

Parent Training for Childhood Anxiety Disorders: The SPACE Program

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Anxiety disorders are the most prevalent disorders of childhood and adolescence. Cognitive behavioral therapy (CBT) for anxiety poses a challenge for clinicians as it requires active client participation, and many children either decline or do not adequately comply with treatment. In addition, even after treatment with CBT, up to 50% of children remain symptomatic, and many still meet diagnostic criteria. Parent-directed clinical work has been advocated as a potential enhancer of treatment outcomes, and exclusively parent-based interventions might replace child treatment when the child is reluctant. However, parent involvement has yet to be shown to significantly improve outcomes, relative to child-only therapy. Studies so far have focused mainly on including parents in children's therapy, training parents as lay therapists, or teaching parenting skills. Parent training focused on parental behaviors specific to childhood anxiety, such as family accommodation, may be more effective. In this treatment development report we present the theoretical foundation, structure, and strategies of a novel parent-based intervention for childhood anxiety disorders. We will also present the results of an open trial of the treatment, with an emphasis on feasibility, acceptability, and initial outcomes. Participants in the trial were parents of 10 children, aged 9 to 13. Children had declined individual child treatment. Multiple excerpts from the treatment manual are included with the hope of "bringing the treatment to life" and conveying a rich sense of the therapeutic process. Parents participated in 10 weekly sessions. Significant improvement was reported in child anxiety and family accommodation as well as in the child's motivation for individual treatment. No parents dropped out and satisfaction was high. The SPACE Program (Supportive Parenting for Anxious Childhood Emotions) is a novel, manualized parent-based intervention that is feasible and acceptable and may be effective in improving childhood anxiety.

ANXIETY disorders constitute the most prevalent group of child psychiatric disorders (Costello, Egger, & Angold, 2005). Anxiety disorders have negative implications for child development and functioning, create burden for parents and family members, and carry significant societal cost (Creswell & Cartwright-Hatton, 2007; de Abreu Ramos-Cerqueira, Torres, Torresan, Negreiros, & Vitorino, 2008; Essau, Conradt, & Petermann, 2000; Newman, 2000). Cognitive-behavior therapy (CBT) has been strongly supported as an effective treatment for childhood anxiety, but many children continue to meet diagnostic criteria after treatment and many more continue to have significant symptoms of anxiety (Compton et al., 2004; Rapee, Schniering, & Hudson, 2009). CBT involves teaching skills to identify and

challenge maladaptive thoughts, self-regulate anxiety, and systematically engage in previously avoided situations. As such, successful CBT requires active collaboration between child and therapist, a degree of participation that is frequently unattainable. Furthermore, many patients decline to participate in treatment altogether (Krebs & Heyman, 2010; Walkup et al., 2008). Some children are too anxious to agree to participate in a treatment that will require them to confront their fears, others are loath to recognize that they have a problem at all and others may be aided in avoiding the anxiety through family accommodation of their symptoms. Oppositional tendencies may also preclude a productive alliance of clinician and child (Garcia et al., 2010).

When child participation in treatment is not possible, or when a child is not responding to treatment, parent training may offer a more viable alternative. Various parent and family factors have been tied to the development and maintenance of childhood anxiety disorders (Dadds, Barrett, Rapee, & Ryan, 1996; Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004; Rapee, 1997; Siqueland, Kendall, & Steinberg, 1996; Wood, McLeod, Sigman, Hwang, & Chu, 2003), and family variables have been shown to predict outcomes for child treatment

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(Crawford & Manassis, 2001; Southam-Gerow, Kendall, & Weersing, 2001). Parent training has also been effective in the treatment of other disorders. In externalizing disorders, for example, in which child motivation for treatment is often low, parent training has been an effective, evidence-based method of treatment (Eyberg, Nelson, & Boggs, 2008; Kaminski, Valle, Filene, & Boyle, 2008). The evidence supporting a role for family factors in the etiology of child anxiety, the data tying family variables to child outcomes, and the success of parent work in other disorders have all led to a common assumption that parent involvement in treating childhood anxiety would enhance treatment outcomes. However, in the case of anxiety disorders, parent involvement in treatment has not yet produced the desired results. A number of clinical trials have compared child treatment with parental involvement to child only treatment and have failed to convincingly show superior results for the inclusion of parents (Barmish & Kendall, 2005; Breinholst, Esbjorn, Reinholdt-Dunne, & Stallard, 2012; Reynolds, Wilson, Austin, & Hooper, 2012; Silverman, Pina, & Viswesvaran, 2008). Overall, child therapy with parent involvement has been largely equally effective to child-alone treatment, but not more so.

Of the approximately 10 randomized control trials (RCTs) that have compared outcomes for childhood anxiety with and without parental involvement in treatment, one has shown clear benefit of including parents (Barrett, Dadds, & Rapee, 1996), while other have shown nonsignificant trends in this direction (Cobham, Dadds, & Spence, 1998; Heyne et al., 2002; Mendlowitz et al., 1999; Spence, 2000; Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006), no effect (Nauta, Scholing, Emmelkamp, & Minderaa, 2001; Nauta, Scholing, Emmelkamp, & Minderaa, 2003; Siqueland, 2005), or even an advantage for child-only treatment (Bodden et al., 2008). Very few studies have tested parent-only interventions for childhood anxiety and among the few existing studies (Cartwright-Hatton et al., 2011; Lyneham & Rapee, 2006; Thienemann, Moore, & Tompkins, 2006) the emphasis has been on training parents as lay therapists to implement CBT with the child.

One explanation for the underwhelming results of including parents in child CBT may be in the lack of theory-driven interventions that target parental behaviors specific to the context of childhood anxiety. Parent inclusion in treatment has so far focused primarily on making parents more involved in the child's treatment (for example, by having parents attend child sessions), training parents as lay CBT therapists, and teaching generic parenting skills such as problem-solving. A recent study of childhood obsessive-compulsive disorder (OCD), which reported significantly improved response rates when including parents in treatment (Peris &

Piacentini, 2012), stands out with its theory-driven focus on particular aspects of the parent-child relationship and its concentration on cases that otherwise are likely to be refractory.

In the case of most anxiety disorders, a relatively small number of programs have focused on modifying parental behavior specific to the context of a child's anxiety symptoms. Among these are such programs as *Timid to Tiger* (Cartwright-Hatton, 2010; Merry, 2011) and modifications of Parent Child Interaction Therapy (PCIT) for use with anxiety disorders (Pincus, Santucci, Ehrenreich, & Eyberg, 2008; Puliafico, Comer, & Pincus, 2012). These interventions integrate the parent training know-how developed in the areas of parent management and treatment of disruptive behaviors within the framework of a therapy for childhood anxiety. However, these interventions are aimed primarily at younger children. PCIT modifications such as the CALM program (Puliafico et al., 2012) are aimed at children up to age 7, and *Timid to Tiger* is geared to children through age 8. PCIT relies on child participation in the treatment sessions, and although this can be difficult, it is a challenge that can generally be overcome with young children. *Timid to Tiger* does not actively involve children, but it is a group intervention and also focuses on younger ages.

This report presents a manualized parent-based treatment intervention (Lebowitz & Omer, 2013). The SPACE Program (Supportive Parenting for Anxious Childhood Emotions) moves away from teaching parents specific sets of skills and aims to target the fundamental dynamics underlying the interaction between parents and anxious children. SPACE has shown promise in parent-based treatment of childhood and adolescent OCD (Lebowitz, 2013). SPACE is designed to be implemented with school-age children and adolescents and is exclusively parent-based, allowing for treatment delivery without the need for child collaboration.

Theoretical Foundation

Anxiety as a Systemic Phenomenon

Like most mammals, children are born physically and psychologically unprepared to contend with danger. Rather, they rely on caretakers (typically, though not exclusively, "biological parents" as we will henceforth refer to them) for many of the basic functions involved in dealing with threat. Parents provide protection from threat, reassurance of safety when appropriate, and aid in the regulation of inner states of arousal. Various theoretical perspectives, such as attachment theory have described the bond between parents and children, and the ways in which anxiety "activates" those bonds, causing children to seek parental soothing or protection and parents to provide them (J. Bowlby, 1969; R. Bowlby & King, 2004). In Harlow's seminal experiments on primate

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