International Journal of Biomedical and Clinical Sciences
Vol. 5, No. 2, 2020, pp. 56-63
http://www.aiscience.org/journal/ijbcs

Disorders Guided Parent-Delivered Cognitive Behavioral Therapy for Childhood Anxiety: Review of Literature

Javaneh Javdani[1, *], Habibollah Naderi[1, 2]

[1]Department of Psychology, University of Lincoln, Kuala Lumpur, Malaysia
[2]Department of Psychology, University of Mazandaran, Babolsar, Iran

Abstract

There are a variety of anxiety disorders that can affect children including generalized anxiety, social phobias, separation anxiety, school phobia, and panic disorder. The anxiety disorders not only affect their current wellness but can also affect future psychological health and increase the risk of substance abuse. Cognitive-behavioral therapy (CBT) is a type of therapy used for anxiety disorders that helps people understand negative thought patterns and change their response to anxious situations. However, time commitment, resources, and costs can make it difficult for some to follow and complete treatment. This article is based on a review of journal articles that focused on Parent-Delivered Cognitive Behavioral Therapy. There were at least 61 articles reviewed. Of 61 articles 23 were empirical and meta-analysis reviews on the most important factors of anxiety. The association of parental depression with child anxiety has received relatively little attention in the literature. In this paper we initially present several reasons for examining this relationship. We then summarize the empirical support for a link between these two variables. Finally, we discuss directions for future research and clinical implications of an association of parental depression with child anxiety.

Keywords

Schema Therapy, Emotional Schema, Resiliency, Drug Addicted People

Received: January 24, 2020 / Accepted: February 27, 2020 / Published online: March 24, 2020

1. Introduction

Children comprise a majority of the world's population, attention to their physical, emotional, mental and behavioral growth always has been emphasized by researchers, so that during recent 25 years, children's behavioral, social and emotional problems has been discussed as one of the main subjects of psychotherapy and psychology [1]. When a child is born may has the highest and the most complete features for growing. He/she may be ready to grow as worthy as possible, that's enough born normally and a perfect family and environment be provided to flourish, and find his/her venerable position in this world. But family life and health, educational, social and cultural environment of many people around the world is such that makes difficult or impossible achievement to such goal. Childhood anxiety disorders often do not present as a single disorder. Rather, they overlap significantly in symptoms and are highly comorbid among themselves [2], with 40-75% of anxious children meeting criteria for more than one anxiety disorder [3， 4]. Childhood anxiety disorders are also highly comorbid with other internalizing disorders, such as depression, and moderately comorbid with externalizing disorders, which adds to an already complex diagnostic profile [5]. Therefore, the treatment of childhood anxiety disorders must necessarily take into account the presence of comorbid conditions.

Epidemiological studies show that 5e10% of children and adolescents suffer from an anxiety disorder, which means

* Corresponding author
E-mail address: j.javdani62@gmail.com (J. Javdani)

that it is one of the most common mental disorders for this age group [6]. Anxiety disorders are associated with suffering and impairments in everyday life of the affected individual as well as in the family and among relatives, and increase the risk for depression, substance abuse and impairment in social and emotional functioning during adolescence and early adulthood [7]. Thus, childhood anxiety disorders should be identified and treated as early as possible. There is strong support for cognitive behavior therapy (CBT) as an effective treatment for anxiety disorders in children [8], and CBT is regarded to be the treatment of choice for this group. However, the vast majority of children and adolescents with anxiety disorders do not receive evidence-based psychological treatment. It is therefore important to find means to increase the availability of CBT for this population.

In fact anxiety is a state of inquietude, anyone experiences anxiety and it is a pervasive, undesirable and vague inquietude which is result in automatic device symptoms, such as headache, sweating, palpitations, feeling stenosis in the chest and brief discomfort of stomach. Anxious Person may feel restlessness which its symptom is that cannot sit or stand for a long time. A set of symptoms during anxiety, is different in any person from the others. Remarkable studies also show that now childhood anxiety is turned to a serious problem for mental health. Since anxiety disorders have a high co-affliction with other psychiatric disorders children, hence is less noticed by clinical psychologists [9]. Separation anxiety disorder is determined by extreme anxiety, at the time of separation from people whom the child is attached to them. According to different research findings some of very important factors in children infection to separation anxiety disorder can be cited as children attachment quality, a parent's infection to anxiety disorder and new child birth [10]. Cognitive-behavioral treatment is a purposeful effort to keep the effects of regulating the behavior and combination of cognitive activities for making therapeutic changes. In this therapeutic approach, the role of knowledge in emerging the behavioral and emotional changes is emphasized.

Cognitive-behavioral treatment is a short-term organized therapeutic method which is directed to the problem and its goal is adjustment of incorrect and irrational recognition [11]. This therapeutic method helps patients to identify their negative thoughts and examine them. This skill is the main core of CBT. Cognitive-behavioral approach mainly is based on self-help and therapist aim is contribute to the patient so that promote the required skills not only for solve the current issues, but similar issues in the future [12].

2. The Source of Anxiety

Anxious person often does not know the cause and source of his/her anxiety and does not know that anxiety is caused by an internal insecurity feeling or an external position that makes the fear. Like concern, Anxiety is imaginary, but differs from concern in two aspects:

1. Concern is related to specific situations, such as exams, financial problems, etc., while anxiety is a generalized emotional state.
2. Concern is related to objective problems, while anxiety is caused by a mental problem.

Anxiety is a kind of attitude and internal worry that its source is unclear. It should be noted that anxiety differs from fear, because the source of discomfort is clear in fear, but this source is not obvious in anxiety. Anxiety involves a feeling of uncertainty, frustration and physiological arousal, and a person complains of tension and nervousness and restlessness [13]. From social-cultural theorists' point of view, anxiety and panic disorders are more likely found in those who face social stresses and social dangerous situations [14]. In people who live in threatened environments, a widespread sense of tension, worry, restlessness, and sleep disorders that determine generalized anxiety are more. Studies have shown that the prevalence of panic and anxiety disorders is more in the poor social group; For example, the abundance of panic in those whose annual income is less than ten thousand dollars a year is twice compared with those whose annual income exceeds that figure. In fact, it can be said that the decrease in income is associated with an increase in the frequency of anxiety [15], [16]. The more unsuccessful and insecure people who feel that they are unable to face problems are more anxious, and according to studies, girls are more likely to experience anxiety than boys [17].

3. Difference Between Fear and Anxiety

Anxiety differs from fear. In a state of fear, the source of the discomfort is known, but anxiety is actually fear without cause and does not have a certain origin. The patient has apprehension, but he/she does not know why?

In psychoanalytic theories, there are differences in the recognition of anxiety and fear or "phobia" that are:

1. Anxiety is a reaction against forbidden intrinsic motives, but fear is a response to an external and exterior horror object.
2. An external situation may first be frightened, then internal and interior motivations will aggravate it to be anxiety, so

that fear and anxiety appear together and consecutively.

3. Phobia is generally from an object that is known, but anxiety arises from an unknown object [18].

4. Children with Different Anxiety Disorders

Childhood anxiety disorders are common and negatively impact healthy development [19]. Results from systematic reviews demonstrate recovery rates of approximately 60% [20]. Typically, clinical trials have utilized heterogeneous groups of anxious children with primary diagnoses of Generalized. Anxiety Disorder (GAD), Separation Anxiety Disorder (SAD), and Social Anxiety Disorder [21]. This is largely due to the high rates of comorbidity between anxiety disorders in childhood. Although separate anxiety disorders can be differentiated in childhood, it is generally agreed that there is an underlying construct of anxiety that can be treated within a broad-based protocol. Thus, many treatment studies in the field provide information about the efficacy of CBT for anxiety disorders in general rather than specific disorders.

The differential recovery rates of anxious children with specific disorders receiving standard CBT protocols are less clear [22]. An increasing number of randomized controlled trials have emerged that target specific anxiety conditions and provide information about the response of specific anxiety disorders to these targeted CBT [23]. For example, Spence et al. [24] randomized 7e14 year old children with SoAD to either await list condition or cognitive behavioral treatment (with or without parental involvement). Both CBT conditions demonstrated significant improvements over time compared to the waitlist condition. Similarly, a number of other disorder-specific studies have shown significant reductions in anxiety symptoms following targeted CBT in children with Obsessive Compulsive Disorder and Post-Traumatic Stress Disorder. Together these studies demonstrate that treatments targeting specific disorders are efficacious in reducing anxiety symptoms, yet they provide limited knowledge about the comparative efficacy of children presenting with different anxiety disorders. That is, do children with particular anxiety disorders respond more poorly to psychological treatment than children with other anxiety disorders?

Findings within the adult literature provide information about likely differential response to CBT for specific childhood anxiety disorders. Adult treatment research in the anxiety disorders is predominantly disorder specific; treatments are targeted to specific anxiety disorders. In a meta-analysis comparing effect sizes across adult studies, CBT was efficacious for all of the anxiety disorders, yet individuals with SoAD had poorer outcomes than individuals with GAD and Panic Disorder (PD) [25]. In a similar meta-analysis, the effect sizes for OCD and Acute Stress Disorder were the largest, while the lowest effect sizes were for PD (Hofmann & Smits, 2008). In this study, the effect sizes for GAD, PTSD, SoAD and PD were significantly lower than the effect sizes for Acute Stress Disorder. These results suggest differential response to CBT for adults with anxiety disorders.

Within the child literature the disorder heterogeneity typical of clinical trials provides a unique opportunity to study the comparative efficacy of standard CBT protocols across anxiety disorders. Historically, such analyses have not been feasible because of the small sample sizes typically utilized in clinical trials of child anxiety. In one study however, Crawley, Betides, Benjamin, Martin, and Kendall [26] examined outcomes for children with and without a primary diagnosis of SoAD in a sample of 166 children aged from 7 to 17 years. In this study, children with primary SoAD (n ¼ 48) were less likely to be free of their anxiety diagnosis at post treatment compared to children with GAD or SAD. When children with comorbid mood disorders were removed from the analysis (approximately 6 children), the difference between children with and without SoAD was no longer significant, suggesting that the presence of mood disorders may have accounted for the differences in CBT response between children with and without SoAD. Nevertheless, this study provides some evidence that children with GAD and SAD have better outcomes following CBT than children with SoAD.

5. Anxious Parents of Children

Anxiety disorders are among the most common psychological disorders in childhood, affecting up to five percent of children under 12 years of age [27]. They are associated with numerous adverse con-sequences, including effects on the child's social and educational functioning [28], are associated with the development of other disorders in childhood (e.g., depression, conduct disorder) and place children at increased risk for other psychiatric disorders in adolescence and adulthood [29]. As a result, these disorders carry a substantial health and social cost [30].

Anxiety disorders are the most common mental health diagnoses in youth, and carry risks for ongoing impairments and subsequent development of other psychiatric comorbidities into adulthood [31]. However, this also means a significant proportion of children fail to lose their primary anxiety diagnosis following a course of CBT. Consequently, it has been suggested that parents who are highly anxious may have a limited ability to tolerate their

child's distress, and that this may lead to antigenic parental behaviors that may interfere with treatment [32]. One subgroup identified as potentially being at greater risk of failing to make clinical gains through CBT is children of parents who are themselves highly anxious. Although findings are inconsistent when parental anxiety is considered as a continuous measure, there is consistent evidence of poorer treatment outcomes for children whose parents report clinical levels of trait anxiety or a current anxiety disorder. It has been hypothesized that this failure to make optimal treatment gains may be partially due to highly anxious parents responding to their child's anxiety in a manner that inadvertently maintains the disorder and runs con-trary to the principles of CBT [33].

6. Important Factors of Anxiety

Statistical population of this research consists of all drug dependent men who referred to drug quitting campus of Bandartorkman city who were 112 people. Present research sampling method is one-step random cluster sampling in this way that sample camp was selected randomly from among campus in Bandartorkman city and its all members as sample group after identifying those who had low resiliency and negative schemas, samples were randomly selected and 15 persons were selected for experimental group and 20 persons for control group.

6.1. Parent's Dispute

The primary cause of concern in the child is parent's dispute. The family is a safe and comfortable privacy; but if there is conflict between parents, comfort and relief will be lost to the children of that family. Researches have shown that children who live in such families have severe concern and emotional and psychological problems. When the parents disagree and argue, the child is exposed to their disagreement and disparity, and this is not only uncomfortable for him/her, but a diversionary pattern is created for the child to resolve the conflict. In families with a lot of conflicts and disputes between parents, children are usually taciturn, dissociable, and captious, and they worry that conflict and dispute cause one parent or both to quit them and leave them alone.

6.2. Unrealistic Impression of Yourself

One of the most important factors which has the cause and effect relationship with anxiety is the individual's perception of himself/herself. On one hand, an individual feels humble and is fleeing his/her true personality, and, on the other hand, anxiety reinforces this issue. In other words, the unrealistic impression of oneself is the source and cause of anxiety and other psychological problems and also the result and effect of anxiety.

6.3. Perfectness

Some people think that they should be perfect and flawless in all aspects. They want to be complete in terms of literacy, science, ethics and behavior, know everything and have all goodness in them. A perfectionist person has less calm; he/she doesn't have enough self-confidence and before the implementation of any action, he/she is distressed and anxious because he/she is afraid that he/she will fail to do that. He/she even dreamed that he/she had fallen from a great height. This causes the person to not be assertive in many situations. For example, a student who does not participate in the class discussion, despite enough information about the subject, and fears that if he/she says something wrong or cannot present the lesson in the best way, the image of his/her perfection is in danger, uses progress and success areas less. The objective sample is the student who has written his/her problem in advance before consulting: "... from the moment of entering the classroom, because of being worried about that maybe I am directly or indirectly asked and I cannot answer that question in a proper way, what I have learned is forgotten. Especially from the moment of standing in front of the board, I constantly think that if I cannot answer completely, I fail. This idea grows so fast in me so that my mind goes out and I feel that I have a fever, my body shakes and I am really anxious over the next few days...." A perfectionist has some expectations from herself/himself and obliges herself/himself to meet them. "Do's" and "don'ts" that arise from his/her expectations from himself/herself rule him/her as dictatorship.

1. You have to behave like this;
2. You must solve your problems very soon;
3. You should not resent anything;
4. You should not look like this.

If a perfectionist does not follow the inner ruler which inspires do's and don'ts in him/her, he/she will be anxious and worried. In the case of the example mentioned, the inner ruler of the perfectionist student tells him/her that you have to look good [33]. These commands cause an individual to be anxious during responding.

6.4. Past Issues and Future Events

Other factors which cause concern and anxiety are to leave the current situation and focus on the past or future issues. This anxiety is more common during the exam. For example, a student's or university student's concern about the previous exam would prevent her/him trying and studying for the

current exam, or the thought on a future exam creates such anxiety and apprehension so that he/she cannot focus on the current lesson. Sometimes, past memories, such as a situation that was a factor of anxiety in the past or even during childhood, affect a person at the present time and cause him/her to be anxious and concerned. A person's concerns about the future are also one of the important factors of anxiety. The anxious person is concerned that maybe he/she or his/her family suffer a terrible event or maybe all of his/her plans will be thwarted. Such a person can never use the current status fully and correctly, and his/her concerns prevent any progress and movement. He/she stops his/her life for things that may never happen. This kind of anxiety involves a variety of issues; such as worrying about your health, educational status, job, future, financing, your death or the death of darling, and even not having any worries, that is, some people say: "I'm worried that everything is good and desirable and my life is calm and I have no worries. Because I do not know what will happen!

6.5. Fear of Your Death or the Death of Others

Another component of concern in the children is the fear of death and annihilation of themselves or others. Because of observing the death of others or some stories that the child has heard, he/she is constantly worried about his/her death or losing one of his/her close relatives. Now, in some educational systems, death tolerance and its acceptance are taught to the children as a dimension of life. Keeping animals or birds at home by the child is a useful activity in teaching the responsibility and accepting the death. Children often love their animals and are able to become familiar with different aspects of life through the animal death. Absence of parents at home is another factor in making the children's concern. Especially, when the child returns from the school and sees that the mother or the father or both are not at home, he/she feels anxious.

Sometimes, worries appear because a suspicion has overcome the child's feeling. He/she has done something with his/her potential and power, and wants to be appreciated, but unfortunately, because of occupation and probably inattention and underrating the child's effort, parents don't appreciate him/her or don't value his/her act. The child is saddened by this and embarrassed to defend himself/herself, so he/she is worried too much. Sometimes, the child's concern is caused by disciplinary contradictions. In the house, the father and mother give different orders. Sometimes, this conflict can be seen between the home and the school; it means that the child takes one kind of order from the parents and another kind of order from the teacher or headmaster. Therefore, the child suffers from a contradiction so that he/she doesn't know he/she must accept which order or consider which one. Part of the child's concern is made by this.

6.6. Preventing the Child from Participating

Play is the language of the child, and thus the child states his/her issues clearer and better. The game is an experience that drowns the child in itself so much and is even more important than work for an adult. Some parents implicitly state that the game does not have a preference over unemployment. The lack of some parents' awareness of the positive and constructive effects of the game on preventing and solving the mental and psychological problems of the children has caused the parents to prevent their game. The child considers the prohibition of the game as punishment and worries about the parents' behavior and their love towards him/her.

6.7. Sense of Ownership of the Child

The child loves his/her toys and is not easily satisfied to give them to another; because the sense of ownership is very strong in her/him. Unfortunately, due to the lack of recognition of some parents about the issue of "the sense of ownership of children" and its role in the growth of their personality, irreparable mental-psychological damages are done to the child's personality; for example, when a child comes home as a guest, parents try to inspire the child to give her/his toys to the guest child. They inspire him/her that the guest child is his/her friend and must partner with him/her in playing with toys. If the child disagrees with the parents' opinion, they force the child, first by encouragement then by threat or punishment, to give his/her toys to the guest child despite herself/himself, while at the same time, the sense of ownership appears in the child and he/she wants to announce through not giving the toys to the other child that they are in his/her possession, and due to receive the parents' love and attention, he/she inevitably gives them to the guest child. If the parents force the child to give his/her toys to another child, or themselves take her/his toys by force and give them to the guest child, then the child feels insecurity and always worries that maybe somebody takes his/her toys, and as a result, he/she becomes anxious when each child approaches to his/her playing privacy.

6.8. Emotional Relationships with the Child

The child needs love, kindness, support and care, and the lack of sincere love and kindness makes him/her anxious, and causes the child to always be in a state of defensive and devote his/her talents to alleviation and elimination of his/her inner apprehension and anxiety. Kindness to the child makes a sense of the worth and self-confidence in him/her. Recent

researches show that children are in urgent need of parents' emotional cares in the early years of life. Emotional and psychological cares of the child in the first three years of life play the most important role in finding the personality of the child in the next periods of life.

As a lack of affection affects the child, a lot of kindness is also problematic for the child. Many parents take care of their children extremely and they are always worried about their health, and because of this concern and passion, they nurture the child completely reliant and dependent. At the time of entering the community, these children, because of their shaky personality and destabilization, droop and succumb against the smallest problem. Another kind of inappropriate relationships between parents and children that may be the cause of his/her future anxieties is conditional affection. For example, the child feels that if he/she does not score well in the exams, then he/she loses the love of parents or he/she is lovable as long as he/she pays attention to his/her parents' orders. Therefore, if a child cannot meet the expectations of parents, he/she feels humiliated. The three factors cause anxiety in the child and also bring about her/his future anxiety [33]. Discrimination among children causes anxiety in different aspects. On the one hand, the child always seeks ways to attract attention and affection, and if he/she doesn't succeed, he/she feels disappointed, and such a child doesn't value himself/herself and thinks that he/she is valueless. On the other hand, he/she gets angry towards his/her parents and siblings, and he/she has to suppress this anger and hatred. Suppressed hatred is also one of the major factors of anxiety [34].

6.9. Punishment

Parents who always blame or reprimand their children nurture a disillusioned, vulnerable, and poor person for the community. Such a child considers himself/herself an unprotected and shelter less person. These factors are named predisposing factors of anxiety, because they are like a farm that the anxiety weed seeds are sprayed within it. But the greenness and greatness of the grasses and prevention of growing product which is talent and progresses of human or drought and eradication of grasses depend on operation and the way of facing with these predisposing factors. In other words, a person who can face with life issues in a correct and logical way and tries to enjoy a healthy and natural personality prevents the appearance of problems which probably arise from predisposing factors. However, predisposing factors make a person who faces with issues without realism and through negative and irrational methods susceptible to any psychological and mental agitations [35].

7. Conclusion

Cognitive behavioral therapy (CBT) is a well-established treatment for anxiety disorders in children and adolescents (hereafter youth [36]. Meta-analyses have shown that approximately 60% of youth recover from their anxiety disorders and experience significant symptom reduction following treatment [37]. However, there has been less focus on the question of whether treatment outcomes are maintained in the long term. Relapse can lead to detrimental consequences at individual, family, and societal levels, as early anxiety disorders predict later emotional, social, academic, and vocational problems ([38]. Successful CBT treatment for youth anxiety disorders on the other hand, provides protection from later squeal. Furthermore, investigating long-term outcomes is essential in establishing treatment efficacy in youth anxiety disorders [39].

Long-term follow-up is commonly defined as follow-up at least two years post-treatment. To date, five studies based on separate samples have examined the long-term effects of CBT protocols in youth with mixed anxiety disorders in the form of separation anxiety disorder (SAD), Social anxiety disorder (SOP), and/or generalized anxiety disorder (GAD) [40], over follow-up periods ranging from 2 to 19 years post-treatment (M =7.9 years; Mdn= 6.2 years). These studies indicate that post-treatment outcomes were either maintained or improved at long-term follow-up, with 46.5–85.7% of study participants no longer fulfilling the diagnostic criteria for anxiety disorders. A recent review of long-term follow-up studies of youth treated for any anxiety disorder (with the exception of obsessive-compulsive disorder and post-traumatic stress disorder), with follow-up assessments a mean of 5.9 years post-treatment, found that 64.6% of youth were in remission.

More specifically, 57.0% and 76.7% had lost all inclusion anxiety diagnoses and their primary anxiety diagnosis, respectively. Furthermore, heterogeneity in reported outcomes makes comparisons across long-term follow-up studies difficult and hence challenges the generalizability of the study findings. Consequently, this calls for more detailed information on diagnostic outcomes following treatment, including loss of the principal anxiety diagnosis, all comorbid anxiety diagnoses, as well as symptom measure outcomes [41].

Several short-term effectiveness studies with follow-up assessments 3–15 months post treatment (M= 9.8 months, Mdn =9 months) reported recovery rates ranging from 52% to 78% [42]. Overall, the studies confirmed the maintenance of treatment gains from post-treatment to follow-up, albeit with slightly lower recovery rates compared to those obtained from efficacy trials. However, there is a need to examine

effectiveness of CBT for mixed anxiety disorders in youth beyond 15 months post-treatment. It has been argued that the three main anxiety disorders SAD, SOP, and GAD are manifestations of the same underlying anxiety construct and therefore are amenable to treatment with the same CBT protocols [43].

References

[1] Mash, E. J., & Barkley, R. A. (Eds). (2014). Child psychopathology (3rd Ed.). New York: Guilford Press.

[2] Kendall, P. C., Compton, S. N. Walkup, J. T., Birmaher, B., Albano, A. M., Sherrill, J., Piacentini, J. (2010). Clinical characteristics of anxiety disordered youth. Journal of Anxiety Disorders, 24 (3), 360-365. doi: 10.1016/j.janxdis.2010.01.009.

[3] Rapee, R. M., Schniering, C. A. & Hudson, J. L. (2009). Anxiety disorders during childhood and adolescence: origins and treatment. Annual Review of Clinical Psychology, 5, 311-341.

[4] Seligman, L. D., Ollendick, T. H. (1998). Comorbidity of anxiety and depression in children and adolescents: An integrative review. Clinical Child and Family Psychology Review, 1 (2).125–144. Doi: 10.1023/A: 1021887712873.

[5] Russo, M. F., & Beidel, D. C. (1994). Comorbidity of childhood anxiety and externalizing disorders: Prevalence, associated characteristics, and validation issues. Clinical Psychology Review, 14 (3). 199–221. doi: 10.1016/0272-7358(94)90008-6.

[6] Pine, D., & Klein, R. (2008). Anxiety disorders. Rutter's child and adolescent psychiatry (pp. 628e647). Oxford, UK: Blackwell Publishing Ltd.

[7] Fichter, M., Quadflieg, N., Fischer, U., & Kohlboeck, G. (2009). Twenty-five-year course and outcome in anxiety and depression in the Upper Bavarian Longitudinal Community Study. Acta Psychiatrica Scandinavica, 122 (1), 75e85.

[8] James, A. C., James, G., Cowdrey, F. A., Soler, A, & Choke, A. (2013). Cognitive behavioural therapy for anxiety disorders in children and adolescents. Cochrane Database of Systematic Reviews, (6). doi: 10.1002/14651858.CD004690.pub3.

[9] Heydari, Mahmoud, Bakhtiyarpour, Saeed, McVandi, Behnam, Naderi, Farah and Hafezi, Fariba. (2018). Effectiveness of FRENDS program training on children anxiety in Shiraz. Psychological methods and models, 7 (24), 38-23.

[10] Mousavi, Roghiyeh, Mousavi, Seyyed Sajjad; Mahmoudi Gharaei, Javad; and Akbari Zardkhani, Saeed. (2008). Tools for evaluation and diagnosis of anxiety disorders in children and adolescents. Journal of the Army Medical Sciences Academy of the Islamic Republic of Iran, 6 (2), 154-147.

[11] Motabi, Angel; and Fati, Ladan. (2017). Route therapy in cognitive-behavioral theory. Tehran: Dangeh Publishing.

[12] Chavira, D. A., Drahota, A., Garland, A. F., et al. (2014). Feasibility of two modes oftreatment delivery for child anxiety in primary care. Behavior Research and Therapy, 60, 60–66.

[13] Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: Access, effectiveness and efficiency Narrative literature review. British Journal of Psychiatry, 186 (1), 11–17.

[14] Last, C. G., Hansen, C., & Franco, N. (1998). Cognitive-behavioral treatment of school phobia. Journal of the American Academy of Child and Adolescent Psychiatry, 37 (4), 404–411.

[15] Hudson, J. L., Keers, R., Roberts, S., et al. (2015). Clinical predictors of response to cognitive-behavioral therapy in pediatric anxiety disorders: The genes for treatment (GxT) study. Journal of the American Academy of Child and Adolescent Psychiatry, 54 (6), 454–463.

[16] Compton, S. N., Peris, T. S., Almirall, D., Birmaher, B., Sherrill, J., Kendall, P. C., et al. (2014). Predictors and moderators of treatment response in childhood anxiety disorders: results from the CAMS trial. Journal of Consulting and Clinical Psychology, 82 (2), 212e224. http://dx.doi.org/10.1037/a0035458.

[17] Anassis, K., Mendlowitz, S. L., Scapillato, D., Avery, D., Fiksenbaum, L., Freire, M., et al. (2002). Group and individual cognitive-behavioral therapy for childhood anxiety disorders. A randomized trial. Journal of the American Academy of Child & Adolescent Psychiatry, 41 (12), 1423e1430.

[18] Chavira, D., Stein, M., Bailey, K., & Stein, M. (2005). Child anxiety in primary care: prevalent but untreated. Depression and Anxiety, 20 (4), 155e164.

[19] Thirlwall, K., Cooper, P., & Creswell, C. (2017). Guided parent-delivered cognitive behavioral therapy for childhood anxiety: Predictors of treatment response. *Journal of anxiety disorders*, *45*, 43-48.

[20] Cartwright-Hatton, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review, 26* (7), 817-833. doi: 10.1016/j.cpr.2005.12.002.

[21] Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: a randomized clinical trial evaluating child and family modalities. Journal of Consulting and Clinical Psychology, 76 (2), 282e297.

[22] Scharfstein, L., & Beidel, D. C. (2011). Behavioral and cognitive-behavioral treatments for youth with social phobia. Journal of Experimental Psychopathology, 2 (4), 615e628. http://dx.doi.org/10.5127/jep.014011.

[23] Ollendick, T. H., €Ost, L.-G., Reuterski€old, L., Costa, N., Cederlund, R., Sirbu, C., et al. (2009). One-session treatment of specific phobias in youth: a randomized clinical trial in the United States and Sweden. Journal of Consulting and Clinical Psychology, 77 (3), 504.

[24] Spence, S. H., Donovan, C., & Brechman-Toussaint, M. (2000). The treatment of childhood social phobia: the effectiveness of a social skills training-based, cognitive-behavioural intervention, with and without parental involvement. Journal of Child Psychology & Psychiatry & Allied Disciplines, 41 (6), 713e726.

[25] Norton, P. J., & Barrera, T. L. (2012). Tran's diagnostic versus diagnosis-specific CBT for anxiety disorders: a preliminary randomized controlled no inferiority trial. Depression and Anxiety, 29 (10), 874e882.

[26] Crawley, S. A., Beidas, R. S., Benjamin, C. L., Martin, E., & Kendall, P. C. (2008). Treating socially phobic youth with CBT: Differential outcomes and treatment considerations. Behavioural and Cognitive Psychotherapy, 36, 379–389. http://dx.doi.org/10.1017/ S1352465808004542.

[27] Murray, L., Creswell, C., & Cooper, P. J. (2009). The development of anxiety in children: An integrated review. Psychological Medicine, 39 (9), 1413-1423. doi: 10.1017/S0033291709005157.

[28] Essau, C. A., Conradt, J., & Petermann, F. (2000). Frequency, comorbidity, and psychosocial impairment of anxiety disorders in German adolescents. Journal of Anxiety Disorders, 14 (3), 263–279.

[29] Bittner, A., Egger, H. L., Erkanli, A., Jane Costello, E., Foley, D. L., & Angold, A. (2007). What do childhood anxiety disorders predict? Journal of Child Psychology andPsychiatry, 48 (12), 1174–1183.

[30] Bodden, D. H., Dirksen, C. D., & Bögels, S. M. (2008). Societal burden of clinically anxious youth referred for treatment: a cost-of-illness study. Journal of Abnormal Child Psychology, 36 (4), 487–497.

[31] Ipser, J. C., Stein, D. J., Hawkridge, S., & Hoppe, L. (2009). Pharmacotherapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews*, (3).

[32] Creswell, C., & Willetts, L. (2012). *Overcoming Your Child's Fears and Worries*. Hachette UK.

[33] Hudson, J. L., Comer, J. S., & Kendall, P. C. (2008). Parental responses to positive and negative emotions in anxious and no anxious children. Journal of Clinical Child& Adolescent Psychology, 37 (2), 303–313.

[34] Breinholst, S., Esbjørn, B. H., Reinholdt-Dunne, M. L., & Stallard, P. (2012). CBT forth treatment of child anxiety disorders: a review of why parental involvement has not enhanced outcomes. Journal of Anxiety Disorders, 26 (3), 416–424.

[35] Costello, E. J., Egger, H., & Angold, A. (2005). 10-year research update review: the epidemiology of child and adolescent psychiatric disorders: I. Methods and public health burden. Journal of the American Academy of Child & Adolescent Psychiatry, 44 (10), 972–986. Creswell, C.

[36] Higa-McMillan, C. K., Francis, S. E., Rith-Najarian, L., & Chorpita, B. F. (2016). Evidence base update: 50 years of research on treatment for child and adolescent anxiety. Journal of Clinical Child & Adolescent Psychology, 45 (2), 91–113.

[37] James, A., James, G., Cowdrey, F., Soler, A., & Choke, A. (2013). Cognitive behavioral therapy for anxiety disorders in children and adolescents (p. CD004690). http:// dx.doi.org/10.1002/14651858.CD004690.pub3. The Cochrane Database of Systematic Reviews, 6.

[38] Copeland, W. E., Angold, A., Shanahan, L., & Costello, E. J. (2014). Longitudinal patterns of anxiety from childhood to adulthood: The Great Smoky Mountains Study. Journal of the American Academy of Child & Adolescent Psychiatry, 53, 21–33.

[39] Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. Journal of Consulting and Clinical Psychology, 66, 7–18.

[40] Benjamin, C. L., Harrison, J. P., Settipani, C. A., Brodman, D. M., & Kendall, P. C. (2013). Anxiety and related outcomes in young adults 7 to 19 years after receiving treatment for child anxiety. Journal of Consulting and Clinical Psychology, 81, 865–876. http:// dx.doi.org/10.1037/a0033048.

[41] Gibby, B. A., Casline, E. P., & Ginsburg, G. S. (2017). Long-term outcomes of youth treated for an anxiety disorder: A critical review. Clinical Child and Family Psychology Review, 20, 201–225. http://dx.doi.org/10.1007/s10567-017-0222-9.

[42] Nauta, M. H., Scholing, A., Emmelkamp, P. M., & Minderaa, R. B. (2003). Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: no additional effect of a cognitive parent training. Journal of the American Academy of Child & Adolescent Psychiatry, 42 (11), 1270–1278.

[43] Ollendick, T., & King, N. (2011). Empirically supported treatments for children and adolescents: Issues and commentary. In P. C. Kendall (Ed.). Child and adolescent therapy: Cognitive-behavioral procedures (4th ed., pp. 499-520). New York: Guilford Press.