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Prescriptive Treatment for Generalized Anxiety Disorder in Children

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This investigation compared the preliminary efficacy of prescriptive and nonprescriptive cognitive-behavioral interventions (i.e., cognitive therapy/exposure or relaxation training/exposure) for problematic response classes (cognitive or somatic symptoms) of 4 overanxious children (8 to 12 years) using a multiple baseline design across subjects. Participants also met *DSM-IV* criteria for generalized anxiety disorder. All children improved on pre-post child and parent self-report measures, independent clinician ratings, and physiologic recordings. Treatment gains were generally maintained at 6-month follow-up. Although both treatments were effective, only prescriptive treatments produced sufficient improvement for participants to meet positive end-state criteria. Implications for the prescriptive treatment of anxiety disorders in children are discussed.

The nature of generalized anxiety in children is continuing to change. In the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III-R*; American Psychiatric Association, 1987), overanxious disorder (OAD) was characterized by the presence of excessive worries, somatic complaints, and self-consciousness. In the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994), OAD was subsumed under the category of generalized anxiety disorder (GAD). In this system, the frequency and controllability of worry became cardinal features, whereas the experience of physical symptoms was relegated to a lesser role. This conceptual shift has created a new research agenda that requires an examination of individuals with GAD across the lifespan (Kendall, MacDonald, & Treadwell, 1995).

Epidemiological data examining children with generalized anxiety are limited to studies employing children with OAD. Data suggest that OAD com-

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prises 3% to 4% of the general population (Anderson, Williams, McGee, & Silva, 1987; Bowen, Offord, & Boyle, 1990) and 24% to 29% of specialty clinics for childhood anxiety disorders (Last, Hersen, Kazdin, Finkelstein, & Strauss, 1987; Mattison, Bagnato, & Brubaker, 1988). Despite OAD's prevalence in community and clinical settings, treatment research has lagged behind the study of specific fears and phobias (Silverman & Eisen, 1993; Silverman & Rabian, 1993). Recently, however, OAD treatment investigations are beginning to emerge (Eisen & Silverman, 1993; Kane & Kendall, 1989; Kendall, 1994; Kendall et al., 1997).

Kane and Kendall (1989) examined the effectiveness of an integrated treatment protocol with 4 overanxious children (aged 9 to 13) using a multiple baseline design across participants. The treatment protocol included cognitive (self-monitoring, self-evaluation, and self-reinforcement) and behavioral (in vivo exposures, relaxation training, modeling, contingency management) strategies. The results indicated that all 4 children experienced improvements on child, parent, and clinician ratings that were generally maintained at 6-month follow-up.

In a controlled clinical trials design, Kendall (1994) further examined the effectiveness of the integrated treatment protocol in a sample of 47 children meeting *DSM-III-R* criteria for anxiety disorders. Sixty-four percent of the sample ($n = 30$) received a primary diagnosis of OAD. The results indicated that 64% and 5% of the treatment and control groups, respectively, no longer warranted a diagnosis at posttreatment. Treatment gains were generally maintained at 1-year follow-up.

In a second randomized clinical trial, Kendall et al. (1997) administered the integrated treatment protocol to a larger sample of 94 children (aged 9 to 13 years) meeting *DSM-III-R* criteria for anxiety disorders. Fifty-nine percent of the sample ($n = 55$) received a primary diagnosis of OAD. The results indicated that 53% and 6% of the treatment and control groups, respectively, no longer warranted a primary diagnosis at posttreatment. Treatment gains were generally maintained at 1-year follow-up. Overall, the findings from these studies are impressive. However, the specific ingredients responsible for behavior change are difficult to determine due to the combination of cognitive and behavioral procedures employed.

Although randomizing treatment across participants is an excellent experimental mechanism to evaluate treatment effectiveness, clinical researchers are beginning to recognize the importance of matching or prescribing treatment to specific patient characteristics (e.g., Beutler, 1991; Kazdin, 1993; Kearney & Silverman, 1990; Ost, Jerremalm, & Johansson, 1981; Ost, Johansson, & Jerremalm, 1982). It is generally believed that an idiographic approach to treatment is a more effective strategy in producing positive treatment outcomes than a nomothetic, statistically based approach (e.g., Barlow, Hayes, & Nelson, 1984). Regarding generalized anxiety, Eisen and Silverman (1993) provided preliminary evidence suggesting that such a strategy may be useful.