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# 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 behavioral interventions as efficacious strategies for treating anxiety disorders in youth (Ollendick & King, 1998). Numerous between-group design investigations 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 implementation 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 proportion 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 posttreatment 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 diagnostic 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 individualized manner (e.g., Hudson et al., 2001). However, this strategy must be balanced against the evidence that lack of structure in a protocol can compromise integrity and lead to poorer outcomes (Wilson, 1996). Fortunately, research 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 disorder (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 primarily cognitive features of GAD, and a different approach for children presenting with primarily somatic symptoms of GAD and found that treatments prescribed or matched with client characteristics resulted in greater improvements 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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