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Expectations and perspectives of cognitive behavioural therapy for childhood anxiety and related disorders

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Abstract

Background: Anxiety disorders are the most frequently diagnosed psychiatric conditions in children and adolescents. Cognitive behavioural therapy (CBT) is a well-established and effective treatment for anxiety and related disorders across the lifespan. Expectations of psychotherapy have been demonstrated to affect outcomes, yet there is sparse existing literature on adolescent patient and parent perspectives of CBT prior to engagement with treatment.

Aims: This study aimed to qualitatively explore the expectations and perceptions of CBT for anxiety and related disorders among adolescent patients and parents.

Method: Fourteen adolescent patients and 16 parents participated in semi-structured individual interviews or focus groups consisting of 2–3 participants. Interview transcripts were analysed using inductive analysis.

Results: Three themes were identified: worries about CBT, expectations and knowledge of the CBT process, and the role of parents and families. Overall, we found that adolescents and parents had generally positive views of CBT. The outset of CBT saw adolescents and parents express concern about stigma as well as the ambiguity of CBT. Parents continued to express a lack of understanding of what CBT entailed during their child's treatment course.

Conclusion: These results suggest that both adolescents and parents would benefit from early discussion and reinforcement of expectations for CBT treatment. Further research efforts are warranted and should be directed towards determining appropriate expectations for parental involvement in a child's CBT course and effective communication of treatment expectations to both adolescents and parents.

Keywords: Anxiety disorders; Children and adolescents; Cognitive behavioural therapy; Parents; Patients' perspective

Introduction

Anxiety disorders are the most frequently diagnosed psychiatric conditions in children and adolescents (Merikangas *et al.*, 2009). Seven per cent of children aged 3–17 years are estimated to have an anxiety disorder diagnosis, and 2–3% of youth meet criteria for obsessive-compulsive disorder (OCD) (Ghandour *et al.*, 2019; Zohar, 1999). Anxiety disorders and OCD have been shown

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to have negative effects on youth development and are often associated with functional impairment that can persist into adulthood (Maldonado *et al.*, 2013; Piacentini *et al.*, 2003; Swan and Kendall, 2016; Van Ameringen *et al.*, 2003). Fortunately, multiple lines of treatment including psychotherapy and pharmacotherapy have been found to be efficacious for these disorders in childhood. Notably, cognitive behavioural therapy (CBT) is a well-established and efficacious treatment for both childhood anxiety disorders and OCD (Freeman *et al.*, 2018; Higa-McMillan *et al.*, 2016).

Existing research has focused on assessing perspectives of psychotherapy following initiation of therapy sessions, generally yielding positive reviews. Youth and their parents have described CBT as a beneficial learning process that provides participants with tools to help better manage anxiety and develop greater autonomy (Donald *et al.*, 2018; Donnellan *et al.*, 2013; Jones, 2017; Shahnavaz *et al.*, 2015). Youth indicated that support from their parents provided scaffolding for them to begin utilizing skills learned in therapy independently (Donnellan *et al.*, 2013; Jones, 2017). Other less positive themes that have been reported include that CBT was repetitive and uncomfortable, and that some patients were surprised at the amount of work CBT required of them (Donnellan *et al.*, 2013; Jones, 2017; Lundkvist-Houndoumadi and Thastum, 2017; Taylor *et al.*, 2021).

Parents' knowledge of CBT and their role in this type of treatment for their child has been investigated via qualitative measures primarily in the context of parent-delivered CBT or CBT enhanced with a parent training module. Parents commonly endorse initial feelings of surprise when learning about the negative consequences of accommodating their child's anxiety and endorsed feelings of guilt when practising behaviours such as selective ignoring and carrying out exposures to help their child confront pathological fear (Allard *et al.*, 2022; Jones, 2017; Pishva, 2017). This 'paradoxical parenting' became easier for most parents to implement as they changed roles during their child's treatment progression from comforters and protectors to supporters and advocates (Allard *et al.*, 2022; Jones, 2017; Pishva, 2017). After completion of these programmes, parents were also able to identify the nature of anxiety, its relationship with thoughts and physiological symptoms, and have conversations with their child about their anxiety (Jones, 2017; Pishva, 2017).

Expectations of psychotherapy have been demonstrated to affect the outcome of psychotherapy treatment (Constantino *et al.*, 2018; Snyder, 2002), although it is unclear to what extent (Antichi *et al.*, 2022). Arnkoff *et al.* (2002) found studies demonstrated a correlation between positive treatment expectations and beneficial therapy response. The above studies focused on adult patient populations, with little research devoted to assessing expectations and perceptions of CBT in the child and adolescent population. Studies of expectations of psychotherapy within the paediatric population tend to use quantitative measures of assessment, such as surveys, with the primary intention being to compare patient and parent expectations with results. While easier to administer and standardizable, quantitative measures may not identify unexpected, common themes among children and parents engaged in CBT that could be addressed prior to therapy to increase understanding of and adherence to treatment. Therefore, there is a need to qualitatively explore expectations of CBT among paediatric patients and their parents.

We interviewed adolescent patients participating in CBT for the treatment of anxiety and related disorders as well as their parents to add to the literature on expectations and perception of CBT. Specifically, qualitative methodology was used to better understand retrospective expectations of children and parents upon beginning CBT. We explored the ways initial perceptions changed during the CBT process and the differences between parent and child expectations and understandings.

Method

Design

This study was a part of a larger investigation that sought to develop informational videos regarding CBT for children with anxiety and related disorders (OCD was included due to the similarity of CBT across anxiety disorders and OCD). As part of this project, one-time individual

interviews and focus groups consisting of 2–3 individuals were conducted with current patients and parents, separately. The interview focused on gathering insight into what would be helpful to include in these videos for consumers, as well as gaining information regarding perspectives and knowledge about CBT (see Supplementary material online). The framework of this study was guided by Johnson's Comprehensive Model of Information Seeking (Johnson and Case, 2012) and Brashers' Uncertainty Management Theories (Brashers, 2001).

Sample

Participants were recruited from an out-patient psychology clinic at a single university centre which specializes in exposure-based CBT (i.e. has a focus on exposure therapy as the core element of CBT). To initiate treatment at this clinic, patients are first referred, internally or externally, through primary care providers such as paediatricians or licensed mental health providers such as psychologists or psychiatrists. Parental involvement in treatment varies and is strongly encouraged.

Inclusion criteria included either (a) being aged 10–16; diagnosis of specific phobia, social phobia, panic disorder, generalized anxiety disorder (GAD), separation anxiety and/or OCD following a psychological evaluation consisting of a clinician-led interview and validated scales of psychological symptoms with a focus on their anxiety disorder or OCD; or (b) being the parent of a youth meeting these criteria. Exclusion criteria were diagnoses of autism spectrum disorder or an intellectual disability. Recruitment occurred from February 2018 to January 2020. Potential participants were screened through examination of medical records and discussion in case conferences. Eligible participants who gave consent to their clinicians to speak with study staff were then invited to participate and informed consent was obtained.

Data collection

In total, 24 unique interviews/focus groups were conducted, with children and parents meeting separately. For the youth sample, there were nine individual interviews, one focus group of two participants, and one focus group of three participants. For the parent sample, there were 10 individual interviews and three focus groups of two participants.

A semi-structured interview guide was developed through successive collaborative consultations between health communication and clinical psychology experts and trainees. The interview guide was developed with the consideration that interviews would be conducted by individuals with varying levels of experience in qualitative research (Turner, 2010). Two versions of the interview guide were developed, one for interviews with children and one for interviews with parents and caregivers. The topics covered in the interview guide included gauging existing CBT knowledge, information seeking, and information application. Before the interviews were initiated, the research team met to provide orientation to the project, train interviewers, and conduct three practice interviews to ensure fidelity and to establish a conversational style appropriate for young adolescents (O'Reilly and Dogra, 2016). A standard note-taking guide and interview process protocol were developed and implemented (Brinkmann and Kvale, 2015). Interviews were conducted in group and individual settings with one interviewer and one note-taker present each time.

Interviewers included several authors of the study (S.D., A.F., R.M., J.C.-N., Y.S.) and two research assistants. Training in conducting the interviews was provided by one of the authors of this study (Y.S.) who is a doctoral researcher in journalism. Interviews lasted between 14 and 72 min ($M = 36$ min). Interviews were audio-recorded and transcribed verbatim, with all identifying information removed.

Demographics were gathered via self-report. Information regarding diagnoses, the number of therapy sessions with CBT specified as the treatment modality over the past two years, and

parental involvement in CBT (via proportion of sessions attended by parent) was acquired through medical record review.

Data analysis

An inductive analysis was conducted following Braun and Clarke's (2006) recommendations. All transcripts were read and re-read by the entire study team, who brainstormed initial ideas after immersion in the data. Next, two authors (A.F. and R.H.) completely coded each transcript in QSR NVivo and created subcodes to characterize the most salient ideas. These codes were subsequently clustered to themes and subthemes, and transcript data were reviewed based on these preliminary themes. This review generated definitions for each theme/subtheme, and themes were elaborated through the use of coded data.

Reflexivity

In order to accommodate the interpretative aspects of analysis, the team employed reflexive discussions in order to examine the impact of positionality on findings. Two authors (A.F. and R.H.), both without direct experience conducting CBT, led the data analysis. The second author was an undergraduate psychology major who aided in the treatment of children with anxiety disorders but was not trained to deliver CBT. The first author involved with data analysis was an MD/PhD candidate in medical anthropology without CBT experience. As a part of discussion of themes, these authors discussed their own perspectives, histories and pre-conceived notions of CBT and anxiety in paediatric patients. The rest of the research team participated in this process, including the author S.D., a graduate student in psychology with experience in using CBT for paediatric patients, and both senior authors (C.M. and J.M.), senior clinicians with expertise in CBT for paediatric populations, who consulted with the team about the data and participated in discussion of the themes. Both coders met frequently to discuss the data and themes, and inconsistencies in coding were reviewed, resulting in refinement of the theme definitions.

Results

Our final sample consisted of 30 participants, of whom 14 were adolescent patients and 16 were parents. Twelve parent-child dyads accounted for 24 of the participants in the study. For the other six participants, three parents did not have their child participate, and one parent had two of their children participate.

The adolescent patient sample ranged in age from 10 to 16 years old ($M = 12.83$, $SD = 1.86$). Gender identification was mostly even between male ($n = 7$) and female ($n = 6$), with one individual identifying as non-binary. The majority of the sub-sample ($n = 12$, 85.7%) identified as White/Caucasian and not Hispanic/Latino. Common diagnoses in the sample included GAD ($n = 10$, 71.4%), social anxiety ($n = 6$, 42.9%), attention deficit/hyperactivity disorder ($n = 5$, 35.7%), OCD ($n = 4$, 28.5) and major depressive disorder ($n = 4$, 28.5%). The number of sessions that the participants attended over the past two years labelled as CBT ranged from 3 to 58 ($M = 19.8$). A complete demographics breakdown of the patient sample is provided in Table 1.

The parent sample ranged in age from 35 to 68 years old ($M = 48.4$, $SD = 7.25$). Eleven (68.8%) identified as female and their child's mother, while five (31.2%) identified as male and their child's father. Fifteen (93.8%) identified as White/Caucasian and not Hispanic/Latino. Thirteen (81.3%) reported having at least a four-year college degree. Six (37.5%) attended less than 25% of their child's CBT sessions, four (25%) attended between 25 and 75% of sessions, and six (37.5%) attended more than 75% of sessions. Parent demographics are further detailed in Table 2.

Table 1. Adolescent sample demographics

Child ID	Age	Gender	Race/ethnicity	Diagnoses	No. of CBT sessions	Linked parent ID
Child 1	13	Male	White/Caucasian	GAD	4	Parent 1
Child 2	14	Female	White/Caucasian	OCD, social anxiety	17	Parent 2
Child 3	12	Male	White/Caucasian	GAD, MDD	48	Parent 3
Child 4	12	Male	White/Caucasian	Social anxiety, ADHD	16	Parent 4
Child 5	13	Female	White/Caucasian	GAD, MDD	3	Parent 5
Child 6	13	Male	White/Caucasian	GAD, ADHD	3	Parent 6
Child 7	16	Non-binary	White/Caucasian	GAD, MDD, PTSD, Social anxiety	35	Parent 7
Child 8	16	Female	White/Caucasian, Asian	Social anxiety, MDD	58	Parent 8
Child 9	12	Male	White/Caucasian	GAD, ADHD, DMDD	11	Parent 9
Child 10	14	Female	White/Caucasian	Social anxiety, other anxiety disorder	26	Parent 10
Child 11	16	Male	White/Caucasian	OCD, GAD, ADHD	32	Parent 11
Child 12	11	Female	White/Caucasian, Asian, Native American	Social anxiety, other depressive disorder, trichotillomania	11	Parent 12
Child 13	10	Female	White/Caucasian	OCD, ADHD	10	Parent 13
Child 14	12	Male	White/Caucasian	OCD, GAD	3	Parent 13

No. of CBT sessions is the total number of sessions in medical record with CBT specified as treatment modality in the two years prior to interview. GAD, generalized anxiety disorder; OCD, obsessive-compulsive disorder; MDD, major depressive disorder; ADHD, attention deficit/hyperactivity disorder; PTSD, post-traumatic stress disorder; DMDD, disruptive mood dysregulation disorder.

Three main themes emerged from analysis of both data sets: (a) Worries about CBT, (b) Expectations and Knowledge of the CBT Process, and (c) The Role of Parents and Families. While these themes were shared across adolescent/parent participants, we found that some subthemes differed substantially between the parent and adolescent groups.

Worries about CBT

Stigma

Some parents ($n = 9$) experienced worries as they began CBT. Parents reported worrying that their children felt stigmatized by the experience of being brought to therapy, either from peers, media depictions of therapy, or through the process of referral itself. As one parent put it, he worried that his daughter ‘thought . . . she’s here because she’s in trouble’ (Parent 12). Parents also reported worries about whether their child’s need for therapy was attributable to failures of parenting. As one parent said, ‘in the case of a parent, yeah there’s a little bit of stigma. “Why is my kid having to go to therapy? What did I do wrong?” That kind of a situation going on in my head’ (Parent 10). To a lesser extent, adolescents ($n = 4$) also reflected they had at the outset perceived therapy as stigmatizing, worrying that it set them apart from their peers or marked them as ‘crazy’.

Both parents and adolescents described a process of normalization, in which they realized that therapy was ‘more common than you realize’ (Parent 2). However, while parents interviewed felt that therapy had been completely normalized and destigmatized, adolescents’ reports were more ambiguous. For example, most said they had friends who were also in therapy but reported they did not discuss therapy with peers. Adolescents described peers in therapy as having worse or more severe problems and desired a more open discussion of therapy among peers to normalize their experiences. As one adolescent put it, ‘It was really depressing, like I felt all by myself, and it kind of hurt because I felt weird and like I didn’t really mean anything. So I talk about it [with my friends] because I don’t want other people to feel like that. I want other people to know it’s not a bad thing’ (Child 5).

Table 2. Parent sample demographics

Parent ID	Age	Gender	Race/ethnicity	Parent role	Education	Income	Parent involvement in child's CBT	Linked child ID
Parent 1	43	Female	White/Caucasian	Mother	College graduate	150,000+	Moderate	Child 1
Parent 2	42	Female	White/Caucasian	Mother	College graduate	50,000–99,999	High	Child 2
Parent 3	44	Female	White/Caucasian	Mother	College graduate	n/a	High	Child 3
Parent 4	54	Male	White/Caucasian	Father	Postgraduate work	150,000+	Low	Child 4
Parent 5	36	Female	White/Caucasian	Mother	Some college	50,000–99,999	Low	Child 5
Parent 6	46	Female	White/Caucasian	Mother	Postgraduate work	150,000+	Low	Child 6
Parent 7	53	Female	White/Caucasian	Mother	Postgraduate work	50,000–99,999	Low	Child 7
Parent 8	53	Male	White/Caucasian	Father	Postgraduate work	100,000–149,999	Low	Child 8
Parent 9	45	Female	White/Caucasian	Mother	College graduate	50,000–99,999	Moderate	Child 9
Parent 10	53	Male	White/Caucasian	Father	Postgraduate work	150,000+	Moderate	Child 10
Parent 11	68	Male	White/Caucasian	Father	Some college	50,000–99,999	Low	Child 11
Parent 12	56	Male	White/Caucasian	Father	Postgraduate work	150,000+	High	Child 12
Parent 13	46	Female	White/Caucasian	Mother	College graduate	n/a	High	Child 13 and 14
Parent 14	44	Female	White/Caucasian, Asian	Mother	College graduate	50,000–99,999	High	None
Parent 15	44	Female	White/Caucasian	Mother	Associate's degree	100,000–149,999	High	None
Parent 16	48	Female	White/Caucasian	Mother	Postgraduate work	100,000–149,999	Moderate	None

Parent involvement in child's CBT: Low, <25% of sessions attended by parent; Moderate, 25–75% of sessions attended by parent; High, >75% of sessions attended by parent. Percentage of sessions attended by parent determined by review of medical record.

Perceptions of severity

Some parents ($n = 8$) said that on referral for CBT they felt therapy may be inappropriate for their children due to their perception of their children's symptoms as too mild to warrant intervention. This was due both to the perception that therapy was only for individuals with severe mental illness, and because parents felt they had difficulty identifying symptoms in their children. As one put it, 'the only times that I've ever heard about it is for the severe cases . . . you may hear about it when it comes to like childhood sexual abuse but you don't hear about it being used for other things' (Parent 3). Parents said that they did not want to associate their children with the stigma associated with severe mental health problems: 'I think there is this stigma of, "Okay your daughter is going to go to therapy." And right away, you think psychiatry, and you think drugs and you think wacky people' (Parent 10). By contrast, no adolescents reported feeling that their symptoms might not be severe enough to warrant therapy.

Parents described difficulties with appropriately identifying symptoms in their children. Those who reported lower levels of knowledge about mental health in general felt guilty that they had missed the problems their children were experiencing: 'I was confused because I didn't know what [anxiety] was to begin with. I have never really looked for it in a person so I never got to see it yet it was right there in my son' (Parent 11). When they were able to identify symptoms, parents often felt that they could not gauge how badly their children were feeling or how debilitating symptoms might be. As one parent described, 'I didn't deem my daughter's issue to be that severe . . . I don't know how it compares to some other people, but there were some moments, according to my daughter, where she was freaking out inside, so she wasn't able to do certain things . . . I guess that could metastasize into something else later in life' (Parent 10). While many parents continued to characterize their children's issues as 'less severe' than those of others, this sense of having missed or misinterpreted symptoms sometimes caused a 'sense of panic [due to] not understanding how it kicked in . . . and this feeling of a little bit of helplessness . . . I had a little bit of a sense of panic, on my part, of wanting to be able to help my daughter and not understanding why it kicked in for her' (Parent 12).

Expectations and Knowledge of the CBT Process

Both parents ($n = 13$) and adolescents ($n = 12$) reported that at the outset of therapy they had not understood key features of the CBT process and had unclear expectations of what CBT would involve, how long it would last, and what would be required. For parents, this lack of clarity created anxiety about how long their child would require therapy and if it would be helpful. Parents and adolescents reported that they had not initially recognized that CBT was a gradual, continual process requiring participation and 'hard work' rather than a quick and easy solution. As one parent put it, he had to learn 'that [CBT] takes commitment, time. It's not just a cure and it goes away. You learn coping strategies and you still work on it' (Parent 9).

Other parents said that they initially pictured that CBT would be similar to talk therapy and imagined a long therapeutic course without concrete improvements. One parent said of the outset, 'I wanted to make sure that there was an end goal, that it wasn't just open one-sided discussion. That there was feedback . . . and goal setting that occurred during the sessions' (Parent 7). Many were unsure how long CBT would take in order to be effective and wondered if success was guaranteed. One reflected, 'Initially for CBT I guess we wanted to know what the prognosis is? Does everyone . . . succeed and flourish doing CBT or is it only certain types of personalities or types of challenges you have. So, we kind of wanted to know, is CBT for everybody? Is it like getting the flu shot, you know?' (Parent 13). Parents were concerned that their children would be caught in a long and time-consuming process without clear milestones or goals and were worried about planning for the future. One described her advice to other parents beginning CBT, saying: 'Give it time to work. If it feels weird the first time in the first session it's ok. It's not just talk therapy. There is a purpose for it. There is a goal in mind. You are not just going to be stuck in talk

therapy forever so give it three to five sessions before you make a strong opinion about what it is and how it is affecting your child's behaviour' (Parent 16).

Adolescents were likewise unsure how and if CBT would help them. Both groups felt they had not fully appreciated that CBT requires commitment and work to achieve concrete goals. One adolescent described his experience with CBT, saying 'if I was to say one thing I would definitely say . . . perseverance. How you may not want to do it. It may seem intimidating. It may seem tedious. It may seem hard. It may like seem like it sucks at first, but it's gonna pay off' (Child 11). Adolescents also felt worried at the outset of CBT that they would be pushed outside of their comfort zone or would be forced to do things they did not feel comfortable doing. They reported that at the outset of therapy, they were apprehensive about the process and fearful of what it entailed. When asked what had surprised him about the CBT process, one adolescent replied 'I guess that you're pretty much in control of what you're going to do, kind of. I thought that I was going to have to do all these things that I wouldn't necessarily be comfortable with. Then they just kept telling me that if you don't want to do this, you don't have to. You are in control of what you're going to [do] . . . of how it's going to work . . . I was really nervous. I was like "Oh my gosh, I'm going to be so scared to do these situations and scenarios", when in reality I was making the decisions every step of the way' (Child 10). Adolescents repeatedly returned to the idea that they were in control of their experience and expressed that this feeling of control helped alleviate initial anxieties.

The Role of Parents and Families

Parents' level of knowledge of CBT was extremely mixed. Similarly, Tables 1 and 2 show that parent engagement varied and did not seem to be associated with age of child. Some parents ($n = 7$) reported that they were engaged with the CBT process and confidentially described CBT goals and methods. They felt they had a role in the CBT process and that their involvement with CBT was key to their child's success. These parents reported that they were initially surprised by the level of engagement required of them in the CBT process, as they had initially pictured more traditional one-on-one talk therapy. They saw a need to better explain the role of parents in CBT in initial visits to set expectations for the high level of parental engagement required. As one parent described, 'There is a lot more that I would have to be involved with than I initially realized as a parent, [CBT] is really for us too . . . I'm learning and having to take notes and having to do these exercises at home . . . I think letting parents know that you will have to be daily involved in the sessions, but also the work at home. You know, kind of be prepared to be present physically, mentally, and emotionally throughout the whole process more so than maybe you initially might think' (Parent 14).

Other parents ($n = 9$) had extremely low levels of knowledge about CBT and the CBT process. They felt unprepared to answer basic questions about CBT and reported they did not have a good idea of what their children did in therapy. One parent explained his lack of knowledge by saying: 'Because of patient confidentiality you don't really have much insight to what is actually happening on a day-to-day basis. [It is] somewhat dependent on what the child tells you . . . so I don't have a good sense of what . . . individual activities he did' (Parent 4).

These parents felt that their role was to respect their child's privacy and relationship with their therapist. For these parents, the need to respect their child's boundaries was a key part of the CBT process even if it prevented them from fully participating: 'I think . . . you should respect the privacy of your child. It's hard to say well you know say "tell me all about your session? What did y'all talk about?" And that negates the safe space and expectation . . . I think that's really important and a necessity so that as a parent to be respectful of that process and to not be intrusive, especially grilling them after sessions of what was discussed because that's their therapy. It's not for you' (Parent 7).

Likewise, adolescents whose parents were more engaged saw parental involvement as key to CBT. When asked about the role of parents in CBT, one adolescent responded, 'They're basically your home therapist' (Child 9). Another adolescent echoed this thought: 'I think parents helping in exposures is really important. I don't think enough parents know . . . [and] obviously not all kids maybe want that, but . . . it's really good to have a person at home who can help when your therapist isn't there' (Child 6). For other adolescents, parental respect for privacy and the ability to limit parental involvement helped them to feel in control of the overall CBT process. One adolescent expressed relief that he was able to control his parents' engagement in CBT, saying '[At first] I thought that my parents were going to have to sit in on the whole session with me every single time which isn't the case . . . you can choose, I guess, how much your parents know. I think the first session you can choose to have your parent in there or not and you don't necessarily have to say everything when your parent is in there. So you definitely are in control of how much you want them to know. I know my parents always ask me about what did you talk about and how did it go and, of course, if your therapist thinks anything is wrong then they'll talk to your parents about it . . . that's a big thing too' (Child 7).

Discussion

This study sought to examine expectations and perceptions of CBT among adolescents with anxiety and related disorders and their parents. Specifically, we aimed to retrospectively assess participants' expectations and understanding of CBT at the outset of therapy, how these perceptions were remembered to have changed over time, and how they differed between adolescents and parents.

Overall, we found that adolescents and parents had generally positive views of CBT in accordance with existing literature (Donnellan *et al.*, 2013; Donald *et al.*, 2018; Jones, 2017; Shahnavaz *et al.*, 2015). Both groups felt that the expectations for CBT were not clearly defined prior to treatment; however, adolescents expressed a more definite understanding of CBT and what it involved after beginning treatment. This differed from the parent perspective in that CBT remained difficult for parents to define without direct involvement in their child's treatment. Adolescents had mixed opinions on direct parental involvement with CBT: some felt that parental involvement helped facilitate continued improvement outside of therapy while others appreciated having control over the degree of parental participation.

Referral for CBT and initiation of treatment came with worry about stigmatization from both adolescents and parents. This is in accordance with literature showing that children with mental illness are more stigmatized than those with physical illness or learning disability (Wilkins and Velicer, 1980). Stigma has also been found to be a significant barrier to seeking treatment for mental illness (Clement *et al.*, 2015), a point that is represented in this study by parents expressing concern that their parenting skills would be called into question if their child needed CBT. Interestingly, parents believed that psychotherapy had been largely normalized among their children's peer groups and did not express the same level of concern for how their children might be othered by their peers as the parent might be for having a child requiring CBT. Adolescents felt that there was more work to be done to destigmatize therapy and mental illness, and were willing to make themselves vulnerable by sharing their experiences in the hope that others would feel emboldened to do the same. This is in line with social movements over the past two decades advocating for disclosure and acceptance of mental illness. Further study of change in feelings concerning stigmatization of youth with mental illness is warranted along with identification of associated large-scale social movements in order to put more successful de-stigmatization efforts into action.

Worry about what referral for CBT meant about the severity of an adolescents' anxiety and/or related diagnoses was consistently expressed among parents. Parents felt they had difficulty identifying signs and assessing the severity of their child's mental illness. Parents desire to know

more about anxiety and how to recognize signs and symptoms of it in their child, as has been found in previous research on childhood anxiety (Reardon *et al.*, 2018a). Multiple methods could be employed to assist in earlier recognition of childhood anxiety such as standardized screenings in paediatrician offices, parental education on signs and symptoms of anxiety in their child, and education of teachers to recognize anxiety in the school setting. Each of these, however, comes with barriers to implementation such as time and resources needed to plan and implement the intervention (Reardon *et al.*, 2018b).

Adolescents and parents were unfamiliar with what CBT involved, how long it would last, and what would be required at the beginning of treatment. This created worry for parents about the time frame and effectiveness of treatment. Adolescents' worries centred on being uncomfortable with what would be asked of them. As CBT progressed, both parents and adolescents reported resolution of these feelings. Adolescents and some parents attributed this to a greater understanding of the CBT purpose and process; other parents became more comfortable with CBT through seeing their child improve. Consistent with prevailing clinical practice, these findings indicate that both adolescents and their parents benefit from initial education on the purpose of CBT and setting expectations. Future efforts could be aimed at reinforcing patient and parent expectations of CBT during sessions subsequent to the initial encounter to ensure parental understanding of CBT. In the child and adolescent population, parent expectations should ideally be addressed and studied in a similar manner to those of patients as parents often play a role in their child's therapy and provide logistical access to care.

The role of parents and families in adolescents' CBT was understood in two broad categories of essential and beneficial *vs* unnecessary and invasive. Parents generally thought that being involved with their child's CBT was beneficial, but some expressed a feeling of disrespecting their child's autonomy if they were to participate in CBT with their child. Several adolescents felt more independent and in control of their treatment when afforded the opportunity to go through CBT largely on their own. For parents and adolescents that felt support system involvement to be essential, this was due to the continued improvement that can be carried out in the home environment with both parent and child aware of the happenings within CBT sessions and the areas in which an adolescent or parent may need help from the other. Parent-enhanced CBT for anxiety has yielded mixed results when considering whether or not parental involvement leads to decreased child anxiety symptoms (Barmish and Kendall, 2005); however, Walczak *et al.* (2017) found that children with anxiety whose parents actively participated in CBT had significantly higher rate of remission at 3-year follow-up than children with limited parental involvement. Research aimed at further elucidating the effect of parental involvement in a child's CBT should be conducted to determine an ideal level of involvement. This is particularly challenging given the developmentally normal transitions towards independence that occur during adolescence. This recommendation is not only for the benefit of paediatric patients, but also for the comfort of parents.

Limitations

Several limitations of this study warrant consideration. Our sample was derived from a single university-based psychology clinic, was mostly White, and exhibited a large bias towards higher income and parental education, which limits generalizability of our findings. All pre-treatment expectations were retrospectively reported as the larger investigation required individuals with pre-existing CBT knowledge; as such, reports may have been impacted by treatment experience. Further variability in perceptions of CBT may have related to differing therapeutic approaches between clinicians as well as the significant variation of number of sessions adolescents and parents participated in. Relatedly, number of CBT sessions was determined by review of limited information provided by the medical record, which may have inaccurately 'carried forward' designation of using CBT and over-estimated the number of CBT sessions in the past two years.

Further studies should assess pre-treatment perceptions prospectively to accurately capture treatment expectations. To further identify and address barriers to treatment, future studies should engage with youth and parents who did not undertake CBT when offered. Researchers may also benefit from directly comparing the various strategies learned in CBT with patient and parent perspectives of the treatment.

Conclusion

This study demonstrated that adolescents and parents had generally positive perceptions of CBT treatment of childhood anxiety and related disorders. Three themes related to expectations and perceptions of CBT were identified: worries about CBT, expectations and knowledge of the CBT process, and the role of parents and families. This study suggests that both adolescents and parents would benefit from early discussion and reinforcement of expectations for CBT treatment of childhood anxiety and related disorders. Thus, there is a need for further research to determine appropriate expectations for parental involvement in a child's CBT course and effectively communicate treatment expectations to both adolescents and parents.

Supplementary material. To view supplementary material for this article, please visit <https://doi.org/10.1017/S1352465823000346>

Data availability statement. The data that support the findings of this study are available from the corresponding author upon reasonable request.

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