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Specific Phobias in Youth: A Randomized Controlled Trial Comparing One-Session Treatment to a Parent-Augmented One-Session Treatment

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Abstract

Objective—Examine the efficacy of a parent-augmented One Session Treatment (A-OST) in treating specific phobias (SP) in youth by comparing this novel treatment to child-focused OST, a well-established treatment.

Method—A total of 97 youth (ages 6–15, 51.5% female, 84.5% white) who fulfilled diagnostic criteria for SP were randomized to either A-OST or OST. SPs were assessed with semi-structured diagnostic interviews, clinician improvement ratings, and parent and child improvement ratings. In addition, measures of treatment satisfaction and parental self-efficacy were obtained. Blind assessments were completed pretreatment, post-treatment, and 1-month and 6-months following treatment. Analyses were undertaken using mixed models. In addition, gender, age, internalizing/externalizing problems, parent overprotection, and parent anxiety were examined as potential predictors and moderators of treatment outcome.

Results—Both treatment conditions produced similar outcomes with approximately 50% of youth in both treatments diagnosis free and judged to be much or very much improved at post-treatment and 1-month follow up. At 6-month follow up, however, the treatments diverged with OST resulting in marginally superior outcomes to A-OST, contrary to predictions. Only age of child predicted treatment outcome across the two treatments (older children did better); unexpectedly, none of the variables moderated treatment outcomes.

Conclusions—Parent augmentation of OST produced no appreciable gains in treatment outcomes. Directions for future research are highlighted.

Keywords

specific phobia; children and adolescents; randomized controlled trial; one-session treatment; treatment outcome

Specific phobias (SPs), characterized by an excessive and persistent fear of a specific object or situation, are among the most common anxiety disorders (APA, 2000, 2013). The phobic stimulus is actively avoided or endured with intense fear or anxiety and, typically, the fear or anxiety persists over time. In children, the fear or anxiety may be expressed behaviorally as crying, tantrums or clinging to one's caretaker. Furthermore, the fear or anxiety is impairing and interferes with the individual's daily functioning. SPs are categorized into five subtypes: animal type, natural environment type, blood-injection-injury type, situational type, and other type (e.g., choking, loud noises, costumed characters).

Clinically significant SPs are present in approximately 5% of children in community samples and in about 15% – 20% of children presenting at anxiety disorder clinics. The lifetime prevalence rates in children and adolescents range from 5 – 11%, depending on the type of SP (Kessler, Berglund, Demler, Jin, & Walters, 2005). For many children, phobias result in considerable academic, social, and personal distress, as well as interference in day-to-day functioning (Essau, Conradt, & Petermann, 2000; Ollendick, King, & Muris, 2004). Moreover, they may lead to other anxiety, mood, and substance use disorders (Kendall, Safford, Flannery-Schroeder, & Webb, 2004).

Treatment

Cognitive-behavioral treatments (CBTs) have been shown to be efficacious in treating youth with anxiety disorders, with approximately 50 – 60% diagnosis free following treatment (In-Albon & Schneider, 2007; Seligman & Ollendick, 2011; Silverman, Pina, & Viswesvaran, 2008). Moreover, treatment gains are maintained at long-term follow up, sometimes up to seven years later (e.g., see Barrett, Duffy, Dadds, & Rapee, 2001 and Kendall et al., 2004). One Session Treatment (OST), a variant of CBT developed by Öst (1989, 1997), has been found to be a rapid and efficacious treatment for children with a variety of SPs including animal, natural environment, situational and “other” types (see Ollendick & Davis, 2013, for a recent review). This 3-hour, one session treatment involves psychoeducation, *in vivo* exposure, cognitive challenges, participant modeling, and reinforced practice.

In our recent Randomized Controlled Trial (RCT) of OST (Ollendick, Öst, Reuterskiöld, Costa, Cederlund, Sirbu, Davis, & Jarrett, 2009), we found that OST was more efficacious in treating SPs in youth than Education/Support Treatment (EST) or Wait List Control (WLC) conditions at post-treatment (60%, 26%, and 0% diagnosis free, respectively) and superior to Education/Support at 6-month (60% versus 42%) and 1-year follow-up (73% versus 48%). Although OST was shown to be superior to these two control conditions, it was evident that up to 40% of the youth who received this brief, intensive treatment were not diagnosis free at post-treatment or at 6-month follow-up. Many of the youths who were

not diagnosis free continued to report significant distress, avoidance, and conflicts within the family.

Of particular interest to the current study, Öst, Svensson, Hellstrom, and Lindwall (2001) compared child-focused OST to parent-involved OST and a WLC group in another RCT. In the parent-involved condition, one of the parents was present in the room during the entire treatment. The therapist determined the amount and type of parental involvement on a case by case basis (e.g., the parent could model approach behavior if the child had difficulty interacting with the phobic stimulus, reinforce their child for approach behavior, or simply observe the ongoing treatment). Parent involvement was not standardized in this study. Although Öst and colleagues found the two treatment groups to be superior to the WLC group, no differences were found between the two treatment conditions.

Somewhat surprisingly, in a review of 24 RCTs in the treatment of childhood phobias and anxiety disorders, In-Albon and Schneider (2007) concluded there were negligible differences between child-focused CBT interventions and parent-augmented interventions. That is, the inclusion of parents in treatment did not enhance treatment outcomes over those obtained with child-focused treatments alone. Still, as noted by In-Ablon and Schneider, the format of parent involvement differed greatly in these studies and, in some studies, significant differences favoring family based CBT were found (e.g., Barrett, Dadds, & Rapee, 1996; Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006). For example, Wood and colleagues showed that their “Building Confidence” program which specifically targeted parent-child interactions in addition to parental over-protectiveness and parental anxiety produced superior outcomes than did a child-focused CBT program. Recently, Breinholst, Esbjorn, Reinholdt-Dunne, and Stallard (2012) examined these discrepant findings further and suggested that the failure of family augmented treatments to enhance treatment outcomes may be because these interventions have not directly targeted specific parenting practices, which have been shown to be associated with the onset and maintenance of anxiety in children. Thus, it is conceivable that a parent augmentation that directly targets parenting behaviors and teaches parents how to interact with their fearful child may help to more clearly determine the impact of parent involvement.

Potential Predictors and Moderators of Change

In the context of treatment outcome research, variables that specify for whom a treatment “works” or the conditions under which the treatment “works” are described as either predictors or moderators of outcomes (Kraemer, Wilson, Fairburn, & Agras, 2002). Predictors and moderators are variables that exist prior to treatment and that affect treatment outcomes. Predictors affect outcomes regardless of treatment condition whereas moderators affect outcomes differentially, dependent upon specific treatment parameters.

Demographic variables such as age and gender are important predictor and moderator variables to consider when analyzing effects of any treatment for children and adolescents (Silverman & Ollendick, 1999). In the treatment of SPs with OST, previous research has shown that although age did not predict treatment outcomes (Ollendick et al., 2009; Öst et al., 2001), gender did predict outcomes in one study (Öst et al., 2001); however, neither age

nor gender were explored as moderators in these studies. It has also been suggested that presence of pre-existing comorbid disorders or heightened levels of internalizing/externalizing problems in children may have a negative impact on treatment outcomes (Fraire & Ollendick, 2013; Ollendick, Jarrett, Grills-Tauchel, Hovey, & Wolff, 2008). In the treatment of SPs with OST, however, Öst et al. (2001) and Ollendick, Öst, Reuterskiöld, and Costa (2010) did not find comorbid disorders or heightened levels of internalizing/externalizing problems to predict treatment outcomes. However, these studies also failed to explore these problems as possible moderators of treatment outcome. Given that heightened levels of internalizing/externalizing problems can signal greater distress and impairment (Kendall, Brady, & Verduin, 2001; Seligman & Ollendick, 2011), the need to continue to examine such variables as predictors and moderators of change is evident.

Furthermore, in as much as parental anxiety and parental overprotective behaviors can play a role in the development and maintenance of anxiety disorders more broadly and SPs in particular (Breinholst et al., 2012), they too might be expected to serve as predictors or moderators of treatment outcomes. A significant percentage of parents of anxious and phobic children have been found to be psychologically controlling and overly protective, exercising excessive regulation over their children's day-to-day routines and demonstrating vigilance and intrusiveness when in anxiety-producing situations (e.g., Bogels & Brechman-Toussaint, 2006; McLeod, Wood, & Weisz, 2007). In addition, a high proportion of parents of anxious and phobic children have phobic or other anxiety disorders themselves (e.g., Barmish & Kendall, 2005; Ginsburg, Silverman, & Kurtines, 1995; Silverman & Ginsburg, 1998). Despite these findings, most studies fail to address this familial pattern in either the assessment or treatment of these children (Breinholst et al., 2012; Kendall & Ollendick, 2005). Targeting how parents interact with their children when in the presence of phobic stimuli and helping the parents manage their own levels of anxiety may have significant implications for treatment outcome.

Current Study

The current RCT compared OST to A-OST in the treatment of SPs in children. In both conditions, children received the standard 3-hour OST. In addition, in the A-OST condition, parents were provided with psychoeducation about the causes and course of SPs in children and were taught strategies to reinforce courageous approach behaviors and reduce distress and avoidance in their children. Following the lead of Silverman and colleagues (Ginsburg et al., 1995; Silverman & Kurtines, 1996), a transfer of control model was used to teach parents how to help their children when in the presence of the phobic stimulus. Specifically, this model involved the gradual transfer of knowledge and skills from the therapist to the parent (see below for more information about the treatments). The effects of these two brief treatments were determined at post-treatment as well as 1-month and 6-months following treatment. Based on our attempts to address weaknesses evident in other parent-involved treatments, we predicted that A-OST would lead to better treatment outcomes than OST. In addition, we explored predictors and moderators of change associated with these two treatments. More specifically, we explored a subset of child variables (age, gender, internalizing/externalizing problems) and parent variables (parental overprotection and parent anxiety) as potential predictors and moderators of change. We did not put forth

specific hypotheses as to whether the child sociodemographic characteristics would function as predictors or moderators as there was insufficient support in the literature to do so. On the other hand, we predicted that the parent variables would serve primarily as moderators of change; that is, A-OST was hypothesized to “work” better than OST for families in which the parents possessed high levels of anxiety and overprotectiveness since we were attempting to address these parenting dimensions in our augmented condition. However, given that these analyses were secondary analyses, these hypotheses were viewed more as “hypothesis-generating” and informative for future studies than “hypothesis testing,” as recommended by Kraemer et al. (2002).

Method

Participants

In total, 97 children and adolescents (ages 6–15; 51.5% females; 84.5% white) diagnosed with a SP were randomized to one of the two treatment conditions. The participants largely came from 2-parent households (76.3%); approximately half of the mothers (58.8%) and fathers (45.4%) graduated from a 4-year college/university, and families had an average household income of \$88,548 (SD = \$68,969; range = \$10,000 to \$500,000). The primary caregiver in most cases was the mother (91.8%). Inclusion criteria were as follows: 1) 6 to 15 years of age, 2) current Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV-TR; APA, 2004) diagnosis of a SP, and 3) a parent willing to participate in the treatment. Exclusion criteria included: 1) current diagnosis of an autism spectrum disorder, 2) current psychotic symptoms, 3) estimated IQ below 80, and 4) other conditions in need of treatment prior to the treatment of the SP (e.g., suicidal behavior, child sexual abuse).

Participants were recruited primarily from Southwestern Virginia. Mental health professionals, medical practitioners, local schools, and churches in the New River Valley and Roanoke Valley areas were contacted, fliers were distributed in businesses (e.g., restaurants, grocery stores), and ads were placed in local newspapers.

Treatments

Participants were randomized to either A-OST ($n = 51$) or standard OST ($n = 46$)¹. Both treatment conditions involved a functional assessment (FA, see below), a 3-hour therapy session, and four weekly phone contacts following treatment. The differences in the two treatment conditions, which pertain mainly to parental involvement, are described next.

Child-focused OST (Öst & Ollendick, 2001)—In this condition, the child alone received treatment with minimal parental involvement. During the FA with the child, information about the precipitating and maintaining factors of the SP was obtained and a graduated exposure plan was developed with the child. The rationale and structure of treatment was explained to the child and subsequently to the parent. Approximately one week after the FA, the family returned for the treatment session, with only the child participating in treatment. The objective of the 3-hour session was to gradually expose the

¹We also treated 38 out of town cases, who were assigned to A-OST; however, they are not included here as they were not assigned randomly to treatment conditions.

child to the phobic stimulus and to assist the child in challenging anxious cognitions associated with the feared stimulus and its feared consequences. Following treatment, the parents were contacted weekly by the clinician for four consecutive weeks to determine how the child was doing. No prescribed maintenance program for the child was enacted.

Augmented-OST (Ollendick, 2007)—In the augmented condition, two clinicians were assigned to each family: one clinician worked with the child and the other with the parent. One parent, typically the mother, participated in treatment for the majority of cases ($n = 37$; in the other cases either the father, $n = 8$, or both parents participated, $n = 6$). For the FA, information about the etiology and maintenance of the SPs, as well as relevant information to devise appropriate exposures, was obtained from both the parent and child. Additionally, both the parent and the child received psychoeducation about anxiety and the SP targeted for treatment. The rationale behind the treatment was explained to both parent and child. In the treatment phase, similar to the child-focused OST condition, the child clinician assisted the child with graduated exposures to the phobic stimuli and challenged anxious cognitions associated with the feared stimuli and their consequences. The parent and parent clinician observed the treatment from behind a one-way mirror for the first hour. In addition to observing how to conduct exposures, the parent received instructions on how to reinforce appropriate approach behaviors and decrease avoidance behaviors and distress associated with the phobic stimuli. In the second hour, parents were assisted in designing exposures for the child utilizing a reward system to engage their child in exposure activities following treatment, and how to deal with their own anxiety when helping their child in the exposure situations. In the third hour, the parent again observed the treatment from behind a one-way mirror and then joined the child in treatment and practiced the observed skills. The child clinician provided feedback and gradually transitioned control of the session over to the parent. Afterwards, the parent clinician contacted the parent once a week for four weeks to encourage the family to continue with ongoing exposures and to troubleshoot difficulties associated with continued exposures outside of session.

Therapists—The therapists received a 4-hour training workshop on OST and A-OST prior to the beginning of the project. In addition, they observed at least two treatment sessions prior to beginning treatment and received supervision for 75 minutes each week from Dr. Ollendick. Nine female and four male graduate clinicians enrolled in a clinical science doctoral program in psychology, all of whom possessed the Masters' degree, served as therapists. Therapists were randomly assigned to either OST or A-OST cases.

Therapist adherence/competency ratings—Therapy sessions were videotaped whenever possible; of the 97 3-hour sessions, 83 (85.6%) were videotaped. The remaining 14 sessions were not videotaped (6 OST, 8 A-OST) because the majority of the treatment session for those cases was conducted outside the clinic (e.g., horticulture garden, town park, airport). The 83 videotaped sessions were coded for adherence/competence using a 12-item rating scale developed for this study. Each item was rated on a 0–6 scale ranging from this activity was “not implemented,” to “implemented but poorly so,” to “implemented in an exemplary fashion.” Representative items included “provided factual information about the phobic object/situation,” “handled difficulties in the exposure procedure,” and “elicited and

worked with the child's catastrophic beliefs." Inter-rater reliability estimates were obtained on 21 of the 83 (25.3%) videotaped sessions. The intraclass correlation coefficient (ICC) averaged across the 12 items was .83, indicating acceptable reliability. Item means were 5.11 ($SD = .49$) for the OST condition and 5.17 ($SD = .51$) for the A-OST condition, indicating a high level of competence in administering the treatments. Adherence/competence ratings did not differ between the two treatments.

A similar 12-item adherence/competence scale (0 to 6) was developed for the videotaped parent sessions in the A-OST condition. Representative items included "clinician provided a description and rationale for the treatment," "clinician described how to continue/monitor exposure after the sessions," and "clinician advised parent(s) on how to handle difficult situations/questions that arose while in the session with the child." Tapes were available for 43 of the 51 sessions (84.3%; tapes were not available for the 8 A-OST cases treated outside the clinic). Reliability estimates were obtained for 15 of the 43 (34.9%) videotaped sessions. The ICC averaged across the 12 items was .73, indicating acceptable reliability of coding. Item means were 5.20 ($SD = .34$), indicating a high level of competence in delivering the parent component of treatment.

Predictors and Moderators of Change

Age and Gender: Chronological age in years and gender were recorded.

Internalizing/Externalizing Problems were obtained from the Child Behavior Checklist/6-18 (CBCL; Achenbach & Rescorla, 2001). The CBCL is a well-validated, multidimensional parent-report measure of the child's behavioral and emotional functioning. Parents rate how true each item is for their child on a 3-point scale (0 = *not true*, 1 = *somewhat or sometimes true*, and 2 = *very true or often true*). The two broad band scales, Internalizing and Externalizing behaviors, were examined as predictors and moderators of treatment outcome. Test-retest reliability over a 1-week interval has been found to be .95 for these problem scales (Achenbach, 1991).

Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) is a 25-item measure designed to assess two dimensions of parenting, care and overprotection, as reported by the parents. In the present study, the overprotection scale was used as a predictor and moderator of treatment outcomes. The overprotection scale, comprised of 13 items, reflects parental allowance of independence, autonomy, and on the opposite end, control, overprotection, intrusion, and prevention of independent behavior (Cronbach's $\alpha = .77$). The PBI has been shown to have good psychometric properties in other studies as well (Parker et al., 1979).

Brief Symptom Inventory (BSI; Derogatis, 1975) is composed of 53 items designed to assess psychological functioning in adults. In this self-report measure, individuals are asked to rate their functioning on a 5-point scale (1 = *not at all* to 5 = *extremely*). The BSI has been found to have adequate reliability and validity (Boulet & Boss, 1991). Primary caregiver report (i.e., T-scores) on the anxiety subscale (Cronbach's $\alpha = .75$) of the BSI was used to assess parental anxiety in the current study.

Treatment Outcome Measures: *Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Versions* (ADIS-C/P; Silverman & Albano, 1996) is a semi-structured diagnostic interview in which clinicians assign a clinician severity rating (CSR) on a 9-point scale (0–8, with a rating 4 suggesting a clinical level of interference) for each endorsed disorder.

In the current study, diagnoses and CSRs were derived separately from the ADIS-P and ADIS-C. Trained-to-criterion clinicians, blind to treatment condition, conducted the diagnostic interviews. Clinicians were supervised research assistants with at least a bachelor's degree and graduate students in a doctoral clinical science program. Training consisted of a 3-hour workshop on the ADIS-C/P, two practice interviews with the trainer, two live observations of administration of the ADIS-C/P with a previously trained clinician, and two interviews conducted with the trainer in the session with the trainee. In addition, all interviews were videotaped, and 25% of the diagnostic interviews were reviewed by a second clinician to compute inter-rater reliabilities. ICCs for the CSRs ranged from .48 to .96, revealing fair to acceptable levels of reliability. Prior to treatment and for the 6-month follow-up, the full ADIS-C/P was administered. At post-treatment and 1-month follow-up, only the ADIS-C/P modules that were endorsed at pretreatment were administered. At each time point, consensus diagnoses and CSRs were determined based on the independent outcomes of the ADIS-C and ADIS-P in weekly staff meetings with a doctoral-level clinical psychologist who supervised the diagnostic assessments. Presence of diagnosis (CSR 4) and CSR changes following treatment were used to measure treatment outcomes.

Clinician Improvement Rating Forms: Designed for this study, the Parent Clinician Improvement Rating form (PCIR) and the Child Clinician Improvement Rating form (CCIR) consist of 6-item instruments measuring improvement in the child's fear level, avoidant behaviors, and overall functioning. Each item was rated on a 9-point scale (0 = *markedly worse* to 8 = *marked improvement*) by the parent and child independent evaluators who conducted the assessments at each point in time. Cronbach's α was .92, .93, and .92 for the parent scale at post-treatment, 1-month follow up, and 6-month follow up, respectively; and Cronbach's α was .91, .91, and .95 for the child scale at post-treatment, 1-month follow up, and 6-month follow up, respectively. Higher total scores at each time point reflect greater improvement as judged by the independent evaluators.

Parent and Child Improvement Rating Forms: Developed for this study, the Parent Improvement Rating (PIR) form consisted of three items measuring fear, avoidance, and phobic interference, rated on a 0–8 point scale. Cronbach's α was .94, .96, and .91 for posttreatment, 1-month follow up, and 6-month follow up, respectively. Lower scores indicate greater improvement.

The Child Improvement Rating (CIR) form also consisted of three items measuring fear, avoidance, and distress; however, these items were rated on a 1–5 point scale, acknowledging the developmental level of the children. Cronbach's α was .80, .86, and .75 for this brief measure at post-treatment, 1-month follow up, and 6-month follow up, respectively. Higher scores reflect greater child-rated improvement.

Parent Self-Efficacy and Satisfaction with Treatment Measures: *Parent Self-Efficacy (PSE)* was measured by a 3-item scale reflecting parents' confidence in their ability to help their child manage their phobia following treatment rated on a 1–5 point scale. Internal consistency for this brief measure was satisfactory at post-treatment (Cronbach's $\alpha = .91$), 1-month follow up (Cronbach's $\alpha = .96$), and 6-month follow up (Cronbach's $\alpha = .95$). Higher scores indicate greater parent self-efficacy.

Parent and Child Treatment Satisfaction (PTS, CTS): Treatment satisfaction was rated separately by parent and child. Parent satisfaction of child outcomes was assessed by a 3-item scale (ranging from 1–5; *strongly disagree* to *strongly agree*). Cronbach's α s were .82, .85, and .94 for post-treatment, 1-month follow up, and 6-month follow up, respectively. Higher scores reflect greater satisfaction. Child satisfaction was also assessed by a 3-item scale (ranging from 1–5; *strongly disagree* to *strongly agree*) measuring general satisfaction with the program. Cronbach's α was .77, .83, and .65, for post-treatment, 1-month follow up, and 6-month follow up, respectively. Higher scores indicate greater satisfaction on both the parent and child measures.

Procedure

Interested parents ($n = 205$) completed a brief phone interview to assess eligibility and appropriateness for study inclusion (see Figure 1 for CONSORT flow chart). Following the phone screen, eligible families were invited for a pretreatment assessment to determine final eligibility and symptom severity ($n = 166$). Upon arrival, the study was described and verbal and written consent/assent was obtained from parents and their children. During the assessment session, one clinician worked with the parent while another worked with the child. If appropriate for the study ($n = 97$), the family was randomized to a treatment condition (OST or A-OST).

After the intervention, depending on the treatment condition, the child or parent clinician conducted weekly phone check-ins with the parents about how things were going and, in the A-OST condition, specifically how the pre-arranged weekly exposure sessions were going. Finally, the families returned for assessments at one-week, 1-month and 6-months following treatment.

Statistical Analyses

Chi square and t-test analyses were used to examine pretreatment differences. Due to the nested nature of our data (i.e., time points within participants), longitudinal analyses were conducted using mixed models with full maximum likelihood estimation to deal with missing data. Expectation maximization was used to address missing data on an item level, and all data were determined to be missing completely at random (MCAR) with the exception of the mother's treatment satisfaction scales for 1-month follow-up, for which missing items were maintained. The diagnosis free analyses used the last data carried forward (LDCF) method and completer analyses were used. All continuous predictor and moderator variables were grand mean centered. Time was dummy coded to reflect the study design (pretreatment = 0, posttreatment = .25, 1-month follow up = 1, and 6-month follow up = 6). In each model, indicators for treatment condition (OST = 0, A-OST = 1), candidate

predictor/moderator, and all two-way and three-way interaction terms² were included. Consistent with the hypothesis generating approach, a 5% two-tailed test of significance with no adjustment for multiple testing was used in the moderator and predictor analyses. Effect sizes were calculated. All 97 randomized participants were included in these intent-to-treat analyses.

A priori power analyses suggested that for a repeated measures analysis with two groups (OST vs. A-OST), four time-points, alpha = .05, and power = .80, a small effect ($d = .20$) required a total sample size of 52, a medium effect ($d = .50$) required a total sample size of 12, and a large effect ($d = .80$) required a total sample size of 6. Therefore, our study was sufficiently powered to detect differences between the treatment groups across time. For moderation analyses with two groups (OST vs. A-OST), four time-points, alpha = .05, and power = .80, a small effect ($d = .20$) required a total sample size of 277, a medium effect ($d = .50$) required a total sample size of 48, and a large effect ($d = .80$) required a total sample size of 22. Given our total sample size of 97 and the small effect sizes anticipated, moderation analyses – as noted above – were undertaken mainly to explore potential differences and generate hypotheses, rather than test specific hypotheses (see Kraemer et al., 2002).

Results

Attrition

Figure 1 depicts participation at each point in time. All 97 participants completed the treatment. Of these, 89 (91.8%) completed the post-treatment assessment, 83 (85.6%) completed the 1-month follow up assessment, and 60 (61.9%) completed the 6-month follow up assessment. Using chi-square and t-tests, there were no significant differences on any demographic or clinical variables (i.e., gender, age, race, phobia type, and pretreatment CSR for the treated phobia) or across the two treatment conditions (i.e., OST vs. A-OST) between assessment completers and dropouts at any of the follow-up intervals (see Table 1).

Sociodemographic and Participant Characteristics

As noted in Table 2, no differences in age, gender, race, type or severity of the SP, or primary caregiver report of overprotection or anxiety were found between the two treatment conditions (i.e., OST, A-OST). All participants met diagnostic criteria for a SP. The treated SP was the primary diagnosis for 70 of the 97 children (72.2%). For the remaining 27 children, the treated SP was the secondary diagnosis; primary diagnoses for these children were Generalized Anxiety Disorder ($n = 15$, 55.6%), Attention-Deficit Hyperactivity Disorder, Combined Type ($n = 7$, 25.9%), Social Anxiety Disorder ($n = 2$, 7.4%), Separation Anxiety Disorder ($n = 2$, 7.4%), and specific phobia of doctors/dentists ($n = 1$, 3.7%). In all

²The following equation represents the unconditional model: $y_{ij} = \beta_1 x_{1ij} + \dots + \beta_p x_{pij} + b_{i1} z_{1ij} + \dots + b_{iq} z_{qij} + e_{ij}$ where y_{ij} is the dependent variable for the j th of n_i observations in the i th of M groups (i.e., OST vs. A-OST); $\beta_1, \dots, \beta_p$ are the fixed effect coefficients (i.e., time, treatment condition, time*treatment condition); $x_{1ij}, \dots, x_{pij}$ are the fixed effect regression for during observation j in group i ; $b_{i1}, \dots, b_{iq}$ are the random effect coefficients (i.e., intercept, time) for group i ; $z_{1ij}, \dots, z_{qij}$ are the random effect regressors; e_{ij} is the error term for observation j in group i .

cases, however, the SP was the primary reason for referral. Comorbidity was the rule rather than the exception; only 7 children (7.2%) had no comorbid diagnosis.

Treatment Outcome Measures

Table 3 displays the estimated marginal means, standard errors and effect sizes (Cohen's d) for the treatment outcomes at each time point.

ADIS-P/C—As expected, analyses revealed a significant time effect for CSRs ($F_{(3, 193)} = 155.05, p < .001$); however, the treatment ($F_{(1, 119)} = 1.29, p = .26$) and time-by-treatment condition ($F_{(3, 193)} = .51, p = .68$) effects were non-significant. Significant decreases in CSRs were observed from pretreatment to post-treatment ($\beta = 3.45, t = 12.05; p < .001$) and from post-treatment to 1-month follow up ($\beta = 1.43, t = 4.98; p < .001$). Significant decreases were also observed from the 1-month follow up to the 6-month follow up ($\beta = .65, t = 2.05; p = .04$). The within-group effect size (Cohen's d) from pre to post was 1.70 for OST and 1.23 for A-OST. Comparable trajectories were observed for the two treatment conditions (see Table 3 and Figure 2).

Using the LDCF method for number of participants who were diagnosis free, no significant differences were noted at post-treatment ($\chi^2 = .03, p = .87$, Cohen's $d = .03$) or at 1-month follow up ($\chi^2 = 2.28, p = .13$, Cohen's $d = .31$). At post-treatment 35.42% of participants in OST and 32.18% of participants in A-OST were diagnosis free and, at 1-month follow up, 56.25% of youth in OST and 44.83% in A-OST were diagnosis free. A marginal difference was observed at the 6-month follow up ($\chi^2 = 3.35, p = .07$, Cohen's $d = .37$), with more youth in OST (67.39%) diagnosis free than youth in A-OST (49.02%). Similar results to those obtained with the LDCF method were obtained using completer analyses.

Parent/Child Clinician-Rated Improvement—A significant time effect ($F_{(2, 129)} = 8.14, p < .001$) was observed for parent clinician-rated improvement, indicating increased improvement ratings in SPs over time. However, treatment and time-by-treatment condition effects were non-significant ($F_{(1, 90)} = .11, p = .74$ and $F_{(2, 129)} = .46, p = .63$, respectively). Similarly, a significant time effect ($F_{(2, 136)} = 9.80, p < .001$) was observed in the child clinician improvement ratings, whereas the treatment condition ($F_{(1, 87)} = .10, p = .76$) and interaction effects ($F_{(2, 136)} = .79, p = .45$) were non-significant. The within-group effect size (Cohen's d) from post to one-month follow-up for parent clinician-rated improvement was $-.28$ for OST and $-.34$ for A-OST. For child clinician rated improvement, the within-group effect size (Cohen's d) from post to one-month follow-up was $-.38$ for OST and $-.52$ for A-OST. See Table 3 for estimated marginal means in each treatment condition across time.

Parent and Child Rated Improvement—High levels of parent rated improvement were obtained (see Table 3 for estimated marginal means). A significant time effect ($F_{(2, 111)} = 17.11, p < .001$) was observed with ratings improving over time. This finding indicates less avoidance and interference due to the SP in the child's life over time following treatment ($\beta_{Post\ to\ 1-m} = -2.26, t = -1.77; p = .08$; $\beta_{1-m\ to\ 6-m} = -.44, t = -.32; p = .75$). Comparable improvements were observed across treatment conditions ($F_{(1, 181)} = 1.41, p = .24$) and the

interaction term was non-significant ($F_{(2, 111)} = 1.44, p = .24$). The within-group effect size (Cohen's d) from post to one-month follow-up was .24 for OST and .13 for A-OST for parent rated improvement.

High levels of child rated improvement were also reported. The time ($F_{(2, 121)} = 2.67, p = .07$), treatment condition ($F_{(1, 85)} = .01, p = .91$) and time-by-treatment condition ($F_{(2, 121)} = .49, p = .62$) for child rated improvement were non-significant, indicating maintenance of improvement across time. The within-group effect size (Cohen's d) from post to one-month follow-up for child rated improvement was $-.01$ for OST and .10 for A-OST. See Table 3 for estimated marginal means broken down by treatment condition and time.

Parent Self-Efficacy and Treatment Satisfaction Measures

Parent Self-Efficacy—Parent self-efficacy in terms of dealing with their child's fear and avoidance and in dealing with their own anxiety in helping their children was high across the various time points. Although the time ($F_{(2, 94)} = .08, p = .93$) and time-by-condition ($F_{(2, 94)} = 1.25, p = .29$) effects were non-significant, the treatment condition effect was significant ($F_{(1, 84)} = 19.60, p < .001$). Parents in A-OST consistently endorsed greater self-efficacy in managing their child's SP and their own anxiety across the follow up time points than did parents in OST ($\beta = -1.79, t = -2.57; p = .01$). The within-group effect size (Cohen's d) from post to one-month follow-up for parent self-efficacy was .09 for OST and .05 for A-OST. See Table 3 for estimated marginal means broken down by treatment condition and time.

Parent and Child Treatment Satisfaction—Across time points, parent rated treatment satisfaction with the treatment program was high, ranging from 12.52 to 13.22 on our 5–15 point scale (see Table 3 for estimated marginal means). The time ($F_{(2, 103)} = .84, p = .43$), treatment condition ($F_{(1, 91)} = .37, p = .55$), and time-by-treatment interaction ($F_{(2, 103)} = .55, p = .58$) were non-significant. The within-group effect size (Cohen's d) from post to one-month follow-up for parent rated treatment satisfaction was $-.05$ for OST and $-.10$ for A-OST. These findings indicate that treatment satisfaction in terms of child outcomes were high at post-treatment and were maintained over time for both treatment conditions.

As with their parents, children also reported high levels of treatment satisfaction, ranging from 12.50 to 13.04 on our 5–15 point scale (see Table 3 for estimated marginal means). No time ($F_{(2, 114)} = .23, p = .80$), treatment condition ($F_{(1, 76)} = .15, p = .70$) or time-by-condition ($F_{(2, 114)} = .42, p = .66$) effects were noted. These findings indicate that child treatment satisfaction was high at post-treatment and remained stable across time and treatment conditions. For child rated treatment satisfaction, the within-group effect size (Cohen's d) from post to one-month follow-up was .01 for OST and .06 for A-OST.

Predictor Analyses

Gender, chronological age, internalizing/externalizing symptoms, parent rated overprotectiveness, and parental anxiety were examined as predictors of the primary treatment outcomes (i.e., CSR, parent/child clinician-rated improvement, and parent and child rated improvement). Age significantly predicted CSRs across time ($F_{(1, 119)} = 7.62, p$

= .02), with older children experiencing a greater decrease in the CSR of the targeted SP than younger children ($\beta = .77$, $t = 1.84$; $p = .14$). Age was also a significant predictor of parent rated improvement in child outcomes ($F_{(1, 146)} = 3.93$, $p < .05$) in that parents of older children reported greater improvement ($\beta = 2.27$, $t = 1.62$; $p = .22$). No other variables predicted CSR outcomes, parent and child clinician improvement ratings or parent and child rated improvement.

Moderator Analyses

These same variables were examined as potential moderators of treatment outcomes; however, none of these variables moderated our treatment outcomes³.

Discussion

The present RCT compared standard, child-focused OST to a parent-augmented-OST in the treatment of various types of SPs in a relatively large sample of children and adolescents. Unexpectedly, both treatments were found to be equally efficacious on our major outcome variables at post-treatment and 1-month follow-up and for most of our measures at 6-month follow-up. At the 6-month follow-up, OST was found to be marginally superior to A-OST in terms of percent of youth who were diagnosis free (67.39% versus 49.02%). We anticipated that A-OST would be superior at each of these time points.

In standard OST, children were treated alone and the parents were not actively involved in treatment. For the most part, the parents brought their children in for treatment, waited while their child received treatment, and were not instructed to arrange for prescribe exposure exercises following treatment. In previous studies, this child-focused treatment resulted in 50% – 60% of treated youth free of their SP diagnosis (see Ollendick & Davis, 2013, for recent review). These results compare favorably to those obtained with more extended treatments (up to 16, 1-hour sessions) for SPs (Silverman, Kurtines, Ginsberg, Weems, Lumpkin, & Carmichael, 1999; Silverman, Kurtines, Ginsburg, Weems, Rabian, & Serafini, 1999) and for other anxiety disorders (Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall, Flannery-Schroeder, Panichelli-Mindel, Southam-Gerow, Henin, & Warman, 1997).

In contrast, A-OST as delivered in the current study utilized a very active parent involvement component, as recommended by Wood et al. (2006) and Breinholst and colleagues (2012). In doing so we attempted to address specific parental risk factors associated with the development and maintenance of anxiety and phobias in children. Yet, no differences in treatment outcomes were obtained at post-treatment, 1-month follow up, and at 6-month follow up (with the exception of percent of youth marginally free from diagnosis at the 6-month follow up). Why might this be so?

First, it should be noted that not all studies that have attempted to supplement or augment CBT with parent involvement have reported improved outcomes (e.g., In-Albon & Schneider, 2007; Nauta, Scholing, Emmelkamp, & Minderaa, 2003; Öst et al., 2001).

³Effect sizes for the moderation analyses are available from the authors.

Furthermore, even in some of the studies that have found enhanced outcomes (e.g., Barrett et al., 1996), such salutatory effects have been found only for girls, younger children, and for children whose parents have an anxiety disorder or heightened levels of anxiety themselves (e.g., Cobham, Dadds, & Spence, 1998). Thus, our failure to find a difference in the two treatments is not without precedent.

In contrast to these earlier studies, however, the current parent-augmented treatment was designed to address not only parenting practices related to their child's anxiety but also heightened levels of parental anxiety when helping their child confront his or her specific phobia. Did we implement the treatments as intended? We think so. The average rating on our adherence/competence scale hovered between "very good" and "excellent" in terms of how well the treatments were implemented, and did not differ between treatments. Moreover, following treatment, parents in the augmented condition indicated high levels of self-efficacy in helping their children deal with their fears. They agreed more strongly than parents in the standard condition that the program "helped *me* understand more about phobias and how they might be treated," "helped *me* learn ways to help my child to overcome his/her phobia" and "helped *me* cope better with my child's phobias." In short, parents in A-OST reported feeling empowered to help their children. Furthermore, on our treatment satisfaction measure, both parents and children reported high levels of satisfaction with both treatments. Thus, we think we delivered the treatments as intended and we delivered them to the parents' and children's satisfaction.

Surely, one would expect the active involvement of parents in the treatment of their children to facilitate change, not impede it, especially given the documented role of parents in the development and maintenance of their child's phobia (Bogels & Brechman-Toussaint, 2006; Breinholst et al., 2012; McLeod et al., 2007). However, our findings suggest that inclusion of parents at best did not contribute to enhanced outcomes and at worst may have contributed to poorer outcomes over the long term. We are puzzled as to why this might have occurred but speculate as follows. It may be the case that parents in the augmented condition who had seen their children do well in treatment and felt empowered to help them following treatment developed inordinately high expectations for their children and perhaps became less tolerant of their children's avoidant behaviors following treatment. Although we did not "track" or document this process following treatment, several parents commented to us how frustrated they became with their children when she or he could not or would not engage the phobic stimulus like they did during treatment, despite their best efforts to help them to do so.

We further speculate that some parents in this study did not possess the risk factors specifically addressed by augmented treatment (i.e., high anxiety, overprotective parenting style). Therefore, these parents may have received less benefit than we anticipated. In fact, inspection of the means on the BSI and the PBI revealed that our parents were reporting average levels of anxiety and average levels of overprotective parenting styles. Only about 15% of our parents reported elevated anxiety scores and only about 20% reported elevated overprotectiveness scores – too few for us to examine statistically. It may be the case that an augmented condition such as the one used here will be of importance primarily if not only for families in whom these risk factors are present. This type of micro-analysis requiring an

idiographic, targeted, person-centered approach will need to await future research. Still, we are mindful of, and agree with, the admonition of Barmish and Kendall (2005) who asserted that “as alluring as it might be to include parents as co-clients for multiple theoretical reasons, this belief cannot be mistaken as evidence” (p. 578).

To explore these outcomes further, we examined whether certain child and parent variables might help us understand for whom the two treatments worked best. Unfortunately, our moderation analyses failed to provide support for any of these variables. Age and gender of the child did not moderate treatment outcomes, nor did the level of internalizing or externalizing symptoms on the parent-rated CBCL. Furthermore, to our surprise, parent ratings of overprotectiveness and parent ratings of their own anxiety did not moderate treatment outcomes either. However, the failure of these variables to moderate treatment outcomes may be due to the fact that levels of these variables were not sufficiently elevated in our sample to produce the expected effects. As noted, the levels of anxiety and overprotectiveness were not sufficiently varied to allow us to identify “high” and “low” families. Yet another possible reason for this finding might be related to our brief, time-limited intervention and whether we were able to change parental overprotectiveness and parental levels of anxiety in one 3-hour session. An examination of the effects of a more extensive treatment on altering these parent variables also awaits further inquiry.

Finally, we examined predictors of treatment outcome. In this study, the same variables that were examined as moderators were also explored as predictors. Only one of the variables was associated with treatment outcomes: Age of the child was associated with lower CSRs and greater parent rated improvement for both treatment groups. That is, older children were rated by their parents to have greater improvements in dealing with their phobias and by our blinded clinicians to have lower clinical severity associated with their phobias following treatment and upon follow-up. Age has also been observed to result in greater treatment response in some treatment studies (In-Albon & Schneider, 2007); however, such effects were not obtained in the earlier SP studies by Öst et al. (2001) and Ollendick et al. (2009). In as much as this study enlisted youth similar in age to those enrolled in the studies by Ollendick et al. (2009) and Öst et al. (2001), it is difficult to comment further on the importance or reliability of these findings. They do, however, suggest the need to continue to examine age in future studies.

As with all RCTs, the present study has its limitations. The major weakness is related to the number of families who failed to return for assessment at the 6-month follow up. Although the failure of families to return for assessment is a significant shortcoming, we did employ longitudinal regression models with maximum likelihood estimation for the incomplete data to address the missing data. As noted by Salim et al. (2008), this approach is generally acceptable even when a “substantial” number of cases are missing as they were in this study. Furthermore, the current guidelines of the Consolidated Standards of Reporting Trials (CONSORT) recommend use of data imputation and longitudinal regression models when outcome data are missing (Moher, Hopewell, Schulz, Montori, Gotzsche et al., 2010). We were able to use such an approach for most of our outcome analyses except for our estimates of diagnostic remission. For this latter analysis, we carried forward diagnostic status from the last available data point as well as undertook completer analyses.

Our study is also limited by our inability to document the link among overprotective parenting practices, levels of anxiety in parents, and response to treatment in our youth with specific phobias. Such documentation would have allowed us to demonstrate connections among our predictor, moderator, and outcome variables. Comparing parents with high and low levels of overprotectiveness as well as parents with high and low levels of anxiety may reveal differences in treatment outcomes, but such was not possible in our study due to the relatively low number of parents self-reporting high anxiety or overprotection. This comparison awaits future study. It should also be noted, the opportunity to further explore the role of phobia type was limited, given the relatively low number of youth evincing the various subtypes. Our study is also limited by the small number of minority participants and the middle to upper-middle class backgrounds of the families who participated. Although these characteristics reflect the racial/ethnic and socioeconomic composition of our surrounding area, it remains unclear how successful our two treatments might have been with youth from more diverse communities. A final limitation is that a majority of our participants were recruited, not clinically referred, and were treated in our university-based research clinic under carefully controlled conditions. As a result, this trial must be viewed as an efficacy trial and not an effectiveness trial.

These limitations notwithstanding, this study possessed several strengths including an examination of this treatment in comparison to a theoretically-driven parent-augmented treatment that attempted to address many of the shortcomings evidenced in earlier studies (Breinholst et al., 2012), collection of treatment adherence and competency measures, inclusion of youth with diverse types of phobias who were highly comorbid with other disorders, and systematic follow-up of treatment gains. Moreover, we explored theoretically-relevant predictors and moderators of change across time. The youth in this study clearly met criteria for a SP on the ADIS-C/P and their phobias were judged to be in the clinically severe range by trained clinicians. Thus, our cases were severe ones with over 90% comorbid with at least one other disorder. Finally, it is important to note the positive effect our 3-hour intensive treatment session, with or without parent augmentation, had for many children and their families on most of our treatment outcome measures.

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Figure 1.

CONSORT Flow chart of participants through the study. A-OST = Augmented OST; OST = One-Session Treatment; SP = specific phobia.

Figure 2.

Clinician severity rating of the targeted SP by treatment condition. A-OST = augmented one-session treatment, OST = one session treatment.

Table 1

Description of participants at each time point on demographic/clinical variables

	Pretreatment (<i>N</i> = 97)	Post-treatment (<i>N</i> = 89)	1-month fu (<i>N</i> = 83)	6-month fu (<i>N</i> = 60)
Categorical Variable	<i>N</i> (%)	<i>N</i> (%)	<i>N</i> (%)	<i>N</i> (%)
Gender				
<i>Female</i>	50 (51.5)	45 (50.6)	45 (54.2)	31 (51.7)
<i>Male</i>	47 (48.5)	44 (49.4)	38 (45.8)	29 (48.3)
Race				
<i>White</i>	82 (84.5)	75 (84.3)	72 (86.7)	53 (88.3)
<i>Non-white</i>	15 (15.5)	14 (15.7)	11 (13.3)	7 (11.7)
Type of phobia				
<i>Animal</i>	30 (30.9)	30 (33.7)	27 (32.5)	18 (30.0)
<i>Environmental</i>	55 (56.7)	48 (53.9)	47 (56.6)	35 (58.3)
<i>Situational</i>	2 (2.1)	2 (2.2)	2 (2.4)	1 (1.7)
<i>Other</i>	10 (10.3)	9 (10.1)	7 (8.4)	6 (10.0)
Treatment condition				
<i>OST</i>	46 (47.4)	43 (48.3)	40 (48.2)	30 (50.0)
<i>A-OST</i>	51 (52.6)	46 (51.7)	43 (51.8)	30 (50.0)
Continuous Variable	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)
Age	8.86 (1.84)	8.97 (1.86)	8.94 (1.91)	8.83 (1.59)
Pretreatment CSR	6.30 (1.02)	6.26 (.98)	6.27 (1.03)	6.17 (1.04)

Note. A-OST = Augmented One Session Treatment, CSR = clinician severity rating, fu = follow up, M = mean, *N* = sample size, OST = One Session Treatment, SD = standard deviation.

Table 2

Comparison of treatment groups on demographic/clinical variables at pretreatment by treatment condition

		OST (N = 46)		A-OST (N = 51)		χ^2	p	η
Categorical Variables	N (%)	N (%)	N (%)					
Gender								
Female	22 (47.8)	28 (54.9)	.49	.49	.07			
Male	24 (52.2)	23 (45.1)						
Race								
White	38 (82.6)	44 (86.3)	.25	.62	.05			
Non-white	8 (17.4)	7 (13.7)						
Type of phobia								
Animal	17 (36.9)	13 (25.5)	1.57	.67	.13			
Environmental	24 (52.2)	31 (60.8)						
Situational	1 (2.2)	1 (1.9)						
Other	4 (8.7)	6 (11.8)						
Continuous Variables	M (SD)	M (SD)	t	p	Cohen's d			
Age	8.79 (1.75)	8.93 (1.93)	-.38	.71	.08			
Phobia CSR	6.30 (0.99)	6.29 (1.06)	.05	.96	-.01			
Internalizing symptoms	58.84 (9.83)	59.04 (7.80)	-.11	.91	.02			
Externalizing symptoms	52.49 (8.92)	51.41 (9.35)	.57	.57	-.12			
Parent overprotection	15.89 (4.66)	14.24 (4.37)	1.78	.08	-.37			
Parent anxiety	48.87 (8.66)	48.78 (8.34)	.05	.96	-.01			

Note. A-OST = Augmented One Session Treatment, CSR = clinician severity rating, M = mean, OST = One Session Treatment, SD = standard deviation.

Table 3

Estimated marginal means and standard errors by treatment condition at each time point

	OST (N = 46)	A-OST (N = 51)		
Measure	M(SE)	M(SE)	p	Cohen's d
ADIS-CSR (N = 97)				
Pretreatment	6.30(.20)	6.29(.19)	.970	-.01
Post-treatment	3.86(.25)	4.27(.24)	.240	.24
1-month fu	3.22(.24)	3.49(.23)	.416	.17
6- month fu	2.46(.28)	2.84(.27)	.325	.20
Parent Clinician Improvement (N = 89)				
Post-treatment	32.95(.93)	34.12(.90)	.370	.19
1- month fu	36.12(1.02)	35.94(.99)	.899	-.03
6- month fu	36.25(1.09)	36.37(1.25)	.939	.01
Child Clinician Improvement (N = 89)				
Post-treatment	32.85(.91)	32.98(.89)	.919	.02
1- month fu	34.84(.97)	36.30(.95)	.284	.22
6- month fu	36.44(1.08)	35.82(1.13)	.688	-.08
Parent rated improvement (N = 79)				
Post-treatment	9.11(.83)	11.07(.76)	.084	.36
1- month fu	7.88(.84)	8.35(.80)	.684	.08
6- month fu	5.77(.99)	6.96(.92)	.375	.18
Child rated improvement (N = 86)				
Post-treatment	12.17(.41)	12.48(.40)	.589	.11
1- month fu	12.91(.43)	12.59(.42)	.589	-.11
6- month fu	13.12(.49)	13.29(.51)	.810	.05
Parent self-efficacy (N = 79)				
Post-treatment	11.12(.40)	13.17(.30)	<.001	.85
1- month fu	10.73(.44)	13.46(.42)	<.001	.92
6- month fu	11.33(.51)	13.13(.48)	.011	.53
Treatment Satisfaction–parent (N = 79)				
Post-treatment	12.52(.31)	12.76(.28)	.561	.12
1- month fu	12.67(.36)	13.22(.35)	.279	.22
6- month fu	12.92(.42)	12.85(.40)	.864	-.02
Treatment Satisfaction–child (N = 86)				
Post-treatment	12.50(.38)	12.98(.37)	.369	.19
1- month fu	12.70(.41)	12.87(.40)	.748	.06
6- month fu	13.04(.47)	12.90(.48)	.838	-.04

Note. ADIS = Anxiety Disorders Interview Schedule, A-OST = Augmented OST, CSR = Clinician Severity Rating, fu = follow up, M = mean, N = sample size, OST = One-Session Treatment, SE = standard error.