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**Pediatrician-friendly perspectives on cognitive behavioral therapy for anxious youth: Current status and clinical implications for the next normal**

Friedberg RD. CBT for anxious youth

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**Abstract**

Pediatric anxiety disorders are common and often debilitating conditions. Cognitive is a psychosocial intervention that represents a potentially powerful antidote to these disorders. This article reviews data from treatment outcome studies, meta-analyses, and systematic reviews as well as from moderation/mediational investigations. The literature supports the efficacy, effectiveness, and durability of positive treatment outcomes for pediatric anxiety disorders. Recommendations for clinical applications are suggested.

**Key Words:** Pediatric anxiety; Cognitive behavioral therapy; Coping cat; Exposure

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**Core Tip:** There are several core tips in this therapeutic advances article. First, while the state-of-the-science supporting cognitive behavioral therapy (CBT) for pediatric anxiety is very strong, proper delivery of genuine CBT by trained providers is fundamental to its success. Clinicians should provide CBT in a manner that balances flexibility within fidelity. Most importantly, exposure is an essential component to any CBT approach to pediatric anxiety disorders.

**INTRODUCTION**

Anxiety disorders are highly prevalent conditions in child and adolescent populations[1-5]. Approximately 6.5% of youth worldwide suffer from anxiety disorders[4]. Anxiety disorders are also gateway disorders[3,6]. Thus, pediatricians frequently care for anxious youth in their practices and these young patients are frequently impaired. Effective psychosocial treatments are needed.

Fortunately, cognitive behavioral therapy (CBT) is widely regarded as the premier psychosocial treatment for pediatric anxiety disorders[7,8]. The approach has been empirically supported by meta-analyses, mediational and moderation studies, systematic reviews, randomized clinical trials (RCTs), controlled investigations, and case reports. Based on the aggregated results, both the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychological Association (APA) see CBT as the gold-standard treatment. More specifically, AACAP[9] referred to CBT as the “front-line” psychosocial intervention for pediatric anxiety disorders. The APA defined CBT for anxiety disorders as a “well-established” treatment[10]. Reaching the “Well-Established” threshold means that CBT was evaluated by at least 2 RCTs indicating efficacy where the treatment outperformed pill placebo, psychological placebo, or another treatment comparison group. Further, the specific intervention must have been manualized and examined by two different research teams. Finally, the protocol is required to have demonstrated equivalence to another Well-Established treatment or two approaches studied in investigations with at least *n* = 30. In sum, the well-established threshold is a stringent criterion. While anxiety disorders are highly prevalent and impairing, CBT is a widely deployed and effective intervention.

In this pediatrician-friendly perspective, CBT basics are briefly summarized and the empirical literature supporting the approach is discussed. Results from treatment outcome evaluations examining the seminal Coping Cat program, data from the Child/Adolescent Anxiety Multi-Modal Studies (CAMS) along with findings from reviews and meta-analyses are delineated. Further, the impact of mediators as well as moderators are presented. Finally, the article concludes with clinical recommendations for the peri- and post pandemic period.

**Basic description of CBT for pediatric anxiety: There’s nothing like the real thing**

CBT is a multi-component treatment paradigm is that is widely adopted[11-14]. Contemporary CBT with youth is increasingly adopting a modular approach to treatment (mCBT)[15-19]. In general, modular approaches identify the best procedures commonly found in many treatment packages/protocols and organize them into conceptual clusters. The techniques are grouped into particular units that share a purpose or function [*e.g.* orienting patients to treatment, cognitive restructuring (CR), *etc.*]. mCBT offers several compelling advantages including parsimony, reduced training burden, personalized/individualized care, and attractiveness to providers[15]. Typical modules include psychoeducation (PE), basic behavioral procedures (BBPs), CR, and exposure/experiments.

PE paves the way for the various intervention strategies. PE teaches patients as well as their families about anxiety disorders and treatment alternatives[20,21]. Moreover, PE enables genuine informed consent as well as increased help-seeking, collaboration, demystification, universality, empowerment, and hopefulness[18,22-25]. It may be delivered verbally or through books, pamphlets, video/audio recordings, internet sites, and mobile applications[17,18].

BBPs are based on “systematic application of conditioning principles to clinical disorders[26].” Typically, these procedures focus on acquiring and applying specific skills to particular problems[14]. BBPs include a stable of familiar approaches including relaxation, contingency contracting, and social skills training.

CR and rational analysis (RA) focus on re-engineering thought content and processes respectively[17,18,27]. Problem-solving, self-instructional, and self-talk techniques are classic CR procedures. A voluminous literature base exists that supports the use of CR methods[27-34]. RA procedures are more advanced methods and enjoy a long history in CBT[35-40]. “Analysis of meaning and attitudes exposes the unreasonableness and self-defeating nature of the attitudes[38].” Tests of evidence, reattribution, decastrophizing, and universal definitions are common techniques used in RA[38-40].

Exposure is seen as essential when treating anxiety disorders in youth[8,17,41-49]. Successful completion of exposure tasks involves young patients’ undivided attention, use of coping skills, and persistence amid negative emotional arousal[50]. The exposure component in CBT treatment uniquely differentiates CBT from supportive treatment[45]. Approximately 88% of the strongest studies evaluating treatment outcome for anxiety disorders in youth incorporated exposure in their intervention protocol[46]. When exposure elements were absent from CBT treatment approaches for anxiety, the effects were significantly attenuated[42,49,51]. In a meta-analysis focusing on dismantling the effective components of CBT for anxiety disorders in youth that included 75 studies, in-session exposure resulted in larger effect sizes when comparing CBT to wait-list control groups[41]. Increasing the emphasis on in-session exposure over anxiety management strategies such as those procedures described in the basic behavioral tasks as well as the CR modules may improve CBT’s efficacy[41].

Proper delivery and dosing of genuine CBT is crucial. There is data that clinicians self-identify as CBT practitioners, yet their in-session behavior does not resemble the true treatment approach[52]. Practicing flexibly with faithful adherence to CBT tenets is the current clinical watchword[11,53-55]. Competent CBT providers are seen as expert multi-taskers[56]. Consequently, they are able to balance faithful adherence to the model while making immediate adaptations in response to young patients’ unique presentations[11]. Flexible applications of CBT enable real-time adaptations, matching treatment to individuals’ psychological characteristics, and incorporating cultural vicissitudes into the intervention[53-55]. In this way relevance matching[57] is better achieved which facilitates building a more personalized treatment package.

**Treatment outcome studies: Coping CAT**

Coping Cat is a CBT protocol that is typically delivered in 12-16 sessions divided into two phases[12,58-60]. The classic FEAR plan punctuates the first 9 sessions.Thefeeling frightened component helps young patients monitor their physiological signs of anxiety. Identifying their catastrophic predictions defines the expecting bad things to happen part. Developing coping counter-thoughts and adaptive problem-solving strategies is the focus of attitudes and actions that can help. The fourth segment, results and rewards, teaches children to reward their productive coping efforts. Exposures and behavioral experiments make up sessions 10-16. During this stage, patients apply the skills acquired *via* the FEAR plan in various anxiety producing situations. Homework assignments called show that I can exercises are completed over the course of the Coping Cat protocol to facilitate treatment generalization and a sense of self-efficacy. The treatment package has been widely implemented in the United States and internationally[59,61].

Early RCTs evaluating the Coping Cat yielded very encouraging findings[62,63]. Coping Cat outperformed a wait-list control group in a RCT on several measures with young patients resulting in less symptoms, greater coping ability, and increased social skills[62]. Moreover, the gains showed durability with improvements holding up at 1 year[62] as well as 3.5 years later[64]. A subsequent RCT[63] also found similar positive results with 50% of patients being symptom-free at the end of treatment. These gains were sustained at 1 year[63] and 7.5 years after treatment[65].

Coping Cat was compared to an active treatment contrast condition (Humanistic Therapy) in a recent study including 133, 9-14 year old youth[45]. Although both treatments yielded similar acute response data, the CBT group was more likely to fully recover and no longer meet diagnostic thresholds at the end of treatment than counterparts receiving the Humanistic approach. Further, the patients in the CBT condition evidenced higher recovery rates at the 1 year follow-up point. The study authors’[45] concluded that CBT resulted in greater breadth and generalizability of treatment gains as well as more durability over time.

In an effectiveness study examining Coping Cat delivered by practitioners in a community setting rather than in a more controlled academic setting, participants in the treatment package outperformed wait-listed control group cohorts and the gains were maintained at 2 year follow up points[66].

Intolerance of uncertainty (IU) was targeted in a study examining Coping Cat’s clinical promise[67]. IU is seen as an important mechanism of action in anxiety disorders. This study found that decreased IU from pre-post treatment was associated with lowered functional impairment, increased coping, and decreased anxiety severity. These results imply that focusing specifically on uncertainty in CBT for anxiety may improve outcomes.

***Treatment outcome studies: The CAMS***

The CAMS was the most wide-ranging RCT evaluating the use of CBT (Coping Cat) and Serotonin Selective Reuptake Inhibitors (SSRI, Sertraline) for the treatment of anxiety in youth[68,69]. The project involved 488 participants (7-17 years of age) across multiple sites and assessed outcomes at 12, 24, and 36 wk. The data indicated that after 12 wk, the CBT, SSRI, and CBT + SSRI conditions all outperformed the placebo group[68]. More specifically, 80.7% of youth in the combination, 59.7% in the CBT alone, and 54.9% in the singular sertraline treatment arm improved on the Clinical Global Impression Scale. A dismantling study of 279 participants enrolled in the CAMS project showed that anxious youth who received more sessions devoted to exposure demonstrated greater symptom reduction and functional improvement[8].

In a project examining response and remission rates, all three arms of CAMS (CBT, SSRI, COMBO) sustained their rates of improvement, however the superiority of the combination treatment did not persist at the 36 wk mark[69]. Extended long term gains were evaluated in a study of 319 youths[70]. Based on linear and quadratic growth models, CBT was associated with faster improvement, academic achievement, and greater life-satisfaction. These gains appear to endure for approximately 6.5 years.

The question of which treatment arm is best-suited for which patients was researched in another secondary data analysis[71]. The single treatments (CBT, SSRI) worked equally well for patients with lower levels of anxiety whereas the combined CBT + SSRI package was essential for symptom remission in patients with more severe anxiety. Additionally, low SES predicted poorer treatment response. Thus, it appears that the combination treatment is indicated for more distressed individuals who may be more financially challenged.

**Reviews and Meta-analyses**

An early review article concluded RCTs evaluating CBT spectrum approaches yielded positive treatment outcomes earning medium effect sizes[72]. In a later review of 24 RCT’s with children and adolescents diagnosed with a variety of anxiety disorders, large pre-post differences were reported[73]. Additionally, rates of clinical improvement ranging from 60%-80% were found. Further, when a conservative benchmark of remission was applied, 50%-70% of patients claimed they were symptom free[73]. A recent comprehensive review evaluated multiple treatment paradigms for anxiety according to various levels[46]. The review concluded that CBT earned a large effect size and demonstrated durability of outcomes with diverse populations. Moreover, when applying another more stringent criteria such as functional improvement in patients, CBT was the only approach that met the Well-Established threshold. Children who received CBT were 3 to 7 times more likely to show improvement than cohorts in the passive control condition[74].

A variety of meta-analyses examining CBT’s potential to reduce anxiety disorders have been conducted[75-78]. In a meta- analysis exploring the efficacy of CBT for anxiety disorders in youth, 11 meta-analyses incorporating 350 comparisons were evaluated[75]. The results yielded medium to large effect sizes for CBT compared to non-active controls [mean weighted effect size (d) = 0.76]. Further, the effect sizes were somewhat smaller when testing CBT *vs* active comparison groups (d = 0.40). Finally, when pre-post differences in anxiety for CBT were studied, large effect sizes were found (d = 0.88). When examining compete symptom recovery, another meta-analysis concluded 61 percent of youth show symptom remittance after a course of CBT[78].

A systematic review and meta-analysis including 115 studies covering 7719 patients with a mean age of 9.2 years showed that when CBT was compared to wait list comparison groups, CBT led to greater symptom reductions and remissions[77]. Moreover, the same meta-analysis found that attrition rates were lower in the CBT condition than the in pill/placebo contrast groups. Moreover there were less adverse events in patients receiving CBT than in counterparts who were in the medication groups (SSRI). These results appear to suggest that CBT is more well-tolerated by young patients than medication[79]. Finally, the combination of CBT with SSRIs was a stronger treatment than either mono-therapy alone[77].

CBT also demonstrates considerable promise when applied to anxious adolescents. Large pre-post differences, medium to large effects sizes, and encouraging remission rates were found. In particular, post-treatment remission rates ranged from 27%-35% and from 52 to 60 percent in various studies[73].

**Moderators and Mediators**

Examining moderator and mediator variables adds another dimension to treatment outcome studies. Moderation analyses can determine what treatment, for what type of patient, under which circumstances works best[80]. A moderator variable is defined as either a qualitative or quantitative construct that “affects the direction and/or strength of the relationship between an independent or predictor variable and a dependent or criterion variable[81]”. Moderator variables represent pre-randomized characteristics that do not explain treatment effects but rather interact with them[82]. In general, moderator analysis examines performance of subgroups in certain conditions[80].

Conversely, mediators specify the mechanisms of change in dependent variables and speak to how or why effects occur[81]. Behavior change, especially decreased avoidance, is a powerful mediator of treatment outcome for anxiety disorders[83]. Negative cognitions especially future-oriented, catastrophic thoughts were also seen as significant mediating variables and homework assignments earned small to medium effect sizes[83]. Results for parental behavior and treatment alliance were deemed inconclusive as far as their contribution to outcomes[83].

Several studies based on the CAMS investigations identified some additional potential mediators. In a follow-up investigation including 488 youths, coping efficacy mediated clinical outcomes[84]. Perception of social threats mediated treatment response in a naturalistic follow-up evaluation of 319 young patients enrolled in CAMS[85]. Somatic symptoms mediated treatment outcome for the sertraline arm of the CAMS study[86]. The most consistent predictors of treatment response found across studies included type of primary anxiety disorder, severity of anxiety, co-morbidities, and parental psychopathology[82].

In an analysis of the CAMS data based on 488 young participants, no demographic variables moderated the clinical outcomes[87]. A recent comprehensive review evaluated research on moderator variables such as co-morbidity, presence of social anxiety, gender, age, race/ethnicity, parental involvement, parental psychopathology, family factors, therapist variables, and dose of therapy[83]. These investigators noted that treatment outcomes did not vary as a function of the severity of illness and regardless of pre-treatment severity, anxious youth demonstrated a similarly favorable treatment response. On the other hand, co-morbid conditions such as autism spectrum disorders, depression, and attention deficit disorder did moderate the outcome. They concluded gender and ethnicity did not significantly influence treatment outcome, indicating that male and female, as well as diverse youth, benefit similarly from CBT. Moreover, parental involvement in treatment and family factors were not seen as significant moderators. Parental psychopathology had some modest influence on treatment depending on the age of the child, with a stronger impact on outcomes for younger youth. Overall, the data on age of the patient was considered inconclusive. Finally, therapist variables such as flexibility and collaboration demonstrated moderating effect on treatment outcomes.

A number of reviews agree that demographic variables (*e.g.* biological sex, race/ethnicity, SES, *etc.*)[43,73,82] do not significantly moderate treatment outcome for anxiety disorders in youth. Nonetheless, there is some evidence that gender and ethnicity are correlated with differential attrition rates[60]. It could be argued that many of these studies are under-powered to detect significance, but this criticism is somewhat recently debunked[72]. The CBT procedures appear to be applicable to a wide range patients[83,87].

**Recommendations**

The literature reviewed tells a compelling story with multiple implications for clinical practice. The data supports CBT’s effectiveness and efficacy as well as its wide applicability to diverse groups of young patients[8,45,62,63,67,83,87]. Additionally, CBT enjoys durable positive effects[64,65,69,70]. CBT is equally as effective as SSRIs but is associated with less adverse side effects[68,77,79]. Psychological distress characterized by anxiogenic cognitions and behavioral avoidance are apparently the most productive targets for intervention[2]. Perhaps most pivotally, the exposure component to treatment is essential to distinguish between more and less effective CBT as well as differentiate CBT from other systems of psychotherapy[8,17,41-51]. Simply, CBT for anxiety without exposure is a diluted approach[88].

The extant literature aids pediatricians in treatment planning. The findings of equivalence between SSRIs and CBT in treating anxious youth gives patients and providers multiple choices. Either mono-therapy is suitable for these individuals, but CBT is associated with less adverse side effects. Pediatricians might consider starting less severely distressed patients on a course of CBT since it is associated with fewer side effects, track progress, and if indicated, augment the CBT with medication. For more severe presentations especially those with strong somatic complaints, the combination treatment seems best.

The world is currently in the midst of a devastating public health crisis caused by the coronavirus disease 2019 (COVID-19) pandemic. In general, pandemics are characterized by increased anxieties and worries[89-92]. Various authors believe the COVID-19 pandemic is a powerful trigger for health anxiety[93,94]. Hospital records in the United States document a startling increase by 24% and 31% in emergency room visits die to anxious symptoms for children and adolescents respectively[95]. Regrettably, the psychological sequelae do not appear to self-limiting[90]. They are here to stay.

Accordingly, ensuring the proper delivery of CBT to young patients is pivotal to meet the rising tide of cases, provide effective and efficient treatment as well as minimize clinical errors. However, there are relatively few clinicians practicing in treatment-as-usual settings who are trained to deliver a proper dose of evidence-based psychotherapies[96]. Unfortunately, many clinicians incorrectly self-label themselves as CBT clinicians[52,97-99]. In fact, when actual clinical practices were studied, few providers who self-labelled themselves as CBT oriented practitioners genuinely delivered a proper dose of CBT[52]. This finding is consistent with the phenomenon of “posing” as a CBT therapist rather than practicing as one[99]. Thus, attention needs to be regularly directed to the proper application of CBT with youth.

Clinicians are also well-advised to practice CBT in a faithful and flexible manner[53-55]. Patients typically arrive to clinics experiencing different family circumstances and living in diverse cultural contexts. Additionally, pediatric patients’ predisposing characteristics and learning styles likely make them more or less receptive to varying therapeutic styles. For instance, some young patients may present to treatment with limited literacy. In these cases, clinicians are well-advised to rely on more concrete behavioral procedures such as exposure techniques. Additionally, scaffolding the cognitive demands to make the methods more accessible is recommended. Fortunately, there are many child-friendly iterations of traditional cognitive interventions available that are suitable for patients with limited literacy[11,16-18,47,58,60,61]. Perhaps, the attention alert CBT-oriented clinicians pay to working faithfully and flexibly partially explains the wide applicability of the approach.

Employing exposure based treatments for youth is a crucial task for clinicians. Exposure is underutilized in general[100-105] especially with younger children and children prescribed medication[8]. For instance, it was found that only 13% CBT oriented therapists used exposure based techniques[100]. In another study, a mere 40% of practitioners employed exposure procedures and these interventions accounted for only 1/5th of all clinical strategies utilized[103]. Further, exposure techniques were applied 19% of the time compared to CR (57%) and breathing exercises (53%)[105]. Finally, 48% percent of clinicians reported not implementing exposure due to lack of training[104]. In sum, continued and close attention to training clinicians in exposure-based treatments is necessary to fully equip practitioners with essential skills.

Multiple guidelines exist to guide clinicians’ work with youth during exposure procedures[11,17,18,44]. Collaboration between clinicians and patients is essential during exposure. It is important to remember that exposure is done with rather than to patients. Children spearhead the exposure journey and the key for practitioners is to nurture young patients’ willingness to encounter instead of avoid anxiety producing situations.

Exposure starts with PE and providing a rationale. Metaphors and analogies such as germ theory where immunity is often bolstered by exposure are helpful. Additionally, the use of videos or books where coping models (*e.g.* Bruce Wayne aka Batman surrounding himself with feared bats) approach their heretofore dreaded circumstances are other options. Graduated exposure is the preferred delivery mode. Accordingly, exposure hierarchies which include different successive steps (*e.g.* challenges) operationalized through collaboratively constructed Subjective Units of Distress (SUDS) (*e.g.*, 1-10, 1-100) are commonly employed. Patience by providers is recommended and a useful axiom for using a hierarchy is “start in the low-mid SUDS range and proceed slowly.”

Exposures should be comprehensive and done repeatedly. In-session exposures should be completed several times and then at-home exposures are attempted regularly between appointments. Moderate to high levels of emotional arousal in response to in-session exposures are favored[106]. Further, the procedure should encompass cognitive, behavioral, physiological, emotional, contextual and interpersonal elements of the anxiety response.

Developmental sensitivity and clinical creativity is pivotal when crafting exposures[11,16,17,44,53-55,58,60,61]. Rewards for successful efforts are strongly suggested for younger individuals. Game and playful exposures are especially engaging for pediatric patients. It is important to remember that the goal in exposure treatment is for new approach learning to occur[107]. Improved self-efficacy and greater self –control should result. Therefore, any exposure-based procedure should not be terminated before new learning emerges through either reductions in subjective distress, increased emotional tolerance, and/or greater approach behavior.

Finally, after the exposure is completed, clinicians and patients debrief the experience. Patients compare their predictions about what might happen to what actually occurred. They then craft their new conclusions and inferences based on the outcomes of the exposure.

The use of telehealth services has dramatically increased during the COVID-19 pandemic[108,109]. Virtual delivery of clinical services offers intriguing advantages and opportunities[110-112]. CBT provided *via* telehealth platforms is convenient and allows for interventions in young patients’ home environment[110,112]. In particular, exposure done *via* telehealth allows for the clinician to process this experience with young patients while they engage in the procedure in their familiar context potentially adding to generalizability.

Finally, integrated pediatric behavior health care settings are well-suited to meet the cascading rate of new cases expected in the post-pandemic period. Ninety percent of children visit a pediatrician[113]. For many families, pediatric offices are the first stop for treating behavioral health complaints[114-116] Additionally, these care settings enable early identification and intervention[112,117-120]. Delivering CBT to anxious youth in pediatric settings increases access in familiar settings and enables better collaboration between pediatrician and behavioral health specialists.

**CONCLUSION**

CBT with anxious children and adolescents is a clear success story. Reaching the Well-Established threshold as well as equivalence with SSRI’s is a major achievement. Extending CBT’s reach into pediatric integrated behavioral health settings is an important next step. Broadening access to services from properly training clinicians will enhance the care of young people and sustain CBT practices.

**REFERENCES**

1 **Badin E**, Alvarez E, Chu BC. Cognitive behavioral therapy for child and adolescent anxiety: CBT in a nutshell. Cognitive and behavioral therapy in youth. New York: Springer, 2020: 41-71 [DOI: 10.1007/978-1-0716-0700-8\_3]

2 **Cervin M**, Storch EA, Piacentini J, Birmaher B, Compton SN, Albano AM, Gosch E, Walkup JT, Kendall PC. Symptom-specific effects of cognitive-behavioral therapy, sertraline, and their combination in a large randomized controlled trial of pediatric anxiety disorders. *J Child Psychol Psychiatry* 2020; **61**: 492-502 [PMID: 31471911 DOI: 10.1111/jcpp.13124]

3 **Crowe K**, McKay D. Efficacy of cognitive-behavioral therapy for childhood anxiety and depression. *J Anxiety Disord* 2017; **49**: 76-87 [PMID: 28460329 DOI: 10.1016/j.janxdis.2017.04.001]

4 **Polanczyk GV**, Salum GA, Sugaya LS, Caye A, Rohde LA. Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *J Child Psychol Psychiatry* 2015; **56**: 345-365 [PMID: 25649325 DOI: 10.1111/jcpp.12381]

5 **Strawn JR**, Lu L, Peris TS, Levine A, Walkup JT. Research Review: Pediatric anxiety disorders - what have we learnt in the last 10 years? *J Child Psychol Psychiatry* 2021; **62**: 114-139 [PMID: 32500537 DOI: 10.1111/jcpp.13262]

6 **Weems CF**, Silverman WK. Anxiety disorders. In: Beauchaine TP, Hinshaw SP. Child and adolescent psychopathology. New York: John Wiley, 2013: 513-542 [PMID: 23376601 DOI: 10.1016/j.janxdis.2012.11.003]

7 **Mohatt J**, Bennett SM, Walkup JT. Treatment of separation, generalized, and social anxiety disorders in youths. *Am J Psychiatry* 2014; **171**: 741-748 [PMID: 24874020 DOI: 10.1176/appi.ajp.2014.13101337]

8 **Peris TS**, Caporino NE, O'Rourke S, Kendall PC, Walkup JT, Albano AM, Bergman RL, McCracken JT, Birmaher B, Ginsburg GS, Sakolsky D, Piacentini J, Compton SN. Therapist-Reported Features of Exposure Tasks That Predict Differential Treatment Outcomes for Youth With Anxiety. *J Am Acad Child Adolesc Psychiatry* 2017; **56**: 1043-1052 [PMID: 29173738 DOI: 10.1016/j.jaac.2017.10.001]

9 **Connolly SD**, Bernstein GA; Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *J Am Acad Child Adolesc Psychiatry* 2007; **46**: 267-283 [PMID: 17242630 DOI: 10.1097/01.chi.0000246070.23695.06]

10 **Hollon SD**, Beck AT. Cognitive and cognitive behavioral therapies. In: Lambert MJ. Bergin and Garfield’s Handbook of psychotherapy and behavior change 6th ed. Hoboken, NJ: Wiley, 2013: 393-442

11 **Friedberg** **RD**, McClure JM. Clinical practice of cognitive therapy with children and adolescents: the nuts and bolts (2nd Ed.). New York: Guilford, 2015

12 **Kendall** **PC**, Crawford EA, Kagan ER, Furr JM, Podell JL. Child-focused treatment for anxiety. In: Weisz JR, Kazdin AE. Evidence-based psychotherapies for children and adolescents (3rd Ed.) New York: Guilford, 2017: 17-34

13 **Kendall** **PC**. Anxiety disorders in youth. In: Kendall PC. Child and adolescent therapy: Cognitive-behavioral procedures (4th ed). New York: Guilford, 2012: 143-189

14 **Friedberg** **RD**, Paternostro JK. Cognitive behavioral therapy with youth: Essential foundations and elementary practices. Handbook of Cognitive Behavioral Therapy for Pediatric Medical Conditions. Cham Switzerland: Springer Nature, 2019: 87-102 [DOI: 10.1007/978-3-030-21683-2\_7]

15 **Boustani M**, Regan J, Stanick C. Modular CBT for youth. In: Friedberg RD, Nakamura BJ. Cognitive behavioral therapy for youth: Tradition and innovation. New York: Springer Neuro, 2020: 231-250 [DOI: 10.1007/978-1-0716-0700-8\_12]

16 **Chorpita BF**, Weisz JR. Modular approach to therapy for children with anxiety, depression, trauma or conduct problems (MATCH-ADTC). Satellite Beach, Fla: Practicewise, 2009

17 **Friedberg** **RD**, McClure JM, Garcia JH. Cognitive therapy techniques for children and adolescents. New York: Guilford, 2009

18 **Friedberg RD**, Gorman AA, Hollar-Wilt L, Biuckians A, Murray M. Cognitive behavioral therapy for busy child psychiatrists and other mental health professionals. New York: Routledge, 2011 [DOI: 10.4324/9780203830390]

19 **Weisz JR**, Chorpita BF. “Mod squad” for youth psychotherapy: Restructuring evidence based treatment for clinical practice. In: Kendall PC, Ed. Child and adolescent therapy: Cognitive-behavioral procedures. New York: Guilford, 2012: 379-397

20 **Frank J**. Persuasion and healing: A comparative study of psychotherapy. New York: Pocket Books, 1961

21 **Ong** **SH**, Caron A. Family-based psychoeducation for children and adolescents with mood disorders. *J Child Fam Stud* 2008; **17:** 809-822 [DOI: 10.1007/s10826-008-9191-4]

22 **Wessely S**, Bryant RA, Greenberg N, Earnshaw M, Sharpley J, Hughes JH. Does psychoeducation help prevent post traumatic psychological distress? *Psychiatry* 2008; **71**: 287-302 [PMID: 19152276 DOI: 10.1521/psyc.2008.71.4.287]

23 **Goldfried** **MR**, Davila J. The role of relationship and technique in therapeutic change. *Psychother: Theo* 2005; **42**: 421-430 [DOI: 10.1037/0033-3204.42.4.421]

24 **Hannesdottir DK**, Ollendick TH. The role of emotion regulation in the treatment of child anxiety disorders. *Clin Child Fam Psychol Rev* 2007; **10**: 275-293 [PMID: 17705098 DOI: 10.1007/s10567-007-0024-6]

25 **Curry JF**, Reinecke MA. Modular therapy for adolescents with major depression. In: Reinecke M, Dattilio FM, Freeman A. (Eds). Cognitive therapy with children and adolescents: A casebook for clinical practice. New York: Guilford, 2003: 95-127

26 **Wilson** **GT**. Behavioral concepts and treatments of neuroses: Comments on marks. *Behav Psychother* 1981; **9**: 155-166 [DOI: 10.1017/s0141347300007333]

27 **Weisz** **JR**, Southam-Gerow MA, Gordis EB, Connor-Smith J. Primary and secondary control training for youth depression: Applying the deployment model of treatment development and testing. In: Kazdin AE, Weisz JR. Evidence-based psychotherapies for children and adolescents. New York: Guilford, 2003: 165-186

28 **Kanfer FH**, Phillips JS. Learning foundations of behavior therapy. New York: John Wiley, 1970

29 **Flannery-Schroeder** **E**, Choudbury MS, Kendall PC. Group and individual cognitive behavioral treatments for youth with anxiety disorders: A randomized clinical trial. *Cogn Ther Res* 2000; **24**: 251-278 [DOI: 10.1007/s10608-005-3168-z]

30 **Kendall PC**, Aschenbrand SG, Hudson JL. Child-focused treatment of anxiety. In: Kazdin AE, Weisz JR. Evidence-based psychotherapies for children and adolescents. New York: Guilford, 2003: 81-100

31 **March** **JS**, Franklin ME. Cognitive behavioral therapy for pediatric OCD. In: Rothbaum BO. Pathological anxiety: Emotional processing in etiology and treatment. New York: Guilford, 2006: 145-165

32 **Piacentini J**, Langley AK. Cognitive-behavioral therapy for children who have obsessive-compulsive disorder. *J Clin Psychol* 2004; **60**: 1181-1194 [PMID: 15389618 DOI: 10.1002/jclp.20082]

33 **Flannery-Schroeder** **E**. Generalized anxiety disorder. In: Morris TL, March JS. Anxiety disorders in children and adolescents. New York: Guilford, 2004: 125-140

34 **Deblinger** **E**, Behl LE, Glickman AR. Treating children who have experienced sexual abuse. In: Kendall PC. Child and adolescent therapy: Cognitive and behavioral procedures (3rd ed). New York: Guilford, 2006: 383-416

35 **Bandura A**. Self-efficacy: Toward a unifying theory of behavior change. *Psychol Rev* 1977; **84:** 191-215 [PMID: 847061 DOI: 10.1037/0033-295x.84.2.191]

36 **Bandura A**. Social learning theory. Englewood Cliffs, NJ: Prentice-Hall, 1977

37 **Beck AT**. Cognitive therapy and the emotional disorders. New York: International University Press, 1976

38 **Beck** **AT**, Rush AJ, Shaw BF, Emery G. Cognitive therapy of depression. New York: Guilford Press, 1979

39 **Beck** **AT**, Emery G, Greenberg RL. Anxiety disorders and phobias: A cognitive perspective. New York: Plenum Press, 1985

40 **Beck** **JS**. Cognitive behavior therapy: Basics and beyond (3rd Ed). New York: Guilford, 2021

41 **Ale CM**, McCarthy DM, Rothschild LM, Whiteside SP. Components of Cognitive Behavioral Therapy Related to Outcome in Childhood Anxiety Disorders. *Clin Child Fam Psychol Rev* 2015; **18**: 240-251 [PMID: 26001645 DOI: 10.1007/s10567-015-0184-8]

42 **Bergez KC**, Ramirez AC, Grebe SC, Perez MI, Viana AG, Storch EA, Schneider SC. Efficacy of exposure-based therapy for youth anxiety and obsessive compulsive disorder. In: Peris TS, Storch EA, McGuire JF. Exposure therapy for children with anxiety. New York: Academic Press, 2020: 21-37 [DOI: 10.1016/B978-0-12-815915-6.00002-0]

43 **Palitz SA**, Davis JP, Kendall PC. Anxiety disorders. In: Prinstein MJ, Youngstrom EA, Mash EJ, Barkley RA. Treatment of disorders in childhood and adolescence (4th Ed.). New York: Guilford, 2019: 281-310 [PMID: 31669785 DOI: 10.1016/j.janxdis.2019.102146]

44 **Friedberg RD**. Where's the Beef? Concrete Elements When Supervising Cognitive-Behavioral Therapy With Youth. *J Am Acad Child Adolesc Psychiatry* 2015; **54**: 527-531 [PMID: 26088653 DOI: 10.1016/j.jaac.2015.03.020]

45 **Silk JS**, Tan PZ, Ladouceur CD, Meller S, Siegle GJ, McMakin DL, Forbes EE, Dahl RE, Kendall PC, Mannarino A, Ryan ND. A Randomized Clinical Trial Comparing Individual Cognitive Behavioral Therapy and Child-Centered Therapy for Child Anxiety Disorders. *J Clin Child Adolesc Psychol* 2018; **47**: 542-554 [PMID: 26983904 DOI: 10.1080/15374416.2016.1138408]

46 **Higa-McMillan CK**, Francis SE, Rith-Najarian L, Chorpita BF. Evidence Base Update: 50 Years of Research on Treatment for Child and Adolescent Anxiety. *J Clin Child Adolesc Psychol* 2016; **45**: 91-113 [PMID: 26087438 DOI: 10.1080/15374416.2015.1046177]

47 **Peterman JB**, Read KL, Wei C, Kendall PC. The art of exposure: Putting science into practice. *Cogn Behav Pract* 2015; **22**: 379-392 [DOI: 10.1016/j.cbpra.2014.02.003]

48 **Whiteside SPH**, Sim LA, Morrow AS, Farah WH, Hilliker DR, Murad MH, Wang Z. A Meta-analysis to Guide the Enhancement of CBT for Childhood Anxiety: Exposure Over Anxiety Management. *Clin Child Fam Psychol Rev* 2020; **23**: 102-121 [PMID: 31628568 DOI: 10.1007/s10567-019-00303-2]

49 **Banneyer KN**, Bonin L, Price K, Goodman WK, Storch EA. Cognitive Behavioral Therapy for Childhood Anxiety Disorders: a Review of Recent Advances. *Curr Psychiatry Rep* 2018; **20**: 65 [PMID: 30056623 DOI: 10.1007/s11920-018-0924-9]

50 **Wu MS**, Caporino NE, Peris TS, Pérez J, Thamrin H, Albano AM, Kendall PC, Walkup JT, Birmaher B, Compton SN, Piacentini J. The Impact of Treatment Expectations on Exposure Process and Treatment Outcome in Childhood Anxiety Disorders. *J Abnorm Child Psychol* 2020; **48:** 79-89 [PMID: 31313062 DOI: 10.1007/s10802-019-00574-x]

51 **Southam-Gerow MA**, Weisz JR, Chu BC, McLeod BD, Gordis EB, Connor-Smith JK. Does cognitive behavioral therapy for youth anxiety outperform usual care in community clinics? An initial effectiveness test. *J Am Acad Child Adolesc Psychiatry* 2010; **49**: 1043-1052 [PMID: 20855049 DOI: 10.1016/j.jaac.2010.06.009]

52 **Creed TA**, Wolk CB, Feinberg B, Evans AC, Beck AT. Beyond the Label: Relationship Between Community Therapists' Self-Report of a Cognitive Behavioral Therapy Orientation and Observed Skills. *Adm Policy Ment Health* 2016; **43**: 36-43 [PMID: 25491201 DOI: 10.1007/s10488-014-0618-5]

53 **Kendall** **PC**, Beidas RS. Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Prof Psychol: Res Pract* 2007; **38:** 13-20 [DOI: 10.1037/0735-7028.38.1.13]

54 **Kendall PC**, Gosch E, Furr JM, Sood E. Flexibility within fidelity. *J Am Acad Child Adolesc Psychiatry* 2008; **47**: 987-993 [PMID: 18714195 DOI: 10.1097/CHI.0b013e31817eed2f]

55 **Kendall PC**, Frank HE. Implementing evidence-based treatment protocols: Flexibility within fidelity. *Clin Psychol (New York)* 2018; **25** [PMID: 30643355 DOI: 10.1111/cpsp.12271]

56 **Shirk** **S**, Jungbluth N, Karver M. Change processes and active components. In: Kendall PC. Child and adolescent therapy: Cognitive behavioral procedures. New York: Guilford, 2012: 471-498

57 **Chorpita BF**, Daleiden EL. Mapping evidence-based treatments for children and adolescents: application of the distillation and matching model to 615 treatments from 322 randomized trials. *J Consult Clin Psychol* 2009; **77**: 566-579 [PMID: 19485596 DOI: 10.1037/a0014565]

58 **Kendall** **PC**, Hedtke KA. Coping cat workbook. Ardmore, PA: Workbook Publishing, 2006

59 **Norris LA**, Kendall PC. A Close Look Into Coping Cat: Strategies Within an Empirically Supported Treatment for Anxiety in Youth. *J Cogn Psychother* 2020; **34:** 4-20 [PMID: 32701473 DOI: 10.1891/0889-8391.34.1.4]

60 **Podell** **JL**, Mychailyszyn M, Edmunds J, Puleo C, Kendall PC. The Coping Cat program for anxious youth: The FEAR plan comes to life. *Cogn Behav Pract* 2010; **17:** 132-14 [DOI: 10.1016/j.cbpra.2009.11.001]

61 **Beidas** **RS**, Podell JL, Kendall PC. Cognitive-behavioral treatment for child and adolescent anxiety: The Coping Cat Program. In: LeCroy, CW. Handbook of evidence-based treatment manuals for children and adolescents. New York: Oxford Press, 2008: 405-430

62 **Kendall PC**. Treating anxiety disorders in children: results of a randomized clinical trial. *J Consult Clin Psychol* 1994; **62**: 100-110 [PMID: 8034812 DOI: 10.1037/0022-006x.62.1.100]

63 **Kendall PC**, Flannery-Schroeder E, Panichelli-Mindel SM, Southam-Gerow M, Henin A, Warman M. Therapy for youths with anxiety disorders: a second randomized clinical trial. *J Consult Clin Psychol* 1997; **65**: 366-380 [PMID: 9170760 DOI: 10.1037/0022-006x.65.3.366]

64 **Kendall PC**, Southam-Gerow MA. Long-term follow-up of a cognitive-behavioral therapy for anxiety-disordered youth. *J Consult Clin Psychol* 1996; **64**: 724-730 [PMID: 8803362 DOI: 10.1037/0022-006x.64.4.724]

65 **Kendall PC**, Safford S, Flannery-Schroeder E, Webb A. Child anxiety treatment: outcomes in adolescence and impact on substance use and depression at 7.4-year follow-up. *J Consult Clin Psychol* 2004; **72**: 276-287 [PMID: 15065961 DOI: 10.1037/0022-006X.72.2.276]

66 **Villabø MA**, Narayanan M, Compton SN, Kendall PC, Neumer SP. Cognitive-behavioral therapy for youth anxiety: An effectiveness evaluation in community practice. *J Consult Clin Psychol* 2018; **86**: 751-764 [PMID: 30138014 DOI: 10.1037/ccp0000326]

67 **Palitz SA**, Rifkin LS, Norris LA, Knepley M, Fleischer NJ, Steinberg L, Kendall PC. But what will the results be?: Learning to tolerate uncertainty is associated with treatment-produced gains. *J Anxiety Disord* 2019; **68**: 102146 [PMID: 31669785 DOI: 10.1016/j.janxdis.2019.102146]

68 **Walkup JT**, Albano AM, Piacentini J, Birmaher B, Compton SN, Sherrill JT, Ginsburg GS, Rynn MA, McCracken J, Waslick B, Iyengar S, March JS, Kendall PC. Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *N Engl J Med* 2008; **359**: 2753-2766 [PMID: 18974308 DOI: 10.1056/NEJMoa0804633]

69 **Piacentini J**, Bennett S, Compton SN, Kendall PC, Birmaher B, Albano AM, March J, Sherrill J, Sakolsky D, Ginsburg G, Rynn M, Bergman RL, Gosch E, Waslick B, Iyengar S, McCracken J, Walkup J. 24- and 36-week outcomes for the Child/Adolescent Anxiety Multimodal Study (CAMS). *J Am Acad Child Adolesc Psychiatry* 2014; **53**: 297-310 [PMID: 24565357 DOI: 10.1016/j.jaac.2013.11.010]

70 **Swan AJ**, Kendall PC, Olino T, Ginsburg G, Keeton C, Compton S, Piacentini J, Peris T, Sakolsky D, Birmaher B, Albano AM. Results from the Child/Adolescent Anxiety Multimodal Longitudinal Study (CAMELS): Functional outcomes. *J Consult Clin Psychol* 2018; **86**: 738-750 [PMID: 30138013 DOI: 10.1037/ccp0000334]

71 **Taylor JH**, Lebowitz ER, Jakubovski E, Coughlin CG, Silverman WK, Bloch MH. Monotherapy Insufficient in Severe Anxiety? Predictors and Moderators in the Child/Adolescent Anxiety Multimodal Study. *J Clin Child Adolesc Psychol* 2018; **47**: 266-281 [PMID: 28956620 DOI: 10.1080/15374416.2017.1371028]

72 **Silverman WK**, Pina AA, Viswesvaran C. Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *J Clin Child Adolesc Psychol* 2008; **37**: 105-130 [PMID: 18444055 DOI: 10.1080/15374410701817907]

73 **Kendall PC**, Peterman JS. CBT for Adolescents With Anxiety: Mature Yet Still Developing. *Am J Psychiatry* 2015; **172**: 519-530 [PMID: 26029805 DOI: 10.1176/appi.ajp.2015.14081061]

74 **Bennett K**, Manassis K, Duda S, Bagnell A, Bernstein GA, Garland EJ, Miller LD, Newton A, Thabane L, Wilansky P. Treating child and adolescent anxiety effectively: Overview of systematic reviews. *Clin Psychol Rev* 2016; **50**: 80-94 [PMID: 27744168 DOI: 10.1016/j.cpr.2016.09.006]

75 **Baardseth TP**, Goldberg SB, Pace BT, Wislocki AP, Frost ND, Siddiqui JR, Lindemann AM, Kivlighan DM 3rd, Laska KM, Del Re AC, Minami T, Wampold BE. Cognitive-behavioral therapy versus other therapies: redux. *Clin Psychol Rev* 2013; **33**: 395-405 [PMID: 23416876 DOI: 10.1016/j.cpr.2013.01.004]

76 **Reynolds S**, Wilson C, Austin J, Hooper L. Effects of psychotherapy for anxiety in children and adolescents: a meta-analytic review. *Clin Psychol Rev* 2012; **32**: 251-262 [PMID: 22459788 DOI: 10.1016/j.cpr.2012.01.005]

77 **Wang Z**, Whiteside SPH, Sim L, Farah W, Morrow AS, Alsawas M, Barrionuevo P, Tello M, Asi N, Beuschel B, Daraz L, Almasri J, Zaiem F, Larrea-Mantilla L, Ponce OJ, LeBlanc A, Prokop LJ, Murad MH. Comparative Effectiveness and Safety of Cognitive Behavioral Therapy and Pharmacotherapy for Childhood Anxiety Disorders: A Systematic Review and Meta-analysis. *JAMA Pediatr* 2017; **171**: 1049-1056 [PMID: 28859190 DOI: 10.1001/jamapediatrics.2017.3036]

78 **Warwick H**, Reardon T, Cooper P, Murayama K, Reynolds S, Wilson C, Creswell C. Complete recovery from anxiety disorders following Cognitive Behavior Therapy in children and adolescents: A meta-analysis. *Clin Psychol Rev* 2017; **52**: 77-91 [PMID: 28040627 DOI: 10.1016/j.cpr.2016.12.002]

79 **Hana LM**, McIngvale E, Davis M, Storch EA. CBT, medication and the combination are effective for childhood anxiety. *Evid Based Ment Health* 2019; **22**: e4 [PMID: 30665991 DOI: 10.1136/ebmental-2018-300023]

80 **Prins** **PJM**, Ollendick TH, Maric M, Mackinnon DP. Moderators and mediators in treatment outcome studies of childhood disorders: The what, why and how. In: Maric M, Prins PJM, Ollendick TH. Moderators and mediators of youth treatment outcomes. Oxford, UK: Oxford University Press, 2015: 1-19 [PMID: 26689629 DOI: 10.1093/med:psych/9780199360345.003.0001]

81 **Baron RM**, Kenny DA. The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. *J Pers Soc Psychol* 1986; **51**: 1173-1182 [PMID: 3806354 DOI: 10.1037/0022-3514.51.6.1173]

82 **Norris LA**, Kendall PC. Moderators of Outcome for Youth Anxiety Treatments: Current Findings and Future Directions. *J Clin Child Adolesc Psychol* 2020: 1-14 [PMID: 33140992 DOI: 10.1080/15374416.2020.1833337]

83 **Herres J**, Cummings CM, Swan A, Makeover H, Kendall PC. Moderators and mediators of youth with anxiety. In: Maric M, Prins PJM, Ollendick TH. Moderators and mediators of youth treatment outcomes. Oxford, UK: Oxford University Press, **2015**: 20-40 [DOI: 10.1093/med:psych/9780199360345.003.0002]

84 **Kendall PC**, Cummings CM, Villabø MA, Narayanan MK, Treadwell K, Birmaher B, Compton S, Piacentini J, Sherrill J, Walkup J, Gosch E, Keeton C, Ginsburg G, Suveg C, Albano AM. Mediators of change in the Child/Adolescent Anxiety Multimodal Treatment Study. *J Consult Clin Psychol* 2016; **84**: 1-14 [PMID: 26460572 DOI: 10.1037/a0039773]

85 **Makover HB**, Kendall PC, Olino T, Carper MM, Albano AM, Piacentini J, Peris T, Langley AK, Gonzalez A, Ginsburg GS, Compton S, Birmaher B, Sakolsky D, Keeton C, Walkup J. Mediators of youth anxiety outcomes 3 to 12 years after treatment. *J Anxiety Disord* 2020; **70**: 102188 [PMID: 32078966 DOI: 10.1016/j.janxdis.2020.102188]

86 **Hale AE**, Ginsburg GS, Chan G, Kendall PC, McCracken JT, Sakolsky D, Birmaher B, Compton SN, Albano AM, Walkup JT. Mediators of Treatment Outcomes for Anxious Children and Adolescents: The Role of Somatic Symptoms. *J Clin Child Adolesc Psychol* 2018; **47**: 94-104 [PMID: 28278599 DOI: 10.1080/15374416.2017.1280804]

87 **Compton SN**, Peris TS, Almirall D, Birmaher B, Sherrill J, Kendall PC, March JS, Gosch EA, Ginsburg GS, Rynn MA, Piacentini JC, McCracken JT, Keeton CP, Suveg CM, Aschenbrand SG, Sakolsky D, Iyengar S, Walkup JT, Albano AM. Predictors and moderators of treatment response in childhood anxiety disorders: results from the CAMS trial. *J Consult Clin Psychol* 2014; **82**: 212-224 [PMID: 24417601 DOI: 10.1037/a0035458]

88 **Crawley SA**, Kendall PC, Benjamin CL, Brodman DM, Wei C, Beidas RS, Podell JL, Mauro C. Brief Cognitive-Behavioral Therapy for Anxious Youth: Feasibility and Initial Outcomes. *Cogn Behav Pract* 2013; **20** [PMID: 24244089 DOI: 10.1016/j.cbpra.2012.07.003]

89 **Taylor** **S**. The psychology of pandemics: Preparing for the next global outbreak of infectious disease. UK: Cambridge Scholars Publishing, 2019

90 **Czeisler MÉ**, Lane RI, Petrosky E, Wiley JF, Rajaratnam SMW. Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *MMWR* 2020; **69**: 1049–1057 [PMID: 32790653 DOI: 10.15585/mmwr.mm6932a1]

91 **Marques de Miranda D**, da Silva Athanasio B, Sena Oliveira AC, Simoes-E-Silva AC. How is COVID-19 pandemic impacting mental health of children and adolescents? *Int J Disaster Risk Reduct* 2020; **51**: 101845 [PMID: 32929399 DOI: 10.1016/j.ijdrr.2020.101845]

92 **Fegert JM**, Vitiello B, Plener PL, Clemens V. Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: a narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child Adolesc Psychiatry Ment Health* 2020; **14**: 20 [PMID: 32419840 DOI: 10.1186/s13034-020-00329-3]

93 **Haig-Ferguson A**, Cooper K, Cartwright E, Loades ME, Daniels J. Practitioner review: health anxiety in children and young people in the context of the COVID-19 pandemic. *Behav Cogn Psychother* 2021; **49**: 129-143 [PMID: 32829718 DOI: 10.1017/S1352465820000636]

94 **Taylor** **S**, Asmundson GJG. Treating health anxiety: A cognitive-behavioral approach. New York: Guilford, 2004 [DOI: 10.1016/S1077-7229(04)80015-4]

95 **Carey B**. For some teens, it’s been a year of anxiety and trips to the E.R. New YorkTimes. [cited 10 March 2021]. Available from: https://www.nytimes.com/2021/02/23/health/coronavirus-mental-health-teens.html

96 **Comer JS**, Barlow DH. The occasional case against broad dissemination and implementation: retaining a role for specialty care in the delivery of psychological treatments. *Am Psychol* 2014; **69**: 1-18 [PMID: 23915401 DOI: 10.1037/a0033582]

97 **McKay D**. So you say you are an expert?: False CBT identity harms our hard-earned gains. *Behav Therapist* 2014; **37**: 213, 215-216 [DOI: 10.1016/s0262-4079(16)31100-9]

98 **Trafalis S**, Friedberg RD, Sullivan P, Teague AM, Hoyman LC, Berlyant MJ. Training community clinicians in CBT for youth. *Curr Psychiatr Rev* 2016; **12**: 88-96 [DOI: 10.2174/1573400511666150930233042]

99 **Sullivan** **P**, Keller M, Paternostro J, Friedberg RD. Treating perfectionistic and emotionally dysregulated youth with transdiagnostic cognitive behavioral procedures. *J Cont Psychother* 2015; **45**: 151-158 [DOI: 10.1007/s10879-014-9293-9]

100 **Hipol LJ**, Deacon BJ. Dissemination of evidence-based practices for anxiety disorders in Wyoming: a survey of practicing psychotherapists. *Behav Modif* 2013; **37**: 170-188 [PMID: 23012685 DOI: 10.1177/0145445512458794]

101 **Deacon BJ**, Farrell NR, Kemp JJ, Dixon LJ, Sy JT, Zhang AR, McGrath PB. Assessing therapist reservations about exposure therapy for anxiety disorders: the Therapist Beliefs about Exposure Scale. *J Anxiety Disord* 2013; **27**: 772-780 [PMID: 23816349 DOI: 10.1016/j.janxdis.2013.04.006]

102 **Farrell NR**, Deacon BJ, Kemp JJ, Dixon LJ, Sy JT. Do negative beliefs about exposure therapy cause its suboptimal delivery? An experimental investigation. *J Anxiety Disord* 2013; **27**: 763-771 [PMID: 23602351 DOI: 10.1016/j.janxdis.2013.03.007]

103 **Whiteside SP**, Deacon BJ, Benito K, Stewart E. Factors associated with practitioners' use of exposure therapy for childhood anxiety disorders. *J Anxiety Disord* 2016; **40**: 29-36 [PMID: 27085463 DOI: 10.1016/j.janxdis.2016.04.001]

104 **Reid AM**, Bolshakova MI, Guzick AG, Fernandez AG, Striley CW, Geffken GR, McNamara JP. Common Barriers to the Dissemination of Exposure Therapy for Youth with Anxiety Disorders. *Community Ment Health J* 2017; **53**: 432-437 [PMID: 28181093 DOI: 10.1007/s10597-017-0108-9]

105 **Reid AM**, Guzick AG, Fernandez AG, Deacon B, McNamara JPH, Geffken GR, McCarty R, Striley CW. Exposure therapy for youth with anxiety: Utilization rates and predictors of implementation in a sample of practicing clinicians from across the United States. *J Anxiety Disord* 2018; **58**: 8-17 [PMID: 29929139 DOI: 10.1016/j.janxdis.2018.06.002]

106 **Moscovitch** **D**, Antony MM, Swinson RP. Exposure based treatment for anxiety disorders:Theory and process. In: Antony MM, Stein MB. Oxford handbook of anxiety related disorders. New York, Oxford, 2009: 461-475 [DOI: 10.1093/oxfordhb/9780195307030.013.0035]

107 **Craske MG**, Barlow DH. Panic disorder and agoraphobia. In: Barlow, DH. Clinical handbook of psychological disorders (4th ed). New York: Guilford, 2008: 1-64 [DOI: 10.1093/med:psych/9780195311341.003.0001]

108 **Gruber J**, Prinstein MJ, Clark LA, Rottenberg J, Abramowitz JS, Albano AM, Aldao A, Borelli JL, Chung T, Davila J, Forbes EE, Gee DG, Hall GCN, Hallion LS, Hinshaw SP, Hofmann SG, Hollon SD, Joormann J, Kazdin AE, Klein DN, La Greca AM, Levenson RW, MacDonald AW, McKay D, McLaughlin KA, Mendle J, Miller AB, Neblett EW, Nock M, Olatunji BO, Persons JB, Rozek DC, Schleider JL, Slavich GM, Teachman BA, Vine V, Weinstock LM. Mental health and clinical psychological science in the time of COVID-19: Challenges, opportunities, and a call to action. *Am Psychol* 2021; **76**: 409-426 [PMID: 32772538 DOI: 10.1037/amp0000707]

109 **Pierce BS**, Perrin PB, Tyler CM, McKee GB, Watson JD. The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. *Am Psychol* 2021; **76**: 14-25 [PMID: 32816503 DOI: 10.1037/amp0000722]

110 **Comer JS**, Timmons A. The other side of the coin: Computer-meditated interactions may afford opportunities for enhanced empathy in clinical practice. *Clin Psychol: Sci Pract* 2019; **26**: e/2308 [DOI: 10.1111/cpsp.12308]

111 **Comer JS**, Furr JM, del Busto C, Silva K, Hong N, Poznanski B, Sanchez A, Cornacchio D, Herrera A, Coxe S, Miguel E, Georgiadis C, Conroy K, Puliafico A. Therapist-led, internet delivered treatment for early child social anxiety: A waitlist-controlled evaluation of the iCalm telehealth program. *Behav Ther* 2021 [PMID: 34452671 DOI: 10.1016/j.beth.2021.01.004]

112 **Georgiadis C**, Peris TS, Comer JS. Implementing strategic flexibility in the122 delivery of youth mental health care. *Evid Based Pract Child Adolesc Ment Hlth* 2020; **5**: 215-232 [DOI: 10.1080/23794925.2020.1796550]

113 **Stancin T**, Perrin EC. Psychologists and pediatricians: Opportunities for collaboration in primary care. *Am Psychol* 2014; **69**: 332-343 [PMID: 24820683 DOI: 10.1037/a0036046]

114 **Rey-Casserly C**, McGuinn L, Lavin A; Committee on psychosocial aspects of child and family health, section on developmental and behavioral pediatrics. School-aged Children Who Are Not Progressing Academically: Considerations for Pediatricians. *Pediatrics* 2019; **144** [PMID: 31548334 DOI: 10.1542/peds.2019-2520]

115 **Yogman MW**, Betjemann S, Sagaser A, Brecher L. Integrated Behavioral Health Care in Pediatric Primary Care: A Quality Improvement Project. *Clin Pediatr (Phila)* 2018; **57**: 461-470 [PMID: 28984148 DOI: 10.1177/0009922817730344]

116 **Green CM**, Foy JM, Earls MF; Committee on psychosocial aspects of child and family health, mental health leadership work group. Achieving the Pediatric Mental Health Competencies. *Pediatrics* 2019; **144** [PMID: 31636144 DOI: 10.1542/peds.2019-2758]

117 **Asarnow JR**, Kolko DJ, Miranda J, Kazak AE. The Pediatric Patient-Centered Medical Home: Innovative models for improving behavioral health. *Am Psychol* 2017; **72**: 13-27 [PMID: 28068135 DOI: 10.1037/a0040411]

118 **Giese** **AA**, Waugh M. Conceptual framework for integrated care: Multiple perspectives to achieve integrated care. In Feinstein RE, Connelly JV, Feinstein MS. Integrating behavioral health and primary care. Oxford, UK: Oxford, 2017: 3-16 [DOI: 10.1093/med/9780190276201.003.0001]

119 **Burkhart K**, Asogwa K, Muzaffar N, Gabriel M. Pediatric Integrated Care Models: A Systematic Review. *Clin Pediatr (Phila)* 2020; **59**: 148-153 [PMID: 31762297 DOI: 10.1177/0009922819890004]

120 **Sandoval BE**, Bell J, Khatri P, Robinson PJ. Toward a Unified Integration Approach: Uniting Diverse Primary Care Strategies Under the Primary Care Behavioral Health (PCBH) Model. *J Clin Psychol Med Settings* 2018; **25**: 187-196 [PMID: 29234927 DOI: 10.1007/s10880-017-9516-9]

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