A Retrospective Examination of the Similarity Between Clinical Practice and Manualized Treatment for Childhood Anxiety Disorders

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The objective of this study was to facilitate the bidirectional communication between researchers and clinicians about the treatment of childhood anxiety disorders, including obsessive-compulsive disorder. Forty-four children were assessed before and after cognitive behavioral treatment with the parent versions of the Spence Child Anxiety Scale and Child Sheehan Disability Scale. In this retrospective study, treatment sessions were coded for the presence of exposures, relaxation, anxiety management, and behavior management. Results showed improved functioning within the clinical sample and suggested that treatment could be shorter, with exposure exercises implemented earlier in the course of treatment than described in manuals. Moreover, improvements in functioning were positively related to the use of exposures, and negatively related to the use of other anxiety management strategies. These results are discussed in the context of efforts to increase the availability of evidence-based treatments and are interpreted as supporting the development of more flexible treatment manuals.

Epidemiological data suggest that anxiety disorders are the most common disorders in childhood (Merikangas & Avenevoli, 2002) and place children at increased risk for other forms of dysfunction (Merikangas & Avenevoli, 2002). Fortunately, efficacious treatments, including cognitive behavioral therapy (CBT), have been identified for a variety of childhood anxiety disorders, including obsessive-compulsive disorder (Abramowitz, Whiteside, & Deacon, 2005; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; In-Albon & Schneider, 2007; POTS, 2004; Walkup et al., 2008). Despite the proliferation of treatment manuals to disseminate the use of CBT, evidence-based behavior therapy is not widely available in community outpatient settings (Goisman, Rogers, Steketee, Warshaw, et al., 1993; Goisman, Warshaw, & Keller, 1999; Storch et al., 2007; Valderhaug, Gotestam, & Larsson, 2004). As a result of the limited availability of behavioral interventions, the effectiveness of treatment in clinical settings has been found to be significantly lower than the efficacy of treatment in research labs (Weisz, Donenberg, Han, & Weiss, 1995; Weisz & Jensen, 2001).

One reason for the lack of availability of evidence-based behavioral therapy is that practitioners in the community infrequently use these approaches. For instance, almost 70% of clinicians report rarely or never using treatment manuals, often citing concerns regarding the perceived length and lack of flexibility of these protocols (Addis, 2002; Addis & Krasnow, 2000). The treatment of anxiety disorders provides a clear illustration of this disconnect between researchers and practitioners. Although there are multiple manuals describing the implementation of evidence-based procedures for childhood anxiety disorders, including obsessive-compulsive disorder (OCD; e.g., Kendall, 2000; March & Mule, 1998), these procedures are rarely used in community settings (Storch et al., 2007; Valderhaug et al., 2004).

The responsibility for increasing the use of empirically based interventions may not rest solely with the practitioner. Despite the fact that many researchers emphasize the importance of exposures (Barlow, 1988; Beidel, Turner, & Morris, 2000; Davis & Ollendick, 2005; Kazdin & Weisz, 1998; Kendall et al., 2005; Marks, 1969; Silverman & Kurtines, 1996), many manualized treatments for childhood anxiety do not clearly deliver this message. Instead, most manuals begin with anxiety management skills (e.g., cognitive restructuring, relaxation training) before beginning exposures. For example, the most recognizable treatment for childhood anxiety disorders, The Coping Cat (Kendall, 2000), begins with eight sessions to develop an anxiety management plan,
followed by eight sessions of graduated exposures. Manuals for the treatment of OCD follow a similar format, although exposure exercises are typically initiated as early as the fourth session (e.g., March & Mulle, 1989). Although other treatments place a clear emphasis on exposures (Beidel et al., 2000; Chorpita, 2007), the manuals that have been held up as the standard for the field in randomized controlled trials, and thus likely receive the most press, have followed a format of cognitive work followed by exposure (e.g., Walkup et al., 2008).

When faced with a multifaceted treatment program without guidelines regarding which components are the most effective, it is perhaps understandable that clinicians view manualized treatments as long and inflexible. As a result, practitioners may decide to select a limited number of CBT techniques and end up focusing on non-exposure-based strategies that are less distressing (for patient and therapist) and easier to administer in the office. In fact, even practitioners who endorse using CBT also report rarely using exposures and instead focus more on cognitive techniques and relaxation (Freiheit, Vye, Swan, & Cady, 2004; Goisman et al., 1993; Valderhaug et al., 2004). This is unfortunate given that a recent review of meta-analyses of treatments for adult anxiety concluded that there is strong support for behavioral treatment (e.g., exposures) but that, at least for some disorders, there does not appear to be increased benefit from adding cognitive techniques (Deacon & Abramowitz, 2004).

To overcome these obstacles, multiple researchers have encouraged the conduction of treatment outcome research by front-line practitioners and clinics with an increased focus on external validity (Addis, 2002; Green, 2008; Hatgis et al., 2001; Weisz et al., 1995). Consistent with this approach, the current study examines the content of clinic-based treatment for childhood anxiety disorders in an effort to influence clinicians and researchers to develop and implement flexible empirically based treatments. Specifically, the content of clinic-based treatment was compared to prominent protocols for the treatment of childhood anxiety disorders and OCD. In addition, the relation between therapeutic techniques and treatment outcome, measured by symptom reduction and improvement in functioning, was also examined. It was hypothesized that clinic-based treatment would be shorter in duration and include exposure exercises earlier in the course of treatment than published protocols while achieving significant symptom improvement. In addition, it was predicted that the degree to which exposures were used in treatment would be positively related to the amount of symptom improvement. Finally, exploratory analyses were conducted to investigate factors that might influence the use of treatment techniques.

Methods

Participants

Data regarding 43 child patients (21 male, 48.8%) ranging in age from 6 to 18 (M=11.59, SD=3.2) seen in an outpatient clinic between January 2005 and March 2008 were extracted from an IRB-approved clinical database. Patients were selected on the basis of having questionnaires regarding anxiety symptoms completed before and after treatment. A wide age range was preserved to reflect the variability in patients likely to be treated for anxiety. The majority of children were Caucasian (34, 79.1%; 14.0% unidentified). Parents were predominantly married (37, 86.0%) and had a 4-year degree (33, 80.5%). Diagnoses were made by a doctoral-level clinical psychologist or child psychiatrist after an evaluation as part of regular clinical practice. Diagnoses for all patients were determined consistent with the criteria outlined in the DSM-IV (American Psychiatric Association, 1994).

The majority of the patients had a primary anxiety disorder (40, 93.0%) and many had multiple diagnoses (28, 65.1%). The most common primary diagnoses were OCD (20, 46.5%) and generalized anxiety disorders (6, 14.0%). Although the majority of patients had at least one non-OCD anxiety disorder (51, 72.1%), children with a primary OCD diagnosis were examined separately for some analyses to remain consistent with common research practices (e.g., In-Albon & Schneider, 2007). Although OCD is an anxiety disorder, for the sake of parsimony these groups will be referred to as the Anxiety and OCD groups throughout this report.

Setting

The patients were seen in a child anxiety disorders clinic that is part of a Department of Psychiatry and Psychology within a midwestern medical center. The anxiety clinic is known within the region for behavioral therapy for anxiety disorders, particularly OCD, and receives referrals from psychiatrists, other physicians, therapists, and families. The majority of the patients are covered by third party payers, including the medical system’s health plan and outside insurers. The institution is a teaching hospital that includes a psychiatry residency and psychology postdoctoral fellowship. Clinical notes are maintained in an electronic medical record.

Treatment

Treatment was provided by one of four therapists: a licensed doctoral-level clinical psychologist specializing in the treatment of childhood anxiety disorders, a postdoctoral clinical psychology fellow, or one of two master’s-level therapists. The care of all the patients was coordinated and supervised by the licensed doctoral psychologist. All therapists had detailed knowledge of and
experience using treatment manuals (i.e., Chorpita, Taylor, Francis, Moffitt, & Austin, 2004; Kendall, 2000) and provided CBT including exposure.

**Data Collection**

Information regarding treatment was gathered through a retrospective chart review under an IRB-approved protocol. The data coding began with a psychiatry resident and a medical student independently reviewing the patient's medical records. These reviewers and the clinical psychologist then prepared guidelines for coding the medical records based on the study hypotheses and the type of information that was typically available in the therapy notes. This process resulted in four categories:

- **Exposures**—intentional prolonged exposure to a feared stimulus;
- **Relaxation**—use of physiological exercises, such as diaphragmatic breathing, to reduce anxiety;
- **Anxiety management**—methods for handling anxiety other than exposures or relaxation, such as psychoeducation or cognitive restructuring;
- **Behavior management**—working with parents to use behavioral principles to encourage behavior change including time-out, active ignoring, or reward systems.

A category was endorsed if the therapist documented implementing the technique in the session or assigning it for homework.

The data were coded by the medical student using the above criteria. To determine the reliability of the coding, five patients (11%) encompassing 39 sessions were also coded by the psychiatry resident. The agreement between the two coders was 88.72%. The items on which the coders disagreed were reviewed with the psychologist who (blind to the original coders' decision) agreed with each coder 50% of the time. Following this process, the medical student re-reviewed all of the ratings and made changes as needed to ensure that all sessions were coded in a manner consistent with the final conceptualization of the categories. In addition, the length of treatment was documented as the number of sessions between pre- and posttreatment assessment and the session in which exposures were first used was recorded.

The outcome of treatment was measured through the parent report forms described below. Parents initially completed these forms as part of an assessment before or just after the initial consultation. The forms were completed again when the therapist, patient, and parent decided that treatment was completed.

**Measures**

*Spence Child Anxiety Scale for Parents (SCAS-P; Nauta et al., 2004)*

The SCAS-P was developed to correspond closely to the items of the Spence Children’s Anxiety Scale (Spence, 1998). The SCAS-P includes 38 items designed to measure anxiety in children and adolescents. The SCAS-P yields six basic scales: panic attack and agoraphobia, separation anxiety disorder, physical injury fears, social phobia, obsessive-compulsive disorder, and generalized anxiety disorder. Only the total score was included in the current study. Psychometric properties, including satisfactory to excellent internal consistency as well as convergent and divergent validity, have been established (Nauta et al.).

*Child Sheehan Disability Scale—Parent version (CSDS; Whiteside, 2009)*

The CSDS-P was designed to measure the extent to which a child's anxiety symptoms interfere with a child's and parent's daily functioning. The CSDS-P is an adaptation of the Sheehan Disability Scale (SDS; Sheehan, 1986) and consists of items inquiring about the degree to which the child's anxiety symptoms interfere with school and social functioning, as well as the parent's work, social, and family functioning. As on the SDS, items are measured on an 11-point Likert-type scale ranging from 0 (not at all) to 10 (very, very much). The CSDS-P includes five items, two items that assess the degree to which the parents perceive the child's anxiety symptoms to be interfering with the child's functioning and three items that assess the degree to which the child's symptoms are viewed as interfering with the parent's functioning. The psychometric properties of the CSDS-P are supported by a factor analysis, and correlations with a child-report version (.60), the interference scale from a structured diagnostic interview (.32), and a measure of family functioning (.45), as well as group differences between clinical and community patients, and sensitivity to treatment (Whiteside, 2009).

**Treatment Protocols**

Since OCD and other anxiety disorders are typically addressed independently in treatment research, two manuals were used to represent recognizable empirically based treatment protocols. Kendall's Coping Cat manual for childhood anxiety disorders was used as the standard for the anxiety group (Kendall, 2000). The treatment protocol OCD in Children and Adolescents: A Cognitive Behavioral Treatment Manual (March & Mulle, 1998) was used as the standard for the OCD group. The following three values were extracted from each manual (Coping Cat, OCD respectively): the total number of prescribed sessions (16, 20); the percentage of sessions that prescribed using exposures (44%, 80%), relaxation (56%, 0%), and anxiety management (75%, 25%); and finally, the earliest session in which the implementation of exposure techniques was recommended (10, 4).
Analyses

The content of the clinic-based treatment is described in terms of percentages of sessions that included each technique. Specifically, for each patient the number of sessions that included each technique were totaled and divided by the number of sessions that the patient received between the completion of the pretreatment and the posttreatment questionnaires. The mean percentage of sessions including each technique was then compared to percentages of sessions prescribing that technique in published manuals through single sample t-tests. In addition, the average session in which exposures were first implemented (e.g., first, second, etc.) was compared to the session number in the manuals in which exposures were first recommended using single sample t-tests. To determine if the clinic-based treatment was effective, two repeated measures analyses of variance were conducted with diagnostic group (Anxiety vs. OCD) as a between-subjects variable and the outcome measure at pre- and posttreatment (i.e., SCAS-P or CSDS-P) as the within subject variable. Finally, correlational analyses were used to explore the relation between frequency of using each therapeutic technique and treatment outcome as well as initial symptoms.

Results

Treatment Descriptions

The first round of data analysis was conducted to describe the nature of the treatment provided and examine how this compared to the treatment manuals. Since there are different commonly accepted manuals for the treatment of OCD versus the other anxiety disorders, these groups were examined separately for these analyses. Single sample t-tests were used to compare the current treatment to the protocol described in the published manuals. The percentage of sessions that included the various strategies is presented in Table 1. All but one patient were considered treatment completers.

<table>
<thead>
<tr>
<th>Table 1 Percentage of Use and Correlations Between Treatment Components</th>
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<tbody>
<tr>
<td>% use</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Exposures</td>
</tr>
<tr>
<td>Relaxation</td>
</tr>
<tr>
<td>Anx. Mgmt</td>
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<tr>
<td>Beh. Mgmt</td>
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</table>

Note. * The first values represents the percentage of session that included each component in the Anxiety group followed by the percentage of use in the OCD group.

Anxiety Disorders

As hypothesized, the length of treatment for non-OCD anxiety disorders ranged from 3 to 18 sessions with an average of 9.22 (SD=4.3) sessions, which was significantly less than the 16 sessions in the Coping Cat manual, t(22)=7.59, p<.05. The most common technique employed by the therapists was non-exposure anxiety management techniques, including cognitive restructuring, followed by exposures. Although the frequency in which exposures were used (48%) did not differ from the session outline in the Coping Cat (44%), the session in which they were first implemented did, session 3.20 vs. 10 in the manual, t(14)=16.80, p<.05. Further, the percentage of sessions using relaxation strategies was significantly lower in the current sample than the manual (8% vs. 56%), t(22)=18.57, p<.05, while the use of other anxiety management strategies did not differ, 67% vs. 75% in the manual.

OCD

A similar pattern was observed when comparing the treatment that the patients with OCD received to the protocol presented in the OCD manual. As hypothesized, the length of treatment for patients with OCD ranged from 6 to 20 sessions with an average of 12.6 (SD=3.6) sessions, which was significantly less than the 20 sessions in the OCD manual, t(19)=9.11, p<.05. The most common technique employed by the therapists was exposures followed by non-exposure anxiety management techniques including cognitive restructuring. Consistent with our hypothesis, the session in which exposures were first implemented differed from the session outline in the OCD manual, session 2.6 vs. 4, t(19)=10.47, p<.05. While the percentage of sessions using relaxation strategies did not differ (1% vs. 0%), the percentage of sessions using other anxiety management strategies was significantly greater in the current sample (46% vs. 25%), t(19)=5.80, p<.05, and the percentage of sessions in which exposures were used (72%) was significantly less than that outlined in the manual (80%), t(19)=2.56, p<.05.

Since treatment techniques can be used concurrently, correlational analyses were conducted to examine the relations between the percentages of sessions in which each were implemented. As the pattern of results was similar within the anxiety disorders and OCD groups, the combined results are presented in Table 1. The frequency of implementing anxiety management strategies was positively correlated with the use of relaxation strategies and negatively correlated with the use of exposures.

Treatment Outcome

To examine the effectiveness of treatment, separate mixed factorial design repeated-measures analyses of variance were conducted with the pre- and posttreatment
scores on the SCAS-P or CSDS-P as within-subject factors and diagnosis type (OCD vs. anxiety disorders) as the between-subject factor. The results of the first analysis indicated a significant effect for SCAS-P, \( F(1, 40) = 81.40, p < .05 \), a nonsignificant main effect of group, \( F(1, 40) = 1.87, p > .10 \), and a nonsignificant group-by-SCAS-P interaction, \( F(1, 40) = 0.20, p > .10 \). Similarly, the main effect of CSDS-P was significant, \( F(1, 41) = 83.44, p < .05 \), while the main effect of group, \( F(1, 41) = 0.00, p > .10 \), and the group-by-CSDS-P interaction, \( F(1, 41) = 1.07, p > .10 \), were nonsignificant. These analyses indicate that the anxiety and functioning scores improved from pre- to posttreatment for both OCD and anxiety disorder patients. Given the lack of a main effect of diagnosis or interaction between diagnosis and outcome, the results are presented for the entire sample, rather than each group separately.

As expected, treatment was effective in reducing anxiety and increasing functioning. The pre- and posttreatment means, as well as effect sizes, are presented in Table 2. Effect sizes were computed by subtracting the posttreatment score from the pretreatment score and dividing by the pooled standard deviation. Cohen (1977) suggested that effect size magnitudes of 0.20, 0.50, and 0.80 correspond to small, medium, and large effects, respectively. The average posttreatment SCAS-P score is more similar to mean scores for nonanxious children (11.8 to 16.0 depending on age and gender), than anxious children (30.1 to 33.0; Nauta et al., 2004).

Correlational analyses were conducted to examine the relation between therapeutic procedures and treatment outcome. These results (Table 3) indicate that improvement in anxiety scores were unrelated to the percentage of sessions in which any of the techniques were used. In contrast, improvements in functioning were positively related to the percentage of sessions in which exposures were used, and negatively related to the use of other anxiety management strategies, such as cognitive restructuring. Additionally, tests of differences between dependent correlations indicated that the correlation between change in functioning and percentage of sessions that used exposures was significantly different than the correlation with relaxation, \( t(40) = 2.41, p < .05 \), and with anxiety management, \( t(40) = 2.53, p < .05 \).

Factors Related to Treatment Technique

To examine factors affecting the use of therapeutic strategies, correlations were computed between the initial SCAS-P and CSDS-P scores on one hand and the percentage of sessions that used each technique on the other hand. These analyses are presented in Table 3 and indicate that the CSDS-P at the initial assessment was negatively related to use of anxiety management strategies and positively related to parent management strategies.

Discussion

The first goal of this study was to compare the structure of treatment administered in a clinical practice to that described in prominent treatment manuals. These analyses indicated that the intervention provided in this clinical setting was shorter and introduced exposures earlier than what is prescribed in the published manuals. In addition, relaxation strategies were rarely used clinically despite their prevalence in the anxiety but not the OCD treatment manual. Although, anxiety management strategies were used more frequently in the OCD group, this difference is likely spurious, arising because these strategies are not specifically mentioned in the later sessions of the manual, but their use may be implied in conjunction with exposures (March & Mulle, 1998). Similarly, the lower rate of exposures in the OCD treatment is likely related to the shorter duration of treatment in the clinical sample. Overall, these findings suggest that, at least for some children suffering from anxiety and OCD, effective CBT can be administered in a manner that is shorter and more flexible than what is described in the most prominent manuals.

The second goal of the study was to use data from clinical practice to help clinicians determine which aspects of CBT are most important. In this regard, mixed support was found for the hypothesis that

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**Table 2**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pretreatment M (SD)</th>
<th>Posttreatment M (SD)</th>
<th>N</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCAS-P Total</td>
<td>35.69 (15.2)</td>
<td>17.74 (8.2)*</td>
<td>42</td>
<td>1.47</td>
</tr>
<tr>
<td>CSDS-P Total</td>
<td>25.47 (11.8)</td>
<td>8.98 (6.6)*</td>
<td>43</td>
<td>1.72</td>
</tr>
</tbody>
</table>

Note: SCAS-P=Spence Child Anxiety Scale for Parents; CSDS-P=Child Sheehan Disability Scale—Parent version. * \( p < .05 \).

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**Table 3**

<table>
<thead>
<tr>
<th>Technique and Symptoms</th>
<th>Pre- to Posttreatment Change</th>
<th>Initial Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SCAS-P</td>
<td>CSDS-P</td>
</tr>
<tr>
<td>Total exposures</td>
<td>.08</td>
<td>.32*</td>
</tr>
<tr>
<td>Total relaxation</td>
<td>.05</td>
<td>-.24</td>
</tr>
<tr>
<td>Anx. Mgmt</td>
<td>-.21</td>
<td>-.36*</td>
</tr>
<tr>
<td>Beh. Mgmt</td>
<td>.23</td>
<td>.21</td>
</tr>
</tbody>
</table>

Note: Anx. Mgmt=Anxiety management including cognitive restructuring and nonexposure techniques; Beh. Mgmt=Behavior management, working with parents on managing children’s behaviors; SCAS-P=Spence Child Anxiety Scale for Parents; CSDS-P=Child Sheehan Disability Scale—Parent version. * \( p < .05 \).
exposures would be most closely related to outcome. Specifically, although reduction in anxiety symptoms was not related to the use of any of the treatment components, improvement in functioning was positively related to use of exposures. This pattern of results may indicate that the emphasis on action inherent in exposures may have a particular advantage compared to other techniques for increasing functioning more so than reducing anxiety. Alternatively, the use of the anxiety total score, rather than symptom specific scores (i.e., the Social Phobia scale for children with social phobia), and reliance on parent report may have masked variability in changes on targeted symptoms, especially those internally experienced by the child.

Surprisingly, the use of non-exposure anxiety management techniques was negatively related to improvement in functioning. This suggests that the more clinicians use anxiety management techniques, such as cognitive restructuring, the lower the improvement in the child’s functioning will be at the end of treatment. This negative relation may stem from the fact that the use of non-exposure-based anxiety management techniques was also negatively related to the use of exposures. That is, the more time the therapist spent doing anxiety management, the less time he or she dedicated to exposure exercises, and perhaps as a result patients made less improvement in functioning. Extensive data regarding how clinicians decided to use different treatment techniques were not available; however, when treating patients with more initial dysfunction, the clinicians were more likely to use behavioral management and less likely to use anxiety management strategies.

As this study is an attempt to appeal to researchers and clinicians alike, it will certainly fall short of meeting the expectations of either group. From a researcher’s standpoint, as a retrospective chart review the data regarding treatment components was limited to information in chart notes, which may be incomplete. In addition, since a criterion for inclusion was the completion of pre- and posttreatment assessment measures, the sample was biased to treatment completers. Thus, the interventions received by those who dropped out of treatment cannot be ascertained. In addition, since patients were not randomly assigned to treatment, it is possible that a third variable, such as nonspecific treatment effects, accounts for the observed relation between treatment components and outcome. Finally, although it appears that the current treatment was effective enough to significantly reduce anxiety to levels similar to nonclinical means, it is impossible to determine how this improvement compares to a structured manual or a no-treatment control.

From a clinician’s standpoint the cognitive behavioral therapists in this study represented a limited slice of theoretical orientations. In addition, the therapists were part of a specialty anxiety clinic and had considerable knowledge of manual-based treatments. Thus, the treatment providers are likely unrepresentative of many clinicians in nonresearch settings. Finally, information was limited to parent report, which may be less sensitive to a child’s internal experience of anxiety. It is unknown whether child report might be more sensitive to differences in treatment technique.

Although these limitations prevent one from concluding that shorter, more flexible treatment is appropriate for all or even most children with anxiety disorders, they do not negate the primary hypothesis of the study that such treatment is appropriate for some children with anxiety disorders. Specifically, the data from this study suggest that some children respond positively to treatment that initiates exposures as early as the third session and terminates after 9 to 10 appointments. As such, the current study lends some credibility to clinicians’ concerns that manual-based treatments are too long and inflexible (Addis, 2002; Addis & Krasnow, 2000). In addition, the data provide support for the primacy of exposures as the necessary component of CBT for childhood anxiety, including OCD, a finding consistent with many researchers (Beidel et al., 2000; Davis & Ollendick, 2005; Kendall et al., 2005; Silverman & Kurtines, 1996), but inconsistent with community practice (Goisman et al., 1993; Storch et al., 2007; Valderhaug et al., 2004).

This study does not suggest that manual-based treatments should be abandoned and replaced with clinical judgment. Rather, the findings indicate that further research needs to be done to design flexible, evidence-based approaches that emphasize the use of exposures. For example, one promising direction is Chorpita’s (2007) Modular Cognitive-Behavioral Therapy for Childhood Anxiety Disorders, which only requires providing psychoeducation and constructing a fear ladder before implementing exposures. Moreover, treatments need to be flexible enough to address different anxiety symptoms and different levels of severity. Although the current study was able to examine OCD separately from the other anxiety disorders and found that dysfunction was related to technique use, the sample size was not sufficient to differentiate between the remaining disorders. In addition, future research will need to explore the potential effect of age and gender on the sequencing of therapy techniques.

Going forward, what clinical studies lack in methodological control may be offset by potentially large and externally valid sample sizes recruited from the multitudes of children receiving community-based mental health treatment. To maximize the utility of such investigations, methods for prospective data collection will need to be employed. If successful, such detailed information about community practice may help


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