

Intensive treatments for generalized anxiety disorder in children and adolescents

Author

Peters, Rosie, Waters, Allison

Published

2014

Journal Title

Psychopathology Review

DOI

[10.5127/pr.033113](https://doi.org/10.5127/pr.033113)

Rights statement

© 2014 Textrum. The attached file is reproduced here in accordance with the copyright policy of the publisher. Please refer to the journal's website for access to the definitive, published version.

Downloaded from

<http://hdl.handle.net/10072/67747>

Griffith Research Online

<https://research-repository.griffith.edu.au>



Intensive Treatments for Generalized Anxiety Disorder in Children and Adolescents

Rosie-Mae Peters, Allison M. Waters

Griffith Health Institute & School of Applied Psychology, Griffith University, Mt Gravatt Campus

Abstract

Worry is a normal part of child development. However, a significant proportion of young people experience excessive worry that causes distress and interference with daily functioning. Although worry is a common feature of all anxiety disorders, it is a defining feature of Generalized Anxiety Disorder (GAD). Cognitive-behavioural therapy is an efficacious treatment for GAD and other anxiety disorders that in recent years has been successfully adapted into short, time-limited formats for other childhood anxiety disorders including Specific Phobia, Social Phobia, Panic, Separation Anxiety and Obsessive Compulsive Disorder. However, intensive treatments for GAD specifically have not been examined to date. This paper provides a brief overview of the characteristics of youth with GAD, followed by a review of current intensive treatments for other anxiety disorders and evidence suggesting these approaches are effective in treating comorbid GAD. Potential benefits of an intensive treatment for GAD are outlined, and directions for future research on intensive treatments for GAD are discussed.

© Copyright 2014 Textrum Ltd. All rights reserved.

Keywords: generalized anxiety disorder, treatment, children and adolescents

Correspondence to: Dr Allison Waters, School of Applied Psychology, Griffith University, Mt Gravatt campus, Australia, Email: a.waters@griffith.edu.au

Received 17-Sep-2013; accepted 03-Nov-2013

Table of Contents

Generalized Anxiety Disorder in Children and Adolescents
Intensive Treatments for Anxiety Disorders in Children and Adolescents
Potential Benefits of an Intensive Treatment for Generalized Anxiety Disorder
Future Directions and Clinical Implications
References

Generalized Anxiety Disorder in Children and Adolescents

Worry is an anticipatory cognitive process, characterised by negative thoughts and images about possible dangers and their potential consequences (Vasey, Crnic, & Carter, 1994). Worry is a normal part of child development, with children as young as four reporting occasional worries (Muris, Merckelbach, Gadet, & Moulart, 2000). Although worry is developmentally appropriate, a proportion of youth experience excessive worry that causes significant distress and interference with daily functioning. Excessive and uncontrollable worry, that is disproportionate to the actual event, is the defining diagnostic feature of Generalized Anxiety Disorder (GAD). For GAD to be diagnosed in children, worry must also be accompanied by at least one persistent physiological symptom. Diagnostic criteria for GAD in youth were first included in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, (DSM-IV; American Psychiatric Association [APA], 1994) when it replaced Overanxious Disorder (OAD) of childhood. Apart from minor wording changes, the criteria for GAD remain the same in the recently released DSM-5 (APA, 2013).

Reported prevalence rates for GAD in children and adolescents range from 0.16% (Ford, Goodman, & Meltzer, 2003) to 11.1% (Boyle et al., 1993), with prevalence rates increasing with age (King, Ollendick, & Mattis, 1994). The average age of onset is difficult to ascertain, in part, due to previous changes to the diagnostic criteria and to the slow but progressive nature of GAD (Rapee, 1985). Nevertheless, the reported age of onset for Overanxious Disorder (OAD) ranged from 8.8 to 10 years (Keller et al., 1992; Last, Perrin, Hersen, & Kazdin, 1992). There is evidence that the increasing prevalence of GAD with age is partially mediated by cognitive development (Muris, Merckelbach, & Lijten, 2002; Muris, Merckelbach, Meesters, & Van Den Brand, 2002; Vasey et al., 1994). As the ability to make predictions about future events and anticipate negative outcomes increases, so too does the capacity to worry in a more complex way (Vasey, 1993). GAD affects more girls than boys (Kashani & Ovaschel, 1990; Muris, Meesters, Merckelbach, Sermon, & Zwahlen, 1998), and has been linked to social problems, poor academic achievement, substance abuse and suicidal ideation (Albano & Hack, 2004). This disorder often has a chronic course and is associated with increased service utilization and health care costs and reduced quality of life in adults (Barerra & Norton, 2009; Kessler, DuPont, Bergland, & Wittchen, 1999; Roy-Byrne, 1996). GAD is frequently accompanied by one or more additional disorders (most commonly with other anxiety disorders, followed by depression and externalizing disorders), with rates of comorbidity as high as 90% (Masi et al., 2004; Masi, Mucci, Favilla, Romano, & Poli, 1999). Due to high comorbidity between GAD and other internalizing and externalizing disorders (e.g., Lahey et al., 2008) and evidence that GAD of all the anxiety disorders loads most strongly on trait dispositions such as negative affect (e.g., Brown, Chorpita, & Barlow, 1998), some have suggested that GAD may represent a broader underlying emotional disorder, rather than a distinct clinical condition (e.g., Barlow, 1988; Rapee, 1991).

Over the past 10 years, researchers have been testing the applicability of adult models of GAD to explain the mechanisms that cause and maintain GAD in youth (see Wilson, 2010). Wells (1995) developed the meta-cognitive model of GAD in adults, which focuses on the role of metacognitive beliefs (i.e., thoughts about thinking) in the development and maintenance of GAD. The meta-cognitive model posits that positive beliefs about the benefits of worry and negative beliefs about the danger and uncontrollability of worry are associated with pathological worry. Whilst there is evidence to support meta-cognitions in children (see Flavell, Green, & Flavell, 2000), there is no evidence to date that differentiates metacognitive beliefs in youth with GAD compared to youth with other anxiety or depressive disorders (see Ellis & Hudson, 2011). However, one of the characteristics found to distinguish GAD from other anxiety disorders in children is the number of worries experienced (Benjamin, Beidas, Comer, Puliafico, & Kendall, 2011; Layne, Bernat, Victor, & Bernstein 2009). In a sample of 7 to 13 year old children, Benjamin et al. (2011) found that three or more parent reported areas of worry differentiated children with GAD from those with separation anxiety disorder and specific phobias.

Intensive Treatments for Anxiety Disorders in Children and Adolescents

Traditionally, the treatment of choice for childhood anxiety disorders, including GAD, has been cognitive behavioural therapy delivered over 10–20 weekly sessions (e.g., Kendall, Pimentel, Rynn, Angelosante, & Webb, 2004). More recently, a number of intensive treatments have been developed for a range of youth anxiety disorders

that provide cognitive behavioural skills within a condensed timeframe (e.g. Specific Phobia (SP); Davis III, Ollendick, & Ost, 2009; Ollendick et al., 2009; Panic Disorder with or without Agoraphobia (PDA); Angelosante, Pincus, Whitton, Cheron, & Pian, 2009; Social Phobia (SoP); Donovan, Cobham, & Waters, under review; Separation Anxiety Disorder (SAD); Santucci, Ehrenreich, Trostler, Bennett, & Pincus, 2009, and Obsessive Compulsive Disorder (OCD); Storch et al., 2007; Whiteside & Jacobson, 2010). Current intensive treatments range from a single, three-hour session of exposure-based therapy (e.g. Davis III et al., 2009) to daily two- to six-hour sessions of exposure-based CBT over eight days (e.g. Angelosante et al., 2009). Common features of these intensive treatments include psychoeducation, cognitive restructuring, in vivo exposure and relapse prevention. The key ingredient of intensive treatments is exposure therapy, the focus of which varies depending on the anxiety disorder. For example, for children with a SP, exposure therapy focuses on their phobic object; for youth with PDA, it is targeting interoceptive cues in addition to feared situations, and for SAD, exposure therapy involves increasingly longer periods of separation from parents.

Crawley et al. (2013) recently demonstrated that GAD in 6–13 year olds, can be effectively treated in a brief, eight session format, halving the traditional duration of CBT. However, to the authors' knowledge, there are no other published studies on more intensive treatments specifically for GAD in youth or adults at this time. Due to high comorbidity amongst anxiety disorders, it is possible to assess the effects of intensive treatments on GAD when GAD is comorbid with another anxiety disorder that is the focus of intensive treatment, such as SP or PDA. For example, Gallo, Chan, Buzzella, Whitton and Pincus (2012) examined the effect on comorbid diagnoses of an eight-day intensive treatment for adolescents with a principal diagnosis of PDA. Of the 55 participants, 18 had a comorbid diagnosis of GAD. At pre-treatment, the mean clinician's severity rating (CSRs) on the *Anxiety Disorder Interview Schedule for DSM-IV* (ADIS-IV-CP; Silverman & Albano, 1996) was 4.28 ($SD = 0.46$) which is considered to be in the clinical range. Immediately after treatment, GAD CSRs were significantly lower ($M = 2.11$, $SD = 1.30$) and no longer in the clinical range. Similarly, one-session treatments for SP have produced positive effects on comorbid diagnoses (Ollendick, Ost, Reuterskiold, & Costa, 2010). In a sample of 50 children with a principal SP diagnosis, 14 had a comorbid diagnosis for GAD. Pre- and post-treatment change in CSRs were not reported separately for each comorbid diagnosis, however the mean CSR for all comorbid anxiety disorders (including GAD) reduced from the clinical range ($M = 5.2$, $SD = 1.24$) to 3.83 ($SD = 1.58$) after treatment, and was maintained at 6-month follow-up ($M = 2.79$, $SD = 1.84$).

This has raised the question as to why GAD appears to respond to brief and intensive treatments for other principal diagnoses even though it has not been specifically targeted for change. Both Ollendick et al. (2010) and Gallo et al. (2012) suggested that this may, in part, be due to an increase in child/youth self-efficacy following the successful treatment of their presenting concern. They may feel more confident in their ability to cope with anxiety and this may generalise to other anxiety disorders, such as GAD. Gallo et al. (2012) also suggested that the favourable effect on comorbid diagnoses may be due to similarities in the core components of intensive treatment and standard (i.e., longer duration) CBT that has been shown to be effective in treating GAD. Thus, children and adolescents with GAD might begin to apply the core CBT skills learnt during intensive treatment to other areas of worry or anxiety, as they do in longer duration treatments.

Potential Benefits of an Intensive Treatment for Generalized Anxiety Disorder

The condensed method of delivery afforded by intensive treatments has a number of potential benefits. As discussed earlier, GAD in young people causes significant interference in various life domains. An intensive treatment may result in quicker alleviation of distress and consequently decrease life interference more rapidly than traditional longer duration treatments. Furthermore, an intense treatment may be more appealing to time poor families who find it difficult to attend weekly sessions due to school and other commitments. An intensive treatment format might also increase accessibility to services for families who live in rural and remote areas who are unable to attend multiple sessions over a long period of time. Finally, an intensive approach may benefit families who have poor motivation and are likely to drop out or attend sessions infrequently (Davis III et al., 2009).

Future Directions and Clinical Implications

Given that the efficacy of intensive treatments has not been examined when GAD is the principal diagnosis, it will be important that future studies first determine whether principal GAD is as responsive to time-limited treatments as other anxiety disorders appear to be. Nevertheless, given the high comorbidity between GAD and other anxiety disorders, and that the current literature suggests that intensive treatments decrease GAD symptoms when it is comorbid with a principal SP or PDA diagnosis (see Ollendick et al., 2010; Gallo et al., 2012), one potential clinical consideration might be to treat a comorbid SP or PDA if they are present, with the expectation that there will be concomitant reductions in GAD.

In cases where GAD is the principal diagnosis in absence of other anxiety disorders with established evidence regarding the efficacy of intensive treatments, another approach might be to modify current intensive treatments so that exposure therapy targets the child's generalised worry domains, akin to either the phobic stimulus in SP treatment or interoceptive cues in PDA treatment. For example, in a one-session treatment format (see Davis III et al., 2009 for details), each of the three hours of treatment could be devoted to exposure tasks targeting a different worry domain, such as performance (first hour), social/ interpersonal situations (second hour) and perfectionism (third hour). A perfectionism exposure task could include the child intentionally making mistakes during in-session activities and presenting their work to an unknown adult for marking. For health concerns or worry about personal presentation/appearance, exposure tasks could involve wearing soiled clothing of another child or having unkempt hair while asking another child to lend a pencil.

Targeting various domains of worry accords with the evidence regarding possible unique etiological and maintaining factors of youth GAD versus other anxiety disorders in that the frequency, intensity and number of worries appear to differentiate GAD from other anxiety disorders in children (e.g., Benjamin et al., 2011). Also, based on findings in previous studies that GAD comorbid with either SP or PDA might improve through increased self-efficacy and mastery over a wide range of stimuli and situations that were the focus of treatment (Ollendick et al., 2010; Gallo et al., 2012), targeting a number of worry domains through varied types of exposure tasks and behavioural experiments in a massed format is likely to yield even stronger improvements. In addition, it might be beneficial to increase active worry about possible consequences during exposure tasks. This might help to strengthen expectancy violations during exposure therapy, as well as encourage children to learn that negative affect can be tolerated, and to help them habituate to fearful images or thoughts that may be motivating worry and avoidance (Waters & Craske, 2005).

In summary, intensive treatments for a range of anxiety disorders affecting children and adolescents have produced promising outcomes and offer enormous potential as cost- and time-effective treatments. To date, encouraging outcomes from intensive treatments on comorbid GAD have been observed, yet studies of intensive treatments for GAD specifically are lacking. Given the high prevalence rates of GAD, its chronic course and impact on daily functioning, intensive treatments for GAD is an important avenue for future research.

References

- Albano, A. M., & Hack, S. (2004). Children and adolescents. In R.G. Heimberg, D. Mennin, & C. Turk (Eds.), *Generalized anxiety disorder* (pp. 383-408). New York: The Guilford Press.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*. Washington DC: American Psychiatric Association Task Force.
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*. Washington DC: American Psychiatric Association Task Force.
- 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. <http://dx.doi.org/10.1016/j.cbpra.2009.03.002>
- Barerra, T. L., & Norton, P. J. (2009). Quality of life in generalized anxiety disorder, social phobia and panic disorder. *Journal of Anxiety Disorders*, 23(8), 1086-1090. <http://dx.doi.org/10.1016/j.janxdis.2009.07.011>
- Barlow, D. H. (1988). *Anxiety and his disorders: The nature and treatment of anxiety and panic*. New York: Guilford.

- Benjamin, C. L., Beidas, R. S., Comer, J. S., Puliafico, A. C., & Kendall, P. C. (2011). Generalized anxiety disorder in youth: diagnostic considerations. *Depression and Anxiety, 28*(2), 173-182. doi: 10.1002/da.20747. <http://dx.doi.org/10.1002/da.20747>
- Boyle, M. H., Offord, D. R., Racine, Y., Sanford, M., Szatmari, P., Fleming, J. E., & Price-Munn, N. (1993). Evaluation of the diagnostic interview for children and adolescents for use in general population samples. *Journal of Abnormal Child Psychology, 21*(6), 663-681. <http://dx.doi.org/10.1007/BF00916449>
- Brown, T. A., Chorpita, B., & Barlow, D. H. (1998). Structural relationships among dimensions of the DSM-IV anxiety and mood disorders and dimensions of negative affect, positive affect, and autonomic arousal. *Journal of Abnormal Psychology, 107*(2), 179-192. <http://dx.doi.org/10.1037/0021-843X.107.2.179>
- Crawley, S. A., Kendall, P. C., Benjamin, C. L., Brodman, D. M, Wei, C, Beidas, R. S.,... Mauro, C. (2013). Brief cognitive behavioral therapy for anxious youth: Feasibility and initial outcomes. *Cognitive and Behavioral Practice, 20*(2), 123-133. <http://dx.doi.org/10.1016/j.cbpra.2012.07.003>
- Davis III, T. E., Ollendick, T. H., & Ost, L. G. (2009). Intensive treatment of specific phobias in children and adolescents. *Cognitive Behavioural Practice, 16*(3), 294-303. doi: 10.1016/j.cbpra.2008.12.008. <http://dx.doi.org/10.1016/j.cbpra.2008.12.008>
- Donovan, C. L., Cobham, V. E., & Waters, A. M. (under review). Intensive group-based CBT for child social phobia: A pilot study.
- Ellis, D. M., & Hudson, J. L. (2011). Test of the metacognitive model of generalized anxiety disorder in anxiety-disordered adolescents. *Journal of Experimental Psychopathology, 2*(1), 28-43. doi: 10.5127/jep.011910. <http://dx.doi.org/10.5127/jep.011910>
- Flavell, J. H., Green, F. L., & Flavell, E. R. (2000). Development of children's awareness of their own thoughts. *Journal of Cognition and Development, 1*(1), 97-112. http://dx.doi.org/10.1207/S15327647JCD0101N_10
- Ford, T., Goodman, R., & Meltzer, H. (2003). The British Child and Adolescent Mental Health Survey 1999: the prevalence of DSM-IV disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*(10), 1203-1211. <http://dx.doi.org/10.1097/00004583-200310000-00011>
- Gallo, K. P., Chan, P. T., Buzzella, B. A., Whitton, S. W., & Pincus, D. B. (2012). The impact of an 8-day intensive treatment for adolescent panic disorder and agoraphobia on comorbid diagnoses. *Behavior Therapy, 43*(1), 153-159. <http://dx.doi.org/10.1016/j.beth.2011.05.002>
- Kashani, J. H., & Orvaschel, H. (1990). A community study of anxiety in children and adolescents. *American Journal of Psychiatry, 147*(3), 313-318.
- Keller, M. B., Lavori, P. W., Wunder, J., Beardslee, W. R., Schwartz, C. E., & Roth, J. (1992). Chronic course of anxiety disorders in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*(4), 595-599. <http://dx.doi.org/10.1097/00004583-199207000-00003>
- Kendall, P. C., Pimentel, S., Rynn, M. A., Angelosante, A., & Webb, A. (2004). Generalized anxiety disorder. In T. H. Ollendick & J. S. March (Eds.), *Phobic and anxiety disorders in children and adolescents* (pp. 334-380). Oxford: Oxford University Press.
- Kessler, R. C., DuPont, R. L., Berglund, P., & Wittchen, H. U. (1999). Impairment in pure and comorbid generalized anxiety disorder and major depression at 12 months in two national surveys. *American Journal of Psychiatry, 156*(12), 1915-1923.
- King, N. J., Ollendick, T. H., & Mattis, S. G. (1994). Panic in children and adolescents: Normative and clinical studies. *Australian Psychologist, 29*(2), 89-93. <http://dx.doi.org/10.1080/00050069408257329>
- Lahey, B. B., Rathouz, P. J, Van Hulle, C., Urbano, R. C, Krueger, R. F, Applegate, B, Garriock, H. A, Chapman, D. A, Waldman, I. D. (2008). Testing structural models of DSM-IV symptoms of common forms of child and adolescent psychopathology. *Journal of Abnormal Child Psychology 36*(2), 187–206. <http://dx.doi.org/10.1007/s10802-007-9169-5>
- 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 and Adolescent Psychiatry, 31*(6), 1070-1076. <http://dx.doi.org/10.1097/00004583-199211000-00012>
- Layne, A. E., Bernat, D. H., Victor, A. M., & Bernstein, G. A. (2009). Generalized anxiety disorder in a nonclinical sample of children: symptom presentation and predictors of impairment. *Journal of Anxiety Disorders, 23*(2), 283-289. <http://dx.doi.org/10.1016/j.janxdis.2008.08.003>

- Masi, G., Millepiedi, S., Mucci, M., Poli, P., Bertini, N., & Milantoni, L. (2004). Generalized anxiety disorder in referred children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(6), 752-760. <http://dx.doi.org/10.1097/01.chi.0000121065.29744.d3>
- Masi, G., Mucci, M., Favilla, L., Romano, R., & Poli, P. (1999). Symptomatology and comorbidity of generalized anxiety disorder in children and adolescents. *Comprehensive Psychiatry*, 40(3), 210-215. [http://dx.doi.org/10.1016/S0010-440X\(99\)90005-6](http://dx.doi.org/10.1016/S0010-440X(99)90005-6)
- Muris, P., Meesters, C., Merckelbach, H., Sermon, A., & Zwakhalen, S. (1998). Worry in normal children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37(7), 43-52. <http://dx.doi.org/10.1097/00004583-199807000-00009>
- Muris, P., Merckelbach, H., Gadet, B., & Moulart, V. (2000). Fears, worries, and scary dreams in 4 to 12-year-old children: Their content, developmental patterns and origins. *Journal of Clinical Child Psychology*, 29(1), 43-52. http://dx.doi.org/10.1207/S15374424jccp2901_5
- Muris, P., Merckelbach, H., & Luitjen, M. (2002). The connection between cognitive development and specific fears and worries in normal children and children with below-average intellectual abilities: a preliminary study. *Behaviour Research and Therapy*, 40(1), 37-56. [http://dx.doi.org/10.1016/S0005-7967\(00\)00115-7](http://dx.doi.org/10.1016/S0005-7967(00)00115-7)
- Muris, P., Merckelbach, H., Meesters, & Van Den Brand, K. (2002). Cognitive development and worry in normal children. *Cognitive Therapy and Research*, 26(6), 775-787. <http://dx.doi.org/10.1023/A:1021241517274>
- Ollendick, T. H., Ost, L. G., Reuterskiold, L., & Costa, N. (2010). Comorbidity in youth with specific phobias: Impact of comorbidity on treatment outcome and the impact of treatment on comorbid disorders. *Behaviour Research and Therapy*, 48(9), 827-831. <http://dx.doi.org/10.1016/j.brat.2010.05.024>
- 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*, 77(3), 504-516. <http://dx.doi.org/10.1037/a0015158>
- Rapee, R. M. (1985). Distinctions between panic disorder and generalised anxiety disorder: Clinical presentation. *Australian and New Zealand Journal of Psychiatry*, 19(3), 227-232. <http://dx.doi.org/10.3109/00048678509158827>
- Rapee, R. M. (1991). Generalized anxiety disorder: A review of clinical features and theoretical concepts. *Clinical Psychology Review*, 11(4), 419-440. [http://dx.doi.org/10.1016/0272-7358\(91\)90116-C](http://dx.doi.org/10.1016/0272-7358(91)90116-C)
- Roy-Byrne, P. P. (1996). Generalized anxiety and mixed anxiety-depression: association with disability and health care utilization. *Journal of Clinical Psychiatry*, 57(7), 86-91.
- Santucci, L. C., Ehrenreich, J. T., Trosper, S. E., Bennett, S. M., & Pincus, D. B. (2009). Development and preliminary evaluation of a one-week summer treatment program for separation anxiety disorder. *Cognitive and Behavioral Practice*, 16(3), 317-331. <http://dx.doi.org/10.1016/j.cbpra.2008.12.005>
- Silverman, W. K., & Albano, A. M. (1996). *The Anxiety Disorders Interview Schedule for DSM-IV, child and parent versions*. Albany, New York: Graywind.
- Storch, E. A., Geffken, G. R., Merlo, L. J., Mann, G., Duke, D., Munson, M.,... Goodman, W. K. (2007). Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: comparison of intensive and weekly approaches. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(4), 469-478. <http://dx.doi.org/10.1097/chi.0b013e31803062e7>
- Vasey, M. W. (1993). Development and cognition in childhood anxiety: The example of worry. *Advances in Clinical Child Psychology*, 15, 1-39.
- Vasey, M. W., Crnic, K. A., & Carter, W. G. (1994). Worry in childhood: A developmental perspective. *Cognitive Therapy and Research*, 18(6), 529-549. <http://dx.doi.org/10.1007/BF02355667>
- Waters, A. M. & Craske, M. G. (2005). Generalised anxiety disorder. In M. M. Antony, D. R. Ledley, & R. G. Heimberg, (Eds). *Improving outcomes and preventing relapse in cognitive behavioral therapy*. (pp. 77-127). New York: Guilford.
- Wells, A. (1995). Meta-cognition and worry: A cognitive model of generalized anxiety disorder. *Behavioural and Cognitive Psychotherapy*, 23(3), 301-320. <http://dx.doi.org/10.1017/S1352465800015897>
- Whiteside, S. P., & Jacobsen, A. B. (2010). An uncontrolled examination of a 5-day intensive treatment for pediatric OCD. *Behavior Therapy*, 41(3), 414-422. <http://dx.doi.org/10.1016/j.beth.2009.11.003>
- Wilson, C. (2010). Pathological worry in children: What is currently known? *Journal of Experimental Psychopathology*, 1(1), 6-33. <http://dx.doi.org/10.5127/jep.008110>