

CHAPTER 1

Introduction

Together we have worked with hundreds of parents of children with anxiety disorders, supervised and trained hundreds of clinicians in a range of settings, and conducted research in this area. Our intention in writing this book is to bring together our shared knowledge and experience to guide therapists in working with parents of children with anxiety disorders. All the case studies in the book are based on composites across many cases. The aim of this first chapter is to introduce the background and philosophy of our overall approach. We appreciate that it might be tempting to skip straight to the practical sections, but we encourage you to stick with us so that you have a good understanding of why we do what we do, and ultimately, why we are suggesting that you do the same!

Treatment for Childhood Anxiety Disorders: How Is This Approach Different?

It is now well known that anxiety disorders are among the most common mental health difficulties and that they typically first occur in childhood or adolescence (Kessler et al., 2005). Indeed worldwide prevalence rates suggest that about 6.5% of children are likely to meet diagnostic criteria for an anxiety disorder at any one time (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015), presenting those children with an increased risk of ongoing anxiety problems as well as other health and social difficulties, most notably, depression (Essau & Gabbidon, 2013).

Both psychological and pharmacological treatments have been evaluated for children with anxiety disorders; however, due to their lower

likelihood of side effects, psychological treatments have been recommended as a first line of treatment for preadolescent children (Rynn et al., 2015). The psychological treatments that have been evaluated to date almost all follow a cognitive-behavioral therapy (CBT) approach, which typically involves a therapist working with the child to address anxious thoughts and avoidant behaviors and to develop coping skills. Most of the CBT-based treatments that are available follow, or are based on, the highly influential Coping Cat program, which was developed by Philip Kendall and his colleagues from Temple University, Philadelphia, and was first evaluated in 1994 (Kendall, 1994). There have now been a large number of trials to evaluate these treatments, with, on average, 60% of children being free of their anxiety disorder by the end of treatment (James, James, Cowdrey, Soler, & Choke, 2013). On the whole, the inclusion of parents within or alongside the children's CBT sessions has not been found to improve children's treatment outcomes (e.g., Reynolds, Wilson, Austin, & Hooper, 2012); however, the extent and way in which parents have been involved in treatments have varied substantially across these trials. A more nuanced analysis, in which the extent and manner of parental involvement have been taken into account, has led to the suggestion that actively including parents in treatment, incorporating a specific focus on helping parents reinforce children's brave behaviors (see Chapter 6), and gradually shifting control of the program from the therapist to the parent are associated with significantly better outcomes for children when assessed a year after treatment (with 82% free of their anxiety diagnosis compared to 53–65% following treatments either with limited parental involvement or without an active focus on contingency management and transfer of control; Manassis et al., 2014).

So, we have CBT treatments that work for many children with anxiety disorders, and it appears that involving parents in particular ways can improve children's outcomes over the medium to long term. However, these treatments are often intensive, involving approximately 14–16 hours of face-to-face child–therapist (and parent–therapist) contact, which presents a challenge for many health care systems. Indeed in the United Kingdom it has been suggested that only a quarter of children with a mental health problem will see a mental health professional (Layard, 2008), and of those that do, many do not access practitioners who are suitably trained or confident in delivering CBT (Stallard, Udwin, Goddard, & Hibbert, 2007). It is essential, therefore, that we find ways to deliver treatments efficiently, while making sure that children continue to have good outcomes from treatment. One way in which to do this is to capitalize on the importance of helping parents feel more empowered to deal with their children's difficulties and to *work primarily with parents or carers* (hereafter, “parents”) to help them

help their children overcome their difficulties with anxiety. In our view, this approach brings many advantages:

- It reduces the burden on children of attending therapy appointments, including missing school and age-appropriate activities and the perceived stigma of attending mental health services.
- It reduces the overall amount of therapy time because
 - There is not the same need for activities and games to increase child engagement and motivation (with working directly with parents, we can often “cut to the chase”).
 - Parents can implement CBT strategies within their children’s day-to-day life.
- Concerns about longer-term difficulties may make parents more motivated to engage in treatment than children, who may be reluctant to attend.
- Parents are more likely (than therapists) to be present at times when children need to put strategies in place between sessions and help them generalize principles in day-to-day life.
- Parents may be in a better position (than children or therapists) to create opportunities to implement strategies and promote their repetition and generalization between sessions.
- Parents are generally in a better position (than children) to liaise with schools or other agencies to encourage the implementation of useful strategies (while retaining control of this within the family rather than it being taken over by the therapist).
- Treatment provides the opportunity to address any parenting practices that may be inadvertently maintaining child anxiety (see Chapter 2) and, instead, empowers parents to help their children overcome their difficulties.
- Parents can apply the principles and strategies on a familywide basis, potentially helping other children within the family and possibly themselves.
 - Parents are more likely (than children) to recall and put strategies in to place if problems recur in the months/years following treatment.
 - Parents’ lives can be significantly affected by having a child who suffers with anxiety, and treatment provides opportunity for them to gain support.

Parents are the most important agent for change that we can access in helping children to overcome difficulties with anxiety. It is essential that we value parents and help them feel skilled and confident in managing their children’s difficulties.

Parent-Led Treatment for Childhood Anxiety Disorders: Does It Work?

As noted above, the majority of treatment trials that have evaluated psychological treatments for children with anxiety disorders have typically involved direct therapeutic work with children, with or without additional input for or from parents. However, in recent years a number of trials have reported positive outcomes for children when the intervention is focused exclusively on parents. This approach was first evaluated in Australia, with the specific aim of supporting families in rural communities who were unable to easily access child mental health services (Rapee, Abbott, & Lyneham, 2006; Lyneham & Rapee, 2006). In these studies, parents of 6- to 12-year-old children were given a book to guide them in how to help their child. Giving the parents the book on its own was associated with a modest impact on children's anxiety problems: 26% of children were free of their anxiety disorder compared to 7% among those who received no treatment. However, the book-based intervention was not as effective as standard group CBT involving children and parents (61% diagnosis free). In a subsequent trial, supplementing the book for parents with therapist support (provided over the telephone) was associated with extremely positive outcomes, with 79% of children being free of their anxiety disorder. Later U.K.-based trials have also demonstrated that children can achieve good outcomes when parent-only treatment is delivered in a group (57% diagnosis free; Cartwright-Hatton et al., 2011) or in a brief format involving only about 5 hours of therapist input (50% diagnosis free; Thirlwall et al., 2013). Of particular note, two trials that have directly compared parent-only treatment to parent and child treatment found no significant differences between treatments in terms of child outcomes, despite the fact that the parent + child treatment involved at least twice the amount of therapist input to deliver parallel parent and child sessions (Waters, Ford, Wharton, & Cobham, 2009; Cobham, 2012; Creswell, Hentges, et al., 2010). Specifically in the Cobham study, a remarkable 95% of children (7–14 years old) were free of all their anxiety disorders after the parents received a brief intervention comprising a 2-hour parent group followed by six phone calls delivered over 2-week intervals to guide the parent through a workbook, compared to 78.3% of children who received a 12-session family-focused CBT treatment and 0% in the wait-list control condition. Although this is still an emerging area for research, it is clear that taking a parent-led approach to treatment can provide an efficient means of bringing about excellent outcomes for children with anxiety disorders.

Guiding parents to put CBT principles into practice in their children's day-to-day life is a brief and effective treatment approach for childhood anxiety disorders.

For Whom Is This Book Intended?

We have written this book for clinicians who work with children with anxiety disorders to provide an overview and a framework for also working with the parents of these children. Although we are assuming a general background in child mental health treatment, we have not assumed any prior knowledge of CBT because we have found that novices in CBT can successfully implement the parent-led treatment approach that we are describing (after brief training and with ongoing supervision; Thirlwall et al., 2013). Furthermore, we have examined the feasibility of this approach within a U.K. primary care mental health service with mental health workers with a broad range of backgrounds (including psychology, social work, nursing and home health visiting) and have found that (again, following brief training and with ongoing supervision) the mental health workers delivered the treatment well and achieved good outcomes (Creswell, Hentges, et al., 2010). However, whether you are a novice or experienced therapist, we strongly recommend that you access regular clinical supervision, which will be essential in supporting the work you do with families.

With Whom Can This Approach Be Used?

Age of the Child

Parent-led approaches to treatment for childhood anxiety disorders have been evaluated with children in ages ranging from 2 years, 7 months (Cartwright-Hatton et al., 2011), up to 14 years (Cobham, 2012), but the majority of study participants have been between 6 or 7 and 12 years of age. Although we have anecdotal reports of the approach being used successfully with both younger and older children (with some adaptations), we do not yet have a firm evidence base on which to recommend the approach, but we would welcome feedback based on your own experiences. Similarly, we have heard anecdotal reports of the approach being used successfully with children with developmental delay and autism spectrum disorders (ASD) (where it might be argued that the increased repetition that comes from working with parents may be particularly useful in promoting generalization;

Puleo & Kendall, 2011); however, as yet we have no solid evidence on which to base recommendations. Finally, the studies of this approach to date have included fairly homogeneous groups in terms of social, economic, cultural, and ethnic backgrounds, and the extent to which the approach is appropriate, acceptable, and effective across, for example, different cultures remains unclear. We would very much welcome any feedback from your experiences of applying the approach in more diverse settings.

Participating Adults

Our preference is to invite the child's primary caregivers in to treatment, so when there is more than one key carer, we encourage them both/all to attend treatment. It may not always be practical for more than one parent to attend every session. Sessions conducted over the telephone may also present challenges when more than one parent is involved, so we ask parents to nominate one of them to be the main point of contact, to commit to attending every session, and to provide feedback to another parent if he or she is not able to join a particular session. If parents are willing, audio recordings of sessions could be shared with a parent who is unable to attend. Of course, it is also sometimes the case that children live with different parents at different times, and that parents do not feel able to come together for their children's treatment. Our view is that the critical factors in deciding who participates in treatment is that (1) the participating parent is able to commit to attending the sessions and (2) is in a position to consistently make relevant changes in their child's life. For example, if a child lives with one parent during the week and another at weekends, and all of the difficulties relate to attending school, it would be critical to have the parent who has to manage those weekday difficulties involved in treatment. The participating parent also needs to be motivated to bring about changes in his or her child's life. For example, from time to time we have worked with families in which one parent is very concerned about the child's anxiety, but the other parent does not share these concerns. As we discuss in Chapter 2, it is obviously important to ascertain each parent's view of the child's difficulties independently, because it is possible that one parent has a particular perception of the other parent's view—for example, that he or she is disinterested or unsupportive—but this may not accurately reflect the other parent's perspective. On the other hand, if it becomes clear that a parent does not consider his or her child to have a problem with anxiety, that parent is unlikely to be motivated to attend therapy sessions focused on helping the child overcome these difficulties. We discuss general considerations for engaging parents and maximizing their motivation throughout the book.

What Does the Treatment Involve?

Fundamental Principles

The overall aim of the treatment is to work collaboratively with parents to help them develop the skills and confidence to support their children in overcoming difficulties with anxiety. In creating an individualized treatment plan, the therapist role is to work with parents to bring together therapist knowledge about the maintenance and treatment of childhood anxiety disorders with the parental knowledge of the child and how that child responds to challenges. Therapists also encourage parents in continuing to work through the program and help them (1) rehearse key skills, (2) recognize their own skills and positive progress, and (3) problem-solve any challenges that might arise. In order for this intervention to be successful, it is critical that parents feel engaged in the treatment process and empowered to make changes in their children's lives.

Content of Sessions

The actual content of the treatment is not dissimilar to other CBT programs for child anxiety disorders, and involves the following elements:

- Establishing clear, achievable treatment goals (Chapter 2).
- Providing psychoeducation and individualizing the treatment model (Chapter 3).
- Promoting independence in day-to-day life (Chapter 4).
- Helping parents promote flexible thinking and a “have a go” attitude (Chapter 5).
- Helping parents support their children in facing their fears (Chapter 6).
- Helping parents promote independent problem solving (Chapter 7).
- Keeping progress going (Chapter 8).

The main differences from other child- and/or parent-focused treatments in terms of the content result from our emphasis on working jointly with parents. For example, to promote parental engagement and empowerment, it is critical that parents have good background information about the treatment program to equip them to identify anxiety appropriately in their children, to feel hopeful about their children's outcomes, to understand the rationale for each element of the treatment program, and to relate these directly to their children's particular difficulties. Because many parents embark on treatment feeling concerned that they have caused their

children's difficulties in some way (or that the therapist may think that they have), it is essential that the therapist be explicit about the underlying treatment model and how parents' responses fit in to that. As we discuss further in Chapter 3, although the treatment does set out, when appropriate, to alter parental responses that may inadvertently maintain anxiety, this is not to suggest that parents are to blame. Instead we recognize (1) that parents' responses are largely a response to their children's anxiety, and (2) that highly anxious children may be more susceptible to influence from particular parental responses than their less anxious peers or siblings. Parents may also express concerns that they are not the "right person for the job" of putting CBT principles and strategies in place, for example, because they are not the "expert," or they feel that their child is more likely to "open up" to a therapist. For these reasons, as well as providing clear information about the treatment model, it is also essential that the therapy process encourage parental empowerment from start to finish. Beyond these specific aspects of the content, the strategies used are typically from child-focused CBT approaches, adapted in ways that parents can apply in their day-to-day lives.

One element of treatment that is commonly used in child-focused CBT that we have *not* included is that of relaxation. Often treatment programs involve regular relaxation practice based on the assumption that highly anxious children may have a condition characterized by chronic hyperarousal or that developing relaxation skills will help them manage their arousal at times of challenge. We have not used relaxation within our treatments for a number of years for the following reasons:

- There is no evidence that children with anxiety disorders have "chronic dysregulation" of their physiological arousal (e.g., Alkozei, Cooper, & Creswell, 2014).
- There is evidence that it is important to fully experience elevated anxiety in order to truly face fears and learn to overcome them (e.g., Craske, Treanor, Conway, Zbozinek, & Vervliet, 2014).
- There is recent evidence that the introduction of relaxation is not associated with significant gains in terms of treatment outcomes (Peris et al., 2015).
- We have found that parents and children rarely practice relaxation extensively at home and often find it difficult to do.

Given these factors and the fact that one of the primary advantages of this treatment approach is that it is time-limited and efficient, we have not included relaxation in any of the programs that we have evaluated. Like

others (e.g., Rapee, 2000), we have found that this absence does not appear to negatively impact children's outcomes, and families generally report that physiological symptoms subside without a direct focus on relaxation in the treatment.

Structure of Sessions

In order for parents to feel equal (or greater) partners in the treatment with the therapist, it is important that the sessions are predictable in terms of their structure and that parents get the opportunity to contribute to the session agenda. As such, all our sessions adhere to the following structure:

- Agenda setting
- Routine outcome monitoring (Chapter 2) and brief update
- Review of home-based tasks
- Structured session activity
- Consideration of other issues parent adds to agenda
- Confirmation of home-based tasks
- Brief review of session to summarize main elements and to ensure that the parent and therapist have a shared understanding

The Work Happens between Sessions

In order to work efficiently with parents, we typically provide them with written materials to read before and between sessions (e.g., Creswell & Willetts, 2007) so that the therapist–parent contact time can be used in a focused way to recap the material covered, reflect on how the material relates to their child, practice key skills, and problem-solve potential difficulties. As is standard in CBT, the inclusion of home-based tasks is critical because we work on the assumption that it is what happens between sessions, rather than within sessions, that brings about change. To support this approach, we always provide parents with worksheets for guiding activities and recording information. These worksheets also provide a means of reviewing progress in the treatment, and they serve as a resource for parents to refer to in future to help them maintain gains that have been made or to overcome setbacks. We always carefully monitor progress with all home-based tasks, and problem-solve with the parent if he or she had difficulties getting through the material between the sessions. This process clearly emphasizes the importance of the work that parents do between sessions as well as helping them to overcome any potential obstacles. It is obviously important to explicitly consider

any potential difficulties with parents, such as language or literacy obstacles, at the outset and consider pragmatic solutions to these (e.g., involving confederates, making audio recordings of session content).

How the Treatment Is Delivered

Parent-led CBT for childhood anxiety disorders has been evaluated in individual and group formats; however, these two formats have not been directly compared to each other to date. Our view is that there are advantages and disadvantages to either format. A group approach gives parents the opportunity to share their experiences and gain support from other parents potentially experiencing similar challenges (which, in our experience, many parents find invaluable), whereas individual sessions allow for a more specific focus on the individual issues facing particular families. A group approach may not be appealing to all parents, some of whom may feel intimidated or anxious about the format. Certainly dropout rates have been found to be relatively high in some studies that have offered parent-only treatment groups (Waters et al., 2009; Monga, Rosenbloom, Tanha, Owens & Young, 2015), although whether this was due to the group format is not clear. Ultimately, in the absence of clear evidence, decisions on whether to offer group or individual parent-led CBT may depend on factors relating to the context. For example, if the throughput of children with anxiety disorders to the service is fairly low, then it would not be reasonable to keep parents waiting for very long periods while a sufficient group is formed; equally, running a group with a small number of parents may not bring benefits in terms of reducing therapist time. In these circumstances an individual approach would be preferable.

Although we have delivered this parent-led CBT approach in both individual and group formats, here we focus primarily on the individual approach because this is what we have formally evaluated. When this approach has been applied in a group setting, the content covered is typically the same and the main differences relate to considerations involving engaging the group members and managing and making the most of the group format.

Whereas some evaluations of parent-led CBT have been entirely clinic-based, a number of studies have demonstrated good outcomes with a less intensive format of delivery, typically including telephone sessions to support parents in applying principles covered in a workbook or manual (e.g., Lyneham & Rapee, 2006; Thirlwall et al., 2013; Cobham, 2012). Although the approach has been applied entirely remotely to reach rural populations (Lyneham & Rapee, 2006), it has also often been delivered in a combination of face-to-face and telephone support sessions (e.g., Thirlwall et al., 2013; Cobham, 2012). We have found that this “combo” approach offers

the opportunity to develop parental motivation and engagement as well as to rehearse key skills in person. As such, most commonly we have delivered parent-led CBT over 8 weekly sessions, but with four of those sessions conducted briefly over the telephone with the primary aim of reviewing progress, problem-solving any difficulties that have arisen, and keeping parents focused on the tasks that fit with that stage of treatment. In our view, having at least weekly contact encourages families to continue to firmly prioritize putting treatment into practice in their busy lives.

Parent-led CBT is a collaborative approach to treatment in which parents are supported in developing skills and confidence to help their children overcome their difficulties with anxiety. Having a clear, consistent structure that emphasizes family work between sessions facilitates collaboration. Individual or group approaches may be beneficial, and much work can be done remotely without bringing parents into the clinic.

How to Use This Book

The chapters that follow are presented in the order that we cover the materials in our sessions, and so the book can be used as a manual following a step-by-step approach. Table 1.1 gives an overview of the content we typically cover in each session to act as a guide for your practice.

TABLE 1.1. Overview of Session Content

Session	Format	Content
1	Face to face	Setting the scene: the treatment model and implications for treatment
2	Face to face	Promoting independence and “have a go” thinking
3	Face to face	Facing fears
4	Telephone	Review
5	Telephone	Review
6	Face to face	Problem solving
7	Telephone	Review
8	Telephone	Review and planning for maintaining progress

We would recommend that you read the whole book before embarking on this treatment, and then revisit each chapter in turn when planning each session. The chapters generally follow a set structure comprising an overview, a brief review of relevant evidence, goals, practical guidance, and consideration of potential sticking points.

We have also included chapters that consider how to apply the approach to specific difficulties that can arise in the context of childhood anxiety disorders or in particularly challenging contexts, specifically:

- Managing sleep difficulties (Chapter 9)
- Managing difficulties with school attendance (Chapter 10)
- Putting the treatment into place in the context of parental mental health difficulties and/or child low mood, behavioral difficulties, and/or social skills difficulties (Chapter 11).

If any of these chapters apply to one of your clients, then you should read the appropriate chapter(s) before embarking on treatment so that the additional material can be incorporated throughout your treatment program. We include some information on assessing and identifying each of these areas in Chapters 2, 9, 10, and 11 to help highlight additional information that may be important to consider in your intervention.

Throughout the book we illustrate the application of particular principles or strategies with case studies and sample scripts based on conversations we have had with parents. These cases and their scripts are not direct representations of encounters we have had, as we are keen to preserve anonymity of the families with which we have worked. Instead we have created examples that bring together elements from different families. There can be a tendency for case examples and scripts to seem contrived when written down. We have tried our best to accurately reflect our experiences and those of the families with which we have worked.

Concluding Words

One of the things that we love about this treatment approach is the sense of empowerment and confidence that we see parents develop. Parents often reflect on the broader benefits this approach has brought to them and their families, and, seeing these alongside the gains children have made is immensely rewarding.

We wish you all the best with applying the principles and strategies in this book and hope that you and the families with which you work will be as excited and enthusiastic about this approach as we have come to be.