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ScienceDirect
Behavior Therapy 39 (2008) 195–206
Behavior Therapy
www.elsevier.com/locate/bt

The Unique Impact of Parent Training for Separation Anxiety Disorder in Children

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This investigation examined the preliminary efficacy of an integrated cognitive-behavioral parent-training protocol for six families of separation-anxious children (7 to 10 years of age) using a multiple baseline design across participants. Although families were assessed on child, parent, and clinician ratings at pre- and posttreatment as well as 6-month follow-up, only parents received education and training. Although the parent-training protocol was largely effective and treatment gains were maintained at 6-month follow-up, only those child participants whose parents experienced clinically significant improvement on parental process measures (i.e., enhanced efficacy or satisfaction, reduced stress) achieved high end-state functioning. Implications regarding the importance of individualized family-based interventions for treating anxious youth are discussed.

A NUMBER OF STUDIES with anxious youth have characterized their family environments as higher in control and conflict and lower in warmth and support than families of children who do not experience internalizing behavior problems (Chorpita, Brown, & Barlow, 1998; Cobham, Dadds, & Spence, 1998; Dumas, LaFreniere, & Serketich, 1995; Siqueland, Kendall, & Steinberg, 1996; Stark, Humphrey, Crook & Lewis, 1990). Given the importance of family factors in the development of anxiety in children and the modest findings associated with child-focused CBT trials for this population (57.5% diagnosis free at posttreatment compared to 34.8% of wait-list controls; see Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004), it's not surprising that family-based treatments are emerging.

The benefits of parent training (PT) include enhanced knowledge and understanding of child development (Budd & Itzkowitz, 1990; Galambos, Barker, & Almeida, 2003), identifying and managing child behavior problems (Barkley, 2005), as well as improving parent-child communication (Foote, Eyberg, & Schuhmann, 1998). Regarding anxious youth, the majority of family-based studies have compared a child-focused CBT to a similar treatment with the addition of parent sessions. Some studies report a greater percentage of diagnosis-free participants with the addition of a parenting component (57% versus 84%, Barrett, Dadds, & Rapee, 1996; Barrett, Rapee, Dadds, & Ryan, 1996; 52.6% versus 78.9%, Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006). Other studies, however, reported no additional benefits of PT over and above child-based CBT (Barrett, 1998; Nauta, Scholing, Emmelkamp, & Minderaa, 2003; Spence, Donovan, & Brechman-Toussaint, 2000). In addition, it is difficult to draw firm conclusions because the studies examined a broad range of anxiety disorders and differed widely regarding the content and format of treatment sessions as well as the outcome measures employed. Most importantly, the process of behavior change was not evaluated.

Recently, Choate, Pincus, Eyberg, and Barlow (2005) demonstrated that targeting both child-directed and parent-directed interactions was an effective way of treating three children with principal diagnoses of *DSM-IV-TR* (American Psychiatric Association, 2000) separation anxiety disorder (SAD). Family-based treatment appears to have remarkable

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0005-7894/08/195–206$1.00/0

relevance for youth with SAD (see Eisen, Brien, Bowers, & Strudler, 2001; Eisen, Engler, & Geyer, 1998; Eisen & Schaefer, 2005, for reviews). The family environments of separation-anxious youth are often associated with insecure-ambivalent parent-child attachments (Main, Kaplan, & Cassidy, 1985; Ollendick, 1998) and high levels of parental overprotection (Hudson & Rapee, 2001; Rapee, 2002). SAD is the most prevalent anxiety disorder of childhood, ranging from 3% to 13% in community samples (Anderson, Williams, McGee, & Silva, 1987; Cohen, Cohen, & Brook, 1993), yet research efforts continue to lag behind.

To date, the individual contribution of a PT intervention for a specific anxiety disorder of childhood has not been examined. The present study investigated the preliminary efficacy of an integrated cognitive-behavioral PT protocol designed specifically for parents of separation-anxious youth (Raleigh, Brien, & Eisen, 2002; see Eisen & Schaefer, 2005). Both child and parent participants were assessed at pretreatment. However, only parent participants received education and training. We hypothesized that PT would lead to important process changes (i.e., enhanced parental self-efficacy, satisfaction, and reduced stress). These changes, in turn, would lead to more effective parenting, and ultimately, reduced childhood anxiety. Thus, child participants would only satisfy positive end-state functioning criteria when their parents achieved treatment responder status (outlined in the method section).

Method

PARTICIPANTS

Participants were six families, with children aged 7 to 10 years (mean age = 8 years, 7 months) who received principal diagnoses of *DSM-IV-TR* SAD with at least moderate impairment (received a 4 or more on a 0-to-8 clinician rating scale) using the Anxiety Disorders Interview Schedule for DSM-IV–Child and Parent versions (ADIS for DSM-IV: C/P; Silverman & Albano, 1996) (described below). Composite diagnoses were assigned based on ADIS for DSM-IV: C/P data, taking into account severity of disorder and the extent to which the disorder led to interference in functioning. Participants were referred to the Child Anxiety Disorders Clinic (CADC), Center for Psychological Services, at Fairleigh Dickinson University (FDU) from multiple community agencies throughout the Bergen County, New Jersey area. Exclusionary criteria included receiving a SAD diagnosis secondary to other disorders or undergoing current pharmacological/other psychotherapeutic treatment for presenting problems. Further descriptive information on each participant is presented below and in Table 1.

Child participant 1 (P1) was an 8-year-old Caucasian female in the third grade. Her primary complaints included high levels of fear and discomfort around separation from her parents, stomachaches, and bedtime fears. She also presented with several mildly impairing comorbid disorders including generalized anxiety disorder (GAD) and specific phobia–animal type (spiders).

Child participant 2 (P2) was a 7-year-old Caucasian female in the second grade. Her primary complaints included intense fear and discomfort around separation from her parents, multiple worries regarding personal harm, and being alone, stomachaches and nighttime fears. She also presented with several severely impairing comorbid disorders including GAD, social anxiety disorder, and specific phobia-blood-injection-injury type (medical procedures).

Child participant 3 (P3) was a 7-year-old Caucasian male in the second grade. His primary complaints included intense fear of being separated from his parents, multiple worries regarding personal harm, and strong fears of being abandoned. Based on maternal reports, he also presented with moderately impairing comorbid disorders including social anxiety disorder and dysthymic disorder. In addition, psychological testing administered by the school disclosed a mild learning disorder.

Child participant 4 (P4) was a 9-year-old Hispanic male (fluent in English, as well as his parents) in the fourth grade. His primary complaints included intense fear and discomfort around separation from his parents, stemming from multiple worries regarding being alone and abandoned. He also presented with mildly impairing comorbid disorders including GAD and specific phobia–animal type (dogs).

Child participant 5 (P5) was a 9-year-old Caucasian female in the third grade. Her primary complaints included intense fear and discomfort around

Table 1
Demographic and treatment characteristics for each participant

Child	Gender	Age	Diagnosis	Parent participant (s)
1	F	8.5	SAD, GAD, SP	Mother
2	F	7.5	SAD, GAD, SOCANX, SP	Mother & Father
3	M	7.5	SAD, GAD, SOCANX, DYS	Mother
4	M	9.5	SAD, GAD, SP	Mother & Father
5	F	9.0	SAD, GAD, SP	Mother
6	M	9.5	SAD, GAD, ADHD	Mother & Father

Note. SAD = Separation Anxiety Disorder; GAD = Generalized Anxiety Disorder; SP = Specific Phobia; SOCANX = Social Anxiety Disorder; DYS = Dysthymia; ADHD = Attention-Deficit Hyperactivity Disorder–Predominantly Inattentive Subtype.