Treatment of children's nighttime fears: the need for a modern randomised controlled trial
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CRD summary
This review investigated the impact of psychological interventions on children with night-time fears. The authors concluded that the findings for the efficacy of brief cognitive-behavioural interventions were encouraging, though further research is required. The review has several methodological weaknesses and it is unclear whether the synthesis of the data can be relied upon.

Authors' objectives
To evaluate research on the treatment of children's night-time fears.

Searching
MEDLINE and PsycINFO were searched for studies reported in English for the period 1962 to 2004; the search terms were not reported.

Study selection
Study designs of evaluations included in the review
Inclusion criteria for the study design were not specified.

Specific interventions included in the review
Studies of psychological treatments were eligible for inclusion. The most common techniques used in the included studies were real life or imaginal desensitisation using techniques such as relaxation; reinforcement using techniques such as verbal praise and treats; and cognitive self-instruction involving the child repeating, before bedtime, positive statements about their bravery or competence. Treatment duration was generally short, on average two to four weekly sessions. Parents were involved in most of the interventions. Control groups, where specified, included waiting-list controls and active comparators.

Participants included in the review
Studies of children with night-time fears were eligible for inclusion. Children with night sleep disorders were excluded, as were children with bedtime refusal and night wakenings who had not been assessed for night-time fear. In approximately half of the included studies the severity of night-time fear experienced by the children was unclear; in the majority of the remaining studies the children had severe night-time fear. The reviewers classified severity based on the level of anxiety or avoidance response to feared stimulus, interference with daily functioning, and duration of the fear, though it was unclear how the different severity levels were defined. Fears included the dark, monsters, intruders and being alone. The participants had single and multiple fears. The age of the participants ranged from 3 to 16 years.

Outcomes assessed in the review
Inclusion criteria for the outcomes were not specified. The outcome was assessed using a variety of different measures, including unstructured or structured diagnostic interviews with parents and/or the child, self-report anxiety and fear scales, visual analogue fear ratings designed for use with children, behavioural tasks, and parent-completed behavioural observations. The length of follow-up ranged from 2 weeks to 12 months.

How were decisions on the relevance of primary studies made?
The authors did not state how the papers were selected for the review, or how many reviewers performed the selection.

Assessment of study quality
The authors did not state that they assessed validity.
Data extraction
The authors did not state how the data were extracted for the review, or how many reviewers performed the data extraction. Pre-treatment assessment, outcomes and follow-up were reported, along with details of the specific fears.

Methods of synthesis
How were the studies combined?
The studies were reported in a narrative synthesis.

How were differences between studies investigated?
Differences were reported in the tables and text.

Results of the review
Twenty-nine papers reporting 28 studies were included: 10 randomised controlled trials (n=532), 7 studies that were described as multiple baseline design (n=38), and 11 case studies (n=21).

A reduction in night-time fears was rapidly achieved with most of the interventions. However, the interventions were multifaceted and it was unclear what aspects of the interventions were important in achieving the positive outcomes.

Authors’ conclusions
The findings for the efficacy of a brief intervention of a cognitive-behavioural nature were encouraging. The controlled studies had quality problems in terms of treatment fidelity, sampling and the limited range of outcome measures used.

CRD commentary
Inclusion criteria were specified for the intervention and participants of interest. The inclusion criteria for the intervention were very broad, which would be acceptable provided the diversity of outcomes was explored adequately in the synthesis; however, this was not the case. Two relevant databases were searched but non-English language studies were excluded and unpublished studies were not sought, thus introducing the risk of publication and language bias. Methods to reduce error and bias in the study selection and data extraction processes were not reported, so it is difficult to judge the likelihood of bias and error. The quality of the studies was not systematically assessed, although in their discussion the authors pointed out a number of broad methodological limitations in the included studies.

Relevant details of the individual studies were presented, but only a summary of their results was provided; this makes it difficult to assess the magnitude of the improvements. The decision to use a narrative synthesis seems appropriate given the diversity of the studies, although the synthesis focused on describing the studies rather than synthesising the results. The review has several methodological weaknesses and it is unclear whether the quality of the included studies and the synthesis of the data can be relied upon.

Implications of the review for practice and research
Practice: Very brief interventions consisting of a few sessions with cognitive-behavioural techniques might be sufficient to reduce children's night-time fear and associated behaviours, and the use of parents as co-therapists could be helpful. Manual-based treatments appear promising. Comprehensive assessment to establish the presence of night-time fears is required.

Research: A randomised controlled trial comparing cognitive-behavioural therapy with an attention placebo and a waiting-list control is required. The trial should be manual based with systematic assessment of the consistency of intervention implementation, the use of multiple outcome measures, and the investigation of long-term outcomes. The effects of parental involvement, home-based treatment and one-session treatment also require investigation.

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