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Child Anqiety in Mental Health Care. Closing the Gaps between Research and Clinical Practice

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Summary

Despite the high prevalence of anxiety disorders in children, only a minority is referred to mental health care. It was found that the impairment in the daily functioning of the child as a result of their anxiety disorders is associated with referral to mental health care. More severe impairment was related to more referral (chapter 3). Nevertheless, the majority of the non-referred children in our sample did suffer from anxiety disorders. It was discussed that a more accessible mental health care, for example by increasing knowledge amongst parents and investing in prevention programs, might increase referral (discussion).

Logan is a boy that suffers from the consequences of his separation anxiety disorder and panic attacks and was referred to mental health care. The clinical case illustration of Logan (chapter 2) describes several child - and family characteristics (i.e. genetic predisposition, anxious modelling, overprotective parenting) that contribute to the origin and maintenance of Logan's anxiety disorder. Despite the anxiety-enhancing/maintaining family characteristics, Logan participated in a *child*-focused group CBT. His parents only participated in two optional parent sessions. The child-focused group CBT helped Logan overcoming his fears (discussion). This positive result is in line with the research findings that are described below.

Parents are involved in child anxiety treatment for two reasons: 1) to increase treatment effectiveness by improving anxiety-enhancing parenting and family functioning; 2) to facilitate the generalization of treatment gains. In chapter 4 it was found that only parent-reported autonomy granting and family relational functioning was *lower* (as hypothesized) for the referred clinically anxious families versus control families. Child-reported autonomy granting was *higher* in the referred families. Parental rejection, overprotection and family control did not differ between the referred versus control families. Nevertheless, it was found that anxiety-enhancing parenting and family functioning improved after both family cognitive behavioural therapy (FCBT) and child-focused cognitive behavioural therapy (CCBT), with no differences between treatments. In addition, good family relational functioning at post-treatment was the only family variable that was consistently associated with more improvement on anxiety measurements at the long term for adolescents, but not for school-aged children (chapter 4).

The results in chapter 4 raise questions about the working mechanisms in child anxiety therapy (discussion). It was discussed that CCBT should be the treatment of choice for child anxiety treatments. The association between parenting and family factors and child anxiety might be overestimated. The 'anxiety-enhancing' parenting behaviours might also be seen in

families of children with other psychopathology. It is suggested that in order to increase treatment effectiveness, researchers should focus on the characteristics of children and their families that do not respond to treatment (discussion).

CBT for child anxiety is considered an efficacious treatment. However, circumstances in research trials might be different to circumstances in real clinical practice, meaning that results from CBT for child anxiety in research trials (efficacy) might be different from results obtained in clinical practice (effectiveness). In this dissertation, it was found that CBT for childhood anxiety was not only effective within the context of a research trial, but also in daily clinical practice. Improvements on anxiety symptoms were similar for the research and real-world condition (chapter 6). More general experience in mental health care and more experience with prior anxiety cases of the therapist were associated with better treatment outcomes three months after treatment. No association were found between anxiety improvement and therapist's pre-treatment training, supervision and treatment adherence (chapter 7). This is contrary to the idea that those variables are necessary for an accurate treatment implementation in clinical practice. It was discussed that the quality of the interventions that therapist perform, might be more predictive for positive treatment outcomes in CBT for child anxiety than the adherence to the manual (discussion).

Results from this dissertation suggest that the CBT protocol Discussing + Doing = Doing is an effective treatment in real clinical practice. Contrary to research trials, clinical practice in this study was characterized by children that were not preselected, therapy was delivered by therapists who had various educational backgrounds and experience in mental health care, and various experience with prior anxiety

cases. Therapists did not all receive specific supervision or pre-treatment training and were not monitored in order to maximize treatment adherence. The majority of treated anxiety-disordered children benefit from manualized CBT. It was noted that real-world effectiveness research provides opportunities for increasing our knowledge about the characteristics of children and families that do not benefit (enough) from CBT and about the additional therapy that they might receive after the manualized CBT is finished (general discussion).