Cognitive Therapy with Children and Adolescents

A Casebook for Clinical Practice

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CHAPTER ONE

Working with Youth

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Précis: A Casebook with Empirically Supported Treatments?

Psychology has long striven to provide optimal care to those in need. A seminal meta-analysis (Smith & Glass, 1977) of the effects of psychological therapy summarized the findings to that date, and the findings allowed the authors to state that the results provided convincing evidence of the efficacy of psychological treatments. In retrospect, their work opened the door to an expanded focus on empirical support for psychological treatments and subsequently the degree to which psychological treatments are effective for children and adolescents (Weisz et al., 2017). Much has transpired over these 40 years.

Within a historical context, a great deal of research has been designed to answer the question, Does psychotherapy for children and adolescents work? As Kazdin (2000) noted, there were more than 1,500 published empirical studies of psychotherapy for youth as of his review in 2000, and we now know that psychological therapy for youth can be effective. Despite support for the efficacy of psychological therapy for children and adolescents, we are not yet at a point where we can definitively answer the question posed by Kiesler (1966) and reasked by Paul (1967): "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?" Research has, however, identified

specific treatment strategies that are effective for identifiable child and adolescent mental health problems. Indeed, this very volume offers a casebook with empirically supported treatments.

Is there an incompatibility in the phrase "casebook with empirically supported treatments"? A "casebook" connotes a series of theoretical details with illustrative and descriptive cases, whereas "empirically supported treatments" connotes a restricted list of science-evaluated therapies. Do these notions blend or stay separate? Are they compatible (or compatibull)? In fact, these seemingly incompatible concepts are very compatible. Indeed, in the chapters of this book you will find clinically rich theoretical material and descriptions of specific cases that have been treated with approaches that have evidence to support their use.

What are empirically supported treatments? An extended discussion of this important theme is beyond the scope of this volume, but a few important points merit consideration. Although one must acknowledge the somewhat arbitrary nature of determining the sufficiency of evidence required for the label "empirically supported treatment," the label is a meaningful indicator that scientific evaluations support the application of the treatment (Hollon & Beck, 2013).

The following labels are typically used (after Chambless & Hollon, 1998).

1. A *well-established treatment* has been supported either by (a) two or more quality group-design studies conducted by different investigators that have demonstrated efficacy by being superior to a pill placebo, psychological placebo, or another treatment and/or by being found to produce equivalent outcomes to a previously established treatment using studies with sufficient statistical power; or (b) a large series of single-case design studies that have demonstrated efficacy while using good experimental designs and by comparing the intervention to another treatment. In both, the studies must have specified the characteristics of the client samples and used treatment that was guided by manuals.
2. A *probably efficacious treatment* has been identified by (a) the presence of at least two studies demonstrating that the treatment is more effective than a waiting-list control group; (b) at least two studies otherwise meeting the well-established treatment criteria but with both having been conducted by the same investigator, or only one good study demonstrating effectiveness by established criteria; (c) two or more quality studies that demonstrate effectiveness but are flawed by the heterogeneity of the client samples; or (d) a series of single-case-design studies otherwise meeting the well-established treatment criteria but that is not yet large enough to be deemed well established.

3. Last, an *experimental treatment* is one that does not yet have enough sound data to be deemed at least probably efficacious.

When seeking to implement an intervention with children and adolescents, those that have met the "empirically supported" label merit first consideration. Indeed, they have met rigorous, yet reasonable, criteria. A recent development in the evolving terminology is the emergence of "evidence-based practice in psychology" (EBPP). Evidence-based practice seeks to integrate science and practice in terms of psychological assessment, conceptualization, and intervention.

Within this context, cognitive-behavioral therapy (CBT) emerges as an evidence-based treatment that also typically qualifies as an empirically supported treatment. It is beyond the scope of this opening chapter to review the extensive research that provides impressive support for a variety of versions of CBT with youth, but there are other sources (e.g., Kendall, 2012a; Weisz & Kazdin, 2017; Weisz et al., 2017) that can be consulted. The contents of the present volume, authored by experts with clinical experience, provides case materials and clinical strategies for the implementation of these evidence-based *and* empirically supported treatments.

On the Need to Be Developmentally Informed

Psychological treatments for children and adolescents are optimally effective when implemented with consideration of developmental factors. Consider these key areas: (1) initiating treatment, (2) age-appropriate delivery, (3) differing levels of cognitive, emotional, and social understanding, (4) roles for parents, and (5) therapist style.

Initiating Treatment

Children and adolescents, unlike adults, rarely initiate psychological services for themselves. In contrast, parents, pediatricians, teachers, or other agents of society are typical referral sources for youth. This "treatment entry" distinction is crucial: Children and adolescents may not be eager or willing to discuss their problems or be "involved" in sessions. Therapists working with youth must create an experience that encourages youth to return. A maxim that we follow is this: "A goal for Session 1 is that the child/adolescent returns for Session 2." Rapport-building activities, depending on the age of the youth, may include get-to-know-you-games, taking a walk or tour of the area, doing some online surfing, and engaging in activities of the youth's choice. Even when parents bring their children and adolescents to a family therapy clinic, they commonly are focused on the child as the problem (see Epstein, Schlesinger, & Kim, Chapter 12,

this volume), and the child may be reluctant to be there, not wanting to be criticized and blamed. A crucial initial task for the family therapist is to gain rapport with the child, demonstrating interest in his or her thoughts and feelings, minimizing the time that parents spend complaining about the child, and setting positive goals (including changes in the family that the child would desire).

Age-Appropriate Delivery

Fun activities can be an age-appropriate and effective way to facilitate the implementation of CBT for youth. Fun activities foster a collaborative relationship between client and therapist and can boost the learning of therapy content. Play activities can also be informative, allowing the therapist to observe the child's expectations and beliefs, as well as coping skills. Fun activities may include art projects, role plays, songs, board games, and computer time. For example, within the Coping Cat program for child anxiety (Kendall & Hedtke, 2006a, 2006b), therapists engage in a "body drawing" art activity that helps youth identify the locations where they feel their anxiety.

Computers are a contemporary delivery system for therapeutic content. Consider anxiety in youth, for example; for adolescents suffering with anxiety, there is the Cool Teens program (Cunningham et al., 2009), and for children ages 6–13 there is the Camp Cope-A-Lot (Kendall & Khanna, 2008) program that offers 12 modules with interactivities and challenges that foster coping and reduce anxiety (Khanna & Kendall, 2010).

Level of Cognitive, Emotional, and Social Understanding

Not all youth are comparably mature, so the implementation of any treatment, including CBT, requires knowledge about cognitive, emotional, and social development. A type of cognitive restructuring used with adults may not be understood by children; for example, a refutation of a personal belief might be taken as punitive rather than explorative. Children may not have the cognitive maturity or vocabulary to distinguish rational and irrational thoughts. By the same notion, they can label thoughts as "helpful or not helpful," or "sad or coping thoughts." The specific probabilities of anticipated outcomes may be difficult for youth, but children can understand that certain events have a "small" or "big" chance of happening, and they can be coached to gather evidence or "clues" about the possibility of an outcome occurring. Gosch, Brookland, and Wolensky (Chapter 4, this volume) illustrate the use of this process with a child experiencing fears of harm. Some parents use parenting techniques that are not appropriate for a child's developmental level (e.g., giving a young child complex rationales for desired behavior). The therapist needs to take development into account not only to guide his or her assessment and interventions but also to educate parents (see also Epstein, Schlesinger, & Kim, Chapter 12, this volume).

Therapists working with children and adolescents benefit greatly from an awareness of the ups and downs of typical normal development and the many and varied "temporary" issues that merit attention but perhaps not a diagnosis. Recognition of a developmental issue in social functioning, in cognitive ability, or in emotional understanding can trigger initial monitoring. Youth face social challenges at different points in their development; peer relationships and academic performance take on increased importance in adolescence. As needed, and when appropriate, developmental needs and social issues can become part of the goals of CBT. For example, see discussion of CBT for youth on the autism spectrum (Mercado, Kratz, Frank, Wolensky, & Kerns, Chapter 8, this volume) and eating disorders (Culbert, Anderson, Bowers, & Le Grange, Chapter 10, this volume).

Roles for Parents

For several reasons, including the fact that children and adolescents are not fully independent, it is critical to consider the role of parents when treating youth. Parents can serve as *consultants* (e.g., providing information about symptoms and impairment), *collaborators* (e.g., bringing their children to treatment, assisting with implementation of therapy techniques), or *co-clients* in the treatment itself (Kendall, 2012b; Epstein et al., Chapter 12, this volume; Rowe & Liddle, Chapter 7, this volume).

The nature and benefits of including parents in CBT for youth vary depending on the specific problem and the child's age (e.g., Culbert et al., Chapter 10, this volume). Younger children may benefit more when parents are involved from the beginning, whereas adolescents may accrue more gains when parents are not regularly included in treatment. Some treatments for disruptive behavior problems involve parent training as a core component of treatment and thus require parental involvement. On the other hand, CBT for child anxiety can be implemented in a child-focused format and, with adolescents, with less parental involvement. Despite the variations in the roles for parents in treatment, there remain the benefits that can be gained from parent education about child development, mental health, and coping strategies. For example, Child Anxiety Tales, an online parent-training program for parents with anxious children (see *www.CopingCatParents.com*), can be an early step in a stepped-care approach to addressing the problem.

Therapist Style

When working with children and adolescents, the CBT therapist fills multiple roles, including diagnostician, consultant, and educator. As

diagnostician, the therapist uses multimethod, multi-informant assessment of the youth's symptomatology and functioning in multiple domains to create a case conceptualization. As a consultant, the therapist works with the youth and parents (and potentially others) to share perspectives and select treatment goals. As an educator, the therapist provides information about the disorder and the course of treatment. It can be helpful to view the therapist's role as that of a *coach* (Kendall, 2012b; Podell et al., 2013) for the youth (not the mean and screaming coach, but the coach who teaches and provides opportunities to learn and perform). The coaching analogy helps communicate that the therapist will provide information, provide opportunities to learn, teach coping skills, and provide opportunities to practice the use of coping skills in real situations. And the same is true in family approaches, in which the key parties are in the room together (see Epstein et al., Chapter 12, this volume).

Illustrative Components in Effective Psychological Treatments for Youth

As you will see in this casebook, many of the main components of effective treatments for children and adolescents reappear, with appropriate adjustments, in the procedures used for different social, behavioral, cognitive, and emotional problems (see also Ehrenreich-May & Chu, 2014; Nangle et al., 2016). Some of the core strategies are also similar to those used with adults, but visual aids, fun activities, and age-appropriate metaphors help make the concepts accessible for youth. Several illustrative treatment components (i.e., problem solving, affective education, cognitive change, modeling and role playing, behavioral contingencies, and relaxation) are described, but note that this list is not exhaustive and that the components are not isolated or applied solely on their own; they are interconnected and build upon one another.

Problem Solving

The problem-solving process generates potential solutions to a dilemma and systematically determines the most effective response (D'Zurilla & Goldfried, 1971). Core problem-solving strategies for children and adolescents (see Anastopoulos, O'Rourke, & Bray, Chapter 9, this volume; Culbert et al., Chapter 10, this volume) are generally consistent with those used with adults (Nezu, Nezu, Friedman, Faddis, & Houts, 1998) and in families (Epstein et al., Chapter 12, this volume). Youth are introduced to a series of steps that they refer to when they identify a problem. For children, the problem-solving steps may be made into an acronym to facilitate learning. For example, a treatment for youth with aggression called

Keeping Your Cool uses the acronym SPEAR (Nelson & Finch, 2008). The SPEAR sequence consists of Stop: what's the problem? (understanding the situation); Plan: what can I do? (generating solutions); Evaluate: what is the best solution? (choosing a plan of action); Act: try it out; React: did it work? (self-evaluation). Other treatments use variations of the same fundamental problem-solving steps and tailor them to a specific disorder. Initially, the therapist helps the child generate solutions and process the outcome of selected strategies. As youth repeat the problem-solving process and apply it to a variety of situations, they learn to think ahead and better resolve future problems (Gosch, Flannery-Schroeder, Mauro, & Compton, 2006).

Problem solving has been incorporated into treatments targeting a variety of child and adolescent mental health problems. Youth with aggression tend to believe that their aggressive behavior is instrumental toward achieving a desired goal (Lochman & Dodge, 1994). An important part of engaging aggressive children in problem solving is helping them to recognize the advantages and disadvantages of each potential plan of action and to choose one with a reasonable outcome (see Lochman, Powell, Boxmeyer, & Jimenez-Camargo, 2011; Mitchell, Pardini, & Lochman, Chapter 6, this volume). Problem solving is a balanced approach that acknowledges the potential benefits of an unproductive or impractical solution, as well as the benefits of a more appropriate solution. In problem solving, the therapist validates the child's experience while also showing that problems can have several potential solutions (see the example for generalized anxiety disorder in Gosch et al., Chapter 4, this volume). It is also illustrative of the collaborative/coach style that is effective with youth. Treatments for aggressive children focus on developing nonaggressive strategies to express anger and alternative means to achieve a desired goal.

Problem solving has also been used with impulsive children (Kendall & Braswell, 1993). The components resemble those from other protocols with the addition of a step to maintain focused attention. For children with depression, problem solving (Stark, Streusand, Arora, & Patel, 2012) may require added attention to negative affect and thoughts that may be an obstacle preventing the youth with depression from taking action. Children are encouraged to do something pleasurable to improve mood and to facilitate problem solving. Therapists may need to pay special attention when youth with depression disqualify potential positive outcomes after a problem-solving strategy has been used effectively (Curry & Meyer, Chapter 5, this volume). Across target problems, considering unorthodox and even silly potential solutions is a welcomed part of brainstorming potential solutions with youth: They add fun to the process and constitute examples of solutions that can be eliminated. Deriving silly solutions to problems adds humor to the setting and highlights the sensibility of other solutions.

Learning about Feelings

Youth are not known for their grasp of the emotional side of their lives. Affective education helps the child recognize, differentiate, and express emotion. Affective education is implemented to be consistent with the youth's presenting problem and the stage of treatment. For example, for a teen who has reached a level of metacognitive development and thinking about his or her own thinking, sad experiences can become the grist for rumination. Therapists can help reduce this problem by, as appropriate, normalizing the youth's experience of sadness: A teen can be told that happiness and sadness are normal emotions experienced by everyone (including adults) but that, when they are too intense or too frequent, they need to be "adjusted."

Youth are taught to distinguish among emotional states. The therapist and young child client might cut out pictures of people from magazines and label their emotions. The labeling can be accomplished based on the situation in the picture and the facial expressions of the character. The labeling exercise can also include discussion about how the feeling might be different if the situation were different or if the child thought about the situation differently. Another option, perhaps for older youth, would be to play "feelings charades," in which the therapist and youth alternate acting out and guessing various emotions. It's not a teacher teaching emotions ("teachy" therapist style) but a collaborative interaction (Creed & Kendall, 2005; Podell et al., 2013) around the content of feelings. Indeed, in cases in which the youth takes off and runs with aspects of the affective education, the therapist can take a back seat.

Learning how to identify one's own physiological cues of emotional distress or arousal is part of affective education. Recognition of a trigger for anger or aggression or a bodily marker of emotional distress can then signal the child to stop and think and use problem solving. To raise physiological awareness, a youth may draw a picture of his or her body and highlight the parts that are active when emotionally charged (e.g., tightened face when angry; "butterflies" in the stomach or sweating palms when nervous). Youth and/or therapists can create a "feelings thermometer" to represent the range of a particular emotion, and the thermometer is then used as a visual aid to help children better comprehend the varying intensity of negative emotions (Lochman et al., 2011). For example, when children with depression reach a particular threshold on their "mood thermometer," they are encouraged to do something they enjoy (Stark et al., 2012). The thermometer can help reveal common triggers that elicit a particular negative emotion, and the mere construction of the thermometer can provide an opportunity for building rapport. Younger children often enjoy decorating and personalizing their feelings thermometer.

Changing Self-Talk (the Inner Dialogue)

Within the cognitive model, dysfunctional and distorted thoughts (self-talk) mediate the relationship between stressful life events and psychopathology (Beck, 1976). Within depression (see Curry & Meyer, Chapter 5, this volume), cognitive distortions refer to negative misperceptions about oneself, the world, or the future. Children with a variety of disorders display distorted thinking (Crick & Dodge, 1996; Kendall, 1993), and there are data to suggest that the content of the negative self-talk reflects the specific psychopathology. For example, a core cognitive feature in depression includes attribution of negative events to internal, stable, and global characteristics of the self and attribution of positive events to external, unstable, and specific causes. Externalizing disorders, on the other hand, are associated with distorted processing of ambiguous situations, such as angry youth seeing ambiguous situations as hostile and provocative (Lansford et al., 2006; Yaros, Lochman, Rosenbaum, & Jimenez-Camargo, 2014) and potentially requiring retaliation. Changing self-talk (also referred to as "cognitive restructuring") refers to the process of helping youth to see alternate ways to make sense of experiences. The process involves identifying distorted beliefs and/or negative self-talk, connecting thoughts to feelings and behaviors, challenging the validity of the thoughts and beliefs with evidence, and developing new and helpful patterns of thinking. This process plays a key role for traumatized youth, in which their cognitive distortions about the safety of the world can either be reaffirmed or shattered. The evidence comes from the youth's experiences in behavioral experiments and in exposure tasks both in and out of session. Given the importance of developmental level in matters that concern self-talk, this strategy is modified depending on the age and presenting problem of the child.

Children learn to recognize some of their unfounded negative thoughts early in cognitive restructuring. In one exercise, children are presented with various cartoons of people in ambiguous situations. Children fill in a blank thought bubble above the character's head to express the thoughts (Kendall & Hedtke, 2006a). After the child has identified the thoughts of others, the therapist can inquire about what is in the child's own thought bubble. For homework, children keep a journal, record their thoughts, and note the situation and their accompanying emotion. This self-monitoring exercise helps children become aware of the link between thoughts, feelings, and behaviors. The therapist can also take time to identify a situation from the child's life, write down thoughts, feelings, and behaviors, and review how the three components are interconnected. Integrating the mood thermometer into the discussion of thoughts (self-talk) is another way to show that emotions and thoughts influence one another.

After identifying maladaptive self-talk, children move on to challenging

their thoughts and beliefs and eventually developing coping thoughts. Children can become "thought detectives" who objectively evaluate the validity of self-talk. The therapist and child examine maladaptive thoughts and ask, "What is the evidence for that?" or "What's another way of looking at it?" The latter question can be helpful for aggressive children who misinterpret ambiguous social cues as having hostile intent. In "decatastrophizing," the therapist asks, "If a feared or nonpreferred outcome happens or if your thought is true, so what?" By exploring the worst-case consequences of some thoughts, the child learns that he or she can very likely cope with the situation. A child learns to identify "thinking traps." Thinking traps, adapted from Beck's cognitive errors for adults (Beck, 2011), include mind reading (knowing what others are thinking), fortune telling (being certain about an ambiguous future event), and black-and-white thinking (dichotomizing things on a continuum), among others. Finally, therapists and children collaborate to develop coping thoughts. An aggressive child might try, "It may have been an accident; I won't get angry until I learn more"; or an anxious child might think, "I tried it a few times, and did OK, so I may do OK when I try it again."

Although not a formal component of cognitive restructuring, several treatments "externalize" the disorder. The idea is for the youth to realize that his or her symptoms do not define who he or she is but represent something to be managed or addressed. "Externalizing" reduces self-blame and distances the child from negative thoughts. A treatment for depression externalizes the collective symptoms into the "muck monster" (Stark et al., 2012). The child draws a picture of the monster and can direct his or her coping statements at it. In treating obsessive–compulsive disorder (OCD; see also Franklin, Morris, & Budzyn, Chapter 3, this volume), children name their symptoms (e.g., "stupid thing"), and a treatment goal is to reclaim control by "bossing back OCD" (March & Mulle, 1998).

Modeling and Role Playing

Modeling, a form of observational learning, allows a child or adolescent to acquire a new skill or improve on an existing one by viewing the behavior of others (despite receiving no explicit reinforcement). Modeling exemplifies social learning theory, in that individuals learn through observation in addition to direct experience (Bandura, 1977). Several types of modeling exist, including covert, filmed, live, and participant-guided modeling. Covert modeling strategies have the child imagine the therapist or another model dealing with a difficult situation. Children can visualize a model (a cartoon character, superhero, or celebrity), in addition to the therapist. In filmed modeling, children might watch a video, whereas in live modeling the therapist might demonstrate a behavior for a child. In some protocols, same-age peers proficient in a particular behavior serve as live models (e.g., Beidel, Turner, & Morris, 2000). In guided modeling, the therapist interacts with the child as they navigate the situation. Research has supported the benefits of participant-guided modeling.

Role-play activities provide a safe environment in which to practice new skills. In a role play, the therapist and child typically act out a scenario in which the child faces a challenge and uses problem-solving and coping skills. Role plays simulate real-life situations (see Rowe & Liddle, Chapter 7, this volume). They do not provide the real-life consequences, but they do provide the opportunity for therapist feedback. For example, the therapist could pretend to be the child's friend who is experiencing negative thoughts (Deblinger & Heflin, 1996). The child's task is to be a good friend and help his or her friend to challenge the negative thoughts. With practice and feedback, the child can internalize the skills and challenge his or her own thoughts. Similarly, children who have experienced trauma benefit from writing narratives about their traumatic experiences and, through repetition, reducing the anxiety caused by the memory of the trauma.

Behavioral Contingencies

Behavioral contingencies include positive reinforcement, shaping, and extinction. Contingency management strategies promote targeted behavior and encourage treatment compliance. Research has found that reductions in children's conduct problems following intervention occurs in part because of intervention-produced improvements in parents' abilities to be consistent in providing consequences (Lochman & Wells, 2002). Often, the initial reinforcers are tangible, whereas later in treatment they may be social or self-chosen rewards. It is important that rewards reflect the developmental level of the child: Younger children may require concrete and frequent rewards (Crawley et al., 2010). However, rewards do not necessarily have to be large or material. Getting to be the person who chooses the meal for a family dinner, earning computer time, or spending time alone with a parent can all be effective rewards. In addition, therapists can print certificates of achievement to increase self-esteem and motivation after the child successfully completes a task. The certificate provides an opportunity for children to brag about their accomplishments to others, which in turn is reinforcing. Separate from the specific reinforcer, it is important that the reward be contingent and meaningful to the child.

In many of the empirically supported programs for youth, parents play a role and are taught how to use behavioral contingencies. Parents are taught to be consistent in their implementation and, depending on the age of the child, may be encouraged to set up a sticker chart or other system to track the child's progress. Effort and partial success are always rewarded (for family therapy, see Epstein et al., Chapter 12, this volume), particularly in children who have perfectionistic tendencies (Kendall & Suveg, 2006).

Relaxation

Relaxation training has been incorporated within some protocols to treat children. Youth can be taught to use relaxation as a means to reduce and/or cope with stress. Debate exists regarding the benefits of relaxation training, as well as the precise mechanism accounting for the effects of relaxation, with some researchers arguing that the process helps children regulate emotional and physiological responses to negative life events (Gosch et al., 2006), whereas others theorize that its effects are due to cognitive changes, such as increased self-efficacy and control (Conrad & Roth, 2007). There is also controversy regarding the necessity of relaxation training within some treatments for children. Some research on treatment of anxiety suggests that CBT may remain effective without relaxation training (Hudson & Rapee, 2000; Peris et al., 2015; Rapee, 2000). Although its centrality varies, relaxation is often a feature in programs targeting a variety of disorders in children.

Epilogue

As you enter this volume, you will find wise theoretical guidance, rich clinical descriptions, and lively case illustrations, all of which will add meaningful flesh to the initial bones described in this opening chapter. Consistent with optimizing practice, the cases and treatment procedures are both (1) organized by the nature of the primary presenting problem and (2) qualified as evidence-based and empirically supported. Enjoy.

References

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York: Guilford Press.

Beidel, D. C., Turner, S., & Morris, T. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology, 68,* 1072–1080.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7–18.

Conrad, A., & Roth, W. (2007). Muscle relaxation therapy for anxiety disorder: It works but how? *Journal of Anxiety Disorders, 21,* 243–264.

Crawley, S., Podell, J., Beidas, R., Braswell, L., & Kendall, P. C. (2010). Cognitive-behavioral therapy with youth. In K. S. Dobson (Ed.), *Handbook of cognitive-behavioral therapies* (3rd ed., pp. 375–410). New York: Guilford Press.

Creed, T., & Kendall, P. C. (2005). Empirically supported therapist relationship building behavior within a cognitive-behavioral treatment of anxiety in youth. *Journal of Consulting and Clinical Psychology, 73,* 498–505.

Crick, N. R., & Dodge, K. A. (1996). Social information-processing mechanisms on reactive and proactive aggression. *Child Development, 67,* 993–1002.

Cunningham, M., Wuthrich, V., Rapee, R., Lyneham, C., Schniering, J., & Hudson, J. (2009). The Cool Teens CD-ROM for anxiety disorders in adolescents. *European Child and Adolescent Psychiatry, 18,* 125–129.

Deblinger, E., & Heflin, A. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach*. Thousand Oaks, CA: SAGE.

D'Zurilla, T., & Goldfried, M. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78,* 107–126.

Ehrenreich-May, J., & Chu, B. (Eds.). (2014). *Transdiagnostic treatments for children and adolescents: Principles and practice*. New York: Guilford Press.

Gosch, E. A., Flannery-Schroeder, E., Mauro, C. F., & Compton, S. N. (2006). Principles of cognitive-behavioral therapy for anxiety disorders in children. *Journal of Cognitive Psychotherapy: An International Quarterly, 20,* 247–262.

Hollon, S. D., & Beck, A. T. (2013). Cognitive and cognitive behavioral therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavioral change* (6th ed., pp. 447–492). New York: Wiley.

Hudson, J., & Rapee, R. (2000). *Treating anxious children and adolescents: An evidence-based approach*. Oakland, CA: New Harbinger.

Kazdin, A. E. (2000). Developing a research agenda for child and adolescent psychotherapy. *Archives of General Psychiatry, 57,* 829–835.

Kendall, P. C. (1993). Cognitive-behavioral therapies with youth: Guiding theory, current status, and emerging developments. *Journal of Consulting and Clinical Psychology, 61,* 235–247.

Kendall, P. C. (Ed.). (2012a). *Child and adolescent therapy: Cognitive-behavioral procedures* (4th ed.). New York: Guilford Press.

Kendall, P. C. (2012b). Guiding theory for therapy with children and adolescents. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (4th ed., pp. 3–24). New York: Guilford Press.

Kendall, P. C., & Braswell, L. (1993). *Cognitive-behavioral therapy for impulsive children* (2nd ed.). New York: Guilford Press.

Kendall, P. C., & Hedtke, K. (2006a). *Coping Cat workbook* (2nd ed.). Ardmore, PA: Workbook.

Kendall, P. C., & Hedtke, K. (2006b). *Cognitive-behavioral therapy for anxious children: Therapist manual* (3rd ed.). Ardmore, PA: Workbook.

Kendall, P. C., & Khanna, M. (2008). *Camp Cope-A-Lot: The computer-assisted Coping Cat program*. Ardmore, PA: Workbook.

Kendall, P. C., & Suveg, C. (2006). Treating anxiety disorders in youth. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (3rd ed., pp. 243–294). New York: Guilford Press.

Khanna, M., & Kendall, P. C. (2010). Computer-assisted cognitive-behavioral therapy for child anxiety: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 78,* 737–745.

Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin, 65,* 110–136.

Lansford, J., Malone, P., Dodge, K., Crozier, J., Pettit, G., & Bates, J. (2006). A 12-year prospective study of patterns of social information processing

problems and externalizing behaviors. *Journal of Abnormal Child Psychology, 34,* 715–724.

Lochman, J. E., & Dodge, K. A. (1994). Social-cognitive processes of severely violent, moderately aggressive, and nonaggressive boys. *Journal of Consulting and Clinical Psychology, 62,* 366–374.

Lochman, J. E., Powell, N., Boxmeyer, C., & Jimenez-Camargo, L. (2011). Cognitive-behavioral therapy for externalizing disorders in children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 20,* 305–318.

Lochman, J. E., & Wells, K. C. (2002). Contextual social-cognitive mediators and child outcome: A test of the theoretical model in the Coping Power Program. *Development and Psychopathology, 14,* 971–993.

March, J., & Mulle, K. (1998). *OCD in children and adolescents: A cognitive-behavioral treatment manual.* New York: Guilford Press.

Nangle, D. W., Hansen, D. J., Grover, R. L., Kingery, J. N., Suveg, C., & Contributors. (2016). *Treating internalizing disorders in children and adolescents: Core techniques and strategies.* New York: Guilford Press.

Nelson, M., & Finch, A. J. (2008). *Keeping your cool: The anger management workbook.* Ardmore, PA: Workbook.

Nezu, A., Nezu, C., Friedman, S., Faddi, S., & Houts, P. (1998). *Helping cancer patients cope: A problem-solving approach.* Washington, DC: American Psychological Association.

Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology, 31,* 109–118.

Peris, T., Compton, S., Kendall, P. C., Birmaher, B., Sherill, J., March, J., et al. (2015). Trajectories of change in youth anxiety during cognitive-behavior therapy. *Journal of Consulting and Clinical Psychology, 83,* 239–252.

Podell, J., Kendall, P. C., Gosch, E., Compton, S., March, J., Albano, A. M., et al. (2013). Therapist factors and outcomes in CBT for anxiety in youth. *Professional Psychology: Research and Practice, 44,* 89–98.

Rapee, R. (2000). Group treatment of children with anxiety disorders: Outcome and predictors of treatment response. *Australian Journal of Psychology, 52,* 125–129.

Smith, M., & Glass, G. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32,* 752–760.

Stark, K., Streusand, W., Arora, P., & Patel, P. (2012). Childhood depression: The ACTION treatment program. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (4th ed., pp. 190–233). New York: Guilford Press.

Weisz, J. R., & Kazdin, A. E. (Eds.). (2017). *Evidence-based psychotherapies for children and adolescents* (3rd ed.). New York: Guilford Press.

Weisz, J. R., Kuppens, S., Ng, M., Eckshtain, D., Ugueto, A., Vaughn-Coaxum, R., et al. (2017). What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications for science and practice. *American Psychologist, 72,* 79–117.

Yaros, A., Lochman, J. E., Rosenbaum, J., & Jimenez-Camargo, L. A. (2014). Real-time hostile attribution measurement and aggression in children. *Aggressive Behavior, 40,* 409–420.