# Comparison of Child–Parent and Parent-Only Cognitive-Behavioral Therapy Programs for Anxious Children Aged 5 to 7 Years: Short- and Long-Term Outcomes

Suneeta Monga, MD, Brittany N. Rosenbloom, MSc, Azadeh Tanha, MSc, Mary Owens, MBChB, Arlene Young, PhD, CPsych

**Objective:** Childhood anxiety disorders (AD) are prevalent, debilitating disorders. The most effective treatment approach for children less than 8 years old requires further investigation. The study's primary objective was to compare 2 cognitive-behavioral therapy (CBT) group programs. CBT was delivered to children 5 to 7 years old and their parents (child–parent) or only to parents (parent-only), whereas children attended group sessions but did not receive CBT.

**Method:** Using a prospective, repeated measures, longitudinal study design, 77 children (29 male, mean age = 6.8 years; SD = 0.8 year) with AD and their parents participated in either a 12-week child–parent or parent-only CBT group treatment after a 3-month no-treatment wait-time. Well-validated treatment outcome measures were completed at 5 assessment time points: initial assessment, pretreatment, immediately posttreatment, 6 months, and 12 months posttreatment. A mixed models analysis was used to assess change in AD severity and global functioning improvements from baseline within each treatment and between treatments.

**Results:** No significant changes were noted in child–parent or parent-only treatment during the 3-month no-treatment wait time. Both treatments saw significant improvements posttreatment and at longer-term follow-up with significant reductions in AD severity measured by clinician and parent report and increases in global functioning. Significantly greater improvements were observed in the child–parent compared to the parent-only treatment.

**Conclusion:** This study suggests that both parent-only and child–parent group CBT improves AD severity in children 5 to 7 years old. Study results suggest that involvement of both children and parents in treatment is more efficacious than working with parents alone.

**Key Words:** anxiety disorder, cognitive-behavioral therapy, young children, long-term outcome, parental involvement

**J Am Acad Child Adolesc Psychiatry 2015;54(2):138–146.**

Childhood anxiety disorders (AD) are highly prevalent.[1,2] Symptom presentations[3,4] and prevalence rates are similar between preschool children and older school-age children.[5] AD are debilitating, affecting all aspects of a child's life including social adjustment, academic achievement, and home functioning.[1] AD rarely remit without treatment,[1,6,7] and even with remittance, high recurrence rates are evident.[7,8] Low remittance rates are associated with early age of onset, older age at intake, and more severe baseline symptoms.[1,8] Burgeoning evidence suggests that treatment effects may be more robust in early childhood, when increased neuroplasticity allows for larger developmental changes,[9,10] thus highlighting the importance of early identification and development of effective treatments for AD in young children.

Recognition of the need for treatment evaluation of AD in children younger than 8 years has led to an exploration of a variety of treatment approaches for this age group. For example, improving general parenting skills[11,12] and adapting parent–child interaction therapy (PCIT)[13] has demonstrated effectiveness for preschool AD. A growing body of evidence also suggests that teaching cognitive-behavioral therapy (CBT) directly to parents to use with their child is an effective treatment option (e.g., parent-focused education programs,[7,14] teaching parents how to implement exposures,[15] or parent-only CBT groups).[16] More recently, innovative approaches for directly teaching cognitive-behavioral strategies to young children have been evaluated.[17-21] Support for delivering individual CBT directly to children has been shown in a pilot study[21] and a randomized controlled trial (RCT),[18] and 2 studies have evaluated group CBT programs.[19,20]

Although there is developing support for using CBT to treat young children with AD, it is not clear who should be delivering the CBT to children. For example, Waters *et al.*[20] investigated whether parents could act as therapists for their young children. Children 4 to 8 years and their parents were randomized to 1 of 2 CBT group treatments. Either both parents and children received CBT directly from therapists aimed at managing child AD, or parents received CBT from therapists aimed at managing child AD and were instructed to teach their child CBT. In this latter treatment group parents

CME This article can be used to obtain continuing medical education (CME) at www.jaacap.org.

acted as therapists by using the same child workbooks as the therapists in the child and parent treatment. Postintervention and at 12-month follow-up, no significant differences between treatments were found, suggesting that direct involvement of children in treatment was not necessary.

Despite some evidence supporting the use of CBT in the treatment of AD in young children, the most effective treatment approach requires clarification. Furthermore, the role of parents and children in the treatment of young children with AD warrants further investigation and is the focus of this study.

Using a prospective, repeated-measures longitudinal design, this study's primary objective was to evaluate and compare the efficacy of 2 treatment programs developed specifically for anxious 5- to 7-year-old children and to evaluate the role the young anxious child has in the management of their AD. Therefore, children in both treatments attended a weekly group program where they met with other peers and therapists. Children in the child–parent treatment received CBT, whereas children in the parent-only treatment did not. In both treatments, parents were taught cognitive-behavioral strategies to use with their child to help manage their child's AD. Both treatments were also compared to a nontreatment wait-time control. Treatment outcomes were assessed immediately posttreatment and at 6-month and 12-month follow-up. It was hypothesized that in both treatments, clinician's severity ratings of anxiety diagnosis would decrease, global adaptive functioning would improve, and fewer children would continue to meet primary anxiety diagnostic criteria. Furthermore, it was hypothesized that greater improvements would be seen in the treatment in which children received CBT directly from therapists (child–parent treatment), as children learn to use strategies to manage their AD. A secondary study objective was to explore factors associated with treatment efficacy such as child age, sex, and parental anxiety.

# METHOD

## Recruitment and Participants

This study was conducted at 2 large urban/suburban sites with ethics approval obtained through the research ethics boards at both sites. Children were eligible if they were 5 to 7 years old, met *DSM-IV* criteria for at least 1 AD, spoke English, and had a parent proficient in English. Comorbid oppositional defiant disorder (ODD) and/or attention-deficit/hyperactivity disorder (ADHD) were not exclusionary criteria, provided that the AD was the most impairing condition. Exclusion criteria for children included the presence of autism spectrum disorder or significant learning problems (based upon school information and clinician judgment) that would interfere with treatment understanding or participation.

New referrals to an anxiety disorders clinic in a children's hospital were the primary source of participants (n = 63), and a smaller group of participants (n = 14) were recruited from patient flow at a university-setting clinical psychology center. Children not meeting eligibility criteria or who declined study participation were treated or referred for standard, appropriate treatment (Figure 1).

## Descriptive Characteristics

A total of 77 children (29 male) aged 5 to 7 years (mean = 6.8 years, SD = 0.8 year) participated (Table 1). The majority of children were of white ethnicity (n = 69), 7 children were of Asian ethnic background, and 1 child was Hispanic. All families were from mid-to-high socioeconomic status (mean = 53.5, SD = 10). Social anxiety was the most common disorder. A total of 66 children (85.7%) had 2 or more AD, 11.7% had comorbid ODD, and 3.9% had comorbid ADHD. No children were on psychotropic medications at treatment start.

## Treatment

Experienced therapists (e.g., child psychiatrists, clinical psychologists, and social workers with ≥5 years' therapeutic experience) led all treatment sessions. Treatment programs ran in the fall or spring. Child groups had 5 to 8 children with at least 2 therapists. Treatment integrity was ensured by the use of the manualized treatment protocols, postsession debriefing, and completion of a postsession checklist by all therapists. In addition, 20% of randomly selected videotaped sessions were reviewed by the research team using a checklist to ensure adherence to the treatment protocols.

Both treatments followed the same manualized parent program (Taming Sneaky Fears CBT Group Program, available from the principal author, SM), which taught parents how to use CBT with their children. In an initial parent-only introduction, session therapists provided a program overview and discussed and problem-solved parental concerns about child–parent separation and child preparation for group. Eleven weekly 1-hour parent and child sessions, which ran separately but concurrently, followed. Initial parent sessions provided parent psychoeducation on child anxiety disorders, temperament, and behavioral management. Parents were taught relaxation strategies to use with their children, how to manage their child's generalized worries, and how to develop and use exposures to help their child confront rather than avoid fears outside of group. In both treatments, parents were given a parent workbook and weekly homework and were encouraged to practice strategies and conduct exposures between sessions with their child. Each parent session started with homework review, and parents shared what they had done with their child during the week. Parental support from therapists and other parents were important components of both parent treatments.

In both treatments, at the end of each parent session, a child therapist met briefly with the parent group to provide feedback to parents about the activities that their children had completed in group. Midway through both treatments, a child therapist met individually with parents of each child to discuss their child's progress.

## Parent-Only CBT Treatment

In the parent-only CBT treatment (parent-only), using the parent manual of the Taming Sneaky Fears CBT Group Program, parents were actively taught CBT strategies to use with their child while children attended weekly 1-hour child group sessions that involved listening to neutral stories, playing games, completing crafts, and socializing with other children. These activities did not include teaching of cognitive-behavioral strategies. Therapists reinforced social skills, managed behaviors, and interacted as group leaders with children; however, therapists did not discuss or acknowledge any anxiety or anxiety inquiry made by children during the program. Children attended these non-CBT group sessions of similar format and duration as the child CBT group to control for the nonspecific aspects of child group attendance.

## Child and Parent CBT Treatment

In the child and parent CBT treatment (child–parent), both the child and parent manuals of the Taming Sneaky Fears CBT Group Program were used. Parents were actively taught how to use CBT with their