 2011 Nov 1;50(11):1140–8.
24. Diamond GS, Reis BF, Diamond GM, Siqueland L, Isaacs L. Attachment-based family therapy for depressed adolescents: A treatment development study. *J Am Acad Child Adolesc Psychiatry*. 2002;41(10):1190–6.
25. Cohen JA, Mannarino AP, Iyengar S. Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Arch Pediatr Adolesc Med*. 2011;165(1):16–21.
26. Sandler IN, West SG, Baca L, Pillow DR, Gersten JC, Rogosch F, et al. Linking empirically based theory and evaluation: the Family Bereavement Program. *Am J Community Psychol*. 1992 Aug;20(4):491–521.
27. Schaeffer CM, Swenson CC, Tuerk EH, Henggeler SW. Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse Negl*. 2013 Aug;37(8):596–607.
28. Högberg G, Hällström T. Active multimodal psychotherapy in children and adolescents with suicidality: Description, evaluation and clinical profile. *Clin Child Psychol Psychiatry*. 2008 Jul;13(3):435–48.
29. Maddern LH, Cadogan JC, Emerson MP. ‘Outlook’: A Psychological Service for Children with a Different Appearance. *Clin Child Psychol Psychiatry*. 2006 Jul;11(3):431–43.
30. Szigethy E, Whitton SW, Levy-Warren A, DeMaso DR, Weisz J, Beardslee WR. Cognitive-Behavioral Therapy for Depression in Adolescents With Inflammatory Bowel Disease: A Pilot Study. *J Am Acad Child Adolesc Psychiatry*. 2004 Dec;43(12):1469–77.

31. Ellis BH, Miller AB, Abdi S, Barrett C, Blood EA, Betancourt TS. Multi-tier mental health program for refugee youth. *J Consult Clin Psychol*. 2013 Feb;81(1):129–40.
32. Valdez CR, Mills CL, Barrueco S, Leis J, Riley AW. A pilot study of a family-focused intervention for children and families affected by maternal depression. *J Fam Ther*. 2011 Feb;33(1):3–19.
33. Kim EY, Miklowitz DJ, Biuckians A, Mullen K. Life stress and the course of early-onset bipolar disorder. *J Affect Disord*. 2007 Apr;99(1–3):37–44.
34. Kjellgren C, Svedin CG, Nilsson D. Child Physical Abuse—Experiences of combined treatment for children and their parents: A pilot study. *Child Care Pract*. 2013 Jul;19(3):275–90.
35. Hains AA. A stress inoculation training program for adolescents in a high school setting: a multiple baseline approach. *J Adolesc*. 1992 Jun;15(2):163–75.
36. Runyon MK, Deblinger E, Schroeder CM. Pilot evaluation of outcomes of combined parent-child cognitive-behavioral group therapy for families at risk for child physical abuse. *Cogn Behav Pract*. 2009;16(1):101–18.
37. Ellis BH, Fogler J, Hansen S, Forbes P, Navalta CP, Saxe G. Trauma systems therapy: 15-month outcomes and the importance of effecting environmental change. *Psychol Trauma Theory Res Pract Policy*. 2012;4(6):624.
38. Jay SM, Elliott CH, Ozolins M, Olson RA, Pruitt SD. Behavioral management of children’s distress during painful medical procedures. *Behav Res Ther*. 1985;23(5):513–20.
39. Goodyer IM, Herbert J, Tamplin A, Secher SM, Pearson J. Short-term outcome of major depression: II. Life events, family dysfunction, and friendship difficulties as predictors of persistent disorder. *J Am Acad Child Adolesc Psychiatry*. 1997;36(4):474–80.

40. Dolgin R. Into the wild: A group wilderness intervention to build coping strategies in high school youth through collaboration and shared experience. *J Creat Ment Health*. 2014 Jan;9(1):83–98.
41. Kerrigan D, Johnson K, Stewart M, Magyari T, Hutton N, Ellen JM, et al. Perceptions, experiences, and shifts in perspective occurring among urban youth participating in a mindfulness-based stress reduction program. *Complement Ther Clin Pract*. 2011;17(2):96–101.
42. Rousseau C, Machouf A. A Preventive Pilot Project Addressing Multiethnic Tensions in the Wake of the Iraq War. *Am J Orthopsychiatry*. 2005 Oct;75(4):466–74.
43. Vinokurov A, Trickett EJ, Birman D. Acculturative hassles and immigrant adolescents: A life-domain assessment for Soviet Jewish refugees. *J Soc Psychol*. 2002;142(4):425–45.
44. Frick P. The Alabama Parenting Questionnaire. Unpublished rating scale: University of Alabama; 1991.
45. Jacob T, Seilhamer RA. Adaption of the areas of change questionnaire for parent-child relationship assessment. *Am J Fam Ther*. 1985;13(2):28–38.
46. Kazdin AE, Holland L, Crowley M, Breton S. Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *J Child Psychol Psychiatry*. 1997;38(8):1051–62.
47. Achenbach TM, Edelbrock C. Child behavior checklist. Burlington Vt. 1991;7.
48. Robin AL, Foster SL. Negotiating parent–adolescent conflict: A behavioral–family systems approach. 1989;
49. Straus MA, Hamby SL, Finkelhor D, Moore DW, Runyan D. Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse Negl*. 1998;22(4):249–70.

50. Kozarek RA, Patterson DJ, Gelfand MD, Botoman VA, Ball TJ, Wilske KR. Methotrexate induces clinical and histologic remission in patients with refractory inflammatory bowel disease. *Ann Intern Med.* 1989;110(5):353–6.
51. Lejuez C, Hopko D, Hopko S. *The brief behavioral activation treatment for depression (BATD): A comprehensive patient guide.* 2002;
52. Essed P. *Understanding everyday discrimination.* 1991;
53. Smith P, Perrin S, Yule W, Hacam B, Stuvland R. War exposure among children from Bosnia-Herzegovina: Psychological adjustment in a community sample. *J Trauma Stress.* 2002;15(2):147–56.
54. McCubbin H, McCubbin M, Thompson A. Family time and routines index. *Fam Assess Invent Res Pract.* 1987;133–41.
55. Epstein NB, Baldwin LM, Bishop DS. The McMaster family assessment device. *J Marital Fam Ther.* 1983;9(2):171–80.
56. Gonzales N, Gunnoe M, Samaniego R, Jackson K. Validation of the Multicultural Events Schedule for urban Adolescents (MESA). In 1995.
57. Hyams JS, Ferry GD, Mandel FS, Gryboski JD, Kibort PM, Kirschner BS, et al. Development and validation of a pediatric Crohn’s disease activity index. *J Pediatr Gastroenterol Nutr.* 1991;12(4):449.
58. Schaefer ES. Children’s reports of parental behavior: An inventory. *Child Dev.* 1965;413–24.