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Parent-only Interventions for Anxiety Disorders in Children and Adolescents

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Abstract: ***Psychotherapy for anxiety disorders in children and adolescents is mostly child-focused treatment, with less attention paid to parental involvement. The important role that parents play in the development, maintenance, and treatment of anxiety disorders in children and adolescents makes parent-only intervention an effective alternative when treatments targeting children and adolescents are inaccessible or ineffective. This article reviews several parent-only interventions for anxiety disorders in children and adolescents that are commonly used in current clinical research and practice, as well as their effectiveness, settings, and procedures, and provides a vision for future research and practice in the hope of informing the development of treatments for anxiety disorders in children and adolescents.***

Keywords: Parenting, Intervention, Anxiety disorders, Child, Adolescent**.**

1. Introduction

Anxiety disorders are one of the most common psychological problems among children and adolescents, characterized by an individual's excessive anxiety, worry, and fear [1]. The global prevalence of anxiety disorders in children and adolescents is 6.5% [2], with a 12-month prevalence of approximately 5-10% [3]. Anxiety disorders affect children and adolescents' academic, social, and family functioning; increase the risk of other psychological problems; and severely reduce their quality of life [4]. Psychotherapy is the primary treatment for anxiety disorders in children and adolescents [5].

Psychotherapy for anxiety disorders in children and adolescents tends to target children and adolescents, with less attention to parental involvement. However, it has been found that with this child-focused treatment approach, even treatment-preferred cognitive behavioral therapy (CBT) still fails to significantly improve some children's anxiety symptoms [6]. As more is learned about the role that family/parental factors play, either positively or negatively, in the development, maintenance, and treatment of anxiety disorders in children and adolescents, the more emphasis we place on parental involvement, or even parent-only, psychotherapeutic programs [7,8].

Parental involvement treatment for anxiety disorders in children and adolescents refers to programs in which both the child-adolescent and his or her parents are involved in treatment, but the degree and form of parental involvement vary. Most of these programs involve the parents either receiving psychoeducation, having parallel parent-only sessions, or receiving child-parent joint family sessions in addition to child-focused psychotherapy [9]. In contrast to the parallel parent-only sessions described above, parent-only intervention does not include the child's contact with the therapist in the overall treatment program, and the parent is the only participant involved in the treatment sessions [10].

Parent-only intervention for anxiety disorders in children and adolescents offers the possibility that when children and adolescents are unable to participate in child-focused treatment due to limited cognitive abilities, resource constraints, or are reluctant to participate due to stigma, lack of motivation, etc., there are ways to take action to improve the child's symptoms of anxiety from the important side of the parent [11]. Although research has not shown that parent-only intervention is superior to child-focused treatment for anxiety disorders in children and adolescents, there have been many studies that have shown it to be an effective alternative treatment option and to consume less time and resources [12,13]. This article describes several common parent-only interventions for anxiety disorders in children and adolescents in current clinical practice, as well as their effectiveness, settings, and procedures, with the hope of informing future treatment research and practice.

2. Parent-only CBT

2.1 Guided Parent-delivered CBT

Parent-only interventions for anxiety disorders in children and adolescents are mostly based on CBT, where a low-intensity guided parent-delivered CBT (GPD-CBT) is common. GPD-CBT was developed from the parent self-help bibliotherapy for children and adolescents with anxiety disorders used by Rapee and his colleagues [14]. In order to address motivation for self-help reading and to improve efficacy, they incorporated therapist support and brief coaching for parents, such as the use of teleconferencing or e-mail [15]. To further improve treatment adherence, Creswell et al. included face-to-face meetings between the therapist and parents [16]. Thirlwall et al. conducted a randomised controlled trial to evaluate the efficacy of GPD-CBT for children and adolescents, comparing full guided parent-delivered CBT (four face-to-face and four telephone sessions), brief guided parent-delivered CBT (two face-to-face and two telephone sessions), and a wait-list control group. The results showed that GPD-CBT was effective in reducing anxiety symptoms in children and adolescents and that full guided parent-delivered CBT had the best efficacy [17]. Importantly, subsequent follow-up results over 3-5 years showed that the treatment effects of both full guided parent-delivered CBT and brief guided parent-delivered CBT were largely maintained, with very few

relapsing into anxiety disorders [18].

GPD-CBT is based on the concept of transfer of control (TC), which means that the therapist teaches the parents specialized knowledge about anxiety and CBT skills so that the parents can become their children's therapists and apply the skills learned to help their children cope with anxiety in their daily lives [19]. At the beginning of treatment, the therapist provides parents with a self-help book, such as "Overcoming Your Child's Fears and Worries: A Self-help Guide Using Cognitive Behavioral Techniques" [20], or "Helping Your Anxious Child: A Step-by-Step Guide for Parents" [21]. These self-help books describe anxiety management techniques and how parents can apply CBT techniques to their children in everyday life. The therapist supports and encourages parents to read the self-help books, practice the skills learned, and work through problems as they arise. During treatment sessions, the therapist follows the treatment manual to educate parents about mental health for anxiety disorders in children and adolescents and teaches parents about identifying and challenging thoughts, graded exposure, and problem-solving skills. Parents complete homework assignments during therapy sessions, both independently and with their children [22,23].

The research practice mostly followed the settings and procedures of full guided parent-delivered CBT as implemented by Thirlwall et al. with varying degrees of adaptation. For example, the group format of GPD-CBT increased in the duration and number of sessions [24,25]. Full guided parent-delivered CBT sessions were conducted once a week for a total of eight sessions, including four 1-hour face-to-face and four 20-minute telephone sessions. The schedule of face-to-face and telephone sessions is as follows: Week 1, 1-hour face-to-face session: introduction to anxiety; discussion of possible causal and maintaining factors, and the implications for treatment; discussion of how to identify child anxious thoughts and challenge them. Week 2, 1-hour face-to-face session: introduction to cognitive restructuring and practice; discussion of parental responses to anxiety. Week 3, 20-minute telephone session: review tasks of cognitive restructuring. Week 4, 1-hour face-to-face session: introduction to graded exposure; devise a graded exposure plan. Weeks 5 and 6, both 20-minute telephone sessions: review tasks of the graded exposure plan. Week 7, 1-hour face-to-face session: introduction to problem-solving strategies and practice; review progress; discussion of how to continue helping the child and plan for long-term goals. Week 8, 20-minute phone session: review tasks of previous weeks.

The goal of GPD-CBT is to teach parents to learn and apply more adaptive cognitive, behavioral, and coping strategies for child and adolescent anxiety so that they can continue to use the techniques even after treatment to reinforce the benefits. GPD-CBT fits the stepped-care model, which emphasizes low-intensity interventions for patients with mild-to-moderate symptoms and high-intensity interventions for patients with more severe symptoms or who do not respond well to low-intensity interventions. This maximizes treatment resources and efficiency by increasing access to low-intensity treatments and decreasing the need for high-intensity treatments [26]. Unfortunately, attention to GPD-CBT is almost invisible in China, probably due to the late start of research on parental interventions for anxiety disorders in children and adolescents. However, considering the same lack of treatment resources in China, GPD-CBT is a possible solution.

2.2 Fear-less Triple P

Another CBT-based parent-only intervention for anxiety disorders in children and adolescents takes a more traditional model of therapist-client sessions, which consists of not only therapist guidance to parents, but also treatments based on different procedures, with Fear-less Triple P(FLTP) being one of them. FLTP is a parent-only group intervention first implemented by Cobham et al. as part of the Positive Parenting Program (Triple P). Triple P is a multilevel parenting and family support system that incorporates five different levels of intervention intensity, and FLTP is part of Level 4 (standard or group parenting skills training) [27,28].

A recent randomized controlled trial by Cobham et al. comparing the FLTP (6-week parent-only group CBT intervention) with a wait-list control group and following up subjects after 3-, 6-, and 12 months of treatment demonstrated that FLTP is an effective low-intensity, low-cost group intervention program for anxiety disorders in children and adolescents [29]. To improve treatment accessibility, a one-day workshop format of FLTP (6 hours) was recently developed by Cobham et al. and compared to a standard 6-week group intervention format. The results showed that this brief intervention is ideal for families for whom the resources and time required to commit to a standard multi-week intervention are prohibitive. Follow-ups at 6 and 12 months after the end of treatment also showed maintenance of treatment effects [30].

FLTP is based on the concepts of transfer of control and parental modeling, in which the therapist teaches parents the principles of a cognitive-behavioral approach to anxiety management, encourages them to apply these themselves, and to instructs their children in the content they are learning. FLTP explicitly targets parental factors associated with anxiety in children and adolescents, such as over-involvement, over-protection, excessive reassurance, and rescuing behaviours, which reduce autonomy and limit opportunities for the development of coping skills [31].

The standard FLTP is conducted once a week for a total of 6 sessions, each being a 90-minute group therapy session with 4-8 families per group. The one-day FLTP workshop takes place in just one 6-hour workshop for up to 17 families. Except that the FLTP workshop involves fewer exercises and in-group communication due to time and format constraints (so it emphasizes content delivery more), both forms of FLTP include essentially the same 6 components: (1) Psychoeducation about anxiety and parents' potential role in the maintenance of children's anxiety. In this part, parents are provided with psychoeducation about anxiety and how it works. Therapists encourage them to reflect on how anxiety affects their family and how their family reacts to anxiety. This part aims to give parents a better understanding of the development of their child's anxiety and why it continues and to establish some goals for change to focus on through the program. (2) Promoting emotional resilience in children. In

this part, parents are introduced to parenting strategies that promote emotional resilience in children. These strategies help parents encourage their children to express, tolerate, and manage their upsetting emotions more effectively. Parents are also introduced to a tool that helps to track how anxious their child is feeling. (3) The role of thoughts in anxiety and mental flexibility. In this part, therapists introduce the importance of parental modelling in understanding children's emotional reactions. Therapists also introduce how thoughts can affect the development and maintenance of anxiety, highlight the importance of flexible thinking, and encourage parents to practice this skill in their children. (4) Avoidance and exposure. In this part, therapists teach parents about avoidance, the most common response to anxiety. Therapists also introduce the value of exposure and the use of the Fear Ladder as an approach to gradually confronting anxiety. (5) Parental strategies for responding to children's anxiety. In this part, therapists discuss with the parents common ways that parents respond to children's anxiety, as well as the advantages and disadvantages of each. Parents are encouraged to reflect on which responses are relevant to them and what they might want to think about changing. Therapists work with parents to develop a parenting plan to encourage children to confront and overcome their fears using a Fear Ladder and to start using it with their children at home. (6) Problem solving. In this part, therapists help parents develop a constructive step-by-step coping plan and offer some guidelines on maintaining changes over time.

Similar to GPD-CBT, FLTP aims to empower parents to take on and enhance their role as the most powerful agent of change for their children. By teaching parents effective anxiety management strategies and passing them on to their children, both parents and children can use the skills learned even after treatment ends. However, FLTP is briefer, and it is in line with the trends of today's psychotherapy research, especially CBT, which is a brief, intensive, and concentrated (BIC) form of treatment aimed at improving accessibility and reducing costs to increase effectiveness [32]. There are relatively few studies on FLTP, and the limited sample condition also restricts its generalization. The related literature is almost unavailable in China at present. However, as part of the more researched Triple P program, the online, individual sessions of FLTP and FLTP workshops are gradually being carried out abroad, pending the publication of relevant research results.

3. Supportive Parenting for Anxious Childhood Emotions

In addition to CBT-based parent-only interventions for anxiety disorders in children and adolescents, the Supportive Parenting for Anxious Childhood Emotions (SPACE) program, developed by Eli R. Lebowitz, is another common treatment option in clinical practice. SPACE promotes the child's ability to learn to deal with anxiety independently and reduce anxiety symptoms by increasing supportive parenting and decreasing family accommodation [33]. Family accommodation refers to changes that parents make in their own behavior aimed at helping their children avoid or alleviate distress caused by anxiety [34]. Family accommodation includes parental involvement in the child's anxiety-related behaviors or changes in family routines, such as sleeping with a child who is afraid to sleep alone, providing constant reassurance to a worried child, answering the same questions repeatedly asked by the child because of anxiety, answering the many phone calls from an upset child, speaking in place of a socially anxious child, helping a child who does not want to go to school or do his or her homework because of anxiety to avoid doing it, and not inviting people into the home because of the child's resistance [35].

Research has shown that family accommodation is associated with more severe anxiety symptoms, greater functional impairment, and poor treatment outcomes [36-38]. Theoretically, anxiety in children and adolescents is characterized by interpersonal interactions, whereby the perceived danger and anxiety instinctively signal parents for help and rely on them to solve the problem, and the parents instinctively respond to the child's signals by stepping in to help their children. However, what parents do only takes away the child's stress and relieves their anxiety in the short term. In the long term, the child becomes dependent on the parent and does not improve his or her ability to deal with anxiety, but rather maintains the anxiety and thus creates a vicious cycle [39]. Treatment programs that target family accommodation can break this vicious cycle. The efficacy of SPACE for anxiety disorders in children and adolescents has been preliminarily demonstrated, particularly in a recent non-inferiority randomized controlled trial comparing SPACE with cognitive behavioral therapy, which found that parent-based SPACE was no less effective for anxiety disorders in children and adolescents than child-focused cognitive behavioral therapy [40].

SPACE promotes the child's ability to learn to handle anxiety independently and reduce anxiety symptoms by increasing supportive parenting and decreasing family accommodation [33]. SPACE is a relatively short-term treatment program conducted once a week for a total of 10-12 sessions, each being a 60-minute therapy session. There are 8 treatment modules included in SPACE:

(1) Setting the stage part and introduction to relevant concepts. The purpose of the first part is to set the stage for the process that is to follow by defining overall goals for the treatment and creating a context for the work that is to come. The therapist introduces the core concepts of the SPACE program: the importance of focusing on the parent's own behavior rather than the child's behavior; the cognitive, physiological, behavioral, and emotional mechanisms of anxiety; the impact of anxiety on personal boundaries between parent and child; and supportive parenting styles that respond to children's anxiety (validation + confidence).

(2) Charting family accommodation. In this part, the therapist introduces the concept of family accommodation and the vicious circle it causes. Then the therapist and the parents work together to identify accommodation in the family and create as detailed a description of the accommodating behaviors of both parents as possible.

(3) Choosing a primary target problem and informing the child. In this part, the therapist and the parents choose the most important target problem based on the accommodation chart, which is a recurrent, anxiety-related, and

accommodation-oriented behavior that parents are motivated to address and that has a significant impact on the child. Then the therapist and the parent write a statement together to inform the child of the behavioral change that the parent is going to make in an empathic, supportive (validation + confidence) way that focuses on the parent's own behavior.

(4) Formulating a plan to reduce accommodating behaviors. In this part, the therapist and the parent work together to make a plan to reduce the accommodating behavior that has been targeted as detailed as possible. The following elements are included in the plan: what is the accommodation parents are planning to reduce; when parents will start implementing the plan and whether all the time or only during particular parts of the day; who the plan will involve, only the parent or anyone else is part of it; how much accommodation parents will do, not to do it at all or limit it to a certain number of times per day; what will parents do instead of accommodating.

(5) Reducing accommodation—Continued. This part focuses on implementing monitoring and gradually developing the plan to reduce parental accommodation to the child's anxiety. Parents inform the child of their plan and record the time of each execution of the plan, what happened, the results, problems encountered, and how parents were handled.

(6) Additional Targets—parents take the lead. The goal of this part is to choose an additional target problem and to formulate a plan for addressing it. Also, this part assumes that the parents have successfully modified their behavior with respect to the child's anxiety, leading to increased confidence and knowledge. When the parents have not yet successfully implemented changes, the therapy continues to follow the previous part.

(7) Additional targer—Continued. In this part, the therapist reviews the parents' report of their progress regarding both target problems: the original problem and the newer one selected in the previous part.

(8) Summary and Termination. In this part, the therapist reviews the changes in the child's anxiety symptoms and changes in parental attitudes and skills learned by parents. The therapist also disscusses with parents the additional goals parents would like to achieve and how to maintain progress and deal with future problems.

SPACE has 5 other additional session modules that therapists consider implementing on a case-by-case basis, designed to help the therapist and parents work through difficulties that arise during the course of treatment, such as disagreements between parents or lack of cooperation from one parent, and the child's adverse reaction to the parent's reduction in accommodating behaviors. The five additional session modules are as follows: teaching the child anxiety regulation strategies; improving collaboration between parents; recruiting and engaging supporters; dealing with extreme disruptive behaviors; dealing with threats of self-injury or suicide.

SPACE targets family accommodation and focuses only on parental behavioral change without making any demands on the children, which solves the potential problem of CBT-based parent-only intervention. For example, if the children are poorly motivated, their symptoms will not be able to improve even if the parents have mastered the CBT skills, especially the practice of the exposure [40]. After many years of exploration, the online and group sessions form of SPACE is also developing [41]. However, SPACE research rarely involves the tracking and follow-up of treatment effects, which is an important issue to be resolved. 2020 Dr. Cheng Wenhong implemented China's first online SPACE training program, which led to a greater understanding of SPACE in China. However, more attention has been paid to the treatment concepts and procedures of SPACE, and the literature related to localized treatment effects has not yet appeared.

4. Summary and Future Directions

In summary, in order to improve the accessibility and effectiveness of treatment for children and adolescents with anxiety disorders and to maximize resources and efficiency, clinical research and practice continue to explore additional forms of effective psychotherapeutic options in addition to child-focused psychotherapy. The growing evidence for the influence of parent-related factors in the development, maintenance, and treatment of anxiety disorders in children and adolescents is not blaming and judging parents, but rather revealing a possible avenue for the treatment of anxiety disorders in children and adolescents. Most of the parent-only interventions for anxiety disorders in children and adolescents that are common in current clinical research and practice are based on CBT, with low-intensity GPD-CBT and FLTP being two of the effective treatment options. In addition to this, SPACE, which focuses on family accommodation, is more targeted and minimizes the demands placed on the child, further addressing the child's lack of motivation. However, it is undeniable that these treatment options need to be further developed to address the problems that exist.

Future research and practice still need to develop and pay attention to the following areas: First, increasing the scope of research on appropriate populations for parent-only intervention for anxiety disorders in children and adolescents. Parent-only intervention is generally considered to be recommended when children are younger, less motivated, or when professional treatment resources are scarce. However, there are fewer studies comparing treatment outcomes in children and adolescents of different ages or with co-morbid problems [42]. There are few and inconsistent findings on the appropriateness of parent-only intervention when parents also suffer from anxiety disorders or have high levels of anxiety [43]. Second, improving treatment programs reduces the dropout rate in parent-only intervention. One study found a higher tendency to drop out of treatment in parent-only CBT compared to parental involvement CBT [44]. Perhaps increasing therapist-parent contact, conducting online lectures, and incorporating varying numbers of group therapy sessions into the program are viable approaches. Third, greater efforts should be made to explore the mechanisms of parent-only intervention in therapy in order to develop more targeted intervention programs. Most current CBT-based treatment programs contain the same components, but what the core treatment components are is currently unclear. For example, exposure-based family treatment programs could be explored

more, as well as CC-ARI, a CBT intervention program similar to SPACE that targets family accommodation [45,46]. Fourth, conduct more qualitative or combined qualitative-quantitative studies. While much of the clinical research has been quantitative in order to explore treatment effectiveness, there have been fewer qualitative studies that have explored process variables from the therapist's or parent's perspective, and qualitative studies have been helpful in identifying factors of treatment effectiveness, as well as addressing the dropout rate [47]. Fifth, conduct more cross-cultural therapy research. Different cultural groups have different parenting philosophies, beliefs, language characteristics, preferences for forms of treatment, etc., and it may be more effective to improve treatment programs based on typical treatment programs by adapting them to different cultural characteristics [48,49].

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