

Parental Involvement in Cognitive-Behavioral Therapy for Children with Anxiety Disorders



Arzu Aydın

SUMMARY

Objective: A growing body of literature suggests that parents play a critical role in the development and/or maintenance of child anxiety. One of the main purposes of this article is to identify common parental involvement techniques and most common obstacles derived from parents in cognitive behavioral therapy (CBT) with anxious children. Another purpose of the present study is to revise empirical studies comparing child-focused CBT with and without parental involvement.

Method: The PsycARTICLES, MEDLINE and PubMed databases were searched to identify articles in English that were published between the years of 1990 and 2012 (October) using the following keywords; (1) anxiety, (2) cognitive behavioral therapy, (3) parental involvement. Studies were only included in this review if they were comparing the treatment effect of child-only CBT and CBT with additional parental components.

Results: Thirteen studies were introduced in the context of method (diagnosis of children, age range of children, follow-up, results, etc.) and therapy characteristics (number of sessions, frequency of sessions, treatment components both child focused CBT and CBT with parental involvement , etc.).

Conclusion: The common techniques of therapy with parental involvement are psychoeducation, contingency management, cognitive restructuring, reducing parental anxiety, improving parent-child relationship, and relapse prevention. Parental psychopathology, parental inappropriate expectations and family dysfunctions are important difficulties derived from parents in CBT with anxious children. The results of the studies suggested that parental involvement have increased the efficacy of the treatment in CBT especially working with young children and having at least one anxious parent.

Key Words: Anxiety, cognitive behavioral therapy, parental involvement.

INTRODUCTION

Cognitive behavioral therapy (CBT) is commonly used to treat children with anxiety disorders. Research on the effectiveness of therapies has indicated that child-focused CBT effectively reduces the symptoms of anxiety in 50%-80% of cases (Barret et al. 1996a; Ishikawa et al. 2012; Silverman et al 1999; Walkup et al. 2008). A number of researchers suggest that treatment outcome can be improved via parental involvement in child-focused CBT (Cobham et al.1998; Creswell and Cartwright-Hatton 2007). It was reported that parental

involvement is important because such parental behaviors as over protection, over control, autonomy hindering, criticism, and rejection, as well as rewarding avoidance behavior play a role in the development and maintenance of anxiety in children (Hudson and Rape 2001; Siqueland et al. 1996).

When Leib et al. (2000) examined the relationship between parental overprotection and social phobia in adolescents they observed that those with social phobia perceived their parents as more protective than did adolescents without social phobia. As noted by Breinholz et al. (2012), over-involved parental

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Assist. Prof., Mersin University, Faculty of Science and Letters, Department of Psychology, Mersin-TURKEY

e-mail: arzugay@hotmail.com

behavior may prevent children from exhibiting age-appropriate behaviors and being exposed to new stress-provoking situations. Thus, such children are deprived of developing skills for coping with new situations via trial and error learning. In 6 studies conducted between 1990 and 2002 it was observed that there is significant relationship between a child's severity of anxiety and parental over controlling behavior (Wood et al. 2003). It was also reported that there is a strong relationship between parental negative behaviors and a child's severity of anxiety (Ginsburg et al. 2004; Muris and Merckelbach 1998). For example, Ginsburg and Schlossberg (2000) reported that there is a significant relationship between parental rejection and criticism, and the severity of childhood anxiety.

Another well-known negative factor associated with childhood anxiety is a parenting style that reinforces a child's avoidance behavior. According to Barret et al. (1996b), anxious or oppositional children perceive ambiguous scenarios as more threatening than nonclinical children. In terms of ambiguous scenarios, they observed that normal children are more likely to have prosocial responses, versus aggressive responses in oppositional children and avoidant responses in those with anxiety. Afterwards, researchers observed children talking to their parents about their personal interpretations and chosen responses to 2 ambiguous scenarios. After having discussed to their parents, both anxious children's avoidant plans and oppositional children's aggressive plans increased.

Another important reason for parental inclusion in treatment of children with anxiety is the observation that the parents of children with anxiety disorders themselves have anxiety disorders (Last et al. 1987; Silverman et al. 1988). Studies from Turkey and other countries report that there is a relationship between the severity of a child's anxiety and parental temperament and psychopathology, and the parent-child attachment pattern (Aslan et al. 1998; Erermiş et al. 2009; Sümer and Şendağ 2009; Türkbay and Söhmen 2001). Despite the findings showing a relationship between the severity of childhood anxiety and family factors, and that predict parental involvement in the therapeutic process can improve outcomes, it remains unclear if such combined treatment positively affects the treatment of childhood anxiety. Research on parental involvement in child-focused CBT for anxiety disorders has reported positive effects immediately after treatment and during 3 years of follow-up (Barrett 1998; Cobham et al. 1998; Rapee 2003; Spence et al. 2006; Wood et al. 2006). In contrast, some studies reported that parental involvement has little or no effect on treatment outcome (Nauta et al. 2003; Spence et al. 2000).

The present literature review aimed to summarize the rationale for parental involvement in child-focused CBT for anxiety disorders and to revise the process of these kinds of treatments

as well as their contents and determined parental obstacles. In addition, this review systematically compares studies on child-focused CBT for anxiety disorders with and without parental involvement.

MATERIALS and METHODS

This review primarily aimed to summarize the positive and negative effects of parental involvement in child-focused CBT for anxiety disorders, and the associated therapeutic techniques. In addition, the PsycARTICLES, PubMed, and MEDLINE databases were searched for studies published between January 1990 and October 2012 on the effectiveness of CBT with and without parental involvement using the keywords anxiety, CBT, and parental involvement. In addition, the Turkish equivalent of the same keywords were used to search for Turkish articles in the Turkish national database (ULAKBIM), but no relevant Turkish study was found. Following these searches and exclusion of articles not about treatment effectiveness, there were 13 relevant studies identified. In each treatment effectiveness study the sample size and types of anxiety disorders were reviewed, as well as if treatment was performed on an individual or group basis. Further examined factors were therapy lengths and frequencies, emphasized techniques, therapy session lengths and frequencies on the condition of parental involvement, as well as used techniques and effectiveness results.

How does the process and content work with parental involvement?

The literature on CBT for children and adolescents with anxiety disorders shows that parental involvement occurs in several forms. In some manualized programs sessions for parents were performed in parallel to their children's (Kendall 2000). For example, Spence et al. (2000) introduced similar sessions with parents which were parallel to those with their children. In addition they suggested parents watching their children's therapy sessions through a one-way screen. On the other hand, according to Mendlowitz (1999), it is assumed that when parents and children participate in the same session, parents may find opportunities to reinforce their children's abilities and promote their therapeutic progress. Other studies reported that in addition to parallel sessions with parents and children, parents joined their children's therapy during the last 5-10 min in order to receive a summarization of the session (Albano and DiBartolo 2007; Sorias et al. 2009). The advantages of these practices are that parents are regularly informed about the therapeutic process and are taught

how to help their children integrate newly acquired skills into everyday life.

In terms of content, CBT for children with anxiety disorders includes basic components of psychoeducation, contingency management, reduction of the severity of parental anxiety, cognitive restructuring, improving the parent-child relationship, and relapse prevention. These techniques are briefly summarized below.

Psychoeducation

One of the most important components of CBT is psychoeducation, which includes working with both sides children, and adults. The goal is to educate parents about their child's developmental characteristics, emotional and behavioral problems, the likely causes of their child's problems, and the methods used to achieve behavioral change, as well as to increase parental awareness of those mentioned problems and thereby simplify the change process. Nonetheless, parents are not passive during psychoeducation; they are encouraged to use such tools such as written and visual materials (therapy manuals, notes and videos about child development, instructions for changing behavior, etc.). These types of resources are used to encourage parents to not only think about or observe their child's therapeutic process, but also to talk about it with the therapist (Friedberg et al. 2000). In addition, psychoeducation includes implicit messages suggesting use of psychoeducational materials outside the clinical setting in an effort to make parents aware of the fact that they also must adopt and internalize information about the therapeutic process in order to acquire target skills.

Contingency Management (CM)

Contingency management is one of the most common therapeutic methods used to educate parents within the framework of learning principles (Khanna and Kendall 2009). The technique includes basic behavior-changing methods, such as positive and negative reinforcement, shaping, and extinction. The primary goal is to direct a child's attention towards positive behaviors and newly acquired skills, and to increase rewards for those new skills. Additionally, CM aims to teach parents how to ignore maladaptive behavior, especially avoidant behavior. Using appropriate rewards for parents, Ginsburg and Schlossberg (2000) suggest explaining how to increase a child's desirable behaviors and how to encourage a child to cope with anxiety. Parents are educated to abrogate unaware reinforcements such as parental attention to undesirable behaviors via extinction in order to decrease the child's avoidant behavior. According to Breinholz et al. (2012), contingency management techniques not only decrease a child's level of

anxiety, but also have a positive effect on negative parental behaviors, such as being a model for anxiety and reinforcement, as well as on cognition and expectation.

Reducing Parental Anxiety

Ginsburg and Schlossberg (2002) reported that up to 60% of children whose parents also have an anxiety disorder. It was suggested that a high parental anxiety disorder rate could be related to over-controlling and negative parental behaviors (Bögels and Brechman-Toussaint 2006). Because of the strong relationship between parental and child anxiety disorders, the treatment of childhood anxiety disorders includes reducing the severity of parental anxiety. In order to do so therapy focuses on increasing parental awareness of the emotional and behavioral components of their own anxiety, and to help them understand the effect of their behaviors on their children. Other components of the treatment are teaching parents to replace anxiety-provoking thoughts with anxiety-reducing and anxiety-coping thoughts. On the other side, parents should face their own fears and anxieties and finally learn to be a model for courageous behavior and coping skills in order to help their children.(Stallard 2005).

Cognitive Restructuring

It is suggested that there is a relationship between parental beliefs and expectations of their children, and anxiety disorders in their children. Kortlander et al. (1997) compared the mothers of anxious children to the ones in a normal control group according to the expectations they had of their children's response to a stress-triggering situation. The mothers of clinically anxious children expected their children to be more upset, to have less coping ability, and to be less confident in managing given tasks. It was reported that the parents' distorted beliefs limited their ability to be supportive of their children and were at the same time obstacles for the treatment. Therefore, the researchers suggested that in addition to teaching cognitive techniques to children they must be taught to their parents as well. In order to do so parents' false beliefs are systematically questioned (Socratic questioning, rational analysis), and then negative and useless beliefs are replaced with those that are realistic and encouraging.

Improvement of the Parent-Child Relationship

An important component of child-focused therapy with parental involvement is improvement of the parent-child relationship, in order to reduce the level of conflict between parents and children and to facilitate communication and problem-solving skills (Long et al. 2009). It is known that positive communication patterns, such as active listening, eye

contact, empathy, and restating and summarizing, instead of criticizing, blaming, and interrupting, can improve communication between parents and children (Stallard 2005).

In order to find a solution to parent-child conflict it is primarily suggested to inform parents about the fact that family conflicts can increase a child's anxiety. Conflict resolution training includes discussing the roles of parents and children, teaching various strategies for decreasing conflict at home (for example, identifying anger-provoking situations for both parents and children, and relaxation and a brief respite) and identifying cognitions that increase anger during arguments, undermining resolution of conflicts (Ginsburg and Schlossberg 2002).

Playing together and joint social activities can help improve a damaged parent-child relationship, and are considered ways to develop/improve the experience of love and warmth between parents and children. According to Oster (2007), parents should be guided in reconstructing their relationships with their children rather than engaging in competitive, didactic, corrective, and controlling behaviors.

Relapse Prevention

It is known that even after successfully completing CBT children can regress and symptoms can recur. Eisen and Schaefer (2005) suggest that therapists teach parents how to recognize the signs of re-emerging anxiety and to carefully monitor them, and that they should be reminded not to engage in over-protective behavior. Parents are recommended to use the skills they learned in therapy (reinforcement, etc.) in addition to more general coping skills (relaxation etc.), and not to ignore anxiety symptoms. Ginsburg and Schlossberg (2002) advise parents to be prepared for problem-provoking factors and to devise an action plan applicable in the future in order to cope with those potential factors.

Obstacles to Parental Involvement in Treatment

It is known that children with anxiety disorders sometimes have difficulties caused by parents that negatively affect their participation in CBT and the benefit gained from it. The most common types of parent-related problems and their causes are discussed below.

Some studies report that 40%-60% of children and adolescents terminate therapy in the early stages (Wierzbicki and Pedarik 1993). Research has shown that parental factors cause children to not participate regularly in CBT or to terminate prematurely, including parental stress and psychopathology, socioeconomic disadvantages, low education level, and negative parental expectations of CBT (Nock and Kazdin 2001; Wilansky-Traynor et al. 2010). Kazdin (1990) studied

a group of antisocial children aged 7-13 years and observed that the mothers of the children that terminated CBT prematurely suffered from depression, were highly self critical, and had lower degrees of attachment. Another study reported that there was a negative correlation in preschool children between participation in CBT and the level of parental stress (Andra and Thomas, 1998). They also reported that as the severity of parental stress and depression increased the degree of emotional attachment to their children decreased.

Parental psychopathology is another factor that negatively affects a child's participation in CBT. Ginsburg et al. (2004) reported that symptoms of anxiety in parents hinder the transfer of control in the therapy process. Transfer of control is the progressive transfer of knowledge and skills from the therapist to parents, and then from parents to child in order to achieve a long-term positive behavioral change (i.e. a decrease in severity of anxiety and in frequency of avoidant behavior) (Suveg et al. 2006). The level of parental stress also has a negative effect on a child's regular participation in therapy. For instance, when mothers of depressive children reduce their level of stress not related to the child-parent relationship their children's participation in therapy increases in consistency (Wilansky-Traynor et al. 2010). In addition, several socioeconomic factors can negatively affect a child's regular participation in therapy, including a single parent household, multiple siblings, and parental low level of education. In some families multiple socioeconomic factors play a role in hindering a child's regular participation in therapy.

Wilansky-Traynor et al. (2001) reported that children of parents with a better education level are more likely to regularly participate in therapy, as such parents are more aware of the importance of psychiatric/psychological treatment. Nock and Kazdin (2001) observed that parents with high and low expectations of therapy attended more therapy sessions and had lower rates of premature termination of therapy than parents with moderate expectations. Having found similar outcomes for parents with either low or high therapy expectations, researchers suggested that the positive changes for those with high expectations had to be attributed to the success of therapy. Positive changes for parents with low therapy expectations, on the other hand, were associated with contentment about the improvement of therapy.

RESULTS

The present review included 13 articles that fulfilled the criteria of comparing child-focused CBT with and without parental involvement. Relevant data from those studies are summarized and listed according to authors in the Table.

TABLE. Methodological characteristics of the studies on child-focused CBT with and without parental involvement.

Study	n/Age (years)	Diagnosis	Child-Focused CBT Sessions and Techniques	Child-Focused CBT + Parental Involvement Sessions and Techniques	Control Group	Follow-up (months)	Results
Barret (1998)	n = 60 7-14	SAD, SoP, OAD	12 weeks, 2-h group sessions, psychoeducation, cognitive restructuring, exposure, performance evaluation, and self-reinforcement	12 weeks child + 12 weeks child and parent sessions, group FAM: Psychoeducation, contingency management, modeling, problem solving, communication training	Wait list	12	No significant difference between treatment groups
Barret et al. (1996)	n = 79 7-14	SAD, SoP, OAD	12-weeks, 60-80 min sessions, individual psychoeducation, cognitive restructuring, exposure, performance evaluation, and self-reinforcement	12 weeks child + 12 weeks child and parent sessions, individual FAM: Psychoeducation, contingency management, modeling, problem solving, communication training	Wait list	6-12 6 year	No significant difference between treatment groups At 12 months FU again significant FCBT > CBT FCBT > CBT for girls and children aged 7-10 years. At 6 years no significant difference in FU between CBT and FCBT (Barret et al. 2001).
Bodden et al. (2008)	n = 128 8-18	OCD and anxiety disorders except PTSD	13 weeks, 60-90 min sessions, individual, psychoeducation, Socratic questioning, behavioral experiments, gradual exposure, reinforcement, relapse prevention	13 sessions: 3 sessions child only, 2 sessions child and parents together, 5 sessions parents only, 3 sessions family psychoeducation, anxiety management, parental beliefs, communication and problem solving skills	Wait list	3	Post treatment CBT significantly > FCBT No significant difference In FU between CBT and FCBT
Cobham et al. (1998)	n = 67 7-14	SAD, SoP, GAD, OAD, SSP	10 weeks, 90-min sessions, group basic relaxation training, cognitive restructuring, exposure, contingency management	4 sessions child + parental involvement Parental Anxiety Management Psychoeducation, cognitive restructuring, relaxation training, contingency management	-	6-12 3 year	No significant difference between treatment groups Only when parental anxiety level is high, FCBT > CBT At 6-12 months FU FCBT > CBT At 3 years FU significant FCBT > CBT (Cobham et al. 2010)
Heyne et al. (2002)	n = 61 7-14	GAD, OCD, SAD, SoP, PD, SSP, AD	8 weeks, 50-min sessions, individual relaxation training, social skills training, cognitive therapy, desensitization	8 weeks, 50-min sessions, behavior management strategies, cognitive therapy	-	Average 4.5	No significant difference between treatment groups
Kendall et al. (2008)	n = 161 7-14	GAD, SAD, SoP	16 weeks, 60-min sessions, individual psychoeducation, cognitive restructuring, relaxation training, exposure, self-reward	16 weeks, 60-min sessions, child and parent together modify maladaptive parental beliefs and expectations, teach parents constructive responses to their child's anxious behavior, encourage parents to support their child's mastery of new skills, communication skills	Active Control	12	On the basis of teacher reports child CBT > FCBT and FESA FCBT > child CBT when both parents had an anxiety disorder
Khanna and Kendall (2009)	n = 53 7-13	GAD, SoP, OAD	16 weeks, 60-min sessions, individual psychoeducation, cognitive restructuring, relaxation training, exposure, self-reward	16 sessions (all but 2) parent and child together parental anxiety management, transfer of control, contingency management, communication training	Active Control	-	FCBT > CBT for child global functioning, Parent training did not significantly contribute to improvement on measures of child anxiety

TABLE. continue

Study	n/Age (years)	Diagnosis	Child-Focused CBT Sessions and Techniques	Child-Focused CBT + Parental Involvement Sessions and Techniques	Control Group	Follow-up (months)	Results
Mendlowitz et al. (1999)	n = 62 7-12	Anxiety Disorder	12 weeks, 90-min sessions, group relaxation training, change negative self-talk, self-evaluation of performance self-reinforcement	12 weeks, 90-min sessions, group psychoeducation, contingency management, systematic desensitization, cognitive restructuring, relaxation training, improving family interactions	Wait List	-	FCBT > CBT for coping skills
Nauta et al. (2001)	n = 18 8-15	SAD, SoP, GAD, PD	12 weeks, 45-60 min individual sessions relaxation training, coping techniques, self-reinforcement	7 weeks, 45-60 -min sessions psychoeducation, problem solving, contingency management, cognitive restructuring, relapse prevention	-	3 - 15	No significant difference between treatment groups
Nauta et al. (2003)	n = 79 7-18	SAD, GAD, SoP, PD	12 weeks, 45-60 min sessions, individual relaxation training, coping techniques, self-reinforcement	7 weeks, 45-60-min sessions psychoeducation, problem solving, contingency management, cognitive restructuring, relapse prevention	Wait List	3	No significant difference between treatment groups
Silverman et al. (2009)	n = 119 7-16	SAD, SoP, SSP, GAD, OCD	12-14 weeks, 60-min sessions, individual (10-min parental involvement in every sessions) exposure, cognitive-behavioral strategies for facilitating exposure	12-14 weeks, 60-min sessions, parent and child together contingency management communication training problem solving	-	12	No significant difference between treatment groups
Spence et al. (2000)	n = 50 7-14	SoP	12 weeks + 2 booster 90- min sessions, group social skills training, relaxation training, social problem solving, cognitive coping techniques, gradual exposure for social situations, after 3 and 6 weeks a review of the techniques	12 weeks child + 12 weeks parental involvement, 30-min group sessions, prompt and reinforce child's practice of target skills outside sessions, ignore and not reinforce socially anxious behavior and avoidance, encourage the child to participate in social activities outside sessions, prompt and reinforce home task completion	Wait List	6-12	No significant difference between treatment groups
Wood et al. (2006)	n = 40 6-13	GAD, SAD, SoP	12-16 weeks, 60-80 min sessions, individual psychoeducation, cognitive restructuring, relaxation training, exposure, self-reinforcement	12-16 weeks, 15-30 min child only, 25-30 min parental involvement 10-15 min whole family Coping techniques, exposure, communication training	-	-	On the basis of independent evaluators' ratings FCBT > CBT for anxiety severity, school functioning, social and family relations On the basis of parents' ratings FCBT > CBT for child anxiety symptoms No significant differences between FCBT and CBT for children's self-reports of anxiety

GAD: Generalized anxiety disorder; SoP: social phobia; SAD: separation anxiety disorder; OCD: obsessive-compulsive disorder; SSP: specific phobia; OAD: over anxiety disorder; PD: panic disorder; AD: adjustment disorder; PTSD: posttraumatic stress disorder; FU: Follow-up; FAM: Family anxiety management; FESA: family-based education/support/attention; FCBT: Family cognitive behavioral therapy.

Sample

As seen in the Table, only 1 study included children with social phobia (Spence et al. 2000), all others included children with various other anxiety disorders, including general anxiety disorder, specific phobia, obsessive-compulsive disorder, and panic disorder. The participants in the studies were children and adolescents aged 6-18 years and the number of participants varied between 18 and 161.

Treatment and Control Groups

Two of the studies (Khanna and Kendall 2009; Kendall et al. 2008) included an active control group of parents that participated in an information-based education program known as Family-Based Education, Support, and Attention (FESA). Another study (Heyne et al. 2002) used child therapy (1), parent/teacher training (2), and a combination of child therapy and parent/teacher training (3) to compare the efficacy of each treatment. In all, 4 of the 13 studies did not include a control group (Silverman et al. 2009; Wood et al. 2006; Nauta et al. 2001; Cobham et al. 1998), whereas 6 (Barret 1998; Barret et al. 1996a; Bodden et al. 2008; Mendlowitz et al. 1999; Nauta et al. 2001; Spence et al. 2000) used patients on waiting lists as controls.

Follow-up Studies

To evaluate the long-term outcomes of therapies follow-up data were collected for 3 months-6 years, whereas in most studies the follow-up period was 6-12 months; 3 studies (Khanna and Kendall 2009; Mendlowitz 1999; Wood et al. 2006) did not provide any follow-up data.

Measurement Methods

All of the examined studies, except Heyne et al. (2002), administered ADIS-C/P (Anxiety Disorders Interview Schedule-Child/Parent Version). Additionally, children were asked to evaluate their level of anxiety using 8 different anxiety measures. CBCL (Child Behavior Checklist) was administered to parents in 8 of the studies and TRF (Teacher Report Form) was administered to teachers in 3 of the 13 studies. Additionally, some studies used such measures as social skills, general functionality, frequency of school attendance, depression, assertiveness, automatic thoughts, and stress. Only 3 of the 13 studies used questionnaires to assess psychopathology; Silverman et al. (2009) used SCL-90 (Symptom Check List-90-Revised) to evaluate the level of general psychopathology in parents; Cobham et al. (1998) used the STAI (State-Trait Anxiety Inventory) self-report anxiety schedule - a tool for parental anxiety evaluation- Kendall et al. (2008) used ADIS-IV-L (Anxiety Disorder Interview Schedule for DSM-IV, Lifetime Version), a structured interview used to diagnose current and past episodes of adult anxiety disorders.

The CBT Techniques

In terms of child-focused CBT practices, 8 studies used the Coping Cat Program (Kendall 2000) or its versions. The Coping Cat Program includes psychoeducation, cognitive restructuring, relaxation training, exposure, and self-reinforcement. The other 5 studies (Bodden et al. 2008; Heyne et al. 2002; Mendlowitz et al. 1999; Silverman et al. 2009; Spence et al. 2000) used treatment protocols developed by the researchers, and in terms of parental involvement parental or family anxiety management, psychoeducation, contingency management, communication training, problem solving education, and relapse prevention techniques were used.

Results of Effectiveness Studies

In all, 6 of the 13 studies reported that parental involvement in child-focused CBT did not provide any additional benefits. Only Bodden et al. (2008) reported that child-focused CBT improved treatment outcome. Studies show that the success of parental involvement in therapies depend on variables such as the child's age, gender, primary diagnosis and the existence of parental pathology. Barret et al. (1996a) reported that parental involvement in CBT for children aged 7-10 years had a greater effect than in CBT for children aged >10 years. For example, there wasn't a difference in the outcome of CBT with and without parental involvement in children aged 11-14 years. According to Barret et al. (1996a), enhancing parental skills may be important for younger children, but for older children individual child-cognitive work and exposure therapy may be sufficient to treat the symptoms of anxiety.

Several studies sought to determine if the effect of parental involvement in child-focused CBT differed according to the gender of children, but the findings were inconsistent. Barret et al. (1996a) suggested that girls benefitted more than boys from child-focused CBT + FAM (family anxiety management), who benefitted equally from each, child-focused CBT and CBT + FAM. Mendlowitz et al. (1999) reported that there wasn't a significant difference in benefitting from family treatment between boys and girls. Cobham et al. (1998), on the other hand, reported that only the girls of parents with a high level of anxiety benefitted more than boys from combined therapy.

Parental psychopathology is another efficient factor to involve parents in therapy. Cobham et al. (1998) reported that compared to child-focused CBT without parental involvement, child-focused CBT with the involvement of at least 1 parent with a high level of anxiety significantly increased the effectiveness of the CBT; however, the significance of the effect did not persist 6-12 months post treatment. Another study showed that among children whose parents had an anxiety disorder, child focused-CBT with parental involvement resulted in better outcomes during 12 months of follow-up than

child-focused CBT without parental involvement (Kendall et al. 2008). A more recent study by Silverman et al. (2009) compared CBT with minimal parental involvement to CBT with active parental involvement for the treatment of anxious children; they also examined the dynamics of change between child anxiety and parental variables (positive-negative parental behaviors towards the child, conflicts in the parent-child relationship, and level of parental anxiety). They reported that there was a significant decrease in the level of anxiety in children in response to both treatment conditions. An interesting outcome of that study is that the dynamics of change not only occurred from parents to children, but also from children to parents.

CONCLUSION

This literature review summarized the theoretical basis for parental involvement in child-focused CBT for children with anxiety disorders, the techniques employed, and the effects of parent involvement on treatment outcome. The review included studies published between January 1990 and October 2012 that examined the effect of parental involvement in child-focused CBT. The number of studies on the efficacy of child-focused CBT has been increasing since the 1990s. The first comparative study on the efficacy of child-focused CBT with and without parental involvement, however, was published in 1996.

It has been suggested that parental involvement in CBT for children with anxiety disorders could benefit the planning of therapeutic goals. This can be done by determining the possible effective variables (pathology levels, parenting styles, etc.) on the therapy process related to parental involvement, and by facilitating opportunities to utilize the therapeutic techniques outside the clinical environment (Cobham et al. 1998; Creswell and Cartwright-Hatton 2007). Although clinicians commonly thought that parental involvement in child-focused CBT would improve treatment outcomes, the findings of comparative studies do not support this point of view (Reynolds et al. 2012). Studies on this subject showed that in general those structured interviews were on diagnostic evaluation, and measures were used to evaluate the child's anxiety level. However, it was suggested that evaluating the contribution of negative family factors due to anxiety (level of conflict, severity of parental pathology, etc.) and related techniques on therapy in addition to diagnostic evaluation, would be a more rational approach. It is thought that parental involvement in child-focused CBT can facilitate determination of the extent to which parents contribute to and maintain anxiety in their children, as well as obtaining data on CBT's effectiveness in positively changing child and parental behaviors.

Although the findings show that parental involvement has a more positive effect on CBT in children with anxiety

disorders younger than 11 and in children with at least 1 anxious parent, under what conditions parental involvement in child-focused CBT improves treatment outcome remains unclear. Consequently, it is suggested that there is a need for additional studies in order to define and evaluate systematically family- or parent-related factors and to determine the effects of parental involvement in CBT on the child's anxiety level.

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