CHILDREN'S MENTAL HEALTH RESEARCH

Quarterly

SPRING 2025 VOL. 19, NO. 2

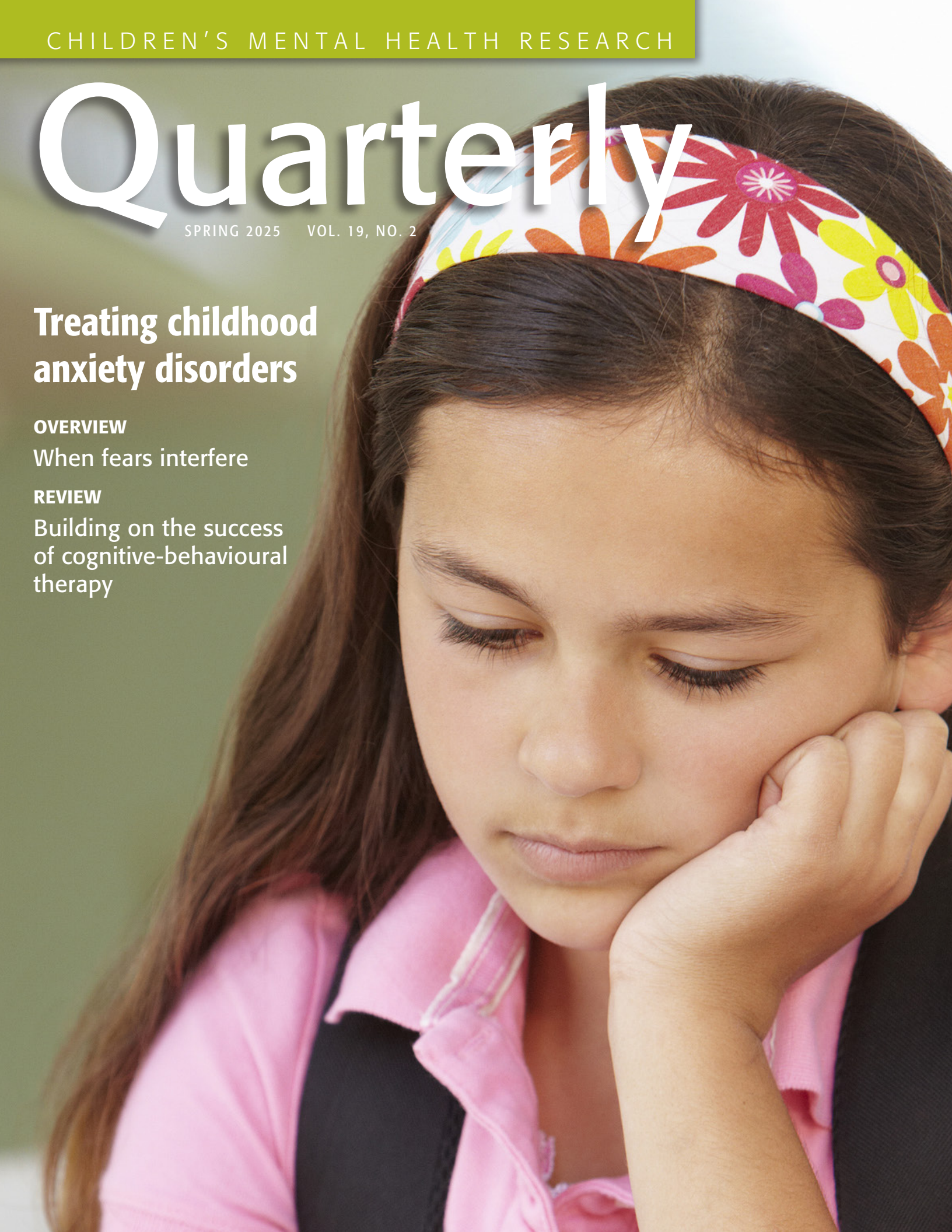
Treating childhood anxiety disorders

OVERVIEW

When fears interfere

REVIEW

Building on the success of cognitive-behavioural therapy



Spring

Quarterly

VOL. 19, NO. 2 2025

Children's Health Policy Centre

About the *Quarterly*

We summarize the best available research evidence on a variety of children's mental health topics, using systematic review and synthesis methods adapted from the *Cochrane Collaboration*. We aim to connect research and policy to improve children's mental health. The BC Ministry of Children and Family Development funds the *Quarterly.*

About the Children's Health Policy Centre

We are an interdisciplinary research group in the Faculty of Health Sciences at Simon Fraser University. We focus on improving social and emotional well-being for all children, and on the public policies needed to reach these goals. To learn more about our work, please see childhealthpolicy.ca.

Quarterly Research Team

Christine Schwartz, PhD, RPsych
Charlotte Waddell, MD, CCFP, FRCPC
Kimberly Thomson, PhD
Jen Barican, MPH
Jessica Tang, BA
Oliver White, BA

Production Editor
Melodie Corbett, BMus

Copy Editor
Naomi Pauls, MPub

Graphic Designer
Warren Clark

COVER: BIGSTOCK_67187794, MONKEYBUSINESSIMAGES

SFU FACULTY OF HEALTH SCIENCES

This Issue

BIGSTOCK_436913978, DOLGACHOV

THE FUTURE OF THE *QUARTERLY*

We regret to announce this will be the last issue of the *Children's Mental Health Research Quarterly* – for now. The Child and Youth Mental Health Policy Branch of the BC Ministry of Children and Family Development was unable to renew our funding. But we will seek other funding so we can continue to encourage the best possible prevention and treatment programs for children in BC and elsewhere. Thank you for sharing this commitment, for reading the *Quarterly* and for being there for children's mental health. All issues of the *Quarterly* and the Subject Index will remain accessible on our website indefinitely, as a resource to assist all those working with children and youth.

How to Cite the *Quarterly*

We encourage you to share the *Quarterly* with others and we welcome its use as a reference (for example, in preparing educational materials for parents or community groups). Please cite this issue as follows:

Schwartz C, White O, Barican J, Tang J, Waddell C, & Thomson K. (2025). Treating childhood anxiety disorders. *Children's Mental Health Research Quarterly*, *19*(2), 1–16. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.

We celebrate the Indigenous Peoples whose traditional lands Quarterly team members live and work on.

OVERVIEW

When fears interfere

Anxiety disorders are the most commonly experienced mental health issue faced by children and youth.

BIGSTOCK_144198341, BJGINNY.

All children experience anxiety. However, for some, anxiety becomes excessive and persistent, interfering with well-being and development. When children's fears last for months and reach a level that disrupts their functioning at home, school or in the community, an anxiety disorder diagnosis may be warranted. And such diagnoses are appropriate for many children, since these disorders are the most common mental disorders among young people.[1] In BC, approximately 42,000 children between the ages of four and 18 will meet criteria for an anxiety disorder at any given time.[1]

All anxiety disorders involve excessive worries and avoidance of a feared situation.[2] What distinguishes each disorder are the specific fears experienced, which can include places, people or situations. Table 1 identifies the diagnostic features of seven common childhood anxiety disorders, including the estimated prevalence for each.[2]

Most children successfully managed challenges without developing any of the assessed anxiety disorders.

Table 1. Common Childhood Anxiety Disorders

Diagnosis	Main symptoms*[2]	Estimated prevalence (%)[1]
Separation anxiety disorder	Extreme worries about being separated from an especially important person, such as a parent	1.6
Selective mutism	Persistent unwillingness to speak in specific social situations, such as with a teacher at school, despite speaking in other situations	Not available
Specific phobia	Marked fear of specific objects or situations, such as seeing blood or being near a dog	3.4
Social anxiety disorder	Excessive anxiety about interacting with peers, fearing negative evaluations, such as being rejected	1.2
Panic disorder	Recurrent, unexpected attacks involving abrupt surges of severe anxiety coupled with symptoms such as sweating, trembling, nausea and fear of dying	0.1
Agoraphobia	Intense fear of being in settings outside the home, such as using public transportation or being in crowds	0.1
Generalized anxiety disorder	Many severe worries, such as receiving poor school grades, accompanied by symptoms including muscle tension, sleep problems and irritability	0.9

* Symptoms must be severe enough to cause clinically significant distress or impairment in functioning.

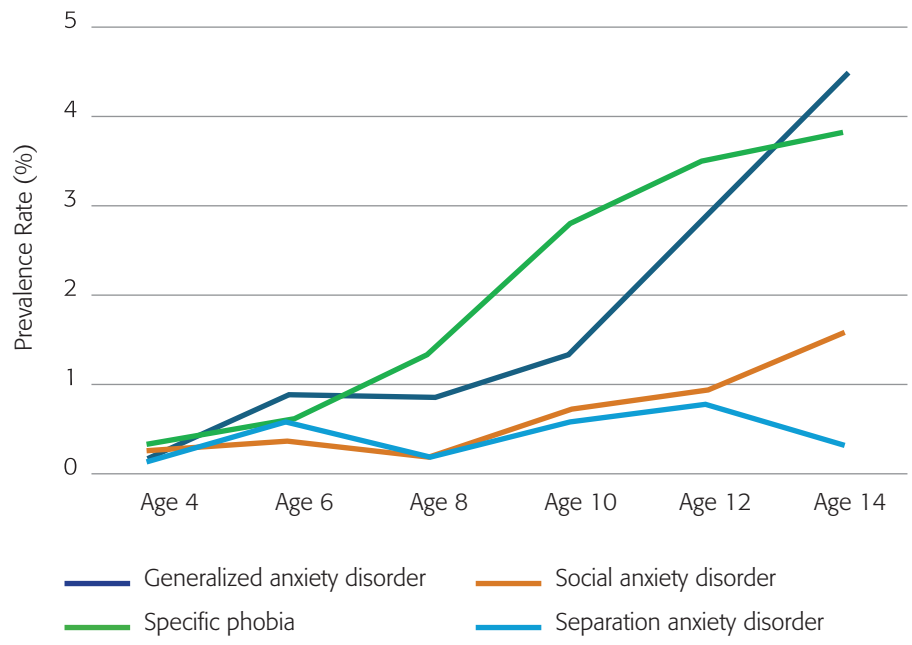
The emergence of anxiety disorders

Young people undergo enormous changes over the course of development. But do their experiences with anxiety disorders also change as they develop? Researchers set out to answer this question by following a large group of Norwegian four-year-olds into adolescence.[3] Researchers ensured participating children were typical of their communities, so results could be applied more widely. Parents, and children when they reached age eight, participated in diagnostic interviews every two years for a decade. The assessed disorders included specific phobia as well as generalized, social and separation anxiety disorders.[3]

Regardless of when a child develops an anxiety disorder, they need rapid access to effective treatments.

The prevalence of these four disorders did change, with most showing increases as children got older, as depicted in Figure 1.[3] For example, specific phobia rates rose slightly every two years. As well, most disorders showed increases from age eight onwards. The study authors suggested that these increases coincided with many children experiencing increasing stressors, such as greater academic challenges. Even so, most children successfully managed challenges without developing any of the assessed anxiety disorders.[3]

Figure 1. Anxiety Disorder Prevalence [3]



Regardless of when a child develops an anxiety disorder, they need rapid access to effective treatments. In the Review article that follows, we examine the latest research evidence on these treatments.

REVIEW

Building on the success of cognitive-behavioural therapy

Helping youth face feared situations, such as public speaking, is important when treating childhood anxiety disorders.

BIGSTOCK_449073459, DANI HOZ

Cognitive-behavioural therapy (CBT) has long been the gold standard for treating childhood anxiety disorders.[4] In fact, high-quality evaluations documenting CBT's success have been accumulating for more than two decades.[5] We previously summarized the benefits of this treatment in a systematic review showing that significantly fewer children met diagnostic criteria for an anxiety disorder after receiving CBT.[6]

Although CBT for anxiety disorders can vary, it typically involves

- educating children and parents about anxiety
- coaching children to reduce physical symptoms of anxiety using techniques such as deep breathing and/or progressive muscle relaxation
- teaching children to challenge unrealistic and unhelpful anxious thinking, and supporting children to practise being in fear-provoking situations (commonly referred to as exposure exercises; please see the sidebar above right for more on the importance of this technique)[7]

Facing fears to overcome them

CBT has long been shown to be an effective treatment for childhood anxiety disorders. But less is known about the impact of the specific techniques used in this treatment. Researchers have addressed this gap by examining findings from 75 studies of CBT.[8] They found that exposing children to feared situations during therapy sessions was associated with better outcomes, compared with versions of CBT that did not include this technique. As well, a dose effect was evident, with more in-session exposure being linked to better outcomes.[8] These findings highlight the importance of including exposure exercises when treating anxious children.

Given the considerable recent research on treating childhood anxiety disorders, we conducted a new systematic review evaluating psychosocial treatments published since our most recent *Quarterly* issue on this topic. (For information on medications used to treat childhood anxiety disorders, please see our previous systematic review.) We used similar inclusion criteria as for our previous review, including requiring studies to use randomized controlled trial (RCT) evaluation methods. We also accepted RCTs comparing CBT to another treatment or comparing different forms of CBT — since this treatment has repeatedly shown success compared to a control group.

After applying our inclusion criteria (detailed in the Methods), we accepted eight RCTs. All eight assessed CBT, comparing it to either no intervention, an educational intervention, another treatment or another form of CBT. We present the finding for the RCT evaluating whether addressing mothers' anxiety improved outcomes when their children had an anxiety disorder in the accompanying sidebar, given the uniqueness of this study.

Does treating mothers' anxiety help anxious children?

A group of researchers set out to answer this question with seven-to-12-year-olds who had anxiety disorders — by adding an intervention for their mothers who also had anxiety disorders.[9] All children received eight individual CBT sessions. Mothers received one of three treatments: CBT for their anxiety disorder, Mother-Child Interaction therapy (focused on parenting to help children cope with anxiety), or a brief healthy lifestyle intervention. None of the added maternal treatments resulted in greater anxiety disorder remission rates for children. This may have been due to success of the CBT provided to the children, most of whom — 68.4% — no longer met criteria for their primary anxiety disorder one year after completing treatment, regardless of the mothers' treatments.[9]

Answering new questions about CBT's effectiveness

Can parents effectively deliver CBT to preschoolers who are highly anxious? To answer this question, parents participated in Cool Little Kids, a six-session group where they learned to deliver CBT to their children. Children participated in separate group sessions focused on social skills.[10] Families in the control group received no intervention.[10]

The study of FRIENDS evaluated whether this CBT program, with and without an added parenting component, could reduce anxiety for children aged seven to 11 with symptoms that interfered with their well-being.[11] Children received either 11 group sessions of FRIENDS or no intervention. Parents of children receiving FRIENDS participated in a nine-session group that included supporting children to use CBT techniques, addressing their own anxiety and learning stress management skills. Parents in the control group received no intervention.[11]

The Coping Cat study compared this CBT program with Child-Centred Therapy among young people aged nine to 14 with anxiety disorders.[12] Young people received 14 individual sessions of either treatment. Children participating in Child-Centred Therapy received non-directive support and encouragement to discuss their feelings. For both treatments, parents or other caregivers participated in two sessions.[12]

The fourth study evaluated the effectiveness of Therapist-Guided Internet-Delivered CBT for young people aged 10 to 17 with social anxiety disorder.[13–14] Young people completed the 10-module online program, which was augmented by three video sessions with a therapist.[14] Parents received a five-module program detailing how to support their child, including avoiding accommodation of children's anxiety. The comparison condition included a 10-module internet program for young people, which provided general support and information on social anxiety, sleep and nutrition. Their parents received a five-module program covering similar content.[14]

The fifth study evaluated whether Skills for Academic and Social Success (SASS) could be successfully delivered by school counsellors to youth with social anxiety disorder.[15] SASS included 14 group and two brief individual sessions as well as four social events for youth. Parents attended two sessions, which provided information about social anxiety and helping their child cope.[15–16] SASS was delivered by either school counsellors or psychologists. Both deliveries were also compared to a group educational program.[15] Table 2 summarizes these five RCTs.

Table 2. Cognitive-Behavioural Therapy (CBT) vs. Control/Comparison Intervention Studies

Program name **Anxiety diagnoses**	**Components**	**Sample size**	**Child ages/grades** (country)
Cool Little Kids + social skills training [10] Specific phobia, generalized anxiety or social anxiety disorder	Parents: 6 group sessions teaching parents to deliver CBT to their children Children: 6 group social skills sessions	72	3 – 5 years (Australia)
FRIENDS	Children: 11 group sessions	61	7 – 11 years (United States)
FRIENDS + parenting group [11, 17–18] Specific phobia, separation anxiety or generalized anxiety disorder*	Children: as above Parents: 9 group sessions†		
Coping Cat [12] Separation anxiety, generalized anxiety or social anxiety disorder	Children: 14 individual sessions Parents: 2 individual sessions†	133	9 – 14 years (United States)
Therapist-Guided Internet-Delivered CBT [14] Social anxiety disorder	Children: 10 internet-based modules augmented by 3 video calls with a therapist Parents: 5 internet-based modules†	103	10 – 17 years (Sweden)
Skills for Academic and Social Success [15–16] Social anxiety disorder	Children: 14 group sessions, 2 individual sessions + 4 social events Parents: 2 group sessions†	138	Grades 9 – 11 (United States)

* All children had symptoms of these disorders that interfered with functioning and 75.4% also met diagnostic criteria for at least one of them.
† These sessions focused on helping parents support their children, including by providing information about the intervention.

CBT's ongoing success

Cool Little Kids plus social skills training resulted in multiple benefits for children. Gains included children being significantly less likely to have an anxiety disorder and having fewer anxiety diagnoses than those in the control group at three-month follow-up.[10] These children also experienced less severe anxiety by clinician rating and fewer anxiety symptoms according to two maternal ratings but not by either paternal rating.[10]

FRIENDS, whether supplemented with a parenting group or not, failed to produce any gains over the control condition at three-month follow-up.[17] At that point, most children no longer met criteria for their primary anxiety disorder and most had not developed a new anxiety disorder, regardless of which group they were assigned to. At 2¾-year follow-up, there were no statistically significant differences between the groups for most outcomes. The exception was symptom severity ratings, which were lower for children who participated in FRIENDS according to parent report only.[18]

CBT can be effectively delivered by a variety of practitioners – including school counsellors, psychologists and social workers.

Coping Cat resulted in significantly fewer children being diagnosed with social, separation or generalized anxiety disorders compared with Child-Centred Therapy at one-year follow-up.[12] In fact, Coping Cat led to more than triple the odds of recovering from an anxiety disorder. As well, a significantly higher proportion of young people who participated in Coping Cat achieved a 35% or greater reduction in anxiety severity. The only anxiety outcome that was not significantly different between the treatments was anxiety symptoms.[12]

Therapist-Guided Internet-Delivered CBT resulted in many gains for youth, including significant reductions in anxiety symptoms and symptom severity compared with the general support program at three-month follow-up.[14] Still, the program made no significant difference in the proportion of youth meeting diagnostic criteria for social anxiety disorder relative to the general support program.[14]

Parents can play an important role in supporting children when they practise being in fear-provoking situations.

BIGSTOCK, SEVENTYFOUR

SASS resulted in multiple positive outcomes. Youth who had the program delivered by school counsellors achieved remission from social anxiety disorder at significantly higher rates than youth in the education group — with nearly five times the odds of having no diagnosis at three-month follow-up.[15] In contrast, no significant difference in diagnostic rates was found for youth who participated in SASS delivered by psychologists compared with youth in the education group. SASS also reduced anxiety symptoms when school counsellors delivered the program, based on one of two youth self-report measures and clinician ratings, but not parent ratings. Psychologist delivery also reduced symptoms, based on youth self-report measures and clinician ratings, but not parent ratings. Symptom severity was also significantly lower for youth who received SASS from either school counsellors or psychologists compared with youth in the education group.[15] Table 3 details the outcomes for all five studies that used control or comparison groups.

Table 3. CBT vs. Control/Comparison Study Results

Program	Follow-up	Anxiety outcomes
Cool Little Kids + social skills training [10]	3 months	↓ Any diagnosis (65.8% CBT vs. 100% no treatment) ↓ Number of diagnoses (1.3 CBT vs. 3.2 no treatment) ↓ Symptoms (2 of 4) ↓ Symptom severity
FRIENDS (with or without parenting group) [11, 17–18]	3 months	NS Primary diagnoses (19.2% CBT vs. 40.0% no treatment) NS New diagnoses (22.2% CBT vs. 29.4% no treatment)
	2¾ years	NS Symptoms (3 of 3) ↓ Symptom severity (1 of 2; Cohen's d [d] = 0.4)
Coping Cat [12]	1 year	↓ Separation, social and/or generalized anxiety diagnoses (17.8% CBT vs. 34.9% Child Centred Therapy; odds ratio [OR] = 3.3) NS Symptoms (2 of 2) ↓ Symptom severity (OR = 2.6)
Therapist-Guided Internet-Delivered CBT [14]	3 months	NS Social anxiety diagnoses (69.4% CBT vs. 82.0% general support) ↓ Symptoms (2 of 2) ↓ Symptom severity (d = 0.7)
Skills for Academic and Social Success [15]	3 months	**School counsellor delivered** ↓ Social anxiety diagnoses (60.9% CBT vs. 88.4% education group) ↓ Social anxiety symptoms (2 of 4; d = 0.4 and OR = 16.2) ↓ Social anxiety symptom severity (d = 0.9) **Psychologist delivered** NS Social anxiety diagnoses (72.3% CBT vs. 88.4% education group) ↓ Social anxiety symptoms (3 of 4; d = 0.3–0.5 and OR = 7.6) ↓ Social anxiety symptom severity (d = 0.8)

↓ Statistically significant benefits favouring intervention over control/comparison condition.
NS No significant difference between intervention and control/comparison condition.

How do different CBT formats compare?

The study of Coping Cat compared individual versus group delivery of the program among young people aged seven to 13 with an anxiety disorder.[19] In both deliveries, children received 12 CBT sessions and parents received two sessions. Children receiving the group delivery participated in three individual sessions before the nine group sessions.[19]

The evaluation of Cool Kids compared the standard version to one with greater emphasis on social anxiety for children and youth aged seven to 16 with social anxiety disorder.[20] While both versions included

10 individual sessions, the modified version provided more training in social skills and on building realistic self-concepts.[20] Table 4 summarizes these two studies.

Table 4. Head-to-Head CBT Study Descriptions

Program name Anxiety diagnoses	Approach	Sample size	Child ages (country)
Coping Cat – Individual delivery	Children: 12 individual sessions Parents: 2 individual sessions	165	7–13 (Norway)
Coping Cat – Group delivery [19] Separation, generalized or social anxiety	Children: 3 individual + 9 group sessions Parents: 2 individual sessions		
Cool Kids – Standard version	Children: 10 individual sessions	200	7–16 (Australia)
Cool Kids – Social anxiety version [20] Social anxiety	Children: 10 individual sessions with a greater focus on social skills		

Coping Cat performed equally well when delivered individually or in group format. At 1¾-year follow-up, the majority of children no longer met diagnostic criteria for their primary anxiety disorder.[19] As well, most children did not meet diagnostic criteria for separation, generalized or social anxiety disorder. Similarly, both formats improved anxiety symptoms equally well.[19]

For Cool Kids, the standard and social anxiety versions produced similar results.[20] Most children no longer met diagnostic criteria for social anxiety disorder at six-month follow-up, regardless of which version they participated in. The two versions also produced similar results on all six anxiety symptom measures.[20] There was, however, one difference between the versions: significantly fewer children who received the social anxiety version had any anxiety disorder diagnosis at six-month follow-up compared with the standard version. Table 5 details the outcomes for both studies.

Table 5. Head-to-Head CBT Study Results

Programs	Follow-up	Anxiety outcomes
Coping Cat: Individual vs. Group Delivery [19]	1¾ years	= Primary diagnoses (18% Individual vs. 9% Group) = Separation, generalized or social anxiety disorder diagnoses (28% Individual vs. 22% Group) = Symptoms (2 of 2)
Cool Kids: Standard vs. Social anxiety version [20]	6 months	= Social anxiety diagnoses (48.8% Standard vs. 31.2% Social Anxiety) ↓ Any anxiety diagnosis (67.5% Standard vs. 47.5% Social Anxiety) = Symptoms (6 of 6)

= Statistically significant improvements that were equivalent between the two treatments.
↓ Statistically significant improvements favouring Social Anxiety version over the standard version.

Learning from the new CBT studies

These new studies provide further evidence of CBT's success in treating childhood anxiety. This includes the finding that CBT is more effective in treating childhood anxiety disorders than other treatments such as Child-Centred Therapy and that its impact can be enduring. This review also showed that CBT can be effectively delivered by a variety of practitioners — including school counsellors, psychologists and social workers.[19] Beyond practitioners, parents of preschoolers can be taught to deliver CBT to their children. Youth can also learn CBT on online and use it to reduce their anxiety symptoms and the severity of them. As well, CBT can be successfully delivered to individuals or groups. This proven psychosocial intervention can also address a variety of anxiety disorders — without needing adaptations for any specific disorder.

Implications for practice and policy

Our findings lead to four recommendations for treating childhood anxiety disorders.

- *CBT continues to be the gold standard for treating childhood anxiety.* This means that practitioners should consider it first when treating children with anxiety — from preschoolers to teens. It also means that policy-makers need to ensure that this treatment is widely available throughout British Columbia.
- *Build on CBT's efficiency for practitioner training.* Similar CBT treatments can be used to treat a variety of anxiety disorders without need for adaptation for any specific disorder. In fact, across the studies we reviewed, programs were typically used to treat children with one of three different anxiety disorders. This means that investments in practitioner training can be efficient, as practitioners will be able to use CBT to treat children regardless of the specific anxiety disorder they are experiencing.
- *Consider the who and where of treatment delivery.* Because parents and school counsellors can successfully deliver CBT, treatment delivery does not need to be limited to mental health clinics. Rather, it can occur in homes and schools. Not only are these settings familiar for children, they are also ideal for creating situations in which children can face their fears, a crucial component of CBT.
- *Build on the success of CBT to reach more children.* Because CBT can be successfully delivered online, it can be offered to children in more remote communities with few or no practitioners. Providing CBT in groups also makes it possible to reach more children.

Increased investments in prevention programs are essential and can reduce the numbers in need.

Anxiety disorders are the most common mental health conditions that children face. These disorders cause significant distress and impede healthy development. Increased investments in prevention programs are essential and can reduce the numbers in need. But for children who do develop an anxiety disorder, CBT is by far the best treatment — and should be readily available to every child in need.

METHODS

We use systematic review methods adapted from the *Cochrane Collaboration*. We build quality assessment into our inclusion criteria to ensure that we report on the best available research evidence, requiring that intervention studies use randomized controlled trial (RCT) evaluation methods and meet additional quality indicators. For this review, we searched for RCTs on programs aimed at treating anxiety disorders in children. Table 6 outlines our database search strategy.

Table 6. Search Strategy

Sources	• Campbell Systematic Reviews, CENTRAL, Cochrane Database of Systematic Reviews, CINAHL, ERIC, Medline and PsycINFO
Search Terms	• Anxiety, anxiety disorder, agoraphobia, generalized anxiety disorder, panic disorder, phobic disorder, selective mutism, social phobia, specific phobia, separation anxiety disorder or social anxiety disorder *and* prevention, intervention, treatment or therapy
Limits	• Published in English between 2018* and 2024 in a peer-reviewed journal • Reported on children aged 18 years or younger • Used systematic review, meta-analysis or RCT methods

* Searches were conducted building on our prior systematic review[6] with search dates from database inception to 2018. We also hand-searched assessed studies published between 2016 and 2018.

To identify additional RCTs, we also hand-searched the reference lists from relevant systematic reviews and previous issues of the *Quarterly*. Using this approach, we identified 240 articles describing 154 studies. Two team members then independently assessed each article, applying the inclusion criteria outlined in Table 7.

Table 7. Inclusion Criteria for RCTs

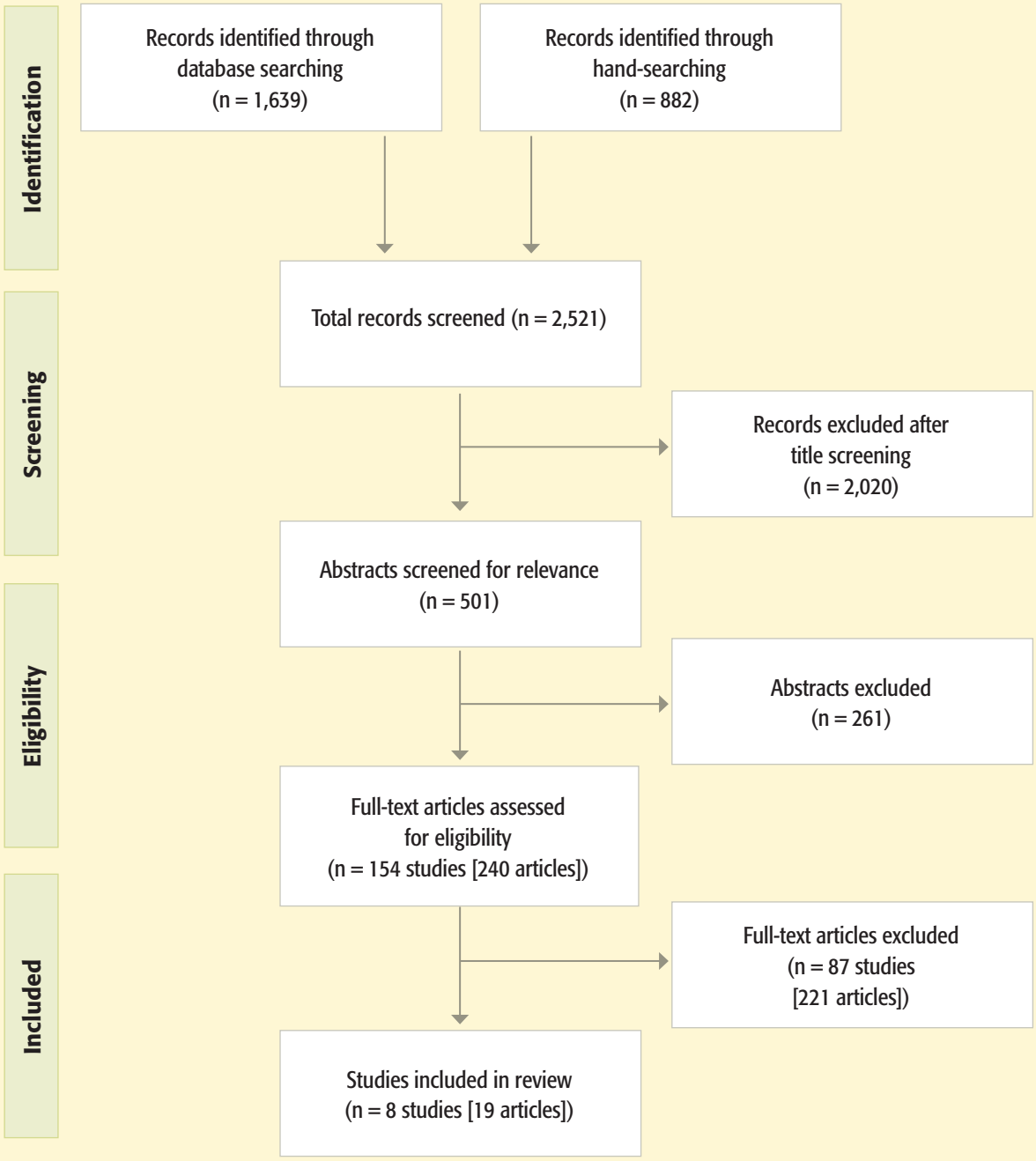
- Participants were randomly assigned to intervention and comparison groups (i.e., no-treatment, treatment-as-usual or active control)
- For head-to-head comparison trials, at least one intervention was already established as being effective in an RCT
- Study authors provided clear descriptions of participant characteristics, settings and intervention
- Interventions were evaluated in high-income countries for comparability to Canadian settings
- Interventions were psychosocial treatments aimed to treat childhood anxiety disorders
- At study outset, most participants had anxiety disorder diagnoses
- Follow-up was three months or more (from the end of the intervention)
- Attrition rates were 20% or less at final assessment and/or intention-to-treat analysis was used
- Child outcome indicators included diagnoses of anxiety disorders
- Child anxiety disorder diagnoses were assessed at follow-up using two or more informant sources
- Reliability and validity were documented for primary outcome measures
- Statistical significance was reported for primary outcome measures
- Studies were excluded where authors indicated insufficient statistical power or no power analysis was conducted

Eight RCTs met all of our inclusion criteria. Figure 2 depicts our search process, adapted from Preferred Reporting Items for Systematic Reviews and Meta-Analyses.[21] Data from these studies were then extracted, summarized and verified by two or more team members. Throughout our process, any differences among team members were resolved by consensus.

For more information on our research methods, please contact

Jen Barican, chpc_quarterly@sfu.ca
Children's Health Policy Centre, Faculty of Health Sciences
Simon Fraser University, Room 2435, 515 West Hastings St., Vancouver, BC V6B 5K3

Figure 2. Search Process for RCTs



RESEARCH TERMS EXPLAINED

Identifying the best available research evidence on how well interventions work for children is crucial in guiding public policy and practice decisions and investments. **Randomized controlled trials** (RCTs) are an important standard in the health sciences for assessing intervention effectiveness. RCTs involve randomly assigning participants to a given group (e.g., intervention or no intervention). The randomization process ensures that every young person enrolled in the study has an equal chance of being assigned to any of the groups. The goal is to create conditions that are fully comparable other than the interventions being evaluated.

To determine how well an intervention works, researchers then analyze relevant child and youth outcomes. Analyses include assessing whether group differences are **statistically significant**. This process gives more certainty that any differences favouring a given intervention were not due to chance. In the studies we reviewed, researchers used the typical convention of having at least 95% confidence that observed results reflected the intervention's real impact.

Beyond determining whether outcomes are statistically significant, it is important to evaluate how much meaningful difference an intervention makes to the young person's well-being — or the intervention's "real life" impact. This outcome, called an effect size, is a quantitative description of the strength of the relationship between the intervention and the outcome. Among those we report on in this issue, **Cohen's *d*** effect sizes are quantified as small (0.20), medium (0.50) or large (0.80). In contrast, **odds ratio** describes the probability of an event occurring, for example, having triple the odds of not meeting criteria for an anxiety disorder after completing cognitive-behavioural therapy compared with Child-Centred Therapy.

By using interventions backed by high-quality research evidence, practitioners and policy-makers can have greater confidence that children will benefit from them.

BIGSTOCK_366768511, SEVENTYFOUR

REFERENCES

BC government staff can access original articles from BC's Health and Human Services Library. Articles marked with * include randomized controlled trial data that was featured in our Review article.

1. Barican JL, Yung D, Schwartz C, et al. (2022). Prevalence of childhood mental disorders in high-income countries: A systematic review and meta-analysis to inform policymaking. *Evidence-Based Mental Health*, *25*, 36–44.
2. American Psychiatric Association (APA). (2022). *Diagnostic and statistical manual of mental disorders: DSM-5-TR* (5thed., text rev.). Washington, DC: APA.
3. Steinsbekk S, Ranum B, Wichstrøm L. (2022). Prevalence and course of anxiety disorders and symptoms from preschool to adolescence: A 6-wave community study. *Journal of Child Psychology and Psychiatry, 63,* 527–534.
4. Schwartz C, Yung D, Barican J, et al. (2020). *Preventing and treating childhood mental disorders: Effective interventions.* Vancouver, BC: Children's Health Policy Centre, Simon Fraser University. https://childhealthpolicy.ca/wp-content/uploads/2022/02/CHPC-Effective-Interventions-Report-2022.02.15-REV.pdf
5. Dadds MR, Holland DE, Laurens KR, et al. (1999). Early intervention and prevention of anxiety disorders in children: Results at 2-year follow-up. *Journal of Consulting and Clinical Psychology*, *67*, 145–150.
6. Schwartz C, Barican JL, Yung D, et al. (2019). Six decades of preventing and treating childhood anxiety disorders: A systematic review and meta-analysis to inform policy and practice. *Evidence-Based Mental Health*, *22*, 103–110.
7. Schwartz C, Waddell C, Barican J, et al. (2016). Helping children with anxiety. *Children's Mental Health Research Quarterly*, *10*(3), 1–16. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.
8. Whiteside SPH, Sim LA, Morrow AS, et al. (2020). A meta-analysis to guide the enhancement of CBT for childhood anxiety: Exposure over anxiety management. *Clinical Child and Family Psychology Review*, *23*, 102–121.
9. Creswell C, Violato M, Cruddace S, et al. (2020). A randomised controlled trial of treatments of childhood anxiety disorder in the context of maternal anxiety disorder: Clinical and cost-effectiveness outcomes. *Journal of Child Psychology and Psychiatry*, *61*, 62–76.
10. * Lau EX, Rapee RM, Coplan RJ. (2017). Combining child social skills training with a parent early intervention program for inhibited preschool children. *Journal of Anxiety Disorders*, *51*, 32–38.
11. * Bernstein GA, Layne AE, Egan EA, et al. (2005). School-based interventions for anxious children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*, 1118–1127.
12. * Silk JS, Tan PZ, Ladouceur CD, et al. (2018). A randomized clinical trial comparing individual cognitive behavioral therapy and child-centered therapy for child anxiety disorders. *Journal of Clinical Child and Adolescent Psychology*, *47*, 542–554.
13. Nordh M, Vigerland S, Öst L-G, et al. (2017). Therapist-guided internet-delivered cognitive-behavioural therapy supplemented with group exposure sessions for adolescents with social anxiety disorder: A feasibility trial. *BMJ Open*, *7*, e018345.
14. * Nordh M, Wahlund T, Jolstedt M, et al. (2021). Therapist-guided internet-delivered cognitive behavioral therapy vs internet-delivered supportive therapy for children and adolescents with social anxiety disorder: A randomized clinical trial. *JAMA Psychiatry*, *78*, 705–713.
15. * Masia Warner C, Colognori D, Brice C, et al. (2016). Can school counselors deliver cognitive-behavioral treatment for social anxiety effectively? A randomized controlled trial. *Journal of Child Psychology and Psychiatry*, *57*, 1229–1238.

16. * Ryan RL, Masia Warner C. (2012). Treating adolescents with social anxiety disorder in schools. *Child and Adolescent Psychiatric Clinics of North America*, *21*, e105.
17. * Bernstein GA, Bernat DH, Victor AM, et al. (2008). School-based interventions for anxious children: 3-, 6-, and 12-month follow-ups. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*, 1039–1047.
18. * Lee SS, Victor AM, James MG, et al. (2016). School-based interventions for anxious children: Long-term follow-up. *Child Psychiatry and Human Development*, *47*, 183–193.
19. * Villabø MA, Narayanan M, Compton SN, et al. (2018). Cognitive-behavioral therapy for youth anxiety: An effectiveness evaluation in community practice. *Journal of Consulting and Clinical Psychology*, *86*, 751–764.
20. * Rapee RM, McLellan LF, Carl T, et al. (2023). Comparison of transdiagnostic treatment and specialized social anxiety treatment for children and adolescents with social anxiety disorder: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, *62*, 646–655.
21. Page MJ, McKenzie JE, Bossuyt PM, et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Journal of Clinical Epidemiology*, *134*, 178–189.

LINKS TO PAST ISSUES

The *Children's Mental Health Research Quarterly* Subject Index provides a detailed listing of topics covered in past issues, including links to information on specific programs.

2025 / Volume 19
1 – Preventing problematic anxiety for youth

2024 / Volume 18
4 – Preventing problematic childhood anxiety
3 – Treating opioid use disorder in young people
2 – Preventing problematic opioid use for young people
1 – Treating childhood eating disorders

2023 / Volume 17
4 – Preventing childhood eating disorders
3 – Treating concurrent mental disorders in children
2 – Preventing concurrent mental disorders in children
1 – Suicide prevention: Reaching young people at risk

2022 / Volume 16
4 – Suicide prevention: Reaching the greatest number of young people
3 – Supporting children after mental health hospitalization
2 – Children's mental health: The numbers and the needs
1 – Helping children with obsessive-compulsive disorder

2021 / Volume 15
4 – Childhood bullying: Time to stop
3 – Fighting racism
2 – Treating posttraumatic stress disorder in children
1 – Helping children cope with trauma

2020 / Volume 14
4 – Helping young people with psychosis
3 – Psychosis: Is prevention possible?
2 – Mental health treatment: Reaching more kids
1 – Prevention: Reaching more kids

2019 / Volume 13
4 – Preventing problematic substance use among youth
3 – Helping youth who self-harm
2 – Celebrating children's mental health: 50 lessons learned
1 – Helping youth with bipolar disorder

2018 / Volume 12
4 – Helping children who have been maltreated
3 – Preventing child maltreatment
2 – Treating substance misuse in young people
1 – Preventing youth substance misuse: Programs that work in schools

2017 / Volume 11
4 – Helping children with depression
3 – Preventing childhood depression
2 – Supporting LGBTQ+ youth
1 – Helping children with ADHD

2016 / Volume 10
4 – Promoting self-regulation and preventing ADHD symptoms
3 – Helping children with anxiety
2 – Preventing anxiety for children
1 – Helping children with behaviour problems

2015 / Volume 9
4 – Promoting positive behaviour in children
3 – Intervening for young people with eating disorders
2 – Promoting healthy eating and preventing eating disorders in children
1 – Parenting without physical punishment

2014 / Volume 8
4 – Enhancing mental health in schools
3 – Kinship foster care
2 – Treating childhood obsessive-compulsive disorder
1 – Addressing parental substance misuse

2013 / Volume 7
4 – Troubling trends in prescribing for children
3 – Addressing acute mental health crises
2 – Re-examining attention problems in children
1 – Promoting healthy dating relationships

2012 / Volume 6
4 – Intervening after intimate partner violence
3 – How can foster care help vulnerable children?
2 – Treating anxiety disorders
1 – Preventing problematic anxiety

2011 / Volume 5
4 – Early child development and mental health
3 – Helping children overcome trauma
2 – Preventing prenatal alcohol exposure
1 – Nurse-Family Partnership and children's mental health

2010 / Volume 4
4 – Addressing parental depression
3 – Treating substance abuse in children and youth
2 – Preventing substance abuse in children and youth
1 – The mental health implications of childhood obesity

2009 / Volume 3
4 – Preventing suicide in children and youth
3 – Understanding and treating psychosis in young people
2 – Preventing and treating child maltreatment
1 – The economics of children's mental health

2008 / Volume 2
4 – Addressing bullying behaviour in children
3 – Diagnosing and treating childhood bipolar disorder
2 – Preventing and treating childhood depression
1 – Building children's resilience

2007 / Volume 1
4 – Addressing attention problems in children
3 – Children's emotional wellbeing
2 – Children's behavioural wellbeing
1 – Prevention of mental disorders

