

Brief Cognitive-Behavioral Therapy for Anxious Youth: The Inner Workings

Rinad S. Beidas, *University of Pennsylvania*
Matthew P. Mychailyszyn, *Towson University*
Jennifer L. Podell, *University of California, Los Angeles*
Philip C. Kendall, *Temple University*

We provide a detailed description of the clinical application of brief cognitive-behavioral therapy (BCBT) for anxious youth. A rationale for the development of BCBT is presented, followed by a description and discussion of the 8 sessions of the treatment. Mike, a 7-year-old youth with anxiety disorders, is used to illustrate the inner workings of implementing BCBT. Case conceptualization, session details, and pre-, post- and follow-up-treatment information are provided. Conclusions regarding clinical advantages and future directions are made.

THE present paper is a companion piece to the report of the initial findings from brief cognitive-behavioral therapy (BCBT; [Crawley et al., 2013-this issue](#)). We provide a session-by-session description of a streamlined 8-session version of a well-established ([Chambless & Ollendick, 2001](#)) empirically supported treatment (EST) for youths with anxiety disorders ([Silverman, Pina, & Viswesvaran, 2008](#)). ESTs refer to interventions that have been evaluated scientifically (e.g., a randomized controlled trial; RCT) and satisfy the criteria outlined in [Chambless and Hollon \(1998\)](#). Specifically, the Coping Cat program ([Kendall & Hedtke, 2006](#)), an intervention that has been deemed efficacious via multiple empirical investigations over the past two decades ([Kendall et al., 1997](#); [Kendall, Hudson, Gosch, Flannery-Schroeder, & Suvieg, 2008](#); [Walkup et al., 2008](#)), was consolidated into an 8-session treatment and subsequently evaluated ([Crawley et al.](#)).

BCBT was developed primarily in response to a need for treatments whose dissemination and implementation are more feasible in the community given existing barriers to care. Dissemination includes the purposeful distribution of relevant information and materials to providers whereas implementation refers to the adoption and integration of ESTs into practice ([Lomas, 1993](#)). The impetus for dissemination and implementation of ESTs for youth anxiety

has been galvanized by epidemiological research suggesting that in the general population, fewer than half of children with anxiety disorders receive care ([Egger & Burns, 2004](#)). Further, in primary care settings, more than two-thirds of children who meet criteria for an anxiety disorder have never received treatment ([Chavira, Bailey, & Stein, 2004](#)). Such findings are concerning given that, if left untreated, childhood anxiety may develop into chronic anxiety, depression, and substance abuse ([Kendall, Safford, Flannery-Schroeder, & Webb, 2004](#)).

Despite the need to disseminate and implement CBT for child anxiety in community settings, there is evidence that ESTs, as designed and evaluated, may need adaptation to fit the context of these settings. For example, a recent study found that community providers implementing CBT for youth anxiety identified the number of sessions (16) to be an obstacle in delivering the treatment ([Beidas, Mychailyszyn, et al., 2012](#)). BCBT was developed with an eye towards making CBT for child anxiety more amenable to community settings by reducing the length of the treatment, and has the potential to reduce costs and increase access to services by making dissemination and implementation more feasible.

The Coping Cat treatment is a cognitive-behavioral intervention for youth with separation anxiety disorder, social phobia, and/or generalized anxiety disorder, delivered over the course of 16 one-hour sessions. BCBT ([Crawley et al., 2013-this issue](#); [Kendall, Beidas, & Mauro, 2012](#); [Kendall, Crawley, Benjamin, & Mauro, 2012](#)) retains most of the core elements of this EST. Like the 16-session Coping Cat, BCBT is divided into two main parts, with the first focusing on psychoeducation (e.g., cognitive restructuring, problem solving), and the second devoted to practice of these skills through exposure tasks. However, BCBT is administered in

Keywords: case study; brief CBT; anxious youth

1077-7229/11/134-146\$1.00/0

© 2012 Association for Behavioral and Cognitive Therapies.
Published by Elsevier Ltd. All rights reserved.

 **Continuing Education Quiz located on p. 245.**

eight 60-minute sessions, with the exception of Sessions 1 and 4 which include an extra 30 minutes for consultation with parents. BCBT includes approximately 40% less treatment time when compared to the original treatment. BCBT materials include a therapist manual (Kendall, Crawley, et al., 2012), child workbook (Kendall, Beidas, et al., 2012), and parent companion guide (Kendall, Podell, & Gosch, 2010).

The present paper provides a description of how BCBT is administered in practice with anxious youth. For each session of BCBT, we summarize the main content, provide session goals, and illustrate with a case example. The interested reader is referred to Crawley et al. (2013-this issue) for a description of the development of BCBT as well as a report of the initial feasibility and outcome data.

Case Example: Pretreatment Diagnostic Information

Mike¹ was a 7-year-old Caucasian male who lived with his biological parents, who were married, and his 10-year-old brother. Mike and his parents were referred by his pediatrician due to excessive worrying, anticipatory anxiety, and difficulty with changes in routine. The pretreatment assessment included diagnostician-rated measures and self-report questionnaires completed by Mike and his parents. Mike was evaluated using the Anxiety Disorders Interview Schedule for Children and Parents (ADIS-C/P; Silverman & Albano, 2006), Pediatric Anxiety Rating Scale (PARS; The Research Units on Pediatric Psychopharmacology Anxiety Study Group, 2002), the Clinical Global Impression–Severity and Improvement Scales (CGI-S & CGI-I; Guy, 1976), and Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997).

As reported during the diagnostic interview, both Mike and his parents stated that he worried excessively, above and beyond the typical worries experienced by children his age. Much of Mike's worry was anticipatory; when Mike was in the moment, he typically did not experience these same high levels of anxiety. Specific areas of worry reported by Mike and his parents included uncertain situations, social performance, and the health of family members. His parents reported that Mike's most interfering worry was about uncertainty and changes in routine. For example, Mike had a very difficult time when he had a substitute teacher at school. In addition, Mike's parents reported that Mike had difficulty with attending assemblies, eating in the cafeteria, and going to friends' houses due to the unknown nature of these situations. Mike's parents also reported that Mike experienced anxiety when performing in front of others due to his own standards for performance. For example, Mike was extremely anxious about participating in

his first grade play and attempted to avoid the performance. Mike also reported worry about his family, specifically about the health of his parents. Mike had particular concerns about his own health and the health of others after vomiting, and reported interfering avoidance when classmates vomited (e.g., Mike reported that he was unable to go to movie theatres because he once observed a peer vomiting while at a movie). Mike's parents reported that Mike exhibited worry more days than not over the past year. Mike experienced somatic symptoms when worrying, including difficulty sitting still, difficulty relaxing, stomachaches, and irritability. Mike's worries caused difficulties at home and impaired his social functioning given his refusal to attend birthday parties or go to friends' houses. Based on these symptoms and interference, Mike met criteria for a principal diagnosis of generalized anxiety disorder (GAD).

In addition to his excessive worries, Mike and his parents reported that he had difficulty separating from caregivers and a specific fear of loud noises (e.g., fire drills, fireworks, toilet flushing). Mike and his parents reported that he would worry ahead of time when he knew that they would be separating. Mike reported that there were locations that he would not go to without his parents (e.g., a friend's house). Mike said that he was worried that "a robber might steal me" when he was not with his parents. Mike also met criteria for a secondary diagnosis of separation anxiety disorder (SAD). Additionally, Mike's parents reported that Mike demonstrated an extreme fear of loud noises (e.g., fire drills, fireworks, thunder) that lasted over the past few years. Mike avoided all loud noises, and if he heard one he would become emotionally distressed. For example, Mike refused to flush the toilet after he used it because of the noise it made. Given the level of impairment and interference, a specific phobia of loud noises was assigned as a tertiary diagnosis.

In addition to the diagnostic interview, diagnostician-rated measures and self-report questionnaires were completed by Mike and his parents. Thorough assessment for other comorbidities, such as other internalizing disorders (e.g., depression) and externalizing disorders (e.g., oppositional defiant disorder), indicated that neither Mike nor his parents reported any other interfering difficulties. Screening for autism spectrum disorders and other psychiatric conditions (e.g., selective mutism) also did not indicate other diagnoses. A review of his developmental history indicated that Mike's mother did not experience any pregnancy or birth complications and that Mike met all of his developmental milestones within the expected time periods. At pretreatment, Mike met criteria for three anxiety disorders, was scored as "markedly ill" on the CGI-S, in the clinical range on the PARS (above 11.5 on the 5-item scale; Ginsburg, Keeton, Drazdowski, & Riddle, 2010), and in the clinical range on the MASC (above 47; Rynn et al., 2006). See Table 1 for pretreatment ratings.

¹ For purposes of confidentiality, name and identifying information have been changed.

Table 1
Pre-, Post-, and Follow-up Treatment Scores

	Diagnoses	CGI-S	CGI-I	PARS	MASC
Pretreatment	Generalized Anxiety Disorder (5) * Separation Anxiety Disorder (4) Specific Phobia (4)	5 markedly ill	—	14	86
Posttreatment	ADHD-Inattentive Type (4)	2 Borderline mentally ill	1 Very much improved	2	67
1-year Follow-up	None	1 normal	1 Very much improved	3	59

Note. CGI-S=Clinical Global Impression Severity; CGI-I=Clinical Global Impression improvement (not measured at pretreatment); PARS=Pediatric Anxiety Ratings Scale; MASC=Multidimensional Anxiety Scale for Children.

* Clinician Severity Rating from Anxiety Disorder Interview Schedule.

BCBT: the Inner Workings

The inner workings of the BCBT protocol are presented session by session. First, we describe content to be covered in each session, followed by a description of Mike's session.

Session 1: Building Rapport, Treatment Orientation, and the First Parent Meeting

See Figure 1 for the main goals to be covered in Session 1. In Session 1, the therapist meets with the child for the first 60 minutes, and the parents for the latter 30 minutes. The overarching goal of time spent with the child is to orient him/her to the therapy experience and to ensure that the child feels hopeful and willing to return for a second session. For anxious youth predisposed to a heightened sensitivity to social evaluation and other threat cues, the importance of taking the time and effort to help the child feel comfortable cannot be overstated. Rapport-building with a fun and friendly attitude is central to Session 1. Putting the child at ease paves the way for the initial therapeutic content, such as the normalization of anxiety and the notion that various

feelings are associated with different physical expressions. Finally, the importance of continued practice of skills outside of session through homework tasks is emphasized, and Session 1 is wrapped up by engaging in a fun activity to reward participation and continue building the therapeutic relationship.

In the second portion of the session, the therapist meets with the parents. The therapist reviews the logistics of BCBT and then opens up the discussion to elicit information about situations in which their child becomes anxious. The therapist offers specific ways the parents can be involved in the BCBT program, such as helping with exposure tasks at home. A key part of the first session with the parents it to identify treatment “deliverables,” or the measuring stick by which the therapist, parents, and child will judge progress. This identification is especially important given the abbreviated format of the treatment. Three treatment deliverables is a manageable number that can be adjusted depending on the needs of the family. It is important that these deliverables be specific, concrete, and tangible. For example, a treatment deliverable for a separation-anxious child might be

Child portion (60 minutes)	Parent portion (30 minutes)
1. Build rapport	1. Provide information about BCBT
2. Orient child to BCBT	2. Learn more about the situations in which the child becomes anxious
3. Normalize anxiety	3. Offer specific ways the parents can be involved in the program
4. Encourage child’s participation	4. Provide parents with a copy of the <i>Parent Companion</i> (Kendall et al., 2010)
5. Introduce the concept that different feelings have different physical expressions	
6. Introduce the concept of an anxiety hierarchy and the feelings thermometer	
7. Assign an initial simple Show-That-I-Can (STIC) task	
8. Engage in a fun end-of-session activity	

Figure 1. Main goals of Session 1.

“sleeping alone in my bed” or “parents go out without child,” whereas a less ideal treatment deliverable might be “feeling less scared about separating from parents.” At the end of the first session, the therapist provides a helpful parent companion guide to treatment (Kendall et al., 2010) so that the parents can follow along and be aware of what will happen in the treatment sessions.

Child Portion (60 Minutes)

When Mike enters the therapy room, he displays nervous energy. He asks repeatedly, “What are we doing today?” and “Are we going to do anything scary?” The therapist invites Mike to make himself comfortable and to look around and see if there are any games that he would like to play. Mike finds Connect4. The therapist lets Mike know that they will save the last few minutes of the session to play Connect4 together. The therapist thanks Mike for coming and they play a “getting to know one another game” where they ask each other some questions.

After spending about 15 minutes getting to know one another, the therapist introduces Mike to some of the logistics of BCBT. They will be working weekly over the next 8 weeks, and will be collaborating to help manage anxiety. The therapist uses the analogy of a fire alarm to introduce the idea that everyone has anxiety but that in some children and adults, the anxious response is triggered even when there is nothing to be fearful of (i.e., false fire alarm when there is no fire). The therapist asks Mike, “What do you think you would do if you didn't have anxiety and saw a lion walking down the street?” Mike answers, “Pet it!” The therapist uses this example as a way to normalize the experience of anxiety and make clear that the goal of treatment is not to “cure anxiety” but to reduce the false alarms and be able to respond more appropriately to anxiety.

The therapist introduces the CBT model by encouraging Mike to think through recent times when he has felt a certain way (e.g., happy) and what types of thoughts he was having during that time. They explore what happens in his body when he feels happy, and Mike begins to learn that various feelings have different physical expressions in his body. Finally, the therapist asks Mike, “How will we know that therapy is over, or what are the three main things you hope to accomplish?” Mike says, “I don't know!” The therapist is ready with a list of situations that came up in the assessment, and Mike states that he would most like the following deliverables: being in the dark alone, being able to go somewhere loud where there are fireworks (i.e., baseball game), and driving on the highway with Mom and Dad. To wrap up, the therapist and Mike play Connect4, as promised, and Mike leaves with a homework task to write about a situation where he felt “good.” Mike is instructed to identify his thoughts and feelings in this situation.

Parent Portion (30 Minutes)

In the parent portion of the first session, the therapist provides additional information about BCBT with regard to how often she will meet with the family and the role of the parents. Mike's mother reports some anxiety about “pushing” Mike to do things that make him nervous, and the therapist normalizes Mike's mother's inclination to protect her son while also discussing how parents can unknowingly reinforce anxious behavior by allowing avoidance and accommodating anxiety.

The majority of time is spent discussing situations in which Mike becomes anxious, particularly the three main treatment deliverables that the family is hoping to accomplish with treatment. The main deliverables for Mike's parents are for Mike to be able to go to playdates and birthday parties at his friends' houses, being able to separate from Mom when she travels, and learning how to cope better with changes in his routine such as driving on the highway. The therapist helps the parents identify tangible goals with clear opportunities for evaluation, such as “going to a birthday party” rather than “feeling less anxious.” At the end of session, the therapist provides the parents with a copy of the parent companion treatment guide.

Session 2: Identifying Anxious Feelings, Self-Talk, and Learning to Challenge Thoughts

Session 2 (see Figure 2 for the main goals) begins the process of introducing the specific skills that will comprise the plan for coping with anxiety. After reviewing the first homework assignment—or “Show That I Can” (STIC) task—the therapist works with the child on increasing his or her identification of particular bodily reactions to feeling anxious. By pairing this focus with basic education about the physiology of the fear/stress response, the therapist has another opportunity to normalize the experience of anxiety for the client. In the context of BCBT, this is known as the “F” step, where youths are taught to ask themselves, am I “Feeling Frightened”? Especially for youths who may not be effective at realizing they are anxious, the therapist emphasizes that the child's idiosyncratic somatic responses

1. Review the STIC task from Session 1
2. Discuss and identify the child's specific somatic reactions to anxiety
3. Present somatic reactions as cues to increasing anxiety
4. Introduce the “F” step
5. Introduce the concept of self-talk
6. Discuss self-talk in anxiety-provoking situations
7. Differentiate anxious self-talk from coping self-talk
8. Introduce the “E” step
9. Begin to construct a hierarchy of anxiety-provoking situations
10. Assign STIC task

Figure 2. Main goals of Session 2.

(i.e., their own personal body sensations in response to anxiety) can serve as an early clue that anxiety is present.

The second main focus of Session 2 is to assist the child in being able to identify the content of his/her thoughts. Specifically, the goal is for the client to be able to recognize the presence of anxious self-talk, or the particular thoughts that reflect what one is worried will happen in a situation. This work constitutes the “E-Step” in which the child learns to become aware whether he or she is “Expecting bad things to happen?” Once this is accomplished, the therapist provides coaching on developing more resourceful “coping self-talk,” where anxious cognitive biases are challenged with thoughts that promote resilience rather than fuel avoidance. At the end of session, the therapist and child begin to collaborate to create a hierarchy of anxiety-provoking situations.

Session 2

Mike comes to session with his BCBT workbook in hand, eager to show his therapist that he completed his STIC task. The therapist and Mike review the situation that he wrote about in his workbook. Mike reports that he felt really great over the past week when he got to go to the zoo with his parents and brothers. Mike identifies that he felt “happy” and that he was thinking, “This is cool!” The therapist takes extra care to use verbal praise to reward Mike’s completion of the STIC task by saying, “Mike, I like how you did your STIC task and how excited you are to show it to me!” She gives Mike one dinosaur sticker in his rewards bank, located in the rear of the BCBT workbook.

Mike has difficulty sitting still and attending to session, so the therapist relies on using games to impart the psychoeducational material for this session, including identifying how Mike experiences anxiety somatically and cognitively. They start out by picking a time when Mike felt anxious recently. Mike says the last time he remembers feeling nervous was when his dad needed to drive on the

highway to bring him to therapy. The therapist, introducing the concept that our bodies are hard-wired to respond to anxiety in a certain way, uses coping modeling to self-disclose her own anxious response (e.g., when she feels nervous, she gets sweaty, her heart races, and her stomach drops). The therapist asks Mike to try and remember what happened in his body when he was feeling scared on the highway. Mike says that when he feels scared, his body responds by giving him a “headache,” an “upset tummy,” and “getting red in the face.” The therapist and Mike draw a picture of how their bodies look when they feel anxious. They discuss that these can be clues for some detective work that they are feeling anxious. Then, the therapist introduces the “F” step, which stands for “Feeling Frightened?”

Next, the therapist introduces the idea that we engage in self-talk as we go about our day, and that there are different types of self-talk. She does this by bringing out some pictures with cartoon bubbles above the heads of the people in the pictures. First, they start with pictures that are non-anxiety provoking, such as a picture of the therapist’s dog standing up on her hind legs. Mike (jokingly) identifies that the dog is thinking, “I am hungry!” After going through a number of nonthreatening images, they move on to pictures that might elicit anxiety, such as a young girl camping in the dark without a light. The therapist suggests that the way that we think impacts how we act and feel, and that two different people could have two very different thoughts in the same situation. She uses a picture of a boy ice-skating to help Mike identify two possible contrasting thoughts the boy might have. Mike identifies that the boy could be thinking, “I’m going to fall!” or “This is fun” and that would heavily impact whether or not he stayed out on the ice. The therapist talks with Mike about coping thoughts that he could have in anxiety-provoking situations, such as, “I can do it,” or “The world won’t end if I feel scared.” To

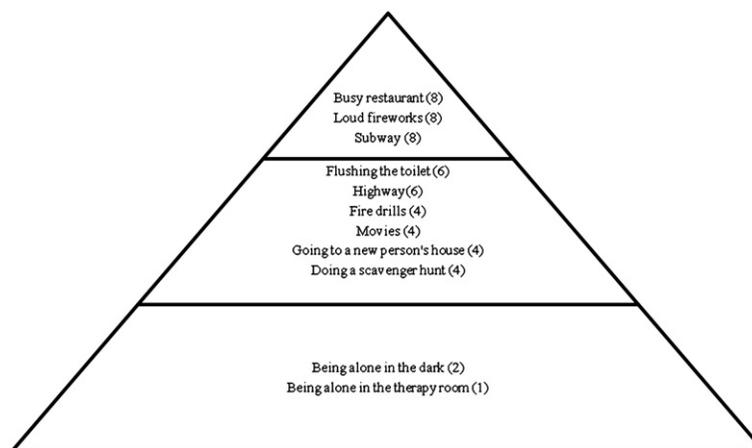


Figure 3. Mike's hierarchy of exposure tasks.

- | |
|--|
| <ol style="list-style-type: none"> 1. Review STIC task from Session 2 2. Introduce the “A” and “R” steps 3. Introduce problem solving 4. Plan for next exposure 5. Assign STIC task |
|--|

Figure 4. Main goals of Session 3.

complete the introduction of self-talk, the therapist presents the “E” step, or “Expecting Bad Things to Happen?”

Towards the end of session, the therapist teams up with Mike to work on the hierarchy of anxiety-provoking situations for future exposure tasks. Mike and the therapist agree to the following hierarchy (rated from 0–8, with 8 being the most anxiety-provoking exposure task). See Figure 3. Note the finalization of this hierarchy occurs in Session 4 (this session just begins the process). The hierarchy is largely based on the treatment deliverables identified in Session 1 and includes tasks of gradually increasing difficulty. At the end of session, the therapist assigns a STIC task for Mike to complete over the next week. The STIC task involves identifying his thoughts and feelings in two different situations when he feels anxious.

Session 3: Introducing Problem Solving, Self-Evaluation, and Self-Reward

See Figure 4 for the main goals to be covered in Session 3. During Session 3, the client continues learning steps of the FEAR plan that will be used to cope with anxiety. Having worked on identifying his/her physiological response to feeling anxious as well as the predictions about negative outcomes that are typically maintained, the focus shifts toward consideration of “Attitudes and actions that can help.” This “A” step encompasses the coping tools already covered (e.g., coping self-talk) and introduces the skill of problem solving. Armed with strategies to challenge the mind’s catastrophization, and flexibly brainstorm solutions to difficult problems, the child is now equipped with the tools necessary to begin effectively managing anxiety. One final important piece remains, however, to complete the coping plan: The “R” step prompts the child to consider the “Results and rewards” of facing one’s fears. This component encourages the client to reflect on the experience (e.g., Did anxiety diminish? Was eye contact maintained?) of being in contact with—rather than avoiding—anxiety, and to reward oneself for effort (trying one’s best) to cope in a difficult situation.

Session 3

Mike walks into the therapy room with his eyes cast downward and says, “I forgot to do my STIC task.” The therapist thanks him for letting her know and lets him know

that he can still earn a mini-sticker for completing the STIC task now in session. Mike’s apprehension lifts and he sits down with his therapist. They identify two situations over the past week when Mike felt anxious. In the first, his dad was driving on the highway. Mike identified that he had an upset stomach and that he felt really hot in his ears and cheeks. The therapist asks Mike what he might have been thinking in the situation. Mike says, “I don’t know!” The therapist provides Mike with a few possible thoughts that other anxious kids might have, and Mike picks one that best fits him: “that we might crash.” In the second situation, Mike reports that he felt nervous because Mom told him she was going away on a business trip. Mike says that he felt hot and had a headache and that he was thinking, “What if she doesn’t come back?” or “What if something bad happens to her?” The therapist makes sure to praise Mike’s hard work identifying body feelings and thoughts when he is nervous and, as promised, provides a mini-sticker. The therapist also asks Mike what made it hard to do his homework. He says, “I left it in my book bag and never took it out.” The therapist saves this situation for when they will talk about problem solving later in the session.

The therapist introduces the idea that they have now learned how their body and mind reacts to anxiety, and that the next step is to learn about the specific coping tools that he can use in anxiety-provoking situations. This is known as the “A” step: “Attitudes or actions that can help.” They review (a) deep breathing and its effect on calming the body down and (b) using coping thoughts to combat anxious thoughts. One of the coping tools is problem solving. The therapist collaborates with Mike about the steps of problem solving, including identifying the problem, generating as many solutions as possible (even silly ones!), evaluating the solutions, and then trying/implementing the best option. To do this in a “real” way, she comes back to his homework. They discuss all the possible ways to solve leaving homework in his book bag the whole week, generating solutions such as, “ask Mom to take it right after session”; “leave a note by the door”; “carry it around with me everywhere I go”; and “just not do the STIC task.” After discussion, they agree that asking Mom to take the workbook right after session is probably the best option.

Next, the therapist introduces the final step of the FEAR plan, the “R” step: “Results and rewards.” Mike and the therapist discuss why rewards for trying our best and rating our performance are important. The therapist takes extra care to note that rewards are not for perfect performance, a common belief of anxious youth, but that rewards are ways we pat ourselves on the back, even if we don’t have the perfect outcome we might have hoped for.

In the latter part of session, the therapist discusses and then solidifies the hierarchy of anxiety-provoking situations with Mike, checking in to make sure the numbers and rankings are appropriate. At this point, the therapist

Child portion (60 minutes)	Parent portion (30 minutes)
<ol style="list-style-type: none"> 1. Review STIC task from Session 3 2. Finalize hierarchy of anxious situations 3. Review the idea of progressing from learning new skills to practicing new skills 4. Review and apply the FEAR plan to a low anxiety-provoking situation 5. Begin practicing using exposure in low anxiety-provoking situation 6. Plan exposure task(s) for Session 5 7. Acknowledge upcoming parent session 8. Assign STIC task 	<ol style="list-style-type: none"> 1. Provide information about the second half of treatment (i.e., exposure tasks) 2. Provide parents an opportunity to ask questions and discuss their concerns 3. Learn more about the situations in which the child becomes anxious 4. Offer specific ways the parents can be involved in the second half of treatment

Figure 5. Main goals of Session 4.

asks Mike, “What might be a good first challenge for us to do next session?” Mike says, “I don't know, they all seem kinda hard.” The therapist points out two of the low rated situations (being alone in the therapy room, being in the dark) and asks Mike which one he would like to start with. Mike chooses being alone in the therapy room for 1 minute. The therapist praises Mike for being brave. They create a FEAR plan together in preparation for this first challenge. Mike identifies that while he is alone in the therapy room, he might feel hot and he might get a headache (“F” step). Also, he might be thinking, “What if I get stuck in here (“E” step)?” If that happens, he will take deep breaths and remind himself, “I probably won't get stuck (“A” step).” The therapist and Mike also problem solve what to do if he does get stuck (i.e., banging on the door, calling out for help). Finally, they plan a reward for his first exposure task, which, as requested by Mike, was to have chocolate ice cream together.

For his STIC task, Mike is to write down two anxiety-provoking situations with regard to his body reaction, anxious thoughts, and how he helped himself over the next week. He also will teach the FEAR plan to his parents.

Session 4: Reviewing Skills Already Learned, Practicing in Low-Anxiety-Provoking Situations, and the Second Parent Meeting

Having introduced the steps of the model for coping with anxiety (i.e., the FEAR plan), treatment shifts toward practice in anxiety-eliciting situations. See [Figure 5](#) for the main goals to be covered in Session 4. Session 4 is a 90-minute session (60 minutes with the youth and 30 minutes with the parents). An emphasis is placed on the progression of moving from the learning of new skills to putting them to use. The fear hierarchy is finalized (although it can be altered later), and a low anxiety-producing situation is chosen for a first exposure task. With guidance and support

from the therapist, the child is able to work through the implementation of the FEAR plan, receiving coaching as needed. Afterward, a brief parent session is conducted in which the therapist provides information about the second half of treatment, learns more about the situations and stimuli that make the child anxious, provides a rationale for engaging in exposure work, and allows the parent to ask questions. The therapist also takes this opportunity to mention to the parents that they will be needed to support the child's practice of the FEAR plan through exposure tasks assigned as STIC tasks.

Child Portion (60 Minutes)

To start the session, the therapist reviews Mike's STIC task, which was to write down two anxiety-provoking situations with regard to his body reaction, anxious thoughts, and how he helped himself over the last week. Mike has completed his STIC task, and the therapist uses labeled verbal praise—“Great job completing your STIC task”—as a reward. Mike gets a sticker, and it is time to pick something from the prize box because he has received four stickers to date for his hard work. Mike picks a toy car. The therapist checks in to make sure the hierarchy that they have been working on is still reflective of Mike's fears. The therapist then suggests that the session is a bridge—a transition to the next part of treatment, which includes exposure tasks (called “challenges” for the youth and families) using the toolkit he has learned in anxiety situations with the therapist as coach.

Next, Mike and the therapist review the FEAR plan they created in the previous session. The therapist checks in to make sure that Mike is still committed to doing the exposure he chose (being in the dark). While preparing for the challenge, the therapist notices that Mike is having a tough time attending to the FEAR plan, so she suggests that they institute a point system, where he gets a point for every 2-minute interval that he is able to stay on task. When he

gets 5 points, he earns another sticker. This helps redirect Mike's attention. For the first exposure, Mike agrees to stay in the dark for 10 seconds. At first, he says, "I don't like to do scary things!!" despite their agreement to do the exposure. However, with some coaxing from his therapist, he agrees to try it for 10 seconds. To help motivate Mike to complete the exposure task, the therapist reminds him that he will get a reward immediately following the challenge. She also reminds him that he has learned lots of new skills and this is a chance for him to practice those skills, and that she will be right there with him. While doing the exposure, the therapist elicits ratings of his anxiety on a scale from 0 to 8 (where 8 is the most frightening). Mike says that he is an 8 for the entire 10 seconds. The therapist asks if they could try the exposure for a little bit longer to see what happens. After success with 10 seconds, Mike agrees to try 30 seconds, then 1 minute, and then 5 minutes. Each time, his ratings start lower, and decrease within the exposure (intra- and inter-exposure habituation). For the last exposure task, Mike agrees to be in the dark room alone, further intensifying the challenge.

After completing the four exposure tasks, Mike and the therapist check in to process the exposure tasks, investigating if what Mike expected to happen actually happened, and discussing lessons learned. Mike notes that he felt hot and like he had a headache at first, and that he was scared something bad would happen. He has the insight to observe that his somatic symptoms decreased over time and that nothing bad happened. When asked about what he has learned, Mike says, "It wasn't as bad as I thought it would be," and that his "scary feelings" go down the longer he is in the situation. The therapist praises Mike for his bravery and makes sure to follow through on the reward they selected, chocolate ice cream. Mike and the therapist discuss what the exposure will be for the next session, and they agree that they will pick something from the medium category on the hierarchy. Mike selects doing a scavenger hunt alone on different floors in the building. For his STIC task, Mike agrees to practice being in the dark basement, somewhere he never goes, at least three times over the next week.

Parent Portion (30 Minutes)

In the second parent session, the therapist reviews information about the second half of treatment and shares Mike's success with his parents. The therapist also provides the parents with an opportunity to ask questions

1. Review STIC task from previous session
2. Practice using exposure in anxiety-provoking situation
3. Plan exposure task(s) for next session
4. Assign STIC task

Figure 6. Main goals of Sessions 5–7.

about the treatment, discuss concerns, and provide more information about anxiety-provoking situations. The parents report being pleased with Mike's progress and that the hierarchy is a good depiction of the desired treatment deliverables. The therapist and parents discuss how the parents can facilitate use of coping skills in challenges conducted at home. A particular emphasis is placed on how the parents can use positive reinforcement to encourage Mike's participation in challenges. The therapist assists the parents in identifying a reward schedule to be used for in-home challenges with rewards with high motivating power for Mike (e.g., his favorite dessert, special time with his parents). The therapist also stresses the importance of immediate rewards and lots of labeled verbal praise (i.e., "Great job being so brave!"). Using the example of being in the dark, the therapist coaches the parents in how they can help support Mike when he completes this exposure at home. The therapist also emphasizes how important it is for Mike to complete at least three exposures before the next session.

Sessions 5 to 7: Practice With Increasingly Anxiety-Provoking Situations

The main goals to be addressed in Sessions 5 to 7 are detailed in [Figure 6](#). Building on the experience of having used the FEAR plan coping skills in a low anxiety-inducing situation, the remaining treatment sessions focus on implementing these skills in progressively more difficult situations. Session 5 begins with a review of the child's experience with the first exposure task, conducted at home with the parent as coach. From there, the child is encouraged to begin ascending the anxiety hierarchy by engaging in an exposure task of moderate difficulty. As before, the therapist is present for support, although encouragement of a greater amount of independence in the application of coping skills is emphasized. The session ends with planning for a moderately anxiety-provoking exposure as a STIC task as well as the exposure task to be covered at the next meeting. Sessions 6 and 7 follow the same format as Session 5. In each subsequent session, the objective is to continue up the hierarchy by facing situations that elicit more anxiety.

Session 5

To start, the therapist reviews Mike's STIC task, which was to practice using his coping skills in the dark at least 3 times. Mike reports that he has been successful in his practices, and even added a challenge this week, completing a total of four practices for homework. Mike is excited to tell his therapist that he went on the highway with his parents and used his coping skills effectively. The therapist uses labeled praise to reward Mike's hard work and gives him an extra sticker.

Mike and the therapist agree to complete the exposure task planned the previous week: Mike will go on a

scavenger hunt by himself on multiple floors of the building—a challenge rated a 4. Prior to the session, the therapist creates a scavenger hunt map and hides SpongeBob SquarePants stickers in different locations (selected because of their high reward value for the client). Mike and the therapist formulate a FEAR plan for the exposure task and run through the scavenger hunt together to make sure that Mike knows how to get back to the office. When Mike returns, his face is flushed with pride that he completed the scavenger hunt. Mike and the therapist process his experience, paying special attention to the mastery he is feeling. For next week, Mike and the therapist agree to go on the subway for their challenge. For homework, they agree that Mike will (a) go to a friend's house, (b) sleep in his own bed while his mother is away on business, and (c) drive on the highway with his parents. Mike runs to his parents after the session and tells them all the challenges he wants to do this week, and his parents confirm that they will be able to set up the playdate.

Session 6

At the outset, the therapist reviews Mike's STIC tasks. Mike reports that he has been successful in his practices, completing three over the past week. Mike was able to go to a friend's house, sleep in his own bed while his mother was away, and go on the highway. The therapist praises Mike's hard work and gives him a sticker.

Mike and the therapist prepare the exposure task planned the previous week: going on the subway (rated an 8). Mike and the therapist formulate a FEAR plan for the challenge and head to the subway to ride the train back and forth. Because of the loud subway noises, Mike reports initially feeling high levels of anxiety and somatic symptoms, which quickly subside. Afterwards, Mike and the therapist process the experience, paying special attention to the lesson learned about anxiety subsiding when he stays in the situation. Mike and the therapist agree to go to a movie for their second-to-last exposure. For homework, they agree that Mike will (a) flush the toilet each time he goes to the bathroom, (b) drive on the highway, and (c) go to a crowded place.

Session 7

The therapist first reviews Mike's STIC tasks. Mike reports that he has been successful in his practices,

completing three over the past week. Mike was able to flush the toilet after going to the bathroom, go on the highway, and eat at a busy restaurant. The therapist praises Mike's hard work and gives him a sticker.

Mike and the therapist prepare the exposure task planned the previous week: going to a movie (rated an 8). Mike and the therapist formulate a FEAR plan for the exposure, and catch 20 minutes of a movie of Mike's choosing. Mike reports that this is the hardest challenge he is done yet, given his worry that he or someone else might vomit at the movies. Behavioral observations by the therapist suggest high levels of anxiety as evidence by frequent skin-picking during the movie. However, Mike is able to stay in the situation until his anxiety goes down. Afterwards, Mike and the therapist process his experience. Mike and the therapist agree that the therapist will set off fireworks for the final challenge, a very highly rated fear for Mike. For homework, they agree that Mike will (a) go to and watch a whole movie, (b) drive on the highway, and (c) go to a crowded place.

Session 8: Practicing in High-Anxiety Situations and Celebrating Success

See [Figure 7](#) for the main goals to be covered in Session 8. Session 8 is the last therapy session of BCBT. After having practiced coping skills across a number of situations with both the therapist and parents providing support, this session is to help the child solidify gains by practicing one last time in one of the harder (e.g., more anxiety provoking) scenarios. It is recommended that this *not be the most difficult* situation, but rather one that the therapist is relatively confident the child can be successful (that is, we want the client to finish the program with a sense of mastery). Once completed, the therapist spends time reviewing and enthusiastically celebrating all that the child has accomplished. This celebration can be done with parents, friends, or other family members, with the child's preferences dictating what will be most meaningful. The therapist also underscores for both the child and parents the importance of being proactive about relapse prevention, which is achieved through continued practice of skills. It is emphasized that the work done in therapy is not a stand-alone cure for anxiety, but rather a foundation to be built upon through regular and ongoing application

- | |
|--|
| <ol style="list-style-type: none"> 1. Review STIC task from Session 7 2. Conduct a final exposure task in a challenging anxiety-provoking situation 3. Review and summarize the treatment program 4. Bring closure to the therapeutic relationship |
|--|

Figure 7. Main goals of Session 8.

of coping. Finally, during this session, the therapist addresses the closure of the therapeutic relationship, letting the client know that it is now time for him or her to go forth and independently be brave and face the anxiety-engendering challenges.

Session 8

The therapist starts by reviewing Mike's STIC tasks. Mike reports that he has been successful in his practices, completing three over the past week. The therapist praises Mike's hard work and gives him a sticker. Because Mike has earned another four stickers, he picks out a prize from the prize box. He selects a glow in the dark slinky.

Mike and the therapist prepare the exposure task planned the previous week: being around sparkler fireworks (rated an 8). Mike and the therapist formulate a FEAR plan for the challenge. The therapist lights the sparklers and models safe behavior for Mike, and then Mike practices holding them as they burn down. Mike reports feeling some anxiety and that as his anxiety subsides that he starts to think this is "super fun." Afterwards, Mike and the therapist process his experience.

Mike and the therapist review and summarize treatment to date. They make a big poster of all of his accomplishments over the course of the 8 sessions. Mike, the therapist, his parents and siblings celebrate Mike's accomplishments with a pizza party, and everyone shares how proud they are of him. The therapist makes sure to ask the parents and Mike if they feel like treatment has achieved the deliverables they were seeking at the beginning. They all agree that Mike has made huge gains by increasing his coping behavior and facing feared situations bravely. Specifically, Mike has been able to achieve all treatment deliverables, including: going to a friend's house, being in the dark alone, tolerating loud noises, separating from his mother when she travels, and tolerating changes in routine. In the last few minutes, the therapist brings closure to the therapeutic relationship by sharing how wonderful it has been working with Mike and his family, and encourages the family to continue doing challenges, modeling, and reinforcing Mike for facing his fears to maintain treatment gains. The therapist discusses relapse prevention and emphasizes the fact that Mike now has skills with which to face his feared situations, even if new situations arise.

Additional Considerations

As with the full protocol (i.e., Coping Cat program), there are issues to consider when implementing the BCBT program, including the role of the parents in the treatment and how to engender youth compliance with exposure tasks.

Role of Parents

As illustrated in Mike's case, parental participation in treatment can be valuable for therapeutic success. Parents are not co-clients, but are involved in treatment as collaborators and coaches (Kendall, 2012). Parents provide information regarding their child's functioning in and out of the home and serve as collaborators/coaches throughout treatment. Appropriate parental involvement may be crucial given the abbreviated nature of BCBT, which requires that many of the exposure tasks occur outside of the therapy session (within the home setting). If parents accommodate their child's anxiety by allowing them to avoid exposures, or if they are underinvolved and do not facilitate exposures, it is likely that the effects of BCBT may be limited (more sessions would be needed for exposure tasks). In our case example, Mike was able to complete his written STIC tasks on his own. However, not all 7-year-olds may be able to do so. In such instances, parental assistance with STIC tasks could be encouraged. Keep in mind that it is important that parents do not "do" the STIC tasks for the youth, but rather assist and facilitate the child doing his/her own STIC tasks. For example, parents can help younger children by scheduling times for them to do their STIC tasks, and parents can also themselves be involved in the actual STIC tasks. In Mike's case, his parents helped him face his fear of separation from them by bringing him to and dropping him off at playdates with peers. His parents did not go on the playdates but facilitated Mike facing his fears by getting him to and from friends' houses. Parental involvement in treatment is tailored for each family to encourage approach rather than avoidance behavior.

Youth Compliance

Youth compliance in the completion of exposure tasks is critical to the success of CBT for child anxiety, including BCBT. Mike was quite compliant in completing his exposure tasks, although he needed some initial convincing when starting the exposure portion of treatment. As illustrated in Mike's case, some gentle coaxing (supportive encouragement) is often all a child needs to try their first exposure, especially if the hierarchy of feared situations is appropriately constructed (i.e., the first exposure task is relatively easy). In our experience, an appropriate reward can be enough motivation to participate in the first exposure task, and success in the first exposure task often comes with mastery and a willingness to do more challenges. Further, giving the child a "choice" in the exact nature of the first exposure task will help engender motivation. When these two points are addressed, we rarely find a child unwilling to engage in an exposure task (especially when the therapist is willing to negotiate if the task feels too difficult for the child). If necessary, an exposure task can be broken down into smaller and manageable parts, so the key is to be creative in coming up with something challenging that the child is

willing to do, while also having an external motivator. That said, youth may be reluctant to engage in exposure tasks and we find it helpful to discuss the pros and cons of anxious behavior. In some rare cases, the addition of a medication (sertraline) can reduce anxiety and allow the child to engage in exposure. If there is a child who is completely resistant or unwilling to do an exposure task, more time may be needed to build the relationship and generate motivation to change.

BCBT Treatment Outcome

Mike responded very well to the 8-session BCBT program, as illustrated by the magnitude of his treatment response (see Table 1 for pre-, post-, and follow-up ratings). At pretreatment, Mike met criteria for three anxiety disorders, was scored as “markedly ill” on the CGI-S, in the clinical range on the PARS (above 11.5 on the 5-item scale; Ginsburg et al., 2010), and in the clinical range on the MASC (above 47; Rynn et al., 2006). At posttreatment, Mike no longer met criteria for any of these anxiety disorders, was rated “borderline” on the CGI-S (with a 3-point decrease), and “very much improved” on the CGI-I. Further, Mike’s score on the PARS dropped 12 points and out of the clinical range. Mike continued to score in the clinical range on the MASC (67) but evidenced a 19-point decrease. At posttreatment, inattention emerged as a concern and the diagnostician made a diagnosis of ADHD–inattentive type based on parent and child report. Evidence of inattention was corroborated by therapist observation throughout treatment, but this was not part of the independent evaluator’s posttreatment assessment. Teacher-report was not solicited, but a recommendation was made to the parents that they seek a comprehensive ADHD assessment. Initially, the parents had conceptualized Mike’s inattention as anxiety, but once his anxiety abated, and the inattention continued, the working hypothesis was that there may be additional attentional concerns. Unfortunately, we do not have information on whether the family sought an evaluation and additional treatment for ADHD. At 1-year-follow-up, Mike did not meet criteria for any mental health diagnoses, was rated “normal” on the CGI-S, and “very much improved” on the CGI-I. Mike’s score on the PARS remained in the normal range. Mike continued to score in the clinical range on the MASC (59) but evidenced a further 8-point decrease.

Discussion

As described in the case example and the feasibility and initial outcomes paper (Crawley, et al., 2013-this issue), BCBT is a promising treatment for youth who meet criteria for a primary diagnosis of SAD, social phobia, and/or GAD. One of the key advantages and most important aspects to highlight is the BCBT 8-session format. The briefer format may facilitate an increased ability to disseminate and

implement the program to populations that typically do not have access to, or the ability to use CBT. Research has documented that CBT is the gold-standard psychosocial treatment for anxiety (Silverman et al., 2008); however, few youth are able to access and receive CBT. Efforts to disseminate ESTs have increased, but barriers exist. Providers trained in CBT for child anxiety reported implementing CBT for child anxiety for an average of 5 sessions over 3 months (Beidas, Mychailyszyn, et al., 2012). This finding suggests that the typical 16-session format may not be feasible in community settings. The brief format of BCBT may help to overcome dissemination and implementation barriers such as these. However, important questions remain around how to best train and support providers in implementing BCBT (Beidas, Edmunds, Marcus, & Kendall, 2012; Beidas & Kendall, 2010; Beidas, Koerner, Weingardt, & Kendall, 2011). Additional questions around evidence-based assessment to guide treatment planning remain. In research settings, semistructured interviews (e.g., ADIS-C/P) and the Pediatric Anxiety Rating Scale (The Research Units on Pediatric Psychopharmacology Anxiety Study Group, 2002) are generally used. In clinical settings, however, the time and training required for use of such tools might not be feasible or cost-effective. Brief assessments (e.g., MASC; March et al., 1997) that allow for the correct identification of childhood anxiety disorders (e.g., Villabo, Gere, Torgersen, March, & Kendall, 2012) are needed in community settings.

Another potential advantage of BCBT is the early emphasis on exposure tasks. Experts consider exposure treatment to be a key element of effective programs for anxious youth (Kazdin, 2004) and many have asserted that exposure is an important, if not the most important, therapeutic ingredient in CBT for anxiety disorders (Antony & Swinson, 2000; Barlow, Gorman, Shear, & Woods, 2000; Bouchard, Mendlowitz, Coles, & Franklin, 2004; Kendall et al., 2005; Rapee, Wignall, Hudson, & Schneiring, 2000). Although BCBT has 8 fewer sessions than the Coping Cat treatment, it includes the same number of exposure tasks and enables the therapist and child to start exposure tasks sooner in the course of treatment. This emphasis is accomplished by explicitly assigning more exposure tasks to be done between sessions (STIC tasks; at least 3). In BCBT, youth complete 1 exposure per session in Sessions 4 to 8, and 3 exposures per week, for a total of 16 exposures over 8 weeks.

BCBT provides a structured format for parental involvement through two parent sessions and a structured parent manual. Kendall et al.’s (2010) *Coping Cat Parent Companion* provides a session-by-session guide for the parent(s), which is included to serve multiple purposes: (a) standardizes the information the parents receive, (b) consolidates the amount of time the therapist spends with the parents, and (c) provides information regarding session content to allow

for parental skill mastery and eventual transfer of control from therapist to parent (Ginsburg, Silverman, & Kurtines, 1995). Research suggests that parent factors, family environment, and parental modeling of anxiety play a role in the development and maintenance of anxiety in youth (Ginsburg & Schlossberg, 2002), thus pointing to the importance of parental psychoeducation in CBT for child anxiety. The structured parent sessions and *Parent Companion* in BCBT help address these areas in a concise and time-efficient manner by providing parents with information regarding not only the treatment but ways in which they can facilitate their child's acquisition of skills.

BCBT has a number of advantages, but it is important to note some limitations. Data from the feasibility study (Crawley et al., 2013-this issue) suggested that youth with social phobia did not have as many initial treatment gains and did not maintain these gains at 1-year follow-up. These preliminary findings are consistent with previous work suggesting that socially phobic youth respond to CBT for child anxiety but somewhat less so than others (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008; Ginsburg et al., in press). It is possible that for socially phobic youth, BCBT did not allow enough time to develop a therapeutic relationship before beginning exposure tasks. Given the limited number of sessions and the need to focus on the anxiety-related behavior, BCBT may not be as effective for youth with multiple comorbidities (e.g., behavioral difficulties). Finally, it is our view that the success of the BCBT program relies heavily on exposure practice (STIC tasks) in between sessions, which requires parents to be available to facilitate and support such activities. Parents with their own psychopathology or who have demanding schedules may not be available and/or able to facilitate these exposure tasks.

Results from the initial study and the present description suggest that BCBT is a feasible and potentially effective treatment for youth ages 7 to 13 who meet criteria for SAD, social phobia, and/or GAD. Future directions include further research on those who did not respond to treatment after 8 sessions. Potential moderators for nonresponse should be explored, including anxiety severity, comorbidity, differential response to massed exposures compared to more distributed exposures, and familial factors. Anecdotally, youth in the initial study who had fewer comorbidities and who had parents that were willing and capable to participate in treatment seemed to have responded better to treatment. Future research, using baseline characteristics of youth, may help predict which treatment works best for whom. Potential next steps include a randomized controlled trial comparing BCBT to the 16-session Coping Cat program.

References

Antony, M. M., & Swinson, R. P. (2000). *Phobic disorders and panic in adults: A guide in assessment and treatment*. New York, NY: American Psychological Association.

- Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2000). Cognitive-behavioral therapy, imipramine, or their combination for panic disorder: A randomized controlled trial. *JAMA*, 283, 2529–2536.
- Beidas, R. S., Edmunds, J. E., Marcus, S. C., & Kendall, P. C. (2012). Training and consultation to promote implementation of an empirically supported treatment: A randomized trial. *Psychiatric Services*, 63, 660–665. <http://dx.doi.org/10.1176/appi.ps.201100401>
- Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice*, 17, 1–30.
- Beidas, R. S., Koerner, K., Weingardt, K. R., & Kendall, P. C. (2011). Training research: Practical recommendations for maximum impact. *Administration and Policy in Mental Health and Mental Health Services*, 38, 223–237.
- Beidas, R. S., Mychailyszyn, M. P., Edmunds, J., Khanna, M. S., Downey, M. M., & Kendall, P. C. (2012). Training school mental health providers in CBT. *School Mental Health*. <http://dx.doi.org/10.1007/s12310-012-9074-0>
- Bouchard, S., Mendlowitz, S. L., Coles, M., & Franklin, M. (2004). Considerations in the use of exposure with children. *Cognitive and Behavioral Practice*, 11, 56–65.
- Chambless, D., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18.
- Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, 52, 685–716.
- Chavira, D. A., Bailey, K., & Stein, M. (2004). Child anxiety in primary care: Prevalent but untreated. *Depression & Anxiety*, 20, 155–164.
- Crawley, S. A., Beidas, R. S., Benjamin, C., Martin, E., & Kendall, P. C. (2008). Treating Socially Phobic Youth with CBT: Differential Outcomes and Treatment Considerations. *Behavioral and Cognitive Psychotherapy*, 36.
- Crawley, S. A., Kendall, P. C., Benjamin, C. L., Brodman, D. M., Wei, C., Beidas, R. S., Podell, J. L., & Mauro, C. (2013). Brief cognitive-behavioral therapy for anxious youth: Feasibility and initial outcomes. *Cognitive and Behavioral Practice*, 20, 123–133 (this issue).
- Egger, H. L., & Burns, B. J. (2004). Anxiety disorders and access to mental health services. In T. H. Ollendick, & J. March (Eds.), *Phobic and anxiety disorders in children and adolescents*. New York, NY: Oxford University Press.
- Ginsburg, G. S., Keeton, C. P., Drazdowski, T. K., & Riddle, M. A. (2010). The utility of clinicians' ratings of anxiety using the Pediatric Anxiety Rating Scale (PARS). *Child Youth Care Forum*, 40, 93–105.
- Ginsburg, G. S., Kendall, P. C., Sakolsky, D., Compton, S., Piacentini, J., Albano, A. M., . . . March, J. (in press). Remission after acute treatment in children and adolescents with anxiety disorders: Findings from the CAMS. *Journal of Consulting and Clinical Psychology*.
- 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. M. (1995). Family involvement in treating children with phobic and anxiety disorders: A look ahead. *Clinical Psychology Review*, 15, 457–473.
- Guy, W. (1976). *Clinical global impressions ECDEU assessment manual for psychopharmacology*. Rockville, MD: National Institute for Mental Health.
- Kazdin, A. E. (2004). Psychotherapy for children and adolescents. In M. C. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York, NY: John Wiley.
- Kendall, P. C. (2012). Treating anxiety in youth. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (4th ed.). New York, NY: Guilford.
- Kendall, P. C., Beidas, R. S., & Mauro, C. (2012). *Brief Coping Cat: The 8-session Coping Cat workbook*. Ardmore, PA: Workbook Publishing.
- Kendall, P. C., Crawley, S., Benjamin, C., & Mauro, C. (2012). *Brief Coping Cat: The 8-session therapist manual*. Ardmore, PA: Workbook Publishing.
- 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, 366–380.

- Kendall, P. C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual*. Ardmore, PA: Workbook Publishing.
- Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology, 76*, 282–297.
- Kendall, P. C., Podell, J. L., & Gosch, E. (2010). *The Coping Cat Parent Companion*. Ardmore, PA: Workbook Publishing.
- Kendall, P. C., Robin, J. A., Hedtke, K., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2005). Conducting CBT with anxious youth? Think exposures. *Cognitive and Behavioral Practice, 12*, 136–150.
- Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact on substance use and depression at 7.4 year follow-up. *Journal of Consulting and Clinical Psychology, 72*(2), 276–287.
- Lomas, J. (1993). Diffusion, dissemination, and implementation: Who should do what? *Annals of the New York Academy of Science, 703*, 226–235.
- March, J., Parker, J., Sullivan, K., Stallings, P., & Conners, C. (1997). The Multidimensional Anxiety Scale for Children (MASC): Factor structure, reliability and validity. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*, 554–565.
- Rapee, R. M., Wignall, A., Hudson, J. L., & Schneiring, C. A. (2000). *Treating anxious children and adolescents: An evidence-based approach*. Oakland, CA: New Harbinger.
- Rynn, M. A., Barber, J. P., Khalid-Khan, S., Siqueland, L., Dembiski, M., McCarthy, K. S., & Gallop, R. (2006). The psychometric properties of the MASC in a pediatric psychiatric sample. *Journal of Anxiety Disorders, 20*, 139–157.
- Silverman, W., & Albano, A. M. (2006). *Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Versions*. Boulder, CO: Graywind.
- Silverman, W., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 37*, 105–130.
- The Research Units on Pediatric Psychopharmacology Anxiety Study Group. (2002). The Pediatric Anxiety Rating Scale (PARS): Development and Psychometric Properties. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*, 1061–1069.
- Villabo, M., Gere, M., Torgersen, S., March, J., & Kendall, P. C. (2012). Diagnostic efficiency of the child and parent versions of the Multidimensional Anxiety Scale for Children. *Journal of Clinical Child and Adolescent Psychology, 41*, 75–85.
- Walkup, J. T., Albano, A. M., Piacentini, J., Birmaher, B., Compton, S. N., Sherrill, J. T., . . . , & Kendall, P. C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine, 359*, 2753–2766.

This research was supported by NIMH grant MH080788 awarded to Philip C. Kendall.

Address correspondence to Rinad Beidas, Ph.D., University of Pennsylvania, 3535 Market Street, 3015, Philadelphia, PA 19104 (e-mail: rbeidas@upenn.edu) or Philip Kendall, Ph.D., Temple University, 1701 N. 13th Street, Philadelphia, PA 19122 (e-mail: pkendall@temple.edu).

Received: May 1, 2012

Accepted: July 26, 2012

Available online 6 September 2012