NHS Education for Scotland

The Matrix Evidence Tables

CHILDREN & YOUNG PEOPLE

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The Scottish Government

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RECOMMENDATIONS KEY

Matrix: Level of Evidence	Recommendation	
At least one meta-analysis/systematic review with medium-large effect sizes; or more than one RCT of high quality and consistency, aimed at target population, showing medium-large effect sizes	A	Highly Recommended
One RCT with medium-large effect size; or meta-analysis/systematic review or multiple RCTs showing small-moderate effect sizes, and demonstrating overall consistency of results	B	Recommended
One RCT with small effect size and/or multiple non-RCT studies with small effect sizes. There may be inconsistency in findings across studies but a general trend towards a positive effect should be noted	C	Limited/developing evidence to date, no indication against use
Findings with an effect size close to zero, or no systematic empirical evidence	/	No recommendation is possible at this time
Findings suggest a harmful effect is possible	NR	A recommendation is made against using this intervention

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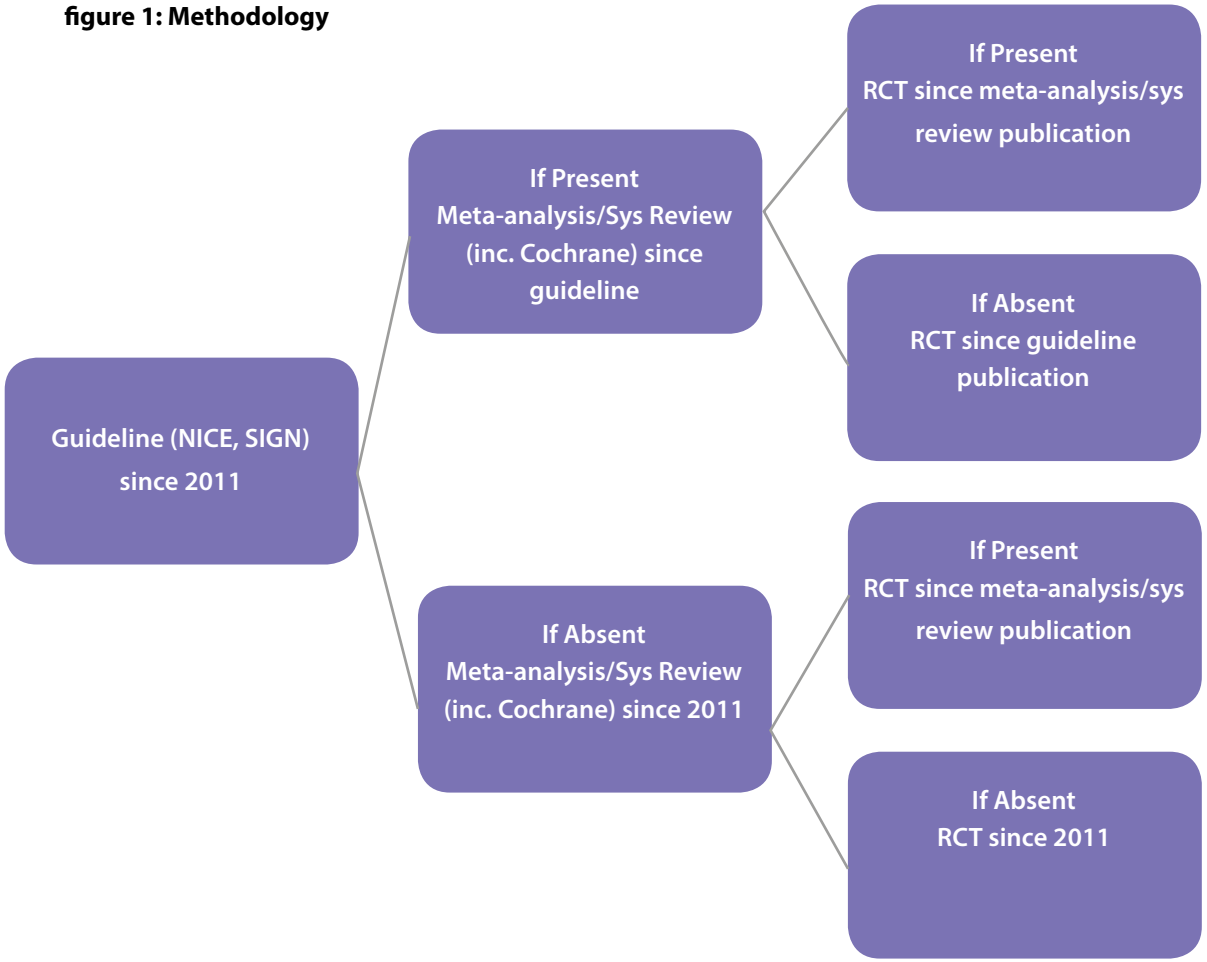
METHODOLOGY

The Matrix summarises the best available evidence for clinical practice in Child and Adolescent Mental Health. It is less rigorous than the National Institute for Care and Health Excellence (NICE) or the Scottish Intercollegiate Guideline Network (SIGN), but attempts to include all research that is least susceptible to bias according to the Cochrane Collaborative, NICE and the Medical Research Council (MRC). Where possible, appraised evidence is limited to systematic reviews, meta-analyses, evidence based clinical practice guidelines, health technology assessments and randomised controlled trials (RCTs). Where not available, poorer quality evidence may be considered. Evidence summaries should be read with this in mind. Assessments of the overall evidence base for each area are considered within the framework of the MRC guidance for developing and evaluating complex interventions:

www.mrc.ac.uk/complexinterventionsguidance

Each chapter has been updated from the 2011 edition using a standardised search strategy (see figure 1). The search has been audited, and the revisions have been reviewed by academics and/or clinicians with expertise in the area.

figure 1: Methodology



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EARLY INTERVENTION, INFANT MENTAL HEALTH RISKS & DISORDERS

INFANCY IS KNOWN TO BE A PERIOD OF IMMENSE PHYSICAL, MENTAL AND EMOTIONAL CHANGE

EVIDENCE OF THE LONG-TERM EFFECTS OF VERY EARLY EXPERIENCE AND OF THE COST EFFECTIVENESS OF EARLY INTERVENTION IS GROWING. EARLY INTERVENTION IS CONSEQUENTLY A PRIORITY IN SEVERAL SCOTTISH GOVERNMENT TARGETS.

The National Scientific Council on the Developing Child[26,27] clearly outlines the case for intervening before emotional or behavioural issues find expression as frank problems. In addition, its publications cogently argue that increased short-term expense can greatly reduce the potential financial costs incurred later down the line. For example, economic analyses suggest that the costs of early intervention may be paid back within 4 years, as the need for further services is reduced over the longer term[29,31]. Translating this into a Scottish context, it is known that maintaining secure care for an adolescent costs more than £200,000 a year[50] . This and other costs such as the long-term economic impact of untreated conduct disorder[36], far exceed the financial cost of implementing early interventions which can assist young children to grow into happy and healthy adults. While the most impressive evidence–base for early interventions is found in interventions with slightly older children, infant mental health represents an increasingly promising area of preventive value.

The focus within the infant mental health field is primarily on the relationships that scaffold the infant's development. NICE guidelines suggest that group based parent-training programmes

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focusing on promoting attachment and parenting skills should be available to all parents willing to access them[25]. This relationship approach to assessment and treatment is a recent development and challenges remain in developing new methodologies to determine short and longer-term effects. Nonetheless, the evidence-base for effective infant mental health interventions is emerging. This progress has been supported by an increase in research confirming the exceptional significance of the very earliest life experiences for future development. To date, there is limited evidence from UK studies, with the main body of evidence deriving from the US[24].

INTERVENTIONS WITH A BEHAVIOURAL FOCUS ON MATERNAL SENSITIVITY ARE MORE LIKELY TO PROMOTE SECURITY OF ATTACHMENT IN INFANTS

Interventions such as the Family Nurse Partnership[28,29] aim to enhance parenting in order to prevent the associated long-term sequelae of infant exposure to unresponsive, coercive or intrusive parenting styles. A review of group based interventions reported mild significant effects in improving the emotional and behavioural adjustment of children under[32]. Parenting programmes such as Triple P[34] and the Incredible Years[43], both of which have been demonstrated to strengthen parent-child relationships from the pre-school period onwards, are now experimenting with extending their models downwards to the infant age group. Evidence for the effectiveness of these programmes in this context is limited at present, but a meta-analysis suggests benefits are limited to at-risk infants and that such interventions should be carefully targeted[1]. Further evidence for the Mellow Babies[32] intervention is in development; independent randomised controlled trials are currently being carried out in Scotland and Northern Ireland to test Mellow Babies for mothers and fathers as well as Mellow Bumps (antenatal programme). Regarding specific components, those consistently associated with larger effects include increasing positive parent-child interactions, the importance of parenting consistency, and requiring parents to practise new skills with their children during parent training sessions[17]. Home visiting interventions achieve, across several trials, a very mild positive effect that may not translate into cost-effective practice.

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EARLY INTERVENTION, INFANT MENTAL HEALTH & RISK DISORDERS

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation
			Individual Interventions	
Moderate/Severe	2-4	High	Video Interactive Guidance	A [1,2,16,40,41,42]
	2/3	High	Family Nurse Partnership (inc. home visiting)	B [28,30]
	2-4	High	Attachment and Bio-behavioural Catch-up	B [3,8]
	2/3	High	Watch Wait Wonder	B [6,7]
			Group Interventions	
Moderate/Severe	2-4	High	Incredible Years	A [11,13,15]
	2-4	High	Circle of Security	C [4,21]
			Interventions for maltreated infants	
Moderate/Severe	2-4	High	Infant Parent Psychotherapy	B [5,6,18,22]
			Interventions for very low birth weight/pre-term infants	
Moderate/Severe	2-4	High	Infant Behavioural Assessment and Intervention Programme	B [14,18,19,23]
	2	High	Home visiting	B [11]
			Interventions for very low birth weight/pre-term infants	
Moderate/Severe	2/3	High	Home visiting with video interaction (inc. modelling, cognitive restructuring and infant massage)	B [9,39]
	2/3	High	Mellow Babies	C [31,32]

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CHILDREN'S ATTACHMENT: ATTACHMENT IN CHILDREN AND YOUNG PEOPLE WHO ARE ADOPTED FROM CARE, IN CARE OR AT HIGH RISK OF GOING INTO CARE

LOOKED AFTER CHILDREN ARE CONSIDERED TO BE AT GREATER RISK THAN THE GENERAL POPULATION

THE SCOPE OF THIS CHAPTER IS LIMITED TO CHILDREN AND YOUNG PEOPLE (AGED 0–18 YEARS) WHO ARE ADOPTED, LOOKED AFTER CHILDREN, AND CHILDREN AT HIGH RISK OF BEING TAKEN INTO CARE.

Of the 67,000 children and young people in care in the UK in 2012, 75% were in foster care, 4% were placed for adoption, 5% were in placements with their parents, 9% were in secure units, children's homes and hostels, and 1% were in a residential school[27]. Two-thirds had been subject to a single placement in the preceding year, 22% had 2 placements and 11% had 3 or more. In Scotland, during 2013, 16,248 children, accounting for 2% of children in Scotland, were looked after by local authorities or on the child protection register. Of these, 57% lived with relatives (of which 31% living at home), 32% placed with foster carers, 2% with prospective adopters, 0.5% at secure units, 5% in residential care homes and 3% at residential schools[31]. Looked after children are considered to be at greater risk than the general population of developing attachment difficulties, as a result of repeated changes of primary caregiver and separation. It is estimated that only 10% are securely attached to their biological parents[27].

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Therapeutic interventions target insecure or disorganised attachment or aim at the prevention of insecure or disorganised attachment through focus on key componenets of attachment: sensitivity, warmth and consistency[4,12]. It is important to note that interventions that are based on attachment theory (e.g. Attachment and Bio-behavioural Catch-up - ABC) are included, even if the study did not measure changes in attachment status per se. As the child's attachment status is not likely to change during the course of an intervention, due to the limited time scope of the latter, various studies measure behavioural or emotional difficulties rather than attachment style per se. Overall, research on the effectiveness of attachment-based interventions for looked-after or adopted children is limited in both quantity and quality, limiting conclusive recommendations[23]. Various additional interventions were identified (e.g. narrative therapy, theraplay, animal assisted therapy), however the evidence base has not yet been developed to recommendation standards. Therefore, these interventions were not included. A Cochrane review on Cognitive Behavioural or Behavioural training interventions for foster carers concludes that to date, it is difficult to offer practice guidelines due to the lack of evidence and therefore the need for further research is emphasised. The identified studies show that such interventions appear to have very little effect on child psychological functioning, interpersonal functioning and behavioural problems[35]. Parenting interventions employing video interactive guidance (VIG or VIPP) currently have the best evidence-base with young children. Dyadic Developmental Psychotherapy[5,6,7,23] in a single small non-randomised trial showed significant improvements across all measures[6]. Further evidence is needed to support this popular intervention.

Finally, caution should be exercised regarding interventions that include physical techniques (for example holding therapy) that have resulted in a number of deaths in the past[2,3,30]. Interventions that include coercion, "re-birthing techniques" and holding therapy should not be used.

OVERALL, RESEARCH ON THE EFFECTIVENESS OF ATTACHMENT-BASED INTERVENTIONS FOR LOOKED-AFTER OR ADOPTED CHILDREN IS LIMITED IN BOTH QUANTITY AND QUALITY

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CHILDREN'S ATTACHMENT

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
Children at Risk				Child	Adolescent
Prevention	3	High	Video-Interactive Guidance	B[19]	/
	3	High	Child-Parent Psychotherapy (CPP)	B[11,34]	/
	2/3	Low	Attachment and Bio-behavioural Catch-up	B[13,14,15,23,25,32]	/
	2/3	Low	Circle of Security	C[34]	/
Fostered children					
Subclinical/mild	2	Low	CBT based programmes (e.g. Fostering Change)	C[8,28]	/
	2	Low	Multidimensional Treatment Foster Care Program- Preschool	C[16,17,18]	/
	2	Low	Parenting programmes (e.g. Incredible Years)	C[9]	/
Moderate/ Severe	2	Low	Group Parenting CBT based interventions	C[35]	C[35]
Adopted Children					
Prevention	2	Low	Parent training interventions using video feedback	B[22,23,33]	/
Mild/Subclinical	3	High	Child Parent Relationship Therapy (CPRT)	C[10,23]	/
Mild/Moderate	3	High	Parent–Child Interaction Therapy (PCIT)	C[1]	/
	3	High	Fostering Attachments	C[20,21,23,24]	/
Moderate/Severe	3	High	Treatment Foster Care	C[26]	C[26]

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AUTISM SPECTRUM DISORDERS

ASD MAY OCCUR IN ASSOCIATION WITH ANY LEVEL OF GENERAL INTELLECTUAL/ LEARNING ABILITY

THE TERM AUTISM SPECTRUM DISORDERS (ASD) IS USED TO DESCRIBE THE COMPLEX NEURODEVELOPMENTAL DISORDERS OF CHILDHOOD AUTISM, ATYPICAL AUTISM, ASPERGER'S SYNDROME AND PERVASIVE DEVELOPMENTAL DISORDER INCLUDED IN ICD-10. ASD MAY OCCUR IN ASSOCIATION WITH ANY LEVEL OF GENERAL INTELLECTUAL/LEARNING ABILITY AND MANIFESTATIONS RANGE FROM SUBTLE PROBLEMS OF UNDERSTANDING AND IMPAIRED SOCIAL FUNCTION TO SEVERE DISABILITIES.

Previously published figures suggest a median ASD prevalence rate of 62 per 10,000 globally with prevalence rates ranging from as low as 30 to as high as 116 per 10,000 individuals[8]. The wide range of prevalence rates may be in part attributable to differences in methodological considerations, such as diagnostic concept, service ability and clinician awareness. UK prevalence figures indicate the overall ASD prevalence rate of between 70.3 per 10,000 in pre-school children[25,21] and 116.1/10,000 in 9-10 year olds with approximately half having an IQ >70[1]. A more recent UK based study examining ASD prevalence using the Special Educational Needs (SEN) register and parent surveying methods of children aged 5-92. The prevalence estimates generated from the SEN register and diagnosis survey were 94 per 10,000 and 99 per 10,000 respectively. The ratio of known:unknown cases was 3:2 and taken together they estimated the total prevalence to be 157 per 10,000, including previously undiagnosed cases.

The SIGN guideline focused on clinical interventions for children and young people with ASD, but

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emphasised their entitlement to additional support if needed to benefit from their education, and to have positive wider life experiences. The current NICE (2013) Autism guidelines aimed at children and young people recommend interventions geared towards life skills and social communication as well as parent/carer mediated interventions[22]. It has been recognised that parents, educationalists, health professionals, social workers and the voluntary sector may use individualised interventions to optimise a child's functioning, either by promoting development of skills, or by adapting the environment to compensate when skills are not present. Further, interventions incorporating the school environment are now becoming more prevalent, and research suggests accommodating schools into child and adolescent interventions may be efficacious.[15, 31]

SIGN recommends that other common difficulties including mental health problems (particularly anxiety and attention deficit disorders common to childhood, and depression which tends to emerge later in childhood), sleep disorders and other neurodevelopmental problems such as tics, should not be assumed to be part of ASD but should be appropriately assessed and managed with reference to other clinical guidelines as relevant. Although approaches to intervention are described here within a categorical system, it is important to note that a variety of aims may be represented within each category. The benefits of an intervention must be considered in light of its aim, for example, different approaches to parent training may aim to improve aspects of parental wellbeing, while others focus on developing parent-child interactions or achieving improvements in the child's own condition. Specifically, the current NICE guidelines recommend group or individual CBT for diagnoses of Autism and Anxiety to alleviate relevant symptoms[25]. Further, technology-based and drama-based music-based interventions are emerging as possibly effective treatment options; however more evidence is still required providing consistent, positive results[5,10,12].

ASPERGER'S SYNDROME MAY BE USED AS A CLINICAL DIAGNOSIS FOR SOME INDIVIDUALS WHO SPEAK WELL LATER, BUT DID IN FACT HAVE EARLY LANGUAGE DELAY

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AUTISM SPECTRUM DISORDERS

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation
				Child to Adolescent
Mild-Severe	2	Low	School based Behavioural interventions	A[6,13]
	2/3	Low	Peer Mediation for school aged youth	A[22,38,43,48]
	2/3	Low/High	Social communication and interaction interventions	A[17,18,20,22,23,32,37,42,46]
	2/3	Low/High	Behavioural interventions (including ABA) for specific behaviours e.g. self injury, sleep to reduce symptom frequency and severity and to increase development of adaptive skills e.g. social skills, daily living skills, life skills.	A[6,13,14,18,19,22,27,44]
	2-4	High	Modified Individual- or Group-based CBT for autism and anxiety	A[22,29,41,45]
	2-4	High	Sensory Integration Therapy	A[4]
	2-4	High	Early Intensive Behavioural Intervention	A[26,35]
	2/3	Low	Communication supports	B[9,34,47]
	2-4	Low/High	Parent or Carer mediated intervention	B[3,7,11,16,20,22,24,30,33,35,36,44]
	2/3	Low	Parent education	B[39,40]
	2/3	Low/High	Music Therapy	B[10]
	2-4	High	Mindfulness-based Approaches	C[15,31]

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DISRUPTIVE BEHAVIOUR AND CONDUCT DISORDERS

UNTREATED, PROGNOSIS IS POOR, REINFORCING THE IMPORTANCE OF EARLY EFFECTIVE TREATMENT AND PREVENTIVE APPROACHES

BOTH OF THESE VARY WIDELY IN THEIR PRESENTATION WITH HIGH LEVELS OF CO-MORBIDITY. IT IS THEREFORE VITAL THAT INTERVENTIONS TARGET A BROAD POPULATION OF INDIVIDUALS. THIS NEEDS TO INCLUDE THOSE WHO FALL WITHIN THE CLINICAL RANGE OF DIAGNOSIS, AS WELL AS THOSE WHO DO NOT, BUT WHOSE BEHAVIOURS PLACE THEM AT SERIOUS RISK FOR LATER MALADJUSTMENT.

Oppositional problems occur in 2.6-15.6 % of non-clinical samples[12]. The 2013 NICE Guideline estimated the prevalence of conduct disorders in children between the ages of 5 and 10 years to be 7% for boys and 3% for girls, and in older children (11–16 years of age), the prevalence of diagnosed conduct disorders is slightly higher, at 8% for boys and 5% for girls[22].

Early onset conduct disorders represent the main reason for referral to CAMHS[24]. Untreated, prognosis is poor, reinforcing the importance of early effective treatment and preventive approaches. This is especially so as the most powerful early interventions alter the maladaptive developmental trajectory of ODD/CD which so readily escalates into academic problems, school exclusion, substance abuse, delinquency and violence, and ultimately into a range of high cost psychiatric disturbances including antisocial personality disorders in adulthood[19,34]. Early intervention is also important as the literature suggests that early starter aggressive tendencies in children may crystallise around age eight and thereafter become less amenable to change[3].

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Conduct disorders have a significant and detrimental impact on the quality of life of both the child and their family or carer(s). Caught early enough, they are however very treatable[23], with significant gains benefiting not only individual children, but also improving maternal mental health and representing significant cost savings for the taxpayer[15,27,35].

Social learning theory-based group-based parenting is the treatment of choice for young children[21,37,22]. With increasing age, multi-modal approaches, especially those incorporating cognitive problem-solving and social skills training become progressively required, such as multi-systemic therapy[34]. By adolescence complex, multi-faceted and far more expensive interventions are required[29,4].

SOCIAL LEARNING THEORY-BASED GROUP-BASED PARENTING IS THE TREATMENT OF CHOICE FOR YOUNG CHILDREN

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DISRUPTIVE BEHAVIOUR AND CONDUCT DISORDERS

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation		
				3-6 years	7-12 years	13-17 years
Mild	2/3	Low	Group or individual Social Learning Theory-based Parent, Guardian or Foster Carer Management training	A[5,9,11,14,16,20,22,30,32]	A[13,14,22,23,26,28,33,36]	B[14]
Moderate	2/3	High	Group or individual Social Learning Theory-based Parent Management Training	B[5,9,11,14,20,22,30,32]	A[13,22,23,26,28,33,36]	B[14]
	2/3	High	Problem Solving Skills Treatment (PSST) (more effective when integrated with Parent Training Program)	B[33]	B[17]	/
	2/3	High	Anger Coping Therapy	/	B[18]	B[18]
	3	High	Functional-Family Therapy	/	B[2]	B[2]
	2-4	High	Multi Systemic Therapy	A[31]	A[31]	A[1,4,22, 31]
Severe	3/4	High	Social Learning Theory-based Parent Management Training	A[5,9,11,14,16,20,22, 30,32]	A[13,14,22,23,26,28,33,36]	B[14]
	3	High	Functional-Family Therapy	/	/	A[2]
	3	High	Multi Systemic Therapy	A[31]	A[31]	A[1,22,31]
	3/4	High	Therapeutic Foster Care	/	C[6,7,8,10]	/
	3/4	High	Social Learning Theory based multimodal intervention	/	/	A[22]
	3/4	High	Child focused group Social and Cognitive Problem Solving Programs	/	B[34]	B[34]
	3/4	High	Psychodynamic Psychotherapy	/	/	B[36]

Webster-Stratton, 1998[30]).

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ANXIETY DISORDERS (INC. PANIC DISORDER)

ANXIETY DISORDERS IN CHILDREN AND YOUNG PEOPLE, WHILE COMMON, ARE VERY LIKELY TO BE UNDER-RECOGNISED AND UNDER-TREATED

ANXIETY DISORDERS REPRESENT A GROUP OF DIAGNOSES INCLUDING GENERALIZED ANXIETY DISORDER, PANIC DISORDER, SEPARATION ANXIETY, OBSESSIVE-COMPULSIVE DISORDER (OCD), PHOBIAS, POST-TRAUMATIC STRESS DISORDER (PTSD), SOCIAL ANXIETY AND PANIC DISORDER.

As such, anxiety disorders are among the most common presentations in children and adolescents with prevalence estimated at 12% per year, and cross-sectional surveys using structured assessment techniques have found prevalence to range between 4 and 16% at any one point in time[25]. Over the course of childhood approximately 10-11% of all children and young people experience anxiety disorders[13].

Anxiety disorders in children and young people, while common, are very likely to be under-recognised and under-treated[17]. In a sample of 8 to 17 year olds, 72% of those with an anxiety disorder that was causing impairment did not receive any treatment, and in this respect fair worse than children with behavioural problems or those with depression[25]. Amongst those who are recognised, cognitive behavioural therapy (CBT) is the treatment of choice, with an approximately 50-60% success rate[59]. This relatively modest success rate has led researchers to focus on both the mode of delivery and relevant mediating factors in treatment success. In particular, group and

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individual treatment delivery to children only, parents only[9], and to both have been compared, with inconsistent findings[7,8]. Some studies have found that, where parental anxiety is present, family CBT (FCBT) is more effective than individual CBT[14]. An RCT of parenting group-based treatment for anxiety in young children (9 years and under) demonstrated good results for both children's anxiety and parental and family functioning[8]. Additionally, 2 RCTs support parent training followed by parent-delivered CBT, with therapist support (by telephone) in school aged children with anxiety[11,59]. One suggestion is that where parental involvement is used as an additive to child-oriented interventions, care should be taken to avoid over-complicating key messages[56]. Finally, recent studies indicate that the addition of booster sessions in CBT is beneficial in sustaining treatment effects[22].

WHERE PARENTAL INVOLVEMENT IS USED AS AN ADDITIVE TO CHILD-ORIENTED INTERVENTIONS, CARE SHOULD BE TAKEN TO AVOID OVER-COMPLICATING KEY MESSAGES

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PANIC DISORDERS

UP TO 90% OF CHILDREN AND ADOLESCENTS WITH PANIC DISORDER HAVE COMORBID ANXIETY AND/OR DEPRESSIVE DISORDER

Panic disorder with/without agoraphobia is considered to be a rare condition before puberty. Some argue that the reason for this trend is that children might not have the cognitive capacity to experience catastrophic attributions of dying, losing control, or going crazy when experiencing bodily symptoms of panic, therefore do not meet the criteria of a diagnosis[50].

Estimates of panic disorder in adolescence vary between 0.5% and 3.3% with the disorder being more common among girls[14,15,20,35]. It is reported that up to 90% of children and adolescents with Panic Disorder have comorbid anxiety and/or depressive disorders[48]. Panic disorder is considered to emerge in adolescence and continue to increase in the transition to adulthood, while for most cases the age of onset is likely to fall between 15 and 19 years[15].

Cognitive behavioural therapy appears to be the most effective treatment for panic disorder in adults[48]. PCT (Panic Control Treatment) is a cognitive behavioural therapy for panic disorder that has been found effective in adults[3] adapted PCT for use with adolescents (PCT-A)[28]. The treatment consists of 11 sessions of individual CBT, including: psychoeducation, breathing retraining, cognitive restructuring, interoceptive exposure and hypotheses testing. Psychoeducation and cognitive restructuring were found to lead to sudden treatment improvements in a study examining effective components of treatment[44], however the results are preliminary. Recently, an intensive treatment version of PCT-A has been developed, which consists of 6 sessions of delivery[1]. Research in panic disorders in childhood and adolescence is scarce. To date, there is one small scale randomised controlled trial examining the effectiveness of PCT-A in adolescence, which reported positive outcomes[54]. Additionally, another study examined a case series, which found improvements in anxiety sensitivity, trait anxiety, fear, and depression[52]. PCT-A appears to be a promising treatment, however the evidence base is still limited.

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For the 2014 update, studies containing data exclusively on panic disorder were documented separately within the anxiety disorders matrix. Social anxiety (social phobia) is considered in a separate matrix. Studies examining these disorders as part of a variety of anxiety disorders (GAD, SAD, SP) were included. Studies including OCD or PTSD are addressed in separate matrices.

RESEARCH IN PANIC DISORDERS IN CHILDHOOD AND ADOLESCENCE IS SCARCE.

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ANXIETY DISORDERS

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild	1/2	Low	School-based prevention and early intervention programmes (e.g. FRIENDS for Life)	A[6,8,13,17,21,22,23,37,39,41, 45,50,56,61]	A[13,21,22,23,27,39,45,46*,56 61]
	1/2	Low	Bibliotherapy based on CBT principles	/	B[47*]
	1/2	Low	Computerised CBT	C[42]	C[47*]
Moderate/Severe	3/4	High	Individual Cognitive Behavioural Therapy without Parental/Family Involvement	A[2,7,8,21,24,30,32,33,38, 55,56,63]	A[2,7,21,24,30,33,46,55,56,63]
	3/4	High	Individual Cognitive Behavioural Therapy with Parental/Family Involvement	A[5,8,21,30,33]	A[8,21,30,33]
	3/4	High	Group Cognitive Behavioural Therapy without Parental/Family Involvement	A[21,29,30,31,38,55]	A[21,30,31,55]
	3/4	High	Group Cognitive Behavioural Therapy with Parental/Family Involvement	A[4,21,30,31,43,57,58]	A[4,21,30]
	3/4	High	Booster Sessions in CBT	A[26]	A[26]
	3/4	High	CBT based parenting programme	A[12,61]	/
	3/4	High	Attention Bias Modification	B[40]	B[40]
	3/4	High	Clinician-assisted Computerised CBT	B[34,37]	B[60,64]
	3/4	Low	Computerised CBT for parents of preschool children, with therapist (online & telephone) support	C[16]	/
	3/4	High	From Timid to Tiger parenting intervention for preschool children	C[10]	/
	3/4	High	Panic Control Treatment (PCT-A) for panic disorder	/	C[5,16,18]

* Extrapolated from adult populations.

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ANXIETY DISORDERS: OBSESSIVE COMPULSIVE DISORDER

OCD IS BOTH UNDER-RECOGNISED AND UNDER-TREATED

ESTIMATES OF PREVALENCE VARY FROM 0.25% TO 4%[9,4,5,16], WITH PEAK ONSET IN THE EARLY SCHOOL YEARS (WHEN BOYS PRESENT MORE FREQUENTLY) AND AGAIN IN EARLY ADOLESCENCE (WHEN GIRLS ARE MORE LIKELY TO PRESENT)[5].

OCD is both under-recognised and under-treated[5] with clear clinical evidence that it is often associated with significant disruption and impairment in family, social and academic life and can have adverse impacts on psychosocial development[15]. Cognitive Behavioural therapy (CBT) is strongly supported by literature as the first-line therapy choice for both children and adolescents diagnosed with Obsessive Compulsive Disorder. In pilot studies, Internet and webcam based CBT programmes have shown effectiveness in child and adolescent populations. However, these treatment options require further evaluation to establish an evidence-base.[3, 7, 19]

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OBSESSIVE COMPULSIVE DISORDER

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild	3	Moderate	Therapist-guided Behavioural Therapy, self-help CBT, or therapist-guided CBT	B [7, 13]	B [7, 13]
Moderate- Severe (CY-BOCS >16[11])	3/4	High	Behavioural Therapy or CBT in combination with medication (SSRI specifically) (better than medication alone)	A [1, 2, 4, 11, 13, 14]	A [2, 9,11, 13, 14]
	3/4	High	12-20 sessions therapist-guided CBT incorporating Exposure and Response Prevention (ERP). Augmented with:	A [1, 2, 7, 9, 10, 12, 14]	A [2, 7,10, 11, 12, 14, 17]
			• Psychoeducation and Anxiety Management	A [1, 10]	A [10]
			• Cognitive Therapy	A [1, 2, 10]	A [2, 10]
			• Family Sessions	A [1, 2, 10, 18]	A [2, 10, 18]
			• Family-based or -enhanced CBT	A [7, 8, 18]	A [7, 8, 17]

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ANXIETY DISORDERS: SOCIAL ANXIETY DISORDER / SOCIAL PHOBIA

FOR YOUNG PEOPLE WITH SOCIAL ANXIETY DISORDER, EARLY INTERVENTION IS PARAMOUNT WITH CHRONICITY QUICKLY BECOMING ESTABLISHED

ESTIMATES OF SOCIAL ANXIETY DISORDER OR SOCIAL PHOBIA PREVALENCE RANGE FROM 0.5% TO 4% OF ADOLESCENTS[8, 9, 15, 27].

It is associated with an increased risk for depression and suicide and will impact adversely on outcomes for people with co morbid mental health problems such as bipolar disorder and eating disorders[27]. There is an overlap between social anxiety and school refusing behaviour, although proper assessment has found that this relationship is not as strong as originally thought[16] with social anxiety appearing more often as a consequence of non-attendance at school.

Cognitive behavioural therapy (CBT) has the best evidence-base with success rates consistently found in approximately 50% of cases. Of particular significance for young people with social anxiety disorder, early intervention is paramount with chronicity quickly becoming established, significantly reducing the likelihood of a positive outcome. Therefore, early intervention should be prioritised, and in all cases, responsible adults should be alerted to the importance of maintaining social contact through activities of daily living.

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SOCIAL ANXIETY DISORDER / SOCIAL PHOBIA

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild	1/2	Low	Skills for Social and Academic Success (SASS) (Group CBT with social skills elements)	/	B[22, 23]
	1/2	Low	FRIENDS prevention and early intervention programme	B[3, 21]	/
Moderate	2/3	Low	Computer-Assisted CBT (7+)	C [18, 19]	C [18, 19]
	2/3	Low	Supported Self-Guided CBT (15+ who have the cognitive and emotional capacity to undertake a treatment developed for adults)	/	C[24]
Moderate/Severe	3	High	Group Cognitive Behavioural Therapy (CGBT) with or without Parental/Family Involvement (7+)*	A[1, 2, 24, 25, 26]	A [10, 11, 12, 13, 24, 25]
	3	High	Social Effectiveness Training for Children and Adolescents (SET– C) **	B [4, 5, 6, 7]	B [7, 10, 11]
	3	High	Individual Cognitive Behavioural Therapy with/without Parental/ Family Involvement (7+)*	A [14, 17, 20, 24, 26]	C [17, 24]
	3	High	Social Skills Training (SST) ***	C [27]	C [27]
		High	Short-Term Psychodynamic Psychotherapy (15+ who have the cognitive and emotional capacity to undertake a treatment developed for adults)	/	C[24]
Mild/Moderate/ Severe	1 - 4		Interventions NOT recommended: Do not routinely offer pharmacological interventions Do not routinely offer mindfulness-based interventions, or supportive therapy to treat social anxiety disorder.	NR[24]	NR[24]

*Both individual CBT and GCBT may include psycho-education and skills training for parents, particularly of young children, to promote and reinforce the child's exposure to feared or avoided social situations and development of skills23.

** Including social skills training, peer generalisation sessions and individualised in vivo exposure.

*** An integrated cognitive behavioural group intervention consisting of social skills training, graded exposure and cognitive restructuring.

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ANXIETY DISORDERS: SPECIFIC PHOBIA

ANIMAL AND ENVIRONMENTAL PHOBIAS ARE THE MOST COMMON SUBTYPES OF SPECIFIC PHOBIA IN CHILDREN

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SPECIFIC PHOBIA IS ONE OF THE EARLIER ANXIETY DISORDERS TO APPEAR DEVELOPMENTALLY, AND INCLUDES ALL PHOBIAS SPECIFIED TO A SINGLE PHENOMENON, AND EXCLUDES SOCIAL PHOBIA WHICH TYPICALLY PRESENTS AS MORE GENERALISED.

The developmentally normal appearance of specific fears at certain stages in childhood provides information about the typical onset of specific phobia, with animal and environmental (natural disasters, weather etc.) phobias most often triggered during toddlerhood (2-3 years) and other specific phobias during primary school years[1]. Animal and environmental phobias are the most common subtypes of specific phobia in children[33]. Prevalence is estimated at 2.3-9.2%[12,33]. Co-morbidity is high, with almost half (47.2%) experiencing an additional anxiety disorder, a third with depression (36.1%) and a third (33.3%) with somatoform disorders. Co-morbid substance use disorders are less commonly seen (8.3%)[8]. Specific phobias have been found in 17-42% of children with a primary anxiety disorder diagnosis. Among children seeking treatment for anxiety disorders, specific phobias appear in 42-75% of cases[15,31,35,38].

Treatment for phobias in children and young people is more likely to be successful in children under 11 years old[10,23]. The involvement of parents appears to confer a mild non-significant benefit in the

short-term[4,11] with one study finding a significant benefit appearing at three-year follow-up[5].

One Session Treatment (OST)[32], an intervention consisting of participant modelling and systematic in vivo desensitisation is the most evidence-based effective treatment. OST is a variation of cognitive behavioural therapy, with the difference of massed instead of spaced exposure[29]. Two trials investigating the added benefit of EMDR to OST found no improvemet in outcomes. Spaced over massed exposure might be preferable, in that One Session Treatment (OST), an intervention consisting of participant modelling and systematic in vivo desensitisation is the most evidence-based effective treatment.

For the purposes of this classification, research on OST has been categorised under Participant Modelling, rather than under Systematic Desensitisation or CBT.

GRADUAL (IN ORDER AND TIME) EXPOSURE TO THE FEARED OR AVOIDED STIMULI REDUCES THE CHANCE OF EXTREME CHILD DISTRESS OR THE RISK OF PREMATURE TERMINATION OF THERAPY

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SPECIFIC PHOBIA

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Moderate/Severe	2/3	High	Behavioural: Participant Modelling (including OST)	A[2,6,17,18,26,28,29,30,31,36,37,43]	A[2,6,17,18,26,28,29,30 31,36,43]
	2/3	High	Behavioural: Reinforced Practice	A[6,16,20,22,27,28]	A[6,16,20,26,27,28]
	2/3	High	Systematic Desensitisation (in vivo desensitisation more effective for younger children)	A[6,7,14,19,20,23,28,39,40,41,42]	A[6,7,14,19,20,23,28,39,41,42]
	2/3	High	Cognitive Behavioural Therapy	B[6,9,17,21,28,34,38,40]	B[6,28,43,38]
	2/3	High	Emotive Imagery (pairing frightening situations with an exciting story involving a hero-figure)	C[3,13,37]	/

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ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

AFFECTED CHILDREN ARE OFTEN EXPOSED TO YEARS OF NEGATIVE FEEDBACK ABOUT THEIR BEHAVIOUR AND SUFFER EDUCATIONAL AND SOCIAL DISADVANTAGE

ADHD AND HYPERKINETIC DISORDER (HKD) ARE COMMONLY DIAGNOSED BEHAVIOURAL DISORDERS IN CHILDREN AND YOUNG PEOPLE AND ARE ASSOCIATED WITH MYRIAD POOR OUTCOMES.

The core symptoms of ADHD and HKD have a significant impact on the child's development, including social, emotional and cognitive functioning and they are responsible for considerable morbidity and dysfunction for the child or young person, their peer group and their family. The secondary effects of ADHD and HKD can be extremely damaging. Affected children are often exposed to years of negative feedback about their behaviour and suffer educational and social disadvantage. It is estimated that up to two thirds of children affected by hyperactivity disorders continue to have problems into adulthood" (p.1)[17].

Prevalence rates for ADHD vary across epidemiological studies and in different countries. Much of this variation is attributable to differences in diagnostic criteria[1,22] and not necessarily to geographical differences. The point prevalence of the more severe form HKD is widely accepted as approximately 1.5 % within the UK's school-aged population (4-16) with attention deficit hyperactivity disorder having an estimated prevalence rate of at least 5% for the same population group. However, a national study by NHS-QIS[15] found significant under recognition of the disorder, approximately 0.6% of Scottish school children had a diagnosis of ADHD/HKD.

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PARENTS OR CARERS OF CHILDREN WITH SYMPTOMS OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) WHO MEET THE NICE ELIGIBILITY CRITERIA ARE OFFERED A REFERRAL TO A PARENT TRAINING PROGRAMME

Recent research supports NICE and SIGN guidelines recommending parent behavioural training, child behavioural treatment and school interventions. The majority of evidence suggests that parent behavioural training (PBT) is an effective and well-established treatment[2,4,6,9,11,18]. However, clarity is still needed regarding the mechanisms of change, for whom treatments work and how outcomes can be enhanced[6]. An earlier Cochrane review found that evidence for PBT was limited and hence could not be used as basis for guidelines of treatment of ADHD in clinics or schools[23]. The SIGN guideline (2009) states that for children aged less than 12 years, behavioural parent training reduces comorbid conduct and internalising problems but does not confer additional benefit to medication or 'routine care' on core ADHD symptoms . Recent evidence continues to support the above finding[4].

A self-help intervention, the New Forest Parent Training programme for ADHD (NFPP)[3] found significant improvements in parent-reported child ADHD symptoms and parental competence. School interventions are effective[5, 6] and in some cases implemented along with behavioural training and PBT[11]. Behavioural treatment is a well-established treatment[4,6,8]. A Cochrane review reports that there is little evidence to support or refute social skills training for adolescents with ADHD[20] .In another meta-analysis, social skills training was classified as a non-effective treatment[6]. Cognitive training has not been considered effective. However, in a recent meta-analysis, cognitive training was found to be effective, but the need for more blinded evidence is highlighted[18]. Thus, cognitive training is considered an experimental treatment[6]. Computerised CBT provided mixed results, indicating a need for further blinded studies; thus no recommendation can yet be made[19]. The NICE quality statement (2013)[13] recommends that parents or carers of children with symptoms of attention deficit hyperactivity disorder (ADHD) who meet the NICE eligibility criteria are offered a referral to a parent training programme. Children and young people with moderate attention deficit hyperactivity disorder (ADHD) are offered a referral to a psychological group treatment programme. A combination of medication and behavioural treatments are recommended for school aged children and young people with ADHD/HKD and comorbid symptoms of ODD and/or aggressive behaviour, and/ or significant anxiety[4,11,16].

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ATTENTION DEFECIT HYPERACTIVITY DISORDER (ADHD)

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation
				Pre-school Children
Mild/Moderate/ Severe	2-4	High	Behavioural parent training. This should be delivered by trained facilitators.	A[2,3,4,6,9,10,18,23]
				School aged children
Mild	2/3	Low	Behavioural approaches at home (parent training programmes) and at school should be considered in the first instance for school-aged children	Recommended best practice A[3,4,6,7,8,9,18,23]
Moderate/Severe	2	High	Individualised school intervention programme including behavioural and educational interventions.	A[5,6,8,19]
Moderate/Severe	3/4	High	Combination of medication and behavioural treatments	A[4,11,16]

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BIPOLAR DISORDER

ADHD AND CONDUCT DISORDER ARE FREQUENTLY SEEN IN YOUNG PEOPLE WITH BIPOLAR DISORDER

THERE ARE VERY FEW STUDIES OF BIPOLAR DISORDERS IN CHILDREN AND ADOLESCENCE. TWO STUDIES IDENTIFIED THE INCIDENCE OF BIPOLAR DISORDER FOR CHILDREN AND YOUNG PEOPLE AS BEING 0.2 AND 0.3%[8,16]. THE ONSET MAY OCCUR FOLLOWING THE INITIATION OF ANTIDEPRESSANT MEDICATION FOR A DEPRESSIVE ILLNESS[4]. THE AGE OF ONSET CAN BE BETWEEN 8 TO 19 YEARS WITH A MEAN ONSET AGE OF 15.9 YEARS6, WITH 20% HAVING THEIR FIRST EPISODE DURING ADOLESCENCE[1].

Both sexes are affected equally[1]. Comorbid disorders with bipolar disorder are not uncommon[10]. ADHD and Conduct Disorder are frequently seen in young people with Bipolar Disorder[5]. Substance abuse has also been noted[3,5].

Individual CBT or IPT have been deemed the primary psychological therapies for young people with bipolar disorder[19]. However, certain family therapies and alternative individual therapies have also shown efficacy and are recommended if primary therapies are deemed ineffective after a 4-6 week period.

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BIPOLAR DISORDER

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation
				Child to Adolescent
Moderate	3/4	High	CBT	A[9*, 13*, 19*]
	3/4	High	Psychoeducation & relapse prevention	B[9*, 13*]
	Tier 3/4	High	Family intervention	B[7*, 9*, 13*, 15, 18, 19*]
	Tier 3/4	High	Interpersonal Therapy	B[13*, 19*]
	Tier 3/4	High	Mindfulness-Based Cognitive Therapy	C[17*]

* Participants include adolescent and child populations.

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BODY DYSMORPHIC DISORDER

MANY ADULTS AND ADOLESCENTS WILL SEEK COSMETIC TREATMENT OR SURGERY TO ADDRESS BDD CONCERNS

IT IS THOUGHT THAT 0.5–1.8% OF THE POPULATION HAVE BODY DYSMORPHIC DISORDER(BDD)[3,11], BUT STUDIES WITH ADOLESCENTS HAVE ESTIMATED THE PREVALENCE TO BE AS HIGH AS 2.2%[9]. BDD HAS A TYPICAL ONSET DURING EARLY ADOLESCENCE AND SUBCLINICAL BDD MAY ONSET IN LATE CHILDHOOD[2,17] AND OFTEN DEMONSTRATES A CHRONIC COURSE[16].

Many adults and adolescents will seek cosmetic treatment or surgery to address body image concerns. Symptoms tend to be the same or worse following the procedure, and sometimes new appearance concerns emerge[13,15]. Surgery and other cosmetic treatments should not be offered to young people[13,17].

Individuals with BDD have high rates of comorbid problems such as eating disorders[4], and social phobia[18]. Children and adolescents with BDD usually have moderate to high functional impairments[11,14]. In particular, social functioning is markedly impaired. BDD shares many clinical features of social phobia, but both the fear and avoidance of social interactions are directly linked to anxiety over others' perception and negative evaluations of the perceived bodily 'defect' or 'deformity' the individual is preoccupied with[6,18]. Academic functioning can also be impaired and some adolescents may even drop out of secondary school due to BDD symptoms[1].

Suicidal ideation is also commonly observed in children and adolescents with BDD[1,14]. Further, 21-44%

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of youth in these studies reported having attempted suicide. The evidence-base for interventions in this area is limited, but CBT with an Exposure Response Prevention (ERP) component is currently the best supported approached. CBT combined with ERP and psycho-education, adapted to be developmentally appropriate, should therefore be offered as first-line treatment[11], should involve parents or carers, and address the family's role in not accommodating BDD symptoms (e.g., not providing reassurance)[5,17]. If CBT is not effective, the addition of an SSRI to ongoing psychological treatment should be offered with careful monitoring, particularly at beginning of treatment (ages 8-18)[11]. Manualised versions specific to BDD are available (e.g. CBT-BDD)[21], within which there are optional modules available to address specific individual concerns such as surgery seeking[21].

INDIVIDUALS WITH BDD HAVE HIGH RATES OF COMORBID PROBLEMS SUCH AS EATING DISORDERS, AND SOCIAL PHOBIA

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BODY DYSMORPHIC DISORDER

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Moderate/Severe	3	High	CBT-BDD + ERP	B [11,17]	B [5,8*,11,12*,17,19*,20*,21*]
	3	High	CBT + SSRI	B [11,17]	B [8*,11,17]
	3	High	Stepped-care model including assessment of young people seeking cosmetic or dermatological procedures	C [11,13*]	C [11,13*]
	3	High	Behaviour Therapy (ERP only)	/	C [7*,10*]

* Indicates evidence from adult studies and adult recommendations.

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CHRONIC FATIGUE SYNDROME

APPROXIMATELY 1% OF CHILDREN IN SECONDARY SCHOOL MISS 1 SCHOOL DAY PER WEEK AS A RESULT OF CFS

THE PREVALENCE OF CHRONIC FATIGUE SYNDROME (CFS, OR MYALGIC ENCEPHALOPATHY-ME) AMONG CHILDREN HAS BEEN ESTIMATED TO BE 0.06%[35], AND AMONG ADOLESCENTS THE ESTIMATES RANGE BETWEEN 0.4% AND 2.4%[4,9,32]. THE DIFFERING PREVALENCE RATES CAN BE ATTRIBUTED TO WHETHER OR NOT THE DIAGNOSTIC DEFINITION REQUIRED 3 OR 6 MONTHS OF FATIGUE[14].

CFS has marked consequences on children and young people as a result of the disorder's potentially impairing effects on emotional, intellectual and physical development[15,33]. One particular problem is its association with high rates of school absenteeism[30]. It is estimated that approximately 1% of children in secondary school miss 1 school day per week as a result of CFS[8]. CBT has the strongest evidence-base, with many CBT interventions include graded increases in activity[34].

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CHRONIC FATIGUE SYNDROME

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild/Moderate	2	Low	Psycho-education	/	B[3,20]
	2	Low	Internet-CBT	/	C[21,27,28]
Moderate/Severe	3	High	Family-Focused CBT	/	A[2,3,5,20,22]
	3	High	CBT	C[26*]	A[22,23,26*,34]
	3	High	CBT + Biofeedback	/	B[1]
Severe	4	High	Multidisciplinary Inpatient Rehabilitation Program	/	B[11,19,22]

* Recommendations for adults

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EATING DISORDERS

WHILST THE MEDIAN AGE OF ONSET IS 12.3 YEARS, PREVALENCE INCREASES WITH AGE.

EATING DISORDERS REPRESENTS GROUP OF DISORDERS CHARACTERISED BY OVER-EVALUATION OF BODY SHAPE AND SIZE AND ATTEMPTS TO CONTROL FOOD INTAKE. THEY INCLUDE ANOREXIA NERVOSA, BULIMIA NERVOSA, BINGE EATING DISORDER AND ATYPICAL EATING DISORDERS.

Prevalence estimates in Scotland are difficult to calculate given the likely numbers who do not seek medical help. Worldwide estimates range from 0.1% and 1%[27] with an average reported rate of around 0.3%[40]. Epidemiological studies typically find a marked gender difference in prevalence although this is shrinking[40].

Historically, in adolescents and young adults around 5–10% of cases have occurred in males[7]. In children between 19–30% of cases have been in boys[10,28,33,39,42]. Whilst the median age of onset is 12.3 years[27], prevalence increases with age. Whilst socio-economic class is implicated, more recent evidence suggests that this may be a mild effect, with confounding variables of culture and family factors that have not been adequately accounted for in earlier research[27].

Over the long-term recovery is seen in 50-80% of young people, although there are high levels of emerging long-term other mental illness, and 10-20% will have a poor outcome[27]. Mortality rates for AN range from 2.16% to 8.3%, and increases with length of follow-up. The risk to physical health in the

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short and long-term has meant that randomised controlled trials of interventions are not perceived as safe to conduct. The result is a paucity of good quality research to guide best practice[27]. The NICE (2004) Guidelines[58] identify this as a priority for future research.

THERE IS INCREASING EVIDENCE FOR FAMILY-BASED THERAPIES IN THE TREATMENT OF ADOLESCENT AN OVER INDIVIDUAL TREATMENTS,

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ANOREXIA NERVOSA

NHS QIS GUIDELINES[60] RECOMMEND INDIVIDUALISED CARE AND TREATMENT BASED ON INDIVIDUAL NEEDS AND NOT ON ARBITRARY TARGETS FOR WEIGHT GAIN OR NUMBER OF SESSIONS OF THERAPY. THE JUNIOR MARSIPAN REPORT[61] OUTLINES BEST PRACTICE BASED GUIDELINES FOR MANAGEMENT OF CHILDREN AND YOUNG PEOPLE WITH EATING DISORDERS INCLUDING RISK MANAGEMENT, LOCATION OF CARE, AND MANAGEMENT ACROSS SECTORS.

THERE IS PRELIMINARY EVIDENCE THAT SHORTER HOSPITALIZATIONS FOR MEDICAL STABILISATION (MS) OF WEIGHT WHEN COMBINED WITH FBT HAS SIMILAR OUTCOMES TO LONGER HOSPITALIZATION FOR WEIGHT RESTORATION

There is increasing evidence for family-based treatment (FBT (manualised treatments, including the Maudsley Model[18,52], that directly target the eating disorder) of adolescent Anorexia Nervosa (AN) over individual treatments, particularly in long-term maintenance of treatment gains and notably low attrition rates – a common problem in ED trials[14,36]. Further, moderator analyses of AN patients with more severe eating pathologies show benefit from FBT in comparison to individual therapies[48]. Although no specific Family Therapy model has been proven to be more effective, a 'separated' form of FBT may be more effective when treating young people that exhibit obsessive compulsive tendencies[2], where there is high expressed emotion, or where they cannot tolerate conjoint work. This reflects that a choice of psychological treatments for anorexia nervosa should be available as part of mental health services. Brief Reward Programmes are effective when used for short-term weight gain limited to 4-5kg to minimise the punitive element[4,8]. Regular physical monitoring is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration[56]. Systematic evaluations of supervised physical exercise following weight restoration in

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adolescents with anorexia or bulimia have found no adverse effects and appears to be safe[59,73].

Specialist inpatient care that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions may be required, but there is no evidence that it is superior to out-patient treatment[56]. There is preliminary evidence that shorter hospitalisations for medical stabilisation of weight when combined with FBT has similar outcomes to longer hospitalisation for weight restoration (WR) + FBT[49]. For severe AN, even if patient is hospitalized for medical stabilisation or weight restoration, out-patient FBT should be offered following patient's release from inpatient services[25,51]. Services should be as close to home as possible to allow families to maintain links[8].

THERE IS PRELIMINARY EVIDENCE THAT SHORTER HOSPITALISATIONS FOR MEDICAL STABILISATION (MS) OF WEIGHT WHEN COMBINED WITH FBT HAS SIMILAR OUTCOMES TO LONGER HOSPITALISATION FOR WEIGHT RESTORATION

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ANOREXIA NERVOSA

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild	1/2	Low	Advice, self-help groups and internet resources	/	C[1]
Moderate/Severe	3	High	Family-based treatment (FBT)	A[43,51,58]	A[25,43,51,53,58]
	2-4	High	A 'separated' model of FBT (see narrative)	B[17,43]	A[17,18,19,43]
	2-4	High	Behavioural interventions (Brief Reward Programmes)	B[43]	B[9,43]
	2-4	High	CBT/CBT-E (may be in combination with parental counselling)	/	C[26,32]
Moderate/Severe	3/4	High	Adolescent Focused Therapy/Ego-oriented Individual Therapy	/	B[54,64]
	4	High	Specialist inpatient care in combination with psychosocial interventions. **No evidence that it is superior to out-patient treatment[31]	B[58]	B[58]

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BULIMIA NERVOSA, OVEREATING AND ATYPICAL EATING DISORDERS

BULIMIA NERVOSA MAY HAVE A BETTER PROGNOSIS IF TREATED EARLY

BULIMIA NERVOSA

SUB-DIAGNOSTIC CLINICAL SYMPTOMS ARE MORE COMMON WITH AROUND 2-3% OF TEENAGERS EXPERIENCING CLINICALLY SIGNIFICANT SYMPTOMS OF BULIMIA NERVOSA (BN) BUT NOT MEETING FULL CRITERIA FOR DIAGNOSIS[20,45].

Most patients with bulimia nervosa can be managed on an outpatient basis[41, 57, 60], with less than 5% requiring inpatient care[22]. Care should be tailored to individuals rather than a rigid pattern or treatment[60] Bulimia nervosa may have a better prognosis if treated early[48].

Interpersonal Psychotherapy (IPT) has a growing evidence base in adults[3,21] and may be considered as an alternative to CBT, but can take longer to achieve results. CBT has the strongest evidence but much of this is derived from adult studies with a small number of RCTs in adolescents confirming efficacy[49]. FBT has shown equivalent outcomes in two RCTs but at significantly greater economic cost to services.

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BINGE EATING DISORDER

OVEREATING ASSOCIATED WITH OTHER PSYCHOLOGICAL DISTURBANCE (ICD-10), OR BINGE EATING DISORDER (BED:DSM-V AND LIKELY ICD 11) IS MARKED BY EPISODES OF LOSS OF CONTROL EATING, BUT IT DIFFERS FROM BULIMIA NERVOSA BECAUSE INDIVIDUALS DO NOT ENGAGE IN THE SAME EXTREME WEIGHT CONTROL MEASURES (I.E. PURGING) FOLLOWING A BINGE. WHILE SOME VALIDATION STUDIES HAVE INDICATED THAT BN AND BED[21] MAY REPRESENT THE SAME DISORDER ON A SINGLE CONTINUUM[29], A STUDY OF A LARGE COMMUNITY SAMPLE INDICATED THAT BN IS ASSOCIATED WITH SIGNIFICANTLY POORER OUTCOMES IN COMPARISON TO BINGE EATING.

SOME VALIDATION STUDIES HAVE INDICATED THAT BN AND OVEREATING MAY REPRESENT THE SAME DISORDER ON A SINGLE CONTINUUM

Overeating typically does not reach the severity of a 'disorder' other than in the context of obesity, particularly when the disordered eating affects the individual's ability to lose weight[37].

In the general population, the prevalence of BED has been estimated at approximately 1-3%[34,33], but these statistics are out-of-date and do not reflect the rapidly developing problem of obesity at a population level. Debate about whether obesity should be classified as a mental health problem as well as a public health issue may have contributed to the relative lack of research in this area to establish prevalence and nature, as well as interventions, in comparison to other eating disorders.

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In the context of psychological treatments for BED, individuals should be informed that these treatments typically target binge eating, but have a limited effect on weight. Interventions for comorbid obesity may be offered concurrently or consecutively with psychological treatments for BED[58]. Cognitive Behavior Therapy for Binge Eating Disorder (CBT-BED) should be adapted to be developmentally appropriate and should attempt to involve parents or carers.

INTERVENTIONS FOR COMORBID OBESITY MAY BE OFFERED CONCURRENTLY OR CONSECUTIVELY WITH PSYCHOLOGICAL TREATMENTS FOR OVEREATING

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LITTLE RESEARCH HAS ASSESSED TREATMENTS FOR THIS GROUP OF YOUNG PEOPLE

ATYPICAL EATING DISORDER

ATYPICAL EATING DISORDERS OR PARTIAL ED SYNDROMES OCCUR IN APPROXIMATELY 2-5% OF YOUNG FEMALES[34] AND ARE THE MOST COMMONLY DIAGNOSTIC GROUP IN CLINICAL PRACTICE[21]

In spite of this, due to the heterogeneity of their clinical presentations, little research has assessed treatments for this group of young people. In the absence of evidence to guide the management of atypical eating disorders, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder[58].

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BULIMIA NERVOSA, OVEREATING AND ATYPICAL EATING DISORDERS

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Subclinical/Mild	1/2	Low	Evidence-based self-help programme**	/	B[12*,58,66,69*,74*]
	2	Medium	Guided CBT self-help**	/	B[1,6,46]
			Bulimia		
Moderate/Severe	3	High	Cognitive behaviour therapy for bulimia nervosa	C[58]	A[3*,6*, 22*,23*,49,50*,58*,67*,76]
	3	High	Family-Based Therapy (FBT-BN)	/	B[46,66]
	3	High	Evidence-based self-help programme**	/	B[12*,58,66,69*,74*]
	3	High	Guided CBT self-help**	/	B[46, 66,74*]
	3	High	Interpersonal Psychotherapy (IPT-BN)	/	C[3*,22*,58 *]
			Binge Eating Disorder		
Moderate/Severe	3	High	Cognitive Behavior Therapy for Binge Eating Disorder (CBT-BED)	C[58]	B[13,16,24*,35]
	3	High	Interpersonal Therapy	/	B[35,55,70,71]
	3	High	Family Therapy		C[35,62]

* Evidence from adult studies and adult recommendations.

** Additional encouragement and support from healthcare professional(s) may improve outcomes3.

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INSOMNIA

ABNORMAL OR DISORDERED SLEEP CAN BE CHARACTERISED BY DELAYED SLEEP ONSET, PROLONGED NIGHT TIME WAKENINGS OR DIFFICULTIES ACHIEVING ADEQUATE RESTORATIVE SLEEP. DEVELOPMENTAL, ENVIRONMENTAL AND SOCIAL FACTORS HAVE BEEN IDENTIFIED AS KEY INDICATORS AND RISK FACTORS FOR UNDERSTANDING AND TREATING DISORDERED SLEEP ACROSS BOTH CHILDHOOD AND ADOLESCENCE.

Longitudinal studies have shown problematic sleep presenting in childhood is significantly associated with poorer sleep in adolescence[19]. Timely interventions are required as the immediate and long term effects of disordered sleep are thought to negatively impact on mood regulation, mental health, family and peer relationships, learning and academic attainment[1,2,16,19]. Therefore the recognition and management of sleep disorders in childhood and adolescence is important in achieving positive treatment outcomes and relapse prevention.

Psychological interventions modelled to address disordered sleep have been developed from the established evidence from adult populations and emerging outcomes from child and adolescent studies. There is growing evidence for the efficacy of multi-modal approaches that encompass psycho-education for sleep (e.g. sleep hygiene practices) and sleep disorders, problem solving and skills based behavioural training and the development of relaxation and cognitive coping strategies.

THE IMMEDIATE AND LONG TERM EFFECTS OF DISORDERED SLEEP ARE THOUGHT TO NEGATIVELY IMPACT ON MOOD REGULATION, MENTAL HEALTH, FAMILY AND PEER RELATIONSHIPS, LEARNING AND ACADEMIC ATTAINMENT

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Further, another multi-modal approach within an evidence-based clinic combined both behavioural interventions and CBT-I (CBT adapted for insomnia) in treating both children and adolescents[3].

One RCT combined CBT-I with Bright Light Therapy in the treatment of adolescent insomnia, with the latter aimed at addressing the changes in circadian rhythm patterns associated with the developmental phase of adolescence[6]. This RCT yielded moderate-to-large improvements, with well-maintained gains at 6 months.

ONE RCT COMBINED CBT-I WITH BRIGHT LIGHT THERAPY IN THE TREATMENT OF ADOLESCENT INSOMNIA

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INSOMNIA

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child*	Adolescent
Subclinical/Mild	1/2	Low	School-based prevention and early intervention well-being programme	/	B [4,13]
Mild/Moderate	2/3	Low	Parenting / Family Psycho-education and Behavioural Programmes***	A [7,8,9,10**,15]	C [9]
Moderate/Severe	3	High	Individual Cognitive Behavioural Therapy (CBT-I) with Parental/ Family Involvement	B [14]	B [6****]
	3	High	Group Cognitive Behavioural Therapy with Integrated Parental/ Family Involvement	B [18]	C [5,17]
	2/3	Low	Brief Parental Behavioural Extinction Intervention	B [9,12]	/
	2/3	Medium	Internet delivered CBT-I	/	C [5]

*Recommendations for children do not include infancy.

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**See Morgenthaler et al (2006)[13] for discussion on guidelines for practice.

***Also supported in infants[11].

****CBT-I plus Bright Light Therapy [6].

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MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

FOR CHILDREN AND ADOLESCENTS DEPRESSION IMPACTS SIGNIFICANTLY ON THEIR ABILITY TO MEET KEY DEVELOPMENTAL TASKS SUCH AS FORMING CLOSE PEER RELATIONSHIPS AND FIRST ROMANTIC RELATIONSHIPS

AT ANY POINT IN TIME ABOUT 1 IN 100 CHILDREN AND 1 IN 33 ADOLESCENTS ARE LIKELY TO BE SUFFERING FROM DEPRESSION[4]. PUBLISHED RESEARCH INDICATES THAT THE CUMULATIVE PREVALENCE OF DEPRESSION UP TO AGE 18 IS 28%: 35% FOR GIRLS AND 19% FOR BOYS[42, 43]. DEPRESSIVE DISORDERS ARE EQUALLY FREQUENT IN BOYS AND GIRLS UNTIL PUBERTY[5], AFTER WHICH THERE IS A PREDOMINANCE OF GIRLS (APPROXIMATELY 2:1)[1, 13, 36, 41, 72].

The course and causes of depression in children and adolescents is varied but for many young people will be severe with several episodes of depression and associated self-harm and/or suicide. Without treatment about 10% recover spontaneously within three months but at 12 months around 50% remain clinically depressed[57].

For children and adolescents depression impacts significantly on their ability to meet key developmental tasks such as forming close peer relationships and first romantic relationships, achieving academic and vocational goals and successfully leaving home. Those young people who have an episode of depression before age 15 and a second episode before 20 are likely to have more

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severe, chronic, suicidal depressions, greater anxiety comorbidity, worse social functioning at 15 years, and poorer psychosocial outcomes at 20[28].

IN COMMUNITY STUDIES OF DEPRESSION, COMORBIDITY WITH OTHER MENTAL HEALTH PROBLEMS IS COMMON

In community studies of depression, comorbidity with other mental health problems is common. The most frequently occurring co-morbid disorders are dysthymia and anxiety disorders, followed by disruptive disorders. Depressive disorders often develop after the other disorders are established[7, 27, 44].

The strongest evidence exists for individual psychological treatments, namely CBT and Interpersonal Pstchotherapy (IPT). Family and Group treatment have a less robust evidence base. Brief therapies and computerised CBT have an emerging evidence base. An emerging evidence base for group based interventions may lead to a future recommendation for group CBT in children and young people with mild depression and could be provided by appropriately trained professionals in primary care, schools, social services and the voluntary sector or in tier 2 CAMHS[58].

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MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Sub-clinical/Mild	2	High	Group CBT	B[17,25,30,49,55, 56,57,58,73]	B[9,12,26,30,55, 56, 57,58,59,64,67, 73,77,78]
	1/2	High	Computerised CBT	B[51,58,65]	B[2,51,65,66]
	2	High	CBT (brief-8 sessions)	B[71]	C[67]
	1/2	Low	Cognitive Bibliotherapy	/	B[3,9,57]
	1/2	Low	Watchful Waiting (further assessment within 2 weeks)	C[57]	C[57]
	2	Low	Relaxation	/	C[75]
	1/2	High	Non-directive Therapy	/	C[72]
Moderate/Severe	3/4	High	CBT	A[11,12,14,19,22,24,29,40,57, 60,61,63,73,74,75]	A[8,11,12,13,19,22,24,29,40,49, 57,60,61,63,65,73]
	3/4	High	Interpersonal Psychotherapy for Adolescents (IPT-A)	/	A[18,19,22,25,30, 52,53,54,57,65]
	3/4	High	Systemic Family Therapy/ Other Family Therapies	B[6,8,57,69]	B[8,57,69]
	3	High	Psychodynamic Psychotherapy & Psychoanalysis	B[33,69,70]	B[13, 43, 44]
	3/4	High	Psychological therapy in combination with SSRIs should be used when a psychological intervention alone is not effective and there is no response within 6-8 weeks.	C[57, 58]	B[57, 58]
	3/4	High	Antidepressant medication should not be used for the treatmentn and young people with moderate to severe depression without concurrent treatment with a psychological therapy.	B[21,57]	B[21,33,34,47,48,57]

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SCHIZOPHRENIA / PSYCHOSIS

THE EARLIER THE ONSET THE MORE SEVERE THE DISORDER. EARLY DETECTION AND TREATMENT ARE IMPORTANT IN REDUCING THE EFFECTS

THE RANGE OF PSYCHOSES AND SCHIZOPHRENIA ARE CHARACTERISED BY DISTORTIONS OF THINKING AND PERCEPTION AND A DISTORTED AFFECT. THE SYMPTOMS ASSOCIATED WITH THESE DIFFICULTIES ARE KNOWN AS POSITIVE SYMPTOMS. NEGATIVE SYMPTOMS SUCH AS APATHY, SOCIAL WITHDRAWAL, POVERTY OF SPEECH AND INCONGRUENT EMOTIONAL RESPONSES MAY ALSO BE PRESENT. SCHOLASTIC ABILITY AND SELF-CARE MAY ALSO BE AFFECTED[8].

There are very few studies determining the incidence of schizophrenia in childhood and adolescence. One study identified the ages at first hospitalisation being 15-25 for males and 25-35 for females, although some females were identified before 25 years[17]. The peak ages for onset are 13-30 years[3]. In another study, the prevalence in children was identified as much lower than adolescents, being 2 per 10,000 children under 12 years[5,6].

The onset of Schizophrenia is therefore rare before 13 years of age[3]. The earlier the onset the more severe the disorder[5, 6.] Early detection and treatment are important in reducing the effects of the disorder[7].

There has been an increase in research investigating the benefits of psychological interventions for patients with an early onset or adolescent onset psychosis, and emerging evidence examining psychological treatments in children. However, most of these studies span client groups between

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teenage years and early twenties. The first-line psychological treatment suggested for all stages and age ranges of individuals diagnosed with schizophrenia is individual cognitive behavioural therapy, with or without the inclusion of family therapy. However, psychological treatments produce more effective results when delivered in conjunction with psychotropic medication, and it is suggested psychotropic medications always accompany set interventions[14].

For children still of school age it is also recommended to liaise with school to address educational needs and stigmatisation or provide adjunctive therapies[10, 14, 15]. Additionally, social skills training interventions have been shown to be efficacious, but is not recommended as an intervention on its own but rather as a component of a wider treatment plan[14, 15]

PSYCHOLOGICAL TREATMENTS PRODUCE MORE EFFECTIVE RESULTS WHEN DELIVERED IN CONJUNCTION WITH PSYCHIATRIC MEDICATIONS

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SCHIZOPHRENIA / PSYCHOSIS

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Pre Diagnosis	2/3	Low	Individual CBT with or without family intervention, including problem solving and crisis management work	A[14]	A[14]
Moderate	3/4	High	Cognitive Behavioural Therapy for: Prodromal symptoms	/	A[13*,19*]
	3/4	High	Transition	/	B[9*,13*,19*]
	3/4	High	Functioning	/	B[18,19]
	3/4	High	Stress Relief	/	A[14]
	3/4	High	Family Intervention with or without Individual CBT	A[14]	A[14,15*]
Severe	3/4	High	Cognitive Behavioural Therapy for: acute symptoms	/	B[4*,16*,18]
	3/4	High	Functioning	/	A[4*,18]
	3/4	High	Mood related to first episodes	/	B[4*,17]
	3/4	High	Family Intervention with or without Individual CBT	A[18,19**]	A[1*,7*,15*,14]
	2-4	Low	Arts Therapies for Alleviation of Negative Symptoms	C[14]	C[14]

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SELF-HARM AND INTERPERSONAL DIFFICULTIES

WHERE ADOLESCENTS REPORTED A LIFETIME HISTORY OF SELF-HARM, GIRLS WERE THREE TIMES MORE LIKELY TO REPORT SELF-HARM THAN BOYS

IN AN INTERNATIONAL COMMUNITY SAMPLE OF YOUNG PEOPLE 13.5% OF FEMALES AND 4.3% OF MALES REPORTED AN EPISODE OF SELF-HARM WITHIN THEIR LIFE TIME, AND 8.9% AND 2.6% RESPECTIVELY REPORTED AN EPISODE DURING THE LAST YEAR[21].

In a recent study in England, 27% of young adolescents reported thoughts of self-harm and 15% reported at least one act of self-harm[41]. Adolescents surveyed in Scotland reported slightly higher levels of self-harm during the last year: 13.6% of girls and 5.1% of boys[30], similar to the prevalence reported in England[12]. Overall 12% of self-harm episodes reported in the previous year resulted in presentation to hospital[21,30] while of those who self-harmed, 18% had sought help for psychological difficulties of anxiety or depression[41]. Where adolescents reported a lifetime history of self-harm, girls were three times more likely to report self-harm than boys[30,21,12]. Between a quarter and a half of those completing suicide have previously self- harmed[11]. In a study for resistant depression in adolescence, self-harm history predicted both future self-harm incidents and suicidal attempts and was a stronger predictor of future attempts than was a history of attempts[2].

Several therapeutic models indicate positive outcomes in the treatment of self-harm yet the evidence base for efficacious interventions for self-harm for children and adolescents is extremely limited and in most cases insufficient to make any negative or positive treatment recommendations[32].

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NICE (2013)[26] suggests Rapid Response Treatment in A&E, while highlighting the limited available evidence. Based on the available research, rapid response treatment (including assessment, formulation and intervention include identifying the nature of crisis, the precipitating events, and the strengths and weaknesses of the adolescent's support system, and reframing any misconceptions, maladaptive behaviours, and communication patters that contributed to the client's or family's stress) appears to be promising in improving adherence of subsequent treatment as well as in reducing suicide-related outcomes[28]. Additionally, in a clinical guideline for the long term management of self-harm, NICE (2011)[25] suggests considering 3-12 sessions of psychological treatment that "should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements", a recommendation that applies to both adults and adolescents.

In Scotland, a National Strategy and Action Plan, Choose Life (www.chooselife.net), has set a target to reduce death resulting from suicide by 20% by 2013. Choose Life co-ordinators are tasked with agreeing, developing and implementing a local suicide prevention plan. This work includes awareness raising programmes such as SuicideTALK and SafeTALK which are available to all, Applied Suicide Intervention Skills Training (ASIST) aimed at professionals, volunteers and informal helpers, and Skills Based Training on Risk Management (STORM) which is intended for frontline workers in health social and criminal justice services. Based on statistics measured between 2011 and 2013, the target has almost been reached, with a 19% fall in suicide rates between 2000-2002 and 2011-2013. The percentage differs by gender, with a 21% fall in suicide rate for males, and 14% for women.

A NATIONAL STRATEGY AND ACTION PLAN, CHOOSE LIFE (SCOTTISH EXECUTIVE,2002), HAS SET A TARGET TO REDUCE DEATH RESULTING FROM SUICIDE BY 20% BY 2013

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SELF-HARM AND INTERPERSONAL DIFFICULTIES

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation
				Adolescent
Moderate/Severe	A&E	High	Rapid Response Out-Patient Team	B[8,20, 24, 26,28]
	3/4	High (12 sessions)	Cognitive Behavioural Therapy for deliberate self- harm + treatment as usual	B[31,39,40,42]
	3/4	High (min. 6 Sessions)	Developmental Group Psychotherapy (containing elements of CBT, DBT and psychodynamic approaches	C[9,22,34,39]
	3/4	High	Attachment-Based Family Therapy	C[6]
	3/4	High	Dialectical Behaviour Therapy	C [7,17,19,22,43]
	3/4	High	Problem-Solving Therapy	C[29]
	3/4	High	Multi-Systemic Therapy	C[16]
	3/4	High	Mentalisation based treatment	C[38]

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SUBSTANCE USE DISORDERS

SUBSTANCE USE DISORDER (SUD) IS MEASURED ON A CONTINUUM OF SEVERITY RANGING FROM MILD TO SEVERE, WHEREBY 2-3 SYMPTOMS INDICATE MILD SUD AND 6+ INDICATE SEVERE. THE DSM-5 RECOGNISES ALCOHOL, CANNABIS, PHENCYCLIDINE, OTHER HALLUCINOGENS, INHALANTS, OPIOIDS, SEDATIVE, HYPNOTIC, OR ANXIOLYTICS, STIMULANTS, TOBACCO AND OTHER AS SUBSTANCES FOR WHICH A PERSON CAN DEVELOP AND MAINTAIN A SUBSTANCE USE DISORDER FOR[3].

Although substance abuse and dependence has been extensively researched across a wide range of human populations, SUD in childhood and adolescence has previously been neglected. However, prevalence rates of co-morbid and stand-alone SUD within youth have increased within the past decade, accompanied by an increased need for research and treatment recommendations.

Although there is no gold-standard treatment of SUD for children and adolescents to date, multi-component interventions, often including family-based, behavioural and motivational components in addition to CBT are often efficacious in adolescent populations. Emerging research has also suggested that culturally sensitive alterations to interventions increase efficacy and treatment gains. Further, school-based interventions have been proven effective in adolescents and act as an easily accessible, cost-effective and feasible means of treatment[1, 14, 15, 16, 4].

EMERGING RESEARCH HAS ALSO SUGGESTED THAT CULTURALLY SENSITIVE ALTERATIONS TO INTERVENTIONS INCREASE EFFICACY AND TREATMENT GAINS

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Another increasing area of interest is preventative measures geared towards decreasing probability of development of SUD, heavy drinking and heavy drug use among youth, including multi-component and school-based interventions[9,16]. Many preventative and brief-intervention measures include family or parent components, and some evidence suggests a greater success rate with inclusion of such components in preventative interventions[15,16,7].

MANY PREVENTATIVE AND BRIEF-INTERVENTION MEASURES INCLUDE FAMILY- OR PARENT- COMPONENTS

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SUBSTANCE USE DISORDERS

				Alcohol	Other	School-Age	Adolescent
Mild, moderate and severe	2-4	High	Individual CBT, with or without medication			A[1, 2]	A[1, 2]
	2-4	High	Group-based CBT	✓	✓	/	A[2]
	2-4	High	Multicomponent Interventions: often including family-based or multisystemic programs, CBT, BI, MI	✓	✓	A[1]	A[1, 7, 5, 6]
	2-4	High	Family/Systemic-base Therapy or Prevention (adolescent)	✓	✓	A[7, 8]	A[10, 2, 7, 8, 5]
	2-4	High	Motivational Interviewing	✓	✓	B[11]	B[11,12, 2]
	2	High	School-based Preventative Measures Interventions	✓		A[13,14,15]	/

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TRAUMA: POST-TRAUMATIC STRESS DISORDER (PTSD)

LIFETIME PREVALENCE (TO AGE 18) OF POST TRAUMATIC STRESS DISORDER (PTSD) IN THE GENERAL POPULATION HAS BEEN FOUND IN 8% OF FEMALES AND 2.3% OF MALES[60] WITH 1.5% IN TOTAL EXPERIENCING SEVERE IMPAIRMENT AS A CONSEQUENCE. INCIDENCE INCREASES STEADILY WITH AGE, AS WOULD BE EXPECTED IN A CONDITION TRIGGERED BY LIFE EVENTS.

Studies of at-risk child populations have demonstrated varying prevalence rates from around 3%[36] to 36%[32]. PTSD occurs across ethnic and cultural groups, but may be manifested in different ways[2,21,23,56].

Cognitive theories of childhood PTSD highlight the need to consider how developmental stages (e.g. language development) influence how a child may encode and resolve a traumatic experience[73]. Due to the implications of the cognitive social and emotional development of the affected child, there is no clear consensus about the typical presentation of PTSD in children[1,7,38,73.] Younger children may display fewer re-experiencing and little avoidance behaviour[32], and more behavioural symptoms (play re-enactment, aggression)[74,80]. Intervention for co-morbid problems such as depression[1], anxiety and substance use[6,9] in children and you g people who have experienced trauma are as important as for PTSD[34].

THEORIES OF CHILDHOOD PTSD HIGHLIGHT THE NEED TO CONSIDER HOW DEVELOPMENTAL STAGES (E.G. LANGUAGE DEVELOPMENT) INFLUENCE HOW A CHILD MAY ENCODE AND RESOLVE A TRAUMATIC EXPERIENCE

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POST-TRAUMATIC STRESS DISORDER (PTSD)

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild	1	Low	Following a traumatic incident, parents/carers should be informed of the possibility of development of PTSD with symptoms described. If symptoms persist beyond one month, contact GP.	C[61]	C[61]
	2/3	Low	Stepped-care model may be beneficial: including psycho-education, provide individual coping skills, and trauma exposure; provision of multiple sessions to at-risk children	A[5,47,49]	A[5,47,49]
Moderate-High	3/4	High	Trauma-focused developmentally appropriate CBT for children aged over 7 years	A[14,19,39,48,61,75,76]	A[8,14,19,39,48,61,75,76]
Moderate	3/4	High	Eye Movement Desensitization & Reprocessing (EMDR)	C[2,30,37,38,61,79]	A[2,22,30,38,61,79]
	3/4	High	Group based grief/trauma-focused psychotherapy	C[30]	B[30,59,63]
	3/4	High	Narrative Therapy	C[39]	C[39]
	3/4	High	Anxiety Management training/ Exposure & parent training	C[30,52]	C[30]

*'level of severity' refers to the symptomatology with which a child or young person presents, not the severity of the traumatic event.

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TRAUMA: COMPLEX TRAUMA

'COMPLEX TRAUMA' CAN ARISE FROM A CHILD'S EXPOSURE TO MULTIPLE AND/OR CHRONIC TRAUMAS, SUCH AS WAR, CHILDHOOD MALTREATMENT AND DOMESTIC ABUSE, WHICH TYPICALLY RESULT IN A WIDE CONSTELLATION OF DIFFICULTIES NOT ADEQUATELY CAPTURED BY THE DIAGNOSIS OF PTSD[10,15].

Complex trauma is not yet a recognised diagnosis, although it is being considered for inclusion in ICD-11. Consequently, empirical evidence centres on specific types of trauma. Sexual trauma has a specific and robust evidence base and is therefore considered separately. Refugee children are also considered due to their individual characteristics.

While sexual and physical assault can and often are parameters of complex trauma, it is important to note that these overt forms of abuse can co-occur with neglect[57]. Further, sustained forms of neglect can by themselves also lead to complex trauma[69]. A study estimating the prevalence of child abuse and neglect in the UK found that 11% of respondents had experienced sexual abuse involving contact, 7% reported physical abuse, and 6% emotional abuse. With respect to neglect, 6% reported absence of care, and 5% an absence of supervision[57].

The response of the victimised child's caregiver(s), particularly the mother, is one of the most critical mediating factors in determining a child's adaptive response to the victimisation[15,31]. It follows that many psychological treatments target the child and their carer[20]. Current expert opinion has

THE RESPONSE OF THE VICTIMISED CHILD'S CAREGIVER(S), PARTICULARLY THE MOTHER, IS ONE OF THE MOST CRITICAL MEDIATING FACTORS IN DETERMINING A CHILD'S ADAPTIVE RESPONSE TO THE VICTIMISATION

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advocated a phase-based approach to treating children who have suffered complex trauma, though systematic empirical evidence is needed to substantiate this approach[13,51]. A key element of this approach is to facilitate when and how to address trauma memories so that the child or young person has sufficient safety and stabilisation in place to make use of intervention without becoming overwhelmed or re-traumatised.

A KEY ELEMENT OF THIS APPROACH IS TO FACILITATE WHEN AND HOW TO ADDRESS TRAUMA MEMORIES SO THAT THE CHILD OR YOUNG PERSON HAS SUFFICIENT SAFETY AND STABILISATION IN PLACE

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SEXUAL TRAUMA

IDENTIFICATION AND MANAGEMENT OF RISK, AND ENSURING CHILDREN'S SAFETY, IS CENTRAL TO ANY TREATMENT RESPONSE TO SEXUAL TRAUMA.

Estimates of prevalence and incidence of sexual trauma vary widely due to methodological problems including how it is defined[54]. International meta-analytic data found approximately 20% of females and 8% of men had experienced some type of sexual abuse by the age of 18[66]. Identification and management of risk, and ensuring children's safety, is central to any treatment response to sexual trauma. In cases of intra-familial abuse, it is of pivotal importance that the offender does not live in the same location or in close proximity to the child victim, and that the offender undertake a treatment programme[24].

It has been suggested a multi-modal approach to treatment is core to this area, including use of specific treatment approaches where indicated (e.g. anxiety management, social skills, anger, problem solving skills based work). Therapeutic intervention with sexually traumatized children/young people (and those who have experienced sexually inappropriate treatment) should not be in isolation and should involve liaison with their wider system. Education, consultation and support to the system are an extremely important part of intervention in most cases. This can happen whether or not the child/young person is receiving individual intervention. Meta-analytic data suggest that longer interventions confer additional benefit to children on a variety of outcomes, and that group and individual treatment modalities are equally effective[41,77]. Treatment engagement/retention is notably poor among foster children, but evidence-based engagement strategies directed at foster youth and foster parents can be successfully implemented to improve treatment retention[24]. Many treatment modalities, including TF-CBT, treat both the child and non-offending parent concurrently[20]. TF-CBT is the best-evidenced treatment for this population.

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REFUGEE CHILDREN

Refugee children who have resettled in high-income Western countries are at increased risk for mental health difficulties, with exposure to violence being a key risk factor that often displays a dose-response relationship[28].

In a systematic review of serious mental health problems among resettled refugees in Western countries, the prevalence of PTSD among children was estimated at 11% (7-17%)[29]. Unaccompanied asylum seeking children are at particularly high risk of mental health difficulties[27].

The current evidence-base for psychological treatment options for children is of very low quality[68]. Tailored CBT, testimonial psychotherapy, narrative exposure therapy and EMDR have all had positive gains in small, uncontrolled studies[27,28,65], but there is a need for more robust evidence to allow a specific recommendation to be made.

THE CURRENT EVIDENCE-BASE FOR PSYCHOLOGICAL TREATMENT OPTIONS FOR CHILDREN IS OF VERY LOW QUALITY

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COMPLEX TRAUMA

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
			Complex Trauma**	Child	Adolescent
Moderate/Severe	3	High	Trauma-focused CBT	B[51]	B[51]
	3/4	High	Real Life Heroes[59]: Attachment-centered intervention	C[44,45,46]	C[44,45,46]
	3	High	Trauma-focused Art Therapy	/	C[53]
			Sexual Trauma**		
Moderate/Severe	3	High	CBT/Trauma-focused CBT (Group/Individual)*	A[11,12,14,18,19,20,39,48,51,54,55,59,61,70,71]	A[11,12,14,18,19,39,51,54,55,61,70,71]
	3	High	Risk Reduction through Family Therapy	/	C[16]
	3	High	Early intervention parent/carer abuse specific therapy (where not perpetrator of abuse)	B[4,16,18,35,41,49,70]	/
	3	High	Art Therapy	B[67,68,69]	B[67]
	3	High	Eye Movement Desensitization and Reprocessing	/	C[43]
	3	High	Child-Parent Psychotherapy	B[37]	/
	3	High	Psychodynamic individual therapy	/[64]	/[64]
	3	High	Longer term child-parent parallel treatment	C[41,77]	C[41,77]
	3	High	Play therapy	C[41]	C[41]
	3	High	Cognitive Processing Therapy	/	C[50]
	3	High	Prolonged Exposure Therapy	/	B[33]

*'level of severity' refers to the symptomatology with which a child or young person presents, not the severity of the traumatic event.

** The sections on sexual trauma and complex trauma are not mutually exclusive

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COMPLEX TRAUMA

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
			Refugee Children Exposed to War	Child	Adolescent
Moderate/Severe	3	High	Narrative Exposure Therapy (KIDNET)	C[72]	C[72]
	2	High	School-based Group CBT	C[26]	C[26]
	3	High	Group-based TF-CBT	/	C[59]

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NEUROPSYCHOLOGY: ACQUIRED BRAIN INJURY (ABI)

TRAUMATIC BRAIN INJURY (TBI) IS THE MOST COMMON CAUSE OF DEATH OR DISABILITY IN CHILDHOOD

ABI IS A BROAD TERM COVERING NEUROLOGICAL DIAGNOSES THAT INVOLVE SOME LEVEL OF COGNITIVE DYSFUNCTION. THE MOST TYPICAL CONDITIONS INCLUDE TRAUMATIC BRAIN INJURY, CHILDHOOD CANCER, CENTRAL NERVOUS SYSTEM INFECTION AND STROKE. A SIGNIFICANT AND CONTROVERSIAL CAUSE OF BRAIN INJURY IN INFANTS ALSO RELATES TO NON-ACCIDENTAL INJURIES. ALL OF THESE CONDITIONS PUT CHILDREN AT SIGNIFICANT RISK OF DIFFICULTIES IN TERMS OF INFORMATION PROCESSING, LANGUAGE, VISUO-SPATIAL SKILLS, MEMORY, ATTENTION, EXECUTIVE FUNCTIONING, EMOTIONAL AND BEHAVIOURAL REGULATION. THESE DIFFICULTIES ARE THEN LIKELY TO IMPACT ON MENTAL HEALTH, EDUCATIONAL ATTAINMENT, EMPLOYMENT AND INDEPENDENT LIVING SKILLS.

These difficulties are then likely to impact on mental health, educational attainment, employment and independent living skills. Traumatic brain injury (TBI) is the most common cause of death or disability in childhood [25] and a recent UK study estimates that every year, 280 children per 100,000 require hospitalisation for 24 hours or more following a TBI [21]. Almost two thirds of these children (63%) are between 5–15 years of age at the time of the injury and are likely to be in mainstream education. The prevalence of childhood cancers likely to lead to neurocognitive impairment

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(leukaemia, brain and spinal tumour) is around 423 per million (NICE, 2005). There continues to be debate about the longer term impacts of mild TBI, which makes up around 90% injuries, with a lack of good quality longitudinal research[31]. However, cross sectional studies, including those recently conducted in Scotland, have reported high rates of cognitive, emotional and behavioural problems, as well as reduced quality of life in children following all severities of TBI[29,34,45,46]. Childhood acquired TBI can often result in 'silent' deficits that do not manifest until a child fails to make the normal developmental gains associated with maturation. Therefore, ensuring longitudinal follow up is essential, particularly for those with more significant injuries. At the moment there are no SIGN/NICE guidelines concerning the post-acute management of ABI in children and adolescents.

TBI CAN OFTEN RESULT IN 'SILENT' DEFICITS THAT DO NOT MANIFEST UNTIL A CHILD FAILS TO MAKE THE NORMAL DEVELOPMENTAL GAINS ASSOCIATED WITH MATURATION

Neuropsychological assessment itself can act as an early intervention, and can be a crucial aspect of developing care and educations plans. Whilst evidence is limited, there are sufficient studies and case reports to suggest that neuropsychological interventions can have a significant positive impact on cognitive[30], academic[9] and adaptive functioning[18]. The inclusion of family- or parent-based components in ABI rehabilitation efforts is increasingly encouraged[16], and has been found to result in end-of-treatment improvements in certain domains[7, 8, 42]. Furthermore, the Amsterdam Memory and Attention Training for Children (AMAT-C)[12, 44], music therapies[4], art-based social therapies[1, 2,] and virtual reality-based interventions[20] are all potentially effective interventions that have all gained recent attention, however still require additional research to determine efficacy.

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NEUROPSYCHOLOGY: ACQUIRED BRAIN INJURY (ABI)

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Mild/Moderate	1-3	High	Problem-solving interventions	A[44]	A[44]
	2/3	Low	Early Counseling and Education	B[37]	B[37]
	2/3	High	Parent or Family-based Skills programs	B[7,8]	/
	3/4	High	Assessment of cognitive impairments, with feedback, liaison and recommendations	B[30,31,32,33]	B[30,31,32,33]
	3/4	High	Cognitive Remediation of attention deficits	B[49]	B[49]
	3/4	High	Metacognitive training for memory deficits	B[17]	/
Moderate/Severe	3/4	High	Cognitive Remediation of / Neuropsychological training for attention deficits	A[9,10,18,41,44,51]	A[9,10,18,44,50,51]
	3/4	High	Metacognitive and process training for memory deficits	A[17,43,51]	A[6,28,38,51]
	3	High	Problem-solving interventions	B[44,13]	A[13,26,27,44,52]
	3/4	High	Assessment of cognitive impairments, with feedback, liaison and recommendations	B[11,22,35]	B[24]
	3/4	High	Metacognitive and cognitive-behavioral training for executive dysfunction	B[19,47]	/
	3	High	Parent or Family-based Skills programs	B[3,8,7]	/

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NEUROPSYCHOLOGY: ACQUIRED BRAIN INJURY (ABI)

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Moderate/Severe	3/4	Low	Motivational Interventions for rehabilitation (i.e. token economies)	B[48]	/
	3/4	High	Training in use of external aids for memory deficits	/	C[18]
	3/4	High	Behavioral intervention for executive dysfunction	/	C[14]
	2-4	High	Educational support	C[40]	/
	3/4	High	Metacognitive training for social skills	/	C[5]
	3/4	High	Cognitive-behavioral therapy for psychological problems	C[39]	C[39]

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NEUROPSYCHOLOGY: EPILEPSY

PSYCHOLOGICAL INTERVENTIONS SUCH AS CBT IN CONJUNCTION WITH ANTI-EPILEPTIC MEDICATION TO CONTRIBUTE TOWARDS IMPROVED QUALITY OF LIFE

EPILEPSY IS THE MOST COMMON SERIOUS NEUROLOGICAL DISORDER, WITH AN ESTIMATED PREVALENCE IN SCOTLAND OF AROUND 4,200 CHILDREN AND YOUNG PEOPLE[13]. AROUND 800 NEW PRINCIPAL DIAGNOSES ARE MADE IN CHILDREN EACH YEAR IN SCOTLAND, ALTHOUGH THE RATE OF MISDIAGNOSIS CAN BE HIGH DUE TO THE COMPLEXITY OF THE CONDITION[13].

The effects of epilepsy extend far beyond having seizures, and include high rates of learning disability, mental health disorder, reduced academic attainment and quality of life (QoL) and social isolation, all of which can extend across the lifespan[14,17].

NICE[14] recommend that neuropsychological assessment should be considered as it is important to evaluate possible learning disability and cognitive dysfunction, with particular emphasis on language and memory function. NICE also recommends psychological interventions such as CBT in conjunction with anti-epileptic medication to contribute towards improved quality of life, and in particular with children with drug-resistant epilepsy.

SIGN guidelines state that around 50% of children with epilepsy require additional support at school and have double the rate of behavioural and psychiatric disorders compared with the general childhood population. Rates of ADHD in epilepsy have been found to be as high as 40%. SIGN recommends that all children with epilepsy should have their behavioural and academic progress

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reviewed, and that those with difficulties should have appropriate educational and psychological intervention.

Children with epilepsy have been found consistently to be more behaviourally disturbed, with lower self-esteem, and to experience poorer academic attainment than children with other chronic diseases of childhood such as diabetes or asthma[6,1]. Some studies have suggested that early neuropsychological assessment can identify those with high risk for academic failure and can potentially lead to improved educational support[3,4]. However, recent research suggests that even those children with normal intellectual ability and moderate seizure control can also have learning problems placing them at risk of poorer attainments[5].

Epilepsy has been associated with markedly reduced quality of life with problems accessing normal social activities, maintaining friendships and coping with mood and behaviour problems[10,11]. There is an emerging evidence base for the effectiveness of group based psychosocial interventions[5,18] along with the development of standardised QoL scales useful in assessing interventions[19], and also for the effectiveness of CBT as an individual treatment[16]. In addition, CBT has also been recommended as an effective treatment for co-morbidities common in epilepsy, such as anxiety and depression[8,12]. Music therapy as an adjunctive therapy has proven efficacious in certain patients, however more robust evidence is still required[9].

EPILEPSY HAS BEEN ASSOCIATED WITH MARKEDLY REDUCED QUALITY OF LIFE WITH PROBLEMS ACCESSING NORMAL SOCIAL ACTIVITIES, MAINTAINING FRIENDSHIPS AND COPING WITH MOOD AND BEHAVIOUR PROBLEMS

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NEUROPSYCHOLOGY: EPILEPSY

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Subclinical-Severe	2/3	Low	Relaxation Therapies as Adjutant to pharmacological treatment	A[15]	A[15]
	3/4	High	cognitive behavioural therapy	A[15, 16]	A[15, 16]
	3/4	High	Neuropsychological assessment	B[3, 4]	B[3, 4]
	3/4	High	Cognitive-behavioural therapy for co-morbid anxiety/depression	B[2,8,12]	B[8,12]
	2-4	Low	Education interventions	B[3,4,5]	B[3,4,5]
	2-4	High	Group interventions to improve psychosocial adjustment	C[11]	B[7, 18]

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PAEDIATRIC PSYCHOLOGY: INTRODUCTION

BETWEEN 10 - 30% OF CHILDREN ARE AFFECTED BY CHRONIC ILLNESS OR PHYSICAL HEALTH PROBLEMS [6,9], AND AROUND 10% OF CHILDREN (UNDER 19 YEARS) ARE ADMITTED TO HOSPITAL EACH YEAR[4]. CHILDREN WITH CHRONIC ILLNESSES HAVE BEEN FOUND TO HAVE A 10%-37% RISK OF DEVELOPING PSYCHOLOGICAL DIFFICULTIES WITH A RECOGNISED INCREASED RISK OF DEVELOPING PSYCHOLOGICAL AND BEHAVIOURAL PROBLEMS COMPARED TO HEALTHY CHILDREN[7,9,10].

This has major implications, not only for the emotional and social development of the young person, but also for their families and others involved in the child's care. Furthermore, with ongoing advances in medical science leading to increasingly complex and demanding treatments, children are surviving chronic and life threatening conditions to a far greater degree than in the past, and it is likely that, in turn, this will result in an increase in the number of children and young people presenting with psychological need.

It is increasingly recognised that psychological factors have an impact on the outcome and quality, actual and perceived, of healthcare[1,2,13,14]. Recent government guidelines recommend that psychological services should be considered as an integral part of children's medical health care.

CHILDREN ARE SURVIVING CHRONIC AND LIFE THREATENING CONDITIONS TO A FAR GREATER DEGREE THAN IN THE PAST, AND IT IS LIKELY THAT, IN TURN, THIS WILL RESULT IN AN INCREASE IN THE NUMBER OF CHILDREN AND YOUNG PEOPLE PRESENTING WITH PSYCHOLOGICAL NEED

There is a growing evidence base to support the clinical effectiveness of psychological interventions for a number of medical conditions[2,5,16]. SIGN Guidelines on the management of diabetes state that "children and adults with type 1 and type 2 diabetes should be offered psychological interventions (including motivational interviewing, goal setting skills and CBT) to improve glycaemic control in the short and medium term"[14] and in the SIGN guidelines on the management of asthma, family therapy is recognised as having a role in cases of difficult childhood asthma[15]. Furthermore, research on psychological influences of health care use has shown that there is a link between psychological distress and increased use of health care[3,8]. It is recognised that psychological input can have a direct impact on health outcomes by addressing problems such as adherence to treatment and managing pain as well as reducing psychological distress. In addition, addressing the child's and family's emotional needs alongside their physical health needs helps increase satisfaction with care (National Service Framework for Children in Hospital[4,11,12]. Furthermore, the psychological well being of medical patients has an impact on treatment and recovery and psychological interventions can often lead to a shorter stay in hospital and fewer medical appointments. Therefore addressing psychological factors may result in reduced overall costs of treatment through shorter length of stay, greater adherence to medical management and reduced rate of abandoned procedures due to distress and lack of co-operation[2].

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THE PSYCHOLOGICAL WELL BEING OF MEDICAL PATIENTS HAS AN IMPACT ON TREATMENT AND RECOVERY AND PSYCHOLOGICAL INTERVENTIONS CAN OFTEN LEAD TO A SHORTER STAY IN HOSPITAL AND FEWER MEDICAL APPOINTMENTS

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PAEDIATRIC PSYCHOLOGY: ADHERENCE

AS OF RECENTLY, TECHNOLOGY HAS BEEN INCREASINGLY UTILIZED TO DELIVER ADHERENCE PROMOTERS WITHIN A PAEDIATRIC POPULATION

Adherence refers to how well an individual's behaviour corresponds with agreed recommendations from a healthcare provider[18.] Poor medication adherence is especially common in chronic illness and is associated with poorer outcomes. The following table outlines the main research to date looking at the efficacy of psychological interventions to promote adherence. However, it should be noted that improvements in adherence have been shown to tend to diminish over time and therefore interventions targeting adherence need to be an ongoing part of the clinical management of a paediatric chronic illness[12].

In addition, interventions aimed at optimising adherence in children and young people should also focus on the need for assessment of any underlying anxiety or depression as this is likely to have a negative impact on the ability of a child or young person to adhere successfully to recommended treatment. Interventions should therefore focus on both barriers to adherence and any underlying anxiety or depression[9].

As of recently, technology has been increasingly utilized to deliver adherence promoters within a paediatric population[20]. Text-message reminders, telephone reminders and other patient-reminder systems (i.e. internet) have been highlighted as both feasible and successful in promoting adherence[3, 19, 25, 34].

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PAEDIATRIC PSYCHOLOGY: ADHERENCE

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Moderate/Severe	3	High	Behavioural (eg monitoring, goal setting, rewards, contingency planning, problem solving, sticker charts)	A[2,8,15,17,18,21]	A[8,15,17,18]
	3	High	Behavioural + Education	A[4,8,17,29,38]	A[4,8,17,26,29,38]
	3	Low	Educational Support- multi-families	/	A[37]
	3	High	Multicomponent intervention (social skills or family therapy + behavioural or education, self-management training, motivational component)	A[11,17,18,28,32]	A[11,17,18,23,30,32]
	3	High	Multicomponent intervention	/	A[11]
	3	Low	Educational Support- multi-families	/	A[37]
	3	High	Behavioural family systems therapy (diabetes) (problem solving, communication, cognitive restructuring, functional-structural family therapy)	/	A[37]
	3	High	Structured parent training programme (psychoeducation, stress management, problem solving) Multidisciplinary	A[31]	/
	3	High	Motivational Interviewing / Strength Based Approaches/Solution Focused	B[27]	A[5,6,7,10,25,27,33]
	2/3	Low	Counselling and Education	B[24]	B[24]
	2/3	High	Parent-Youth Teamwork Intervention (including education and promotion of parental inclusion in management)	/	B[9]
	3	High	Home based telemedicine	C[1]	C[1]
	3	Low	Positive Psychology Interventions (Diabetes)	/	C[16]

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PAEDIATRIC PSYCHOLOGY: ADHERENCE

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Moderate–Severe/ Complex	3	High	Multisystemic therapy	/	A[12]
	3	High	Home based Behavioural Family Systems Therapy	/	B[14]
	3	High	Multicomponent Therapy	/	C[22]

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PAEDIATRIC PSYCHOLOGY: CHRONIC PAIN

PSYCHOLOGICAL INTERVENTIONS HAVE BEEN DEMONSTRATED TO BE EFFECTIVE IN DIMINISHING PAIN AND SEVERAL GOOD META-ANALYSES HAVE BEEN CONDUCTED DEMONSTRATING THE EFFICACY OF INTERVENTIONS

CHRONIC PAIN AFFECTS 15%-30% OF SCHOOL AGE CHILDREN AND ADOLESCENTS AND HAS MAJOR IMPLICATIONS FOR OVERALL QUALITY OF LIFE. MANY CHILDREN WITH CHRONIC PAIN EXPERIENCE SIGNIFICANT PAIN-RELATED DISABILITY SUCH AS LIMITED SOCIAL AND PHYSICAL ACTIVITIES AND FREQUENT SCHOOL ABSENCES[11].

In addition, pain is a significant social stressor for the family often resulting in parental absences from work to care for the child placing additional emotional and financial stresses on families as a whole. Children experiencing chronic pain are also more likely to report higher levels of distress, anxiety and depression and children with chronic pain are at greater risk of continuing into adulthood with chronic pain, physical symptoms and psychological difficulties[11,12].

Psychological interventions have been demonstrated to be effective in diminishing pain and several good meta-analyses have been conducted demonstrating the efficacy of interventions[3, 11]. Whilst to date, the majority of studies on chronic pain in paediatrics have focused on reduction in pain (with a reduction of 50% or more seen as successful), more recent research has begun to look at other aspects of function including level of disability, daily functioning and eating.[11,12,17.]

To date, the majority of the research into chronic pain in children and young people has focused on

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chronic headache (tension type and migraine), recurrent abdominal pain, musculo-skeletal pain and some condition specific studies and therefore the recommendations in the following table come from this body of evidence. However, more recent reviews highlight that in the paediatric population, non-organic factors may be as important as organic factors in maintaining pain and that the distinction often made between these two terms is probably artificial[12]. It would therefore seem reasonable that interventions presented would generalise across other chronic pain conditions in the paediatric population. Due to the specific evidence base for headache pain, this has its own subsection in the table.

MORE RECENT REVIEWS HIGHLIGHT THAT IN THE PAEDIATRIC POPULATION, NON-ORGANIC FACTORS MAY BE AS IMPORTANT AS ORGANIC FACTORS IN MAINTAINING PAIN

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PAEDIATRIC PSYCHOLOGY: CHRONIC PAIN

Level of Severity	Service Tier	Intensity of Intervention	Type of Intervention	Recommendation	
				Child	Adolescent
Moderate/Severe	3	High	Cognitive Behavioural Therapy	A[4,5,10,12]	A[4,5,10,12]
	3	High	Relaxation	A[4,5,10,12]	A[4,5,10,12]
	3	High	Biofeedback	A[4,5,10,12]	A[4,5,10,12]
Mild/Moderate	2/3	Low	Computer CBT (7+)	B[15]	B[15]
Moderate/Severe	3	High	Acceptance and Commitment Therapy	C[13]	C[13,14]
Mild/Moderate	2/3	Low	Internet-delivered Family CBT (11+)	C[11]	C[11]
			Headache Pain		
Mild/Moderate	1/2	Medium	Computer CBT (7+)	B[15]	B[15]
	Tier 2-3	Medium	Internet-delivered Family CBT (11+)	C[11]	C[11]
Moderate/Severe	3	High	Biofeedback	A[4,5,6,10,12]	A[4,5,6,10,12]
	3	High	Relaxation	A[4,5,10,12]	A[4,5,10,12]
	3	High	Cognitive Behavioural Therapy	A[4,5,10,12]	A[4,5,10,12]
	Tier 3	High	Acceptance and Commitment Therapy	C[13]	C[13,14]

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PAEDIATRIC PSYCHOLOGY: PROCEDURAL DISTRESS AND PREPARATION FOR PROCEDURES

MAINTAINING THE PSYCHOLOGICAL WELLBEING OF CHILDREN IS AN IMPORTANT COMPONENT OF CHILD-CENTRED TREATMENT, ASSOCIATED WITH BETTER ADJUSTMENT AND HEALTH OUTCOMES

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FOR MOST CHILDREN, AT LEAST INITIALLY, MEDICAL PROCEDURES, ESPECIALLY THOSE INVOLVING NEEDLES, ARE AN UNPLEASANT EXPERIENCE AND CAN RESULT IN CONSIDERABLE PSYCHOLOGICAL DISTRESS FOR THEM AND THEIR CARERS.

Maintaining the psychological wellbeing of children is an important component of child-centred treatment, associated with better adjustment and health outcomes[13]; and a strong evidence base exists for psychological strategies to reduce distress and the experience of pain in children and young people undergoing procedures. This may be particularly salient for trait-anxious children who have a tendency to recall events as more painful[35]; and as anticipatory state anxiety is negatively associated with the success of procedural sedation[36], children with chronic conditions are arguably more susceptible to this positive feedback loop resulting from increased exposure to painful procedures. Anxiety reduction is therefore particularly important for children with chronic conditions. Experiencing medical fear as a child is also predictive of avoidance of medical situations as an adult, thus early intervention may yield lifetime benefits[34].

Child coping during procedures has also been shown to be influenced by others, including parents

and medical staff and there is some evidence to suggest that parental modelling of anxious behaviour affects children[40,45]; and parents adjusting to a child's diagnosis report higher levels of anxious symptoms[13]. Parental expectations of procedure-related pain reliably predict paediatric procedure-related pain[29] and this association highlights the value of carrying out psychological interventions with parents to support their children[13]. Training parents to support their child using distraction increases child coping and reduces distress[5]. Furthermore, the opportunity for parents to support their child extends beyond the treatment room as specified in, for example, the "Prescriptive Model of Medical and Coping Intervention"[6].

As well as psychological support for managing pain and distress related to procedures, timely provision of information regarding imminent procedures is strongly recommended by bodies such as The Child Friendly Healthcare Initiative (CFHCI)[39] and has been shown to reduce distress and increase co-operation[17]. National policy stipulates the importance of the provision of appropriate support to children who are due to undergo potentially distressing procedures and involve them in a developmentally appropriate manner to both reduce distress and facilitate participation[37,38]. Highly recommended interventions focus on distraction, hypnosis and cognitive-behavioural strategies in children and young people, whilst attachment-based interventions are prioritised for infants. There is a small evidence base supporting music interventions, although it is not known what function these might serve independently of distraction.

HIGHLY RECOMMENDED INTERVENTIONS FOCUS ON DISTRACTION, HYPNOSIS AND COGNITIVE-BEHAVIOURAL STRATEGIES IN CHILDREN AND YOUNG PEOPLE, WHILST ATTACHMENT-BASED INTERVENTIONS ARE PRIORITISED FOR INFANTS

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PROCEDURAL DISTRESS AND PREPARATION FOR PROCEDURES

Service Tier	Intensity of Intervention	Type of Intervention	Recommendation		
			Infant	Child	Adolescent
3/4	Low	Distraction (including the use of virtual reality)	/	/	A[4,20,42,43,44]
3/4	High	Hypnosis	/	A[1,4,25,42,43,44]	A[1,4,12,42,43,44]
2/3	Low	Interventions for preterm infants: kangaroo care, sucking-related interventions, and swaddling/facilitated tucking interventions	A[33]	/	/
2/3	Low	Interventions for neonates: sucking-related interventions and rocking/ holding	A[33]	/	/
3/4	High	Hypnosis		A[4,25,28,42,43,44]	A[4,22,28,42,43,47]
2/3	Low	Distraction		A[4,7,16,31,32, 42]	A[4,44]
3/4	High	CBT (e.g coping skills, graded exposure and distraction)		A[2,42,43]	A[42,43]
3/4	High	Preparation for procedures: therapeutic play, coping skills		A[24,27]	A[24,27]
3/4	High	Preparation for procedures: interactive, cartoon characters/ stories, parental involvement, familiarisation with medical instruments, role playing)		B[2,4,7,11,19,22,23,41,42,43,	/
3/4	High	Parent coaching/training (positioning, distraction, coping skills, exposure and shaping)		B[2,9,30,47]	/
3/4	High	Music interventions		C[815]	/

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SUPPORT, COPING AND ADJUSTMENT IN CHILDREN, YOUNG PEOPLE AND FAMILIES OF CHILDREN WITH CHRONIC ILLNESS

THERE IS A WIDE RANGE OF CHRONIC ILLNESSES THAT IMPACT CHILDREN AND YOUNG PEOPLE

CHRONIC ILLNESS IS DEFINED AS A PERSISTENT OR LONG-TERM ILLNESS, EITHER LIFE-THREATENING OR NOT, THAT IS GENERALLY DIFFICULT TO CURE OR INCURABLE. THERE IS A WIDE RANGE OF CHRONIC ILLNESSES THAT IMPACT CHILDREN AND YOUNG PEOPLE. ASTHMA, CYSTIC FIBROSIS, DIABETES, CEREBRAL PALSY AND CANCER ARE SOME EXAMPLES OF CHRONIC ILLNESS THAT MAY OCCUR IN PAEDIATRIC POPULATIONS.

These types of illness are often preceded by a variety of risk factors and causes that can result in impairment or struggle in social, developmental, psychological and functional domains. Furthermore, many of these illnesses require daily self-management and effective coping and adjustment techniques to prevent non-adherence to treatment regimes, which has been documented to be as high as 75% in adolescents[8], and may be associated with poorer adjustment.

In addition to the impacts of chronic illness upon the patient, families often carry emotional and physical burdens with negative impact on their psychological health[15]. As such, adjustment and

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coping for families of children and young people with chronic illnesses is pivotal, and coping- or support-related interventions for children and young people should include family components[7,11,16]. Subsequently, maladjustment of parents/caregivers and family members of the affected youth can impact the youth's adjustment or ability to cope. Timing of intervention is also important, especially at the time of diagnosis and key points in the illness journey.

Multiple different group and individual interventions exist to promote adjustment and coping in children and young people. Either educational, cognitive, social or a mix of these components are often included in relevant interventions, and it has been evidenced that family-inclusion is beneficial[5,11]. Currently there is no set gold-standard measure for coping, adjustment or support of chronic illness in children and adolescents, however cognitive-behavioral based programs or therapies and adherence promoting interventions have been proven to be efficacious[6,4,16,3]. For parents and siblings specifically, interventions based on education and social support seem to result in positive outcomes[5,6,14].

As of recently, using technology to administer relevant interventions has increased in popularity and internet- and telephone-based interventions have become of interest[1]. Additionally, spiritual coping in children with chronic illness has been depicted as both important and relevant, however it still remains unclear as to how to feasibly incorporate this into a generalised, clinical setting.[2]

COGNITIVE-BEHAVIOURAL BASED PROGRAMS OR THERAPIES AND ADHERENCE PROMOTING INTERVENTIONS HAVE BEEN PROVEN TO BE EFFICACIOUS

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PAEDIATRIC PSYCHOLOGY: SUPPORT, COPING AND ADJUSTMENT IN CHILDREN, YOUNG PEOPLE AND FAMILIES OF CHILDREN WITH CHRONIC ILLNESS.

Level of Severity	Service Tier	Intensity of Intervention	Purpose	Type of Intervention	Recommendation		
					Parent	Sibling	Patient
Mild – Severe	3	High	Coping + Support	Cognitive-Behavioural based programs or Therapy	A[10]	A[10]	A[6,4,10]
	4	High	Coping + support	Residential Camp (including psychoeducation- and social- sessions)	/	A[5]	/
	2	Low	Coping + Support	Social Support Group	/	A[5]	/
	3	High	Coping + Support	Multi-component Family Therapy (psychoeducation, parenting skills, problem prevention)	A[11,7]	/	B[3]
	2/3	Low	Adherence/ Coping + support	Psychoeducation	/	B[5]	C[7]
	2	Low	Coping + support	Peer Support Group	C[2]	/	/

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PAEDIATRIC PSYCHOLOGY: TRANSITION FROM PAEDIATRIC TO ADULT SERVICES

TRANSITION PLANNING SHOULD INCLUDE THE YOUNG PEOPLE AND THEIR FAMILIES IN DECISION MAKING

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PREVALENCE OF DISABILITY OR LONG STANDING ILLNESS IN CHILDREN AND YOUNG PEOPLE UP TO THE AGE OF 15 IS 7.5%[7], WHILE IN 2014, 12% OF YOUNG PEOPLE AGED 16 TO 24 YEARS REPORTED A LONG-TERM ILLNESS OR DISABILITY IN 2014[8].

Transitions between care services are periods when young people are especially vulnerable to losing continuity in the care they receive[6]. Transition planning should include the young people and their families in decision making, while services should provide adequate and sufficient information and advice to the young person. The planning and transfer should include both the paediatric and adult services. Although there appears to be best practice recommendations, evidence suggests that services fail to reflect the guidance and policies available[6]. Young people's experience reflects this gap between recommendations and practice; young people express feeling insecure and unprepared for the culture of adult services[4]. In a UK study on transition from CAMHS to AMHS less than 5% of young people experienced optimal transition[9]. Specific groups are additionally vulnerable, including young people in care, young people excluded from school and young people with specific disorders, such as ADHD[3].

TRANSITION FROM PAEDIATRIC TO ADULT SERVICES INCLUDES PROGRAMMES OF SIGNIFICANT HETEROGENEITY IN DURATION, FOCUS, AND AGE OF TRANSITION

Transition from paediatric to adult services includes programmes of significant heterogeneity in duration, focus, and age of transition. Evidence suggests that duration of interventions varies from one-off events to more than 3 years[2]. Interventions can be categorised according to their foci as: staff focused, patient focused or service focused. Staff focused interventions refer to a named coordinator and to joint clinics. Patient focused interventions include disease specific education and self-management or skills training. Service focused interventions include young adult clinics or telephone support programmes. The age of transition varies, and further research is needed to determine the age range at which transition should occur, taking into consideration the patient's readiness[2,4,5].

Similarly, research evaluating interventions is limited, there are very few randomized controlled trials or controlled trials. A large number of data derives from qualitative research, while most of the evaluation studies adopt a pre- to post-test comparison. To date, only two randomised controlled trials were identified, both of which found no significant effect[1,9]. One study reported using a paediatric nurse-delivered CBT model[1] whilst the other used brief coordinated telephone support9. Outcomes typically focus on physical rather than holistic health and functioning outcomes. Whilst acknowledging psychological aspects of transition, these are not fully-formed psychological interventions, and their poor outcomes suggest that low-intensity psychology-informed transition interventions cannot provide a viable alternative to specialist psychological consultation and intervention within wider service coordination and planning that considers the young person's psychological and physical health needs. More systematically evaluated trials are needed to meet the concerns of young people.

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PAEDIATRIC PSYCHOLOGY: TRANSITION FROM PAEDIATRIC TO ADULT SERVICES

Level of Service	Service Tier	Type of Intervention	Adolescent
Specialist	3/4	Joint paediatric/adult clinics (inc. young adult clinic embedded in adult clinic)	C[2]
Specialist	3	Transition Preparation Training (CBT)	/[1]
Specialist	3	Comprehensive Transition Programme	/[10]

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NICE & SIGN GUIDELINES WITH RELEVANCE TO CAMHS PRACTICE

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Anxiety Disorders, inc Panic Disorder	• National Institute for Clinical Excellence (NICE).(2004). Anxiety: Management of Anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. http://www.nice.org.uk/guidance/cg113 • National Institute for Clinical Excellence (NICE). (2006). Computerised cognitive behaviour therapy for depression and anxiety: Review of Technology Appraisal 51. UK National Institute for Health and Clinical Excellence. London: NICE; Technology Appraisal 97) http://www.nice.org.uk/guidance/ta97
Antisocial Behaviours and Conduct Disorders	• National Institute for Health and Care Excellence (2013). Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management. Clinical NICE guideline 158. Available at http://www.nice.org.uk/guidance/cg158/ • National Institute for Health and Clinical Excellence (2006). Technology Appraisal Guidance 102. Parent Training/ Education Programmes in the Management of Children with Conduct Disorders (reviewed 2007). Available at http://www.nice.org.uk/guidance/ta102
Attention-Deficit Hyperactivity Disorder (ADHD)	• National Institute for Health and Clinical Excellence (NICE). (2008). Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults. UK: National Institute for Health and Clinical Excellence. London: NICE; Clinical Guideline 9. http://www.nice.org.uk/guidance/cg72 • National Institute for Health and Care Excellence (NICE). (2013). Quality Standard [QS39]. Attention deficit hyperactivity disorder. UK: National Institute for Health and Clinical Excellence. London: NICE. http://www.nice.org.uk/guidance/qs39
Autism Spectrum Disorders	• National Institute for Health and Care Excellence (2013). The management and support of children and young people on the autism spectrum. Clinical NICE guideline 170. Available at http://www.nice.org.uk/guidance/cg170/resources/guidance-autism-pdf • Scottish Intercollegiate Guidelines Network (SIGN). (2007). Assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders: A national clinical guideline. Edinburgh: SIGN. (SIGN publication no. 98). Available from URL: http://www.sign.ac.uk/pdf/sign98.pdf

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NICE & SIGN GUIDELINES WITH RELEVANCE TO CAMHS PRACTICE

Bipolar Disorder	• National Institute for Health and Care Excellence (2014). The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. Clinical NICE guideline 185. Available at http://www.nice.org.uk/guidance/cg185
Body Dysmorphic Disorder	• National Collaborating Centre for Mental Health. (2005). Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder. Clinical NICE guidelines 31. Available at https://www.nice.org.uk/guidance/cg31 • National Institute for Health and Care Excellence (2014). The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care. Clinical NICE guideline 185. Available at https://www.guidance.nice.org.uk/cg185
Children's attachment	• National Institute for Health and Care Excellence (NICE) (2013). Children's attachment: final scope. UK: National Institute for Health and Care Excellence. Retrieve from: https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0675/documents
Eating Disorders: Anorexia, Bulimia, Overeating and Atypical Eating Disorders	• National Institute for Health and Clinical Excellence (2004) Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders. NICE clinical guideline 9. Available at https://www.nice.org.uk/guidance/cg9
Mood Disorders, including Depression and Mood Dysregulation	• National Institute for Health and Care Excellence (NICE) (2013) Depression in children and young people: Identification and management in primary, community and secondary care- Centre for Clinical Practice – Surveillance Programme. UK: National Institute for Health and Clinical Excellence. http://www.nice.org.uk/guidance/cg28 • Quality standards: http://www.nice.org.uk/guidance/qs48 • Update: http://www.nice.org.uk/guidance/indevelopment/gid-cgwave0731
Neuropsychology: Acquired Brain Injury	• ational Institute for Health and Clinical Excellence (NICE, 2005) Improving Outcomes in Children and Young People with Cancer. London: NICE; ref NO897. Available at http://www.nice.org.uk/guidance/csgcyp • National Institute for Heath and Care Excellence (NICE, 2014).Children and young people with cancer http://www.nice.org.uk/guidance/qs55

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Neuropsychology: Epilepsy	• National Institute for Health and Clinical Excellence (2012). The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care. NICE clinical guideline 137. http://www.nice.org.uk/guidance/cg137 • Scottish Intercollegiate Guidelines Network (SIGN, 2005) Guideline 81: Diagnosis and Management of epilepsies in children and young people. Available at http://www.sign.ac.uk/pdf/sign81.pdf • National Institute for Health and Clinical Excellence (2004) 'The management and diagnosis of the epilepsies in adults and children in primary and secondary care. http://www.nice.org.uk/guidance/cg20
Anxiety Disorders: Obsessive Compulsive Disorder	• National Institute for Heath and Care Excellence (2014). Obsessive-compulsive disorder and body dysmorphic disorder overview. NICE Pathways – mapping our guidance. Available at http://pathways.nice.org.uk/pathways/obsessive-compulsive-disorder • National Institute for Health and Clinical Excellence (NICE). (2005). Obsessive compulsive disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder. UK: National Institute for Health and Clinical Excellence. London: NICE; Clinical Guideline 31. http://www.nice.org.uk/guidance/cg31
Chronic Fatigue	• National Institute for Health and Clinical Excellence (2007). Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management. London, UK. Available at https://www.nice.org.uk/guidance/cg53
Paediatric Psychology: Transition from paediatric to adult services	• National Institute for Health and Care Excellence (NICE, 2014). Transition from children's to adult services for young people using health or social care services, guideline scope. [GID-SCWAVE0714] London: National Institute for Health and Clinical Excellence. http://www.nice.org.uk/guidance/indevelopment/gid-scwave0714
Trauma: PTSD and Complex Trauma	• National Institute for Health and Clinical Excellence (2005) Post-traumatic Stress Disorder (PTSD): the Management of PTSD in Adults and Children in Primary and Secondary Care. NICE clinical guideline 26. Available at http://guidance.nice.org.uk/CG26 • National Institute for Health and Clinical Excellence (NICE) (2005). Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26. UK: National Institute for Health and Clinical Excellence. http://www.nice.org.uk/guidance/cg26 • National Institute for Health and Clinical Excellence (2009). When to suspect child maltreatment. NICE guideline 89. Available at https://www.nice.org.uk/guidance/cg89

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Schizophrenia / Psychosis	• National Institute for Heath and Care Excellence (NICE, 2013). Psychosis and schizophrenia in children and young people: Recognition and management. Clinical NICE Guideline 155. Available at http://www.nice.org.uk/guidance/cg155/ • Scottish Intercollegiate Guidelines Network (SIGN, 2013). Management of Schizophrenia. SIGN National Clinical Guideline 131. Available at http://www.sign.ac.uk/pdf/sign131.pdf
Self-harm and interpersonal difficulties	• National Institute for Health and Clinical Excellence (NICE) (2004). Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE; Clinical Guideline 16. http://www.nice.org.uk/guidance/cg16 • National Institute for Health and Clinical Excellence (NICE) (2011). Self-harm: Longer-term management. NICE; Clinical Guideline 133. http://www.nice.org.uk/guidance/cg133 • National Institute for Heath and Care Excellence (NICE) (2013). Quality standard for self-harm. NICE; Quality Standard QS34. http://www.nice.org.uk/guidance/qs34
Anxiety Disordrs: Social Anxiety / Social Phobia	• National Institute for Heath and Care Excellence (NICE) (2013). Social anxiety disorder: Recognition, assessment and treatment. Clinical NICE Guideline 159. Available at https://www.nice.org.uk/guidance/cg159
Substance Misuse	• National Institute for Health and Clinical Excellence (NICE) (2011). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical NICE Guideline 115. Available at http://www.nice.org.uk/guidance/cg115

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1. Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., Juffer, F. (2005). Disorganized infant attachment and preventive interventions: A review and meta-analysis. Infant Mental Health Journal, 26(30), 191-216.
2. Barlow, J., & Parsons, J. (2010). Group-based parent training programmes for improving emotional and behavioural adjustment in 0-3 year old children. The Cochrane Database of Systematic reviews, 2.
3. Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organization among maltreated children: Results of a randomised clinical trial. Child Development, 83(2), 623-636.
4. Cassidy, J., Woodhouse, S. S., Sherman, L. J., Stupica, B., & Lejuez, C. W. (2011). Enhancing infant attachment security: An examination of treatment efficacy and differential susceptibility. Development and Psychopathology,23(01), 131-148.
5. Cicchetti, F. A., Rogosch, F. A., Sheree, L. T (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. Development and Psychopathology, 18, 623-649.
6. Cohen, N, J., Loikasek, M., Muir, E., Muir, R., Parker, C. J. (2002). Six-month follow-up of two mother-infant psychotherapies: Convergence of therapeutic outcomes. Infant Mental Health Journal, 23, 4361-4380.
7. Cohen, N, J., Muir, E., Loikasek, M., Muir, R., Parker, C. J., barwick, M., Brown, M. (1999) Watch, wait, and wonder; Testing the effectiveness of a new approach to mother-infant psychotherapy. Infant Mental Health Journal, 20, 429-451
8. Dozier, M., Peloso, E., Lindheim, O., Gordon. M. K., Manni, M., Sepulveda, S., Ackerman, J., Bernier, A., Levine, S. (2006). Developing Evidence-Based Interventions for Foster Children: An Example of a Randomized Clinical Trial with Infants and Toddlers. Journal of Social Issues, (62), 767-785.
9. Filene, J. H., Kaminski, J. W., Valle, L. A., & Cachat, P. (2013). Components Associated With Home Visiting Program Outcomes: A Meta-analysis. Pediatrics, 132, S100-S109.
10. Fujiwara, T., Kato, N., & Sanders, M. R. (2011). Effectiveness of Group Positive Parenting Program (Triple P) in Changing Child Behavior, Parenting Style, and Parental Adjustment: An Intervention Study in Japan. Journal of Child and Family Studies, 20, 804-813.
11. Gardner, F., Burton, J., & Klimes, I. (2006). Randomised Controlled Trial of a Parenting Intervention in the Voluntary Sector for Reducing Child Conduct Problems: Outcomes and Mechanisms of Change. Journal Of Child Psychology And Psychiatry, 47(11), 1123-1132
12. Goyal, N. K., Teeters, A., & Ammerman, R. T. (2013). Home Visiting and Outcomes of Preterm Infants: A Systematic Review. Pediatrics, 132, 502-516.

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13. Gridley, N., Hutchings, J. and Baker-Henningham, H. (2015), The Incredible Years Parent–Toddler Programme and parental language: a randomised controlled trial. Child: Care, Health and Development, 41: 103–111. doi: 10.1111/cch.12153
14. Hedlund R. (1998). The Infant Behavioral Assessment and Intervention Programe, Available from: http://www.ibaip.org.
15. Hutchings J, Bywater T, Daley D, Gardner F, Whitaker C, Jones K, et al.Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. British Medical Journal 2007; 334(7595), 678–82.
16. Juffer, F., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H. (2008). Promoting Positive Parenting: an attachment based intervention. New York: Lawrence Erlbaum Associates / Taylor & Francis Group,
17. Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. Journal of abnormal child psychology, 36(4), 567-589.
18. Koldewijn K, Wolf MJ, v Wassenaer A, Meijssen D, v Sonderen L, v Baar A, et al. (2006a). The Infant Behavioral Assessment and Intervention Program for very low birth weight infants at 6 month corrected age. J Pediatr,;154:33-8.
19. Koldewijn, K., v Wassenaer, A., Wolf, M.J., Meijssen, D., Houtzager, B., Beelen, A. et al. (2010). Effect of the Infant Behavioural Assessment and Intervention Program in very low birth weight infants at 24 months corrected age. Journal of Pediatrics, 156, 359-365.
20. Lieberman, A. F., Van Horn, P. (2008). Psychotherapy with infants and young children. Repairing the effects of stress and trauma on early attachment. Guilford Press.
21. Marvin, R., Cooper, G., Hoffman, K., Powell, B. (2002). The Circle of Security™ Project: Attachment-based intervention with caregiver-pre-school child dyads. Attachment & Human Development, (4), 107-124.
22. McMenamy, J., Sheldrick, R. C., & Perrin, E. C. (2011). Early intervention in pediatrics offices for emerging disruptive behavior in toddlers. Journal of Pediatric Health Care, 25, 77-86.
23. Meijssen D,, Wolf, M. J., Koldewijn, K., Houtzager, B. A., v Wassenaer, A., Tronick, E., Kok, J., v Baar, A. (2010). The effect of the Infant Behavioural Assessment and Intervention Program on mother-infant interaction after very preterm birth. J Child Psych and Psychiat. 15(11), 1287-1295.
24. 24. National Institute for Health and Care Excellence (2012). Social and emotional wellbeing: early years. [PH40]. London: National Institute for Health and Care Excellence.

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EARLY INTERVENTION AND INFANT MENTAL HEALTH RISKS AND DISORDERS

25. National Institute for Health and Care Excellence (2006). Postnatal care: Routine postnatal care of women and their babies [CG37]. London: National Institute for Health and Care Excellence.
26. National Scientific Council on the Developing Child (2007). The Timing and Quality of Early Experiences Combine to Shape Brain Architecture: Working Paper #5. http://www.developingchild.net
27. National Scientific Council on the Developing Child (2009). Maternal Depression Can Undermine the Development of Young Children: Working Paper #8. http://www.developingchild.net
28. Olds, D. (1997). The prenatal/early infancy project: Fifteen years later. In George W. Albee & Thomas P. Gullotta (Eds), Primary Prevention Works. Thousand Oaks, CA: Sage Publications.
29. Olds, D.L. (2002). Prenatal and Infancy Home Visiting by Nurses: From Randomized Trials to Community Replication. Prevention Science, (3), 153-172.
30. Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., Sidora, K., Morris, L. M. & Luckey, D. (1997) Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow up of a randomized trial, Journal of the American Medical Association, 278, 637-643.
31. Olds, D. L., Henderson, C. R. Jr Cole, R., Eckenrode, J., Kitzman, H., Luckey, D. Pettitt, L., Sidora, K., Morris, P., Powers, J. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behaviour: a 15-year follow-up of a randomized trial. JAMA, 280:1238–1244.
32. Puckering, C., Longford, J., Hickey, A. (2008). Mellow Babies. National Programme for Improving Mental Health and Well- Being. The Scottish Government Research. http://www.scotland.gov.uk/Resource/Doc/224302/0060555.pdf
33. Puckering, C., McIntosh, E., Hickey, A., Longford, J. (2010). Mellow Babies: a group intervention for infants and mothers experiencing postnatal depression. Counselling Psychology Review, 2010; 25(1): 28-40.
34. Sanders, M. R. (1999). Triple P- Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. Clinical Child and Family Psychology Review, 2, 71–90.
35. Schappin, R., Wijnroks, L., Venema, M. U., Wijnberg-Williams, B., Veenstra, R., Koopman-Esseboom, C., Mulder-De Tollenaer, S., van der Tweel, I., & Jongmans, M. (2013). Brief parenting intervention for parents of NICU graduates: a randomized, clinical trial of Primary Care Triple P. Bmc Pediatrics, 13.

EARLY INTERVENTION AND INFANT MENTAL HEALTH RISKS AND DISORDERS

36. Scott, S., Knapp, M., Henderson, J., Maughen, B. (2001). Financial cost of social exclusion: follow up study of anti-social children into adulthood. British Medical Journal 2001;323:191

37. Scottish Government/COSLA (2009) The Early Years Framework. http://www.scotland.gov.uk/Topics/People/Young- People/Early-years-framework

38. Shapiro, C. J., Kilburn, J., & Hardin, J. W. (2014). Prevention of behavior problems in a selected population: Stepping Stones Triple P for parents of young children with disabilities. Research in Developmental Disabilities. Vol., 35, 2958-2975.

39. Van Doesum, K., Riksen-Walraven, J. M., Hosman, C. M., & Hoefnagels, C. (2008). A randomized controlled trial of a home-visiting intervention aimed at preventing relationship problems in depressed mothers and their infants. Child development, 79(3), 547-561.

40. Van Zeijl, J., Mesman, J., Van Ijendoorn, M. H., Bakermans-Kranenburg, M. J., Juffer F., Stolk, M. N., Koot, H. M., Alink, L. R. (2006). Attachment-based intervention for enhancing sensitive discipline in mothers of 1-to 3-year-old children at risk for externalizing behavior problems: A randomized controlled trial. Journal of Consulting and Clinical Psychology, (74), 994-1005.

41. Velderman, M. K., Bakermans-Kranenburg, J. J., Juffer, F., van IJzendoorn, M. H. (2006a). Effects of attachment based interventions on maternal sensitivity and infant attachment: Differential susceptibility of highly reactive infants. Journal of Family Psychology, 20, 266-274.

42. Velderman, M. K., Bakermans-Kranenburg, J. J., Juffer, F., van IJzendoorn, M. H., Manglesdorf, S.C., Zevalkink, J. (2006b). Preventing preschool externalizing behaviour problems throughvideofeedback intervention in infancy. Infant Mental Health Journal, 27, 466-493.

43. Webster-Stratton, C., Reid, M. J. (2009). The Incredible Years Program for children from infancy to pre-adolescence: Prevention and treatment of behavior problems. In Murrihy, R; Kidman, A; Ollendick, T (Eds) Clinician's handbook for the assessment and treatment of conduct problems in youth. Springer Press, New York.

CHILDREN'S ATTACHMENT: ATTACHMENT IN CHILDREN AND YOUNG PEOPLE WHO ARE ADOPTED FROM CARE, IN CARE OR AT HIGH RISK OF GOING INTO CARE

1. Allen, B., Timmer, S. G., & Urquiza, A. J. (2014). Parent–Child Interaction Therapy as an attachment-based intervention: Theoretical rationale and pilot data with adopted children. Children and Youth Services Review, 47, 334-341.
2. American Psychiatric Association. (2002). Reactive attachment disorder: Position statement. Washington, DC: Author.
3. Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., ... & Miller-Perrin, C. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. Child maltreatment, 11(1), 76-89.
4. Bakermans-Kranenburg, M.J, van IJzendoorn, M.H. & Femmie Juffer, F. (2003) Less Is More: Meta-Analyses of Sensitivity and Attachment Interventions in Early Childhood. Psychological Bulletin, 129 (2), 195–215.
5. Becker-Weidman, A. & Hughes, D. (2008). Dyadic Developmental Psychotherapy: an evidence-based treatment for children with complex trauma and disorders of attachment.Child & Family Social Work 13(3), 329-337.
6. Becker-Weidman, A. (2006). Treatment for children with trauma-attachment disorders: Dyadic developmental psychotherapy. Child and Adolescent Social Work Journal, 23(2), 147-171.
7. Becker-Weidman, A. (2008). Treatment for children with reactive attachment disorder: Dyadic developmental psychotherapy. Child and Adolescent Mental Health, 13(1), 52.
8. Briskman, J., Castle, J., Blackeby, K., Bengo, C., Slack, K., Stebbens, C., ... & Scott, S. Randomised Controlled Trial of the Fostering Changes Programme. Research Report DFE-RR237. London: Department for Education.
9. Bywater, T., Hutchings, J., Linck, P., Whitaker, C., Daley, D., Yeo, S. T., & Edwards, R. T. (2011). Incredible Years parent training support for foster carers in Wales: a multi-centre feasibility study. Child: care, health and development,37(2), 233-243.
10. Carnes-Holt, K., & Bratton, S. C. (2014). The Efficacy of Child Parent Relationship Therapy for Adopted Children With Attachment Disruptions. Journal of Counseling & Development, 92(3), 328-337.
11. Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. Development and psychopathology, 18(03), 623-649.

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13. Dozier, M., Peloso, E., Lindhiem, O., Gordon, M. K., Manni, M., Sepulveda, S., ... & Levine, S. (2006). Developing evidence-based interventions for foster children: an example of a randomized clinical trial with infants and toddlers.Journal of Social Issues, 62(4), 767-785.
14. Dozier, M., Peloso, E., Lewis, E., Laurenceau, J. P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. Development and psychopathology, 20(03), 845-859.
15. Dozier, M., Lindhiem, O., Lewis, E., Bick, J., Bernard, K., & Peloso, E. (2009). Effects of a foster parent training program on young children's attachment behaviours: Preliminary evidence from a randomised control trial. Child and Adolescent Social Work, 26, 321–332.
16. Fisher, P. A., & Kim, H. K. (2007). Intervention effects on foster preschoolers' attachment-related behaviors from a randomized trial. Prevention Science, 8(2), 161-170.
17. Fisher, P. A., Burraston, B., & Pears, K. (2005). The early intervention foster care program: Permanent placement outcomes from a randomized trial. Child maltreatment, 10(1), 61-71.
18. Fisher, P. A., Kim, H. K., & Pears, K. C. (2009). Effects of Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) on reducing permanent placement failures among children with placement instability. Children and Youth Services Review, 31(5), 541-546.
19. Fukkink, R. G. (2008). Video feedback in widescreen: A meta-analysis of family programs. Clinical Psychology Review, 28(6), 904-916.
20. Golding, K., & Picken, W. (2004). Group work for foster carers caring for children with complex problems. Adoption & Fostering, 28(1), 25-37.
21. Gurney-Smith, B., Granger, C., Randle, A., & Fletcher, J. (2010). 'In Time and in Tune'—The Fostering Attachments Group: Capturing Sustained Change in Both Caregiver and Child. Adoption & Fostering, 34(4), 50-60.
22. Juffer, F., Bakermans-Kranenburg, M. J., & IJzendoorn, M. H. (2005). The importance of parenting in the development of disorganized attachment: Evidence from a preventive intervention study in adoptive families. Journal of Child Psychology and Psychiatry, 46(3), 263-274.
23. Kerr, L., & Cossar, J. (2014). Attachment Interventions with Foster and Adoptive Parents: A Systematic Review. Child Abuse Review. Child Abuse Review, 23, 426–439.

CHILDREN'S ATTACHMENT: ATTACHMENT IN CHILDREN AND YOUNG PEOPLE WHO ARE ADOPTED FROM CARE, IN CARE OR AT HIGH RISK OF GOING INTO CARE

24. Laybourne, G., Andersen, J., & Sands, J. (2008). Fostering attachments in looked after children: Further insight into the group-based programme for foster carers. Adoption & Fostering, 32(4), 64-76.

25. Lewis-Morrarty, E., Dozier, M., Bernard, K., Terracciano, S. M., & Moore, S. V. (2012). Cognitive flexibility and theory of mind outcomes among foster children: Preschool follow-up results of a randomized clinical trial. Journal of Adolescent Health, 51(2), S17-S22.

26. Macdonald G, Turner W. Treatment Foster Care for improving outcomes in children and young people. Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD005649. DOI: 10.1002/14651858.CD005649.pub2.

27. National Institute for Clinical Excellence (NICE) (2013). Children's attachment: final scope. UK: National Institute for Health and Care Excellence. Retrieve from: https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0675/documents

28. Pallett, C., Scott, S., Blackeby, K., Yule, W., & Weissman, R. (2002). Fostering changes: a cognitive-behavioural approach to help foster carers manage children. Adoption & Fostering, 26(1), 39-48.

29. Pignotti, M., & Mercer, J. (2007). Holding therapy and dyadic developmental psychotherapy are not supported and acceptable social work interventions: A systematic research synthesis revisited. Research on Social Work Practice, 17(4), 513-519.

30. Saunders, B.E., Berliner, L. & Hanson, R.F. (2003) Child Physical and Sexual Abuse: Guidelines for Treatment (Final Report, 15 January 2003). National Crime Victims Research and Treatment Center, Charleston, SC.

31. Scottish Government (2014). A National Statistics Publication for Scotland: Children's Social Work Statistics Scotland, 2012-13. Retrieved from http://www.scotland.gov.uk/Resource/0044/00447448.pdf

32. Sprang, G. (2009). The efficacy of a relational treatment for maltreated children and their families. Child and Adolescent Mental Health, 14(2), 81-88.

33. Stams, G. J. J., Juffer, F., Ijzendoorn, M. H., & Hoksbergen, R. (2001). Attachment-based intervention in adoptive families in infancy and children's development at age 7: Two follow-up studies. British Journal of Developmental Psychology, 19(2), 159-180.

CHILDREN'S ATTACHMENT: ATTACHMENT IN CHILDREN AND YOUNG PEOPLE WHO ARE ADOPTED FROM CARE, IN CARE OR AT HIGH RISK OF GOING INTO CARE

34. 34. Toth, S. L., & Gravener, J. (2012). Bridging research and practice: relational interventions for maltreated children. Child and adolescent mental health, 17(3), 131-138

35. 35. Turner W, Macdonald G, Dennis JA. Behavioural and cognitive behavioural training interventions for assisting foster carers in the management of difficult behaviour. Cochrane Database of Systematic Reviews 2007, Issue 1. Art. No.: CD003760. DOI: 10.1002/14651858.CD003760.pub3.

AUTISM SPECTRUM DISORDERS

1. Baird, G., Simonoff, E., Pickles, A., Chandler, S., Loucas, T., Meldrum, D., Charman, T. (2006). Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). Lancet, 368 (9531), 210-215.
2. Baron Cohen, S., Scott, F.J., Williams, J., Bolton, P., Matthews, F.E. & Braynew, C. (2009). Prevalence of autism-spectrum conditions: UK school-based population study, British Journal of Psychiatry, 194, 500-509. doi: 10.1192/bjp.bp.108.059345
3. Beresford et al (2012). Managing behaviour and sleep problems in disabled children: An investigation into the effectiveness and costs of parent-training interventions. Department of Education, DFE-RR204. Retrieved January 28, 2015 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184097/DFE-RR204.pdf.
4. Case-Smith, J., Weaver, L.L. & Fristad, M.A. (2014). A systematic review of sensory processing interventions for children with autism spectrum disorders. Autism, 19(2), 133-148. doi: 10.1177/1362361313517762
5. D'amico, M., Lalonde, C. & Snow, S. (2015). Evaluating the efficacy of drama therapy in teaching social skills to children with autism spectrum disorders. Drama Therapy Review, 1(1), 21-39. doi: 10.1386/dtr.1.1.21_1
6. de Bruin, C.L., Deppeler, J.M., Moore, D.W., & Diamond, N.T. (2013). Public School-based interventions for adolescents and young adults with an autism spectrum disorder: a meta-analysis. Review of Educational Research, 83(4), 521-550. doi: 10.3102/0034654313498621
7. Diggle, T., McConachie, H. R., Randle, V. R. L. (2005). Parent mediated early intervention for young children with autism spectrum disorder (Cochrane review). In The Cochrane Library, Issue 1. London: John Wiley & Sons Ltd.
8. Elsabbagh et al (2012). Global prevalence of autism and other pervasive developmental disorders. Autism Research, 5(3), 160-179. doi: 10.1002/aur.239
9. Flippin , M., Reszka, S., Watson, LR. (2010). Effectiveness of the Picture Exchange Communication System (PECS) on communication & speech for children with Autism Spectrum Disorders: A metaanalysis. American Journal of Speech- Language Pathology Vol.19 178-195 May 2010.
10. Geretsegger, M., Elefant, C., Mossler, K.A., & Gold, C. (2014). Music therapy for people with autism spectrum disorder. Cochrane Reviews, 2014(6). doi: 10.1002/14651858.CD004381.pub3

INDEX
BACK
NEXT

AUTISM SPECTRUM DISORDERS

11. Green, J., Charman, T., McConachie et al. (2010). Parent-mediated communication-focused treatment in children with autism (PACT): a randomized controlled trial. Lancet, 375, 2152-2160.
12. Grynszpan, O., Weiss, P.L., Perez-Diaz, F. & Gal, E. (2014). Innovative technology-based interventions for autism spectrum disorders: a meta-analysis. Autism, 18(4), 346-361. doi: 10.1177/1362361313476767
13. Hoffman, F. (2013). Evidence-based classroom strategies for reducing anxiety in primary aged children with high-functioning autism. New Zealand Journal of Teachers' Work, 10(1), 25-43.
14. Howlin, P., Magiati, I. & Charman, T. (2009). A systematic review of early intensive behavioural interventions (EIBI) for children with autism. American Journal on Intellectual and Developmental Disability, 114, 23-41
15. Hwang, Y. & Kearney, P. (2013). A systematic review of mindfulness intervention for individuals with developmental disabilities: Long-term practice and long lasting effects. Research in Developmental Disabilities, 34(1), 314-326. doi: 10.1016/j.ridd.2012.08.008
16. Kasari C, Gulsrud, AC, Wong C, Kwon S, Locke J. (2010). Randomized controlled caregiver mediated joint engagement intervention for toddlers with Autism. J Autism Dev Disord. 40: 1045-1056.
17. McDonald, T.A. & Machalicek, W. (2013). Systematic review of intervention research with adolescents with autism spectrum disorders. *Research in Autism Spectrum Disorders*, 7(11), 1439-1460. doi:10.1016/j.rasd.2013.07.015
18. Matson, J. L., Benavidez, D. A., Compton, L. S., Paclawskyj, T., Baglio, C. (1996). Behavioural treatment of autistic persons: a review of research from 1980 to the present. Research in Developmental Disabilities, 17 (6), 433-65
19. McConachie, H., Randle, V., Hammal, D., Le Couteur, A. (2005). A controlled trial of a training course for parents of children with suspected autism spectrum disorder. Journal of Pediatrics, 147 (3), 335-340.
20. Medical Research Council (MRC). (2001). MRC Review of Autism Research: Epidemiology and causes. London: Medical Research Council. Available from URL: http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC002394

INDEX
BACK
NEXT

AUTISM SPECTRUM DISORDERS

21. NICE (2013). *The management and support of children and young people on the autism spectrum*. Clinical NICE guideline 170. Available at guidance.nice.org.uk/cg170.
22. Odom SL, Boyd BA, Hall LJ, Hume K. (2010). Evaluation of comprehensive treatment models for individuals with Autism Spectrum Disorders. J Autism Dev Disord. 40(4) 425-436
23. Oono, I. P., Honey, E. J., & McConachie, H. (2013). Parent-mediated early intervention for young children with autism spectrum disorders (ASD).*Evidence-Based Child Health: A Cochrane Review Journal*, 8(6), 2380-2479.
24. Public Health Institute of Scotland (PHIS). (2001). Autistic Spectrum Disorder: Needs assessment report. Glasgow: Public Health Institute of Scotland.
25. Reichow, B., Barton, E.E., Boyd, B.A., & Hume, K. (2012). Early intensive behavioral intervention (EIBI) for young children with autism spectrum disorders (ASD). Cochrane Review, 2012(10). doi: 10.1002/14651858.CD009260.pub2
26. Roth, M.E., Gillis, J.M. & DiGennaro Reed, F.D. (2013). A meta-analysis of behavioural interventions for adolescents and adults with autism spectrum disorders. *Journal of Behavioural Education*, 23 (2), 258-286. doi 10.1007/s10864-013-9189-x
27. Scottish Intercollegiate Guidelines Network (SIGN). (2007). Assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders: A national clinical guideline. Edinburgh: SIGN. (SIGN publication no. 98). Available from URL: http://www.sign.ac.uk/pdf/sign98.pdf
28. Shaker-Naeeni, H., Govender, T., & Chowdhury, U. (2014). Cognitive behavioural therapy for anxiety in children and adolescents with autism spectrum disorder. British Journal of Medical Practitioners, 7(3): a723
29. Shields, J. (2001). The NAS EarlyBird Programme: partnership with parents in early intervention. The National AutisticSociety. Autism, 5 (1), 49-56.
30. Singh, N.N. et al (2011). A mindfulness-based strategy for self-management of aggressive behavior in adolescents with autism. Research in Autism Spectrum Disorders, 5(3), 1153-1158. doi: 10.1016/j.rasd.2010.12.012
31. Silver, M., Oakes, P. (2001). Evaluation of a new computer intervention to teach people with Autism or Asperger syndrome to recognise and predict emotions in others. Autism, 5 (3), 299-316.
32. Sofronoff, K., Leslie, A., Brown, W. (2004). Parent management training and Asperger Syndrome: a randomised controlled trial to evaluate a parent based intervention. Autism, 8 (3), 301-317.

INDEX
BACK
NEXT

AUTISM SPECTRUM DISORDERS

33. Solomon, M., Goodlin-Jones, B. L., Anders, T. F. (2004). A social adjustment enhancement intervention for high functioning autism, Asperger's syndrome and pervasive developmental disorder (NOS). Journal of Autism and Developmental Disorders, 34 (6), 649-68.
34. Strauss, K., Mancini, F., & Fava, L. (2013). Parent inclusion in early intensive behavior interventions for young children with ASD: a synthesis of meta-analyses from 2009 to 2011. Research in Developmental Disabilities, 34(9), 2967-2985. doi:10.1016/j.ridd.2013.06.007
35. Sussman, F. (1999). More than words: Helping Parents Promote Communication and Social Skills in Children with Autism Spectrum Disorder. Toronto: Hanen Centre
36. Thiemann, K. S., Goldstein, H. (2001). Social stories, written text cues and video feedback: effects on social communication of children with autism. Journal of Applied Behavioural Analysis, 34 (4), 425-446.
37. Thiemann, K. S., Goldstein, H. (2004). Effects of peer training and written text cueing on social communication of school age children with pervasive developmental disorder. Journal of Speech and Language Hearing Research, 47 (1), 126-144.
38. Tonge, B., Brereton, A., Kiomall., M., Mackinnon, A., King, N., Rinehart, N. (2006). Effects on parental mental health of an education and skills training programme for parents of young children with autism. A randomised controlled trial. Journal of American Academic Child and Adolescent Psychiatry, 45 (5), 561-569.
39. Tonge, B.J., Bull, K., Brereton, A. & Wilson, R. (2014). A review of evidence-based early intervention for behavioural problems in children with autism spectrum disorder: the core components of effective programs, child-focused interventions and comprehensive treatment models. Current Opinion in Psychiatry, 27(2), 158-165. doi: 10.1097/YCO.0000000000000043
40. Ung, D., Selles, R., Small, B.J., & Storch, E.A. (2014). A systematic review and Meta-analysis of cognitive-behavioural therapy for anxiety in youth with high-functioning autism spectrum disorders. Child Psychiatry & Human Development, 2014, doi: 10.1007/s10578-014-0494-y.
41. Wang, S., Parrila, R. & Cui, Y. (2012). Meta-Analysis of Social Skills Interventions of Single-Case Research for Individuals with Autism Spectrum Disorders: Results from Three-Level HLM. Journal of Autism and Developmental Disorders, 43(7), 1701-1716. doi: 10.1007/s10803-012-1726-2
42. Watkins, L., O'Reilly, M., Kuhn, M., Cevarter, C., Lancioni, G.E., Sigafoos, J., & Lang, R. (2014). A review of peer-mediated social interaction interventions for students with autism in inclusive settings. Journal of Autism and Developmental Disorders, 2014. doi 10.1007/s10803-014-2264-x

AUTISM SPECTRUM DISORDERS

43. Weiskop, S., Richdale, A., Matthews, J. (2005). Behavioural treatment to reduce sleep problems in children with autism or fragile X syndrome. Developmental Medicine and Child Neurology, 47 (2), 94-104.

44. Wellman, H. M., Baron-Cohen, S., Caswell, R., Gomez, J. C., Swettenham, J., Toye, E., Lagatutta, K. (2002). Thought bubbles help children with autism, Asperger's Syndrome acquire an alternative theory of mind. Autism, 6 (4), 343-363.

45. White, A .H. (2004). Cognitive Behaviour therapy in children with autistic spectrum disorder. In Bazian Ltd (ed) STEER: Succinct and Timely Evaluated Evidence Reviews, 4 (5). Wessex Institute for Health Research and Development University of Southampton and Bazian Ltd. (cited 2 Apr 2007). Available from URL: http:/www.wihrd.soton.ac.uk/projx/signpost/steers/STEER_2004(5).pdf

46. Williams, C., Wright, B., Callaghan, G., Coughlan, B. (2002). Do children with autism learn to read more readily by computer assisted instruction or traditional book methods? A pilot study. Autism, 6 (1), 71-91.

47. Yoder, P., Stone, W. L. (2006). Randomised comparison of two communication interventions for preschoolers with autism spectrum disorder. Journal of Consulting Clinical Psychology, 74 (3), 426-435.

48. Zhang, J. & Wheeler, J.J. (2011). A meta-analysis of peer-mediated interventions for young children with autism spectrum disorders. Education and Training in Autism and Developmental Disabilities, 46(1), 62-77.

DISRUPTIVE BEHAVIOUR DISORDERS (DISORDERS OF CONDUCT)

1. Alexander, J. F., Pugh, C., Parsons, B. V., Sexton, T. L. (2000). Functional Family Therapy. In D. S. Elliott (ed.). Blueprints for Violence Prevention (Book 3), Second Edition. Boulder, Colo.: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.
2. Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., Warburton, J. (1985). Generalizing Treatment Effects of Functional Family Therapy: Three Replications. American Journal of Family Therapy, 13 (3), 16–26.
3. Bernazzani, O., Cote, C., Tremblay, R. E. (2001). Early parent training to prevent disruptive behavior problems and delinquency in children. Annals of the American Academy of Political and Social Science, 578, 90-103.
4. Borduin, C. M., Schaeffer, C. M. (2001). Multisystemic treatment of juvenile sexual offenders: A progress report. Journal of Psychology and Human Sexuality, 13, 25-42.
5. Brestan, E. V., Eyberg, S. M., Boggs, S. R., Algina, J. (1997). Parent–child interaction therapy: Parents' perceptions of untreated siblings. Child and Family Behavior Therapy, 19, 13-28.
6. Chamberlain, P. (1990). Comparative evaluation of specialized foster care for seriously delinquent youth: a first step. Community Alternatives: International Journal of Family Care, 2, 21-36.
7. Chamberlain, P., Reid, J. B. (1994). Differences in risk factors and adjustment for male and female delinquents in treatment foster care. Journal of Child and Family Studies, 3 (1), 23-39.
8. Chamberlain, P., Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. Journal of Consulting and Clinical Psychology, 66, 624-633.
9. Edwards, R. T., Céilleachair, A., Bywater, T., Hughes, D. A., Hutchings, J. (2007). Parenting programme for parents of children at risk of developing conduct disorder: Cost effectiveness analysis. British Medical Journal, 334, 682-685.*
10. Evans, M. E., Armstrong, M. I., Kuppinger, A. D., Huz, S., McNulty, T. L. (1998). Preliminary outcomes of an experimental study comparing treatment foster care and family-centered intensive case management. In: Epstein, M. H., Kutash, K., Duchnowski, A. (eds.) Outcomes for children and youth with emotional and behavioral disorders and their families: programs and evaluation best practices. Austin, TX: Pro-Ed, Inc., 543-80.

INDEX
BACK
NEXT

DISRUPTIVE BEHAVIOUR DISORDERS (DISORDERS OF CONDUCT)

11. Farrington, D. P., Welsh, B. C. (2003). Family-based prevention of offending: A metaanalysis. Australian and New Zealand Journal of Criminology, 36, 127-151,
12. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2015). What Works For Whom? A Critical Review of Treatments for Children and Adolescents. New York: The Guildford Press
13. Gardner, F., Burton, J., Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. Journal of Child Psychology and Psychiatry, 47, 1123-1132.*
14. Hawes, D.J., Price, M.J., & Dadds, M.R. (2014). Callous-Unemotional traits and the treatment of conduct problems in childhood and adolescence: A comprehensive review. Clinical Child and Family Psychology Review, 17(3), 248-267. doi: 10.1007/s10567-014-0167-1
15. Hutchings, J. (1996). Evaluating a behaviourally based parent training group: Outcomes for parents, children and health visitors. Behavioural & Cognitive Psychotherapy, 24, 149-70.
16. Hutchings, J., Bywater, T., Daley, D. (2007). A Pragmatic Randomised Controlled Trial of a Parenting Intervention in Sure Start Services for Pre-School Children at Risk of Developing Conduct Disorder: How and why did it work? Journal of Children's Services, 2 (2), 4-14.*
17. Kazdin, A. E., Siegel, T. C., Bass, D. (1992). Cognitive problem solving skills training and parent management training in the treatment of antisocial behavior in children. Journal of Consulting and Clinical Psychology, 60, 733–747.
18. Lochman, J. E., Lampron, L. B., Gemmer, T. C., Harris, S. R., Wyckoff, G. M. (1989). Teacher consultation and cognitive- behavioral interventions with aggressive boys. Psychology in the Schools, 26, 179–188.
19. Loeber, R. (1988). Natural histories of conduct problems, delinquency, and associated substance use: Evidence for developmental progressions. In B. B. Lahey & A. E. Kazdin (Eds.), Advances in Clinical Child Psychology (Vol. 11, pp. 73-124). New York: Plenum Press.
20. Morawska, A., Sanders, M. R. (2006). Self-administered behavioral family intervention for parents of toddlers: Part I. Efficacy.Journal of Consulting and Clinical Psychology, 74, 10-19.
21. National Institute for Clinical Excellence (2006). Technology Appraisal Guidance 102. Parent Training/ Education Programmes in the Management of Children with Conduct Disorders (reviewed 2007) www.nice.org.uk/TA102

DISRUPTIVE BEHAVIOUR DISORDERS (DISORDERS OF CONDUCT)

22. NICE (2013). *Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management.* Clinical NICE guideline 158. Available at http://www.nice.org.uk/guidance/cg158 [NICE Guideline]
23. Patterson, J., Barlow, J., Mockford, C., Klimes, I., Pyper, C., Stewart-Brown, S. (2002). Improving Mental Health Through Parenting Programmes: Block Randomised Controlled Trial. Archives of Disease in Childhood, 87, 472-477.*
24. Reid, J. B. (1993). Prevention of conduct disorder before and after school entry: Relating interventions to developmental findings. Development and Psychopathology, 5, 243-262.
25. Salzer, S., Cropp, C., Jaeger, U., Masuhr, O., & Streeck-Fischer, A. (2013). Psychodynamic therapy for adolescents suffering from co-morbid disorders of conduct and emotions in an in-patient setting: a randomized controlled trial. Psychological Medicine, 44(10), 2213-2222. doi: 10.1017/S003329171300278X
26. Sanders, M. (1999). Triple P-Positive Parenting Program: Toward and empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. Clinical Child and Family Psychology Review, 2, 71-90.
27. Scott, S., Knapp, M., Henderson, J., Maughan, B. (2001a). Financial cost of social exclusion: follow up study of antisocial children into adulthood. British Medical Journal, 323 (7306), 191.
28. Scott, S., Spender, Q., Doolan, M., Jacobs, B., Aspland, H. (2001). Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. British Medical Journal, 323, 194-197.*
29. Sexton, T. L., Alexander, J. F. (1999). Functional Family Therapy: Principles of Clinical Assessment and Implementation. Henderson, N.V.: RCH Enterprises.
30. Sonuga-Barke, E. J. S., Daley, D., Thompson, M., Lavar-Bradbury, C., Weeks, A. (2001). Parent-based therapies for preschool attention-deficit/hyperactivity disorder: A randomized, controlled trial with a community sample. Journal of American Academy of Child and Adolescent Psychology, 40, 402-408.*
31. Von Sydow, K., Retzlaff, R., Beher, S., Haun, M.W., & Schweitzer, J. (2013). The efficacy of systemic therapy for childhood and adolescent externalizing disorders: a systematic review of 47 RCTs. Family Process, 52(4), 576-618. doi: 10.1111/famp.12047
32. Webster-Stratton, C. (1982). Teaching mothers through videotape modeling to change their children's behavior. Journal of Pediatric Psychology, 7, 279–294.

INDEX
BACK
NEXT

DISRUPTIVE BEHAVIOUR DISORDERS (DISORDERS OF CONDUCT)

33. Webster-Stratton, C. (1984). Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52, 666-678.

34. Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parent competencies. Journal of Consulting and Clinical Psychology, 66, 715-730.

35. 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.

36. 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, 105–124

37. Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Phillips, J., Pilling, S., Stein, S., Target, M. (2006). Drawing on the Evidence. Advice for Mental Health Professionals Working with Children and Adolescents. UK: CAMHS Publications.

*Social Learning Theory based Parent Management Training – (Starred entries indicate UK research)

INDEX
BACK
NEXT

REFERENCES

ANXIETY DISORDERS INC. PANIC DISORDER

1. Angelosante, A. G., Pincus, D. B., Whitton, S. W., Cheron, D., & Pian, J. (2009). Implementation of an intensive treatment protocol for adolescents with panic disorder and agoraphobia. *Cognitive and Behavioral Practice*, 16(3), 345-357.
2. Anticich, S. A. J., Barrett, P. M., Gillies, R., & Silverman, W. (2012). Recent Advances in Intervention for Early Childhood Anxiety. Australian Journal of Guidance and Counselling, 22, 157-172
3. Barlow, D. H. (1988). Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic. New York: Guilford Press.
4. Barrett, P. M. (1998). Evaluation of cognitive-behavioral group treatments for childhood anxiety disorders. Journal of Clinical Child Psychology, 27, 459-469.
5. Barrett, P., Dadds, M., Rappee, R. (1996). Family treatments of childhood anxiety: a controlled trial. Journal of Consulting and Clinical Psychology, 64, 2, 333-42.
6. Barrett, P.M., Farrell, L..J., Ollendick, T.H. & Dadds, M. (2006). Long-term outcomes of an Australian universal prevention trial of anxiety and depression symptoms in children and youth: an evaluation of the friends program. Journal of Clinical Child & Adolescent Psychology, 35, 3, 403- 411.
7. Breinholst, S., Esbjørn, B. H., Reinholdt-Dunne, M. L., & Stallard, P. (2012). CBT for the treatment of child anxiety disorders: A review of why parental involvement has not enhanced outcomes. Journal of Anxiety Disorders, 26(3), 416-424.
8. Brendel, K. E., & Maynard, B. R. (2014). Child & Parent Interventions for Childhood Anxiety Disorders: A Systematic Review and Meta-Analysis. Research on Social Work Practice, 24, 287-295.
9. Bögels, S. M., & Siqueland, L. (2006). Family cognitive behavioral therapy for children and adolescents with clinical anxiety disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(2), 134-141.
10. Cartwright-Hatton, S., McNally, D., Field, A. P., Rust, S., Laskey, B., Dixon, C., ... & Woodham, A. (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(3), 242-251.
11. Chase, R. M., Whitton, S. W., & Pincus, D. B. (2012). Treatment of Adolescent Panic Disorder: A Nonrandomized Comparison of Intensive Versus Weekly CBT. *Child & Family Behavior Therapy*, 34(4), 305-323.
12. Cobham, V. E. (2012). Do anxiety-disordered children need to come into the clinic for efficacious treatment?. *Journal of consulting and clinical psychology*, 80(3), 465-476.

INDEX
BACK
NEXT

ANXIETY DISORDERS INC. PANIC DISORDER

13. Corrieri, S., Heider, D., Conrad, I., Blume, A., K√∂nig, H.-H., & Riedel-Heller, S. G. (2014). School-based prevention programs for depression and anxiety in adolescence: a systematic review. Health Promotion International, 29, 427.
14. Costello, E. J., Copeland, W., & Angold, A. (2011a). Trends in psychopathology across the adolescent years: What changes when children become adolescents, and when adolescents become adults?. *Journal of child psychology and psychiatry*, 52(10), 1015-1025.
15. Costello, E. J., Egger, H. L., Copeland, W., Erkanli, A., & Angold, A. (2011b). The developmental epidemiology of anxiety disorders: phenomenology, prevalence, and comorbidity. In Silverman, W. K., & Field, A. P. (Eds.). *Anxiety disorders in children and adolescents* (2nd ed., pp. 56-75). Cambridge: Cambridge University Press.
16. Creswell, C., & Cartwright-Hatton, S. (2007). Family treatment of child anxiety: Outcomes, limitations and future directions. *Clinical child and family psychology review*, 10(3), 232-252.
17. Dadds, M. R., Spence, S. H., Holland, D.E., Barrett, P. M. & Laurens, K. R. (1997). Prevention and early intervention for anxiety disorders: a controlled trial. Journal of Consulting and Clinical Psychology, 65, 627-635.
18. Donovan, C. L., & March, S. (2014). Online CBT for Preschool Anxiety Disorders: A Randomised Control Trial. *Behaviour Research and Therapy*, 58, 24-35.
19. Emslie, G.J. (20080. Pediatric anxiety-under recognised and undertreated. New England Journal of Medicine, 359(26), 2835-2836.
20. Essau, C. A., Conradt, J., & Petermann, F. (1999). Frequency of panic attacks and panic disorder in adolescents. Depression & Anxiety, 9, 19–26.
21. Ewing, D. L., Monsen, J. J., Thompson, E. J., Cartwright-Hatton, S., & Field, A. (2013). A Meta-Analysis of Transdiagnostic Cognitive Behavioural Therapy in the Treatment of Child and Young Person Anxiety Disorders. Behavioural And Cognitive Psychotherapy, 1-16.
22. Farrell, L. J., Barrett, P. M., Claassens, S. (2005). Community Trial of an Evidence-Based Anxiety Intervention for Children and Adolescents (the FRIENDS Program): A Pilot Study. Behaviour Change, 22 (4), 236-248.
23. Fisak, J. B. J., Richard, D., & Mann, A. (2011). The Prevention of Child and Adolescent Anxiety: A Meta-analytic Review. Prevention Science, 12, 255-268.
24. Flannery-Schroeder, E.C. & Kendall, P.C. (2000). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: a randomized clinical trial. Cognitive Therapy and Research, 24, 251–78.

INDEX
BACK
NEXT

ANXIETY DISORDERS INC. PANIC DISORDER

25. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2015). What Works For Whom? A Critical Review of Treatments for Children and Adolescents. New York: The Guildford Press.
26. Gearing, R. E., Schwalbe, C. S. J., Lee, R., & Hoagwood, K. E. (2013). The effectiveness of booster sessions in CBT treatment for child and adolescent mood and anxiety disorders. Depression & Anxiety (1091-4269), 30, 800-808.
27. Ginsburg, G. & Drake, K. (2002). School-based treatment for anxious African American adolescents: a controlled pilot study. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 768–75.
28. Hoffman, E. C., & Mattis, S. G. (2000). A developmental adaptation of panic control treatment for panic disorder in adolescence. Cognitive and Behavioral Practice, 7(3), 253-261.
29. Hudson, J.L., Rapee, R.M., Deveney, C., Schniering, C.A., Lyneham, H.J. & Bovopoulos, N. (2009) Cognitive-Behavioural Treatment Versus and Active Control for Children and Adolescents with Anxiety Disorders: A Randomised Trial. Journal of the American Academy of Child and Adolescent Psychiatry, 48 (5) 533-544.
30. James, A. C., James, G., Cowdrey, F. A., Soler, A., & Choke, A. Cognitive behavioural therapy for anxiety disorders in children and adolescents. Cochrane Database of Systematic Reviews, 6, CD004690.
31. James, A..C.J., Soler, A., & Weatherall, R.W. (2009). Cognitive behavioural therapy for anxiety disorders in children and adolescents (Review). Cochrane Database of Systematic Reviews, Issue 1.
32. Kendall, P. C., Flannery-Schroeder, E., Panichelli-Mindel, S. M., Southam-Gerow, M., Henin, A., Warman, M. (1997). Treatment of anxiety disorders in youth: A second randomised clinical trial. Journal of Consulting and Clinical Psychology, 65, 366–380.
33. 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.
34. Kendall, P. C., Khanna, M. S., Edson, A., Cummings, C., & Harris, M. S. (2011). Computers and psychosocial treatment for child anxiety: Recent advances and ongoing efforts. Depression and anxiety, 28(1), 58-66.
35. Kessler RC, Avenevoli S, Costello E, et al. Prevalence, Persistence, and Sociodemographic Correlates of DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement.Arch Gen Psychiatry. 2012;69(4):372-380.

INDEX
BACK
NEXT

ANXIETY DISORDERS INC. PANIC DISORDER

36. Khanna, M. S., & Kendall, P. C. (2010). Computer-assisted cognitive behavioral therapy for child anxiety: results of a randomized clinical trial. Journal of Consulting and Clinical Psychology, 78(5), 737

37. Kraag, G., Van Breukelen, G.J.P., Kok, G. & Hosman, C. (2009). 'Learn Young, learn Fair', a stress management program for fifth and sixth graders: longitudinal results from an experimental study. Journal of Child Psychology and Psychiatry, 59 (9), 1185-1195.

38. Liber, J.M. Van Widenfelt, B.M., Utens, E.M.W.J, Ferdinand, R.F., Van der Leeden, A.J.M., Van Gastel, W. & Treffers, P.D.A.. (2008). No differences between group versus individual treatment of childhood anxiety disorders in a randomised clinical trial. Journal of Child Psychology and Psychiatry, 49, 886-893.

39. Liddle, I. & MacMillan, S. (2010). Evaluating the FRIENDS programme in a Scottish setting. Educational Psychology in Practice, 26, 53-67.

40. Lowther, H., & Newman, E. (2014). Review: Attention bias modification (ABM) as a treatment for child and adolescent anxiety: A systematic review. Journal of Affective Disorders, 168, 125-135.

41. Maggin, D. M., & Johnson, A. H. (2014). A Meta-Analytic Evaluation of the FRIENDS Program for Preventing Anxiety in Student Populations. Education and Treatment of Children, 37, 277-306.

42. March, S., Spence, S.H. & Donovan, C.L. (2009). The efficacy of an internet-based cognitive-behavioral therapy intervention for child anxiety disorders. Journal of pediatric psychology, 34(5), 474-487.

43. Mendlowitz, S.L, Manassis, K., Bradley, S., Scapillato, D., Miezitis, S. & Shaw, B.F. (1999). Cognitive-behavioural group treatments in childhood anxiety disorders: the role of parental involvement. Journal of the American Academy of Child and Adolescent Psychiatry, 38, 1223-1229.

44. Micco, J. A., Choate-Summers, M. L., Ehrenreich, J. T., Pincus, D. B., & Mattis, S. G. (2007). Identifying efficacious treatment components of panic control treatment for adolescents: A preliminary examination. *Child & Family Behavior Therapy*, 29(4), 1-23.

45. Mychailyszyn, M. P., Brodman, D. M., Read, K. L., & Kendall, P. C. (2012). Cognitive-behavioral school-based interventions for anxious and depressed youth: A meta-analysis of outcomes. [References]. Clinical Psychology: Science and Practice. Vol., 19, 129-153.

46. National Institute for Clinical Excellence (NICE).(2004). Anxiety: Management of Anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.

INDEX
BACK
NEXT

ANXIETY DISORDERS INC. PANIC DISORDER

47. National Institute for Clinical Excellence (NICE). (2006). Computerised cognitive behaviour therapy for depression and anxiety: Review of Technology Appraisal 51. UK National Institute for Health and Clinical Excellence. London: NICE; Technology Appraisal 97)
48. National Institute for Clinical Excellence (NICE)(2011). Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care. NICE; Clinical Guideline 113.
49. Nauta, M. H., Scholing, A., Emmelkamp, P.M. & Mindra, R. B. (2003). Cognitive behavioural 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 and Adolescent Psychiatry, 42, 1270-1278.
50. Nelles, W. B., & Barlow, D. H. (1988). Do children panic? *Clinical Psychology Review*, 8, 359–372.
51. Neil, A.L. & Christensen, H. (2009). Efficacy and effectiveness of school-based prevention and early intervention programs for anxiety. Clinical psychology review, 29 (3), 208-215.
52. Ollendick, T. H. (1995). Cognitive behavioral treatment of panic disorder with agoraphobia in adolescents: A multiple baseline design analysis. Behavior Therapy, 26(3), 517-531.
53. Ollendick, T. O., & Pincus, D. (2008). Panic disorder in adolescents. In R. G. Steele, T. D. Elkin, & M. C. Roberts (Eds.). Handbook of evidence-based therapies for children and adolescents (pp. 83–102). New York: Springer.
54. Pincus, D. B., May, J. E., Whitton, S. W., Mattis, S. G., & Barlow, D. H. (2010). Cognitive-behavioral treatment of panic disorder in adolescence. Journal of Clinical Child & Adolescent Psychology, 39(5), 638-649.
55. Saaverdra, L.M., Silverman, W.K., Morgan-Lopez, A.A., Kurtines, W.M (2010) Cognitive behavioral treatment for childhood anxiety disorders: long-term effects on anxiety and secondary disorders in young adulthood. Journal of Child Psychology and Psychiatry, 51 (8) 924-934
56. Sawyer, M. C., & Nunez, D. E. (2014). Cognitive-Behavioral Therapy for Anxious Children: From Evidence to Practice. Worldviews on Evidence-Based Nursing, 11(1), 65-71.
57. 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 (4), 525-535.

ANXIETY DISORDERS INC. PANIC DISORDER

58. Silverman, W. K., Kurtines, W. M, Ginsburg, G.S, Weems, C.F., Lumpkin, P.W. & Carmichael, D.H. (1999). Treating anxiety disorders with group cognitive-behavioural therapy: A randomized clinical trial. Journal of Consulting and Clinical Psychology, 67, 995-1003.

59. Silverman, W. (2014). Helping the Other 40%: Efforts to Improve Child and Adolescent Anxiety Outcomes. Keynote Lecture, EABCT Conference 2014: The Hague. http://app.eabct.eu/programma_details/441

60. Spence, S. H., Donovan, C. L., March, S., Gamble, A., Anderson, R. E., Prosser, S., & Kenardy, J. (2011). A randomized controlled trial of online versus clinic-based CBT for adolescent anxiety. *Journal of consulting and clinical psychology*, 79(5), 629.

61. Teubert, D., & Pinquart, M. (2011). A meta-analytic review on the prevention of symptoms of anxiety in children and adolescents. Journal of Anxiety Disorders, 25, 1046-1059.

62. Thirlwall, K., Cooper, P. J., Karalus, J., Voysey, M., Willetts, L., & Creswell, C. (2013). Treatment of child anxiety disorders via guided parent-delivered cognitive-behavioural therapy: randomised controlled trial. *The British Journal of Psychiatry*, 203(6), 436-444.

63. Thulin, U., Svirsky, L., Serlachius, E., Andersson, G., & √ñst, L.-G. (2014). The Effect of Parent Involvement in the Treatment of Anxiety Disorders in Children: A Meta-Analysis. Cognitive Behaviour Therapy, 43, 185.

64. Wuthrich, V. M., Rapee, R. M., Cunningham, M. J., Lyneham, H. J., Hudson, J. L., & Schniering, C. A. (2012). A Randomized Controlled Trial of the< i> Cool Teens</i> CD-ROM Computerized Program for Adolescent Anxiety. *Journal of the American Academy of Child & Adolescent Psychiatry*, 51(3), 261-270.

INDEX
BACK
NEXT

REFERENCES

ANXIETY DISORDER: OBSESSIVE COMPULSIVE DISORDER

1. Barrett, P., Healy-Farrell, M.C.P. and March, J. (2004) Cognitive Behavioural Family treatment of Childhood Obsessive Compulsive Disorder: A Controlled Trial. Study. Journal of American Academy of Child and Adolescent Psychiatry, 43 (1), 46-62.
2. de Haan, E., Hoogduin, K.A., Buitelaar, J.K., Kejsers, G.P. (1998) Behaviour therapy versus chlomipramine for the treatment of obsessive-compulsive disorder in children and adolescents. Journal of Child and Adolescent Psychiatry, 37 (10), 1022-9.
3. Donovan, C.L. & March, S. (2014). Online CBT for preschool anxiety disorders: A randomised control trial. Behaviour Research and Therapy, 58, 24-35. doi:10.1016/j.brat.2014.05.001
4. Douglass, H., Moffit, T., Dar, R., McGhee, R., Silva, P. (1995) Obsessive compulsive disorder in a birth cohort of 18 year olds: Prevalence and predictors: study. Journal of American Academy of Child and Adolescent Psychiatry, 34 (11), 1424-31.
5. Flament, M.F., Whitaker, A., et al. (1988) Obsessive compulsive disorder in adolescence: An epidemiological study. Journal of American Academy of Child and Adolescent Psychiatry, 27 (6), 764-771.
6. Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glaser, D. & Allison, E. (2015). What works for whom? A critical review of treatments for children and adolescents. 2nd Ed. New York: Guilford Press.
7. Freeman, J., Garcia, A., et al. (2014). Evidence base update for psychosocial treatments for pediatric obsessive-compulsive disorder. Journal of Clinical Child and Adolescent Psychology, 43(1), 7-26. doi:10.1080/15374416.2013.804386
8. Freeman, J., Sapyta, J., et al. (2014). Family-based treatment of early childhood obsessive-compulsive disorder: the pediatric obsessive-compulsive disorder treatment study for young children (POTS Jr)--a randomized clinical trial. JAMA Psychiatry, 71 (6), 689-698. doi:10.1001/jamapsychiatry.2014.170.
9. Heyman, I., Fombonne, E., Simmons, H., Ford., Meltzer, H. & Goodman, R. (2001). Prevalence of obsessive-compulsive disorder in the British nationawide survey of child mental health. British Journal of Psychiatry, 179, 324-329.
10. March, J.S., et al. (2006); Pediatric OCD Treatment Study (POTS) Team Cognitive-Behavior Therapy, Sertraline, and their Combination for Children and Adolescents with Obsessive-Compulsive Disorder: The Pediatric OCD Treatment Study (POTS) Randomized Controlled Trial: 2-8. Year Book of Psychiatry & Applied Mental Health, 73-74.

INDEX
BACK
NEXT

ANXIETY DISORDER: OBSESSIVE COMPULSIVE DISORDER

11. Neziroglu, F., Yaryur-Tobias, J.A., Walk, J., McKay, D. (2000). The effects of fluvoxamine and behaviour therapy on children and adolescents with obsessive-compulsive disorder. Journal of Child and Adolescent Psychopharmacology, 10 (4), 295-306.
12. National Institute for Health and Clinical Excellence (NICE). (2005). Obsessive compulsive disorder: core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder. UK: National Institute for Health and Clinical Excellence. London: NICE; Clinical Guideline 31.
13. NICE (2014). Obsessive-compulsive disorder and body dysmorphic disorder overview. NICE Pathways – mapping our guidance. Available at http://pathways.nice.org.uk/pathways/obsessive-compulsive-disorder
14. O'Kearney, R.T., Anstey, K., von Sanden, C. & Hunt, A. (2010). Behavioural and cognitive behavioural therapy for obsessive compulsive disorder in children and adolescents (Review). Cochrane Database of Systematic Reviews. 2006, Issue 4. Art. No.: CD004856.
15. Piacentini, JR., Bergman, L., et al. (2003) Functional Impairment in Children & Adolescents with Obsessive Compulsive Disorder. Journal of Child & Adolescent Psychopharmacology, 13 (supplement 1), 61-69.
16. Rapoport, J., Inoff-Germain, G., Weissman, M., Greenwald, S., Narrow, W.E., Jensen, P.S., et al. (2000) Childhood obsessive- compulsive disorder in the NIMH MECA Study: parent versus child identification of cases. Methods for the Epidemiology of Child and Adolescent mental Disorders. Journal of Anxiety Disorders, 14 (6), 535-548.
17. Reynolds, S.A., Clark, S., et al. (2013). Randomized controlled trial of parent-enhanced CBT compared with individual CBT for obsessive-compulsive disorder in young people. Journal of Consulting and Clinical Psychology, 81(6), 1021-1026. doi: 10.1037/a0034429
18. Schlup, B., Farrell, L., & Barrett, P. (2011). Mother-child interactions and childhood OCD: Effects of CBT on mother and child observed behaviors. Child & Family Behavior Therapy, 33(4), 322-336. doi: 10.1080/07317107.2011.623920
19. Storch, E.A., Caporino, N.E., et al. (2011). Preliminary investigation of web-camera delivered cognitive-behavioral therapy for youth with obsessive-compulsive disorder. Psychiatry Research, 189(3), 407-412. doi: 10.1708/1139.12553.
20. Stroch, E.A., Murphy, T.K., Geffken, G.R., Soto, O., Sajid, M., et al. (2004). Psychometric evaluation of the Children's Yale- Brown Obsessive-Compulsive Scale. Psychiatric Research, 129, 91–98.

INDEX
BACK
NEXT

ANXIETY DISORDERS: SOCIAL ANXIETY / SOCIAL PHOBIA

1. Beesdo, K., Knappe, S., & Pine, D. S. (2009). Anxiety and Anxiety Disorders in Children and Adolescents: Developmental Issues and Implications for DSM-V. *The Psychiatric Clinics of North America*, 32(3), 483–524.
2. Blanchard, E. B. (1970). Relative contributions of modelling, informational influences, and physical contact in extinction of phobic behaviour. Journal of Abnormal Psychology, 76, 55-61.
3. 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, 893–905.
4. 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 and Adolescent Psychology, 39, 410–420.
5. Cornwall, E., Spence, S.H, Schotte, D (1996). The effectiveness of emotive imagery in the treatment of darkness phobia in children. Behaviour Change, 13, 223-229.
6. Davis, E.T., Ollendick, T.H (2005). Empirically supported treatments for specific phobia in children: do efficacious treatments address the components of a phobic response? Clinical Psychology: Science and Practice, 12 (2), 144-160.
7. Dewis, L. M., Kirkby, K. C., Martin, F., Daniels, B. A., Gilroy, L. J., & Menzies, R. G. (2001). Computer-aided vicarious exposure versus live graded exposure for spider phobia in children. Journal of Behavior Therapy & Experimental Psychiatry, 32(1), 17-27.
8. Essau, C. A., Conradt, J., & Petermann, F. (2000). Frequency, comorbidity, and psychosocial impairment of anxiety disorders in German adolescents.*Journal of anxiety disorders*, 14(3), 263-279.
9. Graziano, A. M., Mooney, K. C. (1980). Family selfcontrol instruction for children's nighttime fear reduction. Journal of Consulting and Clinical Psychology, 48, 206-213.
10. Hampe, E., Noble, H., Miller, L. C., Barrett, C. L. (1973). Phobic children one and two years post-treatment. Journal of Abnormal Psychology, 82, 446-453.
11. Heyne, D., King, N. J., Tonge, B. J., Rollings, S., Young, D., Pritchard, M., et al. (2002). Evaluation of child therapy and caregiver training in the treatment of school refusal. Journal of the American Academy of Child and Adolescent Psychiatry, 41, 687–695.

ANXIETY DISORDERS: SOCIAL ANXIETY / SOCIAL PHOBIA

12. Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.
13. King, N. J., Cranstoun, F., Josephs, A. (1989). Emotive imagery and children's nighttime fears: A multiple baseline design evaluation. Journal of Behavior Therapy & Experimental Psychiatry, 20, 125-135.
14. Kuroda, J. (1969). Elimination of children's fears of animals by the method of experimental desensitization: An application of learning theory. Psychologia, 12, 161-165.
15. Last, C. G., Perrin, S., Hersen, M., & Kazdin, A. E. (1992). DSM-III-R anxiety disorders in children: sociodemographic and clinical characteristics. Journal of the American Academy of Child & Adolescent Psychiatry, 31(6), 1070-1076.
16. Leitenberg, H., Callahan, E. J. (1973). Reinforced practice and reduction of different kinds of fears in adults and children. Behaviour Research and Therapy, 11, 19–30.
17. Leutgeb, V., Schafer, A., Kochel, A., & Schienle, A. (2012). Exposure therapy leads to enhanced late frontal positivity in 8- to 13-year-old spider phobic girls. Biological Psychology, 90(1), 97-104.
18. Lewis, S. (1974). A comparison of behavior therapy techniques in the reduction of fearful avoidance behavior. BehaviorTherapy, 5, 648-655.
19. Mann, J., Rosenthal, T.T. (1969). Vicarious and direct counterconditioning of test anxiety through individual and group desensitization. Behaviour Research and Therapy, 7, 359-367.
20. MacPhee, A. R., & Andrews, J. J. W. (2003). Twelve-Year Review of In Vivo Exposure: Treating Specific Phobias in Children. Canadian Journal of School Psychology, 18(1/2), 183.
21. Maskey, M., Lowry, J., Rodgers, J., McConachie, H., & Parr, J. R. (2014). Reducing specific phobia/fear in young people with autism spectrum disorders (ASDs) through a virtual reality environment intervention. Plos One, 9(7), e100374-e100374. doi: 10.1371/journal.pone.0100374
22. Menzies, R. G., Clarke, J. C. (1993). A comparison of in vivo and vicarious exposure in the treatment of childhood water phobia. Behaviour Research & Therapy, 31, 9-15.
23. Miller, L.C., Barrett, C.L., Hampe, E., Noble, H. (1972). Comparison of reciprocal inhibition, psychotherapy and waiting list control of phobic children. Journal of Abnormal Psychology, 79, 269-279.

INDEX
BACK
NEXT

ANXIETY DISORDERS: SOCIAL ANXIETY / SOCIAL PHOBIA

24. Muris, P., Merckelbach, H., Holdrinet, I., & Sijsenaar, M. (1998). Treating phobic children: effects of EMDR versus exposure. Journal of Consulting & Clinical Psychology, 66(1), 193-198.
25. Muris, P., Merckelbach, H., Van Haaften, H., & Mayer, B. (1997). Eye movement desensitisation and reprocessing versus exposure in vivo. A single-session crossover study of spider-phobic children. British Journal of Psychiatry, 171, 82-86.
26. Murphy, C. M., Bootzin, R. R. (1973). Active and passive participation in the contact desensitization of snake fear in children. Behavior Therapy, 4, 203–211.
27. Obler, M., Terwilliger, R. F. (1970). Pilot study on the effectiveness of systematic desensitization with neurologically impaired children with phobic disorders. Journal of Consulting and Clinical Psychology, 34, 314-318.
28. Ollendick, T. H., King, N. J. (1998). Empirically supported treatments for children with phobic and anxiety disorders. Journal of Clinical Child Psychology, 27, 156-167.
29. Ollendick, T. H., & Davis, T. E., 3rd. (2013). One-session treatment for specific phobias: a review of Ost's single-session exposure with children and adolescents. Cognitive Behaviour Therapy, 42(4), 275-283.
30. Ollendick, T. H., Halldorsdottir, T., Fraire, M. G., Austin, K. E., Noguchi, R. J. P., Lewis, K. M., . . . Whitmore, M. J. (2014). Specific Phobias in Youth: A Randomized Controlled Trial Comparing One-Session Treatment to a Parent-Augmented One-Session Treatment. Behavior Therapy.
31. Ollendick, T. H., Ost, L.-G., Reuterskiold, L., Costa, N., Cederlund, R., Sirbu, C., . . . Jarrett, M. A. (2009). One-session treatment of specific phobias in youth: a randomized clinical trial in the United States and Sweden. Journal of Consulting and Clinical Psychology(3), 504.
32. Öst, L. G. (1989). One-session treatment for specific phobias. *Behaviour Research and Therapy*, 27(1), 1-7.
33. Öst, L.G. & Reuterskiöld, L. (2013) Specific Phobias. In G. Simos & S.G. Hofmann (Eds.). *CBT for anxiety disorders: a practitioner book*. Oxford: John Wiley & Sons.
34. 34. Öst, L. G., Svensson, L., Hellström, K., Lindwall, R. (2001). One-session treatment of specific phobias in youths: A randomized clinical trial. Journal of Consulting and Clinical Psychology, 69, 814-824.
35. Öst, L. G., & Treffers, P. D. (2001). Onset, course, and outcome for anxiety disorders in children. A*nxiety disorders in children and adolescents: Research, assessment and intervention*, 293-312.

INDEX
BACK
NEXT

ANXIETY DISORDERS: SOCIAL ANXIETY / SOCIAL PHOBIA

36. Ritter, B. (1968). The group desensitization of children's snake phobias using vicarious and contact desensitization procedures. Behaviour Research and Therapy, 6, 1-6.

37. Santacruz, I., Mendez, F. J., & Sanchez-Meca, J. (2006). Play Therapy Applied by Parents for Children with Darkness Phobia: Comparison of Two Programmes. Child & Family Behavior Therapy, 28(1), 19-35.

38. 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, 5, 675–687.

39. St-Jacques, J., Bouchard, S., & Belanger, C. (2010). Is virtual reality effective to motivate and raise interest in phobic children toward therapy? A clinical trial study of in vivo with in virtuo versus in vivo only treatment exposure. Journal of Clinical Psychiatry, 71(7), 924-931.

40. Vigerland, S., Thulin, U., Ljotsson, B., Svirsky, L., Ost, L. G., Lindefors, N., . . . Serlachius, E. (2013). Internet-delivered CBT for children with specific phobia: a pilot study. Cognitive Behaviour Therapy, 42(4), 303-314.

41. Ultee, C.A., Griffioen, D., Schellekens, J. (1982). The reduction of anxiety in children: A comparison of the effects of systematic desensitization in vitro and in vivo. Behaviour Research and Therapy, 20, 61-67.

42. Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Philips, J., Pilling, S., Stein, S., Target, M. (2006). Drawing on the Evidence: Advice for mental health professionals working with children and adolescents (2nd Ed.) London: CAMHS Publications.

43. Zlomke, K., & Davis, T. E., III. (2008). One-session treatment of specific phobias: a detailed description and review of treatment efficacy. Behavior Therapy(3), 207

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BACK
NEXT

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

1. American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). (4 Ed.).Washington, DC: American Psychiatric Association.
2. Charach, A., Carson, P., Fox, S., Ali, M. U., Beckett, J., & Lim, C. G. (2013). Interventions for preschool children at high risk for ADHD: a comparative effectiveness review. Pediatrics, 137,5, 1-21.
3. Daley, D., & O'Brien, M. (2013). A small-scale randomized controlled trial of the self-help version of the New Forest Parent Training Programme for children with ADHD symptoms. *European child & adolescent psychiatry*, 22(9), 543-552.
4. Daley, D., Van der Oord, S., Ferrin, M., Danckaerts, M., Doepfner, M., Cortese, S., ... & European ADHD Guidelines Group. (2014). Behavioral interventions in attention-deficit/hyperactivity disorder: a meta-analysis of randomized controlled trials across multiple outcome domains. *Journal of the American Academy of Child & Adolescent Psychiatry*, 53(8), 835-847.
5. DuPaul, G. J., Eckert, T. L., & Vilardo, B. (2012). The Effects of School-Based Interventions for Attention Deficit Hyperactivity Disorder: A Meta-Analysis 1996-2010. *School Psychology Review*, 41(4), 387-412.
6. Evans, S. W., Owens, J. S., & Bunford, N. (2013). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Clinical Child & Adolescent Psychology*, (ahead-of-print), 1-25.
7. Fabiano, G. A., Pelham, W. E., Cunningham, C. E., Yu, J., Gangloff, B., Buck, M., ... & Gera, S. (2012). A waitlist-controlled trial of behavioral parent training for fathers of children with ADHD. *Journal of Clinical Child & Adolescent Psychology*, 41(3), 337-345.
8. Hodgson, K., Hutchinson, A. D., & Denson, L. (2014). Nonpharmacological Treatments for ADHD A Meta-Analytic Review. *Journal of Attention Disorders*,18(4), 275-282.
9. Lee, P. C., Niew, W. I., Yang, H. J., Chen, V. C. H., & Lin, K. C. (2012). A meta-analysis of behavioral parent training for children with attention deficit hyperactivity disorder. *Research in developmental disabilities*, 33(6), 2040-2049.
10. McCann, D. C., Thompson, M., Daley, D., Barton, J., Laver-Bradbury, C., Hutchings, J., ... & Sonuga-Barke, E. (2014). Study protocol for a randomized controlled trial comparing the efficacy of a specialist and a generic parenting programme for the treatment of preschool ADHD. *Trials*, 15(1), 142.
11. Montoya, A., Colom, F., & Ferrin, M. (2011). Is psychoeducation for parents and teachers of children and adolescents with ADHD efficacious? A systematic literature review. *European psychiatry*, 26(3), 166-175.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

12. National Institute for Health and Clinical Excellence (NICE). (2008). Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults. UK: National Institute for Health and Clinical Excellence. London: NICE; Clinical Guideline 9.
13. National Institute for Clinical Excellence (NICE). (2013). Quality Standard [QS39]. Attention deficit hyperactivity disorder. UK: National Institute for Health and Clinical Excellence. London: NICE.
14. National Institute for Clinical Excellence (NICE). (2006). Technology Appraisal Guidance 102. Parent Training/ Education Programmes in the Management of Children with Conduct Disorders (reviewed 2007) www.nice.org.uk/TA102
15. NHS Quality Improvement Scotland (QIS). (2008). ADHD – Services Over Scotland: Report of the service profiling exercise. Scotland: NHS. www.nhshealthyquality.org
16. Parker, J., Wales, G., Chalhoub, N., & Harpin, V. (2013). The long-term outcomes of interventions for the management of attention-deficit hyperactivity disorder in children and adolescents: a systematic review of randomized controlled trials. *Psychology research and behavior management*, 6, 87-99.
17. Scottish Intercollegiate Guidelines Network (SIGN). (2009). Management of attention deficit and hyperkinetic disorders in children and young people: A national clinical guideline. Edinburgh: SIGN. (SIGN publication no. 112). Available from URL: http://www.sign.ac.uk/guidelines/fulltext/112/index.html
18. Sonuga-Barke, E. J., Brandeis, D., Cortese, S., Daley, D., Ferrin, M., Holtmann, M., ... & Sergeant, J. (2013). Nonpharmacological interventions for ADHD: systematic review and meta-analyses of randomized controlled trials of dietary and psychological treatments. *American Journal of Psychiatry*, 170(3), 275-289.
19. Sonuga-Barke, E., Brandeis, D., Holtmann, M., & Cortese, S. (2014). Computer-based Cognitive Training for ADHD: A Review of Current Evidence. *Child and adolescent psychiatric clinics of North America*, 23(4), 807-824.
20. Storebø OJ, Skoog M, Damm D, Thomsen PH, Simonsen E, Gluud C. Social skills training for Attention Deficit Hyperactivity Disorder (ADHD) in children aged 5 to 18 years. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD008223. DOI: 10.1002/14651858.CD008223.pub2.
21. Willis, W. G., Weyandt, L. L., Lubiner, A. G., & Schubart, C. D. (2011). Neurofeedback as a treatment for attention-deficit/hyperactivity disorder: A systematic review of evidence for practice. *Journal of Applied School Psychology*, 27(3), 201-227.
22. World Health Organization (WHO). (1993). The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research. Geneva: WHO.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

23. Zwi. M., Jones H., Thorgaard. C., York. A., Dennis J.A.. Parent training interventions for Attention Deficit Hyperactivity Disorder (ADHD) in children aged 5 to 18 years. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD003018. DOI: 10.1002/14651858.CD003018.pub3.

BIPOLAR DISORDER

1. American Academy of Child and Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. Journal of the American Academy of Child & Adolescent Psychiatry, 40 (7 Suppl), 4S-23S.
2. American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). (4 Ed.). Washington, DC: American Psychiatric Association.
3. Borchardt, C.M., Bernstein, G.A. (1995). Comorbid disorders in hospitalized bipolar adolescents compared with unipolar depressed adolescents. Child Psychiatry & Human Development, 26 (1), 11-18.
4. Bowring, M.A., Kovacs, M. (1992). Difficulties in diagnosing manic disorders in children and adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 31 (4), 611-614.
5. Carlson, G. A. (1990). Child and adolescent mania: Diagnostic considerations. Journal of Child Psychology & Psychiatry, 31, 331-341.
6. Carlson, G. A., Davenport, Y. B., Jamieson, K. (1977). A comparison of outcome in adolescent and late-onset bipolar manic depressive illness. American Journal of Psychiatry, 134, 919-922.
7. Carr, A. (2014). The evidence base for family therapy and systemic interventions for child-focused problems. Journal Of Family Therapy, (2), 107.
8. Costello, E. J., Costello, A. J., Edelbrock, C., Burns, B. J., Duncan, M. K., Brent, D., Janiszewski, S. (1988). Psychiatric disorders in pediatric primary care: Prevalence and risk factors. Archives of General Psychiatry, 45, 1107-1116.
9. Craighead, W.E. & Miklowitz, D.J. (2000). Psychosocial interventions for bipolar disorder. Journal of Clinical Psychiatry, 61, suppl 13, 58-64.
10. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2000). A Review of the Outcomes of all Treatments of Psychiatric Disorder in Childhood. MCH 17-33. Final Report to the National Service Executive, July 2000. USA: Authors.
11. Frank, E., Swartz, H.A. & Kupfer, D.J. (2000). Interpersonal and social rhythm therapy: managing the chaos of bipolar disorder. Biological Psychiatry, 48, 593-604.
12. Fristad, M.A., Goldberg-Arnold, J.S., & Gavazzi, S.M. (2002). Multifamily psychoeducation groups for families of children with bipolar disorders. Bipolar Disorders, 254-262.
13. Fristad, M. A., & MacPherson, H. A. (2014). Evidence-based psychosocial treatments for child and adolescent bipolar spectrum disorders. Journal Of Clinical Child And Adolescent Psychology, 43(3), 339-355. doi:10.1080/15374416.2013.822309

BIPOLAR DISORDER

14. Inder, M. L., Crowe, M. T., Luty, S. E., Carter, J. D., Moor, S., Frampton, C. M., & Joyce, P. R. (2014). Randomized, controlled trial of Interpersonal and Social Rhythm Therapy for young people with bipolar disorder. Bipolar Disorders, 2014.
15. Kim, E.Y., Miklowitz, D.J., Biuckians, A. & Mullen, K. (2007). Life Stress and the Course of Early-Onset Bipolar Disorder.Journal of Affective Disorders, 99 37 - 44
16. Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., Andrews, J. A. (1993a). Adolescent Psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in High School students. Journal of Abnormal Psychology, 102,133-144.
17. Metcalf, C. A., & Dimidjian, S. (2014). Extensions and Mechanisms of Mindfulness-based Cognitive Therapy: A Review of the Evidence. Australian Psychologist, 49(5), 271-279. doi:10.1111/ap.12074
18. Miklowitz, D.J., George, E.L., Axelson, D.A. (2004). Family-focused treatment for adolescents with bipolar disorder. Journal of Affective Disorder, 82, 113-128.
19. NICE (2014). *The assessment and management of bipolar disorder in adults, children and young people in primary and secondary care*. Clinical NICE guideline 185. Available at guidance.nice.org.uk/cg185

BODY DYSMORPHIC DISORDER

1. Albertini, R. S., & Phillips, K. A. (1999). Thirty-Three Cases of Body Dysmorphic Disorder in Children and Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 38(4), 453-459.
2. Bjornsson, A. S., Didie, E. R., Grant, J. E., Menard, W., Stalker, E., & Phillips, K. A. (2013). Age at onset and clinical correlates in body dysmorphic disorder. Comprehensive Psychiatry, 54(7), 893-903.
3. Buhlmann, U., & Winter, A. (2011). Perceived ugliness: an update on treatment-relevant aspects of body dysmorphic disorder. Current Psychiatry Reports, 13(4), 283-288.
4. Dingemans, A. E., van Rood, Y. R., de Groot, I., & van Furth, E. F. (2012). Body dysmorphic disorder in patients with an eating disorder: prevalence and characteristics. International Journal of Eating Disorders, 45(4), 562-569.
5. Greenberg, J. L., Markowitz, S., Petronko, M. R., Taylor, C. E., Wilhelm, S., & Wilson, G. T. (2010). Cognitive-behavioral therapy for adolescent body dysmorphic disorder. Cognitive and Behavioral Practice, 17(3), 248-258.
6. Kelly, M., Walters, C., & Phillips, K.A., (2010). Social anxiety and its relationship to functional impairment in body dysmorphic disorder. Behavior Therapy, 41, 143–153.
7. Khemlani-Patel, S., Neziroglu, F., & Mancusi, L. M. (2011). Cognitive-behavioral therapy for body dysmorphic disorder: A comparative investigation. International journal of cognitive therapy, 4(4), 363-380.
8. Ipser, J. C., Sander, C., & Stein, D. J. (2009). Pharmacotherapy and psychotherapy for body dysmorphic disorder. Cochrane Database Syst Rev, 1.
9. Mayville, S., Katz, R. C., Gipson, M. T., & Cabral, K. (1999). Assessing the prevalence of body dysmorphic disorder in an ethnically diverse group of adolescents. Journal of Child and Family Studies, 8(3), 357-362.
10. McKay, D., Todaro, J., Neziroglu, F., Campisi, T., Moritz, E. K., & Yaryura-Tobias, J. A. (1997). Body dysmorphic disorder: a preliminary evaluation of treatment and maintenance using exposure with response prevention. Behaviour Research and Therapy, 35 (1), 67-70.
11. National Collaborating Centre for Mental Health. (2005). Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder (a guideline from the National Institute for Health and Clinical Excellence, National Health Service). London, England, British Psychiatric Society and Royal College of Psychiatrists.

INDEX
BACK
NEXT

BODY DYSMORPHIC DISORDER

12. Neziroglu, F. A., & Yaryura-Tobias, J. A. (1993). Exposure, response prevention, and cognitive therapy in the treatment of body dysmorphic disorder. Behavior Therapy, 24(3), 431-438.
13. Pavan, C., Simonato, P., Marini, M., Mazzoleni, F., Pavan, L., & Vindigni, V. (2008). Psychopathologic aspects of body dysmorphic disorder: A literature review. Aesthetic Plastic Surgery, 32(3), 473-484.
14. Phillips, K. A., Didie, E. R., Menard, W., Pagano, M. E., Fay, C., & Weisberg, R. B. (2006). Clinical features of body dysmorphic disorder in adolescents and adults. Psychiatry Research, 141(3), 305-314.
15. Phillips, K. A., Grant, J., Siniscalchi, J., & Albertini, R. S. (2001). Surgical and nonpsychiatric medical treatment of patients with body dysmorphic disorder. Psychosomatics, 42(6), 504-510.
16. Phillips, K., Pagano, M., Menard, W., & Stout, R. (2006). A 12-month follow-up study of the course of body dysmorphic disorder. American Journal of Psychiatry, 163(5), 907-912.
17. Phillips, K. A., & Rogers, J. (2011). Cognitive-behavioral therapy for youth with body dysmorphic disorder: Current status and future directions. Child and Adolescent Psychiatric Clinics of North America, 20(2), 287-304.
18. Pinto, A., & Phillips, K. A. (2005). Social anxiety in body dysmorphic disorder.Body Image, 2(4), 401-405.
19. Veale, D., Anson, M., Miles, S., Pieta, M., Costa, A., & Ellison, N. (2014). Efficacy of cognitive behaviour therapy versus anxiety management for body dysmorphic disorder: A randomised controlled trial. Psychotherapy and Psychosomatics, 83(6), 341-353.
20. Veale, D., Gournay, K., Dryden, W., Boocock, A., Shah, F., Willson, R., & Walburn, J. (1996). Body dysmorphic disorder: a cognitive behavioural model and pilot randomised controlled trial. Behaviour research and therapy, 34(9), 717-729.
21. Wilhelm, S., Phillips, K. A., Didie, E., Buhlmann, U., Greenberg, J. L., Fama, J. M., ... & Steketee, G. (2014). Modular Cognitive-Behavioral Therapy for Body Dysmorphic Disorder: A Randomized Controlled Trial. Behavior therapy,45(3), 314-327.

CHRONIC FATIGUE SYNDROME

1. Al-Haggar, M. S., Al-Naggar, Z. A., & Abdel-Salam, M. A., (2006). Biofeedback and cognitive behavioral therapy for Egyptian adolescents suffering from chronic fatigue syndrome. Journal of Pediatric Neurology, 4, 161–169.
2. Chalder, T. (1999). Family oriented cognitive behavioural treatment for adolescents with chronic fatigue syndrome. Association of Child Psychology and Psychiatry, 16, 19e23, Occasional papers.
3. Chalder, T., Deary, V., Husain, K., & Walwyn, R. (2010). Family-focused cognitive behaviour therapy versus psycho-education for chronic fatigue syndrome in 11-to 18-year-olds: A randomized controlled treatment trial. Psychological Medicine, 40(08), 1269-1279.
4. Chalder, T., Goodman, R., Wessely, S., Hotopf, M., & Meltzer, H. (2003). Epidemiology of chronic fatigue syndrome and self reported myalgic encephalomyelitis in 5-15 year olds: cross sectional study. *Bmj*, 327(7416), 654-655.
5. Chalder, T., Tong, J., & Deary, V. (2002). Family cognitive behaviour therapy for chronic fatigue syndrome: An uncontrolled study. Archives of disease in childhood, 86(2), 95-97.
6. Cockshell, S. J., & Mathias, J. L. (2010). Cognitive functioning in chronic fatigue syndrome: A meta-analysis. Psychological medicine, 40(08), 1253-1267.
7. Crawley, E. (2013). The epidemiology of chronic fatigue syndrome/myalgic encephalitis in children. Archives of disease in childhood, archdischild-2012.
8. Crawley, E. M., Emond, A. M., & Sterne, J. A. (2011). Unidentified Chronic Fatigue Syndrome/myalgic encephalomyelitis (CFS/ME) is a major cause of school absence: Surveillance outcomes from school-based clinics. *BMJ open*,1(2).
9. Crawley, E., Hughes, R., Northstone, K., Tilling, K., Emond, A., & Sterne, J. A. (2012). Chronic disabling fatigue at age 13 and association with family adversity. *Pediatrics*, 130(1), 71-79.
10. Crawley, E., Mills, N., Beasant, L., Johnson, D., Collin, S. M., Deans, Z., ... & Montgomery, A. (2013). The feasibility and acceptability of conducting a trial of specialist medical care and the Lightning Process in children with chronic fatigue syndrome: Feasibility randomized controlled trial (SMILE study). Trials, 14(1), 415.
11. Denborough, P., Kinsella, S., Stevens, J., & Lubitz, L. (2003). Evaluation of a multidisciplinary inpatient rehabilitation programme for adolescents with chronic fatigue syndrome. Australasian Psychiatry, 11(3), 319-324.

CHRONIC FATIGUE SYNDROME

12. Dennison, L., Stanbrook, R., Moss-Morris, R., Yardley, L., & Chalder, T. (2010). Cognitive behavioural therapy and psycho-education for chronic fatigue syndrome in young people: Reflections from the families' perspective. British Journal of Health Psychology, 15(1), 167-183.
13. Evering, R. M., van Weering, M. G., Groothuis-Oudshoorn, K. C., & Vollenbroek-Hutten, M. M. (2010). Daily physical activity of patients with the chronic fatigue syndrome: A systematic review. Clinical Rehabilitation, 0269215510380831.
14. Fukuda, K., Straus, S. E., Hickie, I., Sharpe, M. C., Dobbins, J. G., & Komaroff, A. (1994). The chronic fatigue syndrome: A comprehensive approach to its definition and study. *Annals of Internal Medicine*, 121(12), 953-959.
15. Garralda, M. E., & Rangel, L. (2004). Impairment and coping in children and adolescents with chronic fatigue syndrome: A comparative study with other pediatric disorders. Journal of Child Psychology and Psychiatry, 45(3), 543-552.
16. Gordon, B. A., Knapman, L. M., & Lubitz, L. (2010). Graduated exercise training and progressive resistance training in adolescents with chronic fatigue syndrome: a randomized controlled pilot study. *Clinical rehabilitation*.
17. Haywood, K. L., Collin, S. M., & Crawley, E. (2014). Assessing severity of illness and outcomes of treatment in children with Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME): A systematic review of patient-reported outcome measures (PROMs). Child: Care, Health and Development.
18. Heim, C., Nater, U. M., Maloney, E., Boneva, R., Jones, J. F., & Reeves, W. C. (2009). Childhood trauma and risk for chronic fatigue syndrome: Association with neuroendocrine dysfunction. Archives of General Psychiatry, 66(1), 72-80.
19. Lim, A., & Lubitz, L. (2002). Chronic fatigue syndrome: Successful outcome of an intensive inpatient programme. Journal of Paediatrics and Child Health, 38(3), 295-299.
20. Lloyd, S., Chalder, T., & Rimes, K. A. (2012). Family-focused cognitive behaviour therapy versus psycho-education for adolescents with chronic fatigue syndrome: Long-term follow-up of an RCT. Behaviour Research and Therapy, 50(11), 719-725.
21. Lloyd, S., Chalder, T., Sallis, H. M., & Rimes, K. A. (2012). Telephone-based guided self-help for adolescents with chronic fatigue syndrome: A non-randomised cohort study. Behaviour research and therapy, 50(5), 304-312.
22. Knight, S. J., Scheinberg, A., & Harvey, A. R. (2013). Interventions in pediatric chronic fatigue syndrome/myalgic encephalomyelitis: A systematic review.Journal of Adolescent Health, 53(2), 154-165.

INDEX
BACK
NEXT

CHRONIC FATIGUE SYNDROME

23. Knoop, H., Stulemeijer, M., de Jong, L. W., Fiselier, T. J., & Bleijenberg, G. (2008). Efficacy of cognitive behavioral therapy for adolescents with chronic fatigue syndrome: long-term follow-up of a randomized, controlled trial. Pediatrics, 121(3), 619-625.
24. Mackenzie, C., & Wray, A. (2013). Chronic Fatigue Syndrome in children and young people. Paediatrics and Child Health, 23(1), 35-39.
25. Malouff, J. M., Thorsteinsson, E. B., Rooke, S. E., Bhullar, N., & Schutte, N. S. (2008). Efficacy of cognitive behavioral therapy for chronic fatigue syndrome: A meta-analysis. Clinical Psychology Review, 28(5), 736-745.
26. NICE (2007). Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management. London, UK.
27. Nijhof, S. L., Bleijenberg, G., Uiterwaal, C. S., Kimpen, J. L., & van de Putte, E. M. (2012). Effectiveness of internet-based cognitive behavioural treatment for adolescents with chronic fatigue syndrome (FITNET): A randomised controlled trial. The Lancet, 379(9824), 1412-1418.
28. Nijhof, S. L., Priesterbach, L. P., Uiterwaal, C. S., Bleijenberg, G., Kimpen, J. L., & van de Putte, E. M. (2013). Internet-based therapy for adolescents with chronic fatigue syndrome: Long-term follow-up. Pediatrics, 131(6), 1788-1795.
29. Papadopoulos, A. S., & Cleare, A. J. (2011). Hypothalamic–pituitary–adrenal axis dysfunction in chronic fatigue syndrome. Nature Reviews Endocrinology, 8(1), 22-32.
30. Patel, M. X., Smith, D. G., Chalder, T., & Wessely, S. (2003). Chronic fatigue syndrome in children: A cross-sectional survey. Archives of Disease in Childhood, 88, 894-898.
31. Pinquart, M., & Shen, Y. (2011). Behavior problems in children and adolescents with chronic physical illness: A meta-analysis. Journal of Pediatric Psychology, jsr042.
32. Rimes, K. A., Goodman, R., Hotopf, M., Wessely, S., Meltzer, H., & Chalder, T. (2007). Incidence, prognosis, and risk factors for fatigue and chronic fatigue syndrome in adolescents: a prospective community study. Pediatrics, 119(3), 603-609.
33. Royal College of Physicians, Psychiatrists and General Practitioners. (1996). Chronic fatigue syndrome: Report of a joint working group of the Royal College of Physicians, Psychiatrists and General Practitioners (Vol. Council Report CR54). London: Royal College of Physicians.
34. Stulemeijer, M., de Jong, L. W., Fiselier, T. J., Hoogveld, S. W., & Bleijenberg, G. (2005). Cognitive behaviour therapy for adolescents with chronic fatigue syndrome: Randomised controlled trial. BMJ, 330(7481), 14-20.

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BACK
NEXT

CHRONIC FATIGUE SYNDROME

35. Taylor, R. R., Jason, L. A., & Jahn, S. C. (2003). Chronic fatigue and sociodemographic characteristics as predictors of psychiatric disorders in a community-based sample. *Psychosomatic medicine*, 65(5), 896-901.

36. Van Cauwenbergh, D., De Kooning, M., Ickmans, K., & Nijs, J. (2012). How to exercise people with chronic fatigue syndrome: Evidence-based practice guidelines. European Journal of Clinical Investigation, 42(10), 1136-1144.

37. White, P. D., Goldsmith, K. A., Johnson, A. L., Potts, L., Walwyn, R., DeCesare, J. C., ... & Sharpe, M. (2011). Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial. The Lancet, 377(9768), 823-836.

38. White, P. D., Goldsmith, K., Johnson, A. L., Chalder, T., & Sharpe, M. (2013). Recovery from chronic fatigue syndrome after treatments given in the PACE trial. Psychological Medicine, 43(10), 2227-2235.

39. Wiborg, J. F., Knoop, H., Stulemeijer, M., Prins, J. B., & Bleijenberg, G. (2010). How does cognitive behaviour therapy reduce fatigue in patients with chronic fatigue syndrome? The role of physical activity. Psychological medicine, 40(08), 1281-1287.

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BACK
NEXT

EATING DISORDERS

1. Aardoom, J. J., Dingemans, A. E., Spinhoven, P., & Furth, E. F. (2013). Treating eating disorders over the internet: a systematic review and future research directions. International Journal of Eating Disorders, 46(6), 539-552.
2. Agras, W. S., Lock, J., Brandt, H., Bryson, S. W., Dodge, E., Halmi, K. A., ... & Woodside, B. (2014). Comparison of 2 Family Therapies for Adolescent Anorexia Nervosa: A Randomized Parallel Trial. JAMA psychiatry, 71(11), 1279-1286.
3. Agras, W.S., Walsh, B.T., Fairburn, C.G., Wilson, G.T., Kraemer, H.C. (2000). A multicenter comparison of cognitive- behavioral therapy and interpersonal psychotherapy for bulimia nervosa. Archives of General Psychiatry, 57, 459-466.
4. American Psychiatric Association (2000). Practice guidelines for the treatment of patients with eating disorders. The American Journal of Psychiatry, 157(1), 1-39.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5. (2013). Washington, D.C: American Psychiatric Association.
6. Bailer, U., de Zwaan, M., Leisch, F., Strnad, A., Lennkh-Wolfsberg, C., El-Giamal, N., … & Kasper, S. (2004). Guided self-help versus cognitive-behavioral group therapy in the treatment of bulimia nervosa. International Journal of Eating Disorders, 35, 522-537.
7. Barry, A., & Lippman, B. (1990). Anorexia nervosa in males. Postgraduate Medicine, 87, 161-165.
8. Bell, L., Clare, L., & Thorn, E. (2001). Service Guidelines for people with eating disorders. DCP Occasional paper No.3. The British Psychological Society.
9. Bemis, K. M. (1987). The present status of operant conditioning for the treatment of anorexia nervosa. Behaviour Modification, 11, 432-463.
10. Bryant-Waugh, R. (1993). Anorexia nervosa in young boys. Neuropsychiatre de l'Enfance et de l'Adolescence, 41, 287-290.
11. Carr, A. (2014). The evidence base for family therapy and systemic interventions for child-focused problems. Journal of Family Therapy, 36(2), 107-157.
12. Carter, J.C., Olmsted, M.P., Kaplan, A.S., McCabe, R.E., Mills, J.S., & Aimé, A. (2003). Self-help for bulimia nervosa: A randomized controlled trial. American Journal of Psychiatry, 160, 973-978.
13. Cassidy, O., Sbrocco, T., Vannucci, A., Nelson, B., Jackson-Bowen, D., Heimdal, J., ... & Tanofsky-Kraff, M. (2013). Adapting interpersonal psychotherapy for the prevention of excessive weight gain in rural African American girls. Journal of Pediatric Psychology, jst029.

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BACK
NEXT

EATING DISORDERS

14. Couturier, J., Kimber, M., & Szatmari, P. (2013). Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. International Journal of Eating Disorders, 46(1), 3-11.
15. Dalle Grave, R., Calugi, S., Doll, H. A., & Fairburn, C. G. (2013). Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy? Behaviour Research and Therapy, 51(1), R9-R12.
16. DeBar, L. L., Wilson, G. T., Yarborough, B. J., Burns, B., Oyler, B., Hildebrandt, T., ... & Striegel, R. H. (2013). Cognitive behavioral treatment for recurrent binge eating in adolescent girls: A pilot trial. Cognitive and Behavioral Practice, 20(2), 147-161.
17. Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., & Le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: the results of a controlled comparison of two family interventions. Journal of Child Psychology and Psychiatry, 41, 727-736.
18. Eisler, I., Dare, C., Russell, G. F. M., Szmukler, G. I., Le Grange, D., & Dodge, E. (1997). Family and individual therapy in anorexia nervosa. A 5-year follow-up. Archives of General Psychiatry, 54, 1025-1030.
19. Eisler, I., Simic, M., Russell, G., & Dare, D. (2007). A randomised controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five year follow up. Journal of Child Psychology and Psychiatry, 48(6), 552-560.
20. Fairburn, C. G., & Beglin, S.J. (1990). Studies of the epidemiology of bulimia nervosa. American Journal of Psychiatry, 147(4), 401-408.
21. Fairburn, C. G., Cooper, Z., Doll, H. A., Norman, P., & O'Connor, M. (2000). The natural course of bulimia nervosa and binge eating disorder in young women. Archives of General Psychiatry, 57(7), 659-665.
22. Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, J., … & Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. Archives of General Psychiatry, 48, 463-469.
23. Fairburn, C.G., Kirk, J., O'Connor, M., & Cooper, P.J. (1986). A comparison of two psychological treatments for bulimia nervosa. Behavior Research and Therapy, 24 (6), 629-643.
24. Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioural therapy for binge eating and bulimia nervosa. Behavior Research and Therapy, 24, 629-643.

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BACK
NEXT

EATING DISORDERS

25. Fisher, C. A., Hetrick, S. E., & Rushford, N. (2010). Family therapy for anorexia nervosa. Cochrane Database Syst Rev, 4.
26. Fitzpatrick, K. K., Moye, A., Hoste, R., Lock, J., & Le Grange, D. (2010). Adolescent focused therapy for adolescent anorexia nervosa. Journal of Contemporary Psychotherapy, 40, 31–39. doi:10.1007=s10879-009-9123-7
27. Fonagy, P., Target, M., Cottrell, D., Phillips, J., & Kurtz, Z. (2015). What Works For Whom? A Critical Review of Treatments for Children and Adolescents. New York: The Guildford Press. 2nd Ed.
28. Fosson, A., Knibbs, J., Bryant-Waugh, R., & Lask, B. (1987). Early-onset anorexia nervosa. Archives of Disease in Childhood, 62, 114-118.
29. Godart, N., Berthoz, S., Curt, F., Perdereau, F., Rein, Z., Wallier, J., ... & Jeammet, P. (2012). A randomized controlled trial of adjunctive family therapy and treatment as usual following inpatient treatment for anorexia nervosa adolescents. PloS One, 7(1), e28249.
30. Godfrey, K., Rhodes, P., & Hunt, C. (2013). The Relationship between Family Mealtime Interactions and Eating Disorder in Childhood and Adolescence: A Systematic Review. Australian and New Zealand Journal of Family Therapy, 34(1), 54-74.
31. Gowers, S. G., Clark, A., Roberts, C., Griffiths, V. E., Edwards, V., Bryan, C., … & Barrett, B. (2007). Clinical effectiveness of treatments for anorexia nervosa in adolescents. British Journal of Psychiatry, 191, 427-435.
32. Grave, R. D., Calugi, S., Doll, H. A., & Fairburn, C. G. (2013). Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy? Behaviour Research and Therapy, 51, R9–R12. doi:10.1016=j.brat.2012.09.008
33. Hawley, R. M. (1985). The outcome of anorexia nervosa in younger subjects. British Journal of Psychiatry, 146, 657-660.
34. Hay, P. P. (1998). The epidemiology of eating disorder behaviours: An Australian community-based survey. International Journal of Eating Disorders, 23, 371–382.
35. Hay, P. P., Bacaltchuk, J., Stefano, S., & Kashyap, P. (2009). Psychological treatments for bulimia nervosa and binging. Cochrane Database Syst Rev, 4, CD000562.
36. Hay, P. P. (2013). A systematic review of evidence for psychological treatments in eating disorders: 2005–2012. International Journal of Eating Disorders, 46(5), 462-469.
37. Herpertz, S., Hagenah, U., Vocks, S., von Wietersheim, J., Cuntz, U., & Zeeck, A. (2011). The diagnosis and treatment of eating disorders. Deutsches Ärzteblatt International, 108(40), 678.

EATING DISORDERS

38. Herpertz-Dahlmann, B., & Remschmidt, H. (1993). Depression and psychosocial adjustment in adolescent anorexia nervosa. A controlled 3-year follow-up study. European Child & Adolescent Psychiatry, 2, 146-154.
39. Higgs, J., Goodyer, I., & Birch, J. (1989). Anorexia nervosa and food avoidance emotional disorder. Archives of Disease in Childhood, 64, 346-351.
40. Hoek, H. W., & van Hoeken, D. (2003). Review of the prevalence and incidence of eating disorders. International Journal of Eating Disorders, 34(4), 383-396.
41. Hsu, L. K. (1990). Eating Disorders. London, UK: Guilford.
42. Jacobs, B., & Isaacs, S. (1986). Pre-pubertal anorexia nervosa: A retrospective controlled study. Journal of Child Psychology & Psychiatry, 27, 237-250.
43. Keel, P. K., & Haedt, A. (2008). Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 39-61.
44. Kinzl, J.F., Traweger, C., Trefalt, E., Mangweth, B., & Biebl, W. (1999). Binge eating disorder in males: A population-based investigation. Eating and Weight Disorders, 4(4), 169–174.
45. Kotler, L.A., & Walsh, B.T. (2000). Eating disorders in children and adolescents: Pharmacological therapies. European Child and Adolescent Psychiatry, 9(Supplement 1), 108-I116.
46. LeGrange, D., Crosby, R.D., Rathouz,P. J., & Leventhal, B.L. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. Archives of General Psychiatry, 64(9), 1049-1056.
47. Le Grange, D., & Lock, J. (2010) Family-based treatment for adolescents with bulimia nervosa. In C. Grilo and J. Mitchell (eds) The Treatment of Eating Disorders: A Clinical Handbook (pp. 372–387). New York, NY: Guilford.
48. Le Grange, D., Lock, J., Agras, W. S., Moye, A., Bryson, S. W., Jo, B., & Kraemer, H. C. (2012). Moderators and mediators of remission in family-based treatment and adolescent focused therapy for anorexia nervosa. Behaviour research and therapy, 50(2), 85-92.
49. LeGrange, D., & Schmidt, U. (2005). The treatment of adolescents with bulimia nervosa. Journal of Mental Health, 14(6), 587-597.
50. Lewandowski, L. M., Gebing, T. A., Anthony, J. L., & O'Brien, W. H. (1997). Meta-analysis of cognitive-behavioral treatment studies for bulimia. Clinical Psychology Review, 17, 703-718.

INDEX
BACK
NEXT

EATING DISORDERS

51. Lock, J., Agras, W.S., Bryson, S., & Kraemer, H. (2005). A comparison of short and long-term family therapy for adolescent anorexia nervosa. Journal of the American Academy of Child & Adolescent Psychiatry, 44(7), 632-639.
52. Lock, J., & LeGrange, D. (2001). Can family-based treatment of anorexia nervosa be manualized? Journal of Psychotherapy Practice and Research, 10, 253-261.
53. Lock, J., & LeGrange, D. (2005). Family based treatment of eating disorders. International Journal of Eating Disorders, 37, Supplement S64-7.
54. Lock, J., Le Grange, D., Agras, S. W., Moye, A., Bryson, S. W., & Jo, B. (2010). Randomized treatment trial comparing family- based treatment with adolescent-based individual therapy for adolescents with anorexia nervosa. Archives of General Psychiatry, 67(10), 1025-1032.
55. Lock, J. (2015). An update on evidence-based psychosocial treatments for eating disorders in children and adolescents. *Journal of Clinical Child & Adolescent Psychology*, (ahead-of-print), 1-15.
56. Madden, S., Miskovic-Wheatley, J., Wallis, A., Kohn, M., Lock, J., Le Grange, D., ... & Touyz, S. (2014). A randomized controlled trial of in-patient treatment for anorexia nervosa in medically unstable adolescents. Psychological Medicine, 1-13.
57. Mitchell, J. E., Pyle, R. L., Eckert, E. D., Hatsukami, D., Pomeroy, C., & Zimmerman, R. (1990). A comparison study of antidepressants and structured intensive group psychotherapy in the treatment of bulimia nervosa. Archives of General Psychiatry, 47, 149-157.
58. National Institute for Clinical Excellence (NICE). (2004). Eating Disorders. London, UK: NICE; Clinical Guideline 9.
59. Ng, L. W. C., Ng, D. P., & Wong, W. P. (2013). Is supervised exercise training safe in patients with anorexia nervosa? A meta-analysis. Physiotherapy, 99(1), 1-11.
60. NHS Quality Improvement Scotland (QIS). (2006). Eating Disorders in Scotland: Recommendations for Management and Treatment. Scotland: NHS. www.nhshealthyquality.org
61. Nicholls, D. & Junior Marsipan Project Team. (2011). Report from the Junior Marsipan group consultation. Version 8, Draft Consultation.
62. Nowicka, P., & Flodmark, C. E. (2011). Family therapy as a model for treating childhood obesity: useful tools for clinicians. Clinical child psychology and Psychiatry, 16(1), 129-145.

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BACK
NEXT

EATING DISORDERS

63. Robin, A. L., Siegel, P.T., Koepke, T., Moye, A., & Tice, S. (1994). Family therapy versus individual therapy for adolescent females with anorexia nervosa. Journal of Developmental and Behavioural Pediatrics, 15, 111-116.

64. Robin, A. L., Siegal, P. T., Moye, A. W., Gilroy, M., Dennis, A. B., & Sikand, A. (1999). A controlled comparison of family versus individual therapy for adolescents with anorexia nervosa. Journal of the American Academy of Child & Adolescent Psychiatry, 38,1482–1489. doi:10.1097=00004583-199912000-00008

65. Rossi, G., Balottin, U., Rossi, M., Chiappedi, M., Fazzi, E., & Lanzi, G. (2007). Pharmacologic treatment of anorexia nervosa: a retrospective study in preadolescents and adolescents. Clinical Pediatrics, 46(9), 806-811.

66. Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., Winn, S., … & Eisler, I. (2007). A randomized controlled trial of family therapy and cognitive behaviour therapy guided self-care for adolescents with bulimia nervosa and related disorders. American Journal of Psychiatry, 164(4), 591-598.

67. Shapiro, J., Berkman, N., Brownley, K., Sedway, J., Lohr, K., & Bulik, C. (2007). Bulimia nervosa treatment: A systematic review of randomised controlled trials. International Journal of Eating Disorders, 40, 321-336.

68. Signorini, A., DeFilippo, E., Panico, S., DeCaprio, C, Pasanisi, F., & Contaldo, F. (2007). Long-term mortality in anorexia nervosa: A report after an 8 year follow up and review of the most recent literature. European Journal of Clinical Nutrition, 61, 119-122.

69. Sysko, B., Walsh, T. (2008). A critical evaluation of the efficacy of self-help interventions for the treatment of bulimia nervosa and binge-eating disorder. International Journal of Eating Disorders, 41, 97-112.

70. Tanofsky-Kraff, M., Shomaker, L. B., Wilfley, D. E., Young, J. F., Sbrocco, T., Stephens, M., ... & Yanovski, J. A. (2014). Targeted prevention of excess weight gain and eating disorders in high-risk adolescent girls: A randomized controlled trial. The American Journal of Clinical Nutrition, 100(4), 1010-1018.

71. Tanofsky-Kraff, M., Wilfley, D. E., Young, J. F., Mufson, L., Yanovski, S. Z., Glasofer, D. R., ... & Schvey, N. A. (2010). A pilot study of interpersonal psychotherapy for preventing excess weight gain in adolescent girls at-risk for obesity. International Journal of Eating Disorders, 43(8), 701-706.

72. Tetzlaff, A., & Hilbert, A. (2014). The role of the family in childhood and adolescent binge eating. A systematic review. Appetite, 76, 208.

73. Vancampfort, D., Vanderlinden, J., De Hert, M., Soundy, A., Adámkova, M., Skjaerven, L. H., ... & Probst, M. (2013). A systematic review of physical therapy interventions for patients with anorexia and bulimia nervosa. Disability & Rehabilitation, 36(8), 628-634.

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NEXT

EATING DISORDERS

74. Wagner, G., Penelo, E., Wanner, C., Gwinner, P., Trofaier, M. L., Imgart, H., ... & Karwautz, A. F. (2013). Internet-delivered cognitive–behavioural therapy v. conventional guided self-help for bulimia nervosa: Long-term evaluation of a randomised controlled trial. The British Journal of Psychiatry, 202(2), 135-141.

75. Watson, H. J., & Bulik, C. M. (2013). Update on the treatment of anorexia nervosa: review of clinical trials, practice guidelines and emerging interventions. Psychological Medicine, 43(12), 2477-2500.

76. Whittal, M. L, Agras, W.S., & Gould, R.A. (1990). Bulimia nervosa: meta-analysis of psychosocial and psychopharmacological treatments. Behavior Therapy, 30, 117-135.

INSOMNIA

1. Astill, R. G., Van der Heijden, K. B., Van IJzendoorn, M. H., & Van Someren, E. J. W. (2012). Sleep, cognition, and behavioral problems in school-age children: A century of research meta-analyzed. Psychological Bulletin, 138 (6), 109-1138.
2. Bader, K. & Schfer, V. (2007). Sleep Disturbances following traumatic experiences in childhood and adolescence: a review. Somnologie, 11, 101-110.
3. Byars, K., & Simon, S. (2014). Practice patterns and insomnia treatment outcomes from an evidence-based pediatric behavioral sleep medicine clinic.Clinical *Practice in Pediatric Psychology*, 2(3), 337.
4. Cain, N., Gradisar, M., & Moseley, L. (2011) A Motivational School-Based Intervention for Adolescent Sleep Problems, Sleep Medicine, 12 246-251.
5. de Bruin, E. J., Oort, F. J., Bögels, S. M., & Meijer, A. M. (2014). Efficacy of Internet and Group-Administered Cognitive Behavioral Therapy for Insomnia in Adolescents: A Pilot Study. *Behavioral sleep medicine*, 12(3), 235-254.
6. Gradisar, M., Dohnt, H., Gardner, G., Paine, S., Starkey, K., Menne, A., ... & Trenowden, S. (2011). A randomized controlled trial of cognitive-behavior therapy plus bright light therapy for adolescent delayed sleep phase disorder.*Sleep*, 34(12), 1671.
7. Hill, C. (2011). Practitioner Review: Effective treatment of behavioural insomnia in children. *Journal of Child Psychology and Psychiatry*, 52(7), 731-740.
8. Honaker, S. M., & Meltzer, L. J. (2014). Bedtime Problems and Night Wakings in Young Children: An Update of the Evidence. *Paediatric Respiratory Reviews*, 15 (4), 333 – 339.
9. Meltzer, L. J., & Mindell, J. A. (2014). Systematic review and meta-analysis of behavioral interventions for pediatric insomnia. *Journal of pediatric psychology*,39(8), 932-948.
10. Mindell, J.A., Kuhn, B., Lewin, D.S., Meltzer, L.J. & Sadeh, A. (2006) Behavioural Treatment of Bedtime problems and Night Wakings in Infants and Young Children, Sleep, 29 (10) 1263-1276.
11. Mindell, J. A., Du Mond, C. E., Sadeh, A., Telofski, L. S., Kulkarni, N., & Gunn, E. (2011). Long-term efficacy of an internet-based intervention for infant and toddler sleep disturbances: one year follow-up. *Journal of Clinical Sleep Medicine*, 7 (5), 507 - 511.
12. Moore, B., Friman, P. C., Fruzzetti, A. E. & MacAleese, K. (2007) Brief Report: Evaluating the Bedtime Pass Program for Child Resistance to Bedtime – A Randomised Controlled Trial, Journal of Paediatric Psychology 32 (3) 283 – 287.

INSOMNIA

13. Morgenthaler, T.I., Owens, J., Alessi, C., Boehlecke, B., Brown, T.M., Coleman, J., Friedmans,L., Kapur. V.K., Lee-Chiong, T., Pancer, J. & Swick, T.J. (2006). Practice Parameters for Behavioural Treatment of Bedtime Problems and Night Wakings in Infants and Young Children, Sleep 29 (10) 1277-1281.
14. Paine, S. & Gradisar, M (2011) A randomised controlled trial of Cognitive-Behavioural Therapy for Behavioural Insomnia of Childhood in School- Aged Children. *Behaviour Research & Therapy*, 48(11), 1067 - 1077.
15. Ramchandani, P., Wiggs, L., Webb, V. & Stores, G (2000) A Systematic Review of treatments for settling problems and night waking in young children. *British Medical Journal*, 320 (7229), 209 – 213.
16. Reigstad, B., Jorgensen, K., Sund, A.M. & Wichstrom, L. (2009). Prevalence and correlates of sleep problems among adolescents in speciality mental health services and in the community: What differs? *Nordic Journal of Psychiatry*, 64(3), 172-180.
17. Schlarb, A.A., Liddle, C.C., Hautzinger, M. (2011). JuSt – a multimodal program for treatment of insomnia in adolescents: a pilot study, Nature and Science of Sleep, (3) 13-20.
18. Schlarb, A.A., Velten-Schurian, K., Poets, C.F. & Hautzinger, M. (2011). First effects of a multi-component treatment for sleep disorders in children. Nature and Science of Sleep, 3, 1-11.
19. Wong, M.M., Brower, K.J., Nigg, J.T. & Zucker, R.A. (2010). Childhood Sleep Problems, Response Inhibition, and Alcohol and Drug Outcomes in Adolescence and Young Adulthood. Alcoholism: Clinical and Experimental Research, 34 (6) 1033-1044.

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BACK
NEXT

MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

1. AACAP Work Group on Quality Issues. (1998). Summary of the practice parameters for the assessment and treatment of children and adolescents with substance abuse disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 122-126.
2. Abeles, P. & Verduyn, C. (2009). Computerized CBT for adolescent depression ("Stressbusters") and its initial evaluation through an extended case series. Behavioural and Cognitive
3. Ackerson, J., Scogin, F., McKendree-Smith, N., Lyman, R. D. (1998). Cognitive bibliotherapy for mild and moderate adolescent depressive symptomatology. Journal of Consulting and Clinical Psychology, 66, 685-690.
4. Angold, A., Costello, E. J. (2001). The epidemiology of depression in children and adolescents. In I. M. Goodyer (Eds.), The Depressed Child and Adolescent. 2nd ed. (pp. 143–178). Cambridge Child and Adolescent Psychiatry series. Cambridge: Cambridge University Press.
5. Angold, A., Costello, E. J., Worthman, C. M. (1998). Puberty and depression: the roles of age, pubertal status and pubertal timing. Psychological Medicine, 28, 51–61.
6. Asarnow, J. R., Jaycox, L. H., Tompson, M. C. (2001). Depression in youth: Psychosocial interventions. Journal of Clinical Child Psychology, (30), 33-47.
7. Biederman, J., Faraone, S., Lelon, E. (1995). Psychiatric comorbidity among referred juveniles with major depression: Fact or artifact? Journal of the American Academy of Child & Adolescent Psychiatry, 34, 579-590.
8. Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., Iyengar, S., Johnson, B. A. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. Archives of General Psychiatry, 54, 877-885.
9. Briere, F. N., Rohde, P., Shaw, H., & Stice, E. (2014). Moderators of two indicated cognitive-behavioral depression prevention approaches for adolescents in a school-based effectiveness trial. Behaviour Research and Therapy, 53, 55-62.
10. Calati, R., Pedrini, L., Alighieri, S., Alvarez, M. I., Desideri, L., Durante, D., ... & De Girolamo, G. (2011). Is cognitive behavioural therapy an effective complement to antidepressants in adolescents? A meta-analysis. Acta Neuropsychiatrica, 23(6), 263-271.
11. Carr, V. A. J., Boyd, C. P. (2003). Efficacy of Treatments for Depression in Children and Adolescents. Behaviour Change, 20 (2), 103-108.

INDEX
BACK
NEXT

MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

12. 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, 272-279.
13. Cohen, P., Cohen, J., Kasen, S., Velez, C. N., Hartmark, C., Johnson, J., Rojas, M., Brook, J., Struening, E. L. (1993). An epidemiological study of disorders in late childhood and adolescence: I. Age- and gender-specific prevalence. Journal of Child Psychology & Psychiatry, 34, 851-867.
14. Compton, S. N., March, J. S., Brent, D., Albano, A. M., Weersing, R., Curry, J. (2004). Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders and Children and Adolescents: An Evidence-Based Medicine Review. Journal of American Academy of Child and Adolescent Psychiatry, 43, 930-959.
15. Cox GR, Callahan P, Churchill R, Hunot V, Merry SN, Parker AG, Hetrick SE. Psychological therapies versus antidepressant medication, alone and in combination for depression in children and adolescents. Cochrane Database of Systematic Reviews 2014, Issue 11. Art. No.: CD008324. DOI: 10.1002/14651858.CD008324.pub3.
16. Cox GR, Fisher CA, De Silva S, Phelan M, Akinwale OP, Simmons MB, Hetrick SE. Interventions for preventing relapse and recurrence of a depressive disorder in children and adolescents. Cochrane Database of Systematic Reviews 2012, Issue 11. Art. No.: CD007504. DOI: 10.1002/14651858.CD007504.pub2.
17. Challen, A. R., Machin, S. J., & Gillham, J. E. (2014). The UK Resilience Programme: A school-based universal nonrandomized pragmatic controlled trial. Journal of consulting and clinical psychology, 82(1), 75.
18. Cuijpers, P., Geraedts, A. S., van Oppen, P., Andersson, G., Markowitz, J. C., & van Straten, A. (2011). Interpersonal Psychotherapy for Depression: A Meta-Analysis. American Journal of Psychiatry, 168, 581-592.
19. Dolle, K., & Schulte-Koerne, G. (2014). Complementary Treatment Methods for Depression in Children and Adolescents. Praxis Der Kinderpsychologie Und Kinderpsychiatrie, 63, 237-263.
20. Dunnachie, B. (2007). Evidence-Based Age-Appropriate Interventions – A Guide for Child and Adolescent Mental Health Services (CAMHS). Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development
21. Emslie, G., Kratochvil, C., Vitiello, B., Silva, S., Mayes, T., McNulty, S., Weller, E., Waslick, B., Casat, C., Walkup, J., Pathak, S., Rohde, P., Posner, K., March, J., The Columbia Suicidality Classification Group & The TADS Team. (2006). National Institute of Mental Health Treatment for Adolescents with Depression Study (NIMH TADs): Safety Results. Journal of American Academy of Child and Adolescent Psychiatry 45: 1440-1455.

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MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

22. Erford, B. T., Erford, B. M., Lattanzi, G., Weller, J., Schein, H., Wolf, E., ... & Peacock, E. (2011). Counseling Outcomes From 1990 to 2008 for School-Age Youth With Depression: A Meta-Analysis. *Journal of Counseling & Development*, 89(4), 439-457.
23. Fleming, T., Dixon, R., Frampton, C., & Merry, S. (2012). A Pragmatic Randomized Controlled Trial of Computerized CBT (SPARX) for Symptoms of Depression among Adolescents Excluded from Mainstream Education. Behavioural and Cognitive Psychotherapy, 40, 529-541.
24. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2006). What Works for Whom? A Critical Review of Treatments for Children and Adolescents. The Guildford Press: New York.
25. Garber, J., Clarke, G. N., Weersing, V. R., Beardslee, W. R., Brent, D. A., Gladstone, T. R. G., et al. (2009). Prevention of depression in at-risk adolescents. JAMA: The Journal of the American Medical Association, 301(21), 2215-2224.
26. Gillham, J. E., Reivich, K. J., Brunwasser, S. M., Freres, D. R., Chajon, N. D., Kash-MacDonald, V. M., Chaplin, T. M., Abenavoli, R. M., Matlin, S. L., Gallop, R. J., & Seligman, M. E. P. (2012). Evaluation of a Group Cognitive-Behavioral Depression Prevention Program for Young Adolescents: A Randomized Effectiveness Trial. Journal of Clinical Child and Adolescent Psychology, 41, 621-639.
27. Goodyer, I. M., Herbert, J., Secher, S., Pearson, J. (1997). Short-term outcome of major depression, I: Comorbidity and severity at presentation as predictors of persistent disorder. Journal of the American Academy of Child & Adolescent Psychiatry, 36, 474-480.
28. Hammen, C., Brennan, P. A., Keenan-Miller, D., Herr, N. R. (2008). Early onset recurrent subtype of adolescent depression: clinical and psychosocial correlates. Journal of Child Psychology and Psychiatry, 49 (4), 433-440.
29. Harrington, R. Whittaker, J., Shoebridge, P., Campbell, F. (1998). Systematic review of efficacy of cognitive behaviour therapies in childhood and adolescent depressive disorder. British Medical Journal, 316, 1559-1563.
30. Hazell, P. (2011). Depression in children and adolescents. Clinical evidence, 2011.
31. Hetrick, S. E., Cox, G. R., & Merry, S. N. (2011). Treatment-resistant depression in adolescents: is the addition of cognitive behavioral therapy of benefit? Psychology research and behavior management, 4, 97-112.

MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

32. Hoek, W., Schuurmans, J., Koot, H. M., & Cuijpers, P. (2012). Effects of Internet-Based Guided Self-Help Problem-Solving Therapy for Adolescents with Depression and Anxiety: A Randomized Controlled Trial. Plos One, 7.

33. Horn, H., Geiser-Elze, A., Reck, C., Hartmann, M., Stefini, A., Victor, D., Winkelmann, K. & Kronmüller, K. T. (2005). Efficacy of short term psychotherapy for children and adolescents with depression. Praxis Kinderpsychol Kinderpsychiatr, 54 (7), 578- 597.

34. Kennard, B., Silva, S., Vitiello, B., Curry, J., Kratochvil, C., Simons, A., Hughes, J., Feeny, N., Weller, E., Sweeney, M., Reinecke, M., Pathak, S., Ginsburg, G., Emslie, G., March, J., The TADS Team. (2006). Remission and Residual Symptoms after Short-Term Treatment in the Treatment of Adolescents with Depression Study (TADS). Journal of American Academy of Child and Adolescent Psychiatry, 45, 1404-1411.

35. Kennard BD, Clarke GN, Weersing VRAsarnow JR,Shamseddeen W, Porta G, Berk M, Hughes JL, Spirito A, Emslie GJ, Keller MB, Wagner KD, Brent DA. Effective Components of TORDIA Cognitive–Behavioral Therapy for Adolescent Depression: Preliminary Findings, Journal of Consulting and Clinical Psychology Vol. 77, No. 6, 1033–1041

36. Kessler, R. C., McGonagle, K. A., Nelson, C. B., Hughes, M., Swartz, M., Blazer, D. G. (1994). Sex and depression in the National Comorbidity Survey: II. Cohort effects. Journal of Affective Disorders, 30, 15-26.

37. Kindt, K. C. M., Kleinjan, M., Janssens, J. M. A. M., & Scholte, R. H. J. (2014). Evaluation of a School-Based Depression Prevention Program among Adolescents from Low-Income Areas: A Randomized Controlled Effectiveness Trial. International Journal of Environmental Research and Public Health, 11, 5273-5293.

38. Kisicki, M., & Varley, C. K. (2013). Review: Relative effectiveness of antidepressants and psychological therapies for depression in children and adolescents unclear. Evidence-based mental health, 16, 46-46.

39. Kovacs, M., Gatsonis, C. (1989). Stability and change in childhood-onset depressive disorders: Longitudinal course as a diagnostic validator. In L. N. Robbins & J. E. Barrett (Eds.), The validity of psychiatric diagnosis (pp. 57-73.) New York: Raven.

40. Kroll, L., Harrington, R., Jayson, D., Fraser, J., Gowers, S. (1996). Pilot study of continuation cognitive-behavioral therapy for major depression in adolescent psychiatric patients. Journal of the American Academy of Child & Adolescent Psychiatry, 35, 1156-1161

41. Lewinsohn, P. M., Clarke, G. N., Rohde, P. (1994). Psychological approaches to the treatment of depression in adolescents. In W. M. Reynolds & H. F. Johnston (Eds.), Handbook of depression in children and adolescents (pp. 309-344). New York: Plenum Press.

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MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

42. Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., Andrews, J. A. (1993). Adolescent Psychopathology: I. Prevalence and incidence of depression and other DSM-III-R disorders in High School students. Journal of Abnormal Psychology, 102, 133-144.
43. Lewinsohn, P. M., Rohde, P., Klein, D., Seeley, J. R. (1999). Natural course of adolescent major depressive disorder: I. Continuity into young adulthood. Journal of the American Academy of Child & Adolescent Psychiatry, 38, 56-63.
44. Lewinsohn, P. M., Zinbarg, R., Seeley, J. R., Lewinsohn, M., Sack, W. H. (1997). Lifetime comorbidity among anxiety disorders and between anxiety disorders and other mental disorders in adolescents. Journal of Anxiety Disorders, 11, 377- 394.
45. Lewinsohn, P. M., Clarke, G. N. Hops, H., Andrews, J. (1990). Cognitive-Behavioral Treatment for Depressed Adolescents. Behavior Therapy, 21, 385-401.
46. Ma, D., Zhang, Z., Zhang, X., & Li, L. (2014). Comparative efficacy, acceptability, and safety of medicinal, cognitive-behavioral therapy, and placebo treatments for acute major depressive disorder in children and adolescents: a multiple-treatments meta-analysis. Current Medical Research and Opinion, 30, 971-995.
47. March, J., Silva, S., Vitiello, B., The TADS Team. (2006). The Treatment for Adolescents with Depression Study (TADS): Methods and Message at 12 weeks. Journal of American Academy of Child and Adolescent Psychiatry, 45, 1393-1403.
48. March J.S., & Vitiello B. (2009). Clinical messages from the treatment for adolescents with depression study (TADS) The American journal of psychiatry, 166 (10)1118 -1123.
49. McCarty, C. A., Violette, H. D., Duong, M. T., Cruz, R. A., & McCauley, E. (2013). A Randomized Trial of the Positive Thoughts and Action Program for Depression Among Early Adolescents. *Journal of Clinical Child & Adolescent Psychology*, 42(4), 554-563.
50. Merry SN, Hetrick SE, Cox GR, Brudevold-Iversen T, Bir JJ, McDowell H. Psychological and educational interventions for preventing depression in children and adolescents. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD003380. DOI: 10.1002/14651858.CD003380.pub3
51. Merry, S. N., Stasiak, K., Shepherd, M., Frampton, C., Fleming, T., & Lucassen, M. F. G. (2012). The effectiveness of SPARX, a computerised self help intervention for adolescents seeking help for depression: randomised controlled non-inferiority trial. British Medical Journal, 344.
52. Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., Weissman, M. M. (2004). A Randomized Effectiveness Trial of Interpersonal Psychotherapy for Depressed Adolescents. Archives of General Psychiatry, 61, 577-584.

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MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

53. Mufson, L., Moreau, D., Weissman, M. M., Wickramaratne, P., Martin, J., Samoilov, A. (1994). Modification of interpersonal psychotherapy with depressed adolescents (IPT-A): Phase I and II studies. Journal of the American Academy of Child & Adolescent Psychiatry, 33, 695-705.
54. Mufson, L., Weissman, M. M., Moreau, D., Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-9.
55. Mychailyszyn, M. P., Brodman, D. M., Read, K. L., & Kendall, P. C. (2012). Cognitive-Behavioral School-Based Interventions for Anxious and Depressed Youth: A Meta-Analysis of Outcomes. Clinical Psychology-Science and Practice, 19, 129-153.
56. Murray, J., Cartwright-Hatton, S. (2006). NICE Guidelines on Treatment of Depression in Childhood and Adolescence: Implications from a CBT Perspective. Behavioural and Cognitive Psychotherapy, 34, 129-137.
57. National Institute for Health and Clinical Excellence (NICE). (2005). Depression in children and young people: Identification and management in primary, community and secondary care. UK: National Institute for Health and Clinical Excellence.
58. National Institute for Health and Clinical Excellence (NICE) (2013) Depression in children and young people: Identification and management in primary, community and secondary care- Centre for Clinical Practice – Surveillance Programme. UK: National Institute for Health and Clinical Excellence.
59. Pössel, P., Martin, N. C., Garber, J., & Hautzinger, M. (2013). A randomized controlled trial of a cognitive-behavioral program for the prevention of depression in adolescents compared with nonspecific and no-intervention control conditions. Journal of counseling psychology, 60(3), 432.
60. Reinecke, M. A., Ryan, N. E., DuBois, D. L. (1998). Cognitive behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 26-34.
61. Rohde, P. (2006). Cognitive-Behavioral Treatment for Depression in Adolescents. Journal of Indian Association for Child and Adolescent Mental Health, 1 (1), 6.
62. Rohde, P., Clarke, G. N., Macem D. E., Jorgensen, M. A., Seeley, J. R. (2004). An Efficacy/ Effectiveness Study of Cognitive- Behavioral Treatment for Adolescents with Comorbid Major Depression and Conduct Disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 660-668.
63. Rosselló, J., Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. Journal of Consulting & Clinical Psychology, 67, 734-745.

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BACK
NEXT

MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

64. Stallard, P., Phillips, R., Montgomery, A. A., Spears, M., Anderson, R., Taylor, J., Araya, R., Lewis, G., Ukoumunne, O. C., Millings, A., Georgiou, L., Cook, E., & Sayal, K. (2013). A cluster randomised controlled trial to determine the clinical effectiveness and cost-effectiveness of classroom-based cognitive-behavioural therapy (CBT) in reducing symptoms of depression in high-risk adolescents. Health technology assessment (Winchester, England), 17, vii-xvii, 1-109.

65. Stallard, P., Richardson, T., Velleman, S., Attwood, M. (2011). Computerized CBT (Think, Feel, Do) for depression and anxiety in children and adolescents: Outcomes and feedback from a pilot randomized controlled trial. Behavioural and Cognitive Psychotherapy. 39 (3), 273-284.

66. Stasiak, K., Hatcher, S., Frampton, C., & Merry, S. N. (2014). A Pilot Double Blind Randomized Placebo Controlled Trial of a Prototype Computer-Based Cognitive Behavioural Therapy Program for Adolescents with Symptoms of Depression. Behavioural and Cognitive Psychotherapy, 42, 385-401.

67. Straub, J., Koelch, M., Fegert, J., Plener, P., Gonzalez-Aracil, I., Voit, A., & Sproeber, N. (2013). Innovations in Practice: MICHI, a brief cognitive-behavioural group therapy for adolescents with depression - a pilot study of feasibility in an inpatient setting. Child and Adolescent Mental Health, 18, 247-250.

68. Target, M., Fonagy, P. (1994). The efficacy of psychoanalysis for children with emotional disorders. Journal of the American Academy of Child & Adolescent Psychiatry, 33, 361-371.

69. Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J., Tsiantis, J. (2007). Childhood Depression: A Place for Psychotherapy. An Outcome Study Comparing Individual Psychodynamic Psychotherapy and Family Therapy. European Journal of Child and Adolescent Psychiatry, (16), 157-167.

70. Trowell, J., Rhode, M., Miles, G., Sherwood, I. (2003). Childhood depression: work in progress. Journal of Child Psychotherapy, 29 (2), 147-170.

71. Weisz, J. R., Thurber, C. A., Sweeney, L., Proffitt, V. D., LeGagnoux, G. L. (1997). Brief treatment of mild-to-moderate child depression using primary and secondary control enhancement training. Journal of Consulting and Clinical Psychology, 65, 703-707.

72. Werry, J. S., McClellan, J. M., Chard, L. (1991). Childhood and adolescent schizophrenia, bipolar and schizoaffective disorders: A clinical and outcome study. Journal of the American Academy of Child & Adolescent Psychiatry, 30, 457-465.

73. Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Philips, J., Pilling, S., Stein, S., Target, M. (2006). Drawing on the Evidence: Advice for mental health professionals working with children and adolescents (2nd Ed.) London: CAMHS Publications.

INDEX
BACK
NEXT

MOOD DISORDERS, INCLUDING DEPRESSION AND MOOD DYSREGULATION

74. Wood, A., Harrington, R., Moore, A. (1996). Controlled Trial of a Brief Cognitive-Behavioural Intervention in Adolescent Patients with Depressive Disorders. Journal of Child Psychology and Psychiatry, 37 (6), 737-74.

75. Yannacci, J., Rivard, J.C. (2006). Matrix of Children's Evidence-Based Interventions. National Association of State Mental Health Program Directors (NASMHPD) Research Institute Centre for Mental Health Quality and Accountability (CMHQA) Report.

76. Sawyer, M.G., Pfeiffer, S., Spence, S.H., Bond, L., Graetz, B., Kay, D., Patton, G. & Sheffield, J. (2009). School-based prevention of depression: a randomized controlled study of the beyondblue schools initiative. Jounral of Child Psychology and Psychiatry, 51, 199-209.

77. van Zoonen, K., Buntrock, C., Ebert, D. D., Smit, F., Reynolds, C. F., III, Beekman, A. T. F., & Cuijpers, P. (2014). Preventing the onset of major depressive disorder: A meta-analytic review of psychological interventions. International Journal of Epidemiology, 43, 318-329.

78. Wijnhoven, L. A. M. W., Creemers, D. H. M., Vermulst, A. A., Scholte, R. H. J., & Engels, R. C. M. E. (2014). Randomized Controlled Trial Testing the Effectiveness of a Depression Prevention Program ('Op Volle Kracht') Among Adolescent Girls with Elevated Depressive Symptoms. Journal of Abnormal Child Psychology, 42, 217-228.

SCHIZOPHRENIA / PSYCHOSIS

1. Addington, J., McCleery, A., Addington, A. (2005). Three year outcome of family work in an early psychosis programme. Schizophrenia Research, 79, 107-116.
2. American Academy of Child and Adolescent Psychiatry. (1999) Practice parameters for the assessment of children, adolescents and adults with autism and other pervasive developmental disorders. Journal of the American Academy of Child & Adolescent Psychiatry, 3, 32S-54S.
3. American Academy of Child and Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. Journal of the American Academy of Child & Adolescent Psychiatry, 40 (7 Suppl), 4S-23S.
4. Brandon A. G., Herbert J. D. (2006). Acute treatment of inpatients with psychotic symptoms using Acceptance and Commitment Therapy: Pilot results. Behaviour Research and Therapy, 44, (3), 415-437.
5. Eaton, W. W., Bilker, W., Haro, J. M., Herrman, H., Mortensen, P. B., Freeman, H., Burgess, P. (1992a). Long-term course of hospitalization for schizophrenia: Part II. Change with passage of time. Schizophrenia Bulletin, 18, 229-241.
6. Eaton, W. W., Mortensen, P. B., Herrman, H., Freeman, H., Bilker, W., Burgess, P., Wooff, K. (1992b). Long-term course of hospitalization for schizophrenia: Part I. Risk for rehospitalization. Schizophrenia Bulletin, 18, 217-22
7. Falloon, I. R., Coverdale, J. H., Laidlaw, T. M., Merry, S., Kydd, R. R., Morosini, P. (1998). Early intervention for schizophrenic disorders. Implementing optimal treatment strategies in routine clinical services. British Journal of Psychiatry, 172 (Supplement 33), 33-38.
8. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2000). A Review of the Outcomes of all Treatments of Psychiatric Disorder in Childhood. MCH 17-33. Final Report to the National Service Executive, July 2000. USA: Authors.
9. Haddock, G. & Lewis, S. (2005). Psychological interventions in early psychosis. Schizophrenia Bulletin, 31 (3), 697-704.
10. Hernandez, R.J.C., Rime, J.W., & Jimerson, S.R. (2013). The school psychologist's primer on early onset schizophrenia: a review of research regarding epidemiology, etiology, assessment, and treatment. Contemporary School Psychology, 17(1), 51-69.
11. Lewis, S., Tarrier, N., & Haddock, G. (2002). Randomised controlled trial of CBT in early schizophrenia: acute phase outcomes. British Journal of Psychiatry, 181, 91-97.

INDEX
BACK
NEXT

SCHIZOPHRENIA / PSYCHOSIS

12. Moritz S, Woodward TS. 2007b. Metacognitive training in schizophrenia: from basic research to knowledge translation and intervention. Current Opinions in Psychiatry, 20:619-625.
13. Morrison, A.P., Bentall, R.P., French, P., et al (2002). A randomised controlled trial of early detection and cognitive therapy for preventing transition to psychosis. British Journal of Psychiatry, 181, 78-84.
14. NICE (2013). *Psychosis and schizophrenia in children and young people: Recognition and management*. Clinical NICE Guideline 155. Available at http://www.nice.org.uk/guidance/cg155 [NICE Guidelines]
15. SIGN (2013). *Management of Schizophrenia*. SIGN National Clinical Guideline 131. Avsilable at http://www.sign.ac.uk/pdf/sign131.pdf
16. Tarrier, N., Lewis, S., Haddock, G., Bentall, R., et al (2004). Cognitive-behavioural therapy in first episode and early schizophrenia: 18 month follow up of a randomised controlled trial. British Journal of Psychiatry, 184, 231-239.
17. Wragg, J. A., Whitehead, R. E. (2004). CBT for adolescents with psychosis: investigating the feasibility and effectiveness of early intervention. Behavioural and Cognitive Psychotherapy, 32, 313-329.
18. Wykes, T., Newton, E., Landau, S., Rice, C., Thompson, N., Frangou, S. (2007). Cognitive remediation therapy for young early onset patients with schizophrenia: an exploratory randomised controlled trial. Schizophrenia Research, 94, 221-230.
19. Yung, A. R. (2007). Identification and treatment of the prodromal phase of psychotic disorder: perspectives from the PACE Clinic. Early Intervention in Psychiatry, 1 (3), 224-235.
20. Zigler, E., Levine, J. (1981). Age of first hospitalisation of schizophrenia. Journal of Abnormal Psychology, 90, 458-467

SELF-HARM AND INTERPERSONAL DIFFICULTIES

1. Andover, M.S., Pepper, C.M. & Gibb, B.E. (2007). Self-mutilation and coping strategies in a college sample. Suicide and Life Threatening Behavior, 37, 238-243.
2. Asarnow, J. R., Porta, G., Spirito, A., Emslie, G., Clarke, G., Wagner, K. D., et al. (2011). Suicide Attempts and Nonsuicidal Self-Injury in the Treatment of Resistant Depression in Adolescents: Findings from the TORDIA Study. Journal of the American Academy of Child and Adolescent Psychiatry, 50(8), 772-781.
3. Bancroft, J., Skrimshire, A., Casson, J., et al. (1977). People who deliberately poison or injure themselves: their problems and their contacts with helping agencies. Psychological Medicine, 77, 289–303.
4. Brent, D. A., McMakin, D. L., Kennard, B. D., Goldstein, T. R., Mayes, T. L., & Douaihy, A. B. (2013). Protecting Adolescents From Self-Harm: A Critical Review of Intervention Studies. Journal of the American Academy of Child and Adolescent Psychiatry, 52(12), 1260-1271.
5. De Silva, S., Parker, A., Purcell, R., Callahan, P., Liu, P., & Hetrick, S. (2013). Mapping the Evidence of Prevention and Intervention Studies for Suicidal and Self-Harming Behaviors in Young People. Crisis-the Journal of Crisis Intervention and Suicide Prevention, 34(4), 223-232.
6. Fleischhaker, C., Munz, M., Böhme, R., Sixt, B. & Schulz, E. (2006). Dialectical Behaviour Therapy for adolescents (DBT-A)--a pilot study on the therapy of suicidal, parasuicidal, and self-injurious behaviour in female patients with a borderline disorder. Z Kinder Jugendpsychiatr Psychother., 34 (1), 15-25.
7. Fischer, G., Brunner, R., Parzer, P., Resch, F., & Kaess, M. (2013). Short-term psychotherapeutic treatment in adolescents engaging in non-suicidal self-injury: a randomized controlled trial. Trials, 14
8. Greenfield, B., Larson, C., Hechtman, L, Rousseau, C & Platt, R. (2002). A Rapid-Response Outpatient Model for Reducing Hospitalization Rates Among Suicidal Adolescents. Psychiatric Services, 53, 1574-1579
9. Green, J. M., Wood, A. J., Kerfoot, M. J., Trainor, G., Roberts, C., Rothwell, J., et al. (2011). Group therapy for adolescents with repeated self harm: randomised controlled trial with economic evaluation. British Medical Journal, 342.
10. Hawton, K. & Catalan, J. (1982). Attempted Suicide: A Practical Guide to its Nature and Management. Oxford University Press: Oxford.
11. Hawton, K. & James, A. (2005). Suicide and deliberate self-harm in young people. British Medical Journal, 330, 891-894.

INDEX
BACK
NEXT

SELF-HARM AND INTERPERSONAL DIFFICULTIES

12. Hawton, K., Rodham, K., Evans, E. & Weatherall, R. (2002). Deliberate self-harm in adolescents: a self-report survey in schools in England. British Medical Journal, 325, 1207-1211.
13. Hawton, K., Saunders, K. E. A., & O'Connor, R. C. (2012). Self-harm and suicide in adolescents. Lancet, 379(9834), 2373-2382.
14. Hawton, K., Zahl, D. & Weatherall, R. (2003) Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital. British Journal of Psychiatry, 182, 537–542.
15. Hazell, P.L., Martin, G., Mcgill, K., Kay, T.B., Wood, A, Trainor, G. & Harrington, R. (2009). Group Therapy for Repeated Deliberate Self-Harm in Adolescents: Failure of Replication of a Randomized Trial. Journal of the American Academy of Child & Adolescent Psychiatry, 48 (6), 662-670.
16. Huey, S. J., Henggeler, S.W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., et al. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 183–190.
17. James, A.C., Taylor, A., Winmill, L. & Alfoadari , K. (2008). A Preliminary Community Study of Dialectical Behaviour Therapy (DBT) with Adolescent Females Demonstrating Persistent, Deliberate Self-Harm (DSH). Child and Adolescent Mental Health, 13 (3), 148-152.
18. Kapur, N., House, A., Creed, F., et al. (1998) Management of deliberate self-poisoning in adults in four teaching hospitals: descriptive study. British Medical Journal, 316 (7134), 831–832.
19. Katz, L. Y., Gunasekara, S., Cox, B. J., & Miller, A. L. (2004). Feasibility of dialectical behavior therapy for parasuicidal adolescent inpatients. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 276–282.
20. Latimer, E. A., Gariepy, G., & Greenfield, B. (2014). Cost-Effectiveness of a Rapid Response Team Intervention for Suicidal Youth Presenting at an Emergency Department. Canadian Journal of Psychiatry-Revue Canadienne De Psychiatrie, 59(6), 310-318.
21. Madge, N., Hewitt, A., Hawton, K., Jan de Wilde, E., Corcoran, P., Fekete, S., vans Heeringen, K., De Leo, D. & Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: comparative findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Journal of Child Psychology and Psychiatry, 49 (6), 667-6777.

INDEX
BACK
NEXT

SELF-HARM AND INTERPERSONAL DIFFICULTIES

22. McDonell, M. G., Tarantion, J., Dubose, A. P., Matestic, P., Steinmetz, K., Galbreath, H., McClellan, J. M. (2010). A pilot evaluation of dialectical behavioural therapy in adolescent long-term inpatient care. Child and Adolescent Mental Health, 15 (4), 193-196.
23. Miller, T. R. & Taylor, D.M. (2005). Adolescent Suicidality: Who Will Ideate, Who Will Act? Suicide and Life Threatening Behavior, 35 (4), 425-435.
24. National Institute for Clinical Excellence (NICE) (2004). Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE; Clinical Guideline 16.
25. National Institute for Clinical Excellence (NICE) (2011). Self-harm: Longer-term management. NICE; Clinical Guideline 133.
26. National Institute for Clinical Excellence (NICE) (2013). Quality standard for self-harm. NICE; Quality Standard QS34.
27. National Records in Scotland (2013). Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent. Retrieved from: http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/suicides
28. Newton, A. S., Hamm, M. P., Bethell, J., Rhodes, A. E., Bryan, C. J., Tjosvold, L., ... & Manion, I. G. (2010). Pediatric suicide-related presentations: a systematic review of mental health care in the emergency department.Annals of emergency medicine, 56(6), 649-659.
29. Nock, M.K. & Mendes, W.B. (2008). Physiological arousal, distress tolerance, and social problem-solving deficits among adolescent self-injurers. Journal of Consulting and Clinical Psychology, 76, 28-38.
30. O'Connor, R.C., Rasmussen, S., Miles, J. & Hawton, K. (2009). Self-harm in adolescents: self-report survey in schools in Scotland. The British Journal of Psychiatry, 194, 68–72.
31. Oldershaw, A., Simic, M., Grima, E., Jollant, F., Richards, C., Taylor, L., et al. (2012). The Effect of Cognitive Behavior Therapy on Decision Making in Adolescents who Self-Harm: A Pilot Study. Suicide and Life-Threatening Behavior, 42(3), 255-265.
32. Ougrin, D., & Latif, S. (2011). Specific Psychological Treatment Versus Treatment as Usual in Adolescents with Self-Harm Systematic Review and Meta-Analysis. Crisis-the Journal of Crisis Intervention and Suicide Prevention, 32(2), 74-80.
33. Ougrin, D., Boege, I., Stahl, D., Banarsee, R., & Taylor, E. (2013). Randomised controlled trial of therapeutic assessment versus usual assessment in adolescents with self-harm: 2-year follow-up. Archives of Disease in Childhood, 98(10), 772

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BACK
NEXT

SELF-HARM AND INTERPERSONAL DIFFICULTIES

34. Ougrin, D., Tranah, T., Leigh, E., Taylor, L., & Asarnow, J. R. (2012). Practitioner Review: Self-harm in adolescents. Journal of Child Psychology and Psychiatry, 53(4), 337-350.
35. Owens, D., Horrocks, J. & House, A. (2002). Fatal and non-fatal repetition of self-harm. Systematic review. British Journal of Psychiatry, 181, 193–199.
36. Perepletchikova, F., Axelrod, S. R., Kaufman, J., Rounsaville, B. J., Douglas-Palumberi, H., & Miller, A. L. (2011). Adapting Dialectical Behaviour Therapy for Children: Towards a New Research Agenda for Paediatric Suicidal and Non-Suicidal Self-Injurious Behaviours. Child and Adolescent Mental Health, 16(2), 116-121
37. Pineda, J., & Dadds, M. R. (2013). Family intervention for adolescents with suicidal behavior: a randomized controlled trial and mediation analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(8), 851-862.
38. Rossouw, T. I., & Fonagy, P. (2012). Mentalization-Based Treatment for Self-Harm in Adolescents: A Randomized Controlled Trial. Journal of the American Academy of Child and Adolescent Psychiatry, 51(12), 1304-1313.
39. Slee, N., Garnefski, N., Spinhoven, P., Arensman, E. (2008). The Influence of Cognitive Emotion Regulation Strategies and Depression Severity on Deliberate Self-Harm. Suicide and Life-Threatening Behavior, 38 (3), 274-286.
40. Slee, N., Garnefski, N., van der Leeden, R., Arensman, E., Spinhoven, P. (2008). Cognitive-behavioural intervention for self- harm. Randomised controlled trial. The British Journal of Psychiatry, 192, 202-211.
41. Stallard, P., Spears, M., Montgomery, A. A., Phillips, R., & Sayal, K. (2013). Self-harm in young adolescents (12-16 years): onset and short-term continuation in a community sample. Bmc Psychiatry, 13.
42. Taylor, L. M. W., Oldershaw, A., Richards, C., Davidson, K., Schmidt, U., & Simic, M. (2011). Development and Pilot Evaluation of a Manualized Cognitive-Behavioural Treatment Package for Adolescent Self-Harm. Behavioural and Cognitive Psychotherapy, 39(5), 619-625.
43. Tormoen, A. J., Groholt, B., Haga, E., Brager-Larsen, A., Miller, A., Walby, F., et al. (2014). Feasibility of dialectical behavior therapy with suicidal and self-harming adolescents with multi-problems: training, adherence, and retention. Archives of suicide research : official journal of the International Academy for Suicide Research, 18(4), 432-444.
44. Wood, A., Trainor, G., Rothwell, J., Moore, A., & Harrington, R. (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 40(11), 1246-1253.

SUBSTANCE USE DISORDERS

1. NICE (2011). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.* Clinical NICE Guideline 115. Available at guidance.nice.org.uk/cg115. [NICE Guideline]
2. Hogue, A., Henderson, C.E., Ozechowski, T.J. & Robbins, M.S. (2014) Evidence Base on Outpatient Behavioral Treatments for Adolescent Substance Use: Updates and Recommendations 2007-2013. Journal of Clinical Child & Adolescent Psychology, 43(5). doi:10.1080/15374416.2014.915550
3. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.Hodge, D.R., Jackson, K.F., & Vaughn, M.G. (2012). Culturally sensitive interventions and substance use: a meta-analytic review of outcomes among minority youths. Social Work Research, 36(1),11-19. doi: 10.1093/swr/svs008
4. Winters, K.C., Botzet, A.M. & Fahnhorst, T. (2011). Advances in adolescent substance abuse treatment. Current Psychiatry Reports, 13(5), 416-421. doi: 10.1007/s11920-011-0214-2
5. Bender, K., Tripodi, S.J., Sarteschi, C. & Vaughn, M.G. (2011). A meta-analysis of interventions to reduce adolescent cannabis use. Research on Social Work Practice, 21(2), 153-164. doi: 10.1177/1049731510380226
6. Foxcroft, D.R. & Tsertsvadze, A. (2011). Universal family-based prevention programs for alcohol misuse in young people. Cochrane Reviews, 2011. doi: 10.1002/14651858.CD009308
7. von Sydow, K., Retzlaff, R., Beher, S., Haun, M.W. & Schweitzer, J. (2013). The efficacy of systemic therapy for childhood and adolescent externalizing disorders: A systematic review of 47 RCT. Family Process, 52(3), 576-618. doi: 10.1111/famp.12047
8. Foxcroft, D.R. & Tsertsvadze, A. (2011). Universal multi-component prevention programs for alcohol misuse in young people. Cochrane Reviews, 2011. doi: 10.1002/14651858.CD009307
9. Tanner-Smith, E.E., Wilson, S.J. & Lipsey, M.W. (2013). The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. Journal of Substance Abuse Treatment, 44(2), 145-158. doi:10.1016/j.jsat.2012.05.006
10. Smedslund, G., Berg, R.C., Hammerstrom, K.T., Steiro, A., Leiknes, K.A., Dahl, H.M. & Karlsen, K. (2011). Motivational interviewing for substance abuse. Cochrane Reviews, 2011. doi: 10.1002/14651858.CD008063.pub2

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BACK
NEXT

SUBSTANCE USE DISORDERS

11. Jensen, C.D., Cushing, C.C., Aylward, B.S., Craig, J.T., Sorell, D.M. & Steele, R.G. (2011). Effectiveness of Motivational Interviewing Interventions for Adolescent Substance Use Behavior Change: A Meta-Analytic Review. Journal of Consulting and Clinical Psychology, 79(4), 433.440. doi: 10.1037/a0023992

12. Hides, L., Carroll, S., Scott, R., Cotton, S., Baker, A., & Lubman, D. I. (2012). Quik Fix: A Randomized Controlled Trial of an Enhanced Brief Motivational Interviewing Intervention for Alcohol/Cannabis and Psychological Distress in Young People. *Psychotherapy and psychosomatics*, 82(2), 122-124.

13. Foxcroft, D.R. & Tsertsvadze, A. (2011). Universal school-based prevention programs for alcohol misuse in young people. Cochrane Reviews, 2011. doi: 10.1002/14651858. CD009113

14. Koning, I. M., van den Eijnden, R. J., Verdurmen, J. E., Engels, R. C., & Vollebergh, W. A. (2013). A cluster randomized trial on the effects of a parent and student intervention on alcohol use in adolescents four years after baseline; no evidence of catching-up behavior. Addictive behaviors, 38(4), 2032-2039.

15. Toumbourou, J. W., Gregg, M., Shortt, A. L., Hutchinson, D. M., & Slaviero, T. M. (2013). Reduction of Adolescent Alcohol Use Through Family–School Intervention: A Randomized Trial. *Journal of adolescent health*, 53(6), 778-784.

REFERENCES

TRAUMA: PTSD AND COMPLEX TRAUMA

1. AACAP Work Group on Quality Issues. (1998). Summary of the practice parameters for the assessment and treatment of children and adolescents with substance abuse disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 37, 122-126.
2. Ahmad, A., Larsson, B., & Sundelin-Wahlsten, V. (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. Nordic Journal of Psychiatry, 61(5), 349-354.
3. Ahmad, A., Mohamad, K. (1996). The socioemotional development of orphans in orphanages and traditional foster care in Iraqi Kurdistan. Child Abuse & Neglect, 20, 1161-1173.
4. Banyard, V. L., Englund, D. W., & Rozelle, D. (2001). Parenting the traumatized child: attending to the needs of nonoffending caregivers of traumatized children. Psychotherapy, 38 (1), 74-87.
5. Berkowitz, S. J., Stover, C. S., & Marans, S. R. (2011). The child and family traumatic stress intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*, 52(6), 676-685
6. Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Richardson, D., Canobbio, R., Schweers, J., Roth, C. (1995). Posttraumatic stress disorder in peers of adolescent suicide victims. Journal of American Academy Child & Adolescent Psychiatry, 34, 204-215.
7. Carr, A. (2004). Interventions for post-traumatic stress disorder in children and adolescents. Pediatric Rehabilitation, 7, 231-244.
8. Cary, C. E., & McMillen, J. C. (2012). The data behind the dissemination: a systematic review of trauma-focused cognitive behavioral therapy for use with children and youth. Children and Youth Services Review, 34(4), 748-757.
9. Clark, D. B., Bukstein, O. G., Smith, M. G., Kaczynski, N. A., Mezzich, A. C., Donovan, J. E. (1995). Identifying anxiety disorders in adolescents hospitalized for alcohol abuse or dependence. Psychiatric Services, 46, 618-620.
10. Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. *European Journal of Psychotraumatology*, 4.
11. Cohen, J. A., Deblinger, E., Mannarino, A. P., Steer. R.A. (2004). A multi-site, randomised controlled trial for children with sexual abuse-related PTSD symptoms. Journal of the American Academy of Child and Adolescent Psychiatry, 43, 393-402.

INDEX
BACK
NEXT

TRAUMA: PTSD AND COMPLEX TRAUMA

12. Cohen, J. A., Mannarino, A., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive behavioral therapy for children and adolescents: An empirical update. Journal of Interpersonal Violence, 15, 1202-1223.
13. Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. Child Abuse & Neglect, 36(6), 528-541.
14. Cohen, J., Mannarino, A., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. Child Abuse and Neglect, 29(2), 135-145.
15. Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautard, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. Psychiatric Annals, 35, 390–398.
16. Corcoran, J., & Pillai, V. (2008). A meta-analysis of parent-involved treatment for child sexual abuse. Research on Social Work Practice, 18, 453-464.
17. Cuffe, S. P., McCullough, E. L., & Pumariega, A. J. (1994). Comorbidity of attention deficit hyperactivity disorder and posttraumatic stress disorder. Journal of Child & Family Studies, 3, 327-336.
18. Deblinger, E., Lippman, J., Steer, R. (1996). Sexually abused children suffering post-traumatic stress symptoms: initial treatment outcome findings. Child Maltreatment, 1, 310–321.
19. Deblinger, E., Mannarino, A., Cohen, J., & Streer, R. (2006). A follow-up study of a multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. Journal of the American Academy of Child and Adolescent Psychiatry, 45(12), 1474-1484.
20. Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: impact of the trauma narrative and treatment length. Depression and Anxiety, 28(1), 67-75.
21. Diehl, V. A., Zea, M. C., Espino, C. M. (1994). Exposure to war violence separation from parents: Posttraumatic stress and cognitive functioning in Hispanic children. Rev Int Psicol, 28, 25-41.
22. Diehle, J., Opmeer, B. C., Boer, F., Mannarino, A. P., & Lindauer, R. J. (2014). Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: what works in children with posttraumatic stress symptoms? A randomized controlled trial. European child & adolescent psychiatry, 1-10.

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BACK
NEXT

TRAUMA: PTSD AND COMPLEX TRAUMA

23. DiNocola, V. F. (1996). Ethnocentric aspects of posttraumatic stress disorder and related Disorders among children and adolescents. In A. J. Marsella, M.J. Friedman, E.T. Gerrity, & R.M.Scurfield(Eds.), Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research and Clinical Applications (pp. 389-414). Washington DC: American Psychological Press.
24. Doren, D. (2006) Recidivism risk assessments: making sense of controversies. In W. Marshall, Y. Fernandez, L. Marshall and G. Serran (Eds.), Sexual Offender Treatment. Controversial Issues (pp. 3–15). Chichester: Wiley.
25. Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing Trauma-focused Cognitive Behavioral Therapy with evidence-based engagement strategies. Child abuse & neglect, 38, 1508-1520.
26. Ehntholt, K. A., Smith, P. A., & Yule, W. (2005). School-based cognitive-behavioural therapy group intervention for refugee children who have experienced war-related trauma. Clinical Child Psychology and Psychiatry,10(2), 235-250.
27. Ehntholt, K. A., & Yule, W. (2006). Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry*, 47(12), 1197-1210.
28. Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: Risk and protective factors. The Lancet, 379(9812), 266-282.
29. Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. The Lancet, 365(9467), 1309-1314.
30. Feeny, C. N., Foa, E. B., Treadwell, K. R. H., March, J. (2004). Posttraumatic stress disorder in youth: a critical review of the cognitive and behavioural treatment outcome literature. Professional Psychology: Research and Practice, 35, 466-476.
31. Finkelhor, D., & Kendall-Tackett, K. (1997). A developmental perspective on the childhood impact of crime, abuse, and violent victimization. In D. Cicchetti & S. Toth (Eds.), Developmental perspectives on trauma: Theory, research, and intervention. Rochester symposium on developmental psychology, Vol. 8., (pp. 1-32). Rochester, NY, US: University of Rochester Press.
32. Fletcher, K. E. (2003). Childhood post-traumatic stress disorder. In E.J. Mash & R.A. Barkley (Eds.), Child Psychopathology. 2nd Edition. New York: Guildford Press.

TRAUMA: PTSD AND COMPLEX TRAUMA

33. Foa, E. B., McLean, C. P., Capaldi, S., & Rosenfield, D. (2013). Prolonged exposure vs supportive counseling for sexual abuse–related PTSD in adolescent girls: a randomized clinical trial. JAMA, 310(24), 2650-2657.
34. Fonagy, P., Target, M., Cottrell, D., Phillips, J., Kurtz, Z. (2015). What Works For Whom? A Critical Review of Treatments for Children and Adolescents. New York: The Guildford Press.
35. Forbes, F., Duffy, J. C., Mok, J., Lemvig, J. (2003). Early intervention service for non-abusing parents of victims of child sexual abuse. British Journal of Psychiatry, 183, 66-72.
36. Garrison, C. Z., Bryant, E. S., Addy, C. L., Spurrier, P. G., Freedy, J. R., Kilpatrick, D. G. (1995). Posttraumatic stress disorder in adolescents after Hurricane Andrew. Journal of the American Academy of Child & Adolescent Psychiatry, 34, 1193-1201.
37. Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk?. Child Abuse & Neglect, 35(7), 504-513.
38. Gillies, D., O'Brien, L., Rogers, P., Meekings, C. (2007). Psychological therapies for the prevention and treatment of post- traumatic stress disorder in children and adolescents. (Protocol) Cochrane Database of Systematic Reviews, Issue 3. Art. No.: CD006726.
39. Gillies D, Taylor F, Gray C, O'Brien L, D'Abrew N. Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. Cochrane Database of Systematic Reviews 2012, Issue 12. Art. No.: CD006726.
40. Harvey, S. T., & Taylor, J. E. (2010). A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents. Clinical Psychology Review, 30(5), 517-535.
41. Hetzel-Riggin, M. D., Brausch, A. M., Montgomery, B. S. (2007). A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study. Child Abuse & Neglect, 31, 125 -141.
42. Hiebert-Murphy, D., De Luca, R. V., & Runtz, M. (1992). Group treatment for sexually abused girls: Evaluating outcome. Families in Society, 73(4), 205-213.
43. Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S. O., & Dolatabadi, S. (2004). A comparison of CBT and EMDR for sexually-abused Iranian girls. Clinical Psychology & Psychotherapy, 11(5), 358-368.

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BACK
NEXT

TRAUMA: PTSD AND COMPLEX TRAUMA

44. Kagan, R., Douglas, A. N., Hornik, J., & Kratz, S. L. (2008). Real Life Heroes pilot study: evaluation of a treatment model for children with traumatic Stress.*Journal of Child & Adolescent Trauma*, 1(1), 5-22.
45. Kagan, R., Henry, J., Richardson, M., Trinkle, J., & LaFrenier, A. (2014). Evaluation of Real Life Heroes treatment for children with complex PTSD.*Psychological Trauma: Theory, Research, Practice, and Policy*, 6(5), 588.
46. Kagan, R., & Spinazzola, J. (2013). Real Life Heroes in residential treatment: Implementation of an integrated model of trauma and resiliency-focused treatment for children and adolescents with complex PTSD. *Journal of Family Violence*, 28(7), 705-715.
47. Kassam-Adams, N., Marsac, M. L., Hildenbrand, A., & Winston, F. (2013). Posttraumatic stress following pediatric injury: Update on diagnosis, risk factors, and intervention. JAMA pediatrics, 167(12), 1158-1165.
48. King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. Journal of the American Academy of Child and Adolescent Psychiatry, 39, 1347-1355.
49. Kramer, D. N., & Landolt, M. A. (2011). Characteristics and efficacy of early psychological interventions in children and adolescents after single trauma: a meta-analysis. European journal of psychotraumatology, 2.
50. Lanktree, C. B., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., ... & Freed, W. (2012). Treating Multitraumatized, Socially Marginalized Children: Results of a Naturalistic Treatment Outcome Study. *Journal of Aggression, Maltreatment & Trauma*, 21(8), 813-828.
51. Leenarts, L. E., Diehle, J., Doreleijers, T. A., Jansma, E. P., & Lindauer, R. J. (2013). Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review. European Child & Adolescent Psychiatry, 22(5), 269-283.
52. Lieberman, A., Horn, P. v., & Ippen, C. (2005). Towards evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. Journal of the American Academy of Child and Adolescent Psychiatry, 44(12), 1241-1248.
53. Lyshak-Stelzer, F., Singer, P., Patricia, S. J., & Chemtob, C. M. (2007). Art therapy for adolescents with posttraumatic stress disorder symptoms: A pilot study. Art Therapy, 24(4), 163-169.

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BACK
NEXT

TRAUMA: PTSD AND COMPLEX TRAUMA

54. Macdonald, G. M., Higgins, J. P. T., & Ramchandani, P. (2006). Cognitive-behavioural interventions for children who have been sexually abused. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD001930.

55. Macdonald, G., Higgins, J., Ramchandani, P., Valentine, J. C., Bronger, L. P., Klein, P., ... & Macdonald, G. (2012). Cognitive-behavioural interventions for children who have been sexually. Campbell Systematic Reviews, 14.

56. Manson, S., Beals, J., O'Neill, T., et al. (1996). Wounded spirits, ailing hearts: posttraumatic stress disorder and related disorders among American Indians. In A. J. Masella, M.J. Friedman, E. T. Gerrity et al. (Eds.), Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research and Clinical Applications (pp. 255-283). Washington DC: American Psychological Association.

57. May-Chahal, C., & Cawson, P. (2005). Measuring child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect. Child Abuse & Neglect, 29(9), 969-984.

58. Meca, J. S., Alcázar, A. I. R., & Soler, C. L. (2011). The psychological treatment of sexual abuse in children and adolescents: A meta-analysis. International Journal of Clinical and Health Psychology, 11(1), 67-93.

59. McMullen, J., O'Callaghan, P., Shannon, C., Black, A., & Eakin, J. (2013). Group trauma-focused cognitive-behavioural therapy with former child soldiers and other war-affected boys in the DR Congo: A randomised controlled trial. Journal of Child Psychology and Psychiatry, 54(11), 1231-1241.

60. Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K. & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(10), 980-989

61. National Institute for Health and Clinical Excellence (NICE) (2005). The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26. UK: National Institute for Health and Clinical Excellence.

62. NICE (2009). When to suspect child maltreatment (Update). NICE clinical guideline 89. Available at guidance.nice.org.uk/cg89 [NICE guideline]

63. O'Callaghan, P., McMullen, J., Shannon, C., Rafferty, H., & Black, A. (2013). A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited, war-affected Congolese girls. Journal of the American Academy of Child & Adolescent Psychiatry, 52(4), 359-369.

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BACK
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TRAUMA: PTSD AND COMPLEX TRAUMA

64. Parker, B., & Turner, W. (2013). Psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused. Cochrane Database of Systematic Reviews , Issue 7. Art. No.: CD008162.

65. Patel, N., Kellezi, B., & Williams, A. C. D. C. (2014). Psychological, social and welfare interventions for psychological health and well-being of torture survivors. The Cochrane Library.

66. Pereda, N., Guilera, G., Forns, M., & Gomez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. Clinical Psychology Review, 29(4), 328–338.

67. Pifalo, T. (2007). Jogging the cogs: Trauma-focused art therapy and cognitive behavioral therapy with sexually abused children. Art Therapy, 24(4), 170-175.

68. Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., ... & Tugwell, P. (2011). Evidence-based clinical guidelines for immigrants and refugees. Canadian Medical Association Journal, 183(12), E824-E925.

69. Proctor, L. J., & Dubowitz, H. (2014). Child Neglect: Challenges and Controversies. In Handbook of Child Maltreatment (pp. 27-61). Springer Netherlands.

70. Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. Journal of the American Academy of Child & Adolescent Psychiatry, 42 (3), 269-278.

71. Ramchandani, P., Jones, D. (2003). Treating psychological symptoms in sexually abused children: From research findings to service provision [Review]. The British Journal of Psychiatry, 183, 484-490.

72. Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7-to 16-year-olds: A randomized controlled trial with traumatized refugee children. Journal of Traumatic Stress, 23(4), 437-445.

73. Salmon, K. & Bryant, R.A. (2002). Posttraumatic stress disorder in children: The influence of developmental factors. Clinical Psychology Review, 22, 163-188.

74. Scheeringa, M. S., Zeanah, C. H., Drell, M. J., & Larrieu, J. A. (1995). Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, (2), 191.

75. Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: a randomized clinical trial. Journal of Child Psychology and Psychiatry, 52(8), 853-860.

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TRAUMA: PTSD AND COMPLEX TRAUMA

76. Smith, P., Yule, W., Perrin, S., Tranah, T., Dalgleish, T., & Clark, D. (2007). Cognitive-behavioural therapy for PTSD in children and adolescents: A preliminary randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 46(8), 1051-1061.

77. Trask, E. V., Walsh, K., & DiLillo, D. (2011). Treatment effects for common outcomes of child sexual abuse: A current meta- analysis. Aggression and violent behavior, 16(1), 6-19.

78. Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: a systematic review. PloS one, 9(2), e89359.

79. Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Philips, J., Pilling, S., Stein, S., Target, M. (2006). Drawing on the Evidence: Advice for mental health professionals working with children and adolescents (2nd Ed.) London: CAMHS Publications.

80. Yule, W. (2001). Post-traumatic stress disorder in children and adolescents. International Review of Psychiatry, 13, 194-200.

ACQUIRED BRAIN INJURY

1. Agnihotri, S., Gray, J., Colantonio, A. (2014). Arts-based social skills interventions for adolescents with acquired brain injuries: Five case reports. Developmental Neurorehabilitation, 17(1), 44-63. doi: 10.3109/17518423.2013.844739
2. Agnihotri, S., Gray, J., Colantonio, A., Polatajko, H., Cameron, D., Wiseman-Hakes, C., Rumney, P. & Keightley, M. (2012). Two case study evaluations of an arts-based social skills intervention for adolescents with childhood brain disorder. Developmental Neurorehabilitation, 15(4), 284-297. doi:10.3109/17518423.2012.673178
3. Antonini, T.N., Raj, S.P., Oberjohn, K.S., Cassedy, A., Makoroff, K.L., Fouladi, M. & Wade, S.L. (2014). A pilot randomized trial of an online parenting skills program for pediatric traumatic brain injury: Improvements in parenting and child behavior. Behavior Therapy, 45(4), 455-468. doi: 10.1016/j.beth.2014.02.003
4. Bradt, J., Magee, W.L., Dileo, C., Wheeler, B.L. & McGilloway, E. (2010). Music therapy for acquired brain injury. Cochrane Database of Systematic Reviews, 7. doi: 10.1002/14651858.CD006787.pub2
5. Braga, L.W., Rossi, L., Moretto, A.L., de Silva, J.M. & Cole, M. (2012). Empowering preadolescents with ABI through metacognition: Preliminary results of a randomized clinical trial. NeuroRehabilitation, 30(3), 205-212. doi: 10.3233/NRE-2012-0746.
6. Brett, A.W. & Laatsch, L. (1988) Cognitive rehabilitation therapy of brain injured children in a public high-school setting. Paediatric Rehabilitation, 2, 27-31
7. Brown, F.L., Whittingham, K., Boyd, R. & Sofronoff, K. (2013). A systematic review of parenting interventions for traumatic brain injury: child and parent outcomes. Journal of Head Trauma Rehabilitation, 28(5), 349-360.
8. Brown, F.L., Whittingham, K., Boyd, R.N., McKinlay, L. & Sofronoff, K. (2014). Improving child and parenting outcomes following paediatric acquired brain injury: a randomised controlled trial of Stepping Stones Triple P plus Acceptance and Commitment Therapy. The Jouranl of Child Psychology and Psychiatry, 55(10), 1172-1183. doi: 10.1111/jcpp.12227
9. Butler, R.W., Copeland, D.R., Fairclough, D.L., Mulhern, R.K., Katz, E.R., Kazak, A.E., Noll, R.B., Patel, S.K. & Sahler, O.J.Z. (2008) A multicenter, randomized clinical trial of a cognitive remediation program for childhood survivors of a pediatric malignancy. Journal of Consulting and Clinical Psychology, 76(3), 367-378
10. Butler, R.W. & Copeland, D.R. (2002) Attentional processes and their remediation in children treated for cancer: A literature review and the development of a therapeutic apparoach. Journal of the International Neuropsychological Society, 8(1), 115-124

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ACQUIRED BRAIN INJURY

11. Catroppa, C., Anderson, V.A., Muscara, F., Morse, S.A., Haritou, F., Rosenfeld, J.V. and Heinrich, L.M. (2009) Educational skills: Long-term outcome and predictors following paediatric traumatic brain injury. Neuropsychological Rehabilitation, 19(5),716-732
12. Catroppa, C., Stone, K., Rosema, S., Soo, C. & Anderson, V. (2014). Preliminary efficacy of an attention and memory intervention post-childhood brain injury. Brain Injury, 28(2), 252-260. doi: 10.3109/02699052.2013.860471
13. Chan, D.Y.K. & Fong, K.N.K. (2011). The effects of problem-solving skills training based on metacognitive principles for children with acquired brain injury attending mainstream schools: a controlled clinical trial. Disability and Rehabilitation, 33 (21-22), 2023-2032. doi: 10.3109/09638288.2011.556207
14. Crowley, J.A. & Miles, M.A. (1991) Cognitive remediation in paediatric head injury: A case study. Journal of Paediatric Psychology, 16, 611-627
15. Department of Health (2004) Acquired Brain Injury, National Service Framework for Children, Young People and Maternity Services London: DoH
16. Foster, A.M., Armstrong, J., & Buckley, A…(2012). Encouraging family engagement in the rehabilitation process: a rehabilitation provider's development of support strategies for family members of people with traumatic brain injury. Disability & Rehabilitation, 34(22), 1855-1862. doi: 10.3109/09638288.2012.670028.
17. Franzen, K.M., Roberts, M.A., Schmitdts, D., Verduyn, W. & Manshadi, F. (1996) Cognitive remediation in pediatric traumatic brain injury. Child Neuropsychology, 2, 176-184
18. Galbiati, S., Recla, M., Pastore, V., Liscio, M., Bardoni, A., Castelli, E. & Strazzer, S. (2009) Attention remediation following traumatic brain injury in childhood and adolescence. Neuropsychology 23 (10), 40-49
19. Glang, A., Singer, G., Cooley, E. & Tish, N. (1992) Tailoring direct instruction techniques for use with elementary students with TBI. Journal of Head Trauma Rehabilitation, 7, 93-108
20. Gordon, A.L. & di Maggio, A. (2012). Rehabilitation for children after acquired brain injury: Current and emerging approaches. Pediatric Neurology, 46(6), 339-344. doi: 10.1016/j.pediatrneurol.2012.02.029
21. Hawley, C.A., Ward, A.B., Long, J., Owen, D.W., Magnay, A.R. (2003) Prevalence of traumatic brain injury amongst children admitted to hospital in one health district: A population –based study. Injury, 34, 256-260.

ACQUIRED BRAIN INJURY

22. Jaffe, K., Polissar, N,, Fay, G. and Liao, S. (1995) Recovery trends over three years following pediatric traumatic brain injuryArchives of Physical Medicine and Rehabilitation, 76 (1), 17-26
23. Kerns, K.A. & Thomson, J. (1998) Implementation of a compensatory memory system in a school age child with severe memory impairment. Paediatric Rehabilitation, 2, 77-87
24. Kinsella, G., Prior, M., Sawyer, M., Murtagh, D., Eisenmajer, R., Anderson, V., Bryan, D. and Klug, G. (1995) Neuropsychological Deficit and Academic Performance in Children and Adolescents Following Traumatic Brain Injury. Journal of Pediatric Psychology, 20(6), 753-767
25. Kraus JF, Rock A, Hemyari P. Brain injuries among infants, children, adolescents and young adults. American Journal of Disability in Childhood 1990, 144, 684–691.
26. Kurowski, B.G., Wade, S.L., Kirkwood, M.W., Brown, T.M., Stancin, T. & Taylor, H.G. (2014). Long-term benefits of an early online problem-solving intervention for executive dysfunction after traumatic brain injury in children: A randomized clinical trial. JAMA Pediatrics, 168(6), 523-531. doi: 10.1001/jamapediatrics.2013.5070.
27. Kurowski, B.G., Wade, S.L., Kirkwood, M.W., Brown, T.M., Stancin, T. & Taylor, H.G. (2013). Online problem-solving therapy for executive dysfunction after child traumatic brain injury. Pediatrics, 132(1), 158-166. doi: 10.1542/peds.2012-4040
28. Lawson, M.J. & Rice, D.N. (1989) Effects of training in use of executive strategies on a verbal memory problem resulting from a closed head injury. Journal of Clinical and Experimental Neuropsychology, 6, 842-854
29. Limond, J., Dorris, L. and McMillan, T.M. (2009) Quality of life in children with acquired brain injury: Parent perspectives 1-5 years after injury. Brain Injury, 23(7-8), 617-622
30. Limond, J. & Leeke, R. (2005) Practitioner Review: Cognitive rehabilitation for children with acquired brain injury. Journal of Child Psychology and Psychiatry, 46(4), 339-352
31. McKinlay, A. (2009) Controversies and outcomes associated with mild traumatic brain injury in childhood and adolescences.Child: Care, Health and Development, doi:10.1111/j.1365-2214.2009.01006.x
32. McKinlay, A., Dalrymple-Aflord, J.C., Horwood, L.J., Fergusson, L.M. (2002) Long term psychosocial outcomes after mild head injury. Journal of Neurology, Neurosurgery and Psychiatry, 75, 737-742
33. Middleton, J.A. (2001) Practitioner Review: Psychological sequelae of head injury in children and adolescents. Journal of Child Psychology and Psychiatry, 42, 165-180

ACQUIRED BRAIN INJURY

34. Milroy, G., Dorris, L., McMillan, T.M. (2008) Sleep disturbances following mild traumatic brain injury in childhood. Journal of Paediatric Psychology, 33, 242-247
35. Nadebaum, C., Anderson, V. and Catroppa, C. (2007) Executive Function Outcomes Following Traumatic Brain Injury in Young Children: A Five Year Follow-up. Developmental Neuropsychology, 32(2), 703-728
36. National Institute for Health and Clinical Excellence (2005) Improving Outcomes in Children and Young People with Cancer. London: NICE; ref NO897
37. Nygren-de Boussard, C., Holm, L.W., Cancelliere, C… (2014). Nonsurgical interventions after mild traumatic brain injury: a systematic review. Archives of Physical Medicine and Rehabilitation, 95(3), 257-264. doi: 10.1016/j.apmr.2013.10.009
38. Oberg, L. & Turkustra, L.S. (1988) Use of elaborative encoding to facilitate verbal learning after adolescent traumatic bra9in injury. Journal of Head Trauma Rehabilitation, 13, 44-62
39. Pastore, V., Colombo, K., Liscio, M., Galbiati, S., Adduci, A., Villa, F. & Strazzer, S. (2010). Efficacy of cognitive behavioural therapy for children and adolescents with traumatic brain injury. Disability and Rehabilitation, 33(8), 675-683. doi: 10.3109/09638288.2010.506239.
40. Penkman, L. & Scott-Lane, L. (2007) Prophylactic academic intervention for children treated with cranial radiation therapy. Developmental Neurorehabilitation, 10(1), 19-26.
41. Penkman, L. (2004) Remediation of attention deficits in children: a focus on childhood cancer, traumatic brain injury and attention deficit disorder. Developmental Neurorehabilitation, 7(2), 111-123.
42. Pericall, M.T.L. & Taylor, E. (2013). Family function and its relationship to injury severity and psychiatric outcome in children with acquired brain injury: a systematized review. Developmental Medicine & Child Neurology, 56(1), 19-30. doi: 10.1111/dmcn.12237.
43. Rankin, P.M. & Hood, J. (2005) Designing clinical interventions for children with specific memory disorders. Pediatric Rehabilitation, 8(4), 283-297
44. Ross, K.A., Dorris, L. & McMillan, T. (2011). A systematic review of psychological interventions to alleviate cognitive and psychosocial problems in children with acquired brain injury. Developmental Medicine and Neurology, 53(8), 692-701. doi: 10.1111/j.1469-8749.2011.03976.x

ACQUIRED BRAIN INJURY

45. Ross A, McMillan TM, Sumpter R, Kelly TM & Dorris L. (2011). Friendship and psychosocial functioning in children with traumatic brain injury. Brain Injury, 25(12): 1206-11.
46. Sumpter R, Dorris L & McMillan TM. (2013) "Sleep disturbance after severe traumatic brain injury in childhood". Journal of the International Neuropsychological Society, 19,1-6.
47. Suzman, K.B., Morris, R.D., Morris, M.K. & Milan, M.A. (1997) Cognitive behavioural remediation of problem solving deficits in children with acquired brain injury. Journal of Behaviour Therapy and Experimental Psychiatry, 28, 203-212
48. Tatla, S.K., Sauve, K., Jarus, T., Virji-Babul, N. & Holsti, L. (2014). The effects of motivating interventions on rehabilitation outcomes in children and youth with acquired brain injuries: A systematic review. Brain Injury, 28(8), 1022-1035. doi: 10.3109/02699052.2014.890747
49. Thompson, J.B., & Kerns, K.A. (2000) Cognitive rehabilitation of the child with mild traumatic brain injury. In: S.Raskin & C.A. Mateer (Eds) Neuropsychological management of mild traumatic brain injury. New York: Oxford University Press
50. Thomson, J.B. (1995) Rehabilitation of high school aged individuals with TBI through use of an attention-training programme. Journal of the International Neuropsychological Society, 1, 149
51. van't Hooft, I., Andersson, K., Bergman, B., Sejersen, T., von Wendt, L. & Bartfai, A. (2007) Sustained favorable effects of cognitive training in children with acquired brain injuries. NeuroRehabilitation, 22, 109-116
52. Wade, S.L., Walz, N.C., Carey, J., McMullen, K.A., Cass, J., Mark, E. & Yeates, K.O. (2011). Effect on behavior problems of teen online problem-solving for adolescent traumatic brain injury. Pediatrics, 128(4), 947-953. doi:10.1542/peds.2010-372

INDEX
BACK
NEXT

EPILEPSY

1. Austin JK, Smith MS, Risinger MW, McNelis AM. Childhood epilepsy and asthma: comparison of quality of life. Epilepsia 1994;35:608–15.
2. Blocher, J.B., Fujikawa, M., Sung, C., Jackson, D.C. & Jones, J.E. (2013). Computer-assisted cognitive behavioral therapy for children with epilepsy and anxiety: A pilot study. Epilepsy & Behavior, 27(1), 70-76. doi:10.1016/j.yebeh.2012.12.014
3. Fastenau PS, Johnson CS, Perkins SM, Byars AW, deGrauw TJ, Austin JK, Dunn DW. Neuropsychological status at seizure onset in children: risk factors for early cognitive deficits. Neurology. 2009 Aug 18;73(7):526-34.
4. Fastenau PS, Shen J, Dunn DW, Perkins SM, Hermann BP, Austin JK. (2004) Neuropsychological predictors of academic underachievement in pediatric epilepsy: moderating roles of demographic, seizure, and psychosocial variables. Epilepsia. Oct;45(10):1261-72
5. Davidson M, Dorris L, O'Regan M, Zuberi SM. (2007) Memory consolidation and accelerated forgetting in children with idiopathic generalized epilepsy. Epilepsy Behav. 2007 Nov;11(3):394-400.
6. Hoare P, Mann H. Self-esteem and behavioural adjustment in children with epilepsy and children with diabetes. J Psychosomatic Res 1994;38:859–69.
7. Jantzen S, Müller-Godeffroy E, Hallfahrt-Krisl T, Aksu F, Püst B, Kohl B, Redlich A, Sperner J, Thyen U. (2009) FLIP&FLAP-a training programme for children and adolescents with epilepsy, and their parents. Seizure. 2009 Sep;18(7):478-86.
8. Jones, J.E. (2014). Treating anxiety disorders in children and adolescents with epilepsy: What do we know? Epilepsy & Behavior, 39, 137-142. doi:10.1016/j.yebeh.2014.06.021
9. Lin, L. & Yang, R. (2013). Using music to treat epilepsy in children: A review. Music and Medicine, 5(4), 242-247. doi: 10.1177/1943862113500506
10. McEwan, M.J., Espie, C.A., Metcalfe, J., Brodie, M.J., Wilson, M.T. (2004). Quality of life and psychosocial development in adolescents with epilepsy: a qualitative investigation using focus group methods Seizure 2004; 13: 15–31.
11. Moffat C, Dorris L, Connor L, Espie CA. (2009) The impact of childhood epilepsy on quality of life: a qualitative investigation using focus group methods to obtain children's perspectives on living with epilepsy. Epilepsy Behav. 2009 Jan;14(1):179-89.
12. Mula, M. (2013). Treatment of anxiety disorders in epilepsy: An evidence-based approach. Epilepsia, 51(1), 13-18. doi: 10.1111/epi.12101

EPILEPSY

13. NHS Scotland: Scottish Paediatric Epilepsy Network Annual Report 2008/2009
14. National Institute for Clinical Excellence (NICE) (2004) 'The management and diagnosis of the epilepsies in adults and children in primary and secondary care.
15. NICE (2012). *The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care*. NICE clinical guideline 137. guidance. nice.org.uk/cg13714
16. Ramaratnam S, Baker GA, Goldstein LH Psychological treatments for epilepsy. Cochrane Database of Systematic Reviews. (3):CD002029, 2008.
17. Scottish Intercollegiate Guidelines Network (SIGN, 2005) Guideline 81: Diagnosis and Management of epilepsies in children and young people.
18. Snead K, Ackerson J, Bailey K, Schmitt MM, Madan-Swain A, Martin RC.(2004) Taking charge of epilepsy: the development of a structured psychoeducational group intervention for adolescents with epilepsy and their parents. Epilepsy Behav. 2004 Aug;5(4):547-56.
19. Townshend KH, Dorris L, McEwan MJ, Aylett SE, Brodie MJ, O'Regan M, Espie CA. (2008) Development and validation of a measure of the impact of epilepsy on a young person's quality of life: Glasgow epilepsy outcome scale for young persons (GEOS-YP). Epilepsy Behav. 2008 Jan;12(1):115-23.

PAEDIATRIC PSYCHOLOGY: INTRODUCTION

1. British Psychological Society (2003) Briefing paper: Child clinical psychologists working with children with medical conditions. Faculty for Children and Young People BPS, UK.
2. British Psychological Society, Faculty for Children and Young People, Paediatric Psychology Network (2001) Guidelines for Commissioning and Purchasing Child Clinical Psychology Services.
3. Cote, M., Mullins, L., Hartman, V., Hoff, A., Balderson, B., Chaney, J. and Domek, D. (2003). Psychosocial correlates of health care utilisation for Children and adolescents with Type 1 Diabetes mellitus. Children's Health Care, 32, 1 – 16.
4. Department of Health (2004) National Service Framework for Children – Standard for Hospital Services HMSO: London
5. Drotar (1997) Drotar (1997) J. Paediatric Psychology Vol 22. Intervention Research: Pushing back frontiers
6. Eiser, C. (1995) Growing up with a Chronic Disease. Jessica Kingsley, London
7. Glazebrook, C., Hollis, C., Heussler, H., Goodman, R. and Coates, L. (2003) Detecting emotional and behavioural problems in paediatric clinics. Child: Care, Health and Development, 29, 141-149.
8. Goldman, S.L., Owen, M.T. (1994). The impact of parental trait anxiety on the utilization of health care services in infancy: A prospective study. Journal of Pediatric Psychology, 19/3, 369-381.
9. Kush, S. and Campo, J. (1998). Handbook of pediatric psychology and psychiatry. Allyn and Bacon, Needham Heights, MA.
10. Meltzer, H., Gatward, R., Goodman, R. and Ford, T. (2000) Mental health of Children and Adolescents in Great Britain. The Stationery Office, London.
11. Scottish Government (2009a) Better Health Better Care: Hospital Services for Young People in Scotland.
12. Scottish Government (2010) The Healthcare Quality Strategy for NHSScotland
13. SIGN Guidelines 103: Diagnosis and Management of Chronic Kidney Disease. (2008)
14. SIGN Guidelines 116: Management of Diabetes (2010) ISBN 978 1 905813 58 2 –
15. SIGN Guildelines 101 British Guideline on the Management of Asthma. (2011)

PAEDIATRIC PSYCHOLOGY: INTRODUCTION

1. British Psychological Society (2003) Briefing paper: Child clinical psychologists working with children with medical conditions. Faculty for Children and Young People BPS, UK.
2. British Psychological Society, Faculty for Children and Young People, Paediatric Psychology Network (2001) Guidelines for Commissioning and Purchasing Child Clinical Psychology Services.
3. Cote, M., Mullins, L., Hartman, V., Hoff, A., Balderson, B., Chaney, J. and Domek, D. (2003). Psychosocial correlates of health care utilisation for Children and adolescents with Type 1 Diabetes mellitus. Children's Health Care, 32, 1 – 16.
4. Department of Health (2004) National Service Framework for Children – Standard for Hospital Services HMSO: London
5. Drotar (1997) Drotar (1997) J. Paediatric Psychology Vol 22. Intervention Research: Pushing back frontiers
6. Eiser, C. (1995) Growing up with a Chronic Disease. Jessica Kingsley, London
7. Glazebrook, C., Hollis, C., Heussler, H., Goodman, R. and Coates, L. (2003) Detecting emotional and behavioural problems in paediatric clinics. Child: Care, Health and Development, 29, 141-149.
8. Goldman, S.L., Owen, M.T. (1994). The impact of parental trait anxiety on the utilization of health care services in infancy: A prospective study. Journal of Pediatric Psychology, 19/3, 369-381.
9. Kush, S. and Campo, J. (1998). Handbook of pediatric psychology and psychiatry. Allyn and Bacon, Needham Heights, MA.
10. Meltzer, H., Gatward, R., Goodman, R. and Ford, T. (2000) Mental health of Children and Adolescents in Great Britain. The Stationery Office, London.
11. Scottish Government (2009a) Better Health Better Care: Hospital Services for Young People in Scotland.
12. Scottish Government (2010) The Healthcare Quality Strategy for NHSScotland
13. SIGN Guidelines 103: Diagnosis and Management of Chronic Kidney Disease. (2008)
14. SIGN Guidelines 116: Management of Diabetes (2010) ISBN 978 1 905813 58 2 –
15. SIGN Guildelines 101 British Guideline on the Management of Asthma. (2011)
16. Spirito, A. and Kazak, A. (2006) Effective and Emerging treatments in pediatric psychology. New York: Oxford University Press.

PAEDIATRIC PSYCHOLOGY: ADHERENCE

1. Adkins, JW, Storch, EA, Lewin, AB, Willliams, L, Silverstein, JH, Malasanos, T and Geffen, GR (2006) Home –based Behavioural Health Intervention: Use of a Telehealth Model to Address Poor Adherence to Type-1 Diabetes Medical Regimens. Telemedicine and e-Health, 12 (3), 370-372
2. Al-aqeel, S. & Al-sabhan, J. (2011). Strategies for improving adherence to antiepileptic drug treatment in patients with epilepsy. The Cochrane Library, 2011, 1. doi: 10.1002/14651858.CD008312.pub2
3. Bender, B.G., Cvietusa, P., Goodrich, G… (2014). A 24-month randomized, controlled trial of an automated speech recognition program to improve adherence in pediatric asthma. The Jouranl of Allergy and Clinical Immunology, 33(2), AB166. DOI: http://dx.doi.org/10.1016/j.jaci.2013.12.600.
4. Bonner, S., Zimmerman, B. J., Evans, D., Irigoyen, M., Resnick, D., & Mellins, R. B. (2002). An individualized intervention to improve asthma management among urban Latino and African-American families. Journal of Asthma, 39, 167–179.
5. Channon S, Smith VJ, Gregory JW. (2003) A pilot study of motivational interviewing in adolescents with diabetes. Archive of Diseases in Childhood; 88:680–683.
6. Channon SJ, Huws-Thomas MV, Rollnick S, et al. A multicenter randomized controlled trial of motivational interviewing in teenagers with diabetes. Diabetes Care 2007; 30:1390–1395.
7. Chung, RJ, Burke, PJ, and Goodman, E (2010) Firm Foundations: Strength Based Approaches to Adolescent Chronic Disease. Current Opinion in Paediatrics, 22, 389-397.
8. Dean, AJ, Walters, J and Hall, A (2010) A Systematic Review of Interventions to Enhance Medication Adherence in Children and Adolescents with Chronic Illness. Archives of Diseases in Childhood, 95, 717-723.
9. Duncan, C.L., Hogan, M.B., Tien, K.J… (2012). Efficacy of a parent-youth teamwork intervention to promote adherence in pediatric asthma. Journal of Pediatric Psychology, 38(6), 617-628. doi:10.1093/jpepsy/jss123
10. Easthall, C., Song, F. & Bhattacharya, D (2013). A meta-analysis of cognitive-based behaviour change techniques as interventions to improve medication adherence. BMJ Open, 3(8), e002749. doi:10.1136/bmjopen-2013-002749
11. Ellis, D. A., Frey, M. A., Naar-King, S., Templin, T., Cunningham, P., & Cakan, N. (2005). Use of multisystemic therapy to improve regimen adherence among adolescents with type 1 diabetes in chronic poor metabolic control: A randomized controlled trial. Diabetes Care, 28, 1604–1610.

PAEDIATRIC PSYCHOLOGY ADHERENCE

12. Ellis, DA, Templin, T, Naar-King, S, Frey, M and Cunningham, PB (2007) Multisystemic Therapy for Adolescents with Poorly Controlled Type 1 Diabetes: Stablility of Treatment Effects in an RCT. Journal of Consulting and Clinical Psychology, 75(1), 168-174.
13. Gray, WN, Denson, LA, Baldassano, MD and Hommel, KA (2012) Treatment Adherence in Adolescents with Inflammatory Bowel Disease: The Collective Impact of Barriers to Adherence and Anxiety/Depressive Symptoms. Journal of Paediatric Psychology, 37(3), 282-291.
14. Harris, MA and Mertlich, D (2003) Piloting Home Based Behavioural Family Systems Therapy for Adolescents with Poorly Controlled Diabetes. Children's Health Care 32(1), 65-79.
15. Hovell, M. F., Sipan, C. L., Blumberg, E. J., Hofstetter, C. R., Slymen, D., Friedman, L., et al. (2003). Increasing Latino adolescents' adherence to treatment for latent tuberculosis infection: A controlled trial. American Journal of Public Health, 93, 1871–1877.
16. Jaser, S.S., Patel, N., Rothman, R.L., Choi, L. & Whittemore, R. (2014). Check It! A randomized pilot of a positive psychology intervention to improve adherence in adolescents with type 1 diabetes. Diabetes Education, 40(5), 659-667. doi: 10.1177/0145721714535990
17. Kahana, S, Drotar, D, and Frazier, T (2008) Meta-Analysis of Psychological Interventions to Promote Adherence to Treatment in Paediatric Chronic Health Conditions, Journal of Paediatric Psychology, 33(6), 590-611.
18. Lemanek, K. L., Kamps, J., & Chung, N. B. (2001). Empirically supported treatments in pediatric psychology: Regimen adherence. Journal of Pediatric Psychology, 26, 253–275.
19. Lin, H. & Wu, X. (2014). Intervention strategies for improving patient adherence to follow-up in the era of mobile information technology: A systematic review and meta-analysis. POLS ONE, 9(8), e104266 . doi:10.1371/journal.pone.0104266.g001
20. Linn, A.J., Vervloet, M., van Dijk, L., Smit, E.G. & Van Weert, J.C. (2011). Effects of eHealth interventions on medication adherence: A systematic review of the literature. Journal of Medical Internet Research, 13(4), e103. doi: 10.2196/jmir.1738
21. Luersen, K., Davis, S.A., Kaplan, S.G… (2012) Sticker charts: A method for improving adherence to treatment of chronic diseases in children. Pediatric Dermatology, 29(4), 403-408. doi: 10.1111/j.1525-1470.2012.01741.x

INDEX
BACK
NEXT

PAEDIATRIC PSYCHOLOGY ADHERENCE

22. Martin, C, Southall, A, Liveley, K, Shea, E, and Whitehead, K (2009) Multisystemic Therapy Applied to the Assessment and Treatment of Poorly Controlled Type-1 Diabetes: A Case Study in the UK NHS. Clinical Case Studies, 8(5), 366-382.
23. Mathes, T., Antoine, S., Pieper, D. & Eikermann, M. (2014). Adherence enhancing interventions for oral anticancer agents: A systematic review. Cancer Treatment Reviews, 40(1), 102-108. doi: 10.1016/j.ctrv.2013.07.004
24. M'Imunya JM, Kredo T, Volmink J. Patient education and counselling for promoting adherence to treatment for tuberculosis. Cochrane Database of Systematic Reviews 2012, Issue 5. Art. No.: CD006591. doi: 10.1002/14651858.CD006591.pub2
25. Naar-King, S., Outlaw, A.Y., Sarr, M… (2013). Motivational enhancement system for adherence (MESA): Pilot randomized trial of a brief computer-delivered prevention intervention for youth initiating antiretroviral treatment. Journal of Pediatric Psychology, 38(6), 638-648. doi: 10.1093/jpepsy/jss132
26. Pai, A.L.H. & McGrady, M. (2014) Systematic review and meta-analysis of psychological interventions to promote treatment adherence in children, adolescents, and young adults with chronic illness. Journal of Pediatric Psychology (2014). doi:10.1093/jpepsy/jsu038
27. Powell, P.W., Hilliard, M.E. & Anderson, B.J. (2014). Motivational interviewing to promote adherence behaviors in pediatric type 1 diabetes. Current Diabetes Reports, 14(10), 531. doi 10.1007/s11892-014-0531-z
28. Pradeep, A., Proudlock, F.A., Awan, M., Bush, G., Collier, J. & Gottlob, I. (2014). An educational intervention to improve adherence to high-dosage patching regimen for amblyopia: a randomised controlled trial. British Journal of Ophthalmology, 98, 865-870. doi: 10.1136/bjophthalmol-2013-304187
29. Salema N.E., Elliott R.A., Glazebrook C. (2011). A systematic review of adherence-enhancing interventions in adolescents taking long-term medicines. Journal of Adolescent Health, 49(5), 455-466. doi:10.1016/j.jadohealth.2011.02.010
30. Seid, M., D'Amico, E.J., Varni, J.W… (2012). The in vivo adherence intervention for at risk adolescents with asthma: Report of a randomized pilot trial. Journal of Pediatric Psychology, 37(4), 390-403. doi: 10.1093/jpepsy/jsr107
31. Staab, D, von Reuden, U, Kehrt, R, Erhart, M, Wenninger, K, Kamtsiuris, P, Wahn, U (2002) Evaluation of a Parental Training Programme for the management of childhood atopic dermatitis. Pediatric Allergy and Immunology, 13, 84-90

INDEX
BACK
NEXT

PAEDIATRIC PSYCHOLOGY ADHERENCE

32. van Es SM, Nagelkerke AF, Colland VT, et al. (2001) An intervention programme using the ASE-model aimed at enhancing adherence in adolescents with asthma. Patient Education and Counselling; 44, 193–203.
33. Viner RM, Christie D, Taylor V, Hey S. (2003) Motivational/solution-focused intervention improves HbA1c in adolescents with type 1 diabetes: a pilot study. Diabetes Medicine; 20: 739–742.
34. Wang, K., Wang, C., Zhang, Y., Ouyang, Y., Lou, H., Zhang, W. & Zhang, L. (2013) A randomized controlled trial to assess adherence to allergic rhinitis treatment following a daily short message service (SMS) via the mobile phone. International Archives of Allergy and Immunology, 163(1), 51-58. doi: 10.1159/000356317
35. World Health Organisation (2003) Adherence to Long Term Therapies: Evidence for Action. Geneva: World Health Organisation
36. Wysocki, T., Harris, M. A., Greco, P., Bubb, J., Danda, C. E., Harvey, L. M., et al. (2000). Randomized, controlled trial of behavior therapy for families of adolescents with insulin-dependent diabetes mellitus. Journal of Pediatric Psychology, 25, 23–33.
37. Wysocki, T., Harris, M.A., Buckloh, L.M., Mertlich, D., Lochrie, A.S., Taylor, A., et al. (2006). Effects of behavioral family systems therapy for diabetes on adolescents' family relationships, treatment adherence, and metabolic control. Journal of Pediatric Psychology, 31, 928–938.
38. Yelena, P.W. & Pai, A.L.H. (2014). Health care provider-delivered adherence promotion interventions: A meta-analysis. Pediatrics, 133(6), 1698-1707. doi: 10.1542/peds.2013-3639

PAEDIATRIC PSYCHOLOGY: CHRONIC PAIN

1. Eccleston, C., Malleson, P.N., Clinch, J., Connell, H., &Sourbut, C. (2003). Chronic pain in adolescents: Evaluation of a programme of interdisciplinary cognitive behaviour therapy. Archives of Diseases in Childhood, 88, 881–885.
2. Eccleston, C., Palermo, T. M., Williams, A., Lewandowski, A., & Morley, S. (2009). Psychological therapies for the management of chronic and recurrent pain in children and adolescents. Cochrane Database Syst Rev, 2(2).
3. Eccleston, C., Palermo, T. M., Williams, A. C. D. C., Lewandowski, A., Morley, S., Fisher, E., & Law, E. (2012). Psychological therapies for the management of chronic and recurrent pain in children and adolescents. Cochrane Database Syst Rev, 12.
4. Eccleston, C., Palermo, T. M., Williams, A. C. D. C., Lewandowski Holley, A., Morley, S., Fisher, E., & Law, E. (2014). Psychological therapies for the management of chronic and recurrent pain in children and adolescents. The Cochrane Library, 14.
5. Fisher, E., Heathcote, L., Palermo, T. M., de C Williams, A. C., Lau, J., &Eccleston, C. (2014). Systematic review and meta-analysis: Psychological therapies for children with chronic pain. Journal of Pediatric Psychology, jsu008.
6. Gerber, W. D., Petermann, F., Gerber-von Müller, G., Dollwet, M., Darabaneanu, S., Niederberger, U., ... & Andrasik, F. (2010). MIPAS-Family—evaluation of a new multi-modal behavioral training program for pediatric headaches: clinical effects and the impact on quality of life. *The journal of headache and pain,* 11(3), 215-225.
7. Hechler, T., Ruhe, A. K., Schmidt, P., Hirsch, J., Wager, J., Dobe, M., ... &Zernikow, B. (2014). Inpatient-based intensive interdisciplinary pain treatment for highly impaired children with severe chronic pain: Randomized controlled trial of efficacy and economic effects. PAIN®, 155(1), 118-128.
8. McGrath, P.J., & Finley, G.A. (1999). Chronic and recurrent pain in children and adolescents. Seattle: IASP Press.
9. Palermo, T. M., Wilson, A. C., Peters, M., Lewandowski, A., & Somhegyi, H. (2009). Randomized controlled trial of an Internet-delivered family cognitive–behavioral therapy intervention for children and adolescents with chronic pain. Pain, 146(1), 205-213.
10. Palermo, T. M., Eccleston, C., Lewandowski, A. S., Williams, A. C. D. C., & Morley, S. (2010). Randomized controlled trials of psychological therapies for management of chronic pain in children and adolescents: an updated meta-analytic review. Pain, 148(3), 387-397.
11. Palermo, T. M., Wilson, A. C., Peters, M., Lewandowski, A., & Somhegyi, H. (2009). Randomized controlled trial of an Internet-delivered family cognitive–behavioral therapy intervention for children and adolescents with chronic pain. Pain, 146(1), 205-213.

INDEX
BACK
NEXT

CHRONIC PAIN

12. Sprenger, L., Gerhards, F., &Goldbeck, L. (2011). Effects of psychological treatment on recurrent abdominal pain in children—A meta-analysis. Clinical Psychology Review, 31(7), 1192-1197.
13. Wicksell, R. K., Melin, L., Lekander, M., & Olsson, G. L. (2009). Evaluating the effectiveness of exposure and acceptance strategies to improve functioning and quality of life in longstanding pediatric pain–a randomized controlled trial. Pain, 141(3), 248-257.
14. Wicksell, R. K., Melin, L., & Olsson, G. L. (2007). Exposure and acceptance in the rehabilitation of adolescents with idiopathic chronic pain–a pilot study. *European Journal of Pain*, 11(3), 267-274.
15. Velleman, S., Stallard, P., & Richardson, T. (2010). A review and meta-analysis of computerized cognitive behaviour therapy for the treatment of pain in children and adolescents. Child: Care, Health and Development, 36(4), 465-472.

PAEDIATRIC PSYCHOLOGY: PROCEDURAL DISTRESS AND PREPARATION FOR PROCEDURES

1. Accardi, MC and Milling, LS (2009) The Effectiveness of Hypnosis for Procedure-Related Pain in Children and Adolescents: A comprehensive methodological review. Journal of Behavioural Medicine, 32, 328-339
2. Benore, E., &Enlow, T. (2013). Improving pediatric compliance with EEG: Decreasing procedural anxiety and behavioral distress. Epilepsy & Behavior,27(1), 169-173.
3. Beran, T. N., Ramirez-Serrano, A., Vanderkooi, O. G., & Kuhn, S. (2013). Reducing children's pain and distress towards flu vaccinations: A novel and effective application of humanoid robotics. Vaccine, 31(25), 2772-2777.
4. Birnie, K.A., Noel, M., Parker, J.A., Chambers, C.T., Uman, L.S., Kisely, S.R. & McGrath, P.J. (2014). Systematic Review and Meta-Analysis of Distraction and Hypnosis for Needle-Related Pain and Distress in Children and Adolescents. Journal of PediatricPsychology 39(8), 783–808.
5. Blount, R. L., Powers, S. W., Cotter, M. W., Swan, S., & Free, K. (1994). Making the System Work Training Pediatric Oncology Patients to Cope and Their Parents to Coach them during BMAILP Procedures. Behavior Modification,18(1), 6-31.
6. Blount, R. L., Piira, T., & Cohen, L. L. (2003). Management of pediatric pain and distress due to medical procedures. Handbook of pediatric psychology, 3, 216-233.
7. Brown, N. J., Kimble, R. M., Rodger, S., Ware, R. S., &Cuttle, L. (2014). Play and heal: randomized controlled trial of Ditto™ intervention efficacy on improving re-epithelialization in pediatric burns. Burns: journal of the International Society for Burn Injuries, 40(2), 204-213
8. Caprilli, S., Anastasi, F., Grotto, R. P. L., Abeti, M. S., &Messeri, A. (2007). Interactive music as a treatment for pain and stress in children during venipuncture: a randomized prospective study. Journal of Developmental & Behavioral Pediatrics, 28(5), 399-403.
9. Cavender, K, Goff, MD, Hollon, EC, Guzzetta, CE (2004) Parents' Positioning and Distracting Children During Venepuncture: Effects on Children's Pain, Fear and Distress. Journal of Holistic Nursing, 22(1), 32-56
10. Christie, D., & Wilson, C. (2005). CBT in paediatric and adolescent health settings: A review of practice-based evidence. Pediatric Rehabilitation, 8, 241-247.
11. Cuzzocrea, F., Gugliandolo, M. C., Larcan, R., Romeo, C., Turiaco, N., &Dominici, T. (2013). A psychological preoperative program: effects on anxiety and cooperative behaviors. Pediatric Anesthesia, 23(2), 139-143.
12. Duff, A. J. A. (2003). Incorporating psychological approaches into routine paediatric venepuncture. Archives of Disease in Childhood, 88, 931-937.

INDEX
BACK
NEXT

PAEDIATRIC PSYCHOLOGY: PROCEDURAL DISTRESS AND PREPARATION FOR PROCEDURES

13. Edwards, M. & Titman, P. (2010). Promoting psychological well-being in children with acute and chronic illness. London: Jessica Kingsley Publishers.
14. Forsner, M., Norström, F., Nordyke, K., Ivarsson, A., &Lindh, V. (2013). Relaxation and guided imagery used with 12-year-olds during venipuncture in a school-based screening study. Journal of Child Health Care.
15. Hartling, L., Newton, A. S., Liang, Y., Jou, H., Hewson, K., Klassen, T. P., & Curtis, S. (2013). Music to reduce pain and distress in the pediatric emergency department: a randomized clinical trial. JAMA pediatrics, 167(9), 826-835.
16. Inal, S., &Kelleci, M. (2012). Distracting children during blood draw: Looking through distraction cards is effective in pain relief of children during blood draw.International journal of nursing practice, 18(2), 210-219.
17. Jaaniste, T., Hayes, B., & von Baeyer, C. L. (2007). Effects of preparatory information and distraction on children's cold-pressor pain outcomes: A randomized controlled trial. Behaviour research and therapy, 45(11), 2789-2799.
18. Johnston C, Campbell-Yeo M, Fernandes A, Inglis D, Streiner D, Zee R. Skin-to-skin care for procedural pain in neonates. Cochrane Database of Systematic Reviews 2014, Issue 1. Art. No.: CD008435. DOI: 10.1002/14651858.CD008435.pub2
19. Kain, Z. N., Mayes, L. C., &Caramico, L. A. (1996). Preoperative preparation in children: a cross-sectional study. Journal of Clinical Anesthesia, 8(6), 508-514.
20. Kipping, B., Rodger, S., Miller, K., & Kimble, R. M. (2012). Virtual reality for acute pain reduction in adolescents undergoing burn wound care: a prospective randomized controlled trial. Burns, 38(5), 650-657.
21. Klosky, J. L., Garces-Webb, D. M., Buscemi, J., Schum, L., Tyc, V. L., & Merchant, T. E. (2007). Examination of an interactive-educational intervention in improving parent and child distress outcomes associated with pediatric radiation therapy procedures. Children's Health Care, 36(4) 323-334
22. Klosky, JL, Tyk, VL, Srivastava, DK, Tong, X, Kronenberg, M, Booker, ZJ et al (2004) Brief Report: Evaluation of an interactive intervention designed to reduce pediatric distress during radiation therapy procedures. Journal of Pediatric Psychology, 29, 621-626
23. Kolk, A. M., van, H. R., &Fiedeldij, D. M. J. (1999). Preparing children for venepuncture. the effect of an integrated intervention on distress before and during venepuncture. Child: Care, Health and Development,26(3) 251-260

INDEX
BACK
NEXT

PAEDIATRIC PSYCHOLOGY: PROCEDURAL DISTRESS AND PREPARATION FOR PROCEDURES

24. LaMontagne, L. L., Hepworth, J. T., Cohen, F., & Salisbury, M. H. (2003). Cognitive-behavioral intervention effects on adolescents' anxiety and pain following spinal fusion surgery.Nursing Research, 52(3) 183-190
25. Landier, W, Tse, AM (2010) Use of Complementary and Alternative Medical Interventions for the Management of Procedure-Related Pain, Anxiety and Distress in Paediatric Psychology: An Integrative Review. Journal of Paediatric Nursing, 25, 566-579.
26. Lee, G. Y., Yamada, J., Shorkey, A., & Stevens, B. (2014). Pediatric Clinical Practice Guidelines for Acute Procedural Pain: A Systematic Review. Pediatrics,133(3), 500-515.
27. Li, H. C., Lopez, V., & Lee, T. L. (2007). Psychoeducational preparation of children for surgery: The importance of parental involvement. Patient Education &Counseling, 65(1) 34-41
28. Liossi, C, Hatira, P and White, P (2006) Randomized Clinical Trial of Local Anasthetic versus a Combination of Local Anasthetic with Self-Hypnosis in the Management of Pediatric Procedure Related Pain. Health Psychology, 25 (3), 307-315.
29. Liossi, C., White, P., Franck, L., & Hatira, P. (2007). Parental pain expectancy as a mediator between child expected and experienced procedure-related pain intensity during painful medical procedures. The Clinical journal of pain, 23(5), 392-399.
30. MacLaren, J. E., &Kain, Z. N. (2008). Development of a brief behavioral intervention for children's anxiety at anesthesia induction. Children's Health Care, 37(3) 196-209
31. Miller, K., Rodger, S., Kipping, B., & Kimble, R. M. (2011). A novel technology approach to pain management in children with burns: A prospective randomized controlled trial. Burns, 37(3), 395-405.
32. Nilsson, S., Enskär, K., Hallqvist, C., &Kokinsky, E. (2013). Active and passive distraction in children undergoing wound dressings. Journal of pediatric nursing,28(2), 158-166.
33. Pillai Riddell RR, Racine NM, Turcotte K, Uman LS, Horton RE, Din Osmun L, AholaKohut S, Hillgrove Stuart J, Stevens B, Gerwitz-Stern A. Non-pharmacological management of infant and young child procedural pain. Cochrane Database of Systematic Reviews 2011, Issue 10. Art. No.: CD006275. DOI: 10.1002/14651858.CD006275.pub2.
34. Roberts, M. C., & Steele, R. G. (Eds.). (2010). Handbook of pediatric psychology. Guilford Press.
35. Rocha, E. M., Marche, T. A., & von Baeyer, C. L. (2009). Anxiety influences children's memory for procedural pain. Pain Research & Management: The Journal of the Canadian Pain Society, 14(3), 233.

PAEDIATRIC PSYCHOLOGY PROCEDURAL DISTRESS

36. Schreiber, K. M., Cunningham, S. J., Kunkov, S., & Crain, E. F. (2006). The association of preprocedural anxiety and the success of procedural sedation in children. The American journal of emergency medicine, 24(4), 397-401.
37. Scottish Government (2009). An Evaluation of the Development and Early Implementation Phases of Getting it right for every child in Highland: 2006 – 2009. Retrieved from: http://www.gov.scot/Publications/2009/11/20094407/0
38. Scottish Government (2010) The Healthcare Quality Strategy for NHS Scotland. Retrieved from: http://www.gov.scot/Resource/Doc/311667/0098354.pdf
39. Southall, D. P., Burr, S., Smith, R. D., Bull, D. N., Radford, A., Williams, A., & Nicholson, S. (2000). The Child-Friendly Healthcare Initiative (CFHI): Healthcare provision in accordance with the UN Convention on the Rights of the Child. Pediatrics, 106(5), 1054-1064.
40. Stallard, P. (2009). Cognitive behaviour therapy with children and young people.Clinical Psychology in Practice, 117.
41. Tak, J. H., & van, B. W. H. J. (2006). Pain- and distress-reducing interventions for venepuncture in children. Child: Care, Health and Development, 32(3) 257-268
42. Uman, L. S., Chambers, C. T., McGrath, P. J., &Kisely, S. (2006). Psychological interventions for needle-related procedural pain and distress in children and adolescents. Cochrane Database of Systematic Reviews, (4) CD005179
43. Uman, L. S., Chambers, C. T., McGrath, P. J., &Kisely, S. (2008) A systematic review of randomized controlled trials examining psychological interventions for needle-related procedural pain and distress in children and adolescents. Journal of Paediatric Psychology, 33, 842-854
44. Uman LS, Birnie KA, Noel M, Parker JA, Chambers CT, McGrath PJ, Kisely SR. Psychological interventions for needle-related procedural pain and distress in children and adolescents. Cochrane Database of Systematic Reviews 2013, Issue 10. Art. No.: CD005179. DOI: 10.1002/14651858.CD005179.pub3.
45. Whaley, S. E., Pinto, A., & Sigman, M. (1999). Characterizing interactions between anxious mothers and their children. Journal of consulting and clinical psychology, 67(6), 826.
46. Willemsen, H, Chaudhury, U, Briscall, L (2002) Needle phobia in children: A discussion of aetiology and treatment options. Clinical Child Psychology and Psychiatry, 7, 609-619.
47. Yip, P., Middleton, P., Cyna Allan, M., & Carlyle Alison, V. (2010). Non-pharmacological interventions for assisting the induction of anaesthesia in children. Cochrane Database of Systematic Reviews, (3) CD006447

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PAEDIATRIC PSYCHOLOGY: SUPPORT, COPING AND ADJUSTMENT IN CHILDREN, YOUNG PEOPLE AND FAMILIES OF CHILDREN WITH CHRONIC ILLNESS

1. Chi, N. & Demiris, G. (2014). A systematic review of telehealth tools and interventions to support family caregivers. Journal of Telemedicine and Telecare, 0(0), 1-8. doi:10.1177/1357633X145627345
2. Drutchas, A. & Anandarajah, G. (2014). Spirituality and coping with chronic disease in pediatrics. Rhode Island Medical Journal, 97(3), 26-30.12
3. Ellis, D.A., Naar-King, S., Chen, X., Moltz, K., Cunningham, P.B. & Idalski,Carcone, A. (2012). Multisystemic therapy compared to telephone support for youth with poorly controlled diabetes: findings from a randomized controlled trial. Annals of Behavioral Medicine, 44(2), 207-215. doi:10.1007/s12160-012-9378-1.11
4. Gross, M. & Warschburger, P. (2013) Chronic abdominal pain: Psychosocial strain and treatment-associated changes in coping. Verhaltenstherapie, 23(2), 80=89. doi: 10.1159/000351215 9
5. Hartling, L., Milne, A., Tjosvold, L., Wrightson, D., Gallivan, J. & Newton, A.S. (2010). A systematic review of interventions to support siblings of children with chronic illness or disability. Journal of Paediatrics and Child Health, 50, e26-e38. doi:10.1111/j.1440-1754.2010.01771.x1
6. Kashikar-Zuck, S., Sil, S., Lynch-Jordan, A.M…(2013). Changes in pain coping, catastrophizing, and coping efficacy after cognitive-behavioral therapy in children and adolescents with juvenile fibromyalgia. The Journal of Pain, 14(5), 492-501. doi: 10.1016/j.jpain.2012.12.0198
7. McCusker, C.G., Doherty, N.N., Molloy, B…(2012). A randomized controlled trial of interventions to promote Adjustment in children with congenital heart disease entering school and their families. Journal of Pediatric Psychology, 37(10), 1089-1103. doi:10.1093/jpepsy/jss09210
8. Rapoff, M. (2010). Adherence to pediatric medical regimens. New York, NY: Springer.13
9. Shilling, V., Morris, C., Thompson-coon, J., Ukoumunne, O,, Rogers, M. & Logan, S. (2013). Peer support for parents of children with chronic disabling conditions: a systematic review of quantitative and qualitative studies. Developmental Medicine & Chilid Neurology, 55(7), doi: 10.1111/dmcn.120912
10. Sansom-Daly, U.M., Peate, M., Wakefield, C.E., Bryant, R.A. & Cohn, R.J. (2012). A systematic review of psychological interventions for adolescents and young adults living with chronic illness. Health Psychology, 31(3), 380-393. doi: 10.1037/a002597716
11. Wu, L., Chiou, S., Sheen, J., Lin, P., Liao, Y.M., Chen, H. & Hasio, C. (2013). Evaluating the acceptability and efficacy of a psycho-educational intervention for coping and symptom management by children with cancer: a randomized controlled study. Journal of Advanced Nursing, 70(7), 1653-1662. doi: 10.1111/jan.12328 7

PAEDIATRIC PSYCHOLOGY: SUPPORT, COPING AND ADJUSTMENT IN CHILDREN, YOUNG PEOPLE AND FAMILIES OF CHILDREN WITH CHRONIC ILLNESS

12. Kohut, S.A., Stinson, J., van Wyk, M., Giosa, L. & Luca, S. (2014). Systematic review of peer support interventions for adolescents with chronic illness. International Journal of Child and Adolescent Health, 7(3), 183-197.

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1. Betz, C. L., Smith, K., & Macias, K. (2009). Testing the transition preparation training program: A randomized controlled trial. *International journal of child and adolescent health*, 3(4), 595-607.
2. Crowley, R., Wolfe, I., Lock, K., & McKee, M. (2011). Improving the transition between paediatric and adult healthcare: a systematic review. *Archives of disease in childhood,* 96(6), 548-553.
3. Davidson, J. (2008). Children and young people in mind: the final report of the National CAMHS Review. *London: Department of Health*. Retrieved from: http://webarchive.nationalarchives.gov.uk/20081230004520/publications.dcsf.gov.uk/eorderingdownload/camhs-review.pdf
4. Fegran, L., Hall, E. O., Uhrenfeldt, L., Aagaard, H., & Ludvigsen, M. S. (2014). Adolescents' and young adults' transition experiences when transferring from paediatric to adult care: A qualitative metasynthesis. *International journal of nursing studies,* 51(1), 123-135.
5. Gleeson, H., & Turner, G. (2012). Transition to adult services. *Archives of disease in childhood-Education & practice edition*, 97(3), 86-92.
6. National Institute for Health and Care Excellence (NICE, 2014). Transition from children's to adult services for young people using health or social care services, guideline scope. [GID-SCWAVE0714] London: National Institute for Health and Clinical Excellence.
7. Office for National Statistics (2007). *General Household Survey*, 2007 Report. Retrieved from: http://www.ons.gov.uk/ons/rel/ghs/general-household-survey/2007-report/index.html
8. Office for National Statistics (2014). *Measuring National Well-being – Exploring the Well-being of Young People in the UK*, 2014. Retrieved from: http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/exploring-the-well-being-of-young-people-in-the-uk--2014/rpt---exploring-the-well-being-of-young-people-in-the-uk--2014.html
9. Singh, S. P., Paul, M., Ford, T., Kramer, T., Weaver, T., McLaren, S., ... & White, S. (2010). Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. *The British Journal of Psychiatry*, 197(4), 305-312.
10. Steinbeck, K. S., Shrewsbury, V. A., Harvey, V., Mikler, K., Donaghue, K. C., Craig, M. E., & Woodhead, H. J. (2014). A pilot randomized controlled trial of a post-discharge program to support emerging adults with type 1 diabetes mellitus transition from pediatric to adult care. *Pediatric diabetes.* DOI:10.1111/pedi.12229

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