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CBT for child and adolescent anxiety disorders – an update on recent evidence --Manuscript Draft--

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CBT for child and adolescent anxiety disorders – an update on recent evidence

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Purpose of the review

To present an updated review of recent studies into the effect of cognitive behavior therapy (CBT) for anxiety disorders in children and adolescent, ways to increase access to therapy, and predictors and outcomes of therapy effect.

Recent findings

The evidence base of CBT for anxiety disorders in children and adolescent continues to grow, demonstrating short- and long-term efficacy and effectiveness. However, compared to active control conditions its effect appear to be modest, and a substantial percentage of youth do not show stable long-term remission. Standard CBT is often costly, with high non-completion rates. New strategies to increase access to effective therapy for the large number of youth with anxiety disorders is therefore of priority. Additionally, there is a need for developing new ways to treat non-responders, and to identify predictors and moderators of the effects of CBT.

Summary

Although there is evidence for the efficacy and effectiveness of CBT for youth with anxiety disorders, there is doubt regarding its superiority over active control comparisons. Long-term outcome is uncertain, as a substantial percentage of youth remains impaired at follow-up. It is essential to develop more cost-efficient strategies to reach youth with anxiety disorders with effective treatments, and to identify early indicators for youth needing additional therapy.

Keywords

CBT, effect, youth, anxiety, increased access.

Data Sources and Search

- PUBMED og Psychinfo searched June 19 2018.
- Search term: (CBT OR cognitive behav* therapy OR cognitive behav* treatment) AND (anxiety OR separation anxiety OR generalized anxiety OR social phobia OR specific phobia OR Panic disorder) AND (RCT OR random* OR randomized controlled trial OR controlled trial) AND (pediatric OR child* OR adolescent* OR youth)
- 278 abstracts were identified. After duplicates removal 267 abstracts were screened by all three authors, identifying 46 fulltext papers, of which 25 met final inclusion criteria.
- Study Selection: CBT, 0-17 år, RCT, reviews/meta-analyses, Jan 2017 and onwards, anxiety disorders, not: post-traumatic stress disorder, obsessive-compulsive disorder, selective mutism, anxiety in sleep problems, autism, other neurodevelopmental or medical condition.

INTRODUCTION

Child and adolescent (hereafter: youth) anxiety disorders are found to be prevalent, disabling, and often chronic. Developing and implementing effective early interventions has therefore been a priority for clinical research over the last decades. Cognitive behavior therapy (CBT) has robust empirical support for the treatment of youth anxiety disorders. Generic CBT programs for youth anxiety generally involve 10-16 therapy sessions, with change of dysfunctional thoughts and gradual exposure to feared situations as core elements. We here review recent reports from controlled trials, reviews and meta-analyses, focusing on the effect of CBT for common youth anxiety disorders.

Short-term outcome

When examining how effective CBT is for treating anxiety disorders in youth, we traditionally have considered effect-sizes and rates of treatment response or remission.

Recently, a meta-analysis of 36 CBT studies, in childhood anxiety or depression, reported a large mean effect-size ($d = .76$) when CBT for anxiety was compared to non-active control conditions, but only a moderate effect-size ($d = .40$) when CBT was compared to active control conditions [1]. Also, a meta-analysis of CBT and pharmacotherapy for youth anxiety disorders, demonstrated high response (loss of primary anxiety disorder, $RR = 4.72$) and remission rates (loss of all anxiety disorders, $RR = 4.08$) when CBT was compared to non-active control conditions [2]. However, compared to active control conditions (attention control or treatment-as-usual), CBT was superior only for child reported anxiety symptoms. Postintervention outcomes showed better outcomes than outcomes at follow-up assessments. Authors conclude that while CBT is effective for treating childhood anxiety disorders, it is only moderate superior to active control treatments.

Zhang, Zhang, Yang, Yuan, Zhou, Pu, Liu, Jiang and Xie [3] published a meta-analysis of six randomized controlled trials (RCTs) of CBT and one RCT of behavior therapy (BT) for anxiety disorders in children below 7 years. All were found to effectively reduce anxiety symptoms and increase rates of children free from anxiety diagnoses.

The effect of comorbid disorders was recently reviewed by examining 33 publications from 28 RCTs [4*]. The authors state that comorbid disorders may be more problematic for CBT outcome than previously thought. They recommend the use of specific treatments for different comorbidities alongside CBT. Future RCTs should include predictor and moderator analyses to avoid biased effects and attenuated power.

In an important attempt to standardize evidence reporting from studies of CBT in youth, Rith-Najarian and colleagues [5*] reviewed 136 RCTs, of which 54 focused on CBT for youth anxiety disorders. The suggested new criteria for evaluating evidence were; 1) reporting outcome on multiple target symptom measures, 2) reporting follow-up data, and 3) having an active comparison condition. The first criterion was met by 37% of all included studies, the second by 43%, and the third by 28%. Only 8% met all criteria, and most of these were said to be RCTs of CBT for youth anxiety disorders. The authors recommend shifting from traditional evaluation of evidence to rather focus on relative strengths, features, and evidence type when identifying interventions that match interests and needs of patients.

Effectiveness studies

An important aspect to consider when evaluating the effect of CBT for youth anxiety disorders is the performance in regular child and adolescent mental health service (CAMHS) settings. Such effectiveness studies, differ from efficacy studies performed in specialized university clinics, by having therapists with limited training and supervision, often with a larger case load to treat, and patients who are regular referrals and not self-recruited.

Although a recent review also found many similarities in treatment delivery across research and practice settings [6], it is important for clinics to choose treatment protocols with proven effect from settings similar to their own.

The effectiveness of a 12 sessions CBT program for common anxiety disorders (specific phobia (SP), separation anxiety disorder (SEP), social anxiety disorder (SAD), and generalized anxiety disorder (GAD)) was evaluated in an RCT of 165 7-13 year-olds from regular CAMHS [7*]. Youth were randomized to individual CBT (ICBT), group CBT (GCBT) or wait-list. At posttreatment 65% of GCBT and 52% of ICBT youth were free of their primary disorder, and 56% and 38% respectively were free of all anxiety disorders. For wait-list condition corresponding figures were 14% and 6%. Overall, outcomes were comparable to efficacy studies, demonstrating that CBT can be delivered effectively in CAMHS settings.

It thus appears that recent studies confirm the efficacy and effectiveness of CBT for treating youth with anxiety disorders, but only a minority of studies so far have been in line with suggested criteria needed to improve the level of evidence for studies in this field.

Long-term outcome

Although demonstrating short-term efficacy and effectiveness are important first steps, long-term follow-up studies (LTFUs) are needed to prove duration of treatment effects. Long-term is usually defined as at least two years after treatment.

In a review of 21 papers from 15 LTFUs of CBT for anxiety disorders [8**], average follow-up time was 5.85 years. Overall, 77% were free of their primary disorder at LTFU, and 57% free of all anxiety disorders. Only nine studies reported on interim services received after the treatment, only two compared their findings to a normative range, and no study followed

long-term outcome for untreated controls. Low retention rates (31% to 82%) limited the generalizability of the reports.

Some LTFUs have been published after the inclusion period for this review.

Villabø, Narayanan, Compton, Kendall and Neumer [7*] also reported 2-year follow-up data from their effectiveness study, showing that 57% of youth in GCBT and 47% in ICBT were free of their primary disorder at LTFU.

An LTFU study of guided parent-delivered CBT found 79% to be free of their primary anxiety disorder after 3-5 years, and 63% were free of all anxiety disorders [9]. The study was limited by including only 34% of original sample (treatment completers and youth not needing additional treatment).

A recent LTFU effectiveness study with high retention rates (90.3% of treatment completers, 77.7% of initial sample), reported results from a generic CBT program for youth with anxiety disorders at on average 3.9 years posttreatment [10*]. In this study remission rates increased from posttreatment to LTFU; where 63% were free of their primary anxiety disorder and 53% of all. Anxiety symptoms were also further reduced at LTFU. Although these outcomes are within the range of LTFU efficacy studies, a significant number (40%) of youth were still impaired from an anxiety disorder at LTFU.

Even more modest results were recently reported from the Child/Adolescent Anxiety Extended Long-Term Study [11**], where outcomes for 65.3% of the original sample were reported at 2, 3 and 4 year follow-up. Between 42% and 49% were free of all anxiety disorders at any one time-point, and only 7% were consistently free of all anxiety disorders.

Mechanisms of change and new developments

A report focusing on the role of exposure tasks for outcomes of CBT alone or CBT combined with Sertraline included 279 7-17 year-olds with anxiety disorders [12]. Positive

outcomes were predicted by the number of sessions with exposure, challenging exposures, child coping skills and treatment compliance. Largest effect of challenging exposures was seen for the combined treatment group.

Ollendick, Ost, Ryan, Capriola and Reuterskiold [13] combined data from 251 7-15 year-olds recruited in two RCTs, to study the role of harm beliefs and coping for outcomes of a 3-hour single-session treatment for specific phobia. Treatment included gradual in-vivo exposure and challenging of distorted catastrophic thoughts, without parents attending. Results showed that change in such beliefs was associated with outcome, and that change continued after treatment completion.

In order to improve treatment response of CBT for youth with SAD, disorder specific protocols have been tested and compared to standard, generic CBT. In a study of 125 8-17 year-olds with SAD [14*], youth were randomized to online generic CBT, SAD-specific CBT or wait-list. Treatment response did not differ significantly between the active interventions; 15% versus 13% were free of SAD at posttreatment, increasing to 30% and 35% at 6 months. The authors state that clinic-based delivery may lead to better treatment completion and exposure. A combination of face-to-face, group-based and online delivery may yield the best treatment response.

Suveg, Kingery, Davis, Jones, Whitehead and Jacob [15] reported selected outcomes from a study of 92 7-12 year-olds randomly assigned to regular CBT or to a CBT program with “emotion regulation content” (ECBT). While youth with SAD had higher levels of loneliness both at pre- and post-treatment, there was a significant decrease in loneliness for all youth. SAD parents reported more youth social problems; also these decreased after treatment. The authors suggest focusing more on loneliness in CBT programs for SAD.

The effect of adjunct attention bias modification therapy (ABMT) was studied in 85 8-17 year-olds randomized to CBT plus active ABMT or CBT plus placebo ABMT [16*]. Both

conditions had 12 CBT sessions; active ABMT had 2x5 minutes ABMT in sessions 5 to 12. The groups were compared with 51 healthy controls. The study showed that ABMT enhanced clinical response to CBT. It was concluded that ABMT and CBT seem to have complementary effects, targeting distinct brain circuitry components.

A study of emotions, sleep and social interactions reported on 114 9-14 year-olds randomized to CBT or child-centered therapy (CCT) [17]. The study had an exploratory nature, and focused on identifying factors that would predict better response to CBT versus CCT. Overall, higher positive affect with mother and fewer problems with sleep duration predicted better outcomes.

Increasing therapy access

Generic CBT is costly to administer and inconsistently accessible to families. Up to 80% of youth with mental disorders go untreated every year, and many drop out prematurely. Stepped care is seen as an ideal model for cost-effective service delivery, offering low intensity treatment first, followed by increased amount of therapy in the face of non-response, but it has been little evaluated.

One study randomized 281 6-17 year-olds to standard CBT or stepped care [18*]. The steps were; 1) book/handout/CD + four telephone calls, 2) standard CBT, and 3) a case-formulation based treatment. At 12-months the two arms had similar response and remission rates (69% and 67% were free of primary disorder, 53.0 and 48.0% free of all). There was slightly less therapist time for the stepped care arm. Authors conclude that we currently have little information about efficacious treatment for complex child anxiety cases.

In a review and meta-analysis of brief, intensive and concentrated (BIC) CBT for youth anxiety disorders [19*], the authors argue that BIC is best viewed as part of a stepped-care approach. Seventeen studies of anxiety disorders and three of OCD were included in the

review. BIC CBT was acceptable, effective and durable up to one year posttreatment. There was strong support its effect on specific phobias, but little on other youth anxiety disorders.

A study comparing brief guided parent-delivered CBT with brief solution-focused therapy included 136 5-12 year-olds with anxiety disorders referred to CAMHS [20**]. Parent-delivered CBT did not yield superior outcomes compared to solution-focused therapy, but had lower cost and may therefore be preferred as initial low-intensity treatment.

In an efficacy study evaluating CBT delivered to groups of parents, 63 7-14 year-olds with anxiety disorders were recruited through media or schools [21]. Parents were randomized to six sessions of GCBT or wait-list. At posttreatment youth of parents in GCBT had less anxiety symptoms than wait-list youth; 61% were free of primary disorder, 39% free of all. At 3-months follow-up 59% were disorder free, increasing to 84% at 12 months follow-up. Recovery rates were equal to but cost only at 11% of standard ICBT. Shorter and less expensive treatments may make CBT more accessible to families of anxious youth in the future.

Single-session interventions (SSIs) have the potential to decrease monetary costs and improve accessibility. In a meta-analysis, the mean effect size of 50 included single-session trials was 0.32, with youth-focused behavioral SSIs showing largest overall effect ($g = 0.74$), and largest effect for the 15 trials targeting anxiety ($g = 0.58$) [22].

Digital health interventions (DHIs), and internet-delivered treatment in particular, are recent developments that may improve access to and reduce costs of treatment. Initial support for DHIs was provided by a recent review and meta-analysis [23]. Evidence was strongest for computer-based CBT with therapist support. However, attrition ranged from 15% to 51%. Therapist support may increase adherence and retention, and game-like elements may be needed for children in order to make skills and progression self-reinforcing.

Empirical support for the use of therapeutic video games for youth with anxiety disorders is lacking [24].

In a study of internet-delivered CBT, 84 8-12 year-olds with anxiety disorders were randomized to 10 weeks of parent-led exposure-based CBT with online support [25]. At 3 months follow-up 55% were free of their primary disorder, at 12 months 73%. The effect size for parent-rated child anxiety symptoms was large. The study was limited by missing data and sample size.

Predictors, mediators and moderators of outcome

Knowledge of the predictors of response to treatments and the factors that mediate and moderate the effects of treatment on outcome is important to inform about who CBT is most likely to be effective for, and to adapted CBT programs in order to improve response.

One study found no difference in the effect of generic CBT between primary disorders (5), while others report lower remission rates for youth with SAD (10, 11, 4). BIC CBT has strong support for SP, but little for other youth anxiety disorders (19).

Regarding the effect of comorbidity on outcomes, reviews have reported worse outcome for youth with externalizing symptoms (8), and for youth with mood disorders (4). The latter review also reported an additive negative effect of multiple comorbidities.

A study reporting on the effect of treatment factors, found that positive outcomes were predicted by the number of sessions with exposure, and degree of challenging exposures (12). Also in line with CBT principles, one report found that change of catastrophic thoughts / dysfunctional beliefs in youth with SP was associated with outcome (13). Due to reduced response of generic CBT for youth with SAD, two studies have evaluated specific CBT programs and components for this group (14, 15). Two original studies (7,10) and one meta-analysis (3) found no effect of treatment format (GCBT or ICBT), while one review reported

that format affected outcome in a small minority of their included studies (8). The latter review also found better outcomes for treatment completers in studies from academic settings, but recent effectiveness studies show short- and long-term outcomes in line with efficacy studies (7, 10). Similar outcomes for clinic and community samples were also reported in a meta-analysis of SSIs (22). SSIs had slightly smaller effects than multisession interventions, but greater potential for accessibility and scalability. While outcomes have been found to be associated with treatment completion (14) and compliance (12), generic CBT programs show similar effect across different session number (3).

Regarding moderating effect of gender and age, one review (8) and one study (11) report lower remission for girls, while the study of BIC CBT reported that girls and older youth tended to respond better (19). For computer-based CBT, evidence is also strongest for older adolescents (23). In contrast, younger age predicted more stable remission in an LTFU of generic CBT (11), and exposure has been found to be particularly important for young children (12).

Higher positive affect and longer sleep time predicted better outcomes in one study (17). Negative life events were associated with worse outcomes in one review (8) and one study (11). In the latter, higher general functioning and positive family interactions predicted more stable remission (11).

One review (8) report that more parent involvement predicted lower youth anxiety for BIC CBT parent involvement was found to be inversely related to outcomes (19). Parent only studies were not completed at prescribed time and had higher dropout rates in one study (3), they are not found to be superior to other active therapies (20, 21), but may imply lower cost.

SUMMARY

The present update, focusing on reviews and controlled trials published in the last 18 months, support the evidence base for CBT for anxiety disorders in children and adolescents. Recent studies confirm both short- and long-term effectiveness in regular clinical settings. However, superiority over other active treatments appear to be modest, and long-term studies show that a minority of youth show stable remission, and will be in need of further treatment. New ways of CBT delivery have been developed recently, and may reduce cost, reduce drop-out and increase access to CBT for the majority of anxious youth who go untreated today. The literature also gives some indications about how CBT may be adapted to improve treatment response for various subgroups. There is still a need for increase the standard of studies in the field, and to develop more cost-effective protocols for CBT in the treatment of youth anxiety.

KEY POINTS: In box

- CBT has a solid evidence base for youth anxiety disorders
- Lower response rates for youth with Social Anxiety Disorder
- A number of anxious youth need additional or alternative therapy
- Comorbid conditions may require concurrent specific therapies
- Brief CBT, in groups, through parents or digitally may increase access
- Standard reporting of outcomes, active comparison conditions and long-time outcomes at multiple time-points are needed in future
- Predictors and moderators of effect are beginning to be identified

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Conflicts of interest

There are no conflicts of interest.

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