

THE INVOLVEMENT OF PARENTS IN CHILD-FOCUSED COGNITIVE BEHAVIOUR THERAPY

Paul Stallard

*University of Bath/Avon and Wiltshire Mental Health Partnership
NHS Trust, England*

Abstract: Although there is increasing interest in the use of Cognitive Behaviour Therapy (CBT) with children, the role of parents in child-focused CBT has received comparatively little attention. The different ways in which parents have been involved in child-focused CBT are discussed and the results of those studies comparing child CBT with and without parental involvement are summarised. The results fail to provide consistent support for the widely held clinical belief that parental involvement enhances the effectiveness of child-focused CBT. Further research to determine the optimal way of delivering child-focused CBT in terms of effectiveness and use of limited clinical time is required.

Key words: Children, Cognitive Behaviour Therapy, Parents.

Introduction

The past decade has seen the publication of a number of randomised controlled trials evaluating the effectiveness of Cognitive Behaviour Therapy (CBT) with children. Trials have been undertaken with a range of disorders including generalised anxiety (Kendall 1994; Kendall, Flannery-Schroeder, Panichelli-Mindel, Southam-Gerow, Henin, & Warman, 1997), depression (Wood, Harrington, & Moore 1996), school refusal (King et al., 1998), interpersonal problems (Spence, Donovan, & Brechman-Toussaint 2000), sexual abuse (Cohen & Mannarino, 1996), phobias (Silverman, Kurtines, Ginsburg, Weems, Rabian, & Serafini, 1999a), enuresis (Ronen,

Address: Paul Stallard, Dept. Child & Family Psychiatry, Royal United Hospital Combe Park, Bath BA1 3NG, England. Tel: +44-1225-825075. Fax: +44-1225-825076. E-mail: paul.stallard@awp.nhs.uk

Rahav, & Wozner, 1995), and pain (Sanders, Shepherd, Cleghorn, & Woolford, 1994). Although not all randomised controlled trials provide convincing evidence for the superiority of CBT, particularly when compared with other active interventions, interest in the use of CBT with children and young people has continued to grow (Bailey, 2001; Stallard, 2002a).

The need to adapt CBT programmes to the developmental, cognitive and verbal level of the child has been recognised (Ronen, 1998), and a number of recent publications provide practical examples of how this can be achieved (Barrett, Webster, & Turner, 2000; Friedberg, Crosby, Friedberg, Rutter, & Knight, 2000; Friedberg & McClure, 2002; Stallard, 2002b). However, whilst clinicians are paying greater attention to adapting CBT methods and processes so that they are accessible to children and congruent with their abilities, the unique context of the child and the role of parents in child-focused CBT has received comparatively little attention (Barrett, 2000). This may in part be due to the early tendency for clinicians to download and apply intra-psycho models developed for use with adults, a tendency which resulted in children often being treated as little adults and the important family context being overlooked. A greater awareness and recognition of the systemic context in which children operate has resulted in attention now being focused upon the role of parents in child-focused CBT interventions.

THE PRESENT STUDY

This paper summarises some of the different ways parents have been involved in CBT with children and reviews the outcome of studies comparing child-focused CBT with and without parental involvement. For the purpose of this paper child-focused CBT describes interventions where the child is the main focus and recipient of the intervention. Parenting programmes, which are typically targeted upon and delivered to parents, will not be considered in this paper.

Theoretical rationale for involving parents

There is growing evidence to document the important influences of the immediate family on the development and maintenance of children's psychological problems. Kendall and Panichelli-Mindel (1995) note the

importance of parental psychopathology, parenting styles, and parental management in the development and maintenance of child disorders. This is exemplified in recent studies with children with anxiety disorders where the nature of the relationship between parent and child anxiety and the role of parental behaviour in maintaining child problems has been identified (Dadds & Barrett, 2001; Ginsburg, Silverman, & Kurtines, 1995). For example, Barrett, Rapee, Dadds, and Ryan (1996) note that parents of anxious children are more likely to engage in behaviours that communicate a sense of continued threat and danger to their child. Other research suggests that parents of anxious children tend to be more overly controlling, protective and critical, and that this results in the child having fewer opportunities to develop successful coping skills (Krohnc & Hock, 1991). These findings would suggest that children of anxious parents are very sensitive to the threatening features of their environment and that this is reinforced by their parent's behaviour which conveys a sense of continuing threat and danger and limits opportunities to develop coping skills. Spence et al. (2000) note that interventions that do not attempt to change parental behaviour would therefore be unlikely to be effective.

Clinical benefits

Practically, parental involvement in child-focused CBT programmes would appear to have a number of benefits. Parents are educated into the treatment rationale and are able to prompt and encourage their child's acquisition of more appropriate strategies. The transfer of skills from clinical to real life situations could be encouraged and parents could reappraise their perceptions and expectations of their child. Finally, clinicians can consider and incorporate important systemic influences in therapy (Kendall & Panichelli-Mindel, 1995; Spence et al., 2000). From a developmental perspective, Bailey (2001) notes that parental involvement in child-focused CBT is more likely the younger the age of the child.

Clinical experience also supports the importance and positive benefits of involving parents in child-focused CBT. Mendolwitz, Manassis, Bradley, Scapillato, Mieztis, and Shaw (1999) highlight the benefits of parents being able to monitor and provide feedback to their children about the coping strategies they learn. Toren et al. (2000) note that parental involvement may facilitate continuing improvement after the intervention has ended. In their programmes with abdominal pain

Sanders, Shepherd, Cleghorn, and Woolford (1994) highlight that mothers' caregiving strategies were key predictors of clinical improvement in the children. Finally, some therapists have noted that parental involvement in child CBT programmes is more clinically satisfying (King et al., 2000).

The role of parents

Whilst the involvement of parents in child-focused CBT appears to have some theoretical and pragmatic substance, their actual role and the extent of their involvement varies considerably. Parents have been involved in child CBT in various roles including those of a facilitator, co-therapists, or as a client in their own right. The focus and emphasis of the intervention has ranged from working on the child's problems through to additional parent focused sessions designed to teach the parents new skills or intervene with their mental health problems. Similarly the balance between and the way in which child, parent, and family work is conducted and sequenced have varied.

Parents as facilitators

The most limited role for parents in child-focused CBT is that of the facilitator. Typically, parents are provided with two or three parallel sessions in which they are provided with the rationale for using CBT and information about techniques and strategies that will be taught to their child during the programme. The child is clearly the focus of the intervention and the programme is designed to address their problems. This is exemplified in the Coping Cat programme for children with anxiety disorders (Kendall, 1994). The 16 week individually administered programme is undertaken with the child, with parental participation consisting of two separate sessions focusing upon psychoeducation. A similar model has been described in the Adolescent Coping with Depression Course (Clarke et al., 2002) where young people participate in a 16-session course whilst their parents attend three informational meetings. These meetings are designed to inform parents about the topics being discussed, the skills taught and the rationale for their use. Similarly, the role of parents in the programme by March, Mulle, and Herbel (1995), "How I ran OCD of my land", for children with obsessive-compulsive disorder, also falls within this category.

Parents as co-therapists

As co-therapists, parents are more extensively involved in the intervention. They participate in the same or a similar intervention programme as their child either together or in parallel. Parents are encouraged to be more active and to act as a co-therapist outside of treatment sessions by monitoring, prompting and reinforcing their child's use of cognitive skills. Both Mendlowitz et al. (1999) and Toren et al. (2000) describe joint parent/child interventions for children with anxiety disorders. In these programmes the parent's own behaviour/problems are not directly addressed, the child remains the focus of the intervention and the primary goal is for the parents to help reduce their child's psychological distress.

Parents as co-clients

An alternative model involves parents themselves also being the subject of a direct CBT intervention by, for example, managing self/family anxiety or addressing issues related to child abuse (Cobham, Dadds, & Spence, 1998; Cohen & Mannarino, 1998). With the co-client model, children receive CBT to address their own problems whilst their parents/family acquire new skills in order to address family or personal difficulties that might contribute to the onset or maintenance of their child's difficulties. Cohen and Mannarino (1998), for example, describe a 12-session CBT programme for children who have been sexually abused, where the intervention addresses both child and parent issues related to abuse. Child sessions focus upon feelings of helplessness/powerlessness, attributions of blame, anxiety and behavioural problems related to the abuse. Separate parent sessions focus upon parental attributions of blame, parent history of abuse, feelings towards the perpetrator, and the facilitation of child support and management of abuse related behaviour. Similarly, Cobham et al. (1998) describe a programme in which children with anxiety disorders receive 10 sessions with parents receiving 4 separate sessions. The parents' sessions explore their role in the development and maintenance of their child's problems and explore how to manage their own anxiety and model appropriate anxiety management strategies for their child.

Model of change

In addition to differences regarding the focus and role of parents, the way

they are involved in the treatment programme also varies. Typically, parental involvement results in parents being provided with parallel treatment sessions but often separate from their child (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Heyne et al., 2002; Lewinsohn, Clarke, Hops, & Andrews, 1990). In a variation, parental involvement in the study by Spence et al. (2000) consisted of parents observing the children's group sessions through a one-way screen. In these programmes parents and children work through the same materials but never actually attend any treatment sessions together in the same room. In others, particularly those focusing upon anxiety (Barrett, 1998; Barrett, Dadds, & Rapee, 1996; Cobham et al., 1998), sessions are dedicated for both parents and children to work together.

The underlying model detailing how parental involvement facilitates changes in the child's behaviour or their acquisition of skills has seldom been explicitly stated. Barrett (1998) recognises the importance of this process and describes how the therapist joins with parents and children during joint sessions to form an "expert team". This process involves the open sharing of information and building upon the existing strengths of family members with a view to empowering parents and children to solve and address their own problems. Silverman et al. (1999b) describes parental involvement as part of a process that involves the transfer of expert knowledge and skills from the therapist to the parent to the child. This "transfer of control" model informs the sequencing of treatment sessions and application of skills. Thus in their programme, although parents and children learn skills together, the parents are encouraged to implement the skills first. Once mastered, the parent's use of anxiety reduction strategies is faded out and the child's use of self-control strategies is encouraged.

This brief overview highlights the need for clinicians to carefully consider and plan how parents are involved in child-focused CBT. If parents are involved, their role needs to be defined, the focus of the parental sessions clarified, and the process by which parents facilitate change in their child defined. In turn, this will inform whether parents and children will be seen jointly or separately.

Does parental involvement enhance effectiveness?

Given the different ways in which parents can be involved in child-focused

CBT, a key question facing researchers is whether parental involvement enhances effectiveness and if so, what model of involvement is optimal for which condition. This question is of paramount importance to clinicians in planning child-focused CBT and yet has received surprisingly little attention.

A Medline literature search using the words “cognitive behaviour therapy”, “CBT”, “children and adolescents” and “randomised controlled trial” for the time period from 1997 until June 2002 was undertaken. This was supplemented with a hand search of the *Journal of Child Psychology and Psychiatry*; *Journal of the American Academy of Child and Adolescent Psychiatry*; *Journal of Consulting and Clinical Psychology*; *Journal of Clinical Child Psychology*, and, *Behaviour Research and Therapy*. A total of 43 potential studies were identified of which, 12 involved comparisons of child-focused CBT with and without parental involvement. Of these, two papers reporting post treatment and follow-up data on the same study cohort did not present their findings in a way that allowed the specific effects of parental involvement to be determined (Deblinger, Lippmann, & Steer, 1996; Deblinger, Steer, & Lippmann, 1999). Of the remaining 10, one study (Barrett, Duffy, Dadds, & Rapee, 2001) provided long-term follow up of a cohort where post treatment and one year follow-up data had previously been reported (Barrett, Dadds, & Rapee, 1996). An overview of the remaining 9 studies and their findings is provided below.

Spence, Donovan, and Brechman-Toussaint (2000)

Fifty children, aged 7-14 with social phobia, were randomly assigned to 12-session child-focused CBT, CBT involving parents, or a waiting list control. Compared to the waiting list control group, children in both CBT groups showed significant reductions in children’s social and general anxiety and a significant increase in parental ratings of social skills performance. At post treatment, fewer children in the parental involvement group retained their initial diagnosis (12.5%) compared with child only CBT (42%), a finding that just failed to reach statistical significance. In summary, there were no statistically significant differences between the CBT groups on any measure either at post-treatment or at 12-month follow up. The authors concluded that «parental participation in the program was not found to add significantly to the effectiveness of child only treatment» (Spence et al., 2000, p. 724).

Lewinsohn, Clarke, Hops, and Andrews (1990)

Adolescents ($N = 59$) aged 14-18 with depression were randomly assigned to adolescent only CBT, adolescent and parent CBT, or a waiting list control. Post-treatment analysis revealed significant improvements in diagnostic status in both treatment groups. Parental involvement did not result in any significant additional improvements in diagnostic status, nor on self-report measures, but there was a post treatment gain as assessed by parent completed Child Behaviour Checklist (CBCL) scores. However, these differences had disappeared by 6 months by which time there were no significant differences between the active intervention groups on any measure. The authors concluded that «contrary to expectations, there were no differences on the depression measures between treatment groups» (Lewinsohn et al., 1990, p. 398).

Clarke, Rohde, Lewinsohn, Hops, and Seeley (1999)

Adolescents ($N = 123$) aged 14-18 were assigned to a waiting list control group or two CBT treatment conditions. Parental involvement in a 16 session Adolescent Coping with Depression Course was compared with a child only intervention. Both conditions were effective at post treatment, compared to a waiting list control in terms of depression recovery, reductions in depression scores and general functioning. Consistent with the results of Lewinsohn et al. (1990), there were no statistically significant differences on any measure between CBT with and without parental involvement. The authors concluded that «parental involvement in this treatment modality was not associated with significantly enhanced improvement. As before we recognize that these results are contrary to widely held clinical beliefs regarding the importance of involving parents in any child or adolescent treatment» (Clarke et al., 1999, p. 277).

Heyne, King, Tonge, Rollings, Young, Pritchard, and Ollendick (2002)

Child only CBT was compared with parent/teacher training and child CBT plus child/parent training in the treatment of 61 school refusing children aged 7-14. Statistically and clinically significant post-treatment changes occurred for each group although child CBT was the least effective in increasing school attendance. By follow up (average 4.5 months) there

were no significant differences between the treatment groups on any measure. Attendance and adjustment of those in the child only CBT group equalled that of the other groups. Heyne et al. (2002) conclude that «contrary to expectations combined child therapy and parent/teacher training did not produce better outcomes at post treatment or follow up» (p. 687).

King, Tonge, Mullen, Myerson, Heyne, Rollings, Martin, and Ollendick (2000)

Thirty-six sexually abused children (aged 5-17) were randomly assigned to child CBT, family CBT, or a waiting list control condition. Post-treatment and 12-week follow up revealed significant improvements in both intervention groups in posttraumatic symptoms, self-reports of fear and anxiety, parent reported measures and clinician ratings of global functioning. There was only one significant between group difference with family CBT showing greater improvements as determined by a self-report rating of emotional distress at follow up. The authors concluded that «in general, parental improvement did not improve the efficacy of cognitive-behavioural therapy» (King et al., 2000, p. 1347).

Cobham, Dadds, and Spence (1998)

Children ($N = 67$) aged 7-14 with anxiety disorders were randomly assigned according to parental anxiety level to either child-focused CBT or child-focused CBT plus parental anxiety management. At post treatment, 6 and 12-month follow up there were no statistically significant differences in the number of children who met diagnostic criteria, clinician ratings of improvement, or child self-report measures in either group. On parent report measures, children in the CBT only condition had lower internalizing scores on the maternal CBCL at post treatment and at follow up. Parental anxiety was, however, an important factor. When both parent and child were anxious, CBT with parental involvement resulted in significantly lower rates of diagnosed child anxiety at post treatment (39% vs. 77%). Although still evident, these differences had reduced at 6 months (44% vs. 71%) and 12 months (59% vs. 71%) and were no longer statistically significant. This led the authors to conclude that «the provision of the additional component (parent involvement) did not add anything to the efficacy of CBT for the child alone when neither parent

reported elevated levels of trait anxiety» (Cobham et al., 1998, p. 903).

Mendlowitz, Manassis, Bradley, Scapillato, Miezig, and Shaw (1999)

Sixty-two parents and children (aged 7-12) with anxiety disorders were randomly assigned to a 12-week child only, parent only, or child and parent CBT intervention. There was no follow up but at post treatment all groups demonstrated decreases in self-report anxiety and depression symptoms. Parents in the combined child and parent CBT group rated their child as more improved and children reported a greater use of active coping strategies at post-treatment. The authors concluded that the «concurrent parental involvement enhanced the effect on coping strategies» (Mendlowitz et al., 1999, p. 1223).

Barrett (1998)

Children ($N = 60$) aged 7-14 with anxiety disorders were randomly assigned to 12-session child-focused group CBT, group CBT plus family management or a waiting list control group. Children in both intervention groups improved compared to the waiting list control. Parental involvement did not have any significant effect on diagnostic status at post treatment or 12-month follow up. However, parental involvement did result in significantly greater changes on clinician completed evaluation scales, parental reports on the CBCL and on child reports of anxiety. Barrett concluded that «the group condition with the added family training component showed marginal improvement on a number of measures in comparison with the cognitive-behavioural group intervention treatment» (Barrett, 1998, p. 466).

Barrett, Dadds, and Rapee (1996); Barrett, Duffy, Dadds, and Rapee (2001)

These studies report the 12-month and 6-year follow up of children assigned to either child CBT, CBT plus family management, or a waiting list condition. The initial study involved 79 children aged 7-14. Post treatment, significantly fewer children in the intervention groups fulfilled diagnostic criteria with parental involvement being superior to child only CBT (84.0% vs. 57.1%), a difference that continued to be significant at 12 months (95.6% vs. 70.3%). Similarly, CBT and family management proved

superior to child only CBT at post treatment and follow-up on clinical evaluations of change, self-report, and parent completed measures.

A long-term evaluation of this cohort was undertaken resulting in 52 children being re-assessed six years after completing the programme. Gains were maintained with 85.7% no longer meeting diagnostic criteria although parental involvement did not enhance the outcome. There were no significant differences between the groups on any measures. The authors summarise that «contrary to predictions, the CBT + FAM condition (parental involvement) did not appear more effective than CBT only» (Barrett et al., 2001 p. 139).

DISCUSSION

The results of these studies do not provide consistent support for the widely held clinical belief that parental involvement enhances child-focused CBT. At post treatment, only one of the seven studies noted significantly fewer children meeting diagnostic criteria with parental involvement (Barrett, Dadds, & Rapee, 1996) and only one (Mendolwitz et al., 1999) found differences on self-report measures. Additional benefits of parental involvement were more likely to be noted on parent completed measures, thereby, raising the possibility that parents involved in CBT might be more disposed to report favorable outcomes because of their investment in the programme. Furthermore, although statistically significant differences were noted the clinical significance of these is unclear. Indeed, although some studies reported statistically significant differences between CBT with and without parental involvement on sub-scales of the Child Behaviour Checklist, the number scoring above the clinical cut-off for these scales were not significant (Barrett, 1998; Barrett, Dadds, & Rapee, 1996).

Interestingly, post treatment differences favouring parental involvement in CBT became less marked over time. The only post treatment difference reported by Heyne et al. (2002) in school attendance disappeared; the only difference reported by Lewinsohn et al. (1990) in parent reported CBCL scores was no longer significant. The strongest data suggesting the enhanced role of parents in child-focused CBT came from the work of Barrett, Dadds, and Rapee (1996) although interestingly by the 6 year follow up there were no differences between the groups on any measure. These results suggest the need for researchers to include a suitable length

follow-up in studies and to more carefully consider how post treatment gains can be maintained over time.

In terms of clinical presentation, both studies with children with depression failed to find positive benefits from involving parents (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Lewinsohn et al., 1990). Similarly, parental involvement in child-focused CBT to address social phobia (Spence, Donovan, & Brechman-Toussaint, 2000), school refusal (Heyne et al., 2002), and sexual abuse (King et al., 2000) resulted in few additional gains. The most substantive evidence came from studies treating children with generalised anxiety disorders (Barrett, 1998; Barrett, Dadds, & Rapee, 1996).

Theoretical models detailing the nature of parental behaviour in the onset and maintenance of some child disorders are beginning to emerge. The extent of parental difficulties and degree to which they require direct intervention in their own right have only been assessed in one study. The work of Cobham, Dadds, and Spence (1998) would suggest that this is important and that targeted parental interventions may be more important in achieving change in the child if the parent also has significant problems. Further work clarifying the nature of this relationship and the key interventions of the parental programme are required.

The total number of hours spent in the programme did not appear related to the outcome. The shortest child-focused programme involved a total of 7 hours (Heyne et al., 2002) and the longest 28 hours (Lewinsohn et al., 1990), both programmes that failed to find any substantive benefits of parental involvement. The content and length of the specific parent component of the CBT programme has also been questioned. Cobham, Dadds, and Spence (1998) speculate whether 4 parent sessions are sufficient and whether this is why significant post-treatment reductions in diagnostic status were not maintained at follow up. Similarly, in terms of content King et al. (2000) speculate whether parental involvement in child-focused CBT may be more effective if more of the programme had been devoted to addressing parent related problems. Indeed this relates to the earlier point about clarifying the role of parents in child-focused CBT and thus the specific nature of the parent intervention.

Finally, the way in which child and parent sessions are provided has received surprisingly little interest. In many programmes, parental involvement consists of separate sessions, which run in parallel to those for the child. This has led some to suggest that parental involvement may be

enhanced by co-joint work in which parents and children are involved in treatment sessions together (Ginsburg & Schlossberg, 2002). Indeed the studies that reported the greatest benefits from parental involvement provided joint child/parent sessions (Barrett, 1998; Barrett, Dadds, & Rapee, 1996).

Conclusion

This overview highlights the little attention that has been paid to defining the parental role in child-focused CBT and in evaluating the impact of their involvement on outcome. The papers reviewed demonstrate that despite the widely held belief that parental involvement enhances child-focused CBT outcome data supporting this view is limited. Parent completed measures are more likely to demonstrate positive effects from parental involvement although these benefits become less marked over time.

In reaching these conclusions the limitations of this review are acknowledged. The literature search was limited; comparatively few papers were identified; the majority of studies focused upon internalising problems and comparatively few included a long-term follow up. The number of children involved in these studies is small. It is possible that the trend reported by a number of studies with parental involvement to produce more positive outcomes could become significant with larger samples. Finally, this analysis has simply compared child-focused CBT with or without parents. It is clear that although the CBT programmes shared a number of common features there was some variation between them in length, treatment components, and mode of delivery. There is a possibility therefore that any reported differences may be due to factors other than parental involvement.

These findings would suggest that further work is required to determine the maximum way of involving parents in child-focused CBT. This is particularly important in view of the considerable resource implications that parental involvement may require. Programmes that run separate parent and child sessions almost double the amount of therapeutic time required, thereby raising questions as to whether the marginal gains produced are a good use of limited resources.

REFERENCES

- Bailey, V. (2001). Cognitive-behavioural therapies for children and adolescents. *Advances in Psychiatric Treatment*, 7, 224-232.
- Barrett, P. M. (1998). Evaluation of cognitive-behavioural group treatments for childhood anxiety disorders. *Journal of Clinical Child Psychology*, 27(4), 459-468.
- Barrett, P. M. (2000). Treatment of childhood anxiety: Developmental aspects. *Clinical Psychology Review*, 20(4), 479-494.
- Barrett, P. M., Dadds, M. R., & Rapee, R. M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology*, 64(2), 333-342.
- Barrett, P. M., Duffy, A. L., Dadds, M. R., & Rapee, R. M. (2001). Cognitive behavioural treatment of anxiety disorders in children: Long-term (6 year) follow up. *Journal of Consulting and Clinical Psychology*, 69(1), 135-141.
- Barrett, P. M., Rapee, R. M., Dadds, M. R., & Ryan, S. M. (1996). Family enhancement of cognitive style in anxious and aggressive children. *Journal of Abnormal Child Psychology*, 24, 187-203.
- Barrett, P. M., Webster, H., & Turner, C. (2000). *FRIENDS prevention of anxiety and depression for children. Children's workbook*. Brisbane, Australia: Australian Academic Press.
- Clarke, G. N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., O'Connor, E., Seeley, J. R., & Debar, L. (2002). Group cognitive-behavioural treatment for depressed adolescent offspring of depressed parents in a health maintenance organisation. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(3), 305-313.
- Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-behavioural treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(3), 272-279.
- Cobham, V. E., Dadds, M. R., & Spence, S. H. (1998). The role of parental anxiety in the treatment of childhood anxiety. *Journal of Consulting and Clinical Psychology*, 66(6), 893-905.
- Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(1), 42-50.
- Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. *Child Maltreatment*, 3(1), 17-26.
- Dadds, M. R., & Barrett, P. M. (2001). Psychological management of anxiety disorders in childhood. *Journal of Child Psychology and Psychiatry*, 42(8), 999-1011.
- Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment*, 1(4), 310-321.
- Deblinger, E., Steer, R. A., & Lippmann, J. (1999). Two-year follow-up study of cognitive behavioural therapy for sexually abused children suffering post-traumatic stress symptoms. *Child Abuse and Neglect*, 23(12), 1371-1378.
- Friedberg, R. D., Crosby, L. E., Friedberg, B. A., Rutter, J. G., & Knight, K. R. (2000). Making cognitive behavioural therapy user-friendly to children. *Cognitive and Behavioural Practice*, 6, 189-200.
- Friedberg, R. D., & McLure, J. M. (2002). *Clinical practice of cognitive therapy with children and adolescents: The nuts and bolts*. New York: Guilford.

- Ginsburg, G. S., & Schlossberg, M. C. (2002). Family-based treatment of childhood anxiety disorders. *International Review of Psychiatry, 14*, 143-154.
- Ginsburg, G. S., Silverman, W. K., & Kurtines, W. K. (1995). Family involvement in treating children with phobic and anxiety disorders: A look ahead. *Clinical Psychology Review, 15*(5), 475-473.
- Heyne, D., King, N. J., Tonge, B., Rollings, S., Young, D., Pritchard, M., & Ollendick, T. H. (2002). Evaluation of child therapy and caregiver training in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(6), 687-695.
- Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomised clinical trial. *Journal of Consulting and Clinical Psychology, 62*, 100-110.
- Kendall, P. C., Flannery-Schroeder, E., Panichelli-Mindel, S. M., Southam-Gerow, M., Henin, A., & Warman, M. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology, 65*(3), 366-380.
- Kendall, P. C., & Panichelli-Mindel, S. M. (1995). Cognitive-behavioural treatments. *Journal of Abnormal Child Psychology, 23*(1), 107-124.
- King, N. J., Tonge, B. J., Heyne, D., Pritchard, M., Rollings, S., Young, D., Myerson, N., & Ollendick, T. H. (1998). Cognitive behavioural treatment of school-refusing children: A controlled evaluation. *Journal of American Academy of Child and Adolescent Psychiatry, 37*(4), 395-403.
- King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(11), 1347-1355.
- Krohnc, H. W., & Hock, M. (1991). Relationships between restrictive mother-child interactions and anxiety of the child. *Anxiety Research, 4*, 109-124.
- Lewinsohn, P. M., Clarke, G. N., Hops, H., & Andrews, J. (1990). Cognitive behavioural treatment for depressed adolescents. *Behaviour Therapy, 21*, 385-401.
- March, J. S., Mulle, K., & Herbel, B. (1995). Behavioural psychotherapy for children and adolescents with obsessive-compulsive disorder: An open trial of a new protocol-driven treatment package. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*(3), 333-341.
- Mendlowitz, S. L., Manassis, M. D., Bradley, S., Scapillato, D., Miezitis, S., & Shaw, B. F. (1999). Cognitive behaviour group treatments in childhood anxiety disorders: The role of parental involvement. *Journal of the American Academy of Child and Adolescence Psychiatry, 38*(10), 1223-1229.
- Ronen, T. (1998). Linking developmental and emotional elements into child and family cognitive-behavioural therapy. In P. Graham (Ed.), *Cognitive behaviour therapy for children and families* (pp. 1-17). Cambridge, UK: Cambridge University Press.
- Ronen, T., Rahav, G., & Wozner, Y. (1995). Self-control and enuresis. *Journal of Cognitive Psychotherapy: An International Quarterly, 9*(4), 249-258.
- Sanders, M. R., Shepherd, R. W., Cleghorn, G., & Woolford, H. (1994). The treatment of recurrent abdominal pain in children: A controlled comparison of cognitive-behavioural family intervention and standard pediatric care. *Journal of Consulting and Clinical Psychology, 62*(2), 306-314.
- Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C.F., Lumpkin, P. W., & Carmichael, D. H. (1999b). Treating anxiety disorders in children with group cognitive behavioural therapy: A randomised clinical trial. *Journal of Consulting and Clinical Psychology, 67*(6), 995-1003.

- Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C. F., Rabian, B., & Serafini, L. T. (1999a). Contingency management, self-control and educational support in the treatment of childhood phobic disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 67*(5), 675-687.
- Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: The effectiveness of a social skills training-based, cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology and Psychiatry, 41*(6), 713-726.
- Stallard, P. (2002a). Cognitive behaviour therapy with children and adolescents: A selective review of key issues. *Behavioural and Cognitive Psychotherapy, 30*, 321-333.
- Stallard, P. (2002b). *Think Good Feel Good. A cognitive behaviour therapy workbook for children and young people*. Chichester, UK: Wiley.
- Toren, P., Wolmer, L., Rosental, B., Eldar, S., Koren, S., Lask, M., Weizman, R., & Laor, N. (2000). Case series: Brief parent-child group therapy for childhood anxiety disorders using a manual based cognitive-behavioural technique. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(10), 1309-1312.
- Wood, A., Harrington, R., & Moore, A. (1996). Controlled trial of a brief cognitive-behavioural intervention in adolescent patients with depressive disorder. *Journal of Child Psychology and Psychiatry, 37*(6), 737-746.