BRIEF REPORT

Therapist Strategies for Building Involvement in Cognitive–Behavioral Therapy for Adolescent Depression

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This study examined predictive relations between 9 therapist behaviors and client involvement in manual-guided, cognitive–behavioral therapy for adolescent depression. Analyses included 42 adolescents who met criteria for a depressive disorder (major depressive disorder, dysthymic disorder, or adjustment disorder with depressed mood) and who were treated in school-based clinics. Therapist behaviors hypothesized to promote client involvement were coded from Session 1 audiotapes; client involvement was coded from Session 2. Unlike prior research, the current study examined associations between behaviors and involvement while controlling for initial client resistance to isolate the therapist contribution to involvement. Results show that 3 therapist behaviors from Session 1 (attending to teen’s experience, exploring teen’s motivation, and less structure) predicted greater client involvement in Session 2, controlling for initial resistance. Only exploring motivation and less structure uniquely predicted Session 2 involvement when the 3 behaviors were examined simultaneously. Session 1 therapist behaviors predicted significant variance in involvement at Sessions 2, 4, and 8. Client initial presentation as resistant was associated with more exploring motivation and praising, but initial resistance did not explain associations between therapist behaviors and involvement. Implications for implementing evidence-based treatments are discussed.

Keywords: adolescent, treatment, involvement, depression, CBT

Research on adult psychotherapy has found active client involvement to be a consistent predictor of outcomes across types of treatment (Tryon & Winograd, 2002). Similarly, a recent meta-analysis of child and adolescent treatment studies found that level of involvement predicted treatment outcomes, with a weighted mean effect size across 10 studies of .27 (Karver, Handelsman, Fields, & Bickman, 2006). Unfortunately, the vast majority of these studies focused on treatments of no known efficacy. Recently, a study by Chu and Kendall (2004) showed that child involvement in cognitive–behavioral therapy (CBT) for anxiety predicted treatment gains. Thus, emerging evidence is consistent with the clinical assumption that active client involvement is essential for treatment effectiveness.

Although some research has sought to identify strategies for improving attendance and preventing dropout in child and adolescent treatment (e.g., Nock & Kazdlin, 2005), relatively little research has focused on therapist strategies for facilitating in-session involvement. Yet clinical observation suggests that in-session involvement can be quite challenging with adolescents (Meeks & Bernet, 2002). A few studies with adolescents have focused on therapeutic alliance-building behaviors. Diamond, Liddle, Hogue, and Dakof (1999) found that therapists’ attention to the adolescent’s experience, formulation of meaningful goals, and self-presentation as an ally were associated with improved alliances in a small sample (n = 10) treated with family therapy for depression. Karver et al. (2008) examined alliance-building behaviors in a sample of depressed adolescent suicide attempters and found that therapist behaviors aimed at socializing teens to treatment (including presenting the treatment model) and building rapport (including attending to teens’ subjective experiences and providing support) positively predicted alliance at Session 3. Finally, Russell, Shirk, and Jungbluth (2008) uncovered latent dimensions of first-session therapist behavior that varied over time and predicted alliance at Session 3, but they did not identify specific types or levels of behavior associated with subsequent alliance. It is possible associations were masked by the two intervening sessions of interaction.

With the exception of the small sample study by Diamond et al. (1999), prior research has not considered initial level of client readiness or resistance. Given that research has shown alliance to be related to pretreatment client characteristics (e.g., Eltz, Shirk, & Sarlin, 1995), it is likely that adolescents enter treatment with varying levels of interest, motivation, and resistance. Thus, for some adolescents active involvement may be readily attained, whereas others may be far more difficult to engage. Methodologically, the failure to consider initial levels of adolescent resistance makes it difficult to distinguish the therapist’s and client’s contribution to subsequent involvement. In brief, variance in involvement could be mistakenly attributed to therapist strategies when, in fact, the client was predisposed to actively participate. In the current study, we addressed this limitation by controlling for initial client resistance to more clearly assess the contribution of therapist behavior on subsequent in-session involvement.

Given the high rate of early dropout seen in service clinic settings (e.g., Armbuster & Kazdlin, 1994), it is critical to (a)
identify ways to promote involvement at the outset of treatment and (b) examine the question of therapist engagement strategies in early sessions before attrition has eliminated clients of great clinical interest. Consequently, in the current study we examine the contribution of therapist behavior on involvement very early in treatment. Early treatment involvement has been shown to predict later involvement (Chu & Kendall, 2004).

Our primary aim in the current study was to examine a set of therapist engagement behaviors in relation to proximal, observational ratings of client in-session involvement. Three clusters of therapist behavior—defined by their focus on motivation, experience, or therapy socialization—were derived from reviews of adolescent treatment manuals and from conceptual articles on adolescent alliance (Shirk & Karver, 2006). In particular, therapist behaviors are examined as predictors of client involvement in tasks related to a core treatment component of CBT for adolescent depression—identification of automatic thoughts—while controlling for clients’ level of initial resistance. In the study, we extend prior research by (a) assessing client involvement in a specific therapeutic task, (b) comprehensively coding prior therapist behaviors, (c) accounting for adolescents’ initial level of resistance, and (d) examining predictive associations between therapist behaviors and involvement in the context of a treatment of known efficacy.

Method

Participants and Treatment

Eighty-three adolescents were referred to the study from four high schools in the west Rocky Mountain region. Youths were referred if school-based health or mental health clinicians detected symptoms of depression in routine academic or clinical assessments. On the basis of structured interviews with the Diagnostic Interview Schedule for Children (C-DISC; Shaffer, Fisher, Lucas, Dulcan, & Schweb-Stone, 2000), 49 adolescents met diagnostic inclusion criteria for major depressive disorder ($n = 36$), dysthymic disorder ($n = 10$), or adjustment disorder with depressed mood ($n = 3$) and started treatment. Of the original referrals, 34 adolescents were excluded because they (a) failed to meet criteria for the foregoing depressive disorders, (b) presented with a bipolar or psychotic disorder, or (c) were currently medicated for depression. The sample was further decreased to 42 because two adolescents dropped out before the second session, and five adolescents had sessions that could not be coded because of mechanical failure or because audiotapes were not available. The resulting sample of adolescents with depression included 27 young women and 15 young men between 14 and 18 years of age ($M = 15.7$ years, $SD = 1.1$). Of the sample, 45% self-identified as Caucasian, and 55% self-identified as ethnic minority—primarily Hispanic (26%) and African American (19%). Some of the participants (14%) endorsed multiple categories. Socioeconomic status was indexed by parent occupation on the Hollingshead Index (Hollingshead, 1976), with an average score of 4.1 ($SD = 2.1$) corresponding to skilled manual workers, craftsmen, and small business owners. Of the sample, 67% met criteria for at least one comorbid disorder, including generalized anxiety disorder (41%), conduct disorder (31%), social phobia (24%), and attention-deficit/hyperactivity disorder (14%).

Only clients with full data ($N = 42$) were included in analyses. Clients with missing data were compared with clients with full data on demographic (gender, age, and ethnicity) and diagnostic (pretreatment C-DISC symptoms and diagnoses) variables, with alpha set at .10. Results show that clients with missing data were slightly older ($M = 16.6$ years, $SD = 1.5$ vs. $M = 15.7$ years, $SD = 1.1$), $t(47) = -1.75$, $p < .1$, and endorsed more symptoms of generalized anxiety disorder ($M = 9.6$, $SD = 2.2$ vs. $M = 7.8$, $SD = 2.3$), $t(47) = -1.89$, $p < .1$ at the pretreatment assessment. In addition, no clients with missing data qualified for diagnoses of dysthymic disorder, adjustment disorder with depressed mood, or attention-deficit/hyperactivity disorder.

A 12-session, manual-guided, cognitive–behavioral treatment for adolescent depression (Rosselló & Bernal, 1999) was delivered by eight female, doctoral-level psychologists. This specific treatment has been shown to produce reliable change in two clinical trials (Rosselló & Bernal, 1999; Shirk, Gudmundsen, Kaplinski, & McMakin, 2008). The first session was the least structured in the protocol, providing therapists with sufficient flexibility to get to know the adolescent and to establish initial rapport. Specific guidelines for engaging adolescents were not contained in the manual. The second session of treatment included a segment in which therapists introduced the concept of automatic thoughts. The teen and therapist then explored automatic thoughts that might arise in hypothetical and real-life situations and linked automatic thoughts to the client’s mood. Treatment was delivered with a high degree of fidelity; an audiotape review showed that 91% of prescribed Session 2 components were delivered.

Measures

Computerized C-DISC (Version 4; Shaffer et al., 2000). The C-DISC was used to screen adolescents for inclusion and exclusion disorders at pretreatment and as a measure of co-occurring Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994) anxiety and disruptive behavior disorders and symptoms. The C-DISC demonstrates good reliability and criterion validity for identifying psychiatric disorders in youths (Shaffer et al., 2000).

Therapist engagement behaviors. Eight specific items and two global items from the Adolescent Alliance Building Scale (AABS; Shirk, Gudmundsen, McMakin, Dent, & Karver, 2003) were coded from audiotapes of the first session of therapy. The initial item pool was evaluated in a small sample of adolescents with depression treated with CBT or supportive therapy. Although subsequent factor analysis (Russell et al., 2008) was not fully consistent with the original model, items with adequate frequency and reliability were retained for this study. Given the number and complexity of items, each session was divided into 10-min coding segments to maximize coder accuracy. The specific items were coded for extensiveness on a 5-point scale ranging from 0 (not at all) to 4 (prolonged focus/in-depth treatment). Following Diamond et al. (1999), extensiveness refers to the frequency and thoroughness of specific therapist behaviors. Extensiveness scores were summed across all segments to create a full-session score for each specific item that could be viewed as the first session “dose” of that behavior. The two global items—structuring and supporting—were coded on a 5-point scale ranging from 0 (none) to 4 (a lot) in terms of the overall quality of each segment rather than the...
extensiveness of a particular behavior, and the scores for these two items were averaged across all segments to create full-session structuring and supporting scores. The distributions of two of the items (allying, exploring motivation) were highly skewed and were converted to dichotomous presence or absence variables. Two additional items (exploring objective information, attending to subjective experience) were highly correlated \((r = .69)\) and conceptually overlapping; thus, they were combined to create a single item (attending to client experience) to reduce the number of analyses and to address multicollinearity concerns. All segments were independently rated by four clinical psychology graduate students. Segment order was randomized prior to rating. Raters were trained and evaluated for reliability with previously coded criterion tapes, and reliability was examined within the current sample by double-coding 10% of segments. On average, intrarater reliability was adequate, with a mean two-way random effects intraclass correlation (ICC) of .71 for dimensional items and a mean kappa of .86 for dichotomous items. Item descriptions and reliabilities are presented in Table 1. For one client, the first 10-min segment of Session 1 was distorted because of tape malfunction. For this uncodable segment, we imputed scores for all AABS items using the average of item scores across the remaining nondistorted segments so that full-session composites would not be artificially low for specific items.\(^1\)

**Initial resistance.** We assessed client initial resistance during Session 1 using six items adapted from the observational Vanderbilt Negative Indicators Scale (Suh, Strupp, & O'Malley, 1986). Observers used audiotapes to code a 15-min segment for each client, beginning 5 min into Session 1. This early segment was chosen to begin after introductions and initial scheduling concerns were addressed but before the therapist had time to build much rapport, to better capture the client’s contribution to process. We rated client demeanor using five items covering five dimensions: hostile, frustrated, impatient, intellectualizing, and defensive. A sixth item was used to rate client negative reactions to the therapist. All items were rated on a 5-point scale ranging from 1 (not at all) to 5 (a great deal) and were totaled. Internal consistency for the scale was good \((\alpha = .89)\), and a one-way mixed random ICC (using 25% of scores) demonstrated good intrarater reliability \((ICC = .88)\).

**Client involvement.** We assessed client involvement during Sessions 2, 4, and 8 using the five-item Patient Participation subscale of the Vanderbilt Psychotherapy Process Scale (O’Malley, Suh, & Strupp, 1983). Items (e.g., “actively participated in the interaction”) were rated on a 5-point scale ranging from 1 (not at all) to 5 (a great deal) and were summed to create a composite. Client involvement was coded for 15 min following the introduction of a manual-specified component (described above) near the start of Session 2; this helped to increase uniformity in session content across coding. Client involvement was measured in the same way during focal CBT tasks in Sessions 4 and 8 and was averaged. The measure exhibited excellent internal consistency \((\alpha = .93)\) and intrarater reliability \((r = .97)\) in the current sample.

**Procedure**

Adolescents were informed of the school-based treatment for depression by school psychologists or social workers. Adolescent and parent consent for services and research participation were obtained by school personnel prior to referral for screening. Adolescents were screened with the C-DISC and intake interview and additional study questionnaires at a pretreatment evaluation. Therapists arranged treatment appointments with adolescents through school-based clinics during the adolescents’ open periods. All sessions were audio-recorded.

**Results**

Means and standard deviations for all measures are presented in Table 2. Outliers were identified for three of the AABS items (attending to client experience: one outlier; cognitive restructing: one outlier; structuring: two outliers) and for initial resistance (one outlier) and client involvement (four outliers); outliers were adjusted by bringing them in to 1.5 times the interquartile range beyond the first or third quartile to prevent undue influence. Skewness and kurtosis were within acceptable levels for all AABS continuous variables.

Inspection of the distributions for the initial resistance and client involvement variables indicated some degree of skew, with many cases exhibiting relatively low initial resistance \((M = 7.7, SD = 2.0)\) and high client involvement \((M = 22.8, SD = 2.6)\); however, skew and kurtosis were in acceptable ranges \((lskew < 1.3, lkurtosis < 1.0)\). In addition, associations between initial resistance and client involvement at Session 2 \((r = -.58, p < .001)\), and between initial resistance and total number of sessions completed \((r = -.36, p < .05; M = 9.9, SD = 3.6)\), indicate that the variability captured in these measures is meaningful. The correlation between initial resistance and involvement shows that only one third of the variation in involvement is determined by resistance, allowing for possible influence by therapist behaviors. To assess whether initial resistance or second session involvement was associated with level of depressive symptoms, we computed correlations between pretreatment symptoms from the C-DISC and resistance and involvement variables. Correlations were not significant \((rs = -.19, .16, respectively, ns)\).

Table 2 shows the correlations among initial resistance, client involvement, and AABS items. Although some therapist behaviors (exploring motivation and praising) appear to be influenced by clients’ initial presentation as resistant \((rs = .36 and .43, ps < .05 and .01, respectively)\), none are so highly correlated that multicollinearity would preclude entering initial resistance and the AABS behavior simultaneously as predictors of client involvement.

To address the primary aim of this study—that therapist behaviors predict client involvement after controlling for clients’ initial resistance—we computed partial correlations between Session 2 client involvement and AABS items, controlling for initial resistance. Partial correlations are shown in Table 2. Results show that attending to client experience, exploring motivation, and structuring in Session 1 are associated with client involvement in Session 2 \((rs = .35 and .39, ps < .05, and r = -.43, p < .01, respectively)\).

Next, the significant AABS predictors of client involvement were simultaneously regressed onto Session 2 client involvement while controlling for initial resistance, to examine the unique

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\(^1\) Results do not change when this client is excluded from analyses.
contributions of each. A hierarchical regression predicting Session 2 client involvement was conducted, with initial resistance entered alone in the first step and attending to client experience, exploring motivation, and structuring entered in the second step. Results show that exploring motivation and structuring uniquely and significantly predicted client involvement in Session 2 ($\beta = .27$ and $-.29$, respectively, $p < .05$) when controlling for clients’ initial resistance ($\beta = -.64, p < .001$) and attending to client experience ($\beta = .05, ns$). The variables entered in the second step explained 20% of variance in client involvement ($R^2$ change $=.20, p < .01$) beyond what is explained by initial resistance alone ($R^2 = .33, p < .001$).

To examine whether these therapist behaviors influence involvement later in treatment, we conducted the same multiple

### Table 1

**Adolescent Alliance Building Scale (AABS) Item Descriptions and Interrater Reliabilities**

<table>
<thead>
<tr>
<th>Item (Abbreviation)</th>
<th>Reliability</th>
<th>Indicator</th>
<th>Example</th>
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<tbody>
<tr>
<td><strong>Specific items</strong></td>
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<tr>
<td>Therapist attends to client experience</td>
<td>0.68</td>
<td>Elicits information about events, situations, thoughts, feelings, states; summarizes elicited content</td>
<td>“Tell me what happened before you hurt yourself.”</td>
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<tr>
<td>(Attending to client experience)</td>
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<td></td>
<td>“How do you get along with your dad?”</td>
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<td>“Who all lives in your house?”</td>
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<td>Therapist presents self as an ally (Allying)</td>
<td>1.0a</td>
<td>Indicates a willingness to support and advocate for teen’s developmentally appropriate, prosocial goals</td>
<td>“I can hear you don’t like your mom calling your teachers. I can help you talk to her about that.”</td>
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<td></td>
<td>“I’ll try to help you make these changes, even if it takes a while.”</td>
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<td>Therapist presents treatment model or tasks (Presenting treatment model)</td>
<td>0.78</td>
<td>Presents treatment tasks, model of recovery; defines roles</td>
<td>“Part of what we’ll do is work on new skills to deal with stress.”</td>
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<td>“By thinking about things differently, you can have an impact on your mood.”</td>
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<tr>
<td>Therapist expresses positive expectations about change (Expressing positive expectations)</td>
<td>0.77</td>
<td>Therapist shares efficacy beliefs, expectations about recovery, or information that treatment is effective (calm cheerleading)</td>
<td>“The approach we’ll use has helped a lot of teens like you.”</td>
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<td>“If we follow through, I’m confident you’ll begin to feel better.”</td>
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<td>Therapist explores teen’s motivation for change (Exploring motivation)</td>
<td>.71a</td>
<td>Therapist elicits teen’s reasons for working in therapy or challenges teen’s investment in therapy</td>
<td>“What do you hope to get out of treatment?”</td>
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<td></td>
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<td>“Let’s make a list of benefits of changing versus keeping things the same.”</td>
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<td></td>
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<td>“Beating depression is tough; I’m not sure you are up for it.”</td>
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<tr>
<td>Therapist uses cognitive restructuring (Cognitive restructuring)</td>
<td>0.64</td>
<td>Therapist offers an alternative perspective, a new meaning frame, or new interpretation for teen</td>
<td>“My guess is some of those thoughts about giving up on your dream are really depression talking, not you.”</td>
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<td></td>
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<td></td>
<td>“Maybe your depression comes out as ‘attitude’ and that’s what your grandparents are seeing.”</td>
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<tr>
<td>Therapist praises adolescent (Praising)</td>
<td>0.86</td>
<td>Praises teen’s behavior</td>
<td>“That took courage to say, great work.”</td>
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<tr>
<td><strong>Global items</strong></td>
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<tr>
<td>Therapist actively structures session (Structuring)</td>
<td>0.69</td>
<td>High level of therapist activity and direction</td>
<td>Therapist actively pursues line of inquiry or introduces a new concept at length (e.g., how automatic thoughts can influence mood).</td>
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<tr>
<td>Therapist expresses support (Supporting)</td>
<td>0.61</td>
<td>Provides warmth, concern, validation</td>
<td>Therapist expresses warmth or empathy.</td>
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</table>

* Kappa is reported for these dichotomous items; all others values are intraclass correlations.
Results of the current study show that variation in first session therapist behavior was associated with client involvement in the second session and beyond, even after controlling for clients' initial resistance. That is, higher levels of attending to the adolescent’s experience—including prior events, family context, current symptoms and subjective experiences—were associated with greater involvement in a core cognitive task: identification of automatic thoughts. Greater exploration of motivation and lower levels of therapist structuring also were associated with greater task involvement. However, only exploring motivation and structuring uniquely predicted Session 2 involvement when the set of significant predictors was examined together. Although initial adolescent resistance was associated with greater therapist use of exploring motivation, initial resistance did not explain the association between this behavior and later adolescent involvement. Analyses also showed that variations in resistance and involvement could not be reduced to variations in level of depression and that therapists’ level of structuring uniquely predicted client involvement later in treatment in Sessions 4 and 8.

Exploring motivation seems intuitively relevant for promoting adolescent involvement in therapy, and current findings converge with emerging results showing motivational interventions to be effective with adolescents who abuse substances (e.g., McCambridge & Strang, 2004). However, the negative association between structure and later involvement was somewhat surprising. CBT, the psychosocial treatment with the broadest evidence base for treating adolescent depression, has been cast as a rather highly structured therapy. Yet, variations in therapist structuring of the first session accounted for differences in subsequent adolescent involvement. Therapists who structured less in the first session appeared to promote greater involvement across early-treatment and midtreatment tasks than did therapists who structured more. Lower structuring was associated with higher levels of attending to the adolescent’s experience and supportiveness. Thus, low structuring does not reflect inactivity or lack of direction but rather greater therapist focus on eliciting, attending, and supportively responding to client material. Studies of adult client involvement have revealed a similar pattern. For example, Patterson and Forgatch (1985) found that therapist verbal behaviors classified as “facilitate” and “support” were associated with less resistance in parent management training than behaviors involving teaching and confronting. Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that emphasizing therapy tasks over exploring experiences seemed to undermine alliance.

More generally, results seem to support the importance of therapist behaviors in the first session that invite greater client participation. Perhaps therapists who elicit more about the client’s experience and motivations and who limit the introduction of new concepts in the first session are setting the stage for greater verbal disclosure and involvement in later sessions. By eliciting informa-

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**Table 2:** Means, Standard Deviations; Correlations Among Initial Resistance (IR), Client Involvement (CI), and Therapist Behaviors; and Partial Correlations Between Therapist Behaviors and CI After Controlling for IR

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>IR</th>
<th>CI</th>
<th>Attending to client experience</th>
<th>Client involvement experience</th>
<th>Alllying</th>
<th>Exploring motivation</th>
<th>Positive expectations</th>
<th>Cognitive restructuring</th>
<th>Praising</th>
<th>Structuring</th>
<th>Supporting</th>
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<tbody>
<tr>
<td></td>
<td>7.68</td>
<td>0.43</td>
<td>.38</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<td>—</td>
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<td></td>
<td>2.25</td>
<td>2.65</td>
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</table>

Regression with the average of client involvement across Sessions 4 and 8 substituted as the dependent variable (n = 31). The therapist behaviors explained 39% of variance (ΔR² = .39, p < .01) above and beyond initial resistance (β = −.22, ns), though only structuring was uniquely predictive (β = −.58, p < .01).
tion about the adolescent’s experience and motivations early in treatment, therapists may also be gathering material, “grist for the mill,” so to speak, which enables them to personalize cognitive tasks such as identifying automatic thoughts.

Another important area that has been relatively understudied is the impact of initial client presentation on therapist behavior. It would be naïve to presume that skilled therapists are not influenced by client behavior. Current results suggest that adolescent clients who present with greater initial resistance evoke certain therapist strategies more than others. CBT therapists in the current study responded with greater use of verbal reinforcement and exploration of motivation, and the latter behavior appears to have facilitated subsequent involvement.

Two important limitations to the current study must be noted. First, variability was not equal across therapist behaviors, with some items occurring more frequently or extensively than others. As a result, it may not be appropriate to draw conclusions about the utility of behaviors that did not demonstrate significant effects. Further, certain study characteristics may have contributed to limited variability in therapist behaviors: therapy was manual-guided, therapists were all doctoral level and female, and all participated in weekly group supervision under the same supervisor. It is possible that, under different conditions, certain therapist behaviors would have exhibited greater variability and/or greater associations with later client involvement.

Second, like many intensive process studies, the current study was limited by its sample size. Given power limitations and the exploratory nature of the study, we made no alpha adjustment for the number of analyses computed. Similarly, modeling complex interactions among predictors of involvement was not feasible. Therefore, replication of current findings is essential.

Future researchers will need to consider therapist behaviors and involvement in relation to proximal symptom change. In this study, we did not include session-by-session symptom measures, so these associations could not be evaluated. Therapist behaviors should also be examined across disorders, at later points in therapy, and with different therapists, such as male or less experienced clinicians. Other potential moderators, such as race or ethnicity, should be examined as well. Although the current sample was ethnically diverse, sample size precluded cross-group analyses. Ultimately, implementation of evidence-based treatments will be complemented, and facilitated, by the identification of evidence-based therapist strategies for engaging youths.

References


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