

Relapse Prevention Techniques in the Treatment of Childhood Anxiety Disorders: A Case Example

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Abstract Research has shown that cognitive behavioral therapy (CBT) is an efficacious treatment for children and adolescents with anxiety disorders. CBT incorporates techniques such as cognitive restructuring and exposure, which foster symptom reduction. While these components promote sustained fear reduction, greater attention to relapse prevention (RP) may be warranted, particularly given the comorbidity associated with anxiety disorders. A case example demonstrates a comprehensive relapse prevention (RP) component. Specifically, parental involvement was emphasized as well as the creation of a bound book that consolidated skills and provided a concrete resource for potential future anxious episodes.

Keywords Anxiety · Relapse prevention · Children · Cognitive-behavioral

Anxiety disorders are among the most commonly diagnosed mental health problems, affecting between 5 and 18% of children and adolescents (Labellarte, Ginsburg, Walkup, & Riddle, 1999). Left untreated, anxiety disorders, and in particular GAD, have been found to have a chronic, unremitting course and to greatly impact children's functioning (Albano & Kendall, 2002). Anxiety disorders can negatively impact school achievement (Ialongo, Edelsohn, Werthamer-Larsson, Crockett, & Kellam, 1995; Muris & Meesters, 2002) and are associated with an increased likelihood of dropping out of school (Ameringen, Mancini, & Farvolden, 2003).

Problems with school attendance are also common; among children diagnosed with separation anxiety, approximately 75% refuse to attend school (Masi, Mucci, & Millepiedi, 2001).

With regard to treatment, good evidence exists for the efficacy of cognitive behavioral interventions for youth with anxiety. To date, findings from at least six randomized clinical trials have supported the use of cognitive behavioral therapy (CBT) with this population (e.g., Barrett, Dadds, & Rapee, 1996; Flannery-Schroeder & Kendall, 2000; Kendall, 1994; Kendall et al., 1997; Manassis et al., 2002; Silverman et al., 1999a). Kendall (1994) conducted the first clinical trial with 47 children aged 9 to 13 diagnosed with overanxious disorder, separation anxiety, or avoidant disorder. At the end of treatment, 64% of children in the CBT condition ($n = 27$) no longer met criteria for an anxiety disorder, while only one child in the wait-list condition ($n = 20$) no longer met diagnostic criteria. Further, treatment gains were maintained at one year, three year, and seven year follow-up (Kendall, 1994; Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Kendall & Southam-Gerow, 1996). A second larger study (Kendall et al., 1997) found similar results; more than 50% of treated children were diagnosis free at the end of treatment and gains were maintained at a one year follow-up assessment. Other studies have also found CBT to be an effective treatment for anxiety disorders even with varying the format, such as group treatment or family treatment (Flannery-Schroeder & Kendall, 2000; Manassis et al., 2002; Mendlowitz et al., 1999; Silverman et al., 1999a; Silverman et al., 1999b).

Despite these typically good results, some children do not benefit from CBT. First, a considerable proportion of children (approximately 20–40% in some studies) still meet criteria for a primary anxiety disorder following 16–20 sessions of CBT (see Barrett et al., 1996; Kendall, 1994).

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Additionally, when outcomes are evaluated based on an intent-to-treat sample (analyzing treatment completers as well as noncompleters), more modest outcomes are reported (Flannery-Schroeder & Kendall, 2000). Furthermore, several studies have shown that comorbidity is the rule rather than the exception in children with anxiety and other psychiatric disorders (Masi, Mucci, Favilla, Romano, & Poli, 1999; Verduin & Kendall, 2003). If comorbid disorders are untreated during treatment it may contribute to poorer outcomes post-treatment. Although one recent study found that comorbid anxious children had equivalent treatment outcomes to those without a comorbid diagnosis (Kendall, Brady, & Verduin, 2001).

It is therefore important to think more critically about inclusion of relapse prevention techniques for childhood anxiety disorders. Components of a thorough RP plan are derived primarily from the adult depression treatment literature (Overholser, 1998; Overholser & Nasser, 2000) and substance abuse literature. Foremost it is important to discuss and define lapse and relapse for the client. A lapse is commonly defined as a temporary state, and a relapse is typically defined as recurrent lapses accompanied by a feeling of loss of control (Brownell, Marlatt, Lichtenstein, & Terence Wilson, 1986). Next, it is necessary to prepare the client to anticipate a recurrence of some symptoms, and to educate the client that a recurrence of some anxiety is likely (Overholser, 1998). One technique is to “practice” a relapse, so the client will have an experience of anxiety and can review and practice appropriate coping strategies with their therapist. It is also important to identify upcoming challenges or situations that in the past produced high levels of anxiety (Overholser & Nasser, 2000). The client may experience anticipatory anxiety if an event had previously caused distress, and by reviewing appropriate coping strategies for that event, the client will feel more prepared and less anxious when the event occurs again. Finally, another important component of RP is to incorporate repetition and to review all the skills learned during treatment (Overholser & Nasser, 2000). One strategy used to facilitate relapse prevention in child treatment protocols is to have the child make a commercial advertising all the coping skills learned (Kendall, Chu, Pimentel, & Choudhury, 2000). However, empirical studies on relapse prevention techniques in the treatment of childhood anxiety disorders are lacking. The purpose of the present paper is to describe CBT with an anxious child, highlighting an enhanced relapse prevention component of treatment.

Case description

The client is a 9-year-old female whose parents referred her for an evaluation of anxiety and depression. The interview consisted of modules from the Schedule for Affective Disorders and Schizophrenia for school-aged children-present and

lifetime version (K-SADS, Kaufman et al., 1997), a standardized DSM-IV diagnostic instrument, and several child self-reports: the Children’s Depression Inventory (Kovacs, 1992), Multidimensional Anxiety Scale for Children (March, 1997), and a parent report measure, the Child Behavior Checklist (Achenbach, 1991).

The client lived with her mother, stepfather, and 5 year-old sibling. She and her sibling spent Wednesday afternoons and Friday evenings with their biological father. The client’s parents were divorced seven years prior and maintained an amicable relationship. Her mother had been remarried for three years and her father was involved in a serious relationship. She performed well in third grade, attaining mostly A’s and B’s. Her anxiety did not impact academic functioning per mother’s report because she was able to successfully complete her homework and tests, despite high anxiety around these events. She participated in several activities, including basketball and soccer. Developmental history was normal per mother’s report, and family history of psychiatric illness was denied, as was recent stressors (e.g. death in the family, moving).

Notably, the client’s mother reported that her child had longstanding anxiety in several settings including fears related to school, peers, and recently anxiety when separating from mother. This separation anxiety had been occurring for the past month and occurred when the client left to go spend the night at her father’s house, per the parents’ custody agreement. The client’s mother reported that the client ruminated about leaving, and when the father would arrive, she would cry excessively, cling to her mother, and refuse to get into the car. Separation anxiety was not present when the client separated from the father to go back to the mother’s house; however the father/daughter relationship was reported to be good. That is, the client reported that she really liked to be at her father’s house and to spend time with him, but that it was leaving her mother that was anxiety provoking for her. The client’s mother was also concerned about her excessive reassurance seeking from parents and teachers, which had been occurring for some time.

Results of interviews and questionnaires were consistent with the picture of a clinically anxious child. The client and her mother reported anxiety in a variety of settings, multiple somatic symptoms of anxiety, and her mother reported the client was unable to control her worry. Anxiety was most apparent when separation from her mother was imminent, such as when leaving to go to her father’s house or going to school. The client also discussed and worried about separation from her mother frequently, as well as worried about harm occurring to her mother. Thus, a diagnosis of separation anxiety disorder (SAD) was warranted. In addition, anxiety related to school and social situations significantly affected the client. She excessively sought reassurance

from others in social and school settings, was irritable, had difficulty sleeping, and experienced frequent somatic symptoms. Despite these symptoms, she did not meet full criteria for generalized anxiety disorder (GAD) as the symptoms had only been impacting functioning for approximately three months. Thus, a secondary diagnosis of Anxiety Disorder NOS was assigned. Included in the referral was a concern regarding depressive symptoms. However, the client did not meet criteria for a depressive disorder based upon structured interviews and questionnaires.

Baseline data

At baseline, several self-report and parent questionnaires were administered. The client completed the Children's Depression Inventory and she only endorsed one item, placing her in the normal range. She also completed the Multidimensional Anxiety Scale for Children and her score was elevated on several dimensions, including separation anxiety ($T = 59$) and harm avoidance ($T = 59$). Although the separation anxiety score is only slightly elevated, it may be indicative of her wanting to please others (e.g. picking the "right" answers) or that as a young child, she may have had difficulty self-reflecting on these behaviors. On the Child Behavior Checklist, the client's mother reported behavioral difficulties with anxiety/depression ($T = 78$), withdrawn ($T = 60$), thought problems ($T = 71$), and aggression ($T = 60$). For the broad band scales, the internalizing ($T = 70$) and total ($T = 63$) scores were in the clinical range.

Course of treatment

The client was seen for a total of 20 therapy sessions. Treatment was provided on a weekly, outpatient basis over a period of seven months. The guiding manuals for treatment were Kendall's Coping Cat Treatment Manual (Kendall, 2000) as well as Rapee, Wignall, Hudson, and Schnieiring's (2000b) book on treatment of anxiety disorders.

Sessions 1–2: Psychoeducation

Sessions 1 and 2 were conducted with both the client and her mother. The first session was primarily devoted to describing the cognitive-behavioral model of anxiety, procedures for therapy, and the rationale for choosing CBT. In particular, the connections between thoughts, feelings, and behaviors were explicitly described, making use of visual representations to aid in understanding. Both the client and her mother appeared to understand the model and rationale for choosing CBT. Education regarding basic emotions (e.g., sad, scared, mad, happy) and how to differentiate among these feelings was provided. This discussion was supplemented through the use of modeling (e.g. anxious face) and age appropriate pictorial

representations. In addition, an emotion thermometer was explained to the client to enhance communication regarding the intensity of her fears. Education about anxiety in general was also discussed using a picture of a body and having the client draw her common somatic reactions.

Session 3: Relaxation techniques

Session 3 was devoted to relaxation techniques, primarily deep breathing, progressive muscle relaxation, and pleasant mental imagery. An audiotape of these procedures was made for the client to take home and use for practice of these skills. The client appeared to enjoy learning these skills and noted that she felt more relaxed after this session. The client was asked to practice these techniques each day with the accompaniment of the audiotape and to monitor on a written schedule if improvement in anxiety occurred. Additionally, at this session, behavioral contracts were discussed. These contracts were utilized throughout treatment to develop clear behavioral expectations, to reward non-anxious behavior, and were developed collaboratively with the client and her mother. More specifically, this session's behavior contract entailed the time of transition during separation from mother, which was currently taking at least a half an hour. In the contract developed, the client had a maximum of 15 min to leave the house once her father arrived in order to earn her desired reward, and each subsequent session we reduced the amount of time for separation until she eventually was leaving as soon as her father arrived. For these sessions and throughout treatment, homework compliance was quite high, and only on a few occasions was the homework not fully completed.

Sessions 4–5, 7: Cognitive restructuring

The next several sessions consisted of an explanation of cognitions and development of more helpful ways of thinking. The client came up with adaptive self-statements she could use in a variety of situations. The client identified situations in which she generally used unhelpful thinking, and realistic, positive coping statements for each situation were identified. For example, she frequently worried about test performance despite having adequate preparation and cognitive ability. The coping statements that she generated for this situation included, "I studied for this test," and "Most of the time I do well on tests." Related to the separation anxiety, the client generated statements such as "I will be back to mom's house soon." The client was also taught to use detective thinking (Rapee et al., 2000b), a developmentally appropriate method of cognitive restructuring. This technique teaches the client to determine the evidence for her thoughts, and evaluate how probable the outcome is that she is worrying about. The client

began to use her coping statements frequently and generated new statements throughout therapy.

Additionally, at each of these sessions and throughout the rest of treatment, new behavior contracts were established. Sessions 3 through 6 targeted separation behaviors, which were greatly improved by the fourth week of using a behavioral contract. Improvement was measured by parent report of her behavior during the separation episodes; primarily that the client separated more quickly, and decreased her crying and clinging to the mother. At session 7, the behavior contracts shifted focus to other anxiety symptoms. For example, reassurance seeking at bedtime and irritability directed toward her younger sibling were identified as problematic. Reassurance seeking was targeted by laying out a clear bedtime routine, and the irritability was targeted by rewarding appropriate behavior, such as using nice words and playing a game with her sibling.

Sessions 6, 13: Parent sessions

Over the course of treatment, several individual parent sessions were held. The purpose was to review treatment progress and techniques with the client's mother and to get a report on the client's symptoms and functioning. At session 6, we also reviewed a book written specifically for parents on child anxiety (Rapee, Spence, Cobham, & Wignall, 2000a). The client's mother was receptive to feedback and appeared willing to make environmental changes that would decrease the client's avoidance of anxiety provoking situations and would provide rewards for non-anxious behavior. Additionally, we discussed detective thinking, and how the mother could help when the client was overestimating events or catastrophizing. The mother agreed to finish reading the Rapee et al. (2000a) book throughout treatment and we continued to discuss how she could be helpful in supporting the use of the skills her daughter was learning and practicing.

Sessions 8–12, 14–15: Exposure and social skills

A standard rationale for exposure was provided to the client and her mother. It was explained that avoidance of fear related situations maintains one's fears and that by confronting feared situations; one will have the opportunity to learn that the feared outcome is unlikely to occur. To facilitate *in vivo* exposure, a fear hierarchy of least to most feared situations was constructed. During each exposure, anxiety was monitored before, during, and after using the emotion thermometer. Items on the client's hierarchy, in order of least to highest anxiety, were leading a group, approaching a new person, new situations, and test taking. Exposure began with the least feared situation, leading a group. In this session, the client lead the therapist in the relaxation skills previously taught. This activity provoked high levels of anxiety in the

client; however she successfully completed the task. Afterward, during a discussion of the experience, the client noted that she felt positive about being able to complete the task and that by the end of the exposure her anxiety decreased. For *in vivo* homework, the client led two separate activities during family time. We continued to gradually move up the hierarchy when the client, parent, and therapist felt each situation was mastered (typically one per session) both in session and through *in vivo* homework.

Since many of the feared situations were related to social situations, we spent a session reviewing social skills. This included communication techniques, including asking open-ended questions, and approach behaviors, including how to break into a group. *In vivo* activities consisted of exposure to social situations and general "new situations." For example, role-plays of a soccer practice were conducted since she would soon be starting a new team and had been worrying about this event for several weeks. In session, she practiced approaching the therapist multiple times in an outdoor venue complete with soccer balls. Initially, she had difficulty initiating and maintaining conversation; however after repeated exposure she improved her conversation skills and decreased her anxiety. Homework following this session was for her to approach two new children at her first soccer practice the upcoming week, which she successfully completed. Homework assignments typically followed from the exposure activity conducted during the session.

These exposure sessions resulted in rapid improvement in a variety of anxiety symptoms. The client and her mother reported less social anxiety, as well as decreased time spent worrying over school achievement. These reductions translated to more experiences with adaptive social interactions (e.g. at soccer practice and recess) and less reassurance seeking and avoidant behaviors related to homework and social situations. By parent report, the client began to initiate social interactions without their prompting.

Sessions 16–20: Relapse prevention and termination session

In order to address relapse prevention (RP), the client and therapist spent four sessions reviewing helpful strategies, identifying stressors, preparing for them, and anticipating a relapse. The explicit goal for these four sessions was to construct a RP book. Prior to the start of these sessions, the therapist collected papers that were produced by the client or therapist throughout treatment. For example, a picture of the emotion thermometer and a picture of the human body with the client's somatic anxiety reactions that were previously written up were collected from the client's chart. At each RP session, a review of strategies the client learned and if applicable, a brief practice of the skill (e.g. relaxation) would take place. The book consisted of several sections,

which mirrored the phases of therapy, the chapters were as follows: rationale/psychoeducation, tools learned throughout treatment, and planning for the future.

At the first RP session, the rationale for making a RP book was discussed. It was explained to the client and her mother that this book would help the client to anticipate future stressors as well as manage her anxiety in the future. Additionally, we discussed the definitions of a lapse and relapse ensuring that the client and her mother understood that anticipating a relapse can be a good tool to prevent future overwhelming episodes of anxiety (Westra, 2003).

The first section of the book, which the client entitled the “Help Book,” was on treatment rationale and affective education. We reviewed the model of cognitive-behavioral treatment of anxiety, basic pictures of different feelings, how anxiety affects the body, an emotion thermometer, and an introduction to self-talk (e.g. pictures of children in a variety of situations with thought bubbles). While some of these forms were made specifically for the purposes of inclusion in the Help Book, several were saved from the early sessions and did not need to be reproduced. For example, the emotion thermometer and corresponding anxiety provoking situations completed at session 3 was kept in the client’s chart, and a post-exposure thermometer, highlighting the decreases in anxiety in these situations was completed. This provided a concrete reminder for the client that over a 50% reduction in her rating of anxiety in those situations was achieved, which also fostered a sense of accomplishment.

The second section of the book consisted of all coping skills learned during treatment. The skills included cognitive tools, such as coping statements, relaxation techniques, including steps of deep breathing and muscle relaxation, and how to develop a behavioral chart. Additionally, a page of “friend tools” was written by the client, which included the social skills that were included during the exposure phase of treatment. Each coping skill included a general explanation, when to use the skill, and the client’s generated statements or examples for specific anxiety-provoking situations. Each page in this section was hand-written by the client during the session and for homework, she went back through each page and added decorations (e.g. stickers, borders).

The final section of the book was titled “planning for my future.” In this section, the client and therapist collaboratively identified potential future stressors that may produce anxiety given that these situations had been difficult prior to treatment. For each of the future stressors, the client identified which tool would be most helpful to use in that situation or in preparing for that stressor. Finally, a list of coping skills that were her favorites was compiled and provided a quick reference sheet (titled “Tip Sheet”) as the last page of the book. This Tip Sheet included the client’s summary statements of treatment such as “take a deep breath,” “think positive,” and “face your fears.”

Each section was decorated with markers and stickers, using color printer paper. The book was bound at a copy store for a minimal price (\$2.00). The client’s homework after each of the RP sessions was to review the section with her parents and personalize the pages with drawings or other decorations. Each new RP session consisted of the client describing the chapter that had been completed at the prior session to ensure her comprehension of each skill. At the final RP session, the client’s mother attended so she could listen to the client review the book and have a final overview herself of the skills. Additionally, at this session, we discussed anticipating trouble spots (e.g. new school year) and reviewed with the client and her mother the coping skills to use if these trouble spots did cause moderate to high levels of anxiety.

The final session of treatment (session 20) was a graduation party designed to review the relapse prevention book and to recognize the gains achieved during treatment. The client was in charge of reviewing and explaining the book for the purpose of additional repetition and to ensure her understanding of the concepts. We reviewed the symptom reduction in the client as measured by parent and child verbal report, and she and her mother felt proud of the client’s accomplishments and progress made during therapy.

Outcome data—post-treatment

The Child Behavior Checklist, Children’s Depression Inventory, and the Multidimensional Anxiety Scale for Children (MASC) were re-administered at the final treatment session. On the Child Behavior Checklist and the Children’s Depression Inventory all scores were in the normal range. Finally, on the MASC, the client reported minimal levels of anxiety symptoms. In particular, her T score on harm avoidance decreased 22 points (59–37).

The client demonstrated improvements in her ability to separate from mother, increased confidence in social situations, and decreased need to seek reassurance from adults. The client also appeared to have improved peer relationships as indicated by fewer arguments and increased invitations to peer activities. Finally, the client showed improvement in general cognitive processes evidenced by her frequent use of coping statements particularly related to school concerns.

12-month follow-up

A brief follow-up was conducted with the client’s stepfather approximately one year post-treatment. The follow-up was conducted via verbal communication from the stepfather to the therapist. The stepfather reported that the client was doing well and had not had any impairing anxiety symptoms since treatment termination.

Discussion

An comprehensive relapse prevention (RP) component was added to the treatment of a 9-year-old with comorbid Separation Anxiety and Anxiety Disorder NOS. A major focus of RP was the construction of a book, which consisted of the psychoeducation provided, all coping skills presented, and treatment related handouts (e.g. pictures of faces depicting different emotions). In addition, the RP phase provided ample opportunity for practice of skills, both in session and through homework assignments. Repetition is important in strengthening and consolidating skills and increasing the likelihood that skills will be generalized to other situations. While an enhanced RP phase has not specifically been shown to be a necessary ingredient in treatment outcomes for children diagnosed with anxiety disorders, it is potentially important in the maintenance of gains and helping the client deal with future recurrences of anxiety.

In the case presented here, the final sessions of treatment devoted to relapse prevention consisted of the major RP components discussed earlier: defining lapse and relapse, anticipating episodes of future anxiety, preparing for problem situations, and promoting generalization of coping skills (Overholser, 1998; Overholser & Nasser, 2000). The book created during these sessions provided for the client a sense of achievement and a reference tool to which she can refer to post-treatment. In terms of cost, it was quite minimal, requiring the use of markers, paper, and a nominal price to bind it at a copy store. These sessions may generally extend the length of CBT protocols, which can be problematic in an era of managed care. However, the number of sessions was within the range of many of the published randomized clinical trials (16–20) and it is likely that an enhanced RP component could be completed in fewer sessions, given adequate preparation and planning on the part of the therapist.

The idea for this technique was derived in part from Kendall's Coping Cat treatment (Kendall et al., 2000) which suggests the production of a commercial at the end of treatment authored by the child. It may be that a book produced by the child has advantages over this video format. One advantage is that a book may be more accessible to the child in the future. The child can access a book at any time and does not need access to a television and VCR. Another advantage is that the child can use the RP book in the privacy of their room, which may be important with older children and adolescents who do not share their episodes of anxiety with caregivers. Finally, the book is easily transported, particularly useful if the child would like to review the coping statements at an event that had previously resulted in overwhelming anxiety.

Several CBT manuals for children diagnosed with anxiety disorders contain at least one session devoted to relapse prevention (Chorpita, Taylor, Francis, Moffitt, & Austin, 2004;

Silverman et al., 1999a). The description of Chorpita et al. (2004) session on RP is similar to that described in this paper, including reviewing the tools learned during treatment and increasing the child's sense of accomplishment as a direct result of their efforts during treatment. However, empirical support for an enhanced, comprehensive RP component as described in this paper is lacking and is needed before inclusion of this treatment component is globally advocated for in the treatment of childhood anxiety disorders.

It is important to empirically evaluate the need for an enhanced relapse prevention component in the treatment of childhood anxiety. The use of a RP book was useful in this case and application of this method with other clients may be equally useful. Future directions for research in this area include evaluation of the specific techniques to enhance skill consolidation and generalization beyond therapy.

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