

Utilization of Individual versus Family Therapy among Adolescents with Severe Emotional Disturbance

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Abstract:

Service utilization patterns among children with severe emotional and/or behavioral disturbances are described for 89 children and families, interviewed at two time points across a 6-month period. Children received a greater number of individual therapy sessions than family therapy sessions, and children significantly decreased their levels of internalizing and externalizing behaviors. Family therapy was associated with decreases in internalizing behaviors when children reported outcomes. Individual therapy was not associated with changes in either internalizing or externalizing behaviors regardless of reporter. Symptom severity did not dictate whether children were provided individual or family therapy. Recommendations for individualized treatment plans are offered.

Article:

One innovative model of community mental health service delivery lies within system of care (Stroul & Friedman, 1996). A system of care is an adaptive network of structures, processes, and relationships grounded in system of care values and principles that provides children and youth with serious emotional disturbance (SED) and their families with access to and availability of necessary services and supports across administrative and funding jurisdictions (Hodges, Ferreira, Israel, & Mazza, 2006). Given the severity of mental health needs among children with SED, this plan often includes a variety of therapeutic services such as individual and family therapy. This study examines service utilization of individual and family therapy, as well as how these services relate to changes in both child variables (i.e., internalizing and externalizing behaviors) and family variables (i.e., caregiver depression and family empowerment).

Recent recommendations for moving the research base on system of care forward propose examining the therapeutic services received as well as how these services are linked to outcomes. That is, it is of interest to understand how therapeutic utilization plays out in real-world settings (Weisz, Sandler, Durlak, & Anton, 2006). Common therapeutic approaches in community settings include individual and family-based therapies. Individual-based treatments focus on the targeted youth for therapeutic change, with the average treated child functioning better than 75% of control group children (Weisz et al., 1987; Weisz et al., 1995). Therefore, it is surprising to find that only about 5–10% of children and their families utilize outpatient child-based therapy services (Burns, Hoagwood, & Mzazek, 1999). Family-based treatments include “any modality involving parents as essential participants in treatment” (Diamond & Josephson, 2005, p. 874). Although there are many types of family-based treatments (see Kaslow, Dausch, & Celano, 2003, for a full review), most family-based treatments fall within a general systems theory perspective with the recognition that the behavior of one family member can influence the behavior of other family members (e.g., parents, target child, siblings).

Given the recent clinical trial research documenting that, across both externalizing and internalizing disorders, integrating family therapy *with* child therapy can result in enhanced outcomes for children and adolescents with mental health problems (Barmish & Kendall, 2005), the present study investigates whether such an integrative approach is occurring in community-based treatment. It was predicted that: (a) children would be more likely to receive individual therapy than family therapy; (b) children would benefit more when they receive a combination of family and child therapy compared to child therapy alone; and (c) caregivers who participated in family therapy also would achieve treatment gains in terms of a decrease in depressive symptoms and an increase in empowerment.

METHOD

Participants

Participants were 102 children with SED and their families enrolled in one Center for Mental Health Services (CMHS)-funded grant site in North Carolina. Of those 102 families, 13 dropped out of the longitudinal program evaluation within the first six months (12% attrition), resulting in a final sample of 89 ($n = 89$). Analyses indicated that the only variable predicting attrition was age, $t(100) = -2.48$, $p < .05$, with those dropping out tending to be older ($M = 13.67$, $SD = 2.46$) than those remaining in the evaluation ($M = 11.83$, $SD = 1.40$). No other group differences were noted. Demographic information describing the sample is depicted in Table 1. In terms of ethnicity, youth were collapsed into majority or minority groups for analyses because there were only two youth who identified as Native American and six youth who identified as Hispanic, precluding the possibility of examining group differences beyond majority/minority status.

Table 1: Descriptive statistics describing the sample.^{a, b}

Indicator	%	Mean	SD	Range
Age		11.83	1.40	10.00–17.00
Male	75			
Minority	42			
Custody Status				
Single-Parent Family	43			
Two-Parent Family	29			
Grandparents	3			
Adoptive/Foster Parents	5			
State Custody	20			
Family Income				
Less than \$15,000	43			
Above \$15,000	57			
Clinical Diagnoses				
AD/HD	32			
Mood Disorder	26			
Oppositional Defiant Disorder	14			
Anxiety Disorder	8			
Disruptive Behavior Disorder	7			
Conduct Disorder	6			
Adjustment Disorder	5			
Co-morbid Disorders	85			
At Least One Psychotropic Medication	63			
Average # of Individual Therapy Sessions		11.44	16.57	0.00–64.00
Average # of Family Therapy Sessions		5.18	12.60	0.00–60.00

^a All demographic statistics are based on information provided at Time One.

Procedure

Children were referred to their local community mental health program from a variety of sources, including caregivers, child-serving agencies (e.g., Department of Social Services, Department of Juvenile Justice, Department of Public Health), and schools. Consent forms were signed by the primary caregiver (or legal guardian) and the child, if age 11 or older. At baseline (Time One; T1) and 6 months later (Time Two; T2), trained evaluators conducted in-home interviews lasting approximately two hours for caregivers and one hour for children. All instruments were read to both children and their caregivers to minimize possible error due to differential reading abilities. Families received \$25 for T1 interviews and \$30 for T2 interviews; children received gift certificates donated from local fast food restaurants at both T1 and T2.

Measures

Demographics. *The Descriptive Information Questionnaire* (DIQ; CMHS, 1997) is a 37-item caregiver-reported questionnaire completed at T1 that measures age, ethnicity, income, and other demographic variables.

Individual and family therapy. Services received over the past six months were reported using the Multi-Sector Service Contact (MSSC; CMHS, 2000). Although this measure contains 25 items pertaining to a variety of services children and their families might receive, only three items were used in the present study in order to focus exclusively on the combination of individual and family therapy to predict changes in child symptoms. These items include: Did your child receive medication treatment (used as a control variable); How many individual therapy sessions did he/she receive during the last six months; and How many family therapy

sessions did you receive during the last six months. Individual therapy did not include case management services. If caregivers were unsure of whether their family received family therapy services, evaluators defined family therapy sessions as those sessions that included more than just the child and focused on aspects of family functioning.

To assess levels of family functioning, caregivers completed the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1994). The present study utilized the Home Role subscale, which assesses the degree of family impairment. The CAFAS is rated on a 30-point scale (0 = no impairment to 30 = severe impairment). Thus, higher scores indicate greater impairment. Inter-rater reliability and validity have been demonstrated in previous studies (Hodges & Wong, 1996), and mental health professionals were trained to achieve high inter-rater correlations ($> .80$) between their ratings and criterion ratings established by the author (Hodges, 1994).

Internalizing and externalizing behaviors. Caregivers completed the Child Behavior Checklist (CBCL; Achenbach, 1991a) at both assessments, and youth completed the Youth Self-Report (YSR; Achenbach, 1991b) at both assessments. The earlier versions of the CBCL and YSR were used at both T1 and T2 for measure consistency across time. The present study utilized T -scores from the internalizing and externalizing broadband scale. Internal consistency reliability (α 's $> .82$), test-retest reliability (α 's $> .87$ for all scales), and validity have been demonstrated in previous studies (Achenbach, 1991a, 1991b). Correlations among caregiver and youth reports were non-significant for both internalizing and externalizing symptoms at both time points. Because of these low cross-informant correlations, analyses were run separately by reporter rather than combined into a composite score of internalizing and externalizing behaviors. For child-reported internalizing behaviors, internal consistency (Cronbach's alpha) was .72 at T1 and .76 at T2. For child-reported externalizing behaviors, alphas were .78 at T1 and .77 at T2. For caregiver-reported internalizing behaviors, alphas were .88 at T1 and .81 at T2. For caregiver-reported externalizing behaviors, alphas were .87 at T1 and .86 at T2.

Caregiver depression. Caregivers reported their own levels of depression using the Center for Epidemiological Studies-Depression (CES-D; Radloff, 1977). Caregivers responded on a 3-point scale from 0 = *Rarely or none of the time (less than 1 day)* through 3 = *Most or all of the time (5–7 days)*. Internal consistency (Cronbach's alpha) was .78 at T1 and .84 at T2.

Family empowerment. Caregiver-reported family empowerment was obtained at both T1 and T2 using the total score from the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992). The FES consisted of 34 items rated on a 5-point Likert-type scale from 1 (*not true at all*) to 4 (*very true*). Internal consistency (Cronbach's alpha) was .90 at T1 and .95 at T2.

RESULTS

Independent samples *t*-tests were conducted between demographic and outcome variables. Those tests indicated that caregiver-reported internalizing behaviors at T1 differed significantly by ethnicity, $t(88) = -2.44, p < .01$, (Caucasian children $M = 70.88, SD = 9.92$; minority children $M = 65.51, SD = 11.30$). Furthermore, levels of empowerment also differed by ethnicity, $t(70) = 2.87, p < .01$, (Caucasian caregivers $M = 3.79, SD = .57$; minority caregivers $M = 4.21, SD = .64$). Thus, minority caregivers felt more empowered and reported less internalizing among their children. Neither gender nor age was related with any of the independent or dependent variables; only ethnicity was controlled in further analyses.

Initial Analyses

To confirm the assumption that, given the characteristics of this population, the large majority of children and families were in need of family therapy services, frequency analyses were conducted between levels of family dysfunction and service utilization of family therapy. These analyses indicated that 88.3% of families had either moderate or severe impairment in family functioning, with 5.8% reporting mild impairment and 5.8% reporting no impairment. These estimates confirm that almost all families have family dysfunction to a degree at which at least some level of family therapy would be indicated.

Because of the number of analyses, we utilized the Benjamini-Hochberg procedure for controlling the false positive rate in multiple comparisons (see Thissen, Steinberg, & Kuang, 2002, for a full review). As depicted in Table 2, both caregivers and children reported decreases in child internalizing and externalizing behaviors, but there were no changes in caregiver depression or family empowerment. Additionally, a one-way analysis of variance (ANOVA) indicated that the clinical severity of children's internalizing and externalizing symptoms as measured by the CBCL and YSR were not related to group status (neither IT nor FT, only IT, only FT, both IT and FT), and correlational analyses indicated that family dysfunction at T1 did not predict the receipt of individual therapy ($r = .09, ns$), or family therapy ($r = .16, ns$). Thus, neither child nor family dysfunction predicted services received.

Table 2: Paired Samples T-Tests Examining Change Across Six Months.^a

Comparisons	<i>t</i>	<i>df</i>	<i>p</i> value	Index	B-H critical	Effect Size (<i>r</i>)
Child-Reported Internalizing	4.63	55	.001	1	.025*	.53
Caregiver-Reported Internalizing	3.52	88	.001	2	.021*	.35
Child-Reported Externalizing	3.09	55	.002	3	.017*	.38
Caregiver-Reported Externalizing	4.86	88	.001	4	.013*	.46
Caregiver Depression	.12	70	.453	5	.008	.01
Family Empowerment	-1.84	70	.035	6	.004	.07

*Indicates comparisons for which the direction of the difference is confidently interpreted at the $\alpha/2$ level using the Benjamini-Hochberg (B-H critical) method.

^a Because of the severity of the sample, the *n*'s differed depending upon whether the child was in the home or removed from the home. Of the 89 children and families that remained in the program over six months, there were 18 children who were in state custody. For those children, staff-as-caregiver interviews were completed, but these individuals did not complete the caregiver depression or family empowerment measures, resulting in an *n* of 71 for family-level analyses. Furthermore, 33 children did not complete the YSR because they were below the age of 11, resulting in an *n* of 56 when children reported their own levels of internalizing and externalizing behaviors. All caregiver reporters were mothers.

Hypothesis Testing

A paired sample *t*-test confirmed that children received a higher number of individual therapy sessions ($M = 11.44$, $SD = 16.58$) than family therapy sessions ($M = 5.43$, $SD = 12.86$) over a 6-month period, $t(88) = 3.31$, $p < .01$ (B-H corrected alpha level of .02). Approximately 67% received at least one session of IT; 37% received at least one session of FT; and 30% received at least one session of IT *and* one session of FT (22% did not report receiving any IT or FT). To test the second study aim, a series of hierarchical multiple regressions (see Table 3 & Table 4) were conducted using the two main outcome variables (i.e., internalizing and externalizing behaviors) and the number of individual therapy sessions alone, the number of family therapy sessions alone, and the interaction between individual by family therapy sessions as the predictor variables. Analyses were run separately by reporter. Control variables in all analyses included ethnicity (majority/minority), medication use (yes/no) to rule out change in functioning based on medication, and baseline levels of internalizing and/or externalizing behaviors.

Table 3: Regression Analyses To Predict T2 Externalizing with Individual and Family Therapy.

Variables Entered	<i>b</i>	<i>t</i>	β	<i>F</i>	R^2	B-H Critical (Effect Size)
<i>Child-Reported Externalizing (n = 56)</i>						
Block One				12.22***	.51	
Ethnicity	-.16	-.06	-.01			.025
Medication Use	-.66	-.26	-.03			.021
Externalizing (T1)	.65	6.90	.71			.017* (.68)
Block Two				8.99***	.57	
Individual Therapy	.19	2.10	.30			.008
Family Therapy	-.16	-2.00	-.26			.013
Block Three				7.64***	.58	
IT X FT	.00	.97	.18			.017
<i>Caregiver-Reported Externalizing (n = 89)</i>						
Block One				6.36***	.24	
Ethnicity	.38	.16	.02			.025
Medication Use	3.68	1.62	.18			.021
Externalizing (T1)	.59	4.04	.46			.017* (.40)
Block Two				4.07**	.26	
Individual Therapy	.01	.02	.01			.013
Family Therapy	.10	1.08	.14			.008
Block Three				3.33**	.26	
IT X FT	.00	.02	.00			.004

*Indicates comparisons for which the direction of the difference is confidently interpreted at the $\alpha/2$ level using the Benjamini-Hochberg (B-H critical) method.

For externalizing behaviors, higher levels of T1 externalizing behaviors were linked with higher levels of T2 externalizing behaviors, but neither individual nor family therapy was related to change in externalizing behaviors regardless of who reported externalizing behaviors (child or caregiver report). For internalizing behaviors, higher levels of T1 internalizing behaviors were linked with higher levels of T2 internalizing behaviors. Neither individual nor family therapy was related to change in internalizing behaviors when caregivers reported internalizing behaviors. However, when children reported internalizing behaviors, there was a main effect of family therapy, with a greater number of family therapy sessions linked with lower levels of internalizing behaviors at T2. Thus, hypothesis two was partially supported for internalizing disorders when child reports were considered, but did not receive support when caregiver reports were the focus. Because there were no changes in caregiver functioning in terms of caregiver

depression or empowerment from T1 to T2 (as depicted in Table 2), further analyses investigating the links between individual versus family therapy and change in family-level variables were not conducted.

Table 4: Regression Analyses to Predict T2 Internalizing with Individual and Family Therapy.

Variables Entered	<i>b</i>	<i>t</i>	β	<i>F</i>	<i>R</i> ²	B-H Critical (Effect Size)
<i>Child-Reported Internalizing (n = 56)</i>						
Block One				22.37***	.60	
Ethnicity	.23	1.00	.01			.025
Medication Use	-2.19	-.97	-.09			.021
Internalizing (T1)	.75	8.14	.78			.017* (.74)
Block Two				16.43***	.66	
Individual Therapy	.14	1.92	.21			.013
Family Therapy	-.21	-2.60	-.28			.008* (.33)
Block Three				13.51***	.66	
IT X FT	.00	-.53	-.07			.004
<i>Caregiver-Reported Internalizing (n = 89)</i>						
Block One				8.44***	.26	
Ethnicity	2.94	1.17	.12			.025
Medication Use	-.56	-.23	-.02			.021
Internalizing (T1)	.51	4.28	.47			.017* (.42)
Block Two				5.31**	.28	
Individual Therapy	.07	.85	.10			.013
Family Therapy	.04	.39	.05			.008
Block Three				5.06**	.31	
IT X FT	.01	1.75	.24			.004

*Indicates comparisons for which the direction of the difference is confidently interpreted at the $\alpha/2$ level using the Benjamini-Hochberg (B-H critical) method.

IMPLICATIONS AND APPLICATIONS FOR PROFESSIONAL PSYCHOLOGISTS

The current study examined service utilization of individual and family therapy, as well as how those services related to changes in both child variables (i.e., internalizing and externalizing behaviors) and family variables (i.e., caregiver depression and family empowerment) among children with SED and their families.

The results showed partial support for the hypotheses. In regards to the first hypothesis, children received more individual therapy sessions than family therapy sessions. However, given the severity of the sample, it was surprising to find that only 67% of children received at least one session of IT, and that 22% of children did not receive IT or FT. Given the research indicating that the average treated child functions better than 75% of control group children (Weisz, Weiss, Alicka, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995), and that family therapy has been shown to relieve internalizing and externalizing problems, it appears that therapy services (both individual and family) were under-utilized in this sample.

Regarding the lack of family therapy found in this study, perhaps it is more challenging to engage families in treatment compared to one individual. This might be the case for multiple reasons, including more preparation time for the clinician, increased need for coordination, less “predictability” of the session, and, at times, family preference for a particular kind of therapy (individual therapy only). In addition, clinicians may have had less training in family therapy or a predilection toward using individual therapy, and systems may have been less supportive of

family interventions. The lower utilization of family therapy also was noteworthy when considering that some support was found for the second hypothesis that children would benefit more from a combination of individual and family therapy than individual therapy alone. Specifically, individual therapy alone was not linked with changes in either child externalizing and internalizing behaviors, while family therapy alone was associated with decreases in internalizing behaviors when children reported their own symptoms.

Perhaps children were not receiving enough individual therapy sessions to be effective over a 6-month period; children received approximately 11 sessions over six months, averaging to less than two sessions per month. Based on Grawe's (2002) consistency theory of therapeutic change, this is not optimal. Instead, this theory suggests that in order to establish healthy patterns of relating while simultaneously decreasing problematic behavior, therapists should be consistent with the children they serve. In the same vein, a recent study utilizing a sample of children in foster care reported that as the *number* of individual therapy sessions increased, there was a measurable decrease in negative behaviors (Cotton-Cornelius, 2004). Furthermore, there was no relationship between the therapy services received and the severity of the symptoms at either an individual level (child internalizing and externalizing) or family level (family functioning) at intake. Given the best practice approach of individualized service plans, it was discouraging to find that children were not matched to an intensity of services appropriate for their level of functioning. Clearly, this represents an opportunity to develop additional training on individualized treatment planning.

Support was not found for the third hypothesis that caregivers would achieve treatment gains in terms of a decrease in depressive symptoms and an increase in empowerment. Instead, these levels remained relatively stable, which was surprising given that previous research had documented that child improvement leads to improvements in parental symptomology and family functioning (Kazdin & Wassel, 2000). Perhaps a longer time frame is needed to detect differences in caregiver-reported outcomes.

One study limitation was that information about services received was collected only from the caregiver. In future work, it would be informative to compare service utilization records directly with consumer reported utilization to assess whether there are differences in the services received and why these discrepancies might exist. Second, due to the marked comorbidity in this sample, youth with internalizing and externalizing problems were combined in the analyses. For samples with lower levels of comorbidity, or with youth in whom either internalizing or externalizing problems are more dominant, it may be valuable to consider the relative outcomes of individual versus family therapy separately by diagnostic grouping. Third, the focus of the study was on child symptoms rather than child functioning or psychiatric diagnoses, and it may be that different types of interventions have differential effects based on the child's diagnosis. Fourth, the therapeutic orientation utilized in individual and family therapy was not identified

(e.g., behavioral versus cognitive-behavioral; structural family therapy versus parent training) nor was there information on the extent to which the interventions used were evidence-based. Thus, whether there were differences in the degree to which children and caregivers improved based on the type of therapy received could not be tested. Finally, it is possible that in addition to the differences in the amount of individual and family therapy received, the groups also differed on other services (e.g., respite, family preservation, medications, etc.), which could not be captured in the present study.

Despite these limitations, there are several strengths of this study, with perhaps the strongest being a closer empirical examination of service utilization of individual and family therapy among a sample of children with SED delivered within the community. The current study works toward expanding the research base on systems of care as recommended by Weisz and colleagues (2006) to best serve children with SED and their families. Considering the severity and persistence of symptoms among youth with SED, the gains actualized in a relatively short, six-month period are promising. To continue to build on these findings, it is recommended that agencies examine their service utilization records to determine whether consumers are receiving the most empirically supported treatment modalities available. Further, given that family therapy appeared to be associated with more positive outcomes than individual therapy in this sample (at least in terms of internalizing symptoms and according to child report), and that current evidence-based practices for treating externalizing disorders almost universally include a parent/family component, it is imperative that family therapy be more emphasized in the community. Service organizations are challenged to assess their capacity to provide family therapy in terms of both knowledgeable clinicians and resources as well as whether families are aware of family therapy as an option and understand its rationale.

Future studies on how to integrate individual and family therapy among samples of youth with SED, as well as cost-effectiveness studies to examine the cost savings of integrating treatments, would be beneficial. Lastly, because the study's results did not provide evidence to support that family therapy lead to increases in parent empowerment, greater understanding of the factors that lead to parent empowerment are needed, particularly given that empowerment has been shown to be an essential element of systems of care and changes in child functioning (Graves & Shelton, 2007).

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