

TARGETING PARENTAL OVERCONTROL
IN COGNITIVE BEHAVIOR THERAPY
FOR ANXIOUS YOUTH

A Dissertation
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
DOCTOR OF PHILOSOPHY

By
Alexandra L. Hoff
December 2017

Examining Committee Members:

Philip Kendall, Ph.D., Advisory Chair, Department of Psychology
Deborah Drabick, Ph.D., Examining Chair, Department of Psychology
Lauren Alloy, Ph.D., Department of Psychology
Elizabeth Gosch, Ph.D., Philadelphia College of Osteopathic Medicine
Richard Heimberg, Ph.D., Department of Psychology
Michael McCloskey, Ph.D., Department of Psychology

ABSTRACT

Many parent factors have been associated with child anxiety, and researchers have examined how parents may be most beneficially involved in cognitive behavior therapy (CBT) for anxious youth. Results have been mixed as to whether parent CBT, family CBT, and parent interventions addressing parental anxiety or overcontrol have an added benefit over youth-focused CBT. The present study compared (a) a parent group intervention targeting autonomy granting, (b) a parent CBT skills group, and (c) a parent support control group, all provided in conjunction with individual CBT for anxious youth ages 7 to 17. Randomly assigned group conditions, as well as variance in overall parent attendance across conditions, were examined as predictors of change in parenting behaviors and in child anxiety. No significant differences in youth anxiety outcomes were found across parent group conditions, and parental beliefs and involvement improved most for the support control group. However, youth whose parents attended more group sessions showed a significantly greater decrease in anxiety severity than youth whose parents attended fewer (0, 1) sessions, which was mediated by a significantly greater decrease in parental avoidance of child anxiety. The results suggest that additional parent participation in treatment may have an added benefit, even with an unstructured support group format, but do not offer clarity about the benefit of targeted interventions for parents.

TABLE OF CONTENTS

	Page
ABSTRACT.....	ii
LIST OF FIGURES.....	iv
LIST OF TABLES.....	v
CHAPTER	
1 TARGETING PARENTAL OVERCONTROL IN COGNITIVE BEHAVIOR THERAPY FOR ANXIOUS YOUTH.....	1
2 A REVIEW OF PARENTAL INVOLVEMENT IN PSYCHOSOCIAL TREATMENT FOR INTERNALIZING AND EXTERNALIZING DISORDERS IN YOUTH.....	53
3 SUPPLEMENTARY ANALYSES.....	109
REFERENCES CITED.....	117
APPENDIX	
A PROMOTING INDEPENDENCE AND AUTONOMY PARENT GROUP MANUAL.....	146
B CBT SKILLS FOR PARENTS: PARENT GROUP MANUAL.....	161
C PARENTING AN ANXIOUS CHILD SUPPORT GROUP MANUAL.....	179

LIST OF FIGURES

	Page
FIGURE	
1 CONSORT Diagram for Study Enrollment, Randomization, and Attrition.....	35

LIST OF TABLES

	Page
TABLE	
1 Pre-Treatment Sample Demographics across Treatment Conditions.....	36
2 Pre-Treatment Sample Demographics across Low and High Parent Group Attendance.....	38
3 ANCOVAs for Parenting Behavior Outcomes by Parent Group Condition, with Child Gender and Social Phobia Diagnosis as Covariates.....	39
4 ANCOVAs for Child Anxiety Outcomes by Parent Group Condition, with Child Gender and Social Phobia Diagnosis as Covariates.....	43
5 ANOVAs for Parent Behavior Outcomes by Parent Group Attendance.....	47
6 ANOVAs for Child Anxiety Outcomes by Parent Group Attendance.....	50
7 Treatment Studies for Externalizing Disorders Involving Parents.....	90
8 Treatment Studies for Internalizing Disorders Involving Parents.....	99
9 Linear Regressions of Change in Parenting Variables on Number of Parent Group Sessions Attended.....	109
10 Linear Regressions of Change in Child Anxiety Variables on Number of Parent Group Sessions Attended.....	110
11 Correlations Between Change in Parenting Variables and Change in Child Anxiety Variables.....	111

CHAPTER 1
TARGETING PARENTAL OVERCONTROL
IN COGNITIVE BEHAVIOR THERAPY FOR ANXIOUS YOUTH

Anxiety disorders generally emerge during childhood, and it is estimated that as many as 20% of youth are affected by distressing anxiety (Costello, Egger, & Angold, 2005; Ronald C. Kessler, Chiu, Demler, & Walters, 2005). In addition to its prevalence among youth, anxiety in childhood and adolescence is associated with psychosocial impairment, educational problems, and a heightened risk for later mood and substance use disorders (Langley, Bergman, McCracken, & Piacentini, 2004; Woodward & Fergusson, 2001). Left untreated, youth-onset anxiety disorders and their associated problems are likely to persist into adulthood (Benjamin, Harrison, Settapani, Brodman, & Kendall, 2013; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Wolk, Kendall, & Beidas, 2015). The importance of efficacious interventions for anxiety disorders in childhood and adolescence is clear.

Cognitive behavioral therapy (CBT) has been deemed a well-established and efficacious treatment for anxiety disorders in youth (e.g., Hollon & Beck, 2013; James, James, Cowdrey, Soler, & Choke, 2013; Reynolds, Wilson, Austin, & Hooper, 2012). CBT typically involves the teaching of coping skills such as problem solving and cognitive restructuring (change in self-talk), with graduated exposure to feared and avoided situations as a key component (e.g., Kendall et al., 2006). Several randomized controlled trials (RCTs) have provided empirical support for CBT's efficacy over an active education and support treatment (e.g., Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008), as well as pill placebo (e.g., Beidel et al., 2007; Walkup et

al., 2008). The results of these trials and others indicate that around 60% of youth demonstrate significant improvement following CBT alone, with as many as 80% showing improvement following CBT combined with sertraline (Walkup et al., 2008). Although these findings indicate that CBT is an efficacious treatment for anxious youth, not all youth benefit. Parent factors influencing the etiology, maintenance, and treatment of child anxiety disorders may be particularly important to consider in the improvement of outcomes for these youth.

Several parent characteristics have been associated with the etiology and maintenance of anxiety disorders in youth (for reviews, see Drake & Ginsburg, 2012; Ginsburg & Schlossberg, 2002; Wei & Kendall, 2014). Authoritarian and permissive parenting styles, for example, have been associated with heightened levels of anxiety in youth (Baldwin & Dadds, 2007). In addition, parents who demonstrate high levels of rejection and criticism of their children, especially of their expressed emotions, are more likely to have anxious children (Ginsburg & Schlossberg, 2002). Parents of anxious children have been observed to be more intrusive and as granting less psychological autonomy to their children than parents of non-anxious children (Siqueland, Kendall, & Steinberg, 1996). Parental anxiety may be an important factor in the development of child anxiety: a review indicated that up to 80% of anxious youth's parents are also anxious (Ginsburg & Schlossberg, 2002).

Certain behaviors on the part of anxious parents may be particularly influential in maintaining anxiety in their children. These parental behaviors include overinvolved and overprotective parenting, modeling of anxious behavior, and reinforcement or

accommodation of youth's own avoidance behaviors (Dadds, Barrett, Rapee, & Ryan, 1996; Drake & Ginsburg, 2012a; Ginsburg & Schlossberg, 2002; Hudson & Rapee, 2001; McLeod, Wood, & Weisz, 2007). Of the parenting behaviors and characteristics associated with child anxiety, the research findings indicate that parental overcontrol has the strongest association (Drake & Ginsburg, 2012a; Wei & Kendall, 2014). Meta-analyses indicate that the associations between child anxiety and parental overcontrol and its subdimensions, including overprotection, overinvolvement, and lack of autonomy granting, have moderate effect sizes that are significantly higher than effect sizes for other parenting characteristics (McLeod et al., 2007; van der Bruggen, Stams, & Bögels, 2008). Given that, during CBT for anxious youth, parents are involved in helping their children practice coping skills and exposure tasks between sessions, failing to address the parental factors that may influence child anxiety could inhibit treatment progress and outcomes. Indeed, Peris et al. (2012) reported that anxious youth in families with higher rates of conflict and parental blame were less likely to respond to CBT.

Widely used individual CBT programs for anxious youth include a few sessions in which the therapist meets with parents to discuss their role in treatment (e.g., Kendall, 2000). Several studies have examined the efficacy of treatments that include more extensive parental involvement. Two studies evaluated the efficacy of group CBT for youth anxiety that included a parent group CBT training component and found them to be efficacious compared to wait-list control groups (Shortt, Barrett, & Fox, 2001; Silverman et al., 1999). Other studies have directly compared CBT that included parent CBT training with CBT for youth only and obtained inconsistent results. Mendlowitz and

colleagues (1999) and Nauta and colleagues (2003) did not find added parent group training in CBT strategies to be advantageous over group CBT for youth alone in terms of anxiety reduction. However, the findings of other studies suggest that parent CBT training may have added benefit for anxious youth (Cartwright-Hatton et al., 2011; Schneider et al., 2013a). Studies investigating the added benefit of addressing parental anxiety and anxious modeling behaviors have also had mixed results. Some findings have suggested that addressing parents' anxiety symptoms, beliefs, and behavior is beneficial in the context of CBT for anxious youth (Cobham, Dadds, & Spence, 1998; Cobham, Dadds, Spence, & McDermott, 2010a; Lebowitz, Omer, Hermes, & Scahill, 2014; Smith, Flannery-Schroeder, Gorman, & Cook, 2014), but others did not find significantly better outcomes compared to youth-focused CBT (Hudson et al., 2014a; Kendall et al., 2008a; Waters, Ford, Wharton, & Cobham, 2009).

Given its strong association with child anxiety, parental overcontrol has potential as a target of parent training as part of CBT for anxious youth. A few recent studies of parent training that included components specifically addressing parental overcontrol produced mixed results. Two studies that did not find a significant added benefit of parent training that addressed parental overcontrol compared to typical individual or family CBT, even at 3-year follow-up, had small sample sizes that may not have had adequate power to detect effects (Barbara H. Esbjørn et al., 2015; Siqueland, Rynn, & Diamond, 2005; Walczak, Esbjørn, Breinholst, & Reinholdt-Dunne, 2016). In both studies, parental overcontrol significantly decreased, but the effect was no different for the family-based or the child-focused conditions (Esbjørn et al., 2014; Siqueland et al.,

2005). Two other interventions that addressed parental overcontrol along with parental anxiety and anxious modeling in a family-based format were not found to have added benefit compared to child-focused CBT, neither in terms of youth anxiety outcome nor parental anxiety-maintaining behaviors (Bodden et al., 2008; Jongerden & Bögels, 2015). However, one study that specifically investigated parental autonomy-granting and the reduction of intrusiveness as the main parenting targets of a family-based intervention did find significantly greater reduction in child anxiety than in individual CBT—and the result produced a large effect size (Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006). There was also a significant reduction in parental intrusiveness for the family-based condition, and preliminary analyses suggest that reduction in parental intrusiveness mediated child anxiety outcomes (Wood, McLeod, Piacentini, & Sigman, 2009). Based on the literature indicating that parental control has a strong association with child anxiety, it is worth further investigating whether focusing on elements of parental overcontrol, such as overprotection, intrusiveness, and lack of autonomy-granting, as specific targets of a parent training component of CBT for anxious youth, would result in reductions in these parenting behaviors and subsequent improved treatment outcomes for those youth. Specifically, is targeting parental overcontrol the optimal way to include parents in CBT for anxious youth?

This study evaluated the efficacy of a parent education group, addressing parenting behaviors strongly associated with anxiety in youth, in conjunction with individual CBT for child anxiety, within an RCT. The study examined the effects of Promoting Independence and Autonomy (PIA), a parenting group treatment that focuses

on parental intrusiveness, parental overprotection, and granting psychological autonomy relative to two comparison group conditions: a group providing parent education about CBT principles (PEC) to supplement their child's treatment, and a therapist-facilitated parent support (PS) group to control for the potential positive effects of therapist contact and the support of other parents. Providing the parent training in groups separate from the youth's individual therapy sessions allowed the parent-specific components to be addressed, while allowing each child's and family's needs to be addressed on an individual basis. The study tested the differential effects of these conditions on self-, child-, and therapist-reported change in parenting behaviors and youth treatment outcome based on changes in clinician-rated, parent-rated, and child-rated anxiety severity. As parent group attendance was expected to vary (but was not randomly assigned), an exploratory aim was to examine how the degree of attendance of group meetings overall was related to both parenting behaviors and child anxiety outcomes. As an additional exploratory aim, change in parenting behaviors was examined as a mediator of youth treatment outcome.

It was hypothesized that parents in the PIA group would demonstrate a greater post-treatment reduction in measures of parental over-involvement and over-control than parents in the other two groups. In terms of youth treatment outcome, it was predicted that (1) youth involved in individual CBT whose parents concurrently attend the PIA group would have greater pre- to post-treatment change in therapist-rated anxiety severity than youth whose parents are in the PEC group, and (2) youth involved in both parent education conditions (PIA and PEC) would have higher rates of treatment response than

those whose parents were in the support-only control group. It was hypothesized that overall parent group attendance (across all conditions) would not be associated with change in overcontrolling parenting behaviors. However, because some studies have found that parent involvement in therapy has an added benefit, it was hypothesized that youth whose parents attended more group meetings would show a greater treatment response. Based on preliminary results from Wood and colleagues (2009), it was hypothesized that a reduction in parental accommodation, intrusive parenting, and overcontrol would partially mediate the relationship between parent group condition and youth treatment outcome.

Method

Participants

Participants were parents of 47 youth (26 male, 55%) ages 7 to 17 years ($M = 11.78$, $SD = 2.84$) enrolled in individual CBT for youth anxiety at a university clinic specializing in the treatment of anxiety disorders in children and adolescents. Mean parent age was 45.16 years ($SD = 6.24$). Parents of participating youth included 46 mothers, 45 fathers, and 2 parents for whom gender was not reported. Of the sample, 89% identified as Caucasian, 12.8% as Black or African-American, and 6.3% as Other. Of participating families, 63.8% had an estimated annual household income greater than \$80,000. Of participating parents, 72.3% were married, 14.9% divorced, 6.3% separated, and 4.3% never married. Of participating youth, 78.7% reported living with both mother and father.

Inclusion criteria consisted of at least one parent or other primary caregiver fluent in English and at least one primary caregiver able to attend the three parent group meetings. Participants were not excluded on the basis of any demographic variables. Inclusion criteria for youth consisted of youth having at least one principal DSM-5 anxiety disorder diagnosis at pre-treatment. Exclusion criteria included youth having a diagnosis of obsessive-compulsive disorder, autism spectrum disorder, psychosis, or bipolar disorder. Participants were recruited from families seeking treatment at the Child and Adolescent Anxiety Disorders Clinic at Temple University. These families are typically referred to the clinic for services by school mental health providers and medical professionals in the Philadelphia area. Out of 61 youth who completed an intake assessment at the clinic during the study period, 14 were either referred elsewhere for therapy services due to exclusion criteria or chose not to participate and were not enrolled in the study. Participants who were enrolled in the study did not differ significantly from those who did not enroll on any demographic variables.

Among the 47 youth enrolled in the study, at pre-treatment, 44 (93.6%) met criteria for generalized anxiety disorder (GAD), 40 (85.1%) met criteria for social phobia, 20 (42.6%), met criteria for separation anxiety disorder, 16 (34.0%) met criteria for a specific phobia, and 1 (2.4%) met criteria for anxiety not otherwise specified (NOS). No youth met criteria for panic disorder or agoraphobia. As the principal diagnosis, 22 participating youth (46.8%) had GAD, 18 (38.3%) had social phobia, 5 (10.6%) had a specific phobia, 1 (2.1%) had separation anxiety disorder, and 1 (2.1%) had anxiety disorder NOS. Eighteen participating youth (38.3%) had a comorbid ADHD diagnosis, 5

(10.6%) had comorbid oppositional defiant disorder, and 1 (2.1%) met criteria for a current major depressive episode at pre-treatment.

Power analyses were conducted using G*Power, version 3.1.7, a software program capable of conducting a priori power analyses for F -tests and regressions to determine ideal sample size given parameters of expected effect size, alpha error probability, power, and the number of predictors (Faul, Erdfelder, Buchner, & Lang, 2009). Existing literature suggests that effect sizes for parent training for youth with anxiety disorders are moderate (e.g., Khanna, Carper, Harris, & Kendall, in preparation). Therefore, power analysis was conducted for the primary aim of the study, in which the dependent variables were parent, youth and therapist report of parent behavior and parent, youth, and independent evaluator (IE) report of youth anxiety. Analysis used parameters of effect size $f^2 = 0.25$ (medium effect), alpha error probability set at 0.05, power set at 0.80, three groups, and two time points. The analysis resulted in a proposed sample size of $N = 42$. This sample size is comparable to a similar treatment study involving parents with three treatment conditions, in which the group sizes ranged from 18 to 23 participants (Mendlowitz et al., 1999a).

Measures

Parent outcome measures.

Child Report of Parent Behavior Inventory (CRPBI; Schaefer, 1965; Schludermann & Schludermann, 1970). The CRPBI was originally designed to measure children's perceptions of their parents' behavior on 18 scales. Three subscales have

emerged based on factor analyses (e.g., Schludermann & Schludermann, 1970): Acceptance/Rejection, Psychological Autonomy/Psychological Control, and Lax Control/Firm Control. For this study, a 90-item parent self-report version (Raskin, Boothe, Reatig, Schulterbrandt, & Odle, 1971) and a 30-item child-report version (Schludermann & Schludermann, 1988) were completed at pre-treatment and at Session 14 of individual therapy (after parent groups were completed). Youth completed the full measure for each parent. Items consist of statements about parenting behavior, such as “*My mother believes in having a lot of rules and sticking with them,*” and youth are asked to rate each statement as “*Not Like My Mother,*” “*Somewhat Like My Mother,*” or “*A Lot Like My Mother.*” Youth completed identical items for fathers. The parent self-report version includes similar items with language reflecting their own behavior as a parent. Internal consistency of the three subscales has shown alpha coefficients from 0.75 to 0.80 for the child-report version (McKernon et al., 2001). In the present sample, alpha coefficients ranged from 0.58 for fathers’ Lax Control to 0.91 for fathers’ Acceptance. For the parent-report version in the present sample, alpha coefficients ranged from 0.77 for the Lax Discipline subscale to 0.88 for the Involvement subscale. The three-factor structure has shown consistency across reporters (Schwarz, Barton-Henry, & Pruzinsky, 1985).

Parenting Style Index (PSI; Steinberg, Lamborn, Darling, Mounts, & Dornbusch, 1994). The PSI is a youth report of perceptions of their parents, yielding dimensions of acceptance/involvement and strictness/supervision (or lack of autonomy-granting). The acceptance/involvement dimension consists of 18 items rated on a four-

point Likert scale from 1 = *strongly disagree* to 4 = *strongly agree*, yielding an Involvement subscale score. The strictness/supervision dimension consists of four items in which youth report on how late they are allowed out and how much their parents try to know about their activities, yielding an Autonomy subscale score. Scores on both dimensions are used to categorize parenting style as authoritarian, authoritative, neglectful, or indulgent, according to the typology proposed by Baumrind (1971) and Maccoby and Martin (1983). In other samples, the acceptance/involvement items have demonstrated an alpha coefficient of 0.72 and the strictness/supervision items have shown an alpha coefficient of 0.76 (Hines & Holcomb-McCoy, 2013). In the present sample, alpha coefficients were 0.73 for the Involvement subscale and 0.57 for the Autonomy subscale. The PSI was administered to youth at pre-treatment and at Session 14 to assess parenting style before and after the parent groups.

Parental Beliefs about Anxiety Questionnaire (PBA-Q; Francis & Chorpita, 2010). The PBA-Q is a 17-item self report assessing parents' cognitions about their children's anxiety, including anxiety sensitivity, catastrophic thinking about their children's anxiety, and the perceived benefits of worrying about their children. Parents rate items such as "*It scares me when my child is nauseous*" and "*If my child gets too nervous, it could be really harmful.*" The measure has demonstrated internal consistency ($\alpha = 0.81$), as well as good convergent validity as shown by significant correlations with parents' self-reported anxiety, depression, and stress (Francis & Chorpita, 2010) and by accounting for much of the variance in the relationship between parental anxiety and child anxiety (Francis & Chorpita, 2011). This measure was completed at pretreatment

and at therapy session 14 (while youth were in session) to assess parental intolerance of and involvement in their children's negative emotional states before and after the parent group intervention. Internal consistency in the present sample was comparable to prior studies, with Cronbach's $\alpha = 0.83$.

Parental Acceptance and Action Questionnaire (PAAQ; Cheron, Ehrenreich, & Pincus, 2009). The PAAQ is a 15-item self report assessing parental experiential avoidance of their children's negative emotions. It contains two subscales: the Unwillingness subscale measures the parent's unwillingness to witness negative emotions in their children, and the Inaction subscale measures the parent's inability to effectively manage their reactions to their children's affective experiences. Parents rate items on a 7-point Likert scale from 1 = *Never True* to 7 = *Always True*. The PAAQ has shown temporal stability ($r = 0.68 - 0.74$) and internal reliability ($\alpha = 0.64 - 0.65$), as well as convergent validity supported by significant correlations with measures of parental affective expression and controlling parenting behavior (Cheron et al., 2009). The PAAQ was administered to parents at pretreatment at therapy session 14. Alpha coefficients for internal consistency in the present sample were 0.57 for the Unwillingness subscale and 0.62 for the Inaction subscale.

Family Accommodation Scale – Anxiety (FASA; Lebowitz et al., 2013). The FASA is a 9-item self-report questionnaire assessing the frequency of parental participation in their children's anxiety-related behaviors (e.g., assisting their child in avoiding anxiety-provoking situations) and associated impact on family functioning (e.g., modifying family routines) over the past month. Parents rate items on a 5-point Likert

scale from 0 = *Never* to 4 = *Daily*, producing a total score, a Participation subscale score, and a Modification of Functioning subscale score. In previous research, the FASA has demonstrated internal reliability ($\alpha = 0.91$), as well as convergent and divergent validity as shown by a significant correlation ($r = 0.45$) with a measure of anxiety severity and a non-significant correlation ($r = 0.17$) with a measure of depression severity (Lebowitz et al., 2013). In the present sample, alpha coefficients for internal consistency were 0.79 for the Participation subscale and 0.80 for the Modification of Functioning subscale. The FASA was administered to parents at pre- and post-treatment.

Parental Accommodation Scale (PAS; Benito et al., 2015). The PAS measures family accommodation and associated impairment across several domains for youth with anxiety. The original 14-item version was designed as a clinician-administered structured interview of parents, asking parents to rate the frequency of each item and the level of impairment for the child and/or family over the past week. Items consist of various types of parental accommodation of anxiety, such as *“In the past week, how often did you help your child to avoid things or situations that make him/her more anxious?”* with examples provided by the clinician specific to the child. For the present study, a 5-item, clinician-rated version of the PAS was completed by each child’s individual therapist following Session 2 and Session 14 of individual therapy to capture therapists’ perceptions of parental accommodation of youth’s anxiety before and after the parent groups. The 14-item PAS has demonstrated internal consistency (alphas = 0.76 to 0.80) and convergent validity with measure of anxiety severity and impairment (Benito et al., 2015). In the

present sample, the 5-item modified version had alpha coefficients of 0.89 for frequency of accommodation and 0.82 for impairment.

Youth treatment outcome measures.

Anxiety Disorders Interview Schedule for DSM-5, Child and Parent Versions (ADIS-5-C/P; Albano & Silverman, in press). The ADIS-C/P is a well-established semi-structured clinical interview for assessing the presence and severity of anxiety and comorbid disorders in youth (Silverman & Albano, 1996). IE's interview the child or adolescent and his/her parents separately and assign clinical severity ratings (CSRs) for each diagnosis based on information from both interviews. CSRs range from 0 = *not at all* to 8 = *very, very much*, and a CSR of 4 or above is considered a clinical diagnosis. In the proposed study, the ADIS-5-C/P was administered during the intake assessment and after treatment session 16, providing both pre-treatment and post-treatment CSRs. Intraclass correlation coefficients for inter-rater reliability in the present sample were 0.96 for the parent interview and 0.87 for the child interview.

Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997). The MASC assesses anxiety symptoms in youth, using both self report and parent report. Both versions consist of 39 items and comprise four main subscales: Physical Symptoms, Social Anxiety, Separation Anxiety/Panic, and Harm Avoidance. The MASC has demonstrated favorable psychometric properties in previous studies, including good retest reliability (March et al., 1997), good divergent and convergent validity (Baldwin & Dadds, 2007; March et al., 1997; Rynn et al., 2006), and good internal reliability within the four subscales (Baldwin & Dadds, 2007; Dierker et al.,

2001; March et al., 1997). Alpha coefficients in the present sample ranged from 0.64 (Harm Avoidance subscale) to 0.88 (Social Anxiety subscale) for the parent-report version and from 0.70 (Separation Anxiety subscale) to 0.94 (Social Anxiety subscale) for the child-report version. The MASC also has demonstrated utility as a self-report measure in predicting the presence and severity of anxiety disorder diagnoses (Grills-Taquechel, Ollendick, & Fisak, 2008; van Gastel & Ferdinand, 2008; Villabø, Gere, Torgersen, March, & Kendall, 2012; Wei et al., 2014). The MASC was administered to youth and their parents at pre- and post-treatment.

Child Sheehan Disability Scale (CSDS; Whiteside, 2009). The CSDS is a 3-item measure of anxiety-related impairment, adapted for children from the Sheehan Disability Scale (Sheehan, 1986). Youth and parents rate how much the child's anxiety impacts functioning in school, social, and family domains, on a scale from 0 = *not at all* to 10 = *very, very much*. The CSDS has shown good internal consistency ($\alpha = 0.81$), convergent validity with measures of anxiety severity, and divergent validity with externalizing symptoms (Whiteside, 2009). The CSDS was completed by youth and parents at pre- and post-treatment. Internal consistency alpha coefficients were 0.78 for the child self-report version and 0.69 for the parent-report version.

Procedure

Randomization is preferred when making an assignment to treatment conditions. The group design of the treatment conditions presented challenges for coordinating parents' schedules with those of other parents in the same condition. To address this, random assignment with restriction (parent schedules) was used. Groups for each

condition were randomly assigned to meet on a particular day of the week (Monday through Thursday) at the same time in the evening, and parents' schedules guided their choice of which day to attend a group. In the event that parents equally preferred multiple options, their meeting day was assigned randomly. To not bias their choice, parents were not told about the content of the group. Although parent schedule preference is not expected to correlate with any factors related to parenting or treatment outcome, analyses tested whether participants in each group differed significantly on any demographic variables or on pre-treatment anxiety diagnoses or severity. Although both parents in two-parent families were encouraged to attend the groups, this was often not feasible, and only one parent was required to attend.

At pre-treatment, parents and youth completed the ADIS-C/P with IE's to determine youth eligibility for individual CBT and assess specific diagnoses and their severity. Youth completed the MASC, CSDS, PSI, and CRPBI and parents (both parents in two-parent families) completed the MASC-P, CSDS, PBA-Q, PAAQ, CRPBI, and FASA. Youth who met eligibility criteria began weekly individual CBT in cycles, with youth whose parents were in the same group starting therapy in the same week. This procedure "synced" the parent groups with the progression of individual therapy. Parents were assigned to attend the PIA ($n = 15$), PEC ($n = 14$), or PS ($n = 18$) parent groups as described.

Three parent group meetings took place in approximately the same week as Sessions 5, 10, and 13 of individual CBT. Following Session 2 of CBT, prior to the first parent group meeting, child therapists completed the PAS. While youth attended Session

14 of CBT, which occurred after parents completed the three parent group sessions, youth, parents, and therapists completed the parent behavior measures (PSI, CRPBI, PBA-Q, PAAQ, FASA, and PAS). After youth completed the 16 individual CBT sessions, parents and youth completed the IE-administered ADIS-C/P to assess post-treatment diagnoses and severity. Youth and parents completed the MASC and SDS. This post-assessment occurred within two weeks posttreatment and prior to any follow-ups. Figure 1 shows the CONSORT flow diagram for participant enrollment, randomization, and completion of treatment.

Child individual CBT. Youths' individual therapists met with youths for 16 weekly one-hour sessions, using *Coping Cat*, a manual-based CBT for youth with anxiety disorders (Kendall & Hedtke, 2006a; 2006b). The first 8 sessions focus on building skills for coping with anxiety, such as identifying somatic feelings associated with anxiety, using relaxation, identifying and modifying anxious self-talk, problem-solving, and rewarding coping/brave efforts. In the next 8 sessions, therapists guide youth to conduct in-session and at-home exposure tasks according to a hierarchy of feared situations. Two parent meetings (sessions 4 and 9) give parents an opportunity to provide additional information about their child's anxiety and learn strategies to facilitate at-home exposure tasks. Throughout treatment, therapists were flexible in tailoring treatment components to the youth's needs. However, so that the added benefit of parent interventions in the group format could be assessed, direct work with parents in individual CBT was restricted to the two parent-only sessions and a maximum 10-minute "check-in" at the end of each child session.

Parent intervention conditions. All parent group sessions were led by a therapist using a manual-based protocol, with time for parents to ask questions and share their experiences. Parents were told to attend three 90-minute group sessions, following approximately Sessions 5, 10, and 13 of their child's individual therapy. The first two meetings were set to occur following each of the two individual parent sessions (Sessions 4 and 9) and the third during the exposure phase of treatment. Ten parent group sessions (one randomly selected from each group leader, 22% of the total sessions) were checked for fidelity. In randomly selected 10-minute segments from the checked sessions, no cross-condition contamination was noted.

Promoting Independence and Autonomy (PIA). The PIA group manual (Hoff, 2016b) was based on material in a parenting chapter about promoting autonomy (Faber & Mazlish, 2012) and applied specifically to parents of youth with anxiety. The first PIA session consisted of psychoeducation about parenting behaviors that promote independence and autonomy (e.g., allowing choices, refraining from asking too many questions, refraining from immediately solving problems for children, allowing children to struggle and learn from mistakes). The second PIA session involved training parents in how to best conduct at-home exposure tasks, with an emphasis on granting autonomy by using the skills learned in the first session. The third PIA session involved discussing parents' experiences with the autonomy-granting skills used in exposures and how to continue practicing the skills. Role-plays were used for practice.

Parent Education about CBT (PEC). The manual for the PEC group (Hoff, 2016a) was written using material from the *Coping Cat*, aimed at an adult audience. The

first PEC session involved psychoeducation about anxiety according to the CBT model and an overview of CBT coping strategies for addressing both parental and youth anxiety, including the identification of somatic anxiety symptoms and identifying and challenging automatic thoughts. The second PEC session reviewed these strategies and discussed coordinating at-home exposure tasks, including role-play practice. The third PEC session involved discussion of at-home exposure tasks conducted thus far and practice with exposure task facilitation using role-plays.

Parent Support (PS). PS group leaders were instructed not to provide any explicit educational material during sessions. The therapist provided support as parents shared their experiences managing their children's anxiety throughout individual treatment. Parents were encouraged to take turns sharing their experiences managing their children's anxiety. The PS manual (Hoff, 2016) included discussion prompts related to parents' experiences with their children's anxiety in the first session, related to the therapy experience thus far in the second session, and related to their child's exposure tasks in the third session. The PS group leader was instructed to only use the provided prompts if needed, and the discussion was not restricted to these topics.

Results

Preliminary Analyses

Comparison of treatment dropouts and treatment completers. Out of the 47 participants who began individual CBT, 13 dropped out of treatment before completing the 16 sessions. Chi-square and between-subjects *t*-tests were conducted to analyze any pre-treatment differences between the 13 dropouts and the 34 treatment completers.

Dropout participants did not differ from treatment completers on likelihood of parent group condition, principal diagnosis, child gender, child race, child age, estimated total household income level, or parent marital status (p -values ranged from 0.09 to 0.95).

Dropouts also did not differ from treatment completers on likelihood of any ADIS diagnoses at pre-treatment or on pre-treatment principal diagnosis composite CSR, MASC-C total score, MASC-P total score, the PSI Autonomy subscale, or PBA-Q scores (p -values ranged from 0.07 to 0.91).

Dropouts rated their mothers as lower on acceptance on the CRPBI at pre-treatment ($M = 24.67$, $SD = 2.58$) than completers [$M = 27.60$, $SD = 2.46$; $t(24) = 2.54$, $p = 0.02$]. They did not differ on any other CRPBI scales for child or parent report.

Dropouts also rated their parents as more involved in their lives, per the PSI ($M = 32.50$, $SD = 3.26$), than treatment completers [$M = 29.69$, $SD = 3.82$; $t(42) = 2.26$, $p = 0.03$].

Parents of dropouts reported lower scores on unwillingness to experience their children's negative emotions on the PAAQ at pre-treatment ($M = 26.67$, $SD = 5.84$) than treatment completers [$M = 30.74$, $SD = 5.33$; $t(41) = 2.19$, $p = 0.03$]. They did not differ on the PAAQ Inaction subscale or total score. Parents of dropouts rated their children as having significantly more anxiety-related impairment in the home and family domain on the CSDS ($M = 6.08$, $SD = 2.56$) than parents of treatment completers [$M = 4.35$, $SD = 2.21$; $t(42) = 2.25$, $p = 0.03$]. They did not differ on their ratings of CSDS school or social impairment, and child CSDS ratings did not differ. Full information maximum likelihood (FIML) analysis was used to accommodate missing data.

Pretreatment demographics across parent group conditions. Descriptive statistics for demographic variables, parent group attendance, and pretreatment diagnoses across the three parent group conditions are presented in Table 1. One-way ANOVAs and chi-square analyses compared participant demographic variables across parent group conditions. There was an uneven child gender distribution across conditions, as well as a significant difference in the likelihood of a social phobia diagnosis in youth. Therefore, child gender and social phobia diagnosis were included as covariates in all analyses.

Pretreatment demographics across low and high parent group attendance.

Parent group attendance was dichotomized, with low attendance (0 or 1 sessions) compared to high attendance (2 or 3 sessions). Thus, parents with high attendance would have attended at least one group session in which exposures were discussed. Descriptive statistics for demographic variables and pretreatment diagnoses for participants with low and high parent group attendance are presented in Table 2. Two-tailed *t*-tests and chi-square analyses compared participant demographic variables across the two attendance levels. Although there were no significant differences in child age, gender, parent marital status, or pretreatment diagnoses between participants with low and high parent group attendance, there was a significant difference in the range of reported annual family income. All participants reporting estimated annual household income below \$40,000 were in the low attendance group, whereas attendance did not differ for participants reporting \$40,000 and above, $X^2(8) = 16.55, p = 0.04$.

Outcome differences across parent group conditions

Parenting behaviors. To determine the effect of parent group condition on parent behavior outcomes, mixed-model 3×2 ANOVAs were conducted with pre- and post-group parenting measures (PSI, PBA-Q, CRPBI, FASA, PAS, and PAAQ) as the within-subjects factors and parent group condition as the between-subjects factor, with child gender and pre-treatment social phobia diagnostic status as covariates. Planned contrasts comparing each group to each other group were conducted for any significant interactions. Results are reported in Table 3. There was a small but significant main effect increase in child-reported acceptance from fathers on the CRPBI over time, $\eta^2 = 0.14$. There was also a small but significant main effect increase over time for the child-reported Psychological Control subscale on the CRPBI for fathers, $\eta^2 = 0.10$. There was a significant main effect decrease in PAAQ Unwillingness subscale scores over time, $\eta^2 = 0.13$. The condition-by-time interaction was significant for the parent-reported CRPBI Involvement subscale and for the PBA-Q (self-reported parental negative beliefs about anxiety). Contrasts showed a significantly greater decrease in parent-reported involvement over time in the PS condition than the PEC condition, $t(44) = 2.91$, Scheffe-adjusted $p = 0.02$; no other contrasts were significant. For the PBA-Q, contrasts showed a significantly greater increase in scores in the PS condition than the PIA condition, $t(44) = 3.14$, Scheffe-adjusted $p = 0.01$; no other contrasts were significant.

Child treatment outcomes. To determine the effect of parent group condition on youth treatment outcome, mixed-model 3×2 ANOVAs were conducted with pre- and post-treatment youth outcome measures (ADIS CSR of principal diagnosis, MASC, and SDS) as the within-subjects factors and parent group condition as the between-subjects

factor, with child gender and pre-treatment social phobia diagnostic status as covariates. Results are reported in Table 4. There were no significant main or interactive effects for child anxiety severity or impairment.

Outcome differences based on overall level of parent group attendance

To examine the overall effect of parent group attendance on outcomes (in any condition), mixed model 2×2 ANOVAs were conducted with low (0 or 1 sessions)/high (2 or 3 sessions) attendance as the between-subjects factor. Parenting behaviors and child anxiety outcomes were examined as within-subjects factors.

Parenting behaviors. Results for parenting behaviors are shown in Table 5. There was a significant main effect decrease over time for FASA Modification of Functioning subscale scores, $\eta^2 = 0.11$. There were significant time-by-attendance interactions for the PSI Involvement subscale, PBA-Q, and PAAQ Unwillingness subscale. For the PSI, there was a significantly greater decrease over time in child-reported parental involvement for the low attendance group than for the high attendance group, $\eta^2 = 0.09$. For the PBA-Q, there was a significantly greater increase in parent-reported negative beliefs about anxiety in the high attendance group than the low attendance group, $\eta^2 = 0.14$. For the PAAQ, parents' self-reported unwillingness to experience their child's anxiety decreased over time for the high attendance group, but not for the low attendance group, $\eta^2 = 0.10$.

Child treatment outcomes. Results for child anxiety severity and impairment are shown in Table 6. There was a significant main effect pre- to post-treatment decrease in the composite CSR for the principal ADIS-5-C/P diagnosis from pre-treatment, $\eta^2 = 0.23$.

There was a significant main effect increase in child-reported impairment in the social domain of the CSDS over time, $\eta^2 = 0.16$. For the parent-report CSDS, there were significant main effect decreases in impairment across the home ($\eta^2 = 0.32$), school ($\eta^2 = 0.15$), and social ($\eta^2 = 0.21$) domains. There was a significant time-by-attendance interaction for the total child-reported MASC score, such that total anxiety severity decreased for youth whose parents had higher group attendance, whereas scores increased for youth whose parents had lower group attendance, $\eta^2 = 0.10$. Similarly, interactions were significant for the Physical Symptoms ($\eta^2 = 0.13$) and Harm Avoidance ($\eta^2 = 0.08$) subscales of the child-reported MASC, with severity scores decreasing for youth whose parents had higher group attendance, but not for youth whose parents had lower attendance.

Change in parenting behaviors as a mediator of child treatment outcome

To explore change in parent behaviors as a mediator of youth anxiety treatment outcome, mediation analyses using bootstrapping (Hayes, 2013) were planned for any parenting behavior outcomes and child treatment outcomes that were significantly different across parent group conditions or attendance levels. Parent group condition or attendance was planned as the predicting variable, change in parenting behavior measures at post-group (difference scores from pre-treatment) were planned as the mediating variable, and change in child anxiety measures at post-treatment (difference scores from pre-treatment) were planned as the outcome variable. Bootstrapping was set at 5,000 samples. Temporal precedence was established by having post-group parenting measures

completed at Session 14 of individual treatment, after the parent groups had concluded but prior to the post-treatment assessment conducted at Session 16.

Inasmuch as no child outcomes were significantly associated with parent group condition, mediation analyses were conducted for the effect of parent group attendance only. Using the PROCESS SPSS macro (Hayes, 2013), bootstrap mediation analyses tested change (pre-treatment – post-group) in PAAQ Unwillingness scores, PSI Involvement scores, and PBA-Q scores as mediators of the relationship between parent group attendance and change (pre-treatment – post-treatment) in the total score, Physical Symptoms subscale, and Harm Avoidance subscale of the child-report MASC. Change in PAAQ Unwillingness scores was found to be a significant mediator of the relationship between parent group attendance and change in MASC-C total scores, *indirect effect* = 7.64, Bootstrap 95% CI [1.03, 21.55], $R^2 = 0.06$. It was also a significant mediator of change in MASC-C Harm Avoidance subscale scores, *indirect effect* = 2.06, Bootstrap 95% CI [0.23, 6.81], $R^2 = 0.05$. For the MASC-C Physical Symptoms subscale, the condition of significant correlation with PAAQ Unwillingness scores, controlling for parent group attendance, was not met, $t(44) = 1.70$, $p = 0.10$. Change in PSI Involvement subscale scores was a significant mediator of the relationship between parent group attendance and change in MASC-C total scores (*indirect effect* = 9.13, Bootstrap 95% CI [0.12, 20.79], $R^2 = 0.07$), as well as change in MASC-C Physical Symptoms subscale scores (*indirect effect* = 4.41, Bootstrap 95% CI [0.04, 10.53], $R^2 = 0.10$), but not MASC-C Harm Avoidance subscale scores. For the PBA-Q, change in scores was not a mediator of change in MASC-C total scores or Harm Avoidance subscale scores, and the condition

of significant correlation between mediator and outcome, controlling for predictor, was not met for the Physical Symptoms subscale, $t(44) = 1.79, p = 0.08$.

Discussion

Although this study is the first to directly compare two different types of parent interventions, along with a support-only control condition, the results provide little evidence that either a parent group focused on promoting autonomy, a group providing added CBT skills education, or a non-educational support group is of superior benefit when paired with individual youth CBT. Regarding changes in parental behaviors associated with child anxiety, the results suggest that, inconsistent with hypotheses, parent-reported involvement decreased most when parents attended a support-only parent group without any targeted educational content, although the difference was only significant compared to the CBT-focused parent group. However, self-reported parental negative and avoidant beliefs about anxiety *increased* more for the support-only group than for the autonomy-focused group. Perhaps parents who had more time to share their experiences freely with other parents instead of learning skills had more of an opportunity for their child's anxiety to become normalized, thus reducing the need for control. On the other hand, specifically targeting parental control's role in anxiety may have mitigated parents' concerns about anxiety as harmful. As far as child anxiety outcomes following treatment, there was no indication that participation in any particular type of parent group had any effect.

Although the findings did not generally support the hypothesis that an autonomy-focused parent group would have better parenting and child anxiety outcomes, the results

do indicate that participation in a parent group as part of individual CBT for anxious youth has some general added benefit. For youth whose parents attended two or three out of the three total parent group sessions offered, compared to youth whose parents did not attend parent groups at all or only one session, there was a significantly greater decrease in child-reported anxiety severity, which was mediated by an increase in parental willingness to witness and experience their child's anxiety for parents who attended more group meetings. Surprisingly, parents' negative and avoidant beliefs about anxiety *increased* when they attended more parent groups, whereas these beliefs did not change for parents who attended fewer groups. However, this difference did not mediate the relationship between higher parent group attendance and decreased child-reported anxiety severity. Another unexpected finding was that child-reported parental involvement decreased more for parents who attended few or no groups compared with parents with higher attendance. Perhaps this was a reflection of youths' perceptions of their parents' involvement in their treatment. Indeed, youths' self-reported greater decrease in anxiety severity when parents attended more groups was mediated by the smaller decrease in their report of parental involvement.

Several studies to date have tested whether providing additional didactic training to parents (CBT skills, ways to address parental anxiety, or reducing parental overcontrol) adds benefit to youth-focused CBT (e.g., Cartwright-Hatton et al., 2011; Cobham, Dadds, Spence, & McDermott, 2010b; Barbara H. Esbjørn et al., 2015; Hudson et al., 2014; Kendall et al., 2008; Mendlowitz et al., 1999b; Wood et al., 2009). Results have been mixed, making it difficult to discern whether and in what way parents may best

be included in treatment for child and adolescent anxiety. Part of this difficulty appears to stem from the variety of modalities and areas of focus among the different studies that investigated parent involvement in treatment, exploring the many parent factors that have been associated with child anxiety. Some studies have included parents in a family session format compared to meeting with the child individually (Bodden et al., 2008; Barbara H. Esbjørn et al., 2015; Kendall et al., 2008a; Schneider et al., 2013b; Siqueland et al., 2005; Wood et al., 2006), whereas others have conducted both child and parent interventions in a group format (Cartwright-Hatton et al., 2011; Cobham et al., 2010; Hudson et al., 2014; Mendlowitz et al., 1999; Shortt et al., 2001; Waters et al., 2009) or worked with individual parents only or separately from youth (Lebowitz et al., 2014; Nauta et al., 2003; Smith et al., 2014). The targets of intervention have included providing CBT skills to parents, similar to what is provided to youth; addressing parental anxiety, accommodation and anxious beliefs; addressing parent-child attachment; reducing parental overcontrol; and combinations thereof. Despite many attempts, it appears that investigating parent involvement compared to youth-focused interventions has not clarified whether or how parent interventions may add to CBT for anxious youth.

The present study attempted to advance the study of parental involvement in CBT for anxious youth by directly comparing a parenting intervention targeted specifically at overcontrolling parenting behavior found to be associated with child anxiety and that has shown some recent promise when targeted in parenting interventions (e.g., Wood et al., 2009), with another commonly studied form of parent involvement – teaching CBT skills to parents so that they may facilitate skill-building and exposures for youth outside

sessions (e.g., Cartwright-Hatton et al., 2011; Mendlowitz et al., 1999b; Nauta et al., 2003; Schneider et al., 2013). In addition, the study further explored the benefit of the group format itself by including a support-only control group with no targeted education or intervention. Although the parenting factors targeted in the autonomy-focused parenting intervention did not show much evidence of change over time, and no particular type of group was superior to the others in its impact on child anxiety outcomes, the study results do indicate that the experience of meeting in a group with other parents of anxious children in treatment and a supportive therapist is beneficial in reducing parental avoidance of child anxiety and, in turn, child anxiety severity, regardless of the group content.

As previous research has found that parental engagement and involvement in treatment is associated with better child outcomes (Podell & Kendall, 2011), the three parent group meetings may have provided a beneficial opportunity for parents to be more engaged in their child's treatment without necessarily having to participate heavily in weekly individual therapy sessions with their child. Even in a support group where there was no education or skills provided by the group leader, spending time talking about their child's anxiety and treatment may have prompted parents to become more engaged in learning and facilitating at-home practice of skills and exposure tasks with their child, leading to more treatment gains by the end of 16 sessions. The fact that youth whose parents attended more group sessions reported more consistent parental involvement across treatment than youth whose parents had low group attendance (where there was a perceived decrease in involvement), which mediated greater decreases in youth-reported

anxiety severity, lends support to the benefit of greater parental involvement in treatment. It is important to note that level of parent group attendance was not randomly assigned, and may have been associated with confounding variables, such as level of engagement in treatment in general, flexibility of schedule, or childcare resources, that may better explain the differences in treatment outcome. Indeed, parents reporting lower income had lower group attendance (whereas middle and high income families varied more in their attendance), so socioeconomic status may have been a confounding variable. The directionality of parent group attendance and general parental engagement in treatment is not entirely clear from this study. However, the fact that parent-reported unwillingness to engage in their child's anxiety decreased more when parents attended more groups, which mediated decreases in child-reported anxiety severity, supports the inference that talking with other parents about their children's anxiety may have lessened their avoidance of it, increasing their willingness to engage in treatment.

In addition to increasing their overall engagement in their children's anxiety treatment, parents who tolerate and accept their children's anxiety more after talking about it with other parents of anxious youth may be less likely to engage in controlling and accommodating behaviors (Cheron et al., 2009) or the modeling of anxiety-maintaining behaviors (Dadds et al., 1996). The results of the present study suggest that parental accommodation of youth anxiety decreased over the course of CBT, unrelated to participation in parent groups. However, perhaps parents with the opportunity to talk to other parents about their common experiences with their children's anxiety and treatment were better equipped to "put to work" their new skills and attitudes to support their

child's improvement in anxiety severity and impairment. An analysis of parental anxiety beliefs, attitudes, and accommodation, as well as child anxiety severity and impairment, at multiple timepoints across treatment might clarify whether the beliefs and actions of parents participating in groups change earlier or at a faster rate, which might explain their youth's greater level of improvement after 16 sessions of treatment. Prior research on accommodation suggests that mothers higher in empathy, although less likely to insist their child face highly anxiety-provoking situations, are also more adaptable in responding to their child's anxiety and less likely to accommodate when distress level is reasonably low (Settipani & Kendall, in press). Perhaps parents participating in groups were able to process their changing attitudes about anxiety in such a way that their empathy and/or flexibility in responding to their child's anxiety rendered them more effective at reducing anxiety-maintaining avoidance (Dadds et al., 1996) and encouraging coping efficacy, a mediator of treatment gain (Kendall et al., 2016).

Given parental overcontrol's robust association with youth anxiety (Drake & Ginsburg, 2012a; McLeod et al., 2007; van der Bruggen et al., 2008; Wei & Kendall, 2014), it was somewhat surprising that measures of parental overcontrol generally did not show much change over the course of 14 weeks of treatment. Previous parent involvement studies targeting parental overcontrol found it to decrease, even if the effect was no different for the parent intervention compared to child-focused CBT (Esbjörn et al., 2014; Jongerden & Bögels, 2015; Wood et al., 2009). The study by Wood and colleagues (2006; 2009) even found evidence that reductions in parental intrusiveness mediated the relationship between the family-based intervention and child treatment

outcome. In that study, however, parent involvement and training were a part of each individual therapy session. It is possible that condensing parent training in autonomy granting to three 90-minute group sessions is inadequate to effect significant change in parenting. The three meetings were designed to provide an opportunity for parents to be more involved and gain support from other parents without adding too much burden on top of weekly individual therapy sessions. Although it is promising that participation in the groups was associated with reductions in parental avoidance of youth anxiety and greater treatment gains for youth, suggesting the added group opportunity was beneficial, more time may be necessary to target changes in parental overcontrol, potentially leading to even greater gains. The Wood and colleagues (2006, 2009) studies indicate that involving parents weekly may accomplish the goal of greater parental engagement *and* improvement in parental overcontrol; however, this format requires a greater commitment from parents, and it may be less feasible that both parents can participate.

In addition to considering the amount of time parents are involved in targeted interventions, longer study designs with multiple observation timepoints would help clarify the process of change in parenting behaviors and how much intervention is needed for meaningful change. The parenting variables in the present study were measured shortly after the conclusion of parent groups to establish temporal precedence to post-treatment measures for mediation analyses, potentially not leaving enough time for meaningful and noticeable change in parenting behaviors to occur, especially after only three parenting sessions. The finding that negative parental beliefs about anxiety remained relatively stable for those in the PIA group, whereas they increased

significantly more in the support condition, suggests that mitigating these beliefs may be a mediator for eventual meaningful change in parenting, which could be further explored with longer-term studies. Clinician-observed protocols for rating parents' autonomy granting would also be a helpful addition to self-reported and child-reported measures of control. To expand on the finding that attendance of *any* parent group was associated with a greater reduction in child anxiety severity via reductions in parental avoidance of child anxiety, future research should include an added condition in which parents may be randomized to not attend a group as part of their child's treatment (at least for a waitlist period). Additionally, the role of a less structured parent support group should be explored further, using both qualitative and quantitative methods, to clarify how sharing and processing experiences with other parents may help parents support their anxious children's progress in treatment by impacting their beliefs and behaviors.

When it comes to targeted parent interventions, future research that examines *who* may benefit from certain types of parent involvement in treatment may help bring the benefit of parent involvement into focus. Although there are many parent and family factors associated with child anxiety in aggregate, individual families may not need any or all of these factors addressed in treatment. Taking a "one size fits all" approach to parent involvement in research may be clouding the impact that these interventions may have for certain families who actually need them. Thus, as Wei and Kendall (2014) have suggested, research should focus on matching families with certain types of parenting involvement as needed based on case conceptualization. Some researchers have begun moving in that direction, with some promising results (Esbjörn et al., 2015; Lundkvist-

Houndoumadi, Thastum, & Hougaard, 2016). It may be that only youth who have parents with high levels of overcontrol, psychopathology, or conflict that are maintaining the youth's anxiety show improved outcomes when those factors are addressed in treatment.

Figure 1

CONSORT diagram for study enrollment, randomization, and attrition

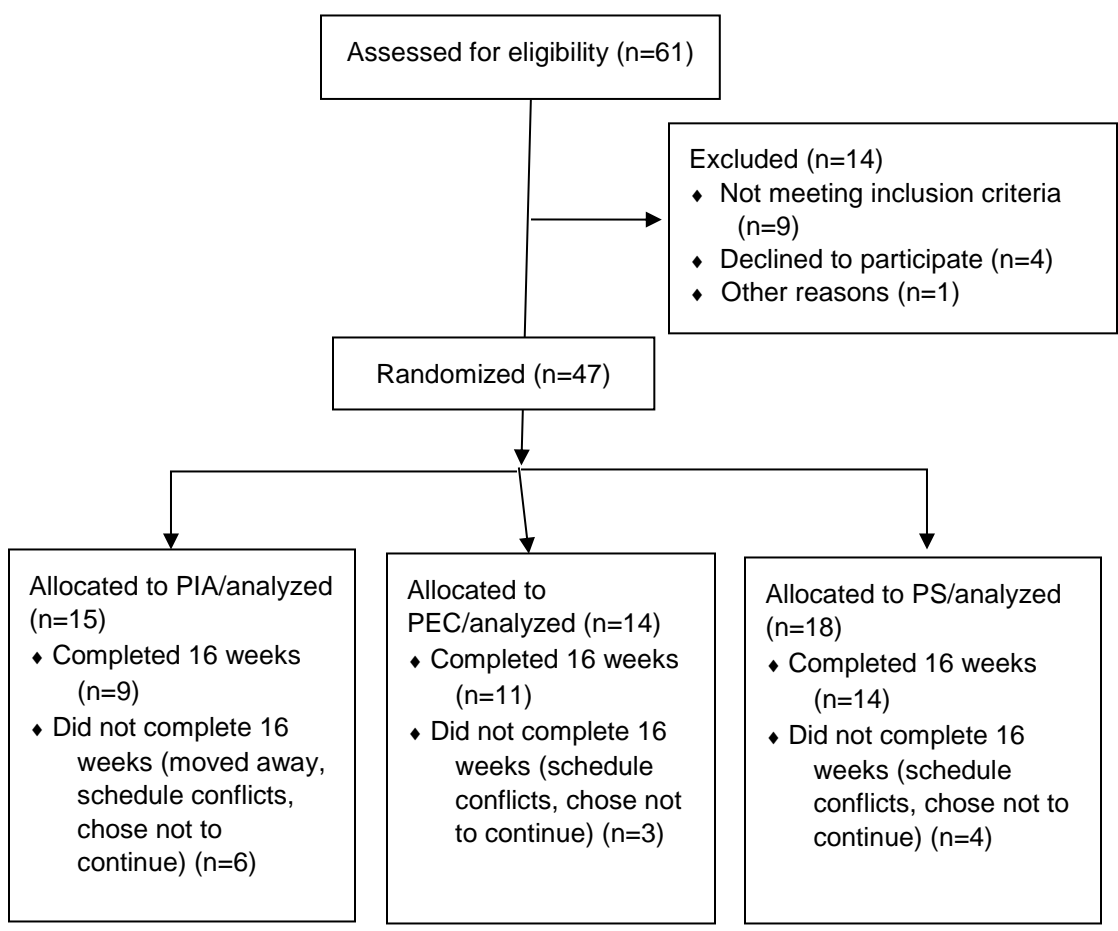


Table 1

Pre-treatment sample demographics across parent group conditions

Variable	PIA (<i>n</i> = 15)		PEC (<i>n</i> = 14)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Child age	11.56	2.46	11.01	2.47
# parent group sessions attended	1.53	1.06	1.50	1.02
	<i>n</i>	%	<i>n</i>	%
Male	7	46.7	13	92.9
Female	8	53.3	1	7.1
Caucasian	10	66.7	13	92.9
Black	3	20	0	0
Other race	2	13.3	1	7.1
Parents never married	0	0	0	0
Parents married	13	92.9	9	64.3
Parents separated	0	0	2	14.3
Parents divorced	1	7.1	3	21.4
GAD	13	86.7	13	92.9
Separation anxiety	6	40	6	42.9
Social phobia	14	93.3	9	64.3
Specific phobia	6	40	4	28.6
ADHD	5	33.3	6	42.9
ODD/CD	2	13.3	2	14.3
MDD	0	0	0	0
Anxiety NOS	1	6.7	0	0

Table 1

Continued

Variable	PS (<i>n</i> = 18)		
	<i>M</i>	<i>SD</i>	<i>F</i>
Child age	12.55	3.33	1.24
# parent group sessions attended	2.00	1.08	1.16
	<i>n</i>	%	χ^2
Male	6	33.3	
Female	12	66.7	11.96 **
Caucasian	15	83.3	
Black	3	16.7	
Other race	0	0	5.55
Parents never married	2	11.1	
Parents married	12	66.7	
Parents separated	1	5.6	
Parents divorced	3	16.7	7.31
GAD	18	100	2.45
Separation anxiety	8	44.4	0.07
Social phobia	7	94.4	6.83 *
Specific phobia	6	33.3	0.43
ADHD	7	38.9	0.28
ODD/CD	1	5.6	0.80
MDD	1	5.6	1.65
Anxiety NOS	0	0	2.18

Note: PIA = Promoting Independence and Autonomy group; PEC = Parent Education about CBT group; PS = Parent Support group; GAD = generalized anxiety disorder; ADHD = attention deficit/hyperactivity disorder; ODD = oppositional defiant disorder; CD = conduct disorder; MDD = major depressive disorder (current episode); NOS = not otherwise specified

* $p < 0.05$

** $p < 0.01$

Table 2

Pretreatment sample demographics across low (0-1 sessions) and high (2-3 sessions) parent group attendance

Variable	Low Attendance (<i>n</i> = 19)		High Attendance (<i>n</i> = 28)		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Child age	11.51	2.81	11.95	2.90	0.53
	<i>n</i>	%	<i>n</i>	%	χ^2
Male	12	63.2	14	50.0	
Female	7	36.8	14	50.0	0.79
Caucasian	14	73.7	24	85.7	
Black	3	15.8	3	10.7	
Other race	2	10.5	1	3.6	1.29
Parents never married	2	11.1	0	0	
Parents married	12	66.7	22	78.6	
Parents separated	2	11.1	1	3.6	
Parents divorced	2	11.1	5	17.9	4.60
GAD	18	94.7	26	92.9	0.07
Separation anxiety	8	42.1	12	42.9	<0.01
Social phobia	16	84.2	24	85.7	0.02
Specific phobia	6	31.6	10	35.7	0.09
ADHD	7	36.8	11	39.3	0.03
ODD/CD	4	21.1	1	3.6	3.64
MDD	1	5.3	0	0	1.51
Anxiety NOS	0	0	1	3.6	0.69

Note: GAD = generalized anxiety disorder; ADHD = attention deficit/hyperactivity disorder; ODD = oppositional defiant disorder; CD = conduct disorder; MDD = major depressive disorder (current episode); NOS = not otherwise specified

Table 3

ANOVAs for parenting behavior outcomes (pre-treatment to post-group) by parent group condition, with child gender and social phobia diagnosis as covariates

Variable	PIA (<i>n</i> = 15)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
PSI involvement	31.77	3.64	25.59	12.12
PSI autonomy	24.37	4.19	26.75	7.79
CRPBI mother acceptance	27.81	7.58	26.50	5.52
CRPBI mother psychological control	14.21	8.89	13.83	12.71
CRPBI mother firm control	21.41	6.59	21.42	8.57
CRPBI father acceptance	24.33	18.05	25.78	5.51
CRPBI father psychological control	12.85	6.55	11.57	15.64
CRPBI father firm control	20.59	6.74	19.84	14.86
CRPBI-PR involvement	57.16	4.30	56.59	9.66
CRPBI-PR negative control	21.01	5.24	22.37	7.06
CRPBI-PR lax discipline	25.04	3.77	25.89	3.75
PBA-Q total	41.34	8.35	42.25	12.58
PAAQ Inaction	24.41	8.32	28.62	10.87
PAAQ Unwillingness	28.93	8.62	29.51	7.90
PAAQ total	53.35	11.04	57.65	15.51
FASA total (pre-post)	18.37	8.01	15.83	11.46
FASA participation	12.17	3.95	11.25	7.62
FASA modification of functioning	6.20	4.57	4.45	4.55
PAS frequency	8.13	17.72	9.59	8.31
PAS impairment	6.66	11.97	6.91	6.91

Table 3

Continued

Variable	PEC (<i>n</i> = 14)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
PSI involvement	30.36	3.56	27.30	11.54
PSI autonomy	24.43	4.55	25.56	6.23
CRPBI mother acceptance	28.08	3.19	26.23	3.32
CRPBI mother psychological control	15.59	6.86	14.96	4.52
CRPBI mother firm control	20.69	7.87	21.94	5.60
CRPBI father acceptance	24.21	7.39	24.66	8.57
CRPBI father psychological control	14.51	5.42	15.09	4.23
CRPBI father firm control	20.59	6.74	19.23	5.97
CRPBI-PR involvement	57.92	5.54	59.23	5.32
CRPBI-PR negative control	22.34	5.57	19.95	7.33
CRPBI-PR lax discipline	26.77	2.30	28.16	2.68
PBA-Q total	44.23	6.74	47.71	7.32
PAAQ Inaction	24.33	8.57	24.76	7.71
PAAQ Unwillingness	27.93	5.38	25.07	6.99
PAAQ total	52.26	12.94	49.27	11.44
FASA total (pre-post)	12.49	10.12	8.00	5.46
FASA participation	9.07	7.14	5.98	4.22
FASA modification of functioning	3.45	3.68	1.89	2.38
PAS frequency	16.01	22.83	9.59	5.42
PAS impairment	10.99	12.42	7.21	5.34

Table 3

Continued

Variable	PS (<i>n</i> = 18)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
PSI involvement	29.91	4.15	28.90	11.53
PSI autonomy	25.62	4.18	25.99	6.14
CRPBI mother acceptance	26.25	4.32	24.84	5.72
CRPBI mother psychological control	13.74	7.47	16.57	7.62
CRPBI mother firm control	19.55	6.96	21.82	5.56
CRPBI father acceptance	24.15	7.17	25.67	6.15
CRPBI father psychological control	15.82	5.03	17.60	11.75
CRPBI father firm control	21.05	4.99	19.37	7.32
CRPBI-PR involvement	57.64	4.62	51.08	7.05
CRPBI-PR negative control	22.23	2.97	23.30	8.33
CRPBI-PR lax discipline	25.58	3.07	26.36	2.92
PBA-Q total	42.09	5.66	56.38	12.59
PAAQ Inaction	21.33	5.74	22.78	10.65
PAAQ Unwillingness	31.78	4.60	27.61	12.22
PAAQ total	53.11	6.49	50.54	20.49
FASA total (pre-post)	11.96	7.57	9.22	7.81
FASA participation	8.02	4.76	6.20	5.49
FASA modification of functioning	3.94	3.17	2.94	2.61
PAS frequency	7.61	5.30	6.36	9.26
PAS impairment	5.94	4.01	4.10	7.30

Table 3

Continued

Variable	F_{time}	$F_{time*condition}$
PSI involvement	2.68	0.92
PSI autonomy	0.16	0.46
CRPBI mother acceptance	0.01	0.27
CRPBI mother psychological control	3.46	2.19
CRPBI mother firm control	3.03	0.77
CRPBI father acceptance	6.79 *	1.29
CRPBI father psychological control	4.87 *	1.05
CRPBI father firm control	0.14	0.99
CRPBI-PR involvement	0.35	3.83 *
CRPBI-PR negative control	0.04	0.62
CRPBI-PR lax discipline	2.53	<0.01
PBA-Q total	0.95	4.76 *
PAAQ Inaction	<0.01	0.52
PAAQ Unwillingness	6.44 *	1.53
PAAQ total	2.72	1.07
FASA total (pre-post)	<0.01	0.64
FASA participation	0.32	1.20
FASA modification of functioning	1.15	0.20
PAS frequency	0.10	0.69
PAS impairment	0.04	0.45

Note: PIA = Promoting Independence and Autonomy group; PEC = Parent Education about CBT group; PS = Parental Support group; PSI = Parenting Style Inventory; CRPBI = Child Report of Parent Behavior Inventory; PR = parent report; PBA-Q = Parental Beliefs about Anxiety Questionnaire; PAAQ = Parental Attitudes and Actions Questionnaire; FASA = Family Accommodation Scale - Anxiety; PAS = Parent Accommodation Scale

* $p < 0.05$

Table 4

ANOVAs for child anxiety outcomes (pre-post) by parent group condition, with child gender and social phobia diagnosis as covariates

Variable	PIA (<i>n</i> = 15)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
Principal diagnosis composite CSR	5.27	0.59	3.58	3.23
MASC-C Total	47.67	23.67	52.72	50.04
MASC-C Physical	9.97	5.52	15.43	16.30
MASC-C Social	10.73	8.25	8.37	16.01
MASC-C Separation	11.40	6.46	12.35	11.53
MASC-C Harm	16.67	6.61	18.66	15.52
MASC-P Total	54.29	13.87	45.17	35.30
MASC-P Physical	10.16	6.52	7.11	9.00
MASC-P Social	15.73	6.25	14.37	11.07
MASC-P Separation	13.60	6.20	10.48	7.98
MASC-P Harm	16.60	3.48	14.52	11.96
CSDS school	3.80	2.46	3.28	7.26
CSDS social	2.13	2.00	4.32	7.26
CSDS home	4.77	2.69	2.21	7.23
CSDS-P school	6.53	3.64	2.92	7.73
CSDS-P social	5.80	2.83	3.85	3.04
CSDS-P home	5.09	2.57	1.92	3.34

Table 4

Continued

Variable	PEC (<i>n</i> = 14)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
Principal diagnosis composite				
CSR	5.29	0.73	3.81	2.14
MASC-C Total	49.41	21.61	38.27	35.69
MASC-C Physical	10.64	7.19	8.63	12.45
MASC-C Social	12.54	9.85	10.31	12.78
MASC-C Separation	11.48	5.47	8.28	7.09
MASC-C Harm	17.10	4.47	11.78	8.96
MASC-P Total	60.09	17.74	55.78	31.09
MASC-P Physical	11.85	5.05	9.55	6.24
MASC-P Social	18.42	8.37	16.86	12.15
MASC-P Separation	12.01	5.03	14.41	6.75
MASC-P Harm	19.74	5.92	17.92	10.99
CSDS school	3.29	2.81	1.93	4.53
CSDS social	2.36	3.03	3.22	4.85
CSDS home	2.86	2.91	2.88	4.17
CSDS-P school	6.97	2.96	3.42	7.91
CSDS-P social	6.87	3.24	4.12	4.09
CSDS-P home	4.92	1.76	2.83	3.34

Table 4

Continued

Variable	PS (<i>n</i> = 18)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
Principal diagnosis composite				
CSR	5.28	0.75	4.02	2.20
MASC-C Total	60.21	15.97	52.20	34.46
MASC-C Physical	15.48	6.27	12.79	13.98
MASC-C Social	15.11	7.86	14.80	11.96
MASC-C Separation	12.43	5.27	9.91	6.63
MASC-C Harm	18.47	3.88	15.18	6.30
MASC-P Total	51.31	17.75	49.72	34.78
MASC-P Physical	9.94	6.39	10.45	10.80
MASC-P Social	15.31	8.04	17.08	12.10
MASC-P Separation	11.38	4.96	9.24	6.96
MASC-P Harm	17.28	4.41	15.79	9.89
CSDS school	4.22	2.90	6.18	6.81
CSDS social	2.27	3.93	5.77	7.45
CSDS home	4.58	3.01	5.03	5.57
CSDS-P school	6.00	2.40	3.94	5.69
CSDS-P social	5.67	3.11	4.44	4.22
CSDS-P home	4.72	2.80	2.88	3.40

Table 4

Continued

Variable	F_{time}	$F_{time*condition}$
Principal diagnosis composite		
CSR	0.49	0.77
MASC-C Total	0.69	1.12
MASC-C Physical	0.03	2.23
MASC-C Social	0.50	0.15
MASC-C Separation	1.77	1.56
MASC-C Harm	2.01	1.63
MASC-P Total	0.62	0.67
MASC-P Physical	0.13	0.98
MASC-P Social	1.06	1.36
MASC-P Separation	0.23	0.62
MASC-P Harm	<0.01	0.10
CSDS school	0.11	1.42
CSDS social	0.51	0.61
CSDS home	0.01	1.09
CSDS-P school	0.39	0.51
CSDS-P social	0.62	1.16
CSDS-P home	2.07	0.68

Note: PIA = Promoting Independence and Autonomy group; PEC = Parent Education about CBT group; PS = Parental Support group; MASC-C = Multidimensional Anxiety Scale for Children - child report; MASC-P = MASC parent report; CSDS = Child Sheehan Disability Scale; CSDS-P = CSDS parent report
All p 's > 0.05

Table 5

ANOVAs for parenting behavior outcomes (pre-treatment to post-group) by parent group attendance (0-1 sessions vs. 2-3 sessions)

Variable	Low Attendance (<i>n</i> = 19)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
PSI involvement	31.49	3.50	23.83	14.85
PSI autonomy	24.41	4.76	25.55	7.44
CRPBI mother acceptance	27.47	6.09	25.67	5.22
CRPBI mother psychological control	16.70	10.22	16.58	12.97
CRPBI mother firm control	21.31	7.63	22.30	8.91
CRPBI father acceptance	23.30	12.77	24.46	7.49
CRPBI father psychological control	15.24	7.00	16.02	15.90
CRPBI father firm control	21.89	5.39	19.53	12.66
CRPBI-PR involvement	57.90	4.92	56.25	8.81
CRPBI-PR negative control	21.34	5.62	20.76	8.70
CRPBI-PR lax discipline	25.49	3.71	26.59	3.65
PBA-Q	43.50	6.36	44.08	12.76
PAAQ Inaction	25.43	7.45	28.49	10.61
PAAQ Unwillingness	29.32	6.12	31.36	9.26
PAAQ total	54.75	9.69	59.18	16.09
FASA total (pre-post)	15.50	10.81	15.39	11.60
FASA participation	10.33	6.78	10.91	7.70
FASA modification of functioning	5.19	4.84	4.22	4.51
PAS frequency	12.66	18.94	11.06	7.24
PAS impairment	9.75	11.35	8.59	6.28

Table 5

Continued

Variable	High Attendance (<i>n</i> = 28)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
PSI involvement	30.11	3.98	29.56	8.50
PSI autonomy	25.15	3.96	26.45	6.14
CRPBI mother acceptance	27.19	4.84	25.86	4.95
CRPBI mother psychological control	13.04	5.25	14.37	4.86
CRPBI mother firm control	19.97	6.70	21.37	4.64
CRPBI father acceptance	24.80	10.93	25.99	6.14
CRPBI father psychological control	14.01	4.76	14.25	8.40
CRPBI father firm control	20.94	5.32	19.44	7.90
CRPBI-PR involvement	57.36	4.67	54.66	7.87
CRPBI-PR negative control	22.21	4.33	22.78	6.90
CRPBI-PR lax discipline	25.93	2.77	26.85	2.92
PBA-Q	41.86	7.22	52.52	11.55
PAAQ Inaction	21.84	7.32	23.15	9.29
PAAQ Unwillingness	29.97	6.72	25.04	9.04
PAAQ total	51.80	10.20	48.25	15.91
FASA total (pre-post)	13.33	7.46	8.23	5.79
FASA participation	9.24	4.70	5.78	4.34
FASA modification of functioning	4.10	3.23	2.42	2.27
PAS frequency	8.79	14.69	6.66	8.05
PAS impairment	6.39	8.85	4.27	6.45

Table 5

Continued

Variable	F_{time}	$F_{time*attendance}$
PSI involvement	6.12 *	4.60 *
PSI autonomy	2.10	0.01
CRPBI mother acceptance	1.63	0.04
CRPBI mother psychological control	0.36	0.50
CRPBI mother firm control	0.68	0.02
CRPBI father acceptance	0.37	<0.01
CRPBI father psychological control	0.09	0.03
CRPBI father firm control	2.10	0.10
CRPBI-PR involvement	3.08	0.18
CRPBI-PR negative control	<0.01	0.28
CRPBI-PR lax discipline	3.75	0.03
PBA-Q	8.90 **	7.14 *
PAAQ Inaction	2.61	0.42
PAAQ Unwillingness	0.89	5.17 *
PAAQ total	0.03	2.83
FASA total (pre-post)	3.66	3.34
FASA participation	2.05	4.03
FASA modification of functioning	5.53 *	0.40
PAS frequency	0.49	0.01
PAS impairment	0.97	0.08

Note: PSI = Parenting Style Inventory; CRPBI = Child Report of Parent Behavior Inventory; PR = parent report; PBA-Q = Parental Beliefs about Anxiety Questionnaire; PAAQ = Parental Attitudes and Actions Questionnaire; FASA = Family Accommodation Scale - Anxiety; PAS = Parent Accommodation Scale

* $p < 0.05$

** $p < 0.01$

Table 6

ANOVAs for child anxiety outcomes (pre-treatment to post-group) by parent group attendance (0-1 sessions vs. 2-3 sessions)

Variable	Low Attendance (<i>n</i> = 19)			
	<i>M_{pre}</i>	<i>SD</i>	<i>M_{post}</i>	<i>SD</i>
Principal diagnosis composite				
CSR	5.33	0.84	4.66	3.20
MASC-C Total	57.17	24.56	64.04	52.07
MASC-C Physical	12.61	6.77	18.32	19.12
MASC-C Social	15.06	9.23	13.97	17.88
MASC-C Separation	12.83	6.46	13.59	10.82
MASC-C Harm	18.00	5.64	19.48	14.77
MASC-P Total	60.42	17.39	61.93	34.86
MASC-P Physical	12.72	7.12	11.54	9.78
MASC-P Social	18.10	7.82	20.08	13.13
MASC-P Separation	13.09	6.00	13.51	7.01
MASC-P Harm	18.33	4.57	18.79	12.06
CSDS school	4.11	2.83	4.34	8.97
CSDS social	2.94	3.00	6.02	9.38
CSDS home	5.06	2.96	3.41	8.27
CSDS-P school	6.63	3.48	4.72	10.35
CSDS-P social	6.29	3.32	5.41	4.51
CSDS-P home	5.62	2.36	3.53	4.56

Table 6

Continued

Variable	High Attendance (<i>n</i> = 28)			
	<i>M</i> _{pre}	<i>SD</i>	<i>M</i> _{post}	<i>SD</i>
Principal diagnosis composite				
CSR	5.24	0.58	3.29	1.84
MASC-C Total	50.40	17.96	38.40	26.97
MASC-C Physical	12.07	6.78	8.72	8.78
MASC-C Social	11.64	8.12	9.82	10.14
MASC-C Separation	11.19	5.05	8.10	6.15
MASC-C Harm	17.17	4.66	12.67	6.58
MASC-P Total	51.44	15.49	42.72	30.85
MASC-P Physical	9.26	4.85	7.61	8.28
MASC-P Social	15.29	7.35	13.71	10.02
MASC-P Separation	11.77	4.98	9.72	7.40
MASC-P Harm	17.47	4.90	14.30	9.68
CSDS school	3.62	2.66	3.77	4.53
CSDS social	1.82	3.11	3.63	4.14
CSDS home	3.55	2.82	3.54	3.75
CSDS-P school	6.35	2.67	2.68	3.49
CSDS-P social	5.93	2.91	5.41	4.51
CSDS-P home	4.45	2.38	1.95	2.11

Table 6

Continued

Variable	F_{time}		$F_{time*attendance}$	
Principal diagnosis composite				
CSR	13.07	**	3.12	
MASC-C Total	0.35		4.7	*
MASC-C Physical	0.45		6.69	*
MASC-C Social	1.09		0.07	
MASC-C Separation	1.46		3.96	
MASC-C Harm	1.04		4.11	*
MASC-P Total	0.61		1.23	
MASC-P Physical	1.23		0.04	
MASC-P Social	0.02		1.77	
MASC-P Separation	0.41		0.96	
MASC-P Harm	0.64		1.15	
CSDS school	0.06		<0.01	
CSDS social	8.26	**	0.55	
CSDS home	0.86		0.84	
CSDS-P school	7.74	**	0.77	
CSDS-P social	12.10	**	2.85	
CSDS-P home	21.04	***	0.18	

Note: PIA = MASC-C = Multidimensional Anxiety Scale for Children - child report; MASC-P = MASC parent report; CSDS = Child Sheehan Disability Scale; CSDS-P = CSDS parent report

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

CHAPTER 2

A REVIEW OF PARENT INVOLVEMENT IN PSYCHOSOCIAL TREATMENT FOR EXTERNALIZING AND INTERNALIZING DISORDERS IN YOUTH

Recent estimates suggest that as many as 60 percent of youth in the U.S. meet criteria for a mental health disorder at some point during childhood and/or adolescence (Copeland, Shanahan, Costello, & Angold, 2011) and that as many as one-third to one-half of these youth receive treatment (Merikangas et al., 2011). When it comes to psychosocial treatments for mental health disorders in youth, such interventions typically involve, to varying degrees, parents and other caregivers. At the very least, parents typically provide consent for their child's treatment and may bring them to therapy appointments, but the involvement of parents in treatment for disordered youth often extends beyond this minimal role. The parent may be a *consultant* to provide information about youth's problems and progress, a *collaborator* by facilitating youth's therapy progress at home and in the community, or a *client* or *co-client* by receiving intervention services themselves to change their behavior, parenting practices, and/or aspects of the home and family environment, either together with their child or on their own (Kendall, 2012).

Several factors may influence the degree and content of parental involvement. Parent involvement may depend on the age and developmental level of the child, such that parents may be more involved in treatment for younger children and less involved for more independent adolescents. In addition to developmental considerations, parental factors (e.g., behavior, psychopathology, parenting practices, parent-child communication, relationship quality, the family environment) that have been found to be

associated with child disorders may suggest differential parent involvement and may become targets of intervention. For example, theories of the development of disruptive behavior in children include coercive parenting and parental negative reinforcement of antisocial behavior as important contributors to these child problems (e.g., Forgatch & Patterson, 2010), and therefore developing more effective parenting behavior is an important target of intervention. Because youth with anxiety disorders often have anxious parents, some interventions for child anxiety have included components to address parent anxiety to complement individual child-focused therapy (Drake & Ginsburg, 2012b; Wei & Kendall, 2014).

Research on the role of parents in youth psychopathology and its treatment has been active for decades. At this juncture, what do we know about the degree to which various ways to operationalize parent involvement, as well as the content of parent interventions, contribute to differential child and adolescent mental health outcomes? This review considers various forms of parental involvement in psychosocial treatments for youth that have received empirical support. For externalizing disorders, empirically supported interventions that involve parents typically include some form of parent behavior management training as a primary focus of treatment, whether on its own or as an addition to child-focused treatment. Empirically supported psychosocial treatments for youth with internalizing disorders, such as cognitive behavioral therapy (CBT) are typically child-focused, with varying degrees of parent involvement depending on the age of the child and any parent factors that may be additional targets of intervention. The existing research on parent involvement in interventions for externalizing and

internalizing disorders in youth is reviewed, with specific consideration given to (a) the type of parental involvement and (b) the content of parent involvement.

Externalizing Disorders

A wealth of research has investigated the effects of parenting-focused interventions for youth with disruptive behavior disorders, including ODD and conduct problems. Many of the treatments that have received empirical support stem from social learning theories, specifically the notion that parenting practices, and subsequently parent-child relationships, play a key role in the etiology of disruptive and antisocial behavior problems in children and adolescents (e.g., Forgatch & Patterson, 2010). These disruptive behavior treatments are also influenced by Baumrind's (1971) theory that authoritative parenting, characterized by high levels of emotional warmth and consistent limit-setting, is most effective for increasing pro-social behaviors in children. Thus, interventions for externalizing disorders have typically included parents as co-clients, with a focus on training parents to model positive communication, along with minimizing negative and aggressive verbalizations by reinforcing desired behavior and implementing clear and direct consequences for undesired behavior. A summary of the reviewed parent intervention studies for externalizing disorders is provided in Table 7.

Disruptive behavior

One protocol that involves social-learning-based behavioral parent training, The Oregon Model, as well as similar variations on this model, have been compared to client-centered therapy, community care, and family therapy. In a study involving children with ODD, this parent training program resulted in a significantly greater reduction in

oppositional and defiant behavior than did a client-centered therapy or a waitlist condition per parent report. Significant differences were not found for observations of child and parent behavior, and the significant parent-reported differences at posttreatment were not maintained during a two-year follow-up period (Bernal, Klinnert, & Schultz, 1980). However, when the Oregon Model parent behavior management training intervention was compared with usual community care for conduct problems in children, clinician observations indicated that children's oppositional and defiant behavior improved significantly more than children who received community care (Patterson, Chamberlain, & Reid, 1982). Interventions focused on training parents in behavior management have yielded improvements significantly greater than those achieved by family therapy. In a comparison of parent behavior management training for youth with oppositional and defiant behavior (including providing rewards and positive attention contingent on desirable behavior, giving effective commands, and timeout for noncompliant behavior) with structural family therapy, parents in the behavior management condition were observed to show significantly more reinforcement and contingent attention at post-treatment than those in the structural family therapy condition, and children were observed to demonstrate significantly greater compliance with commands (Wells & Egan, 1988).

Parent training for behavioral management of disruptive behaviors has been found to be efficacious even for high risk youth, in comparison to both no treatment and standard community services, such as those provided through the juvenile justice system. In a study investigating Oregon Model parent behavioral management training (e.g., monitoring target behaviors and using effective consequences for negative behavior) for

pre-adolescents with conduct problems and a history of criminal offenses compared to usual services provided by the community and court system, youth in the parent training condition showed significantly lower rates of serious criminal offenses and incarceration time than those receiving community services across the five years after the start of treatment (Bank, Marlowe, Reid, Patterson, & Weinrott, 1991). At a nine-year follow-up of Oregon Model parent management training for recently divorced mothers aimed at lessening the risk of child (6 to 9 years) externalizing problems and parent-child conflict, youth in the parent management training condition had significantly lower levels of teacher-reported disruptive behaviors, fewer arrests, and longer latency to first arrest than youth in a control group who did not receive treatment, with treatment condition explaining 3 to 5 percent of the variance in arrests (Forgatch, Patterson, Degarmo, & Beldavs, 2009). Social-learning-based training in positive parenting has been found to have significant benefits even when additional family risk factors (e.g, marital conflict, parental stress and psychopathology) are not directly addressed. In a study conducted with families of children with ADHD and disruptive behavior who were at high risk for conduct problems, positive parenting training was associated with significantly better outcomes in terms of both child and parent behaviors than a waitlist control, and an enhanced treatment that also addressed specific family risk factors was no more effective than standard, non-enhanced positive parenting treatment (Bor, Sanders, & Markie-Dadds, 2002).

Although the above reviewed studies demonstrate that parent training interventions based in social learning theory, such as the Oregon Model and its variants, have been found to be efficacious for addressing disruptive behavior in youth, additional

research has attempted to further investigate how parent training contributes to outcomes, either as a standalone intervention or as a specific component of broader treatment for youth with behavior problems. Findings from an investigation of the long-term maintenance of gains in the study of parent management training for divorced mothers suggested that improvements in maternal depression were subsequent to improvements in child behavior, which were subsequent to improvements in parenting practices (DeGarmo, Patterson, & Forgatch, 2004). These findings suggest that parent training on its own may directly and indirectly contribute to multiple positive outcomes over time. A study involving adolescents with ADHD and ODD attempted to extract key components of behavioral treatment in terms of content and whether parents alone or parents and youth participated, but results were inconclusive. The results indicated that parental behavior management training involving reinforcement and contingency management strategies was equally efficacious as working with parents and youth together on problem solving and communication strategies, and combining the two treatments was no more efficacious than the parent-child treatment on its own (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001). Studies that have examined parent training in comparison to child-focused and teacher-focused treatment have resulted in somewhat mixed findings, with results indicating that parent-, child-, and teacher-training interventions may all result in beneficial outcomes. A study that compared child group behavior training alone with parent group behavior management training alone and combined child and parent group training for young children with conduct problems found that having the parent training component resulted in significantly greater parent-reported child behavior improvements and independently observed positive parent behaviors than child training

only, but improvements in observed child problem solving and conflict management were significantly greater when child training was involved than with parent training alone (Webster-Stratton & Hammond, 1997). When the addition of teacher training to either child training, parent training, or both was investigated, all treatment conditions were found to be significantly more effective than the control condition in reducing conduct problems; however, regarding more specific outcomes, the inclusion of parent training was associated with significantly fewer negative parenting behaviors and more positive parenting behaviors, the inclusion of child training was associated with significantly more prosocial skills with peers and less negative parenting, and the inclusion of teacher training was associated with significant improvement in classroom behavior management (Webster-Stratton, Reid, & Hammond, 2004). These results suggest that, in addition to parent training, additional intervention components that involve teachers or the child directly may each contribute unique outcomes in different contexts. Indeed, a study investigating a parent training program offered through an elementary school for entering kindergarten students identified as having behavior problems indicated that parent behavior management training did not have any added benefit to a classroom intervention, and parent training in the absence of a classroom intervention was no more effective than no treatment at reducing disruptive behavior at home or at school (Barkley et al., 2000). On the other hand, studies investigating the Coping Power program for aggressive youth as they transition to middle school have shown combined child and parent group components to be superior to a universal classroom prevention program, as well as a child-only Coping Power intervention, when it comes to reducing substance use, aggression, and disruptive classroom behavior over three years post-treatment (Lochman

& Wells, 2002, 2004; Lochman, Wells, Qu, & Chen, 2013; Zonneville-Bender, Matthys, van de WIEL, & Lochman, 2007). These results add to the evidence that management of disruptive behavior may need to be addressed in multiple contexts, although there is some evidence that the parent training component is especially key.

It may be especially beneficial to consider the many contexts that influence youth's behavior when addressing severe externalizing and antisocial problems. One intervention for children and adolescents with conduct problems, known as multisystemic therapy, incorporates behavioral parent training along with improving family interactional patterns and relationships, addressing maladaptive peer relationships, and increasing positive participation in the school and community environments, to address the many contexts that may be involved in maintaining antisocial behavior.

Multisystemic therapy has been found to be efficacious for reducing criminal activity and improving family functioning for adolescents who have a history of criminal offenses, compared to typical court-mandated intervention services and individual therapy.

Juvenile offenders, identified as having been involved in "serious criminal activity," receiving multisystemic therapy had significantly lower arrests (effect size $d=0.45$) and peer aggression ($d=0.34$) and significantly greater family cohesion ($d=0.56$) than offenders receiving usual community services (Henggeler, Melton, & Smith, 1992). A similar study comparing multisystemic family therapy, which targeted both family relationships and problem behaviors, with typical juvenile justice services for youth with multiple criminal offenses found that those in the multisystemic therapy condition showed significantly greater improvements in aggressive behavior, psychological distress, depression, and parental monitoring than offenders receiving typical community

services (Scherer, Brondino, Henggeler, Melton, & Hanley, 1994). Another investigation of multisystemic treatment for serious juvenile offenders indicated that it was more effective than individual therapy in improving family member adjustment problems, family relations, family communication, and future criminal offenses (Borduin et al., 1995). More recently, a study that compared multisystemic therapy for adolescents court-ordered for treatment to the usual justice system intervention found that, although the number of offenses throughout 18 months post-treatment did not significantly differ between conditions, the rate of offense reduction was significantly faster for youth in multisystemic therapy, and youth who had received multisystemic therapy had a more than four times lower risk of offense than usual care in the last six months of the follow-up period (Butler, Baruch, Hickey, & Fonagy, 2011). Another recent study found that youth with aggressive antisocial behavior (many of whom had committed crimes) who received multisystemic therapy had significantly more parent-reported decreases in disruptive behavior and observed increases in positive parenting and parent-child relationship quality than youth in usual community care (Asscher et al., 2013). This body of research lends support to the theory that the parent-child relationship is a necessary target of treatment for disruptive behavior in youth, along with the family as a whole, the school environment, and the community.

Many of the parent training interventions that have received empirical support are largely didactic in format, with some modeling and role-playing included. One intervention, however, uses a largely experiential format with in vivo observation and coaching from a therapist to help parents achieve mastery in effective parenting skills with their young children. Parent-child interaction therapy (PCIT) has an emphasis on

increasing positive interactions through positive attending and allowing child autonomy, as well as effectively managing negative behavior through direct commands, planned ignoring, and timeouts (Zisser & Eyberg, 2010). PCIT has been associated with significant improvements in observed positive parent-child interactions and parent-reported child compliance, parenting stress, and overall child behavior compared to a waitlist control condition in one study with preschool-age children with ODD (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). In another study, PCIT was associated with significantly more improvement in disruptive behavior than a waitlist control condition by parent report ($d=0.83$) and behavioral observation ($d=0.96$) (Nixon, Sweeney, Erickson, & Touyz, 2003).

Based on studies that have examined varying degrees of parent training, it appears that behavioral parent management interventions need not be intensive and lengthy to produce positive outcomes. Three studies have found brief interventions to be beneficial compared to no treatment or usual care, and results of another suggested that a brief version of a parent-training intervention may be as efficacious as a longer version. From an early prevention perspective, families of toddlers at risk for conduct problems who received three brief “check-up” sessions with up to six follow-up sessions involving parent behavior management training had significantly greater reductions in child disruptive behavior ($d=0.45$) and significantly more maternal involvement than controls during the two years following the intervention (Shaw, Dishion, Supplee, Gardner, & Arnds, 2006). A similar brief check-up program was found to be effective at preventing substance use in adolescents, with maintenance (instead of decline) in parental monitoring practices mediating outcomes (Dishion, Nelson, & Kavanagh, 2003). A brief

primary-care-based positive parenting intervention implemented with families of children with autism spectrum disorders who had externalizing behavior problems was associated with significantly better improvements in child disruptive behavior and family function than usual care according to parent report, although not according to observation of child and parent behaviors (Tellegen & Sanders, 2014). A study of brief PCIT for preschoolers with oppositional defiant disorder found that, although standard-length PCIT may have shown significantly more reliable and clinically significant change at post-treatment (as defined by parent-reported disruptive behavior below the clinical cutoff and 1.96 standard errors below pre-treatment) than the waitlist, whereas the abbreviated treatment did not, the two PCIT interventions were not different in terms of reliable change at six-month follow-up (Nixon et al., 2003). Although brief intervention may still be effective, face-to-face interaction with a clinician may be important. One study found that clinician-directed training in positive parenting and effective discipline for 3-year-olds with disruptive behavior was associated with significantly less disruptive child behavior and dysfunctional parent behaviors at post-treatment than self-directed training and a waitlist control condition (Sanders, Markie-Dadds, Tully, & Bor, 2000).

Interventions targeting ADHD

Because there is a great deal of overlap between ADHD and disruptive behavior disorders (R. C. Kessler et al., 2014), many of the youth participating in parent training studies for oppositional and defiant behavior also had ADHD, suggesting that parent behavior management interventions may be helpful for addressing problematic behavior in ADHD youth. An additional body of research has investigated parent involvement in behavioral treatments for ADHD directly. Two of these have involved parents as

collaborators in child-focused or school-based treatments, which showed benefits compared to control conditions. In a study in which parents of 6 to 12-year-old children with and without ADHD were given psychoeducational training to facilitate their children's progress in a social skills group treatment, the children in treatment showed significantly greater improvement in assertiveness and self-control than children on a waitlist (Frankel, Myatt, Cantwell, & Feinberg, 1997). In an investigation of a school-based intervention for children with ADHD and disruptive behavior which implemented a daily report card with target behavior goals, parents were trained in contingency management strategies with rewards and consequences based on performance on target behaviors at school, in monthly meetings throughout the school year. Teachers reported significant improvement in academic functioning, attention, and teacher relations in the treatment condition compared to waitlist controls, and parents reported significantly greater improvement in oppositional and defiant behavior at home (Owens et al., 2005). These studies suggest that psychosocial interventions for ADHD that involve parents as collaborators may be efficacious, although it is unclear what role the parent component plays in treatment outcomes.

Other studies have included parents as co-clients by incorporating training in social-learning-based behavior management as a component of treatment in a variety of settings. A large RCT evaluating the efficacy of stimulant medication treatment, behavioral intervention, and their combination compared with usual community care incorporated a parent training component in the behavioral intervention that emphasized rewarding appropriate behavior and compliance, ignoring negative behavior, and planned consequences for non-compliance. At post-treatment, medication management alone and

combined treatment were found to be more effective than community care on measures of hyperactive and impulsive behavior, social skills, and parent-reported parent-child conflict, whereas the behavioral intervention alone was not significantly more effective than community care (The MTA Cooperative Group, 1999). Follow-up analyses with outcomes calculated as a composite of ADHD symptoms and functioning, however, indicated that combined treatment had a small but significant superior effect compared to medication alone (Hinshaw, Arnold, & For the MTA Cooperative Group, 2015). In a trial evaluating concurrent child and parent group treatments for social skills and managing behavior in elementary-school children with ADHD, participants in the treatment condition showed significant improvements in functioning and parent use of behavior modification strategies than those in the control group, but only in the home setting (Tutty, Gephart, & Wurzbacher, 2003). A study that investigated behavioral parent group training for children with ADHD in a managed care setting, consisting of didactic content and role plays regarding behavior charts, effective commands, rewarding positive behavior, and timeout procedures, concurrent with a child social skills group, found that two-thirds of parents reported at least a 0.5 standard deviation decrease in disruptive behavior from pre- to post-treatment, although the lack of a control condition limits the conclusions that can be drawn (Tynan, Schuman, & Lampert, 1999). Similar to the studies involving parents as collaborators, these studies suggest that including parents as co-clients in ADHD treatment may be beneficial, but they do not provide conclusions about the benefit of the parent component specifically.

Additional research has investigated the efficacy of parent behavior management training interventions on their own for ADHD youth, with the parents as clients. In two

studies that did not include control conditions, both showed significant decreases in parenting stress, but only one showed a significant decrease in child behavior problems. In one study, which incorporated psychoeducation and behavior management techniques for the home setting, such as positive communication, effective discipline, consequences, timeout, and a token economy, parents reported significantly decreased parenting stress at post-treatment, but they did not report a significant decrease in the degree of child behavior problems in the home setting (Weinberg, 1999). In a study investigating training parents of children with ADHD and defiance in behavior management strategies (e.g., effective commands, praise, timeout, and other consequences) using a flowchart as a visual guide, significant improvements in children's hyperactive, aggressive, and oppositional behavior, as well as parent behavior and parenting stress, were found at post-treatment (Danforth, Harvey, Ulaszek, & McKee, 2006). Two studies found that parent training programs were efficacious compared to control conditions, with both child and parent benefits. In a trial evaluating a program training parents of 6 to 9-year-olds with ADHD to promote positive relationships with their children using praise, planned quality time, and reward systems and to effectively manage behavior using clear rules and consequences, timeouts, and planned ignoring, parents in the treatment condition reported significantly greater reductions in child disruptive behaviors and less verbosity in their disciplinary responses than parents in a waitlist control condition (Hoath & Sanders, 2002). In a randomized controlled trial investigating the efficacy of parent training to facilitate attention, organization, and behavioral management in preschoolers with ADHD using strategies for clear commands and reminders, emphasis on praise, clear limit-setting, and timeouts, participants in the behavioral training group showed

significantly greater improvements in child ADHD symptoms and maternal well-being at post-treatment and four-month follow-up than those in a parent support comparison group and a waitlist control group (Sonuga-Barke, Daley, Thompson, Laver-Bradbury, & Weeks, 2001). When this parent training was delivered by routine primary care health providers instead of specialists, however, there was not significant improvement in either ADHD symptoms or maternal well-being at post-treatment in either the treatment condition or the waitlist control condition (Sonuga-Barke, Thompson, Daley, & Laver-Bradbury, 2004).

Although few studies have directly studied the use of PCIT to treat ADHD symptoms in young children, the measurement of ADHD symptomatology in studies investigating the efficacy of PCIT for oppositional and defiant behavior suggests that this behavioral management intervention, with its parent coaching format and ongoing mastery assessment, may be effective as a treatment for ADHD in preschoolers (Wagner & McNeil, 2008). A recent preliminary study began implementing PCIT with additional emotion regulation coaching components to target ADHD in preschoolers, and early findings suggest that it may be an effective intervention, although more research is needed (Chronis-Tuscano et al., in press).

Summary

Parent involvement in psychological interventions targeting youth with externalizing problems, either on its own or as a component of broader treatment focused on youth, teachers, and/or the community, has empirical support for effectively addressing these externalizing problems. Promising outcomes extend beyond the reduction of disruptive behaviors in children to include improvements in parenting

practices, classroom management, parent mental health, and criminal involvement.

Numerous studies that involved parents as clients or co-clients in treatment resulted in significant decreases in disruptive behavior symptoms, suggesting that this type of parent involvement is an efficacious intervention for youth with externalizing problems. In terms of content, parent interventions that involve training in behavior management based on social learning theories have shown significant benefits over waitlist controls, usual care in healthcare settings and the juvenile justice system, and structural family therapy, indicating that behavior management training for parents in the social learning tradition is efficacious for disruptive behavior (Eyberg, Nelson, & Boggs, 2008). Most studies of parent interventions for externalizing problems target pre-adolescent children, with PCIT geared towards pre-school-age children and multisystemic therapy showing efficacy for adolescents. More research is needed, however, to compare different treatment formats in such a way that the optimal form of parent intervention for different age ranges can be determined.

Although social learning theories suggest that parenting practices are a key component of the etiology of disruptive behavior problems and should therefore be a target of treatment, it is not quite clear at this juncture whether the inclusion of parents at the co-client level or training in behavior management are necessary for beneficial outcomes, because few studies compared parent training interventions to child-focused treatments. Results of those that did compare parent training to child training and classroom-based interventions suggested that each of these components may contribute specific beneficial outcomes in different contexts (e.g., at home, at school, with peers). The efficacy of multisystemic therapy, which addresses problems across contexts, adds to

the evidence that interventions that include parents as part of broader treatment are beneficial. However, research is needed to more definitively conclude whether behavioral parent training is necessary and/or sufficient for treating externalizing disorders in youth.

Internalizing Disorders

Parent involvement in psychosocial treatments for internalizing disorders (anxiety and depression) in children and adolescents has consisted of consultant, collaborator, and co-client roles. When parents have been included at the co-client level, a variety of parent behaviors and characteristics have been addressed as part of the interventions, typically those that have been found to correlate with child anxiety or depression. That said, empirical support for parental involvement as a necessary component of treatment has been mixed. For depression interventions, few studies have directly assessed the added benefit of parent involvement compared to youth-focused treatment without parent involvement. More anxiety intervention studies have investigated the specific added benefit of parent involvement, but some have found it to be more beneficial than child treatment alone and some have found it to be equally efficacious. A summary of the reviewed treatment studies for internalizing disorders that involve parents is provided in Table 8.

Anxiety Disorders

A number of parental factors have been associated with child anxiety, such as parent anxiety and subsequent modeling of anxious behavior, parental intrusiveness and overcontrol, accommodation of avoidance behavior, and dysfunctional parent-child

relationships characterized by high levels of rejection and criticism (e.g., Wei & Kendall, 2014). Therefore, some parent interventions have aimed to address these factors with parents as co-clients, while others target parents as collaborators in facilitating their children's therapy progress, such as by coordinating out-of-session behavioral exposure tasks. Others involve only brief consultation with parents to help assess symptoms and progress. The format of parent involvement in treatments for anxious youth also varies in the literature, with some interventions working with parents and children in a family therapy format, others working to coach parents more directly, and others utilizing a didactic group treatment format.

Parents as collaborators in CBT.

Because CBT has been established as an efficacious treatment for anxiety disorders in youth (Hollon & Beck, 2013b; Ollendick & King, 2012), many studies have investigated how involving parents in CBT for anxious youth may be beneficial. Some research has involved parents as collaborators in their child's treatment by instructing them in the CBT principles and coping strategies that are provided to their child, as well as strategies for coordinating at-home exposures, such as reward systems and contingency management, and these interventions have been shown as efficacious. One study investigated the efficacy of a group CBT treatment that involved a separate parent group treatment, as compared to a waitlist control. Parents were instructed in contingency management strategies for youth's completion of behavioral exposures, as well as in allowing their child to use learned coping strategies. Youth in the treatment condition showed significantly more improvement in anxiety symptoms at post-treatment than those in the control condition, with an effect size of $\eta^2 = 0.37$ (W. K. Silverman et

al., 1999b). In a similar study of group CBT, parents were taught contingency management strategies in one condition, promotion of youth's use of cognitive coping strategies in another condition, and both of these were compared to an education and support control group. All conditions had significant parent-reported and child-reported decreases in anxiety from pre- to post-treatment but did not differ from each other (W. K. Silverman et al., 1999). In a study in which parents only were trained in managing their young children's anxiety through the reinforcement of confident behavior and at-home behavioral exposures, significantly more youth whose parents were in the treatment condition no longer met criteria for an anxiety disorder at post-treatment than those in a waitlist control group with those in the treatment condition over seven times more likely to be diagnosis-free than controls (Cartwright-Hatton et al., 2011). These results suggest that CBT interventions that involve parents are efficacious in treating anxiety in youth, but it is unclear whether parent involvement has superior benefits compared to child-focused CBT.

Findings from research that has directly investigated the added benefit of parent collaboration in CBT for anxiety have not found much convincing evidence for improved outcomes. In a study in which family CBT, child-only CBT, and parent-only CBT for child anxiety were compared, the family and parent-only conditions involved parents as collaborators by teaching them strategies to effectively promote coping behaviors in children, including psychoeducation, relaxation and cognitive restructuring strategies, and improving family interactions. There was no significant difference between treatment conditions in terms of post-treatment anxiety symptom reduction, but children in the family condition demonstrated better post-treatment coping than youth in the other

conditions (Mendlowitz et al., 1999). In a study that added parental cognitive training to CBT for anxious youth, in which parents were educated about anxiety and taught cognitive restructuring, problem solving, and contingency management so they could collaborate in their child's treatment, there was no observed benefit of adding the parent training (Nauta et al., 2003). However, children in a family-based CBT treatment for separation anxiety that included parents as collaborators and consisted of cognitive restructuring, coping strategies, and training in implementing exposures had significantly faster reductions in separation avoidance across treatment than those in an individual-based CBT treatment, according to maternal report, although the treatments did not differ from each other at post-treatment or one-year follow-up (Schneider et al., 2013a).

Parents as co-clients to address parental anxiety.

Studies with parent interventions aimed at addressing parental anxiety, with parents as clients or co-clients, have also had mixed results. In one recent study, the addition of a parental anxiety management module to family-based CBT for youth anxiety did not significantly improve anxiety outcomes, for youth or their parents (Hudson et al., 2014b). In another recent study, however, youth in group CBT for anxiety whose parents completed a group treatment to manage parental anxiety were significantly less likely to have an anxiety diagnosis three years post-treatment than youth who received group CBT alone, with a medium effect size of $\omega=0.5$ (Cobham et al., 1998, 2010a). A parent-only CBT-based treatment was developed for anxious youth who refused individual treatment. Parents in this study were trained in reducing anxiety-accommodating behaviors and decreasing anxious modeling, and 60% of these youth were rated by clinicians as improved at post-treatment (Lebowitz et al., 2014).

Additional interventions have included parent anxiety management and the reduction of anxious modeling in addition to other CBT strategies for parents, with two recent studies showing that including this content for co-client parents was efficacious compared to a waitlist control group and compared to school-based treatment only. In one study, parents who participated in a CBT-based training program to respond adaptively to their children's anxiety, reduce anxious modeling, and facilitate behavioral exposures showed significantly greater decreases in child anxiety interference ($\eta^2 = 0.30$) than those in a waitlist control group (Smith et al., 2014). In the other, in which a parent training group was added to school-based group CBT for youth with social phobia whose parents had high levels of expressed emotion, parents were trained in positive communication, reducing anxious modeling, contingency management, and encouraging non-avoidant behavior. Youth in the condition that included the parent training showed significantly lower self-reported anxiety symptoms at post-treatment than youth whose parents were not involved in treatment with an effect size of $d=0.65$ (Garcia-Lopez, Díaz-Castela, Muela-Martinez, & Espinosa-Fernandez, 2014). However, several other studies did not find that parental anxiety management and CBT skills training had any additional benefit to child-focused treatment. In an RCT that taught parents adaptive expectations about anxiety, how to respond constructively to children's anxious distress and encourage mastery, as well as how to manage their own anxiety in a family-based CBT treatment, youth in this condition did not differ in outcome from youth in individual CBT, although both had significantly greater decreases in clinician-rated anxiety severity than a family education and support control condition (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008b). Similarly, in a study that compared a parent education treatment, in

which parents learned strategies for assisting in their child's treatment, coping with their own anxiety, and effective communication and problem solving, to parent education in conjunction with group child CBT, both treatments were efficacious compared to a waitlist control, but they did not differ significantly from each other (Waters et al., 2009). In a study investigating parent involvement in youth group CBT for social phobia, youth in a parent-involvement condition, in which parents were instructed to model non-anxious and pro-social behavior, encourage practice of social skills, and reinforce social interaction and therapy homework completion, did not show significantly better outcomes than youth who participated in group CBT without parent involvement (Spence, Donovan, & Brechman-Toussaint, 2000). Children in CBT for anxiety whose parents received training in contingency management, parental anxiety management, and effective communication and problem-solving skills were significantly more likely to no longer meet criteria for an anxiety disorder at post-treatment than children in CBT whose parents did not receive training, but there was no difference between the conditions at 6-month or 6-year follow-up (Barrett, Dadds, & Rapee, 1996; Barrett, Duffy, Dadds, & Rapee, 2001).

Parents as co-clients to address parental overcontrol.

Reviews and meta-analyses have indicated that parental overcontrol, including a lack of psychological autonomy granting, has the strongest association with child anxiety among parenting behaviors (Drake & Ginsburg, 2012b; McLeod et al., 2007; Wei & Kendall, 2014). A meta-analysis by van der Bruggen and colleagues (2008) determined that the association between parental control and child anxiety has a medium effect size of $d = 0.58$. McLeod and colleagues (2007) found that parental control had a weighted

mean effect size of 0.25 and accounted for 6% of the variance in child anxiety, and out of five subdimensions of rejection and control, lack of autonomy granting had the largest weighted mean effect size (0.42), accounting for 18% of the variance in child anxiety. However, studies of parent involvement in CBT for anxious youth that directly address autonomy granting have been limited, and those that have addressed it have had mixed results. Two studies specifically targeted parental intrusiveness and the granting of psychological autonomy as a main goal of intervention, with parents as co-clients, and one addressed autonomy granting along with parental anxiety management. In one study that specifically addressed parental autonomy granting, parents were instructed in communication skills that allowed their children to make decisions and learn by trial-and-error on their own without their parents intervening for them. Children in this family-based treatment experienced a significantly greater decline in anxiety than children in individual-based CBT, with a large effect size of $d = 0.92$ (Wood et al., 2006). The other study was smaller and investigated a family-based CBT treatment for adolescent anxiety as compared to individual CBT. Parents in the family condition were instructed in promoting psychological autonomy in their child and reducing family conflict. There was no significant difference in diagnostic status or child-reported anxiety symptoms between the family-based and child-based conditions, although the small sample size may have limited the power to detect effects, and there was a trend towards more child-reported autonomy granting in the family-based condition (Siqueland et al., 2005). In the study that focused on the granting of autonomy along with targeting parental anxiety and modeling of anxious behavior, in family-based CBT for child anxiety, results indicated that significantly more children in the individual-based treatment no longer met criteria

for an anxiety disorder than in the family-based CBT condition, although the difference between treatment conditions disappeared at three-month follow-up (Bodden et al., 2008). These results collectively suggest that including parents as co-clients may have added benefit when the focus of the intervention is on reducing intrusiveness and granting autonomy.

One recent study investigated different degrees of parental involvement in CBT for anxious youth (e.g., collaborator or co-client), as well as addressing intrusive parenting. Two treatment conditions compared the inclusion of parents as co-clients in treatment, during which parents were trained to decrease intrusive behavior, use positive problem solving, and encourage courageous behavior through contingency management, to inclusion of parents as “co-facilitators” in the child’s treatment (i.e., minimal involvement at the end of sessions to inform parents about at-home exposures), but outcomes for the two conditions did not differ (Barbara H. Esbjørn et al., 2015). Of note, this most recent study was preliminary, with the aim of pilot-testing two different treatment formats to inform a future study investigating the benefit of selecting a type of parent involvement based on case conceptualization. In this preliminary study, families were assigned randomly to treatment conditions, not based on case conceptualization, and thus the treatments may have significantly different outcomes if selected based on conceptualization of the child’s and family’s needs.

Although only recently implemented to address anxiety in young children, PCIT has emerged as an intervention with some empirical support that has a focus on granting autonomy, with parents as co-clients. A pilot study that investigated the use of PCIT in 4 to 8-year-old children with separation anxiety and their parents found that traditional

PCIT components, including encouraging child autonomy and managing children's negative behavior, resulted in some reductions in children's separation anxiety symptoms, but symptoms remained at a clinical level (Pincus, Eyberg, & Choate, 2005; Pincus, Santucci, Ehrenreich, & Eyberg, 2008). However, preliminary data suggests that the addition of an anxiety-focused component to traditional PCIT, which provided psychoeducation and encouraged parents to promote "bravery-directed interactions" (BDI's) through separation exposure situations, ignoring avoidant behavior, and rewarding brave behavior, results in significant improvement in separation anxiety symptoms to a non-clinical level (Pincus et al., 2008). A PCIT-based, parent-focused treatment was developed to treat a wider range of anxiety disorders in young children (under 7 years), which incorporated parent mastery of positive, non-intrusive attending, followed by in-session coaching of parents in directing behavioral exposures, encouraging parents to model brave behavior, attend positively to the child's approach behaviors, and actively ignore the child's anxious and avoidant behaviors (Puliafico, Comer, & Albano, 2013). A small pilot study involving nine families resulted in 85.7% of treatment completers and 66.7% of the intent-to-treat sample being diagnosis-free at post-treatment (Comer et al., 2012). In an investigation of a PCIT-based group intervention for preventing social anxiety in behaviorally-inhibited preschool-age children, children in the treatment group showed significantly greater improvements in total anxiety symptoms (effect size $g=0.88$) and parent-rated social anxiety symptoms ($g=0.84$) compared to waitlist controls (Chronis-Tuscano et al., 2015).

Depression

Several investigations of the efficacy and effectiveness of psychosocial treatments for depression in youth have included parents as part of the intervention, to varying degrees. In some studies investigating CBT for depression in youth, parents were involved as collaborators to facilitate their child's treatment. For example, some interventions have included parent education about the coping skills and strategies that are taught in their child's treatment. Although one of these studies found the intervention to be beneficial compared to a waitlist control condition, others did not find psychosocial interventions that included parent collaboration to be significantly more beneficial than usual community care or SSRI medication treatment. 8 to 12-year-old children in a brief psychoeducational group treatment whose parents participated in a separate psychoeducational group focused on problem-solving, coping skills, and communication skills showed greater improvement in depression symptom severity than those in a waitlist control group (Fristad, Verducci, Walters, & Young, 2009). However, a study that involved parents in three informational sessions as part of group adolescent CBT for depression within a healthcare setting did not find that CBT was any more effective than usual care (Clarke et al., 2002). One RCT comparing individual CBT for depressed adolescents to SSRI treatment and combination treatment involved concurrent parent therapy sessions and two family sessions in the CBT condition, and parent session components included psychoeducation, behavior management, problem-solving, and communication skills, as well as relaxation training and cognitive restructuring. The CBT-only condition had greater rates of treatment response than the SSRI-only and combination conditions, but the conditions did not differ in rates of full remission from depression (Melvin et al., 2006). One brief CBT intervention for depressed adolescents

in conjunction with an SSRI and treatment as usual that included monthly parent education meetings was not found to be significantly more effective than SSRI treatment alone (Clarke et al., 2005). Similarly, a brief CBT treatment for adolescent depression added to typical SSRI treatment, which included some parent involvement at the end of each session, was no more effective than typical SSRI treatment alone (Goodyer et al., 2007). In an RCT in which CBT showed significantly greater post-treatment reduction in depression symptoms in adolescents than placebo only when combined with fluoxetine, the CBT treatment included two parent education sessions and one to three family sessions (Treatment for Adolescents with Depression Study (TADS) Team, 2004).

Several parent factors, such as parental depression, rejection, withdrawal, overcontrol, and criticism, as well as poor parent-child attachment, have been associated with depression in youth (see Stark, Banneyer, Wang, & Arora, 2012, for a review). Therefore, some CBT interventions for depression in youth have involved parents as co-clients to address these parental factors in addition to helping parents facilitate their child's progress through psychoeducation. In a small, uncontrolled pilot study, 66% of 8 to 12-year-old children in a CBT-based, family-focused intervention that addressed communication, family interactions, and problem-solving had recovered at post-treatment, although conclusions are limited due to the lack of a control group (Tompson et al., 2007). Two studies have found that CBT with parents as co-clients in conjunction with antidepressant medication was associated with significant benefits compared to medication alone. In a sample of depressed adolescents who were SSRI non-responders, switching to another antidepressant while participating in CBT that involved three to six family sessions to address communication and problem-solving resulted in a significantly

higher likelihood of clinically significant improvement in depression symptoms (effect size $g=0.29$) than switching to a new antidepressant alone (Brent et al., 2008). Depressed adolescents who participated in CBT following a response to antidepressant medication, which included family sessions to address expressed emotion, family wellness, and family attributions, were significantly less likely to relapse than adolescents who continued medication management alone, with a hazard ratio of 8.80 (Kennard, Emslie, et al., 2008; Kennard, Stewart, Hughes, Jarrett, & Emslie, 2008). Overall, there exists a good deal of empirical support for CBT for depressed adolescents that involves parents as co-clients, with some findings indicating that it may be beneficial for younger children as well. However, it is unclear from this body of research whether parent involvement is a necessary component of CBT to produce beneficial outcomes in depressed youth.

Few studies have directly investigated the added benefit of parent involvement in therapy for depressed youth by comparing an intervention with parent involvement to the same intervention without parent involvement. In one study, which compared individual CBT for adolescent depression with systemic behavior family therapy and a nondirective supportive therapy, CBT showed significantly better symptom improvement outcomes than the other two treatments (Brent et al., 1997). Three studies have compared CBT with a parent component to CBT without the parent component, with results suggesting that there may be some benefits of involving parents, but not a significant difference in depression symptom improvement compared to CBT without parent involvement. In one study, adolescents in group CBT for depression whose parents met in a concurrent group that reviewed CBT skills as well as conflict-resolution and problem-solving skills did not show significantly more improvement in depression symptoms than adolescents whose

parents did not receive treatment, although both groups showed significantly more improvement than a waitlist control group. Parents in the parent-treatment condition also reported better overall adolescent functioning than parents in the adolescent-only condition (Lewinsohn, Clarke, Hops, & Andrews, 1990). In a similar study using the same comparison, but in which parents and adolescents met together for two sessions to practice problem-solving and communication skills, there was still no significant outcome difference between the adolescent-only and parent-included conditions, but both treatments were still superior to waitlist (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999). In a recent study that investigated whether adding a parent training component had additional benefit over youth-focused CBT for depression alone, the parent training focused on a positive emotional family environment, positive behavior management, improved empathic communication, problem solving, and positive family interactions. Although youth did not show significantly different improvement in depression when a parent group was added, results indicated significantly greater improvement in family communication and cohesion (Stark et al., 2012).

Parental involvement has been studied in non-CBT interventions for depressed youth as well. In a pilot study of contextual emotion regulation therapy for 7 to 12-year-old children with dysthymia in which parents were involved as “coaches” in emotion regulation throughout treatment, depression symptom severity decreased significantly from pre- to post-treatment, although the lack of a control group limits conclusions about findings (Kovacs et al., 2006). In a pilot study that evaluated the use of PCIT with an additional emotional development module to coach parents in teaching their depressed pre-schoolers’ emotion recognition and regulation skills, no significant differences were

found in post-treatment depression symptoms compared to a child development education control condition; however, the power to detect differences may have been limited by a small sample size and large number of dropouts in the comparison condition. Children in the PCIT condition did show significantly better emotion recognition and executive functioning than controls, and parents showed significantly less parenting stress (Luby, Lenze, & Tillman, 2012).

Based on the associations between negative parent-child communication and poor attachment and depression in youth, several interventions have targeted parent-child relationships and overall family functioning in family-based treatment. Two studies have found family therapy to be superior to a waitlist control condition and to usual care in reducing depressive and suicidal symptoms. In a study that examined the efficacy of an attachment-based family therapy for adolescent depression, in which the focus was on repairing family relationships, resolving conflicts, and empathetic and supportive parent communication, adolescents in treatment showed significantly lower rates of depression diagnoses, fewer self-reported depression symptoms (effect size = 1.24), and less self-reported parent-child conflict (effect size = 1.21) than those in a waitlist control group (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002). In a randomized clinical trial evaluating the effectiveness of attachment-based family therapy for depressed adolescents expressing suicidal ideation compared to usual care, the family treatment focused on strengthening parent-adolescent relationships, parental empathy and emotion-focused parenting, problem-solving, communication, and adolescent autonomy. Results indicated that youth in attachment based family therapy experience significantly greater decreases in suicidal ideation compared to youth in usual care, and they may show

greater improvement in depressive symptoms (Diamond et al., 2010). However, two studies that compared family therapy to individual treatment call into question whether family therapy is necessary in improving depressive symptoms, although it may have other benefits. Families of adolescents who received family therapy focused on education about depression and improvement of family communication, interaction, and problem-solving, in addition to usual individual treatment for depression (e.g., medication, individual or group counseling) reported greater positive functioning and relationships than families of adolescents who received usual depression treatment alone, but the adolescents in the family therapy condition showed only marginally significantly fewer depression symptoms (Sanford et al., 2006). Depressed 8 to 15-year-old youth in a systems-based family treatment, in which the focus was on improving family interaction patterns and relationships, showed significantly lower depression severity at post-treatment than youth in a weekly individual psychodynamic psychotherapy treatment that included separate bi-weekly parent sessions, but there was no difference between the two treatment groups at six-month follow-up (Garoff, Heinonen, Pesonen, & Almqvist, 2012).

Summary

A number of studies have investigated interventions for anxiety and depression in youth that involve parents. Parent involvement in CBT for anxious children and adolescents has ranged from a role of collaborator, in which parents are educated about anxiety and CBT to help parents facilitate out-of-session exposures and trained in contingency management to encourage non-avoidant behavior, to a role of co-client, in which parents are trained in positive communication and problem solving, managing their

own anxiety and anxious modeling, and reducing parental intrusiveness and overcontrol. Additionally, the coaching of parents in child-directed interactions, positive attending, and encouragement of brave behavior through PCIT has recently been studied in young anxious children. Similarly, parent involvement in CBT for depression has ranged from psychoeducation in a collaborator role to training in communication and problem solving, behavior management training, and improving family relationships in a co-client role. Family-based interventions for depressed youth that focus on repairing dysfunctional family relationships improving family interactions have also been studied. Most of the depression intervention studies have involved only adolescents, with few studies including younger children in the sample. Although many of these depression interventions that involved parents were found to be efficacious, few studies compared them to similar interventions that did not involve parents. Therefore, reviews of the depression literature have typically refrained from drawing any conclusions about the added benefit of parent involvement in treatment due to the limited number of studies that have directly investigated this question (e.g., Stark et al., 2012).

Among studies that directly addressed the question of whether parent involvement has any added benefit to youth-focused treatment for anxiety, the results of the current literature suggest that involving parents as collaborators, by educating them in CBT skills to assist their children with exposures, does not have a significant benefit over youth-focused CBT with minimal parent involvement. When parents are included as co-clients, however, the literature suggests that their involvement may have a significant benefit, which may depend on the content of the parent intervention. It is difficult to determine the optimal content for parent co-client interventions based on existing research, because

many interventions address multiple parent factors in varying combinations. Parental anxiety management was included as a component in many interventions with parents as co-clients, but most studies did not find these interventions to be superior to child-focused treatment. The one study that addressed parental anxiety specifically, however, did find that treatment that included this component had superior long-term gains compared to treatment without it (Cobham et al., 2010a). Similarly, a study that specifically targeted parental intrusiveness and granting autonomy in family treatment found this condition to be superior to child treatment (Wood et al., 2006). Although there are not yet enough studies of this nature to draw definitive conclusions, it appears that parent involvement may have a significant added benefit to CBT for anxious youth when a specific parenting factor, such as parental anxiety or intrusive behavior, is targeted.

Conclusions

Different levels of parent involvement in youth's psychological therapy for externalizing and internalizing problems have been examined. Because etiological models of externalizing behavior problems in youth view a coercive cycle of parent-child interactions as an important factor in the development of these problems, parent training is seen as a key component of reducing youth's disruptive behaviors. The efficacy of several different parent training interventions for disruptive behaviors associated with ODD, conduct disorder, and ADHD has been well-established (Eyberg et al., 2008). Although the delivery has varied across interventions, with some presented didactically and some involving direct coaching of parents in interactions with their children, these interventions involve parents as co-clients and have been similar to each other in content, with the majority based in social learning and reinforcement theories of disruptive

behavior. Parent training interventions have typically included components focused on monitoring target desired and undesired behaviors, increasing positive attending and rewards for desired behavior, giving effective commands, reducing coercive and negative verbalizations, and implementing clear and direct consequences (e.g., timeouts, removal of privileges) for undesired behaviors. Because several interventions involving similar parent training components have resulted in positive outcomes in terms of child behavior, parent behavior, criminal involvement, and parent mental health, it is clear that parent behavior management training is efficacious for addressing externalizing behavior problems in youth.

What is less clear about parent involvement and youth externalizing behavior is whether having parents as co-clients is necessary for successful outcomes. The few studies that have compared different combinations of parent and child treatment, as well as teacher training, have suggested that each type of treatment contributes to positive outcomes in different contexts, indicating that including parents may be necessary for maximum gains, although further research is needed to confirm such considerations. Furthermore, because most studies involved pre-adolescent youth, research is needed to investigate the benefit of parent involvement in addressing externalizing problems at later ages. The few studies that included adolescents support the efficacy of parent training in this age group when an intervention targets multiple contexts.

For internalizing disorders, the well-established psychosocial treatments for anxiety and depression (i.e., CBT and interpersonal therapy) are typically focused on the youth individually, with parent involvement varying from consultant to co-client. Studies that compared an intervention that involves parents to a no-treatment control condition do

not allow conclusions regarding the specific added benefit of involving parents in treatment versus treating youth only. Among those studies that compared parent involvement to child-focused treatment without parent involvement, several factors obscure conclusions. For depression, although parent training to reduce dysfunctional communication and improve parent-child relationships may be promising targets of treatment, too few studies have compared the inclusion of these components directly with individual treatment (Stark et al., 2012). Also, most of the depression literature has studied adolescents, with few controlled studies examining parent involvement in depressed pre-adolescent children. For anxiety, although meta-analyses indicate that parent involvement appears to be beneficial (e.g., Manassis et al., 2014), the available research does not adequately address the necessary degree or the needed content of parent involvement. The available research suggests that including parents as CBT collaborators has no significant added benefit over child CBT with minimal parent involvement (i.e., as consultants) and that including parents as co-clients to address parent factors associated with anxiety may have added benefit. However, a recent preliminary study compared including parents in a collaborator role and including them in a co-client role, and no differences in child outcomes were found.

The present review identified the content addressed in parental involvement for anxiety disorders as an area in need of research. Regarding content of interventions for parents who were co-clients in CBT for youth anxiety, most of the interventions studied to date have addressed multiple targets, including any combination of parent anxiety management, modeling of anxious behavior, contingency management to reduce avoidance behavior, facilitating exposure tasks, positive communication, problem

solving, and increasing autonomy granting. As Barmish and Kendall (2005) concluded in their review, caution must be taken regarding conclusions about the benefit of parent involvement in anxiety treatment due to the variability of the content across studies. Although parenting interventions have been based on the parent factors associated with child anxiety, including multiple interventions in different combinations across studies makes it difficult to determine which components are necessary. The beneficial effects of one important component may be “watered down” by the inclusion of others. For example, several studies that included parental anxiety management as one of multiple targets of parent involvement in CBT did not find the addition of parents as co-clients to be superior to child-focused treatment. However, one study that included a parent intervention focused specifically on parental anxiety found significantly better long-term outcomes than CBT without parents as co-clients. More research in which co-client parent interventions are focused on specifically targeting parental anxiety will help elucidate the benefits of addressing parent anxiety in child CBT.

Because research suggests parental overcontrol has the strongest association with child anxiety compared to other parent factors (Drake & Ginsburg, 2012b; McLeod et al., 2007; Wei & Kendall, 2014), addressing parental overcontrol directly offers promise as a specific target for parent involvement. Only one study with sufficient statistical power (Wood et al., 2006) addressed parental overcontrol as the focus of the parent intervention without attempting to address other parent factors. Parents were trained to grant their child more psychological autonomy by offering choices rather than choosing for them, allowing them to learn from their mistakes and struggles instead of stepping in to solve the problem, and validating their emotional experiences. This intervention produced

significant outcomes over individual-based CBT with an effect size of $d = 0.92$.

Therefore, focusing on autonomy granting as a target of parent involvement in CBT for anxiety may be key in the treatment of anxiety disorders in youth. In general, studies are needed that include parents as co-clients in CBT for anxious youth, in which the parent intervention focuses on a specific parenting factor.

Research examining the involvement of parents in psychosocial interventions for children and adolescents offers some support for the conclusion that interventions that involve parents as collaborators or as co-clients can provide added benefit. Needed areas of future research in treating externalizing problems include comparing the efficacy of well-established parent-training programs to child-focused treatments to determine the necessity of parent involvement. For internalizing problems, research is needed comparing the inclusion of parents at the co-client level to their inclusion as collaborators or consultants, as well as parental interventions that have a targeted focus on specific parenting factors. Furthermore, because youth have comorbid disorders that may include both internalizing and externalizing problems, the efficacy of parenting interventions for multiple areas of concern merit development and evaluation.

Table 7

Treatment studies for externalizing disorders involving parents

Study	N/Condition	Age	Principal Dx	Tx Format	Parent Sessions	Outcomes
<i>Disruptive Behavior Disorders</i>						
Bernal et al., 1980	BPT = 12 Client-centered = 12 WLC = 12	5-12	above-average conduct problems	Parent Management Training - Oregon Model	10	BPT > Client-Centered = WLC by parent report; no differences by behavioral observation
Patterson et al., 1982	BPT = 10 TAU = 9	3-11	Disruptive behavior \geq 90th percentile	Parent Management Training - Oregon Model	1 to 32	BPT > TAU by behavioral observation
Wells and Egan, 1988	BPT = 9 SFT = 10	3-8	ODD	Social-learning-based parent training	8 to 12	BPT > SFT by behavioral observation
Bank et al., 1991	BPT = 28 TAU = 27	12-16	\geq 2 criminal offenses	Parent Management Training - Oregon Model	unlimited ($M = 21.5$ hrs.)	BPT > TAU at end of Year 1 (tx year) by number of offenses; BPT = TAU at 1-yr. & 2-yr. FU

Table 7

Continued

Henggeler et al., 1992	FT = 43 TAU = 41	13-16	"serious criminal activity"	Multisystemic Therapy	5 to 23 (<i>M</i> = 13.4)	FT > TAU by arrests & incarceration rates
Scherer et al., 1994	FT = 31 TAU = 24	11-17	≥ 3 criminal arrests	Multisystemic Family Preservation	unlimited (<i>M</i> = 3.5 mos.)	FT > TAU by parent report
Borduin et al., 1995	FT = 92 IT = 84	12-17	≥ 2 criminal arrests	Multisystemic Therapy	5 to 49 (<i>M</i> = 23.9)	FT > IT by observed post-treatment family interactions; FT > IT by risk of arrest over 4 years post-treatment
Webster-Stratton and Hammond, 1997	BPT = 26 CT = 27 BPT+CT = 22 WLC = 22	4-7	ODD & CD	Incredible Years Parent Training	22	BPT = CT = BPT+CT > WLC by parent report; BPT = BPT+CT > CT = WLC by observed parent-child interactions
Schuhmann et al., 1998	BPT = 37 WLC = 27	3-6	ODD	Parent-Child Interaction Therapy	unlimited (<i>M</i> = 13)	BPT > WLC by observed parent praise and criticism and parent-reported child behavior

Table 7 <i>Continued</i>	BPT = 39	4-6		social-learning-based parent training	15	Classroom = BPT+classroom > BPT = No Tx by parent and teacher reports
Barkley et al., 2000	Classroom = 37 BPT+classroom = 40 No Tx = 42		disruptive behavior \geq 93rd percentile			
Sanders et al., 2000	Standard BPT = 77 Enhanced BPT = 76 Self-directed BPT = 75 WLC = 77	3	elevated behavior problems	Triple P - Positive Parenting Program	10 (Standard BPT) 12 (Enhanced BPT)	Enhanced BPT = Standard BPT > Self-directed BPT = WLC
Barkley et al., 2001	PSCT = 58 PSCT+BPT = 39	12-18	ODD & ADHD	Social-learning-based parent training; Family problem-solving and communication training	18	PSCT = PSCT+BPT; both had statistically significant pre to post improvement
Bor et al., 2002	Standard BPT = 29 Enhanced BPT = 26 WLC = 32	3	ODD & ADHD	Triple P - Positive Parenting Program	10 (Standard BPT) 12 (Enhanced BPT)	Enhanced BPT = Standard BPT > WLC

Table 7

<i>Continued</i>	BPT/CT+PT M = 61	10-12	31% most aggressive in classroom	Coping Power (child groups and parent groups)	16	1-yr. FU: CP conditions > NoTx conditions for aggression and social skills 3-yr. FU: CP conditions > NoTx conditions (linear effects)
Lochman and Wells, 2002; Lochman et al., 2013	NoTx+PTM = 62 BPT/CT only = 59 NoTx = 63					
Dishion et al., 2003	BPT = 35 Assessment only control = 36	11-15	High risk for substance abuse	Family Check-Up (motivational interviewing)	3 per year for 3 years	BPT > control for substance use, mediated by parental monitoring
Nixon et al., 2003	PCIT = 17 Abbreviated PCIT = 20 WLC = 18	3-5	ODD	Parent-Child Interaction Therapy	12 (PCIT) 5 (Abbreviated PCIT)	both PCIT > WLC by parent report and observation
Lochman and Wells, 2004	BPT+CT = 60 CT only = 60 TAU = 63	10-12	Boys with high teacher-rated aggression	Coping Power	16	BPT+CT > CT > TAU for school behavior; BPT+CT > CT = TAU for parent-reported substance abuse

Table 7

Continued

Webster-Stratton et al., 2004	BPT = 31 CT = 30 BPT+TT = 24 CT+TT = 23 BPT+CT+TT = 25 WLC = 26	4-8	ODD	Social-learning-based parent training	22 to 24	all treatment conditions equal and > WLC for mothers' parenting and child behavior; BPT = BPT+TT = BPT+CT+TT > CT+TT = CT = WLC for fathers' parenting by parent report and observation
Shaw et al., 2006	BPT = 60 No Tx = 60	2	family risk factors for conduct problems	Family Check-Up (social-learning-based)	up to 6	BP > No Tx by parent report of child behavior and observation of maternal involvement
Zonnevylle-Bender et al., 2007	BPT+CT = 30 TAU = 31	8-13	Disruptive behavior disorder	Coping Power (adapted slightly)	15	After 5 years: BPT > TAU for marijuana/cigarette use; No difference for delinquency
Forgatch et al., 2009	BPT = 153 No Tx = 85	6-9	recently separated single mothers	Parent Management Training - Oregon Model	14	BPT > No Tx by teacher report and average arrests over 9-year FU

Table 7

Continued

Butler et al., 2011	FT = 56 TAU = 52	13-17	Court-ordered for treatment or 6 months after release from prison	Multisystemic Therapy	11 to 30 weeks	FT > TAU by rate of decline in number of offenses
Ascher et al., 2013	FT = 147 TAU = 109	12-18	severe and violent antisocial behavior	Multisystemic Therapy	unlimited (<i>M</i> = 6 months)	FT > TAU by parent- reported decrease in disruptive behavior & observation of positive discipline and relationship quality
Tellegen and Sanders, 2014	BPT = 35 TAU = 29	2-9	ASD	Primary Care Triple P	4	BPT > TAU by parent report but not observation
<i>ADHD</i>						
Frankel et al., 1997	SST = 49 WLC = 24	6-12	ADHD & ODD	Facilitation of social skills training	12	SST > WLC by teacher and parent report

Table 7

Continued

MTA Cooperative Group, 1999	BT = 144 MM = 144 BT+MM = 145 TAU = 146	6-10	ADHD	Social-learning- based parent training	35	BT+MM = MM > BT = TAU by parent and teacher reports
Tynan et al., 1999	BPT+CT = 55	5-11	ADHD	Social-learning- based parent training	8	2/3 had clinically significant pre to post improvement by parent report (≥ 0.5 standard deviations)
Weinberg, 1999	BPT = 25	4-12	ADHD	Social-learning- based parent training	6	significant pre-post improvement in parenting knowledge and stress but not parent-reported child behavior
Sonuga- Barke et al., 2001	BPT = 30 PCS = 28 WLC = 20	3	ADHD	Social-learning- based parent training	8	BPT > PCS = WLC by parent report and observation of ADHD symptoms
Hoath and Sanders, 2002	BPT = 9 WLC = 11	5-9	ADHD	Group Triple P	5 (+4 phone consultations)	BPT > WLC by parent report of behavior problems at post; both

Table 7
Continued

Tutty et al., 2003	BPT+CT = 59 TAU = 41	5-12	ADHD	Social-learning-based parent training & facilitating social skills	8	groups showed significant reduction over time BPT+CT > TAU by parent report but not teacher report
Sonuga-Barke et al., 2004	BPT = 59 WLC = 30	3	ADHD	Nurse-delivered social-learning-based parent training	8	BPT = WLC
Owens et al., 2005	SBT = 30 WLC = 12	5-12	ADHD & other externalizing concerns	Social-learning-based parent training	bi-weekly during school year	SBT > WLC for parent-reported OD behavior and teacher-reported attention & academics
Danforth et al., 2006	BPT = 49	4-12	ADHD with disruptive behavior	Behavior Management Flow Chart	8	significant pre-post decrease in parent-reported and observed behavior problems
Chronis-Tuscano et al., in press	PCIT-ED = 6 PCIT-EC _o = 3	2-7	ADHD	Parent-Child Interaction Therapy with Emotional Development or Emotion Coaching	unlimited	PCIT-ED: majority showed significant pre-post improvement by parent & teacher report; PCIT-EC _o : 2/3 had significant pre-post improvement by

Table 7
Continued

parent & teacher
 report

Note: BPT = behavioral parent training; WLC = waitlist control; TAU = treatment as usual; ODD = oppositional defiant disorder; SFT = structural family therapy; FT = family treatment; IT = individual therapy; CT = child treatment; CD = conduct disorder; PSCT = problem-solving and communication training; PTM = parent and teacher meetings; ADHD = attention deficit hyperactivity disorder; SST = social skills training; ASD = autism spectrum disorder; MM = medication management; PCS = parent counseling and support; SBT = school-based treatment; PCIT-ED = parent-child interaction therapy with emotional development; PCIT-EC_o = parent-child interaction therapy with emotion coaching; FU = follow-up

Table 8

Treatment studies for internalizing disorders involving parents

Study	N/Condition	Age	Principal Dx	Tx Format	Parent Tx Components	Parent Sessions	Outcomes
<i>Anxiety</i>							
Barrett et al., 1996 & 2001	CT = 28 CT+FT = 25 WLC = 26	7-14	SAD, GAD, or SoP	CBT	contingency management, parent anxiety management, communication & problem-solving skills	12	Percentage no longer meeting anxiety criteria: CBT+FT > CBT > WLC at post; CBT+FT = CBT > WLC at 6-mo. And 6-year FU
Cobham et al., 1998 & 2010	CT = 35 CT+PT = 32	7-14	SAD, GAD, SoP, or Specific Phobia	CBT	parent anxiety management	4	Diagnostic status: CBT = CBT+PT overall at post; CBT+PT > CBT at post if parents had anxiety & overall at 3-yr. FU
Mendlowitz et al., 1999	CT = 23 PT = 21 FT = 18 WLC = 40	7-12	any anxiety disorder	Group CBT	CBT skills, behavioral strategies	12	Significant reduction in anxiety symptoms for females in CT, PT, & FT. No significant change for WLC and no difference between

groups.

Table 8
Continued

Silverman et al., 1999a	CT+PT = 37 WLC = 19	6-16	SAD, GAD, or SoP	Group CBT	CBT skills, contingency management	not reported	Diagnostic status: CT+PT > WLC at post
Silverman et al., 1999b	CT+PT(CM) = 40 CT+PT(SC) = 41 ESC = 23	6-16	Specific Phobia	Group CBT	contingency management <i>or</i> cognitive coping skills	10	All conditions had significant decrease in parent- and child- reported anxiety symptoms and did not differ from each other.
Spence et al., 2000	CT = 19 CT+PT = 17 WLC = 14	7-14	SoP	Group CBT	coping modeling, facilitating exposures, contingency management	12	Clinician-rated anxiety severity: CT = CT+PT > WLC
Nauta et al., 2003	CT = 29 CT+PT = 30 WLC = 30	7-18	SAD, GAD, SoP, or Panic	CBT	cognitive restructuring, problem-solving, contingency management	11	diagnostic status: CT = CT+PT > WLC

Table 8
Continued

Siqueland et al., 2005	CT = 6 CT+FT = 5	12- 18	SAD, GAD, or SoP	CBT & attachment -based family therapy	granting psychological autonomy, reducing family conflict	16	CT = CT+FT for diagnostic status and child-reported anxiety symptoms. Trend CT+FT > CT for child-reported autonomy granting
Pincus et al., 2005 & 2008	PT = 27	4-8	SAD	adapted PCIT	granting autonomy, positive attention, contingency management, facilitating exposures	approx. 9	significant pre to post improvement in clinician-rated anxiety severity
Wood et al., 2006	CT = 19 FT = 19	6-13	SAD, GAD, or SoP	CBT	granting autonomy, reducing intrusiveness, contingency management	12 to 16	clinician-rated anxiety severity: FT > CT
Bodden et al., 2008	CT = 64 FT = 64 WLC = 25	8-17	any anxiety disorder	CBT	coping modeling, beliefs about control & protection, granting autonomy	13	diagnostic status: CT > FT > WLC at post; CT = FT at 3-mo. FU

Table 8

Continued

Kendall et al., 2008	CT = 55 FT = 56 ESC = 50	7-14	SAD, GAD, or SoP	CBT	maladaptive beliefs, constructive responses to anxiety, parental anxiety	16	diagnostic status & clinician-rated anxiety severity: CT = FT > ESC
Waters et al., 2009	PT = 25 CT+PT = 24 WLC = 11	4-8	SAD, GAD, SoP, or Specific Phobia	Group CBT	CBT skills, communication, problem-solving, parental anxiety	10	diagnostic status & clinician-rated anxiety severity: PT = CT+PT > WLC
Cartwright- Hatton et al., 2011	PT = 38 WLC = 36	2-9	above clinical anxiety threshold by parent report	Group CBT	CBT skills, contingency management	10	diagnostic status: PT > WLC
Comer et al., 2012	PT = 9	4-8	SAD, GAD, SoP, or Specific Phobia	adapted PCIT	positive attention, granting autonomy, coping modeling, facilitating exposures	12	66.7% of intent-to- treat and 85.7% of completers diagnosis- free at post

Table 8

Continued

Schneider et al., 2013	CT = 33 FT = 31	8-13	SAD	CBT	CBT skills, facilitating exposures	16	diagnostic status: CT = FT; faster decrease in separation avoidance for FT by maternal report
Garcia-Lopez et al., 2014	CT = 32 CT+PT = 20	13- 18	SoP and high expressed emotion in parents	CBT	coping modeling, positive communication, contingency management	5	diagnostic status: CT = CT+PT; child report: CT+PT > CT
Hudson et al., 2014	FT = 100 FT+PT = 109	6-13	any anxiety disorder	CBT	CBT skills, parent anxiety management	5	child and parent diagnostic status: FT = FT+PT
Lebowitz et al., 2014	PT = 10	9-13	SAD, GAD, SoP, or OCD	CBT	coping modeling, reducing accommodation	10	60% rated as improved by clinicians at post
Smith et al., 2014	PT = 18 WLC = 13	7-13	SAD, GAD, SoP, or Specific Phobia	CBT	CBT skills	10	diagnostic status & clinician-rated severity: PT > WLC
Esbjorn et al., 2015	CT = 26 CT+PT = 28	7-12	SAD, GAD, SoP, or Specific Phobia	CBT	modifying beliefs to reduce intrusiveness, contingency management,	7	diagnostic status: CT = CT+PT

Table 8
Continued

					problem-solving		
Chronis-Tuscano et al., 2015	CT+PT = 18 WLC = 22	3-5	elevated parent-reported behavioral inhibition	adapted group PCIT	positive attention, granting autonomy, coping modeling, facilitating exposures, contingency management	8	clinician-rated diagnoses & severity: CT+PT > WLC (marginal); parent-reported social anxiety: CT+PT > WLC
<i>Depression</i>							
Lewinsohn et al., 1990	CT = 19 CT+PT = 21 WLC = 19	14-18	MDD	Group CBT	CBT skills, problem-solving & communication	7	diagnostic status: CT = CT+PT = WLC; parent report: CT+PT > CT
Brent et al., 1997	CT = 37 FT = 35 ESC = 35	13-18	MDD	Systemic Family Therapy	communication & problem-solving, improving interaction patterns	12 to 16	diagnostic status: CT = FT; CT > ESC
Clarke et al., 1999	CT = 45 CT+PT = 42 WLC = 36	14-18	MDD or Dysthymia	Group CBT	CBT skills, problem-solving & communication	9	diagnostic status: CT = CT+PT > WLC

Table 8

Continued

Clarke et al., 2002	CT+PT = 41 TAU = 47	13- 18	MDD or Dysthymia & parent treated for depression	Group CBT	CBT skills	3	CT+PT = TAU by diagnostic status and self-report
Diamond et al., 2002	FT = 16 WLC = 16	13- 17	MDD	Attachment -based family therapy	repairing attachments, empathetic communication, granting autonomy	12	FT > WLC for self- reported depression and parent-reported conflict
TADS Team, 2004	CT = 111 SSRI = 109 CT+SSRI = 107 PC = 112	12- 17	MDD	CBT	psychoeducation	3 to 5	clinician-rated severity: CT+SSRI > CT = SSRI = PC; clinician-rated improvement: CT+SSRI = SSRI > CT = PC
Clarke et al., 2005	CT+SSRI = 75 SSRI = 77	12- 18	MDD	CBT	psychoeducation	monthly	CT+SSRI = SSRI by diagnostic status and self-report
Kovacs et al., 2006	CT = 20	7-12	Dysthymia	contextual emotion regulation therapy	coaching emotion regulation	30	significant decrease in diagnosis rate across 12-mo. FU

Table 8

Continued

Melvin et al., 2006	CT = 22 SSRI = 26 CT+SSRI = 25	12- 18	MDD, Dysthymia, or Depression NOS	CBT	CBT skills	12	diagnostic status: CT > SSRI; full remission: CT = SSRI = CT+SSRI
Sanford et al., 2006	FT = 16 TAU = 15	13- 18	MDD	family psychoedu- cation	psychoeducation, communication, problem-solving	12	self-report depression: FT = TAU; self- & parent- report family functioning: FT > TAU
Goodyer et al., 2007	CT+SSRI = 105 SSRI = 103	11- 17	MDD	CBT	CBT skills (check- in at end of each session)	12	CT+SSRI = SSRI
Tompson et al., 2007	FT = 9	8-12	MDD, Dysthymia, or Depression NOS	CBT and family systems features	improving family interaction patterns, communication, problem-solving	12	diagnostic status: 66% recovered at post & 77% recovered at 9-mo. FU

Table 8

Continued

Brent et al., 2008	SSRI = 86 SSRI+CT = 83 VF = 83 VF+CT = 83	12- 18	MDD and had not responded to 2-month SSRI trial	CBT	positive communication, problem-solving	3-6 family sessions	clinician-rated improvement: SSRI+CT = VF+CT > SSRI = VF
Kennard et al., 2008a & 2008b	SSRI = 24 SSRI+CT = 22	11- 18	MDD and responded to 12 weeks of SSRI	CBT	expressed emotion, family functioning, family attributions	≥3 family sessions	risk for relapse: SSRI+CT > SSRI
Fristad et al., 2009	FT = 78 TAU = 87	8-12	MDD or bipolar disorder	psychoedu cational psychother apy	psychoeducation, communication, problem-solving, symptom management	8	clinician-rated severity: FT > TAU
Diamond et al., 2010	FT = 35 TAU = 31	12- 17	elevated suicidal ideation & ≥ moderate self-reported depression	attachment -based family therapy	increasing empathy, granting autonomy, communication & problem-solving, strengthening relationships	12	self-reported suicidal ideation: FT > TAU at post, no difference at 3-mo. FU

Table 8
Continued

Garoff et al., 2012	CT = 35 FT = 37	8-15	MDD or dysthymia	psychodyn amic therapy (child); systemic family therapy	improving family relationships	14	self-report: FT > CT at post but not FU
Luby et al., 2012	PT = 27 ESC = 27	3-7	parent- reported risk for depression	adapted PCIT	granting autonomy, positive attention, contingency management, emotion coaching	14	clinician-rated severity: PT = ESC; parent report of emotion regulation & executive function: PT > ESC
unpublished study described in Stark et al., 2012	CT = not reported CT+PT = not reported WLC = not reported	not repo rted	not reported	Group CBT	positive behavior management, conflict management, improving family interactions	10	self-reported family functioning: CT+PT > CT = WLC

Note: CT = child treatment; FT = family treatment, WLC = waitlist control; SAD = separation anxiety disorder; GAD = generalized anxiety disorder; SoP = social phobia; CBT = cognitive behavioral therapy; PT = parent treatment; ESC = education/support control; CM = contingency management; SC = self-control; PCIT = parent-child interaction therapy; MDD = major depressive disorder; TAU = treatment as usual; SSRI = selective serotonin reuptake inhibitor; VF = venlafaxine

CHAPTER 3

SUPPLEMENTARY ANALYSES

Table 9

Linear regressions of change in parenting variables (pre-post) on number of parent group sessions attended

Dependent Variable	β	t	R^2
PSI involvement	-2.84	1.82	0.07
PSI autonomy	0.40	0.51	0.01
CRPBI mother acceptance	-0.05	0.04	<0.01
CRPBI mother psychological control	-0.52	0.54	0.01
CRPBI mother firm control	0.18	0.14	<0.01
CRPBI father acceptance	-0.61	0.34	<0.01
CRPBI father psychological control	-0.01	0.01	<0.01
CRPBI father firm control	-0.64	0.52	0.01
CRPBI-PR involvement	0.25	0.21	<0.01
CRPBI-PR negative control	0.43	0.42	<0.01
CRPBI-PR lax discipline	-0.17	0.35	<0.01
PBA-Q	-4.30	2.43 *	0.12
PAAQ Inaction	0.68	0.54	0.01
PAAQ Unwillingness	2.67	1.84	0.07
PAAQ total	3.19	1.43	0.04
FASA total (pre-post)	-16.91	1.82	0.07
FASA participation	-11.32	2.05 *	0.09
FASA modification of functioning	-5.60	1.31	0.04
PAS frequency	0.24	0.10	<0.01
PAS impairment	0.11	0.07	<0.01

Note: PSI = Parenting Style Inventory; CRPBI = Child Report of Parent Behavior Inventory; PR = parent report; PBA-Q = Parental Beliefs about Anxiety Questionnaire; PAAQ = Parental Attitudes and Actions Questionnaire; FASA = Family Accommodation Scale - Anxiety; PAS = Parent Accommodation Scale

* $p < 0.05$

Table 10

Linear regressions of change in child anxiety variables (pre-post) on number of parent group sessions attended

Dependent Variable	β	t	R^2
Principal diagnosis composite CSR	0.58	1.73	0.06
MASC-C Total	6.80	1.65	0.06
MASC-C Physical	3.88	2.36 *	0.11
MASC-C Social	0.66	0.51	0.01
MASC-C Separation	1.00	1.08	0.03
MASC-C Harm	1.46	1.03	0.02
MASC-P Total	5.94	1.40	0.04
MASC-P Physical	0.71	0.60	0.01
MASC-P Social	1.90	1.54	0.05
MASC-P Separation	1.28	1.09	0.03
MASC-P Harm	2.07	1.32	0.04
CSDS school	0.36	0.49	0.01
CSDS social	0.85	1.09	0.03
CSDS home	-0.68	0.82	0.01
CSDS-P school	1.24	1.35	0.04
CSDS-P social	0.81	1.78	0.07
CSDS-P home	0.10	0.22	<0.01

Note: MASC-C = Multidimensional Anxiety Scale for Children - child report; MASC-P = MASC parent report; CSDS = Child Sheehan Disability Scale; CSDS-P = CSDS parent report

* $p < 0.05$

Table 11

Correlations between change in parenting variables (pre-group - post-group) and change in child anxiety variables (pre-CBT - post-CBT)

Variables	CSR		MASC-C		Phys-C		Social-C	
PSI involvement	-0.56	***	-0.54	***	0.63	***	-0.49	***
PSI autonomy	-0.29		-0.27		-0.21		-0.42	**
CRPBI mother acceptance	-0.40	**	-0.34	*	-0.30	*	-0.50	***
CRPBI mother psychological control	0.05		-0.24		-0.23		0.14	
CRPBI mother firm control	0.49	***	0.01		0.09		0.22	
CRPBI father acceptance	-0.22		-0.18		-0.16		-0.20	
CRPBI father psychological control	-0.04		-0.31	*	-0.30	*	0.01	
CRPBI father firm control	-0.28		-0.50	***	-0.41	**	-0.60	***
CRPBI-PR involvement	-0.24		-0.27		-0.30	*	-0.51	***
CRPBI-PR negative control	0.09		0.23		0.30	*	0.21	
CRPBI-PR lax discipline	-0.29	*	-0.28		-0.38	**	-0.07	
PBA-Q	-0.15		-0.25		-0.36	*	0.08	
PAAQ Inaction	0.16		0.51	***	0.40	**	0.20	
PAAQ Unwillingness	0.40	**	0.45	**	0.34	*	0.26	
PAAQ total	0.34	*	0.55	***	0.43	**	0.28	
FASA total (pre-post)	-0.33	*	-0.50	***	-0.50	***	-0.54	***
FASA participation	-0.35	*	-0.52	***	-0.52	***	-0.49	***
FASA modification of functioning	-0.28		-0.41	**	-0.42	**	-0.55	***
PAS frequency	0.34	*	0.27		0.17		0.24	
PAS impairment	0.39	**	0.28		0.17		0.20	

Table 11

Continued

Variables	Sep-C		Harm-C		MASC-P		Phys-P
PSI involvement	-0.25		-0.18		-0.37 *		-0.34 *
PSI autonomy	-0.07		-0.01		-0.29 *		-0.49 ***
CRPBI mother acceptance	-0.14		-0.04		0.01		-0.05
CRPBI mother psychological control	-0.40 **		-0.40 **		0.38 **		0.51 **
CRPBI mother firm control	-0.22		-0.26		0.21		0.34 *
CRPBI father acceptance	-0.07		-0.09		0.02		0.03
CRPBI father psychological control	-0.41 **		-0.33 *		0.23		0.31 *
CRPBI father firm control	-0.29		-0.22		-0.11		-0.17
CRPBI-PR involvement	0.06		0.08		-0.09		-0.29 *
CRPBI-PR negative control	0.08		<0.01		-0.20		-0.06
CRPBI-PR lax discipline	-0.20		-0.22		-0.03		-0.01
PBA-Q	-0.26		-0.29 *		-0.17		0.01
PAAQ Inaction	0.62 ***		0.54 ***		0.08		-0.08
PAAQ Unwillingness	0.51 ***		0.37 *		0.05		-0.03
PAAQ total	0.63 ***		0.51 ***		0.09		-0.04
FASA total (pre-post)	-0.28		-0.15		-0.33 *		-0.30 *
FASA participation	-0.37 *		-0.21		-0.29 *		-0.23
FASA modification of functioning	-0.14		-0.07		-0.35 *		-0.36 *
PAS frequency	0.27		0.28		0.19		0.19
PAS impairment	0.31 *		0.29		0.22		0.22

Table 11

Continued

Variables	Social-P	Sep-P	Harm-P	CSDS Sch
PSI involvement	-0.33 *	0.29 *	-0.28	-0.44 **
PSI autonomy	-0.33 *	-0.15	-0.12	-0.43 **
CRPBI mother acceptance	-0.09	-0.17	0.15	-0.41 **
CRPBI mother psychological control	0.42 **	0.22	0.29	0.21
CRPBI mother firm control	0.12	0.22	0.08	0.39 **
CRPBI father acceptance	0.01	-0.02	0.07	-0.27
CRPBI father psychological control	0.21	0.18	0.17	-0.04
CRPBI father firm control	-0.11	-0.14	0.05	-0.49 ***
CRPBI-PR involvement	-0.33 *	0.11	0.15	-0.63 ***
CRPBI-PR negative control	-0.04	-0.36 *	-0.35 *	0.48 **
CRPBI-PR lax discipline	-0.07	0.05	0.04	-0.04
PBA-Q	-0.13	-0.10	-0.27	0.14
PAAQ Inaction	0.04	0.10	0.19	-0.04
PAAQ Unwillingness	-0.01	0.08	0.07	0.23
PAAQ total	0.04	0.10	0.15	0.15
FASA total (pre-post)	-0.23	-0.38 **	-0.31 *	-0.29
FASA participation	-0.18	-0.38 **	-0.28	-0.23
FASA modification of functioning	-0.27	-0.34 *	-0.32 *	-0.32 *
PAS frequency	0.08	0.13	0.18	0.13
PAS impairment	0.13	0.15	0.19	0.13

Table 11

Continued

Variables	CSDS Soc	CSDS Hm	SDS Sch
PSI involvement	-0.44 **	-0.32 *	-0.52 ***
PSI autonomy	-0.25	-0.31 *	-0.49 **
CRPBI mother acceptance	-0.09	-0.35 *	-0.12
CRPBI mother psychological control	-0.01	0.12	0.41 **
CRPBI mother firm control	0.11	0.21	0.32 *
CRPBI father acceptance	-0.32 *	-0.25	-0.11
CRPBI father psychological control	-0.22	-0.03	0.21
CRPBI father firm control	-0.46 **	-0.44 **	-0.15
CRPBI-PR involvement	-0.41 **	-0.40 **	-0.42 **
CRPBI-PR negative control	0.51 ***	0.39 **	0.16
CRPBI-PR lax discipline	-0.24	0.02	-0.02
PBA-Q	-0.24	0.12	-0.06
PAAQ Inaction	0.15	-0.09	-0.19
PAAQ Unwillingness	0.31 *	0.18	0.07
PAAQ total	0.30 *	0.07	-0.02
FASA total (pre-post)	-0.10	-0.12	-0.36 *
FASA participation	-0.04	-0.08	-0.27
FASA modification of functioning	-0.17	-0.16	-0.43 **
PAS frequency	0.25	0.11	0.12
PAS impairment	0.29 *	0.14	0.12

Table 11

Continued

Variables	SDS Soc	SDS Hm
PSI involvement	-0.49 ***	-0.48 **
PSI autonomy	-0.40 **	-0.47 **
CRPBI mother acceptance	-0.20	-0.44 **
CRPBI mother psychological control	0.28	0.12
CRPBI mother firm control	0.45 **	0.44 **
CRPBI father acceptance	-0.08	-0.22
CRPBI father psychological control	0.09	0.15
CRPBI father firm control	-0.28	-0.32 *
CRPBI-PR involvement	-0.40 **	-0.48 **
CRPBI-PR negative control	0.10	0.17
CRPBI-PR lax discipline	-0.08	-0.08
PBA-Q	-0.07	0.10
PAAQ Inaction	0.05	-0.22
PAAQ Unwillingness	0.24	0.11
PAAQ total	0.20	-0.02
FASA total (pre-post)	-0.28	-0.32 *
FASA participation	-0.26	-0.28
FASA modification of functioning	-0.28	-0.34 *
PAS frequency	0.23	0.20
PAS impairment	0.29	0.20

Table 11

Continued

Note: PSI = Parenting Style Inventory; CRPBI = Child Report of Parent Behavior Inventory; PR = parent report; PBA-Q = Parental Beliefs about Anxiety Questionnaire; PAAQ = Parental Attitudes and Actions Questionnaire; FASA = Family Accommodation Scale - Anxiety; PAS = Parent Accommodation Scale; CSR = Composite clinician severity rating for principal pre-treatment diagnosis; MASC-C = child-report MASC total score; Phys-C = child-report MASC Physical Symptoms subscale; Social-C = child-report MASC Social subscale; Sep-C = child-report MASC Separation subscale; Harm-C = child-report MASC Harm Avoidance subscale; MASC-P = parent-report MASC total score; Phys-P = parent-report MASC Physical Symptoms subscale; Social-P = parent-report MASC Social subscale; Sep-P = parent-report MASC Separation subscale; Harm-P = parent-report MASC Harm Avoidance subscale; CSDS Sch = child-report Sheehan Disability Scale - School; CSDS Soc = child-report SDS - Social; CSDS Hm = child-report SDS - Home; SDS Sch = parent-report SDS - School; SDS Soc = parent-report SDS - Social; SDS Hm = parent-report SDS - Home

* $p < 0.05$

** $p < 0.01$

*** $p < 0.001$

REFERENCES CITED

- Albano, A. M., & Silverman, W. (in press). *Anxiety Disorders Interview Schedule for DSM-5, Child and Parent Versions (ADIS-5-C/P)*.
- Asscher, J. J., Dekovic, M., Manders, W. A., van der Laan, P. H., Prins, P. J., & M. (2013). A randomized controlled trial of the effectiveness of multisystemic therapy in the Netherlands: post-treatment changes and moderator effects. *Journal of Experimental Criminology*, 9(2), 169–187.
<https://doi.org/http://dx.doi.org.libproxy.temple.edu/10.1007/s11292-012-9165-9>
- Baldwin, J. S., & Dadds, M. R. (2007). Reliability and validity of parent and child versions of the Multidimensional Anxiety Scale for Children in community samples. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46, 252–260.
- Bank, L., Marlowe, J. H., Reid, J. B., Patterson, G. R., & Weinrott, M. R. (1991). A comparative evaluation of parent-training interventions for families of chronic delinquents. *Journal of Abnormal Child Psychology*, 19(1), 15–33.
<https://doi.org/10.1007/BF00910562>
- Barkley, R. A., Edwards, G., Laneri, M., Fletcher, K., & Metevia, L. (2001). The efficacy of problem-solving communication training alone, behavior management training alone, and their combination for parent–adolescent conflict in teenagers with ADHD and ODD. *Journal of Consulting and Clinical Psychology*, 69(6), 926–941. <https://doi.org/10.1037/0022-006X.69.6.926>
- Barkley, R. A., Shelton, T. L., Crosswait, C., Moorehouse, M., Fletcher, K., Barrett, S., ... Metevia, L. (2000). Multi-method psycho-educational intervention for

preschool children with disruptive behavior: Preliminary results at post-treatment. *Journal of Child Psychology and Psychiatry*, *41*(3), 319–332.

<https://doi.org/10.1111/1469-7610.00616>

Barmish, A. J., & Kendall, P. C. (2005). Should Parents Be Co-Clients in Cognitive-Behavioral Therapy for Anxious Youth? *Journal of Clinical Child and Adolescent Psychology*, *34*(3), 569–581. https://doi.org/10.1207/s15374424jccp3403_12

Barrett, P. M., Dadds, M. R., & Rapee, R. M. (1996). Family treatment of childhood anxiety: a controlled trial. *Journal of Consulting and Clinical Psychology*, *64*(2), 333.

Barrett, P. M., Duffy, A. L., Dadds, M. R., & Rapee, R. M. (2001). Cognitive-behavioral treatment of anxiety disorders in children: Long-term (6-year) follow-up. *Journal of Consulting and Clinical Psychology*, *69*(1), 135.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology*, *4*, 1–103.

Baumrind, D. (1971b). Current patterns of parental authority. *Developmental Psychology*, *4*(1, Pt.2), 1–103. <https://doi.org/10.1037/h0030372>

Beidel, D. C., Turner, S. M., Sallee, F. R., Ammerman, R. T., Crosby, L. A., & Pathak, S. (2007). SET-C versus fluoxetine in the treatment of childhood social phobia. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*, 1622–1632.

Benito, K. G., Caporino, N. E., Frank, H. E., Ramanujam, K., Garcia, A., Freeman, J., ... Storch, E. A. (2015). Development of the pediatric accommodation scale:

- Reliability and validity of clinician- and parent-report measures. *Journal of Anxiety Disorders*, 29, 14–24. <https://doi.org/10.1016/j.janxdis.2014.10.004>
- Benjamin, C. L., Harrison, J. P., Settapani, C. A., Brodman, D. M., & Kendall, P. C. (2013). Anxiety and related outcomes in young adults 7 to 19 years after receiving treatment for child anxiety. *Journal of Consulting and Clinical Psychology*, 81, 865–876.
- Bernal, M. E., Klinnert, M. D., & Schultz, L. A. (1980). Outcome Evaluation of Behavioral Parent Training and Client-Centered Parent Counseling for Children with Conduct Problems. *Journal of Applied Behavior Analysis*, 13(4), 677–691. <https://doi.org/10.1901/jaba.1980.13-677>
- Bodden, D. H. M., Bögels, S. M., Nauta, M. H., De Haan, E., Ringrose, J., Appelboom, C., ... Appelboom-Geerts, K. C. M. M. J. (2008). Child versus family cognitive-behavioral therapy in clinically anxious youth: An efficacy and partial effectiveness study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47, 1384–1394.
- Bor, W., Sanders, M. R., & Markie-Dadds, C. (2002). The effects of the Triple P-positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties. *Journal of Abnormal Child Psychology*, 30(6), 571–587. <https://doi.org/10.1023/A:1020807613155>
- Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, 63(4), 569–578. <https://doi.org/10.1037/0022-006X.63.4.569>

- Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., ... Johnson, B. A. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, *54*, 877–885.
- Brent, D., Emslie, G., Clarke, G., Wagner, K. D., Asarnow, J. R., Keller, M., ... others. (2008). Switching to another SSRI or to venlafaxine with or without cognitive behavioral therapy for adolescents with SSRI-resistant depression: the TORDIA randomized controlled trial. *Jama*, *299*(8), 901–913.
- Butler, S., Baruch, G., Hickey, N., & Fonagy, P. (2011). A Randomized Controlled Trial of Multisystemic Therapy and a Statutory Therapeutic Intervention for Young Offenders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*(12), 1220–1235.e2. <https://doi.org/10.1016/j.jaac.2011.09.017>
- Cartwright-Hatton, S., McNally, D., Field, A. P., Rust, S., Laskey, B., Dixon, C., ... others. (2011). A new parenting-based group intervention for young anxious children: Results of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *50*, 242–251.
- Cheron, D. M., Ehrenreich, J. T., & Pincus, D. B. (2009). Assessment of parental experiential avoidance in a clinical sample of children with anxiety disorders. *Child Psychiatry and Human Development*, *40*, 383–403.
- Chronis-Tuscano, A., Lewis-Morrarty, E., Woods, K. E., O'Brien, K. A., Mazursky-Horowitz, H., & Thomas, S. R. (in press). Parent–Child Interaction Therapy With Emotion Coaching for Preschoolers With Attention-Deficit/Hyperactivity

Disorder. *Cognitive and Behavioral Practice*.

<https://doi.org/10.1016/j.cbpra.2014.11.001>

Chronis-Tuscano, A., Rubin, K. H., O'Brien, K. A., Coplan, R. J., Thomas, S. R.,

Dougherty, L. R., ... Wimsatt, M. (2015). Preliminary Evaluation of a

Multimodal Early Intervention Program for Behaviorally Inhibited Preschoolers.

Journal of Consulting and Clinical Psychology. <https://doi.org/10.1037/a0039043>

Clarke, G., Debar, L., Lynch, F., Powell, J., Gale, J., O'Connor, E., ... Hertert, S. (2005).

A Randomized Effectiveness Trial of Brief Cognitive-Behavioral Therapy for

Depressed Adolescents Receiving Antidepressant Medication. *Journal of the*

American Academy of Child & Adolescent Psychiatry, *44*(9), 888–898.

[https://doi.org/10.1016/S0890-8567\(09\)62194-8](https://doi.org/10.1016/S0890-8567(09)62194-8)

Clarke, G. N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., O'Connor, E., ... Debar, L.

(2002). Group Cognitive-Behavioral Treatment for Depressed Adolescent

Offspring of Depressed Parents in a Health Maintenance Organization. *Journal of*

the American Academy of Child & Adolescent Psychiatry, *41*(3), 305–313.

<https://doi.org/10.1097/00004583-200203000-00010>

Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-

Behavioral Treatment of Adolescent Depression: Efficacy of Acute Group

Treatment and Booster Sessions. *Journal of the American Academy of Child &*

Adolescent Psychiatry, *38*(3), 272–279. [https://doi.org/10.1097/00004583-](https://doi.org/10.1097/00004583-199903000-00014)

[199903000-00014](https://doi.org/10.1097/00004583-199903000-00014)

- Cobham, V. E., Dadds, M. R., & Spence, S. H. (1998). The role of parental anxiety in the treatment of childhood anxiety. *Journal of Consulting and Clinical Psychology, 66*, 893.
- Cobham, V. E., Dadds, M. R., Spence, S. H., & McDermott, B. (2010). Parental anxiety in the treatment of childhood anxiety: A different story three years later. *Journal of Clinical Child & Adolescent Psychology, 39*, 410–420.
- Cobham, V. E., Dadds, M. R., Spence, S. H., & McDermott, B. (2010b). Parental Anxiety in the Treatment of Childhood Anxiety: A Different Story Three Years Later. *Journal of Clinical Child & Adolescent Psychology, 39*(3), 410–420. <https://doi.org/10.1080/15374411003691719>
- Comer, J. S., Puliafico, A. C., Aschenbrand, S. G., McKnight, K., Robin, J. A., Goldfine, M. E., & Albano, A. M. (2012). A pilot feasibility evaluation of the CALM Program for anxiety disorders in early childhood. *Journal of Anxiety Disorders, 26*(1), 40–49. <https://doi.org/10.1016/j.janxdis.2011.08.011>
- Copeland, W., Shanahan, L., Costello, E. J., & Angold, A. (2011). Cumulative Prevalence of Psychiatric Disorders by Young Adulthood: A Prospective Cohort Analysis From the Great Smoky Mountains Study. *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(3), 252–261. <https://doi.org/10.1016/j.jaac.2010.12.014>
- Costello, E. J., Egger, H. L., & Angold, A. (2005). The developmental epidemiology of anxiety disorders: Phenomenology, prevalence, and comorbidity. *Child and Adolescent Psychiatric Clinics of North America, 14*, 631–648.

- Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*, *60*, 837–844.
- Dadds, M. R., Barrett, P. M., Rapee, R. M., & Ryan, S. (1996). Family process and child anxiety and aggression: An observational analysis. *Journal of Abnormal Child Psychology*, *24*, 715–734.
- Danforth, J. S., Harvey, E., Ulaszek, W. R., & McKee, T. E. (2006). The outcome of group parent training for families of children with attention-deficit hyperactivity disorder and defiant/aggressive behavior. *Journal of Behavior Therapy and Experimental Psychiatry*, *37*(3), 188–205.
<https://doi.org/10.1016/j.jbtep.2005.05.009>
- DeGarmo, D. S., Patterson, G. R., & Forgatch, M. S. (2004). How Do Outcomes in a Specified Parent Training Intervention Maintain or Wane Over Time? *Prevention Science*, *5*(2), 73–89. <https://doi.org/10.1023/B:PREV.0000023078.30191.e0>
- Diamond, G. S., Reis, B. F., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment-Based Family Therapy for Depressed Adolescents: A Treatment Development Study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(10), 1190–1196. <https://doi.org/10.1097/00004583-200210000-00008>
- Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-Based Family Therapy for Adolescents with Suicidal Ideation: A Randomized Controlled Trial. *Journal of the American*

Academy of Child & Adolescent Psychiatry, 49(2), 122–131.

<https://doi.org/10.1016/j.jaac.2009.11.002>

- Dierker, L. C., Albano, A. M., Clarke, G. N., Heimberg, R. G., Kendall, P. C., Merikangas, K. R., ... Kupfer, D. J. (2001). Screening for anxiety and depression in early adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 929–936.
- Dishion, T. J., Nelson, S. E., & Kavanagh, K. (2003). The Family Check-Up With High-Risk Young Adolescents: Preventing Early-Onset Substance Use by Parent Monitoring. *Behavior Therapy*, 34(4), 553–571. [https://doi.org/10.1016/S0005-7894\(03\)80035-7](https://doi.org/10.1016/S0005-7894(03)80035-7)
- Drake, K. L., & Ginsburg, G. S. (2012). Family factors in the development, treatment, and prevention of childhood anxiety disorders. *Clinical Child and Family Psychology Review*, 15, 144–162.
- Drake, K. L., & Ginsburg, G. S. (2012b). Family factors in the development, treatment, and prevention of childhood anxiety disorders. *Clinical Child and Family Psychology Review*, 15(2), 144–162. <https://doi.org/10.1007/s10567-011-0109-0>
- Esbjörn, B. H., Reinholdt-Dunne, M. L., Nielsen, S. K., Smith, A. C., Breinholst, S., & Leth, I. (2015). Exploring the effect of case formulation driven CBT for children with anxiety disorders: A feasibility study. *Behavioural and Cognitive Psychotherapy*, 43, 20–30.
- Esbjörn, B. H., Sømhøvd, M. J., Nielsen, S. K., Normann, N., Leth, I., & Reinholdt-Dunne, M. L. (2014). Parental changes after involvement in their anxious child's

cognitive behavior therapy. *Journal of Anxiety Disorders*, 28(7), 664–670.

<https://doi.org/10.1016/j.janxdis.2014.07.008>

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-Based Psychosocial Treatments for Children and Adolescents With Disruptive Behavior. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 215–237.

<https://doi.org/10.1080/15374410701820117>

Faber, A., & Mazlish, E. (2012). Encouraging Autonomy. In *How to Talk So Kids Will Listen & Listen So Kids Will Talk* (Updated edition, pp. 139–174). Scribner.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, 41, 1149–1160.

Forgatch, M. S., & Patterson, G. R. (2010). Parent Management Training: An intervention for antisocial behavior in children and adolescents. In J. R. Weisz & A. Kazdin (Eds.), *Evidence-based therapies for children and adolescents* (2nd ed., pp. 159–177). New York: Guilford Press.

Forgatch, M. S., Patterson, G. R., Degarmo, D. S., & Beldavs, Z. G. (2009). Testing the Oregon delinquency model with 9-year follow-up of the Oregon Divorce Study.

Development and Psychopathology, 21(2), 637–60.

<https://doi.org/http://dx.doi.org.libproxy.temple.edu/10.1017/S0954579409000340>

0

Francis, S. E., & Chorpita, B. F. (2010). Development and evaluation of the parental beliefs about anxiety questionnaire. *Journal of Psychopathology and Behavioral Assessment*, 32, 138–149.

- Francis, S. E., & Chorpita, B. F. (2011). Parental beliefs about child anxiety as a mediator of parent and child anxiety. *Cognitive Therapy and Research, 35*, 21–29.
- Frankel, F., Myatt, R., Cantwell, D. P., & Feinberg, D. T. (1997). Parent-Assisted Transfer of Children's Social Skills Training: Effects on Children With and Without Attention-Deficit Hyperactivity Disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(8), 1056–1064.
<https://doi.org/10.1097/00004583-199708000-00013>
- Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Archives of General Psychiatry, 66*(9), 1013–1021.
- Garcia-Lopez, L. J., Díaz-Castela, M. del M., Muela-Martinez, J. A., & Espinosa-Fernandez, L. (2014). Can parent training for parents with high levels of expressed emotion have a positive effect on their child's social anxiety improvement? *Journal of Anxiety Disorders, 28*(8), 812–822.
<https://doi.org/10.1016/j.janxdis.2014.09.001>
- Garoff, F. F., Heinonen, K., Pesonen, A., & Almqvist, F. (2012). Depressed youth: Treatment outcome and changes in family functioning in individual and family therapy. *Journal of Family Therapy, 34*(1), 4–23. <https://doi.org/10.1111/j.1467-6427.2011.00541.x>
- Ginsburg, G. S., & Schlossberg, M. C. (2002). Family-based treatment of childhood anxiety disorders. *International Review of Psychiatry, 14*, 143–154.
- Goodyer, I., Dubicka, B., Wilkinson, P., Kelvin, R., Roberts, C., Byford, S., ... Harrington, R. (2007). Selective serotonin reuptake inhibitors (SSRIs) and routine

specialist care with and without cognitive behaviour therapy in adolescents with major depression: randomised controlled trial. *BMJ*, 335(7611), 142–142.

<https://doi.org/10.1136/bmj.39224.494340.55>

Grills-Taquechel, A. E., Ollendick, T. H., & Fisak, B. (2008). Reexamination of the MASC factor structure and discriminant ability in a mixed clinical outpatient sample. *Depression and Anxiety*, 25, 942–950.

Hayes, A. F. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach*. Guilford Press. Retrieved from <http://books.google.com/books?hl=en&lr=&id=iWFSpQFh-y4C&oi=fnd&pg=PP1&dq=%22the+boundary+conditions+of+the+mechanism+or+mechanisms%22+%22methods+when+testing+causal+processes,+I+end+with+a%22+%22do+or+not.+After+the+participants+in+the+study+completed+the+instrument,%22+&ots=1y5-tC4IK1&sig=6Cx2UdRJYPj7t5vyzOECxvWDn50>

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60(6), 953–961.

<https://doi.org/10.1037/0022-006X.60.6.953>

Hines, E. M., & Holcomb-McCoy, C. (2013). Parental characteristics, ecological factors, and the academic achievement of African American males. *Journal of Counseling & Development*, 91, 68–77.

Hinshaw, S. P., Arnold, L. E., & For the MTA Cooperative Group. (2015). Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome:

- evidence, paradox, and challenge. *Wiley Interdisciplinary Reviews: Cognitive Science*, 6(1), 39–52. <https://doi.org/10.1002/wcs.1324>
- Hoath, F. E., & Sanders, M. R. (2002). A feasibility study of Enhanced Group Triple P - positive parenting program for parents of children with Attention-deficit/hyperactivity Disorder. *Behaviour Change*, 19(4), 191–206.
- Hoff, A. L. (2016). *CBT Skills for Parents: Parent Group Therapist Manual*. unpublished manuscript, Temple University.
- Hoff, A. L. (2016). *Parenting an Anxious Child: Support Group Therapist Manual*. unpublished manuscript, Temple University.
- Hoff, A. L. (2016). *Promoting Independence and Autonomy: Parent Group Therapist Manual*. unpublished manuscript, Temple University.
- Hollon, S. D., & Beck, A. T. (2013a). Cognitive and Cognitive-Behavioral Therapies. In M. J. Lambert (Ed.), *Handbook of Psychotherapy and Behavior Change* (6th ed., pp. 393–442). Hoboken, N.J.: John Wiley & Sons.
- Hollon, S. D., & Beck, A. T. (2013b). Cognitive and cognitive-behavioral therapies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 393–432). Mahwah, NJ: Wiley.
- Hudson, J. L., Newall, C., Rapee, R. M., Lyneham, H. J., Schniering, C. C., Wuthrich, V. M., ... Gar, N. S. (2014). The impact of brief parental anxiety management on child anxiety treatment outcomes: A controlled trial. *Journal of Clinical Child & Adolescent Psychology*, 43, 370–380.
- Hudson, J. L., Newall, C., Rapee, R. M., Lyneham, H. J., Schniering, C. C., Wuthrich, V. M., ... Gar, N. S. (2014b). The Impact of Brief Parental Anxiety Management on

Child Anxiety Treatment Outcomes: A Controlled Trial. *Journal of Clinical Child & Adolescent Psychology*, 43(3), 370–380.

<https://doi.org/10.1080/15374416.2013.807734>

Hudson, J. L., & Rapee, R. M. (2001). Parent–child interactions and anxiety disorders:

An observational study. *Behaviour Research and Therapy*, 39, 1411–1427.

James, A. C., James, G., Cowdrey, F. A., Soler, A., & Choke, A. (2013). Cognitive

behavioural therapy for anxiety disorders in children and adolescents. *The*

Cochrane Database of Systematic Reviews, (6), CD004690.

<https://doi.org/10.1002/14651858.CD004690.pub3>

Jongerden, L., & Bögels, S. M. (2015). Parenting, family functioning and anxiety-

disordered children: Comparisons to controls, changes after family versus child

CBT. *Journal of Child and Family Studies*, 24(7), 2046–2059.

<https://doi.org/10.1007/s10826-014-0005-6>

Kendall, P. C. (2012). Guiding theory for therapy with children and adolescents. In P. C.

Kendall & P. C. (Ed) Kendall (Eds.), *Child and adolescent therapy: Cognitive-*

behavioral procedures (4th ed.). (pp. 3–24). New York, NY, US: Guilford Press.

Kendall, P. C., Cummings, C. M., Villabø, M. A., Narayanan, M. K., Treadwell, K.,

Birmaher, B., ... Albano, A. M. (2016). Mediators of change in the

Child/Adolescent Anxiety Multimodal Treatment Study. *Journal of Consulting*

and Clinical Psychology, 84(1), 1–14. <https://doi.org/10.1037/a0039773>

Kendall, P. C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children:*

therapist manual (3rd ed.). 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., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008b). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology, 76*(2), 282–297. <https://doi.org/10.1037/0022-006X.76.2.282>
- Kendall, P. C., Robin, J. A., Hedtke, K. A., Suveg, C., Flannery-Schroeder, E., & Gosch, E. (2006). Considering CBT with anxious youth? Think exposures. *Cognitive and Behavioral Practice, 12*, 136–148.
- Kennard, B. D., Emslie, G. J., Mayes, T. L., Nightingale-Teresi, J., Nakonezny, P. A., Hughes, J. L., ... Jarrett, R. B. (2008). Cognitive-Behavioral Therapy to Prevent Relapse in Pediatric Responders to Pharmacotherapy for Major Depressive Disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(12), 1395–1404. <https://doi.org/10.1097/CHI.0b013e31818914a1>
- Kennard, B. D., Stewart, S. M., Hughes, J. L., Jarrett, R. B., & Emslie, G. J. (2008). Developing Cognitive Behavioral Therapy to Prevent Depressive Relapse in Youth. *Cognitive and Behavioral Practice, 15*(4), 387–399. <https://doi.org/10.1016/j.cbpra.2008.02.006>
- Kessler, R. C., Adler, L. A., Berglund, P., Green, J. G., McLaughlin, K. A., Fayyad, J., ... Zaslavsky, A. M. (2014). The effects of temporally secondary co-morbid mental disorders on the associations of DSM-IV ADHD with adverse outcomes in the US

National Comorbidity Survey Replication Adolescent Supplement (NCS-A).

Psychological Medicine, 44(8), 1779–1792.

<https://doi.org/10.1017/S0033291713002419>

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 617.

Khanna, M. S., Carper, M. M., Harris, M. S., & Kendall, P. C. (in preparation). Web-based training for parents of youth with impairment from anxiety.

Kovacs, M., Sherrill, J., George, C. J., Pollock, M., Tumuluru, R. V., & Ho, V. (2006). Contextual Emotion-Regulation Therapy for Childhood Depression: Description and Pilot Testing of a New Intervention. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(8), 892–903.

<https://doi.org/10.1097/01.chi.0000222878.74162.5a>

Langley, A. K., Bergman, R. L., McCracken, J., & Piacentini, J. C. (2004). Impairment in childhood anxiety disorders: preliminary examination of the child anxiety impact scale-parent version. *Journal of Child and Adolescent Psychopharmacology*, 14, 105–114.

Lebowitz, E. R., Omer, H., Hermes, H., & Scahill, L. (2014). Parent training for childhood anxiety disorders: The SPACE Program. *Cognitive and Behavioral Practice*, 21, 456–469.

Lebowitz, E. R., Woolston, J., Bar-Haim, Y., Calvocoressi, L., Dauser, C., Warnick, E., ... Leckman, J. F. (2013). Family accommodation in pediatric anxiety disorders. *Depression and Anxiety*, 30, 47–54.

- Lewinsohn, P. M., Clarke, G. N., Hops, H., & Andrews, J. (1990). Cognitive-behavioral treatment for depressed adolescents. *Behavior Therapy, 21*(4), 385–401.
[https://doi.org/10.1016/S0005-7894\(05\)80353-3](https://doi.org/10.1016/S0005-7894(05)80353-3)
- Lochman, J. E., & Wells, K. C. (2002). The Coping Power program at the middle-school transition: Universal and indicated prevention effects. *Psychology of Addictive Behaviors, 16*(4, Suppl), S40–S54. <https://doi.org/10.1037/0893-164X.16.4S.S40>
- Lochman, J. E., & Wells, K. C. (2004). The Coping Power Program for Preadolescent Aggressive Boys and Their Parents: Outcome Effects at the 1 -Year Follow-Up. *Journal of Consulting & Clinical Psychology, 72*(4), 571–578.
- Lochman, J. E., Wells, K. C., Qu, L., & Chen, L. (2013). Three Year Follow-Up of Coping Power Intervention Effects: Evidence of Neighborhood Moderation? *Prevention Science, 14*(4), 364–376. <https://doi.org/10.1007/s11121-012-0295-0>
- Luby, J., Lenze, S., & Tillman, R. (2012). A novel early intervention for preschool depression: Findings from a pilot randomized controlled trial. *Journal of Child Psychology and Psychiatry, 53*(3), 313–322. <https://doi.org/10.1111/j.1469-7610.2011.02483.x>
- Lundkvist-Houndoumadi, I., Thastum, M., & Hougaard, E. (2016). Effectiveness of an individualized case formulation-based CBT for non-responding youths with anxiety disorders. *Journal of Child and Family Studies, 25*(2), 503–517.
<https://doi.org/10.1007/s10826-015-0225-4>
- Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent-child interaction. In P. H. Mussen & E. M. Hetherington (Eds.), *Handbook of*

child psychology: Vol. 4. Socialization, personality, and social development (4th ed., pp. 1–101). New York: Wiley.

- Manassis, K., Lee, T. C., Bennett, K., Zhao, X. Y., Mendlowitz, S., Duda, S., ... Wood, J. J. (2014). Types of parental involvement in CBT with anxious youth: A preliminary meta-analysis. *Journal of Consulting and Clinical Psychology, 82*(6), 1163–1172. <https://doi.org/10.1037/a0036969>
- March, J. S., Parker, J. D. A., Sullivan, K., Stallings, P., & Conners, C. K. (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.
- McKernon, W. L., Holmbeck, G. N., Colder, C. R., Hommeyer, J. S., Shapera, W., & Westhoven, V. (2001). Longitudinal study of observed and perceived family influences on problem-focused coping behaviors of preadolescents with spina bifida. *Journal of Pediatric Psychology, 26*(1), 41–54.
- McLeod, B. D., Wood, J. J., & Weisz, J. R. (2007). Examining the association between parenting and childhood anxiety: A meta-analysis. *Clinical Psychology Review, 27*, 155–172.
- Melvin, G. A., Tonge, B. J., King, N. J., Heyne, D., Gordon, M. S., & Klimkeit, E. (2006). A Comparison of Cognitive-Behavioral Therapy, Sertraline, and Their Combination for Adolescent Depression. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(10), 1151–1161. <https://doi.org/10.1097/01.chi.0000233157.21925.71>

- Mendlowitz, S. L., Manassis, K., Bradley, S., Scapillato, D., Mieziitis, S., & Shaw, B. F. (1999). Cognitive-behavioral group treatments in childhood anxiety disorders: The role of parental involvement. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 1223–1229.
- Mendlowitz, S. L., Manassis, K., Bradley, S., Scapillato, D., Mieziitis, S., & Shaw, B. F. (1999). Cognitive-behavioral group treatments in childhood anxiety disorders: The role of parental involvement. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(10), 1223–1229. <https://doi.org/10.1097/00004583-199910000-00010>
- Mendlowitz, S. L., Manassis, K., Bradley, S., Scapillato, D., Mieziitis, S., & Shaw, B. F. (1999). Cognitive-behavioral group treatments in childhood anxiety disorders: The role of parental involvement. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 1223–1229.
- Merikangas, K. R., He, J., Burstein, M., Swendsen, J., Avenevoli, S., Case, B., ... Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. Adolescents: Results of the National Comorbidity Survey-Adolescent Supplement (NCSA). *Journal of the American Academy of Child & Adolescent Psychiatry, 50*(1), 32–45. <https://doi.org/10.1016/j.jaac.2010.10.006>
- Nauta, M. H., Scholing, A., Emmelkamp, P. M. G., & Minderaa, R. B. (2003). Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: No additional effect of a cognitive parent training. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 1270–1278.

- Nixon, R. D. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003). Parent-child interaction therapy: A comparison of standard and abbreviated treatments for oppositional defiant preschoolers. *Journal of Consulting and Clinical Psychology, 71*(2), 251–260. <https://doi.org/10.1037/0022-006X.71.2.251>
- Ollendick, T. H., & King, N. J. (2012). Evidence-based treatments for children and adolescents: Issues and commentary. In P. C. Kendall & P. C. (Ed) Kendall (Eds.), *Child and adolescent therapy: Cognitive-behavioral procedures (4th ed.)*. (pp. 499–519). New York, NY, US: Guilford Press.
- Owens, J. S., Richerson, L., Beilstein, E. A., Crane, A., Murphy, C. E., & Vancouver, J. B. (2005). School-Based Mental Health Programming for Children With Inattentive and Disruptive Behavior Problems: First-Year Treatment Outcome. *Journal of Attention Disorders, 9*(1), 261–274. <https://doi.org/10.1177/1087054705279299>
- Patterson, G. R., Chamberlain, P., & Reid, J. B. (1982). A comparative evaluation of a parent-training program. *Behavior Therapy, 13*(5), 638–650. [https://doi.org/10.1016/S0005-7894\(82\)80021-X](https://doi.org/10.1016/S0005-7894(82)80021-X)
- Peris, T. S., Sugar, C. A., Bergman, R. L., Chang, S., Langley, A., & Piacentini, J. (2012). Family factors predict treatment outcome for pediatric obsessive-compulsive disorder. *Journal of Consulting and Clinical Psychology, 80*, 255–263.
- Pincus, D. B., Eyberg, S. M., & Choate, M. L. (2005). Adapting parent-child interaction therapy for young children with separation anxiety disorder. *Education & Treatment of Children, 28*(2), 163–181.

- Pincus, D. B., Santucci, L. C., Ehrenreich, J. T., & Eyberg, S. M. (2008). The Implementation of Modified Parent-Child Interaction Therapy for Youth with Separation Anxiety Disorder. *Cognitive and Behavioral Practice, 15*(2), 118–125. <https://doi.org/10.1016/j.cbpra.2007.08.002>
- Podell, J. L., & Kendall, P. C. (2011). Mothers and fathers in family cognitive-behavioral therapy for anxious youth. *Journal of Child and Family Studies, 20*(2), 182–195. <https://doi.org/10.1007/s10826-010-9420-5>
- Puliafico, A. C., Comer, J. S., & Albano, A. M. (2013). Coaching Approach Behavior and Leading by Modeling: Rationale, Principles, and a Session-by-Session Description of the CALM Program for Early Childhood Anxiety. *Cognitive and Behavioral Practice, 20*(4), 517–528. <https://doi.org/10.1016/j.cbpra.2012.05.002>
- Raskin, A., Boothe, H. H., Reatig, N. A., Schulterbrandt, J. G., & Odle, D. (1971). Factor analyses of normal and depressed patients' memories of parental behavior. *Psychological Reports, 29*(3, Pt. 1), 871–879. <https://doi.org/10.2466/pr0.1971.29.3.871>
- Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012). Effects of psychotherapy for anxiety in children and adolescents: a meta-analytic review. *Clinical Psychology Review, 32*(4), 251–262. <https://doi.org/10.1016/j.cpr.2012.01.005>
- 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.
- Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed

behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology*, 68(4), 624–640.

<https://doi.org/10.1037/0022-006X.68.4.624>

Sanford, M., Boyle, M., McCleary, L., Miller, J., Steele, M., Duku, E., & Offord, D.

(2006). A Pilot Study of Adjunctive Family Psychoeducation in Adolescent Major Depression: Feasibility and Treatment Effect. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(4), 386–395.

<https://doi.org/10.1097/01.chi.0000198595.68820.10>

Schaefer, E. S. (1965). Children's reports of parental behavior: An inventory. *Child Development*, 36(2), 413–424. <https://doi.org/10.2307/1126465>

Scherer, D. G., Brondino, M. J., Henggeler, S. W., Melton, G. B., & Hanley, J. H. (1994).

Multisystemic Family Preservation Therapy: Preliminary findings from a study of rural and minority serious adolescent offenders. *Journal of Emotional and Behavioral Disorders*, 2(4), 198–206.

<https://doi.org/10.1177/106342669400200402>

Schludermann, E., & Schludermann, S. (1970). Replicability of factors in children's report of parent behavior (CRPBI). *The Journal of Psychology: Interdisciplinary and Applied*, 76(2), 239–249. <https://doi.org/10.1080/00223980.1970.9916845>

<https://doi.org/10.1080/00223980.1970.9916845>

Schludermann, E., & Schludermann, S. (1988). *Children's report on parent behavior*

(*CRPBI-108, CRPBI-30*). Winnipeg, Canada: Unpublished manuscript,

Department of Psychology, University of Manitoba.

Schneider, S., Blatter-Meunier, J., Herren, C., In-Albon, T., Adornetto, C., Meyer, A., &

Lavallee, K. L. (2013). The efficacy of a family-based cognitive-behavioral

treatment for separation anxiety disorder in children aged 8–13: A randomized comparison with a general anxiety program. *Journal of Consulting and Clinical Psychology, 81*, 932–940.

Schneider, S., Blatter-Meunier, J., Herren, C., In-Albon, T., Adornetto, C., Meyer, A., & Lavallee, K. L. (2013b). The efficacy of a family-based cognitive-behavioral treatment for separation anxiety disorder in children aged 8–13: A randomized comparison with a general anxiety program. *Journal of Consulting and Clinical Psychology, 81*(5), 932–940. <https://doi.org/10.1037/a0032678>

Schuhmann, E. M., Foote, R. C., Eyberg, S. M., Boggs, S. R., & Algina, J. (1998). Efficacy of parent–child interaction therapy: Interim report of a randomized trial with short-term maintenance. *Journal of Clinical Child Psychology, 27*(1), 34–45. https://doi.org/10.1207/s15374424jccp2701_4

Schwarz, J. C., Barton-Henry, M. L., & Pruzinsky, T. (1985). Assessing child-rearing behaviors: A comparison of ratings made by mother, father, child, and sibling on the CRPBI. *Child Development, 56*(2), 462–479. <https://doi.org/10.2307/1129734>

Settipani, C. A., & Kendall, P. C. (in press). The Effect of Child Distress on Accommodation of Anxiety: Relations With Maternal Beliefs, Empathy, and Anxiety. *Journal of Clinical Child & Adolescent Psychology, in press*(0), 1–14. <https://doi.org/10.1080/15374416.2015.1094741>

Shaw, D. S., Dishion, T. J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family-centered approach to the prevention of early conduct problems: 2-year effects of the family check-up in early childhood. *Journal of Consulting and Clinical Psychology, 74*(1), 1–9. <https://doi.org/10.1037/0022-006X.74.1.1>

- Sheehan, D. V. (1986). *The anxiety disease*. New York: Bantam.
- Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS Program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology, 30*, 525–535.
- Silverman, W., & Albano, A. M. (1996). *The Anxiety Disorders Interview Schedule for DSM-IV: Child and parent versions*. San Antonio, TX: Graywind.
- Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C. F., Lumpkin, P. W., & Carmichael, D. H. (1999). Treating anxiety disorders in children with group cognitive-behavioral therapy: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 67*, 995–1003.
- Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C. F., Lumpkin, P. W., & Carmichael, D. H. (1999). Treating anxiety disorders in children with group cognitive-behavioral therapy: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 67*(6), 995.
- Silverman, W. K., Kurtines, W. M., Ginsburg, G. S., Weems, C. F., Rabian, B., & Serafini, L. T. (1999). Contingency management, self-control, and education support in the treatment of childhood phobic disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 67*(5), 675–687.
<https://doi.org/10.1037/0022-006X.67.5.675>
- Siqueland, L., Kendall, P. C., & Steinberg, L. (1996). Anxiety in children: Perceived family environments and observed family interaction. *Journal of Clinical Child Psychology, 25*, 225–237.

- Siqueland, L., Rynn, M., & Diamond, G. S. (2005). Cognitive behavioral and attachment based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders, 19*, 361–381.
- Smith, A. M., Flannery-Schroeder, E. C., Gorman, K. S., & Cook, N. (2014). Parent cognitive-behavioral intervention for the treatment of childhood anxiety disorders: A pilot study. *Behaviour Research and Therapy, 61*, 156–161.
- Sonuga-Barke, E. J. S., Daley, D., Thompson, M., Laver-Bradbury, C., & Weeks, A. (2001). Parent-Based Therapies for Preschool Attention-Deficit/Hyperactivity Disorder: A Randomized, Controlled Trial With a Community Sample. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 402–408.
<https://doi.org/10.1097/00004583-200104000-00008>
- Sonuga-Barke, E. J. S., Thompson, M., Daley, D., & Laver-Bradbury, C. (2004). Parent training for Attention Deficit/Hyperactivity Disorder: Is it as effective when delivered as routine rather than as specialist care? *British Journal of Clinical Psychology, 43*(4), 449–457. <https://doi.org/10.1348/0144665042388973>
- Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: The effectiveness of a social skills training-based, cognitive-behavioural intervention, with and without parental involvement. *Journal of Child Psychology and Psychiatry, 41*(6), 713–726.
- Stark, K. D., Banneyer, K. N., Wang, L. A., & Arora, P. (2012). Child and adolescent depression in the family. *Couple and Family Psychology: Research and Practice, 1*(3), 161–184. <https://doi.org/10.1037/a0029916>

- Steinberg, L., Lamborn, S. D., Darling, N., Mounts, N. S., & Dornbusch, S. M. (1994). Over-time changes in adjustment and competence among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Development, 65*, 754–770.
- Tellegen, C. L., & Sanders, M. R. (2014). A randomized controlled trial evaluating a brief parenting program with children with autism spectrum disorders. *Journal of Consulting and Clinical Psychology, 82*(6), 1193–1200.
<https://doi.org/10.1037/a0037246>
- The MTA Cooperative Group. (1999). A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry, 56*(12), 1073–1086. <https://doi.org/10.1001/archpsyc.56.12.1073>
- Tompson, M. C., Pierre, C. B., Haber, F. M., Fogler, J. M., Groff, A. R., & Asarnow, J. R. (2007). Family-focused Treatment for Childhood-onset Depressive Disorders: Results of an Open Trial. *Clinical Child Psychology and Psychiatry, 12*(3), 403–420. <https://doi.org/10.1177/1359104507078474>
- Treatment for Adolescents with Depression Study (TADS) Team. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292*, 807–820.
- Tutty, S., Gephart, H., & Wurzbacher, K. (2003). Enhancing behavioral and social skill functioning in children newly diagnosed with attention-deficit hyperactivity

- disorder in a pediatric setting. *Journal of Developmental & Behavioral Pediatrics*, 24(1), 51–57.
- Tynan, W. D., Schuman, W., & Lampert, N. (1999). Concurrent parent and child therapy groups for externalizing disorders: From the laboratory to the world of managed care. *Cognitive and Behavioral Practice*, 6(1), 3–9.
[https://doi.org/10.1016/S1077-7229\(99\)80035-2](https://doi.org/10.1016/S1077-7229(99)80035-2)
- Van der Bruggen, C. O., Stams, G. J. J. M., & Bögels, S. M. (2008). Research review: The relation between child and parent anxiety and parental control: A meta-analytic review. *Journal of Child Psychology and Psychiatry*, 49, 1257–1269.
- Van Gastel, W., & Ferdinand, R. F. (2008). Screening capacity of the Multidimensional Anxiety Scale for Children (MASC) for DSM-IV anxiety disorders. *Depression and Anxiety*, 25, 1046–1052.
- Villabø, M., Gere, M., Torgersen, S., March, J. S., & 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.
- Wagner, S. M., & McNeil, C. B. (2008). Parent-Child Interaction Therapy for ADHD: A Conceptual Overview and Critical Literature Review. *Child & Family Behavior Therapy*, 30(3), 231–256. <https://doi.org/10.1080/07317100802275546>
- Walczak, M., Esbjørn, B. H., Breinholst, S., & Reinholdt-Dunne, M. L. (2016). Parental Involvement in Cognitive Behavior Therapy for Children with Anxiety Disorders: 3-Year Follow-Up. *Child Psychiatry & Human Development*.
<https://doi.org/10.1007/s10578-016-0671-2>

- 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. *The New England Journal of Medicine*, *359*, 2753–2766.
- Waters, A. M., Ford, L. A., Wharton, T. A., & Cobham, V. E. (2009). Cognitive-behavioural therapy for young children with anxiety disorders: Comparison of a Child + Parent condition versus a Parent Only condition. *Behaviour Research and Therapy*, *47*, 654–662.
- Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, *65*(1), 93–109.
<https://doi.org/10.1037/0022-006X.65.1.93>
- Webster-Stratton, C., Reid, M. J., & Hammond, M. (2004). Treating Children With Early-Onset Conduct Problems: Intervention Outcomes for Parent, Child, and Teacher Training. *Journal of Clinical Child and Adolescent Psychology*, *33*(1), 105–124. https://doi.org/10.1207/S15374424JCCP3301_11
- Wei, C., Hoff, A., Villabø, M. A., Peterman, J., Kendall, P. C., Piacentini, J., ... March, J. (2014). Assessing Anxiety in Youth with the Multidimensional Anxiety Scale for Children. *Journal of Clinical Child & Adolescent Psychology*, *43*, 566–578.
- Wei, C., & Kendall, P. C. (2014). Parental involvement: contribution to childhood anxiety and its treatment. *Clinical Child and Family Psychology Review*, *17*, 319–339.

- Weinberg, H. A. (1999). Parent training for attention-deficit hyperactivity disorder: Parental and child outcome. *Journal of Clinical Psychology, 55*(7), 907–913. [https://doi.org/10.1002/\(SICI\)1097-4679\(199907\)55:7<907::AID-JCLP11>3.0.CO;2-3](https://doi.org/10.1002/(SICI)1097-4679(199907)55:7<907::AID-JCLP11>3.0.CO;2-3)
- Wells, K. C., & Egan, J. (1988). Social learning and systems family therapy for childhood Oppositional Disorder: Comparative treatment outcome. *Comprehensive Psychiatry, 29*(2), 138–146. [https://doi.org/10.1016/0010-440X\(88\)90006-5](https://doi.org/10.1016/0010-440X(88)90006-5)
- Whiteside, S. P. (2009). Adapting the Sheehan Disability Scale to Assess Child and Parent Impairment Related to Childhood Anxiety Disorders. *Journal of Clinical Child & Adolescent Psychology, 38*(5), 721–730. <https://doi.org/10.1080/15374410903103551>
- Wolk, C. B., Kendall, P. C., & Beidas, R. S. (2015). Cognitive-behavioral therapy for child anxiety confers long-term protection from suicidality. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*, 175–179.
- Wood, J. J., McLeod, B. D., Piacentini, J. C., & Sigman, M. (2009). One-year follow-up of family versus child CBT for anxiety disorders: Exploring the roles of child age and parental intrusiveness. *Child Psychiatry and Human Development, 40*(2), 301–316. <https://doi.org/10.1007/s10578-009-0127-z>
- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family Cognitive Behavioral Therapy for Child Anxiety Disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*, 314–321.

- Woodward, L. J., & Fergusson, D. M. (2001). Life Course Outcomes of Young People with Anxiety Disorders in Adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*, 1086–1093.
- Zisser, A., & Eyberg, S. M. (2010). Parent-child interaction therapy and the treatment of disruptive behavior disorders. In J. R. Weisz, A. E. Kazdin, J. R. (Ed) Weisz, & A. E. (Ed) Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents (2nd ed.)*. (pp. 179–193). New York, NY, US: Guilford Press.
- Zonneville-Bender, M. J. S., Matthys, W., van de WIEL, N. M. H., & Lochman, J. E. (2007). Preventive Effects of Treatment of Disruptive Behavior Disorder in Middle Childhood on Substance Use and Delinquent Behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(1), 33–39.
<https://doi.org/10.1097/01.chi.0000246051.53297.57>

APPENDIX A

PROMOTING INDEPENDENCE AND AUTONOMY

PARENT GROUP MANUAL

**GENERAL TIPS FOR LEADING THIS GROUP AND ADHERING TO
TREATMENT CONDITION**

- This group focuses on parenting skills for promoting independence in children. It starts out more general and then will be specifically applied to anxiety.
- Although there will be some material about applying the skills to managing youth's anxiety, conducting exposures, etc., don't worry about fitting in a comprehensive explanation of CBT, coping skills, and conducting exposures - assume this will be covered in individual therapy.
- Be aware of and understanding that age differences between parents' children (e.g., parent of a 7-year-old and parent of a 15-year-old) mean that there may be normative differences in expectations of independence – this is okay, and can be part of the discussion. But look out for parents who might be dismissive of granting autonomy because their child is “different”/”has different needs” because of their anxiety (or some other reason) – help them understand that some degree of autonomy is appropriate at any developmental level (though the type of autonomy may be different) and helps their child develop resilience and coping ability in managing their anxiety, while dependence maintains their anxiety and sense of helplessness.
- It is OK to **initially** be supportive of the behavior parents have used in response to their children's anxiety, even if we know it might be maintaining the anxiety. We don't want this group to be a lecture on how they've been bad parents! Show understanding of why parents want to protect their kids from struggle, failure, and

distress (these efforts come from a good place) as you provide education about more effective ways to promote confidence and independence.

- If any parents are uncomfortable about sharing their own experiences or examples when asked, their participation can be gently encouraged but is not required.
- Within each session, time estimates are given for each section of the material but do not need to be followed exactly.

SESSION 1 - Skills for promoting autonomy and independence

Introduce the group (5 minutes)

- *[Introduce self]*
- The goal of this group is to talk about ways you can support your children and teens in managing their anxiety by using some parenting skills that promote independence and confidence.
- *[Have parents introduce themselves and briefly talk about their child/teen and his/her anxiety]*

Importance of encouraging autonomy (30 minutes)

- As parents, you understandably want your children to be safe, happy, and fulfilled, and want to do everything in your power to make sure that happens.
- What is your reaction when you see your child or teen upset or struggling with a problem? What do you want to do?
- Your child is dependent on you for many things (food, shelter, education), so it makes sense to provide those things for them. You are an adult with a lot more life experience than your child, so you have lots of advice and help to give for almost any problem they have! It may seem like to thing to do—provide the answers for them. Protect them from any distress. If you have the answer or solution or can do it for them so that they don't have to struggle over it, or if you can prevent them from feeling the disappointment of failure, why wouldn't you?

- What are some drawbacks of always protecting kids from struggle, frustration, anxiety, and disappointment? *[see if parents have any ideas, then move on to the following illustration of the potential drawbacks]*
- Let's imagine that Mark, the father of 10-year-old Chris, says the following things to Chris throughout the day:
 - You're having Cheerios for breakfast. Cocoa Puffs are sugary and bad for you.
 - I laid out some clothes for you to wear today.
 - Are you sure you want to try out for basketball? You were having a hard time making free throws in the driveway the other day... Maybe you should just play for the rec team.
 - How was school? Who did you play with at recess? What did you do? Was that kid Dylan teasing you again? You should tell the teacher when he does that.
 - Are you sure you're okay walking to Sam's house by yourself? I should go with you.
- When Mark is saying each of these things to Chris, of course he is trying to do what's best for Chris and protect him from having to make decisions, struggle with his math homework, experience disappointment, deal with interpersonal problems, and feel nervous, because Mark has the power to protect Chris from all these things! *But...* how do you think Chris feels hearing all these things from his dad throughout the day? *[see if parents have any ideas]*

- Although kids might seem grateful and even feel some relief when they can depend on their parents to answer questions and solve problems, being completely dependent on someone leads to feelings of helplessness, worthlessness, and a lack of resilience. A child might feel like his parents don't think they are capable of doing anything on their own, and they can easily start to believe this themselves.
- On the other hand, what is the advantage of encouraging autonomy instead of dependence? *[see if parents have any ideas]*
- When we allow kids to struggle, make mistakes, and even fail sometimes, they develop independence and confidence to handle tough situations, while still using the support of their parents when they need it. We all learn from our mistakes and failures; these situations are inevitable in life, and if kids are always protected from them, it will be all the more crushing and overwhelming when they eventually happen.

Great ways to encourage autonomy (25 minutes)

- *[Hand out list of autonomy-granting skills]*
- Allow kids to make choices. Making decisions may seem stressful, so it can be tempting to just avoid that stress by making decisions for your child. But kids who never make choices are always being told what to do, and may become distressed when faced with a decision down the road. A parent can still provide boundaries by providing what is called a “forced choice.” Have your child choose from a few options (e.g., Do you want to wear the red dress or the blue one? Do you want a banana or an apple for your snack? Do you want to practice

piano before or after your homework?) They get a sense of autonomy, while still being within parental boundaries.

- Respect the struggle. Jumping in to help when your child is having a difficult time with something is a tempting way to reduce distress, but your child might perceive that she is herself, alone, incapable of completing a task that should be easy. It is OK to show understanding that the task is difficult so they feel validated, and maybe offer something they can try instead of doing it for them (e.g., Algebra can be tricky! It can be really hard to tell a friend that they did something that bothered you. That jar lid looks really stuck - sometimes it helps to tap the lid with a spoon). Allow them a little struggle—they won't fall apart, and it allows the potential for a sense of accomplishment about getting through a difficult task.
- Don't ask too many questions. Of course you are interested in what your child is up to or how he feels, and he might like that you are interested, but too many questions feels invasive. Try asking fewer open-ended questions, only every now and then (e.g., How was your day?) and respect when your child might not want to open up at the moment... he may feel more free to come to you and open up later if he feels that his privacy and autonomy are respected. And when he does, listening shows the interest you want to show.
- Don't rush to answer questions. As adults we can "see the answers" easily. If you always give your child the answers without letting her explore the problem on her own first, it will be harder for her to develop the skills and the confidence to solve

problems when you aren't there. You can show support by guiding her in a preferred direction to figure out the answer.

- Don't take away hope. Sometimes, when parents have the best intentions of protecting their kids from disappointment or failure, they may inadvertently take away their child's excitement and hope about something they want to try.

Although it can be difficult to see your child make a mistake or fail at something, it can be a valuable learning experience for dealing with these things later in life, and helps him feel independent and confident about giving things a try.

The difficulty of promoting independence and autonomy (15 minutes)

- *["Respect the struggle" that parents may have implementing these skills! Discuss why it's hard to do these things and what are some common things they do that may promote dependence]*
- *Some things that may be discussed: difficulty of seeing kids in distress; how it can be nice to feel needed as a parent; often accommodating is easier for everyone in the moment]*

Wrap up (10 minutes)

- *Brief discussion to clarify the definitions of granting autonomy and promoting dependence and the difference between them*
 - *Autonomy = treating the child as an individual person who has the right and ability to make decisions, deal with emotions, and solve problems*

independently, even though he/she may depend on caregivers for basic needs and benefit from their support

- *Dependence = treating the child as totally dependent on a caregiver, without the ability to think, feel, or solve problems independently*
- *Briefly review the parenting skills for granting autonomy*

SESSION 2 - Promoting independence in anxious youth

Ways that parents respond to their child's anxiety (25 minutes)

- *[Have parents share some ways that they have responded to their child/teen's anxiety, if they are willing (not required). Discuss (briefly) whether they think these responses promote dependence or independence. Remember to be supportive even if they are using dependence-maintaining behaviors!]*
- Promoting independence and autonomy is difficult with kids and teens who are anxious, because getting help and reassurance from their parents helps them feel less anxious in the short-term. But research indicates that dependence-promoting parenting and always protecting kids from distress actually maintains anxiety in the long run. Why do you think this is the case? *[see if parents have any ideas]*
- Common ways that parents respond to their children's anxiety that may have the best intentions but can promote dependence and actually maintain their anxiety:
 - *[Discuss with parents how each one can maintain anxiety - e.g., models anxious thinking, kids never learn to cope on their own/think they always need parents' help]*
 - Frequently providing reassurance when their child is worried (e.g., Nobody will break into the house; You will do fine on your test; You won't get sick; You're doing it right)
 - Stepping in right away to help when their child is stressed (e.g., staying at a birthday party or playdate because their child is afraid of being there)

without them; doing homework with their child because the child is worried about making a mistake)

- Allowing their child to avoid situations that make them anxious (e.g., letting them go to school late or stay home because they are anxious; picking their child up from a sleepover because they are afraid to be away from home; asking the teacher if their child can skip a presentation she is afraid to give in front of the class)
- Also, encouraging their child to avoid situations that they anticipate might not go well and where the child might become upset, scared, or embarrassed (e.g., a long car ride where they might throw up, a sleepover where they might get scared and want to come home, a musical audition where they might get anxious and freeze up)
- Frequently “checking in” with their child to make sure he is feeling okay about a situation in which he might be anxious (e.g., Are you sure you’re okay with this? Is this too hard for you? Are you too nervous?)

Ways to promote independence and autonomy with anxious youth (25 minutes)

- By using the skills we talked about last time for promoting independence and autonomy, we can respond to children and teens’ anxiety in a way that helps them become more confident and better able to cope with their anxiety over time.
- Allowing choices - if we regularly let kids make choices (even if you provide a limited number of options), they will be less anxious about having to make decisions later on.

- Respect the struggle - instead of jumping in to help, validate that your child is feeling nervous or fearful, and encourage her to give it a try on her own. This way, she perceives that you understand the difficulty but have confidence that she can still do it, which will help her confidence at that moment and when she is faced with the situation again.
- Don't ask too many questions - instead, let your child come to you if he needs support. This lets him develop confidence in his own ability to know when he needs help.
- Don't rush to answer questions - letting your child work through worries and problems on her own, with some support and brief reminders to use her coping thoughts, gives her more confidence about handling anxiety-provoking situations because she won't always need you to help her.
- Don't take away hope - Allowing your child to potentially feel anxious, make a mistake, not do something perfectly, or experience disappointment teaches him that these experiences are okay and that he can handle them, which will give him more confidence to try things in the future.

Role-play responding to anxiety-provoking situations (25 minutes)

- *[Role-play an exposure task with a parent, with yourself acting as the "parent" and the parent playing their child. First, run through the exposure task in a dependence-promoting way and have parents label whether they thought your actions promoted dependence or independence and why. Then run through it using independence-promoting behaviors and discuss those.]*

- *[Have two parents role-play another exposure task, first showing how they might handle the situation to promote dependence, followed by how to promote independence.]*
- *[Repeat with another example or two.]*
- *[As group leader, you can be as involved in the role plays as you feel is needed, at any point]*

[Feel free to come up with your own exposure examples, but some ideas are: mom goes out for an hour while child stays home with older sibling or babysitter; child has to watch videos of people throwing up; child gives a five-minute presentation in front of the class; adolescent has to take a practice SAT; child/adolescent has to invite a friend over]

Wrap up (10 minutes)

- *Briefly review how to apply the autonomy-granting skills with anxious youth*
- *If parents are willing (not required), have them share some upcoming exposures they will be working on with their child and how they will use the skills to promote independence.*

SESSION 3 - Exposures and beyond

How exposures are going (45 minutes)

- *[If they are willing (not required), have parents share some of the exposures their children have done (some that went well, and maybe some that were difficult) and how they were involved/what they did]*

- *[Discuss together how they have promoted independence or dependence during exposures and what they could try differently, if anything, reviewing the skills they have learned]*
- *[Have parents role-play actual higher-level exposures their youth have coming up and provide coaching during (brief) and during a discussion after the role-play]*

Maintaining gains after treatment with parenting that promotes independence and autonomy (going back to the “big picture”) (40 minutes)

- Using the skills we have learned to promote independence during your children’s therapy challenges is a great way to practice them. But continuing to use these skills with your children after therapy will help them continue to develop confidence and coping behavior and maintain the progress they have made in managing their anxiety.
- *[Review the skills from Session 1]*
- *[Together with the parents, make a list of all the things they can think of to do that would help them raise an independent child. Then make a list of all the things they can think of to do to raise the most dependent child in the world.]*
- *[Have parents share what independence-promoting skills they have found helpful, and what they have found difficult about this kind of parenting.]*
- *[Have each parent choose a skill or two that they want to focus on/work on using more, and discuss ways they can work on it.]*

Promoting Independence and Autonomy

- **Allow kids to make choices**
- **Respect the struggle**
- **Don't ask too many questions**
- **Don't rush to answer questions**
- **Don't take away hope**

APPENDIX B

CBT SKILLS FOR PARENTS:

PARENT GROUP MANUAL

**GENERAL TIPS FOR LEADING THIS GROUP AND ADHERING TO
TREATMENT CONDITION**

- The goal of this group is to teach CBT skills and concepts similarly to how they are taught with youth in Coping Cat/CAT Project.
- Stay away from targeted parenting interventions. That is, DO NOT explicitly refer to, e.g., differential attention, granting autonomy, reducing overprotection, anxious modeling. Even though some of these parenting concepts are indirectly conveyed through some of the typical material (e.g., reward systems, validating anxiety, encouraging kids to try the exposures), don't talk about these concepts but instead stick to the CBT language and the specific behaviors we recommend in exposure scenarios. For example, DO NOT say something like, "If your child appears anxious during the exposure, validate her feelings and encourage her to continue, because this gives her more autonomy over her emotions and independence in dealing with a difficult situation." Instead, just stay with the typical rationale for exposures (e.g., we want kids to feel anxious in the exposure so they experience habituation and get over it).
- When asking parents to share their own experiences, examples of their child's anxiety, exposures they are working on, etc., if some parents are uncomfortable sharing, it is not required that they participate (but you can be encouraging).
- Within each session, time estimates are given for each section of the material but do not need to be followed exactly.

A good rule of thumb: We want to prevent bleeding across conditions. Teach the CBT skills as if you are teaching the skills to one of your child/adolescent clients (but at an adult level is OK).

SESSION 1 - Coping Skills in FEAR Plan

Introduce group (5 minutes)

- *[Introduce self]*
- This group is meant as a way for you as parents to learn more about the skills your kids and teens are learning in therapy and how you can help them use those skills.
- *[Have parents go around and introduce themselves and briefly describe their youth. It is OK if a parent chooses not to do this.]*

Briefly review 3-part CBT model (5 minutes)

- Thoughts, feelings, and behaviors involved in anxiety *[OK to do a little Q and A with the parents]*
- Changing the anxious behaviors is probably most important and effective - this happens in challenges or exposures
- Before we face our fears/to feel more ready, we can try to use some coping skills to reduce our anxious thoughts and feelings.
- We can change what we say to ourselves (with kids, we usually call this “changing self-talk”) to counter our anxious thoughts and we can use relaxation to respond to anxious feelings/tension.

Changing self-talk (cognitive restructuring) (30 minutes)

- The first step is identifying anxious thoughts so that we can respond to them.
- Imagine that you work for a company and that you have to give a presentation in front of your co-workers. What are some thoughts that are going through your head? If you had a thought bubble above your head like a cartoon character, right before you walked up to the podium, what would be in your thought bubble?
- *[Draw a person with a big thought bubble on the board and put parents' thought examples inside it]*
- Would you say any of these seem like anxious thoughts?
- Let's take one of the anxious thoughts and try to challenge how accurate or helpful it is in the situation.
- *[Pick out one of the anxious thoughts that seems most common/straightforward to challenge]*
- *[Hand out a printed copy of the **list of thinking traps**]*
- First, let's see if this thought falls in any thinking traps. Our anxious thoughts might keep us trapped into focusing only on the worst-case scenario, thinking that we can read others' minds, thinking we can predict the future, holding ourselves to impossibly high standards, and other unhelpful scenarios. *[Work with parents to identify thinking traps for thought example]*
- Now that we see this thought as part of a thinking trap, we can challenge it and come up with a more helpful thought.
- *[Hand out a printed list of **challenging questions** and use them to challenge the thought example]*

- Summarize what we just discussed: what might be a more helpful thought we can use in this situation?
- *[Ask about recent times when their child (or any child) has been anxious, identify some anxious thoughts they might have had in those situations, and go through the process again with two or three of those examples. See if you can “back off” and let parents take the lead more in the process as you go.]*

Review problem-solving (15 minutes)

- Coping thoughts are a helpful way to decrease our anxiety about a situation we have to face. Problem-solving is another way we can respond to anxious thoughts in some situations where we feel overwhelmed, and we are able to change something about the situation, to feel more in control.
- Problem-solving steps: defining the problem, coming up with possible solutions without evaluating them, evaluating possible solutions, trying the best solution.
- *[Run through problem-solving steps using an example - e.g., forgot to write down the homework]*

Review relaxation (15 minutes)

- When we are anxious, a lot of physical sensations may take place as part of the “fight or flight” response, which is a natural process our bodies (along with other animals) developed to respond to actual threats in our environment.

- *[Hand out list of **physiological responses to anxiety**]*
- These sensations can be uncomfortable, but often they are a “false alarm”

and there is no real danger, so we can use some relaxation techniques to reduce our anxious feelings.

- *[Describe and demonstrate deep breathing and have parents try it]*
- *[Describe progressive muscle relaxation]*

Wrap up (5 minutes)

- *Briefly summarize anxious/coping thoughts, problem-solving, and relaxation as coping skills.*
- *Answer any remaining questions.*

SESSION 2 - Exposures

Rationale for exposures (20 minutes)

- Going back to 3-part model of anxiety- we can try to use some coping skills, like we discussed last time, to change anxious thoughts and feelings. An effective way to reduce anxiety in all three areas, though, is to change anxious avoidant behavior.
- What do we do when we are afraid of something? Let’s say you are really afraid of snakes, and one day you walk into your garage and there’s a snake there. What

are you going to do as soon as you see that snake? [*run away = escaping/avoiding the snake*]

- What about after that - are you going to want to go back in your garage again?
[*avoidance as anxious behavior*]
- [*Draw anxiety-by-time graph*]
- When you go near the garage the next time, what is going to happen to your anxiety? What will happen to it if you avoid going in the garage? What will happen if you decide to go in?
- When we avoid something that makes us anxious, it makes us feel better in the moment! So we keep avoiding it, because going towards the garage, or looking at a snake at the zoo, makes us feel uncomfortable, and avoiding it makes us feel less uncomfortable.
- What happens if we were to stay in the situation? [*Wait for responses of what parents think will happen*]. What happens is that our anxiety goes up at first, but eventually it can only get so high, and it comes down as our brain realizes that there is no extreme danger and gets used to the situation. One can call this habituation.
- When kids avoid something that makes them anxious, it lets them feel better in the moment (which is why they do it), but in the long run, they only experience feeling anxious in the situation and calm when they escape or avoid the situation, so they are going to stay anxious about that situation. [*point out the two parts of the graph for escape/avoidance scenario*].

- However, when we face our fears and stay in the situation long enough, we can experience an anxiety decrease *in the situation [point out the habituation part of the graph]*.
- This is why having a child face a fear (do a “challenge”), also called an exposure task, is helpful. Challenges also help kids learn that being anxious is okay and something they can cope with, not something they need to avoid.

Building a hierarchy and choosing exposures (10 minutes)

- We typically have kids do challenges gradually, starting with situations they feel like they could handle, and working up to harder challenges. We come up with situations that make them feel anxious, have them rate their anxiety about each one, and then work together to put them in order on a Fear Ladder.
- *[Hand out example **Fear Ladder**]*
- Kids might have different types of situations that make them feel different levels of anxiety, such as seeing somebody throw up, speaking in front of the class, and sleeping by themselves, but we can even break down each of these challenges into some easier steps. For example, a child afraid of throwing up might talk about throwing up as a first challenge, followed by looking at pictures of people throwing up, videos of people throwing up, and looking at, smelling, and touching realistic fake vomit.
- You, your child, and your child’s therapist can work together to pick which area of anxiety to target first with challenges. When choosing a specific challenge to

try next, it's helpful to have the child choose what she feels like she can handle - that way she is more likely to be willing to try it.

Conducting exposures (15 minutes)

- Remember that we want kids to experience their anxious feelings when they do a “challenge”, and we want them to feel anxious long enough, and enough times, so that they learn they can cope with their anxiety and see the natural decrease in anxiety happen. This way they will be more confident and less anxious about approaching the situation in the future.
- It may be difficult at first to see your child feeling anxious during a challenge. Remember that it is okay! In fact, experiencing anxiety during a challenge means it will be more effective at reducing anxiety in the long run.
- Your therapist will work with you and your child to set a clearly measurable goal for the challenge - e.g., look at a picture of vomit for 10 minutes, stay in my room by myself for 15 minutes, text mom fewer than 5 times, raise my hand one time per day in class.
- Not recommended to set goals about not feeling anxious or how well something is done as these are subjective and not as easy to measure. The goal isn't being “anxiety free”; the goal is to complete the task *in spite of* anxiety.
- Review the FEAR plan for the challenge, including the coping skills (especially coping thoughts) your child will use to help her get through it.
- When your child is expressing reluctance about completing the challenge or wants to escape the situation before the goal is completed, it is OK to show acceptance

and understanding of the anxiety (e.g., I know this is hard/scary for you) but encourage her to continue (e.g., but I know you can do it!) and remind her to use her coping thought(s). Don't attend to the anxiety or the anxious behavior—instead, praise brave behavior.

- When the challenge goal is complete, provide lots of praise! (do not expect perfection: reward the effort)
- If your child is not able to complete the goal, praise efforts and say she can try again later.

Rewards (10 minutes)

- In addition to praise, rewards help motivate children and teens to complete challenges and make the experience positive. Some kids are very motivated to complete challenges on their own, and kids are often very proud of themselves for completing them, but it is still helpful to have a reward in place for the effort put forth to accomplish a difficult task.
- Your therapist will work with you and your child to come up with a good reward system for completing challenges. Rewards do not have to be material things, but can be experiences or special time with you or with their friends.
- Brief reminders of the potential reward (but stay away from threats about taking it away) can help kids get through challenges, in addition to their coping thoughts.
- We are not trying to bribe kids to complete challenges, because they can only earn the reward *after* they complete the challenge goal. It helps them feel proud and

confident about what they have accomplished and motivates them to try the next challenge!

Remaining 30 minutes or so:

[Role-play an exposure with a parent as child and yourself as the parent: the challenge is looking at a picture of someone getting a shot]

[Have two parents role-play another exposure situation while you coach them (can ask parents for examples from their own children or come up with one). Repeat as time allows with other example situations.]

SESSION 3 - Review and role-play exposures

Since this session is less structured, timing is not provided – the intention is to spend about half the session (45 minutes) having parents share stories and reviewing skills and the other half (45 minutes) role-playing, but feel free to use your judgment as you see how the discussion goes.

Have parents share how exposures are going with their youth: some challenges that have gone well and some that maybe have gone less well. Answer any questions and review/reinforce the skills discussed in group sessions 1 and 2 as they come up. Some likely questions/problems parents may bring up:

- *“My child did the challenge but was really anxious the whole time.”*
 - *Emphasize the positive that the child completed the goal, and reinforce why experiencing anxiety during the exposure is a good thing.*
- *“Even though I did all the things you suggested, my child couldn’t do the challenge”*
 - *Walk through what the parent and child did when they tried the challenge, praise the parent for what they did well, and problem-solve any adjustments that can be made. Encourage parents to stay consistent with the reward system and check back in with the child to see if there is a different challenge they would like to try. Remind parents that these things take practice and will get better if they keep trying!*

- *“My child got so anxious during the challenge and I felt guilty about making him continue it, so I let him stop.”*
 - *Praise parents for their efforts and show understanding that it is hard to see their child in distress. Reinforce the rationale for facing fears instead of escaping and all the positives that can come from it (experience decrease in anxiety, learn they can handle it, gain pride and confidence to face the fear again)*

Have parents conduct role-plays with each other (one parent plays the “parent” while the other plays the “child” ...they do not have to be parents of the same child, but just group members working together) using higher-level, actual exposures they are working on with their youth. Provide coaching during the role-play (brief) and during a discussion after each one. You can increasingly ask parents to provide feedback/coach each other throughout the session.

Thinking Traps

- The Fortune Teller:* Thinking you know what is going to happen in the future (usually something bad)
- The Mind Reader:* Thinking you know what other people are thinking
- The Catastrophizer:* Assuming the worst-case scenario will happen
- The Perfectionist:* Thinking something has to be absolutely perfect or it's bad/a failure
- The Avoider:* Thinking it is better not to try something than to take the risk that it might not go perfectly

Challenging Questions

Has this happened before? If yes, what was it like?

How likely is it that this will happen?

What is the worst-case scenario? What would be so bad about that?

What are some other possible things that could happen (i.e., things that aren't necessarily negative)?

Physical Reactions to Anxiety

- **Feeling short of breath**
- **Heart beating fast**
- **Dizziness**
- **Shaking**
- **Sweating**
- **Blurred vision**
- **“Butterflies” in the stomach**
- **Nausea**
- **Muscle tension**
- **Headache**
- **Numbness/tingling**

Example Fear Ladder**Challenging**

Go to a party with people I don't know well

Sleep over at a friend's house

Touch fake vomit

Watch a video of someone throwing up

Medium

Text Mom once while she goes out

Text Mom three times while she goes out

Read out loud in front of the class

Easy

Look at a picture of someone throwing up

Raise my hand in class

Say "hi" to someone I don't know in the cafeteria

Talk about throwing up

APPENDIX C
PARENTING AN ANXIOUS CHILD
SUPPORT GROUP MANUAL

**GENERAL TIPS FOR LEADING THIS GROUP AND ADHERING TO
TREATMENT CONDITION**

- The goal of this **support group** is to have the parents lead the discussion, with the clinician as facilitator. Accordingly, there does not need to be any specific structure to the sessions.
- The group leader can let the group conversation take its course, as long as it stays on topic (in the general sense... anything to do with anxiety, parenting, life stress, but use your judgment; e.g., talking about tax preparation would not be OK).
- Specific questions to prompt discussion are provided for each session. Use as needed.
- Throughout the discussion, the group leader should refrain from giving any direct advice or educational information, but should show empathy and support by using supportive reflection and validation.
- If parents solicit your advice, remain neutral and support them in what they have been doing, without giving direct advice on what to do differently.
- Possible responses if parents ask you for advice:
 - Reflect back what they say, e.g., “It sounds like you have been trying *x*, how has that worked? What about it hasn’t been working?”
 - “It sounds like that has been working well for you, so maybe you should keep trying that.”

- “Does anyone have suggestions of things that they have found to work well? Or any other ideas of things to try?”

SESSION 1 - Having an anxious child

Introduce group

- *[Introduce self]*
- This group is meant as a way for you, as parents of children and teens with anxiety disorders, to share your experiences and support one another while your child is in therapy.
- *[Have parents introduce themselves]*

Sharing experiences having an anxious child

- *[Have each parent introduce their child/adolescent and his/her anxiety]*
- *[You can allow the conversation to continue as parents share their experiences. See below for tips on continuing the conversation and discussion prompts to use if needed]*
- If needed to continue the discussion, the following prompts may be used:
 - What has it been like for you as parents to have a child or teen who is anxious?
 - What are some ways that anxiety has impacted your child?
 - What are some ways that your child's anxiety has impacted you or your family?
 - What are some good things about having anxiety? What are some not-so-good things about it?

- How have you responded to your child's anxiety? What have you done to try to help them? Has it worked?
- What are your hopes for treatment?

SESSION 2 - The therapy experience

Sharing experiences with therapy

- *[Have parents share their experiences with their child being in therapy]*
- If needed to continue the discussion, the following prompts may be used:
 - What has therapy been like for you and your child?
 - What are some things that have been going well/not going well?
 - Being a parent of a child in therapy can be hard work! What has this been like for you?
 - What are your expectations for the next part of treatment (exposures/challenges?)
 - What do you think is going to be hard about having your child do challenges?
 - What are some of the things you can do to help your child with challenges?

In this session, parents may be particularly likely to look to you as group leader for advice on whether they have been doing things “right,” things that have not been working well, and what to do when exposures start. Remember to try to stay neutral and refrain from providing direct education or recommendations.

Some possible responses to likely questions or comments:

- My child is not getting better/this did not work/what should I do differently?
 - *Reflect and validate parent's thoughts and feelings to show support.*
 - What has not been working well about it? Why do you think it has not been working?
 - Does anyone have suggestions about other things to try? What has worked for you?
 - *Point out and validate things that have gone well and suggest doing those things more.*

- What should I do if [X] happens?
 - What are some ideas for solutions to that problem?
 - Has this happened before/what did you try before? Did it work?
 - What are some things your therapist has suggested?

SESSION 3 - Exposures

Sharing exposure stories and experiences

- *[Have parents share their/their child's experiences with exposures]*
- If needed to continue the discussion, the following prompts may be used:
 - How are exposures/challenges going? What are some of the challenges your child has tried?
 - Do you feel like the challenges are working?
 - What has been going well with challenges? What has not been going so well?
 - What has been your role as a parent in your child's challenges? What has that been like for you?
 - Are you using rewards for challenges? How has that been? What are some rewards your child has earned?
 - How do you feel your child/teen is progressing in treatment?

Like Session 2, parents may be likely to ask the group leader for advice on whether they have been conducting exposures correctly or things that have not gone well. You can use

similar response strategies to provide support and help parents problem-solve together without providing any explicit recommendations.

Some possible responses to likely questions or comments:

- My child is not getting better/this did not work/what should I do differently?
 - *Reflect and validate parent's thoughts and feelings to show support.*
 - What has not been working well about it? Why do you think it has not been working?
 - Does anyone have suggestions about other things to try? What has worked for you?
 - *Point out and validate things that have gone well and suggest doing those things more.*

- What should I do if [X] happens?
 - What are some ideas for solutions to that problem?
 - Has this happened before/what did you try before? Did it work?
 - What are some things your therapist has suggested?