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Effect of Child-Parent Relationship Therapy on the Severity of Separation Anxiety Disorder in Children: A Clinical Trial with a Parallel Groups Study Design

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Abstract

Background: Separation anxiety disorder (SAD) is one of the most common mental disorders in childhood. Inattention to treat this disorder can be a risk factor for other childhood and adolescence mental disorders.
Objectives: We aimed at investigating the effectiveness of child-parent relationship therapy (CPRT) in children with SAD.
Methods: This quasi-experimental study was conducted in a pre-test and post-test design with a control group. The research population consisted of preschool and first-grade students in primary schools in Zanjan, Iran. Twenty-four mothers whose children were diagnosed with anxiety disorder were selected nonrandomly (volunteers to participate in the research), but they were randomly assigned to the control and intervention groups. The Children's Symptoms Inventory questionnaire (CSI-4) was used to diagnose separation anxiety. Also, the parent-child relationship assessment questionnaire (MCRE), Sherer General Adult Inventory Questionnaire, and Parent Stress Index Questionnaire (PSI) were completed before and after the treatment. The intervention group received ten sessions of 2 hours of group training on CPRT, while the control group did not receive any intervention. One-way analysis of covariance (ANCOVA) and multivariate analysis of covariance (MANCOVA) were used to analyze the data.
***Results*:** The results of covariance analysis showed that the severity of anxiety symptoms were significantly decreased in the experimental group ($p>0.05$). It also reduced mothers' stress (83%), increased mothers' self-efficacy (77%), and improved mother-child relationships.
Conclusion: Child-parent relationship therapy can be an effective intervention in reducing the symptoms of child separation anxiety, and it can be employed as an educational protocol for reducing tension, increasing mothers' self-efficacy, and improving mother-child relationships. Due to the limited sample size of the present study, it is suggested that a study with a larger sample size be conducted to confirm the findings of this study.

Keywords: separation anxiety, parent-child relationship therapy, tension, self-efficacy, mother-child relationship

Introduction

In the primary investigations of psychiatric disorders, anxiety disorder with a rate of 6-18% is one of the most common disorders [1]. Separation anxiety disorder (SAD) is a classical childhood anxiety disorder. Separation anxiety is an

unrealistic and severe anxiety caused by separation from their main attachment figure [2]. The prevalence of this disorder has been reported by about 14% in Iran [3]. Childhood anxiety disorders such as SAD are principal risk factors for other emotional and behavioral disorders, such as adolescence and adulthood anxiety [4,5]. Studies have shown that if children with SAD are not treated early, its negative effects will remain during the individual's life; therefore, efforts to diagnose and treat SAD promptly are necessary [6].

Various treatments, such as individual therapy, behavior therapy, and group therapy, have been suggested to treat anxiety disorders, but these strategies are only effective in the short term [7]. Among psychological treatments, cognitive-behavioral therapy (CBT) has the most research support; however, many children continue to show significant anxiety symptoms after the treatment [8-10]. Several studies have highlighted the role of negative behaviors and negative interactions between parents and the child and the importance of inappropriate parenting in the emergence of child anxiety [11], which indicate that parenting styles and attachment may play an essential role in the development and maintenance of psychopathology in children [12,13]. Parents of anxious children unwittingly reinforce anxious behaviors in children through a pattern of fear, attempts to control child behavior, overprotection, or facilitation of their avoidance behaviors [14,15]. Today, the role of these elements in the etiology and treatment of children's anxiety disorders is paramount.

One of the newest methods for modifying the child's behavior is child-parent relationship therapy (CPRT), which is a game-based therapy for children with behavioral, emotional, social, and attachment disorders. In CPRT, it is hypothesized that a safe relationship with parents is an essential factor for the health and well-being of the child. Parents effectively learn the essential skills to respond to their children's emotional and behavioral needs in a supportive group environment. Children also learn to trust their parents and regularly receive their needs for affection, acceptance, safety, and security [16]. Child-parent relationship therapy intervention is desirable for parents and children since it gives parents the necessary power and skill to work with the child [16,17]. Considering the importance of child-parent relationship in the development of separation anxiety, CPRT can reduce the child's separation anxiety by targeting parent-child interaction.

One of the essential benefits of CPRT is to develop a sense of self-efficacy in the child and parents. Parental self-efficacy is an essential predictor of childcare outcomes and contributes to improved treatment outcomes [18]; it can be considered as parents' beliefs about their ability to behave successfully with their children, strengthening the relationship between the child and the parent and boosting the effects of treatment [19]. Another mechanism of this treatment is using communication games, which reduce children's behavioral and emotional problems. In CRPT, communication improves when parents play with their children and spend time with them. The purpose of these game meetings is to increase the acceptance and empathy of parents with the child. Therefore, playing is an appropriate tool for improving parental relationships with children, which helps address their needs and conflicts. Additionally, CPRT reduces parents' negative feelings, such as parental stress, and diminishes the stress associated with parental roles [20-21].

Although findings point to the role of child-parent relationship in the development of separation anxiety, standard therapies such as CBT do not specifically target parent and child interactions. Besides, CBT does not consider the role of self-efficacy and parental stress. According to the above, CRPT, which focuses on improving parent-child interactions, could result in better outcomes in treating this disorder. Therefore, the present study seeks to investigate the effectiveness of CRPT and its mechanisms in reducing the symptoms of separation anxiety and improving child-parent relationships in children aged 6-7 years.

Methods

This was a clinical trial with a parallel groups study design. The statistical population included all preschool and primary school students in Zanjan, Zanjan Province, Iran (N=28754). In the first phase, 365 people were selected with the nonrandom (Volunteers to participate in the research) sampling method. A battery of

questionnaires evaluating all psychological disorders in children was implemented. Then, the sample was selected based on the inclusion criteria (earning a score of 4 and above on section D of the Child Symptom Inventory-4 (CSI-4), a measure for separation anxiety) and exclusion criteria (the existence of a comorbid psychological disorder in children and mothers with a middle school degree and psychological disorder). In the second phase, the mothers of children who gained a score higher than the cut-off (4 points) in the CSI-4 questionnaire were invited to assess the second stage and diagnose their children's separation anxiety by diagnostic interviews, including DSM-5 (N=76).

We used G * Power software to calculate the sample size. The statistical test was *t*-test for the two independent groups (Input parameters: Tail: one, Effect size (d)= 1,α=0.05, Power=0.75). The calculated parameters were as follows: Critical t=1.70, sample size for each group=12, and total sample size=24.

Twenty-four mothers of children diagnosed with anxiety disorder were selected using the nonrandom sampling method, and they were randomly assigned to the two groups of intervention and control by the permuted block randomization method. Each group included 12 individuals. After selecting the subjects, mothers of both groups responded to the pretest questionnaires, namely CSI-4, mother-child relationship evaluation questionnaire (MCRE), Parent Stress Index Questionnaire (PSI), and Sherer Self-efficacy scale Questionnaire.

After selecting the subjects and obtaining their informed consent, the intervention group took part in CPRT sessions (10 sessions). The treatment was held weekly in two sessions for two hours. The therapist explained the contents of the sessions to the mothers clearly based on the instructions. Role-playing and educational films were used in the meetings (sessions) to resolve the problems and ensure that mothers correctly completed assignments. Also, the assignments related to the previous session were examined at the beginning of each session. The contents of these training sessions are summarized in Table 1.

Table 1: Summary of the Process and Content of Game Therapy Based on CPRT

sessions	Topic	Content
First session	Educational goals and reflective responses	Introducing group members; Describing the goals of teaching CPRT and emphasizing that children use the game to express their experiences, reactions, and feelings; teaching reflexive listening and tracking; role-playing and empathic response exercises; and homework.
Second session	Basic principles for game meetings	Reviewing homework assignments; a more empathetic response plan; explaining the basics and guidelines for 30 minutes of parental cheerleading; a list of toys that are used at certain times of the game; and the homework assignment is given to parents.
Third session	Parent-child play sessions and processes	Reviewing homework assignments; behavioral skills training; presentation a summary of the method of determining the limitations (the main focus of this session is to get prepared for the first 30-minute home-game session); describe the required "should" and "should not" in play sessions for parents.
Fourth session	Monitoring and setting limitations	Each parents' reporting about the first session of the game with their child; reviewing the underlying principles of treatment by the therapist; introducing new teaching materials; designing suggestions on how to respond; displaying the videotape of the parent's play session; teaching the model A (Acknowledge your child's feeling or desire)-C(Communicate the limit) -T(Target acceptable alternatives) in determining the limit; and choosing options.

Fifth Session	View game skills	Teaching freedom to act and help children learn their self-guidance and self-regulation in the fifth session; sessions 5-9: report homework assignments and a brief report of the Parental Game Therapy Session, present and talk about a videotape in one of the parents' meetings, continue to teach and play the role of sessions in each session, and generalize skills to out-of-game situations, address parent concerns about the long-term and critical problems of children who are not involved with game meetings in the last session.
Sixth session	Supervising and electing right	
Seventh session	Supervising, encouragement for acclaim, and constructive self-esteem responses	
Eighth session	Supervising and teaching skills	
Ninth session	Supervising and generalizing skills	
Tenth session	Evaluation and summarization	Parental report from their game sessions; displaying one of the parents' meetings; reviewing the underlying principles of the therapy; evaluating the changes; encouraging the parents to accept their role in changing their children's lives; and encouraging the parents to continue their specific gameplay.

Child Symptom Inventory (CSI-4): Gadow and Sprafkin developed the inventory based on the DSM-IV diagnostic criteria (1994). The questionnaire has two forms for parents and teachers. In this study, the parent form was used. The parent form evaluates 17 disruptions through 97 questions. To identify children with SAD, the form (D) of this questionnaire was used, which has ten questions to be answered by parents. Items are scored on a 4-point Likert scale ranging from 0 (never) to 3 (most often). CSI-4 indicated acceptable convergent validity with the child behavioral model of Akhenbakh and children's diagnostic questionnaire [22]. Besides, the measure showed satisfactory test-retest reliability (r=0.65) over two- and four-month intervals [23]

Mother-child relationship evaluation questionnaire (MCRE): MCRE was edited by Roth (1961). The questionnaire consists of four components, each with 12 questions on child acceptance (A), overprotection (OP), overindulgence (OI), and child rejection (R) [24]. In a study, the mean correlation coefficient between the acceptance scale and non-acceptance scale was -0.55. Zamiri performed a test on 30 people and obtained the following results for the Cronbach's Alpha subscales: Child acceptance=0.77, child rejection=0.72, overindulgence = 0.71, and overprotection = 0.78; Pearson's torque correlations in the first-half scale scores for the second half are as follows: child acceptance= 0.57, overprotection =53.03 and overindulgence=0.41 [24].

Sherer General Self-efficacy questionnaire: This scale has 17 questions; each question's is rated based on a Likert scale ranging from "I strongly disagree" to "I strongly agree." The reliability coefficient of this test was reported to be 0.75 by the Gutman's doubling method and 0.79 by Cronbach's alpha. Also, the correlations obtained with two other self-esteem were used to validate the test construct [25].

Parents Stress Index (PSI) questionnaire: This tool consists of 120 questions with five multiple choices, including 14 individual scales in three areas of childhood (6 scales), parental (7 scales), and one scale for measuring the overall stress of life. The internal consistency through the calculation of Cronbach's alpha for the whole scale was obtained 93.9% in a group of 248 mothers in Hong Kong. This coefficient was 0.85 in children and 0.91 in parents. The reliability coefficient for the total score was 0.88, and the test-retest reliability coefficient with a 10-day interval was 0.94 [26].

Demographic information questionnaire: It included questions about the individual information of children and mothers, such as age, gender, children's school grade, mothers' education, and history of mothers' psychiatric disorders.

Descriptive (mean, standard deviation, frequency, and tables) and inferential statistics were used to analyze the data. Significant differences in demographic variables were investigated in both intervention and control groups using Chi-Square (X^2) test and independent samples t-test. The hedges effect size, which is more suitable for small samples, was used to estimate the effect size of treatment based on CPRT in the intervention

group from the pretest to the posttest stage in reducing the separation anxiety and parent's stress, increasing the self-efficacy of parents, and improving the relationship between parents and the child. In order to compare the intervention and control groups in the dependent variables by controlling the initial differences of the groups in the pretest of the dependent variables, one-way analysis of covariance (ANCOVA) was used for children's separation anxiety and parent's self-efficiency variables. Multivariate analysis of covariance (MANCOVA) was used for parental stress and parent-child relationship variables with multiple components (multilevel). Data were analyzed using SPSS version 20.

Results

The demographic characteristics of the sample in both intervention and control groups are reported in Table 2. According to the Chi-square (X^2) test and independent t-test, the intervention and control groups were homogeneous in terms of demographic variables.

Table 2: Demographic characteristics of the subjects in two groups of intervention and control

Variable		**Intervention group**	**control group**	**X^2**	***P*-value**
		Number (%)	**Number (%)**		
The total sample		12 (100)	12 (100)		
Mother's education	Middle school degree	3 (25)	3 (25)	2.9	0.406
	Diploma	4 (33.3)	5 (41.7)		
	Associate degree	4 (33.3)	1 (8.3)		
	Bachelor	1 (8.3)	3 (25)		
Gender of the child	Boy	4 (33.3)	4 (33.3)	0	1.000
	Girl	8 (66.7)	8 (66.7)		
Child's education	Pre-school	(66.7)	(66.7)	0	1.000
	First grade	4 (33.3)	4 (33.3)		
		M ± SD	**M ± SD**	**T**	***P*-value**
Age of the child (years)		6.3 ± 0.66	6.4 ± 0.46	-0.48	0.637

The mean and standard deviation of the children's separation anxiety, parents' stress, parents' self-efficacy, and child-parent relationship in the intervention and control groups through the pretest and posttest scores are reported in Table 3.

Table 3: The mean and standard deviation of scores of dependent variables in the intervention and control groups

Variables	**Component**	**Stage**	**Intervention group**	**Control group**
			M± SD	**M ± SD**
Separation anxiety		Pretest	13.2 ± 3.4	14.0 ± 2.5
		Posttest	10.1 ± 3.9	13.5 ± 2.6
Parental stress	Stress (mother's territory)	Pretest	150.8 ± 26.7	151.4 ± 11.8
		Posttest	131.4 ± 17.3	151.6 ± 11.3
	Stress (Children's territory)	Pretest	147.3 ± 13.8	142.2 ± 6.6
		Posttest	118.4 ± 12.2	141.5 ± 6.9
Parental self-efficacy		Pretest	52.2 ± 5.8	49.6 ± 4.4
		Posttest	58.3 ± 4.9	49.8 ± 4.1
Parent-child relationship	Acceptance	Pretest	32.9 ± 6.0	33.9 ± 4.3
		Posttest	28.5 ± 4.3	33.2 ± 4.2
	Overprotection	Pretest	41.1 ± 7.5	42.7 ± 6.1
		Posttest	29.9 ± 6.1	42.8 ± 5.7
	Indulgence	Pretest	39.2 ± 6.4	41.3 ± 4.3
		Posttest	30.2 ± 4.0	41.7 ± 4.3
	Child rejection	Pretest	44.1 ± 5.4	48.0 ± 2.7
		Posttest	38.8 ± 1.6	48.3 ± 2.9

The effect size results of CPRT in the intervention group from the pretest stage to the posttest stage indicate a reduction in separation anxiety and parents' stress, increase in parents' self-efficacy, and improvement in parent-child relationship (Table 4). Also, 0.2,

0.5, and 0.8 Hedges' g are reported as small, medium, and large, respectively [27]. The results showed that CPRT significantly reduced children's separation anxiety and parents' stress and improved child-parent relationship and parental self-efficacy.

Table 4: Descriptive statistics and estimation of the effect size of CPRT in the intervention group from pretest to posttest

Variable	Component	Pretest	Posttest	Pre-post
		M ± SD	M ± SD	hedges' g
Separation anxiety		13.2 ± 3.4	10.1 ± 3.9	0.85
Parental stress	Stress (mother's territory)	147.3 ± 13.9	118.4 ± 12.2	2.20
	Stress (children's territory)	150.8 ± 26.7	131.4 ± 17.3	0.86
Parental self-efficacy		52.2 ± 5.8	58.3 ± 4.9	-1.14
Parent-child relationship	Child acceptance	32.9 ± 6.0	28.5 ± 4.3	0.84
	Over protection	41.1 ± 7.5	29.9 ± 6.1	1.64
	Indulgence	39.2 ± 6.4	30.2 ± 4.0	1.7
	Child rejection	44.1 ± 5.4	38.8 ± 1.6	1.33

One-way analysis of covariance (ANCOVA) for comparing children's separation anxiety and parents' self-efficacy and the results of multivariate analysis of covariance (MANCOVA) for comparing parent's stress and the parent-child relationship between the intervention and control groups are reported in Table 5. The main assumptions of ANCOVA were met in this study, except for regression slope coherence ($P<0.05$).

The results of all the four Pillai-Bartlett, Wilks's lambda, Hotelling's Trace, and Roy's Largest Root tests on parents' stress and parent-child relationship showed a significant difference in these variables in between the intervention and control groups ($P <0.01$), which allowed for using MANCOVA in the parent-child relationship and parents' stress variables.

Table 5: Adjusted mean and standard deviation following covariance analysis for comparison between the intervention and control groups

Variable	Component	Adjusted posttests averages after controlling the effect of pretests		*P*-value	η^2
		Intervention group	Control group		
		M ± SD	M ± SD		
Separation anxiety		10.5 ± 0.4	13.1 ± 0.4	0.0001	0.548
Parental stress	Stress(child's)	117.2 ± 2.2	142.9 ± 2.1	0.0001	0.793
	Stress(mother's)	131.7 ± 1.5	151.3 ± 1.4	0.0001	0.819
Parental self-efficiency		57.3 ± 0.53	50.8 ± 0.53	0.0001	0.778
Child-parent relationship	Child acceptance	28.2 ± 1.2	33.4 ± 1.22	0.0001	0.310
	Over protection	30.0 ± 1.6	42.7 ± 1.6	0.0001	0.622
	Indulgence	30.5 ± 0.68	41.4 ± 0.68	0.0001	0.866
	Child rejection	39.4 ± 0.66	47.7 ± 0.66	0.0001	0.799

Analysis of covariance (Table 5) by adjusting the mean of the post-test showed significant differences between the intervention and control groups in separation anxiety ($P <0.0001$), parent's stress ($P <0.0001$), parents' self-efficacy ($P = 0.014$), and parent-child relationship ($P <0.0001$), indicating that CPRT is significantly effective in reducing separation anxiety and parents' stress. Also, the results demonstrated that CPRT, compared to the control group, effectively improves parent-child relationships and parents' self-efficacy.

Discussion

This study was aimed at investigating the effectiveness of CPRT in reducing the severity of

SAD. This study indicated that CPRT reduced the symptoms of separation anxiety by improving the quality of the mother-child relationship, reducing stress, and increasing mothers' self-efficacy. This finding is consistent with the results of Fernandez et al. [28], Cartwright Hatton et al. [11], Chronis-Tuscano et al. [29], and Mostafavi et al. [20]. Research has shown that the engagement of parents in the treatment process increases the positive effects of treatment on the child [30]. This improvement in the health and psychological state of parents affects how the child is treated, and subsequently, has positive consequences for the child. In other words, parents' participation in treatment sessions reduces their stress and helplessness in dealing with problems caused by anxiety symptoms in a child. This has led parents to feel better about their psychological state and better control their harmful behaviors towards their children. Subsequently, this phenomenon also has a beneficial effect on the child's psychological state and reduces his/her anxiety symptoms.

On the other hand, the present study examined the factors that influence the mechanism of treatment effect. This study showed that the participation of mothers in treatment sessions resulted in decreased stress of mothers in the intervention group in both areas of mother and child's territory, but not in the control group. Therefore, CPRT is effective in the reduction of mothers' stress. In several studies, the effectiveness of CPRT has been evaluated, and the results of these studies have shown a significant reduction in parenting stress [14,31,32]. In families with children with behavioral and emotional problems, there is more parenting stress, and there are fewer positive emotions and intimacy in the parent-child relationship.

Our results indicated that CPRT has efficacy in increasing mothers' self-efficacy. After the mothers participated in treatment sessions, their self-efficacy increased significantly compared to control group mothers. Abareshi et al. indicated that psychosocial development program could increase parental self-efficacy in mothers with children under the age of three [33]. Gross et al. also suggested that strengthening parenting skills positively affects parenting self-efficacy [34], which is in line with the present study results. Increasing parental self-efficacy through different parenting programs provides the ability to deal correctly with parenting stress. As a result, the mother's experiences and the confidence she gains with these trainings can boost her self-esteem. CPRT treatment increased child acceptance and reduced child rejection, overprotection, and indulgence in the intervention group. Our results were consistent with studies showing that improving parenting skills improves parent-child communication. A study showed that teaching mothers to deal with children with behavioral and emotional problems and positive parenting programs improved parent-child relationships [35]. According to various studies, it can be believed that changing parent attitudes and parent-child relationship in the game, parent's empathy with the child, and the correct way of the parent regulating with his child, and the weekly attention and time allocated by the parent to play with specific conditions of his child in the model of CPRT, all of which are factors that can improve parent-child interaction.

Conclusion

Based on the results of this study and in light of evidence on the effectiveness of the game therapy [36], due to the small sample size with study power = 0.75, it is suggested to conduct further research on this subject to confirm these findings. Also, it can be suggested that this intervention method can be used in mental health clinics for children and counseling centers in schools and other places related to childcare and education. This program could increase parents' awareness about the principles of good behavior with the child to fewer fewer emotional and behavioral problems. Also, collecting feedback from using this method in centers associated with children could help the researcher make CPRT more effective.

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Conflict of interest

The authors declare no conflicts of interest.

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