Efficacy of Modular Cognitive Behavior Therapy for Childhood Anxiety Disorders

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The present investigation evaluated the initial efficacy of a modular approach to cognitive behavior therapy (CBT) for anxiety disorders in youth. Modular CBT consists of the guided combination of individually scripted techniques that are explicitly matched to the child’s individual strengths and needs. Eleven youth primarily of Asian and Pacific Island ethnicity ranging in age from 7 to 13 were referred for treatment. Comparisons in a multiple baseline across children provided preliminary support for the efficacy of the intervention. Among the 7 completers, all principal diagnoses were absent at posttreatment and 6-month follow-up assessments, and measures of anxiety symptoms and life functioning almost uniformly evidenced clinically significant improvements.

Anxiety disorders are the most commonly diagnosed psychiatric disorders in children and adolescents (Albano, Chorpita, & Barlow, 2002; Bernstein & Borchardt, 1991), frequently presenting with other comorbid anxiety, depressive, or externalizing disorders (Albano et al., 2002; Keller et al., 1992). Anxiety disorders are often characterized by an early onset in childhood or adolescence. Without proper treatment they may worsen over time (Albano et al., 2002; Kendall, 1994) and lead to long-term negative consequences for adult functioning (Kendall, 1992; Ollendick & King, 1994). Accordingly, much effort has been focused on the development of treatments for anxiety disorders in youth.

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The majority of research supports the use of behavioral and cognitive behav-
ioral interventions as efficacious strategies for treating anxiety disorders
in youth (Ollendick & King, 1998). Numerous between-group design investi-
gations examining cognitive behavior therapy (CBT) for anxiety disorders have
demonstrated superior treatment effects for CBT compared with no-treatment
or wait-list control conditions (Barrett, Dadds, & Rapee, 1996; Cobham, Dadds,
& Spence, 1998; Kendall, 1994; Kendall et al., 1997; Silverman et al., 1999).
In addition, research has demonstrated that many benefits exist with the use
of manualized cognitive behavioral treatments for anxiety disorders in youth,
including higher rates of systematic delivery and more accurate implementa-
tion of treatment components (e.g., Kendall, Kane, Howard, & Siqueland,
1990). Research conducted on the efficacy of manualized CBT for anxiety
disorders has established the benefits of this approach in several randomized
clinical trials (Barrett et al., 1996; Dadds, Heard, & Rapee, 1992; Kendall,
1994; Kendall et al., 1997).

Despite this accumulation of support, Ollendick (2000) noted that a pro-
portion of children treated with manualized CBT approaches nevertheless fail
to show symptomatic improvement. For example, Kendall et al. (1997) found,
in comparing CBT with a wait-list control condition, that 47% of children in
the experimental condition still received their initial diagnosis at posttreat-
ment evaluations. In another investigation comparing manual-based CBT to a
wait-list control condition, Barrett et al. (1996) found that 43% of children in
the CBT condition were not diagnosis free at posttreatment. Although diag-
nostic remission rates above 50% are among the most impressive in child
outcome research, it is important to consider whether this ceiling could be
raised further through continued adaptations of CBT protocols (e.g., Hudson,
Krain, & Kendall, 2001).

As argued by Ollendick (2000), one possible means of addressing such
issues may lie in the application of CBT procedures in a more highly individ-
ualized manner (e.g., Hudson et al., 2001). However, this strategy must be
balanced against the evidence that lack of structure in a protocol can compro-
mise integrity and lead to poorer outcomes (Wilson, 1996). Fortunately, re-
search in childhood anxiety is beginning to outline a framework by which to
allow substantial individualization while adhering to a structured protocol.
Such efforts, sometimes referred to as prescriptive treatment approaches,
have been examined among children diagnosed with generalized anxiety dis-
order (GAD; Eisen & Silverman, 1998), as well as among children exhibiting
school-refusal behaviors (Kearney & Silverman, 1990). For example, Eisen
and Silverman (1998) applied one treatment approach for children with pri-
marily cognitive features of GAD, and a different approach for children pre-
senting with primarily somatic symptoms of GAD and found that treatments
prescribed or matched with client characteristics resulted in greater improve-
ments over a shorter duration of time (Eisen & Silverman, 1998). Similar
findings were obtained in a related examination of the prescriptive treatment
of anxiety-disordered youth demonstrating school-refusal behavior (Kearney
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