Children with Anxiety: Which CBT format is best?

McKinnon et al (2018) is the first comparison of the impact of individual CBT, group CBT and guided parent-led CBT, on the severity of symptoms and remission rate for children presenting with one of the following primary disorders; Generalised Anxiety Disorder (GAD), Social Anxiety Disorder (SoAD), Separation Anxiety Disorder (SAD) and Specific Phobia (SP).

Childhood anxiety is plentiful with up to 32% of children and adolescents attending primary care settings showing signs of an anxiety disorder (Hansen, Oerbeck, Skirbekk, & Kristensen, 2016) Addressing this abundance is important because childhood onset of typically continues into adolescence and adulthood (Last 1996; 1997). The front-line treatment cognitive behaviour therapy (CBT) sees approximately 60% of children in remission after completing treatment (James, James, Chowdrey, Soler, & Choke, 2015). This is great news, however; that does leave 40% out in the proverbial rain. Could part of the problem be that different primary diagnoses respond to different formats of cognitive behavioural therapy? It is not unreasonable to think there are disorder-specific responses to different formats. For example, SoAD group CBT may provide precious opportunities for peer social support in a safe environment, however; it could also contribute to anxiety making it difficult for the child to benefit from therapy. Manassis et al (2002) concluded that a subgroup of children reporting high social anxiety may respond preferentially to individual treatment. Although a Cochrane review showed no differences in the effectiveness of individual CBT, group CBT and family/parental CBT (James et al, 2015). This review also concluded that CBT was no more helpful that other active therapies such as self-help books. The varied results may be consequences of methodological differences such as treatment responses were not always evaluated with respect to changes in symptom severity and remission and all used parent or child self-report measures which come with their own problems of response bias. With this in mind; the study to be discussed by McKinnon et al (2018) is the first comparison of individual CBT, group CBT and guided parent-led CBT within individual anxiety disorder categories in the field of child anxiety.

McKinnon et al (2018) pooled data from 1253 children (M=9.3, SD=1.7) from trials in Australia, UK, Norway, Denmark, Germany, Switzerland, Florida, and the Netherlands. The inclusion criteria were a primary diagnosis of GAD, SoAD, SP, or SAD, and taking part in a manualised CBT treatment. The treatment was evaluated using a clinician-rated measure. The primary outcome was change in the clinical severity of the child's primary problem across treatment and the secondary outcome was rate of remission. The results indicated no differences across the three treatment formats for children with primary SoAD, GAD or SAD. However, individual CBT was better than guided parent-led CBT for SP in terms of both improvement in symptoms and remission rates. Individual CBT also performed better than group CBT for SP in the clinical severity change analysis but not in remission analysis. The authors note that individual CBT sessions afford the therapist and child the ability to tailor the therapy to provide specific psychoeducation around the phobia and have in-session guided exposure. This precision is not possible in group and parent-led CBT. Children with primary SoAD diagnosis had significantly smaller reductions in clinical severity during the study period. This mirrors the results of Hudson et al (2015) and it may be that SoAD symptoms have an impact on the child's ability to engage with the therapy. A longer treatment program may be helpful to enhance outcomes for SoAD children by allowing more opportunity for a therapeutic relationship to grow.

McKinnon (2018) shows a stronger clinical benefit is associated with the allocation of children with SPs to individual CBT however there are limitations to be considered. First, the group sizes were uneven with the fewest participants in the SP group ((N=143), GAD (507), SoAD (283), and SAD (319)). More even groups may have produced different results and wide confidence intervals on several of the results shows the analysis is underpowered. In this study 'family/parent-led' CBT was defined as treatment with the direct involvement of parents. In some trials, the whole family was involved, in other trails parents were present for sessions and in others they were separate and in some trials parents were co-therapists. Each of these procedures are different and lumping them all together under one umbrella term may not be appropriate. Are these different procedures at all comparable? The impact of having a parent as a co-therapist will be different to having family therapy, the dynamics of the therapeutic relationship will be diverse between trials. On the plus side however, the gender split was very close to even with 629 of the 1253 participants being female and the average age range between groups was 9.0 – 9.5.

The McKinnon et al (2018) results are potentially valuable for clinicians to assist in decisions about treatment delivery format. As is highlighted by the authors of the paper, individual CBT is more costly and allocation decisions of children to a treatment format are complex, and influenced by multiple factors including the ability of parents to bring child to appointments, waiting lists, and patient preferences. There is need for long term randomised controlled trials with long term follow up periods and the inclusion of an online delivery format as self-help programs are growing in popularity.

Key points:

- This is the first review to compare individual CBT, groups CBT and parent-led CBT within individual anxiety disorder categories for children with anxiety.
- Potential clinical benefit for children with specific phobias being allocated to individual CBT.
- Further research would benefit from the inclusion of online CBT as a delivery format and long-term randomised controlled trials.

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