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Treating nighttime fears in young children with bibliotherapy: Evaluating anxiety symptoms and monitoring behavior change

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ABSTRACT

Objective: Children's nighttime fears are a normal part of child development and are transient for most children, but result in considerable distress for others. The present study evaluated a 4-week bibliotherapy intervention designed to treat young children with persistent and interfering nighttime fears utilizing a multiple baseline design.
Method: Nine children between 5 and 7 years of age with specific phobia diagnoses were randomized into one of three baseline control conditions (1, 2, or 3 weeks). The treatment protocol involved parents reading *Uncle Lightfoot, Flip that Switch: Overcoming Fear of the Dark, Academic Version* (Coffman, 2012) with their children over 4 weeks while engaging in activities prescribed in the book. Assessments took place at baseline, post treatment, and 1 month following treatment. Daily and weekly tracking of nighttime behaviors was also obtained.
Results: Pre-post group analyses revealed that eight of the nine children demonstrated clinically significant change in anxiety severity. In addition, decreases in child-reported nighttime fears were observed, as were parent-reported decreases in separation anxiety and increases in the number of nights children slept in their own bed.
Conclusions: The present study provides initial support for the use of bibliotherapy in the treatment of nighttime fears. Further replication and evaluation are needed to determine appropriate length of treatment and long-term effects. Implications of the findings are discussed.

1. Introduction

Nighttime fears are a normal part of child development (King, Ollendick, & Tonge, 1997; Muris, Merckelbach, Ollendick, King, & Bogie, 2001). However, an estimated 20% of children have severe nighttime fears and sleep problems (Gordon, King, Gullone, Muris, & Ollendick, 2007). In addition, Muris et al. (2001) reported that 58.8% of children between 4 and 6 years of age and 84.7% of children between 7 and 9 years of age report at least mild nighttime fears, suggesting that nighttime fears are quite common in youth. In young children, nighttime and transitioning to sleep can prove to be quite challenging, especially for those children with more severe fears of the dark (Gordon et al., 2007; Sadeh, 2005). Additional research demonstrates links between nighttime fears, nighttime waking, poor sleep quality, and less overall sleep (Kushnir & Sadeh, 2011). If these fears are left untreated, they may persist and have adverse effects on child development and lead to later anxiety and psychopathology in late childhood and adolescence (Bittner et al., 2007; Muris, Merckelbach, Mayer, & Prins, 2000).

Although nighttime fears do not constitute a separate diagnostic entity, young children may have fears related to the dark that are so interfering and impairing they meet criteria for a specific phobia diagnosis. Specific phobias are estimated to be present in about 10% of community samples of children and adolescents and up to 5% of referrals to outpatient centers (Kessler et al., 2005). Additionally, up to 15% of referrals for the treatment of childhood phobias are related to the dark and being alone in the dark (Graziano, Mooney, Huber, & Ignasiak, 1979). These fears can result in the child experiencing significant anticipatory anxiety preceding bedtime and having elevated fear and anxiety symptoms throughout the night and into the next day. For some children, the fears last for years. There is limited research on nighttime fears and sleep related disturbances in youth with anxiety disorders. However, Alfano, Ginsburg, & Kingery (2007) reviewed literature which

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suggests high correlations between childhood GAD and sleep problems. Moreover, this study concluded that 85% of children with anxiety disorders have sleep disturbances which range from difficulty initiating sleep to nocturnal fears (Alfano et al., 2007).

1.1. Treatment for child anxiety

Cognitive behavioral therapy (CBT) is the first line of treatment for child fear and anxiety (Chorpita et al., 2011; Kendall, 2012). Systematic desensitization, graduated in vivo exposure, cognitive restructuring, reinforced practice, and participant modeling have all proven to be effective techniques for treating anxiety and its disorders (Davis & Ollendick, 2005; Ollendick & King, 1998). Although the field has made significant strides in developing evidenced-based treatments for children with anxiety and other disorders, a subset of children do not respond to traditional CBT, with effectiveness rates ranging from 60% to 70% (In-Albon & Schneider, 2007; Kendall et al., 2005; Seligman & Ollendick, 2011; Walkup et al., 2008). These remission rates leave room for improvement to existing treatments and in the development of new treatments. Moreover, as of yet, we have not identified for whom and under what conditions clinic-administered CBT works for a child and his or her family. Furthermore, there may be specific barriers that prevent families from receiving weekly clinic-based treatment, such as distance to the treatment center, work schedules, financial resources, and/or childcare. Researchers have pointed out that self-help treatments may be an effective means of treatment and potentially more efficacious than clinic based treatment for specific disorders (see Elgar & McGarth, 2008; Gould & Clum, 1993; Hirai & Clum, 2006; Rapee, Abbott, & Lyneham, 2006). As such, bibliotherapy has been identified as an alternate approach to treating children and adolescents with varying forms of psychopathology (Paparoussi, Andreou, & Gkouni, 2011; Rickwood & Bradford, 2011).

1.2. Bibliotherapy as a treatment approach

Bibliotherapy is the use of books as therapy in the treatment of mental disorders. The theory behind bibliotherapy is that reading about one's problem areas can produce change that is specific and predictable (Lenkowsky, 1987). The theoretical underpinnings of bibliotherapy for anxiety are such that the books incorporate common anxiety-reduction principles, including coping strategies, exposure to anxiety provoking situations, reinforcement, and modeling of desired behaviors through use of story-telling. One concern with bibliotherapy for young children is the need for the parent/guardian to be highly involved. Bibliotherapy requires an ability to read and comprehend; therefore, bibliotherapy is typically delivered by the parent for younger children. This may present additional concerns of parent psychopathology, implementation consistency, and parenting practices. Nonetheless, prior research on bibliotherapy for anxious youth demonstrates the usefulness of self-help books (Rapee, Spence, Cobham, & Wignall, 2000). Another potential concern with treating children with bibliotherapy is the high rate of comorbidity found amongst children with anxiety disorders (Kendall et al., 1997). One would think that bibliotherapy (therapy) may only target one disorder and leave high levels of impairment. However, in a review of evidence-based treatments of childhood disorders that included the anxiety disorders, Ollendick, Jarrett, Grills-Taquechel, Hovey, and Wolff (2008) found that comorbidity did not adversely affect treatment outcomes for anxious youth. Furthermore, research suggests the generalization of effects of time-limited CBT treatment to non-targeted problems including comorbid anxiety disorders (Ollendick, Ost Reuterskoild, & Costa, 2010).

Recently, Coffman, Andrasik, and Ollendick (2013) identified the following advantages of bibliotherapy for young children: ease of administration, potential to enhance motivation for change, and the ability to incorporate a number of therapeutic components into a format that is intrinsically appealing to children. In one randomized control trial (RCT) of bibliotherapy for anxiety disorders in children aged 6–12, the group who received bibliotherapy showed superior outcomes over a traditional CBT group, and those gains were maintained at a 6-month follow-up (Parslow et al., 2008). Moreover, there has been other research that demonstrates the effectiveness of bibliotherapy for anxious youth (Cobham, 2012; Rapee, 2003; Rapee et al., 2006).

Using an earlier version of the book used in this study, *Uncle Lightfoot* (Coffman, 1983), Mikulas and Coffman (1989) demonstrated that the treatment was more effective than a parent attention control condition. Mikulas, Coffman, Dayton, Frayne, and Maier (1985) first tested out these games developed for bibliotherapy treatment. Subsequently, Santacruz, Mendez, and Sanchez-Meca (2006) conducted a randomized controlled study ($N = 78$) comparing two play therapy treatments to a control group. One of the treatments used was *Uncle Lightfoot* (Coffman, 1980–1983Coffman, 1980–1983). This research demonstrated positive changes in fear of the dark and dark related behaviors utilizing the book. However, only about 50–60% of the children and their families responded to this treatment; as a result, changes were made based on these studies that included greater parental application of the materials and child engagement in the exercises included in the book. Unlike most didactic treatment manuals used by clinicians, books such as *Uncle Lightfoot* (Coffman, 2012, 2014) are designed for parents and have the potential for being widely available to families. For this reason, it is important that the children's book and parent instructions are sufficiently understandable so that most parents can carry out the program with minimal therapeutic guidance.

1.3. Current study

In the present study, we sought to evaluate the effectiveness of this bibliotherapy treatment for young children with specific phobias of the dark and fears of sleeping alone. We utilized the revised version of this book, *Uncle Lightfoot, Flip That Switch: Overcoming Fear of the Dark* (Coffman, 2012), a 19-chapter children's book, which contains a 28-page Parent Guidebook. The book is a child-focused story about a boy named Michael who is afraid of the dark. He conquers his fear of the dark by engaging in exposure games with his Uncle Lightfoot.

Given prior research suggesting the effectiveness of bibliotherapy for child anxiety, we hypothesized that children would demonstrate significant changes in the severity of their specific phobia diagnosis following treatment. Secondly, we hypothesized that children's avoidant behaviors (i.e., refusing to sleep in own bed) would significantly decrease upon completion of treatment. Lastly, we anticipated decreases in child and parent report of fear and anxiety on the Koala Fear Questionnaire (Muris, 2003) and the Preschool Anxiety Scale (Spence, Rapee, McDonald, & Ingram, 2001), as we expected skills to transfer from conquering nighttime fears to dealing with anxiety more generally. Since the book was modified following the previous randomized control trial (Santacruz et al., 2006), we utilized a single case, multiple baseline design to explore our hypotheses and examine whether the revised book was effective with more children and their families (see Chambless and Ollendick (2001) for the suitability of this approach in beginning to establish an evidence base for novel and experimental interventions).

Table 1
Demographics.

Participant	Age	Gender	Race/ethnicity	Family income	PPVT (std age)
1	7	M	Biracial (C/AA)	50 k	123
2	4	F	C	65 k	104
3	7	M	C	NS	127
4	6	F	Biracial (C/H)	60 k	118
5	5	M	C	100 k	130
6	5	M	H	45 k	129
7	6	M	H	45 k	127
8	6	M	C	110 k	112
9	5	M	C	40 k	105

Note: M, male; F, female; C, Caucasian; AA, African American; H, Hispanic, NS, not specified.

2. Method

2.1. Participants

Participants included nine children and their mothers recruited from the local community. Inclusion criteria were as follows: (a) child between the ages of 5 and 7 years at the beginning of treatment, and (b) meet criteria for a diagnosis of specific phobia of the dark/alone according to the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition Text Revised (DSM-IV-TR, 2004). Exclusion criteria were: receptive vocabulary below 80 (as measured by the Peabody Picture Vocabulary Test), acute psychotic symptoms or mood disorders, and involvement in current treatment for nighttime fears.

Following Institutional Review Board (IRB) approval, participants were recruited from Southwestern Virginia by contacting mental health professionals in the area, posting flyers at local restaurants and child friendly venues, and advertising in schools. Interested parents ($n = 19$) underwent a brief phone screen (about 15 min). Children who met eligibility criteria ($n = 13$) were scheduled for an initial assessment. Eligible families were mailed an informed consent, parent permission form, child information form, and several questionnaires. Informed consent and assent were then obtained during the first visit to the clinic. A project team meeting, led by a licensed clinical psychologist, was held following the initial assessment to discuss findings from the Anxiety Disorders Interview Schedule for Children, Parent Version (Silverman & Albano, 1996) and establish initial diagnoses and eligibility for participation.

Of the 13 children who came in for the initial assessment, two were not eligible as their primary difficulties were identified as sleep terror disorder and two others chose not to participate in the study due to conflicts in time/schedules. Thus, the final sample included nine children (mean age = 5.78; $SD = .83$) with a primary or secondary diagnosis of specific phobia and their mothers. Eight of the nine families participated in assessment at all three time points; one family was not available for follow-up assessment due to family re-location. Seven of the children were boys (77.7%), five were Caucasian (55.5%), two were Hispanic (22.2%), and two were biracial (22.2%; one Caucasian/African American, and one Caucasian/Hispanic). Mean receptive vocabulary was 119.4 ($SD = 10.21$, range = 104–130) as obtained from the Peabody Picture Vocabulary Test (PPVT-4; Dunn & Dunn, 2007). Eight of the nine children had a primary diagnosis of specific phobia of the dark and one had a primary diagnosis of separation anxiety disorder, with a secondary diagnosis of specific phobia of the dark. Five of the eight children who had a primary diagnosis of specific phobia met criteria for a secondary diagnosis, most commonly another anxiety disorder (social anxiety disorder = 1, another specific phobia = 3), with the remaining child having a secondary diagnosis of Attention Deficit Hyperactivity Disorder, Combined Type (ADHD-C). There were no children who presented with a primary or secondary diagnosis of Generalized Anxiety Disorder. These comorbidity rates are consistent with past studies (Ollendick et al., 2008). Mean family income was $64,375 (range = $40,000–$110,000) and all nine children were living with both parents. Mother's average age was 40.2 years ($SD = 5.17$) and all mothers completed college (100%). See Table 1 for a summary of demographic information.

2.2. Design and data analysis

Parents and children came to the clinic for an initial assessment and then for an instructional session following the 1, 2, or 3-week baseline period. The treatment for the current study involved parents reading the updated version of *Uncle Lightfoot: Flip That Switch* (Coffman, 2012) with their children over 4 weeks and participating in brief weekly phone check-ins with the therapist. During the 4 weeks, parents completed daily and weekly monitoring forms to track changes in their children's nighttime behavior. At the end of the 4 weeks, families returned to the clinic for a post-treatment assessment, and again 4 weeks later for a 1-month post treatment follow-up assessment. Parents were instructed to read chapters from the book each evening and to read completely through the book at least two times over the 4-week period, playing all of the games that the child was willing to play during the story reading time. Some of the games consisted of finding toys in the dark, identifying sounds, and racing to turn lights out. Essentially, these games were exposures for the children to help conquer their fear of the dark.

The research design was a non-concurrent multiple baseline single-case design. This design is a series of A–B replications with randomized baseline periods (see Chambless & Ollendick, 2001). Single-case designs are often less time intensive and more cost-effective than large scale Randomized Control Trials (RCTs) and therefore are more feasible in the early stages of treatment development and are useful in examining the utility of treatment modifications (e.g., modifications of existing treatments (see Horner et al., 2005; Morgan & Morgan, 2009).

Following pre-treatment assessment, children were randomly assigned to baseline phases lasting 1, 2, or 3 weeks. During baseline, parents completed a daily monitoring form, which tracked their child's nighttime behaviors including whether the child spent the night in their own bed, a sibling's bed, or their parents' bed. Repeated measures continued throughout the baseline period, the 4-week treatment phase, and a week before the 1-month follow-up. Following the baseline period, the family came into the clinic for an hour-long session to receive the book and additional materials (e.g., instruction manual, beads for rewards). The parents were given a brief introduction to the book, the concept behind bibliotherapy was explained, and an instruction sheet was provided. As mentioned above, the family was instructed to read from the book every night for 4 weeks. Brief (~10 min) phone check-ins were conducted approximately every 2 weeks over the 4-week treatment period to address any difficulties encountered during use of the

book. All nine families completed the two phone check-ins. This was the only contact the families had with the clinician during the 4-week treatment period. Comprehensive assessments were conducted at the clinic after completion of the bibliotherapy and again at 1-month follow-up.

Given the small sample size, non-parametric Friedman tests were used followed by post hoc Wilcoxon tests to examine symptoms at baseline, compared to symptoms at post and the 1-month follow-up. Wilcoxon tests were used when the Friedman test was significant. For ADIS CSRs, a method for calculating "clinical significance" was used (Jacobson & Truax, 1991). Jacobson and Truax (1991) recommend a change of two standard deviations from the pretreatment group mean as a cutoff for "recovery" at post treatment. The CSRs were averaged at pre, post, and 1 month separately and these scores were used to calculate the Reliable Change Index score (Jacobson & Truax, 1991).

2.3. Measures

2.3.1. Anxiety Disorders Interview Schedule for Children, Parent Version (ADIS-P; Silverman & Albano, 1996)

The ADIS-C/P is a semi-structured diagnostic interview administered separately to parents and children and designed to assess childhood anxiety disorders, as well as other childhood disorders (e.g., MDD, ADHD). Although the ADIS-C/P was designed for use with children 6 and older, acceptable interrater agreement has been reported for younger children (kappas of .77–.86; Rapee, Kennedy, Ingram, Edwards, & Sweeney, 2005). Only the parent interview was administered during each assessment session (pretreatment, post-treatment, and 1-month follow-up). The parent interview contains modules for several additional disorders (e.g., Conduct Disorder, Oppositional Defiant Disorder, Enuresis), and requests supplementary information with regard to history and interference of specific problems. The clinician assesses symptoms and obtains frequency, intensity, duration and interference ratings which are used to develop a clinician severity rating (CSR). A CSR of 4 or above (range = 0–8) indicates a diagnosable condition. The ADIS-P has demonstrated adequate test–retest reliability (kappas of .65–1.00: Grills & Ollendick, 2003; Silverman & Ollendick, 2005; Silverman, Saavedra, & Pina, 2001).

Trained-to-criterion graduate clinicians conducted diagnostic interviews for this study, and interviews were videotaped. Following the interview, the parent clinician assigned severity ratings (CSRs) for each diagnosis on a scale from 0 to 8, where 0 = no symptoms, 2 = mild, 4 = moderate, 6 = severe, and 8 = very severe. Subsequent to this, a clinical consensus meeting was held during which the final CSRs were reviewed and assigned. To determine reliability of diagnoses, independent assessors randomly selected and reviewed 33% of the videotaped interviews. Agreements at the diagnostic level, using Cohen's kappa (Cohen, 1988), were .68 (substantial agreement) and .55 (moderate agreement) for the primary and secondary diagnoses, respectively. Interrater reliabilities of the CSRs were .98 and .93 for primary and secondary diagnoses. Mean CSR for the treated phobia was 6.67 (SD = .71) on the 0–8 severity scale, reflecting moderately severe levels of disturbance.

2.3.2. Dark Fear Interview

Although not used diagnostically, the children were asked to provide qualitative information regarding the severity of their fear during each assessment. The children answered questions pertaining to their bedtime routine, what is scary about the dark, what happens when they wake up, and the avoidance behaviors in which they engage. Children also provided a general rating of their fear level when in the dark alone and when sleeping alone using a 5-point, 0–4 Likert scale, which included numerical ratings matched with emotion faces.

2.3.3. Koala Fear Questionnaire (KFQ; Muris et al., 2003)

The KFQ is a 31-item interview-based, self-report scale for assessing fears in 4- to 12-year-old children. Children rate their level of anxiety using a visual scale depicting Koala bears that express various degrees of fear (1 = no fear, 2 = some fear, 3 = a lot of fear). A total KFQ score can be obtained by summing the item scores (range 31–93). The measure has five factors, which make up the total scale. According to Muris et al. (2003), psychometric properties of the KFQ have proven to be adequate. Internal consistency and test–retest reliability were reported to be satisfactory and total scores correlated positively with concurrent measures of fear and anxiety. For the current study, internal consistency (α = .79) was in the acceptable range and test–retest reliability was good (α = .8). Additionally, for the current study, a subscale consisting of three items most relevant to nighttime fears ("being alone in the dark", "ghosts", and "scary dreams") was created and internal consistency was low (α = .513). This subscale demonstrated acceptable test re-rest reliability (α = .77). The item "being alone in the dark" was also analyzed separately as a single-item scale and demonstrated questionable test–retest reliability (α = .69). The KFQ was administered to the child at each assessment session.

2.3.4. Peabody Picture Vocabulary Test, Fourth Edition (PPVT-4; Dunn & Dunn, 2007)

The PPVT-4 is a measure of receptive vocabulary that can be administered to children as young as 2 years and 6 months of age. Its ease of administration and applicability to individuals who may not be able to use expressive language, read, or write makes it ideal for pre-school children such as in the current study. The PPVT-4 yields a composite score with a mean of 100 and standard deviation of 15. Dunn and Dunn (2007) documented its construct validity in 3- to 12-year-old children with a correlation of .72 on the Expressive Language subscale of the Clinical Evaluation of Language Fundamentals, Fourth Edition (Dunn & Dunn, 2007). The PPVT-4 was only administered at pre-assessment to determine eligibility for participation.

2.3.5. Preschool Anxiety Scale (PAS; Spence et al., 2001)

The Spence Pre-School Anxiety Scale is a 29-item measure completed by parents of children between the ages of 3 and 6 years. It was completed at each assessment session. The first 28 items are rated on a 5-point scale, ranging from 1 (not at all true) to 5 (very often true) and the last item is an open ended question relating to traumatic experiences. The 28 anxiety items provide an overall measure of anxiety (sum score), in addition to scores on five sub-scales (generalized anxiety, social anxiety, obsessive compulsive disorder, physical injury fears and separation anxiety). This measure was used to determine whether children showed elevated levels of anxiety. In the present study, we focused on the separation anxiety subscale, given its relations to nighttime fears. Psychometric evaluations of the PAS have shown that the questionnaire possesses good reliability (α = .79 in current study) and validity (Broeren & Muris, 2008; Edwards, 2007; Spence et al., 2001). The PAS demonstrated acceptable test re-rest reliability for this study (α = .75).

2.3.6. What My Child Can Do At Night in the Dark (WICDAN-Parent Form; Coffman, 1987)

The WICDAN is an 11-item parent-report measure of children's self-efficacy in dealing with their fear of the dark completed at each assessment session and at the end of each week during treatment. Each item on the scale is answered on a 3-point scale (0 = "No, it would be hard to do", 1 = "Yes but it would be hard to do", and 2 = "Yes easily"). The total score on the WICDAN ranges from 0 to 22. The measure possesses good internal consistency (α = .89 for current study), with child–parent agreement ranging from 87% to

93% (Coffman, 1987). Additionally, this measure display acceptable test–retest reliability (α = .78).

2.3.7. Treatment Satisfaction Survey

A 10-item treatment satisfaction survey was administered at the 1-month follow-up to assess the parents' satisfaction with the program. The survey included items regarding the parents' perception of changes in their child's fears and how much the treatment helped them deal with their child's fears. Responses for each item were recorded on a 1–5 scale.

2.3.8. Treatment Evaluation Survey

A 19-item evaluation form developed for *Uncle Lightfoot* (Coffman, 2012) was administered during the post assessment. The form included questions regarding the specifics of the parents' use of the book such as which chapters they used, how often they read the book, and which games they played. Items regarding improvements in the child's fears and functioning and how much the family enjoyed using the book were also included.

3. Results

3.1. Treatment retention and adherence

All nine families completed treatment and the post-treatment assessments. Eight of the nine families completed the 1-month assessment; however, one family did not do so due to moving from the area.

Six of the nine parents read through the book at least two times over the 4-week period as requested. Five of the nine parents reported using the book more than 2 h per week and eight of nine parents reported at least 1–2 h per week (see Table 5 for treatment adherence/dose). The parents read the book to their child on average 4.64 nights per week over the 4 weeks (on average 5.88 nights the first week, 4.88 nights the second week, 4.0 nights the third week, and 3.77 nights the fourth week).

3.2. Changes in severity of specific phobia

Our first hypothesis suggested that the children would demonstrate significant changes in the severity of their specific phobia diagnosis. To analyze change in the CSRs associated with the specific phobia diagnoses, Friedman tests were conducted. Results of the Friedman tests demonstrated significant change in symptoms on the ADIS-P from pre to follow-up ($\chi^2(2) = 12.92$, $p = .002$). CSR means changed from 6.75 at pre- to 3.89 at post-treatment and 3.38 at follow-up (see Table 2). Post hoc Wilcoxon tests found significant differences from pre- to post-assessment ($Z = -2.54$, $p = .011$) and pre to 1-month ($Z = -2.54$, $p = .011$), but not from post to 1-month ($Z = -.68$, $p = .50$), reflecting stability of change.

Reliable Change Index (RCI) scores were also calculated for specific phobia CSRs to measure clinically significant changes from pre to post and pre to 1 month. Analyses showed that eight of the nine children exceeded the clinical cutoff (>1.96) for change in specific phobia scores from pre to post (see Table 2) and that three (33%) of the nine children were in the non-clinical range at post-assessment (CSR < 4). For the pre to 1-month follow up, eight of the nine children exceeded the clinical cutoff (>1.96) for change between their pre and 1-month CSR scores, with 3 (33%) of the children remaining in the non-clinical range at the 1-month follow-up assessment. One child did not exhibit change in ADIS CSR (see Table 2).

3.3. Changes in avoidant behaviors

Our second hypothesis was that children's avoidant nighttime behaviors would significantly decrease upon completion of treatment. We used inability to sleep in own bed through the night as a measure of avoidant behavior. Fig. 1 reports the number of nights each children slept in their own bed from baseline to follow-up. Mean at baseline was 2.14 nights per week and increased to 5.2 nights per week by the end of treatment. One child did not evidence any change in number of nights slept in own bed; however, it should be noted that this child did show a decrease in the ADIS ratings and the family reported significant progress in nighttime behaviors over the course of the treatment. Fig. 1 displays the number of nights slept in own bed over time.

3.4. Changes in child and parent report of fear and anxiety

Our last hypothesis stated that we expected decreases in child and parent report of nighttime fears and anxiety. To analyze change in child fear and anxiety at the symptom level, Friedman tests were conducted on the following measures: (1) child reported fear on the Dark Fear Interview; (2) the nighttime fear subscales of the KFQ; (3) the separation anxiety subscale of the PAS; and (4) parent reported change in nighttime behaviors (see results in Table 3).

3.4.1. Dark Fear Interview

Results of Friedman tests showed significant decreases in child reported fear on the Dark Fear Interview across pre, post, and 1-month follow-up (χ^2 (2) = 7.52, p=.023). Wilcoxon tests showed significant change in child reported fear from pre to post ($Z = -2.40$, $p = .017$) and from pre to 1-month follow-up ($Z = -2.21$, $p = .027$).

3.4.2. Nighttime fear on the KFQ

Friedman tests also demonstrated significant change on the KFQ nighttime fears subscale across pre, post, and 1-month follow-up ($\chi^2(2) = 11.86$, $p < .05$). Wilcoxon tests showed that there were significant changes from pre to post ($Z = -2.56$, $p = .011$) and from pre to follow-up ($Z = 2.38$, $p = .018$). There were significant changes on

Table 2
Treatment adherence/dose.

Participant	No. of times book read (TES)*	No. of times book read (NMF)**	Average time spent per week*	Average number of games played per week**	Average number of pages read per night**	Number of games enjoyed over all*
#1	2	1.9	1–2 h	6	5.67	14
#2	2	0.8	30–60 min	3.67	1.26	6
#3	2	2	>2 h	5.5	6.15	8
#4	1	0.6	>2 h	4.5	2.03	10
#5	1	1.4	1–2 h	6.5	3.96	7
#6	3+	2.5	>2 h	7.5	7.17	14
#7	3+	2.3	>2 h	7.5	6.82	14
#8	1	1.0	1–2 h	3.25	3.15	5
#9	2	1.8	>2 h	8.25	5.52	7

* Denotes items taken from the Treatment Evaluation Survey (TES).
** Denotes items taken from the Nightly Monitoring Form (NTM).

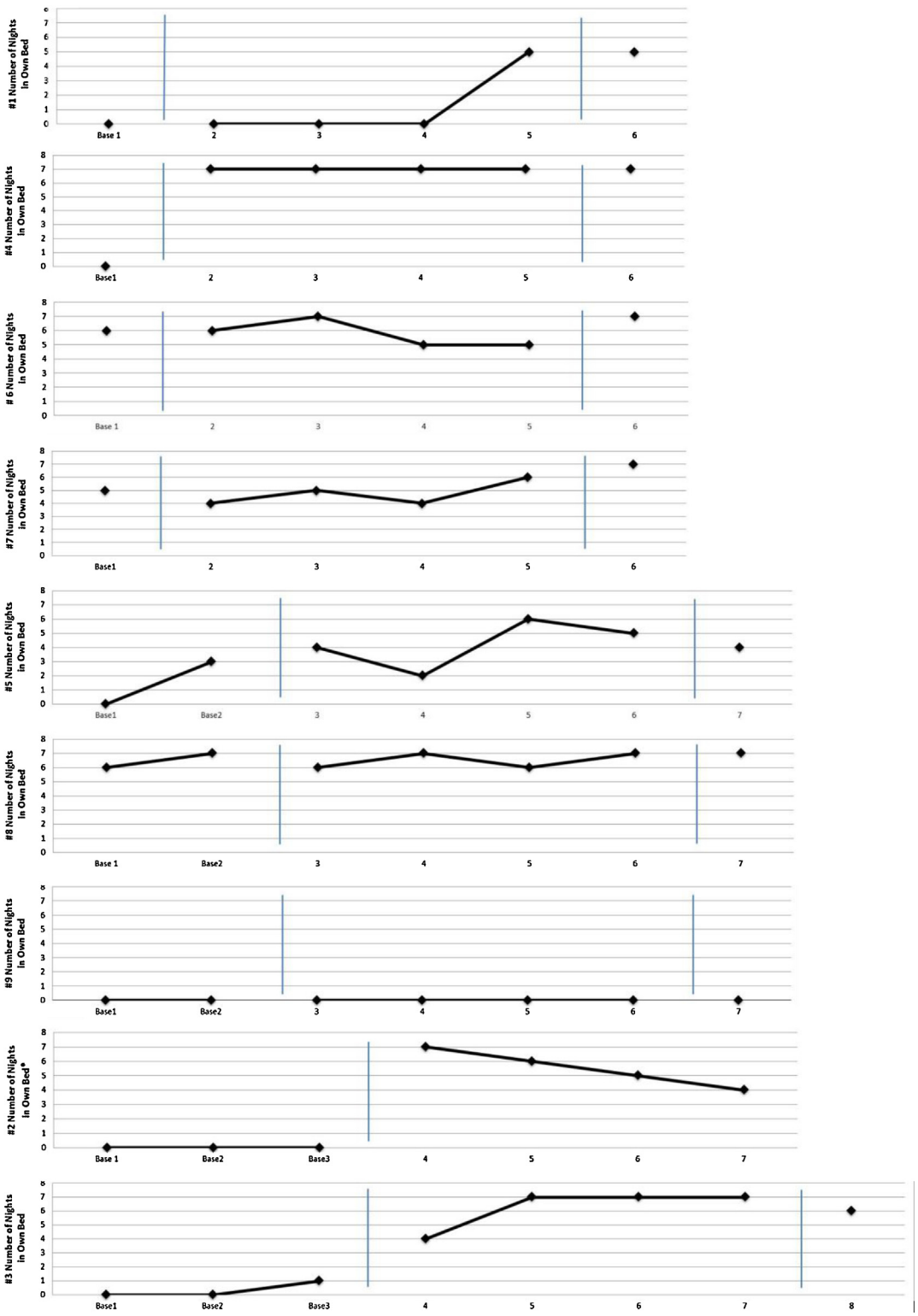

Fig. 1. Number of nights slept in own bed. *Note:* The time-point preceding the second bar is the post treatment and the final time-point is the 1-month follow-up. *Number of nights in own bed was not obtained at 1-month follow-up for this case as the family discontinued participation following the post-treatment assessment.

the KFQ dark related item from pre to post ($Z = -2.43$, $p = .02$) and from pre to follow-up ($Z = -2.43$, $p = .02$).

3.4.3. Separation anxiety symptoms (PAS)

Parents reported on child separation anxiety symptoms at pre, post, and follow-up using the Preschool Anxiety Scale. There were significant decreases in separation anxiety symptoms ($\chi^2(2) = 8.01$, $p = .018$). Wilcoxon tests showed significant change from pre to post ($Z = -2.26$, $p = .024$) and between pre and 1-month follow-up ($Z = -2.32$, $p = .02$).

3.4.4. Parent reported nighttime fears (WICDAN)

We explored changes in parent reported child nighttime behavior across pre, post, and 1-month follow-up. Results of

Table 3
ADIS Diagnostic Status and Reliable Change Index (RCI).

Participant	Pre-treatment	Post-treatment	One-month follow-up	RCI (pre-post)
1	6	**4**	**4**	−6.30*
2	6	5	–	−3.15*
3	6	**1**	**1**	−15.75*
4	7	**1**	5	−18.90*
5	7	**1**	**1**	−18.90*
6	7	7	**4**	0
7	8	5	**3**	−9.45*
8	6	5	**4**	−3.15*
9	7	6	5	−3.15*
Mean (SD)	6.67 (.71)	3.89 (2.44)	3.38 (1.60)	
At or below clinical cut-off	0	4(44%)	6(75%)	
Non-clinical	0	3(33%)	3(37.5%)	

Note: Clinical cut-off = CSR < 4. At or below clinical cut-off are in bold.
* RCI = Sig if >1.96.

Table 4
-- Outcome measures.

Measures	Pre-treatment *M* (*SD*)	Post-treatment *M* (*SD*)	One-month *M* (*SD*)	Friedman test (χ^2)
ADIS CSR	6.61 (.71)	3.89 (2.44)	3.75 (1.60)	12.93
KFQ total	37.62 (9.24)	30.75 (13.36)	27.13(14.61)	3.16
KFQ subscale	5.38 (1.06)	3.25 (1.98)	2.5 (2.07)	11.86*
KFQ dark	1.88 (.35)	.63 (.92)	.5 (.76)	11.22*
PAS-separation	5.63 (4.66)	4.0 (3.3)	2.63 (2.07)	8.07*
Child reported fear (0–5)	3.5 (.76)	1.63 (1.4)	1.5 (1.69)	7.52*
WICDAN	7(3.59)	16.75 (3.69)	16.25 (4.46)	12.45*

* $p < .05$.

Table 5
What My Child Can Do in the Dark (WICDAN).

Participant	Pre	Tx1	Tx2	Tx3	Tx4	Post	One-month
1	8	10	10	10	14	15	15
2	4	3	2	3	3	5	–
3	4	15	18	18	22	21	22
4	10	21	17	21	20	22	17
5	7	14	16	18	20	19	20
6	4	14	13	17	19	16	7
7	8	10	13	13	14	14	18
8	13	12	16	13	15	16	15
9	2	10	13	12	12	11	16
Mean (*SD*)	7.0 (3.6)	16.75 (3.9)	13.25 (3.73)	14.38 (2.6)	15.63 (3.7)	16.75 (3.9)	16.25 (4.5)

Friedman tests showed significant change on the WICDAN scale ($\chi^2(2) = 27.18$, $p = .000$) with Wilcoxon tests demonstrating significant changes between pre-assessment and week 1 of treatment ($Z = -2.39$, $p = .017$). There were also significant changes between pre and week 2 ($Z = -2.53$, $p = .012$), week 3 ($Z = -2.54$, $p = .012$), and week 4 ($Z = -2.38$, $p = .018$) suggesting that children demonstrated significant behavioral change across treatment (see Table 4). Note that all of the children demonstrated increases in their WICDAN score suggesting that parents were able to identify improvements in what their child is able to do in the dark after treatment and through follow-up.

3.5. Satisfaction results

Generally, parents were satisfied with the program, rating it a 4.2 on the 5-point scale for helpfulness on the post-treatment evaluation survey. All nine parents reported that the book helped their child become less fearful of the dark. One parent reported only slight improvement, five indicated moderate improvement, two reported major improvement, and one reported that the child was no longer afraid of the dark at all. All nine parents reported that the child was now able to walk into dark rooms alone while five reported that their child was able to sleep alone in the dark. Overall, the parents reported that their child enjoyed "reading" the book, with a mean enjoyment rating of 3.8 on a 5-point scale compared to other books they have read.

On the treatment satisfaction survey administered during the 1-month follow-up, most parents reported that the program helped them understand more about phobias (rating of 4.25 out of 5), helped them learn ways to help their child overcome their fears (4.37 out of 5), and helped them cope better with their child's fears (4.37 out of 5). Most parents also reported treatment to be helpful and effective (4.5 out of 5), and that they would recommend the program to a friend whose child has a similar problem (4.75 out of 5).

4. Discussion

In this study, we evaluated the initial efficacy of bibliotherapy for nine children with specific phobia of the dark and excessive nighttime fears in a non-concurrent multiple baseline design. Past research on the treatment of specific phobias in young children has utilized individual CBT approaches with success; however, these interventions frequently required up to 16 weekly clinic sessions (e.g., Albano, Marten, Holt, Heimberg, & Barlow, 1995; Kendall, 1994; Silverman et al., 1999). The current study explored the effectiveness of a home-based treatment for nighttime fears, which required minimal clinic contact during treatment. Our hypotheses

were that children would exhibit significant changes in the severity of their phobia, would demonstrate decreases in avoidant behaviors, and that both parents and children would report decreased anxiety and fear symptoms following the 4-week treatment. In line with previous research, the present study found empirical evidence for the efficacy of bibliotherapy for anxiety symptoms in young children.

Overall, our study provides initial support for the effectiveness of the modified *Uncle Lightfoot* (Coffman, 2012) book. Results demonstrated improvement in parent and child report of dark fears and anxiety symptoms as well as improvement in avoidant behaviors associated with nighttime routines. Although gains for some children were limited, a significant decrease in ADIS CSRs was reported for eight of the nine children (88.88%). Likewise, while only three of the nine cases were in the subclinical range (CSR < 4) at the 1-week post treatment and the 1-month follow up assessment, all but one child demonstrated clinically significant improvements in nighttime behavior. Decreases in child avoidance behavior were exhibited, which were reflected in the increased average of nights spent in child's own bed and parental report of children's ability to enter dark rooms alone. Some children exhibited greater gains than other children; however, on average, nights spent in the child's own bed increased from about two nights per week to five nights per week following treatment.

Our results also support short-term improvements in parent reported separation anxiety symptoms (PAS), a finding consistent with reports of generalization of cognitive behavioral treatment for the anxiety disorders (Olatunji, Cisler, & Tolin, 2010; Ollendick et al., 2010). Children reported decreases in their nighttime fears, as measured by the KFQ subscale and decreases in their overall fear of being in the dark alone. Of additional importance, parents reported being satisfied with the treatment, such that they noticed significant changes in their children's fears, learned about fears and how to handle them, and observed that their children enjoyed participating in the treatment. In this regard, the bibliotherapy was not only clinically effective but also proved to be user-friendly and well received by both parents and children.

From a clinical perspective, the children and their parents' responses to our brief, home-based cognitive behavioral bibliotherapy intervention indicates that this approach may be an effective and practical alternative to weekly CBT clinic treatment for such problems. Compared to more traditional CBT treatments, this approach allows the participants more flexibility in the timing and administration of the therapy. In addition, this treatment seems particularly suitable to families from rural areas and for families in which barriers to treatment such as transportation, childcare, or finances may be present. Importantly, this treatment requires full parental participation, which, as some research suggests, results in greater improvements in child anxiety and coping strategies than child-alone treatments (Mendlowtiz et al., 1999; Wood, Piacentini, Southam-Gerow, Chu & Sigman, 2006), especially so with very young children.

As noted earlier, there are several merits to utilizing a single case design in exploring novel treatments. In our particular study, we were able to obtain relatively stable baseline measure of nighttime behavior prior to treatment, which allows greater confidence in establishing a relationship between the treatment variable and behavior change (Watson & Workman, 1981). Moreover, as Hawkins, Sanson-Fisher, Shakeshaft, D'Este, and Green (2007) note, in order for a multiple baseline study to demonstrate methodological rigor, it must show: (1) a change in behavior, (2) that the change was likely due to the intervention, and (3) clinically significant and practical change. This current study meets all three criteria by demonstrating behavioral change following initiation of the treatment and obtaining clinically significant decreases in symptoms and parent report of practical change. Still, it will be important for future research to identify children and families who are most likely to respond to such a treatment as *Uncle Lightfoot* (Coffman, 2012).

In addition, this treatment might be used as a first line treatment to target specific phobias and nighttime fears before recommending more intensive clinic-based treatment. Clinicians can use this book as a resource and reference for parents. Using a stepped/tiered approach, bibliotherapy can offer a simple, non-intrusive treatment that can remove stigma that is often associated with mental health services. Moreover, as a low intensity treatment, it can be stepped up if significant change is not demonstrated. Given the stability of effects from post to follow-up, improvement can be monitored over this period before deciding to seek further treatment. Success with a bibliotherapy treatment may encourage families to pursue more intensive individual treatment for other problems with their therapist.

4.1. Limitations

As with any research study, some limitations must be noted. First, our sample was largely homogenous, as our children came from intact households with highly educated parents. As a result, findings may not generalize to children with parents who have fewer resources and less time to dedicate to reading with their children and to follow through on the exposure exercises. Moreover, cultural relevance will need further exploration, as co-sleeping is an acceptable practice in many cultures. Future studies with more a more diverse sample will need to include an assessment of fear to sleep alone and not just nights slept in own bed. Second, given that this was a parent administered home treatment, the therapist had little control over how much treatment each child received. We obtained information on the number of times the book was read and for how long each night, but these were estimates provided by the parents and they may not have monitored all exposures and related activities as requested. Third, given the known indirect and direct links between parent anxiety and child anxiety (Beidel & Turner, 1997; Cobham, Dadds, & Spence, 1998; McClure, Brennan, Hammen, & Le Brocque, 2001), information regarding parental anxiety diagnoses and other relevant parenting factors were not obtained, but would have been helpful as we would expect more anxious parents to have more challenges helping their children with their fears. Lastly, there was one child who did not show any improvements in the number of nights slept in their own bed (see Fig. 1); however, parents reported improvements in the child's ability to fall asleep in his own room and in the severity of his fear. Our reliance on such a concrete assessment (number of nights slept in children's own bed) does not address other behavioral improvements the child may have made. Moreover, we did not adequately explore other barriers (e.g., parenting practices, parental psychopathology), which may have been maintaining the child's inability to sleep in their own bed.

5. Conclusion

Despite the limitations noted, the present study provides promising findings for the efficacy of this brief bibliotherapy treatment. Our results are encouraging for future research, which will need to identify moderators of treatment outcome, such as for whom and under what conditions bibliotherapy treatment might lead to positive treatment outcomes, as well as the mediators of change. As a tiered approach, bibliotherapy may become a first line treatment for low to moderate fears and anxiety disorders before more resources are invested into longer-term weekly treatment sessions in a clinic setting. Future studies are also needed to include a larger, more diverse sample as most of our children were from 2-parent, highly educated families whose family income was in the

medium range. Because selection of a 4-week treatment period was arbitrary and shorter than many traditional cognitive–behavioral treatments for nighttime fears, future studies might also determine the effects of longer time frames with books such as this (e.g., 6–8 weeks). Additionally, a longer follow-up period would help to determine maintenance of effects and whether children continue to improve over time.

Future studies should also break down the treatment to identify the specific components that contribute to therapeutic success. We know that the most effective treatment components for anxiety with young children have been shown to be exposure, participating modeling, and reinforcement (Ollendick & King, 1998); therefore, it would be useful to determine which specific games are linked to changes in child behavior and symptoms to help strengthen the overall effectiveness of the bibliotherapy treatment. Nonetheless, *Uncle Lightfoot* (Coffman, 2012) illustrates how exposure therapy can be presented in a positive way such that children can actually "celebrate" and enjoy facing their fears.

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