COGNITIVE BEHAVIORAL THERAPY FOR ANXIETY IN YOUNG CHILDREN

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MGH Child CBT Program
Adaptive Anxiety

- Fight-or-flight response
- Separation anxiety
- Freeze response
- Worry
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<tr>
<td>INFANCY:</td>
<td>Sudden loud noises, loss of support, heights, strangers, separation (in the present)</td>
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<td>PRESCHOOL:</td>
<td>Animals, the dark, storms, imaginary creatures, anticipatory anxiety</td>
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<td>SCHOOL-AGE:</td>
<td>Specific realistic fears, social acceptance, school achievement</td>
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<td>ADOLESCENCE:</td>
<td>Fear of fear (ability to think abstractly about fears)</td>
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Anxiety Disorder

• Persistent fear or worry
• Marked distress or avoidance
• Interference with learning, playing, socializing, family functioning
• Time-consuming symptoms
Associated Impairment

- As impairing as other psychiatric disorders (Ezpeleta 2001)
- Lower self-esteem or self-confidence (Messer 1994)
- Poorer family functioning (Ezpeleta 2001)
- Difficulties with peer relations (lower popularity, increased victimization) (Strauss 1987, 1988; Essau 2000)
- Academic dysfunction (Ialongo 1994, 1995)
DSM5 Anxiety Disorders

- Separation Anxiety Disorder
- Social Phobia
- Selective Mutism
- Generalized Anxiety Disorder
- Specific Phobia
- Panic Disorder
- Agoraphobia
ANXIETY DISORDERS

• Most common child psychiatric disorder

• Found in 9%-11% of preschoolers (Bufferd 2011, Eggar 2006).

• Lifetime prevalence by adolescence as high as 31.9% (Merikangas 2010)

• About half of children with anxiety disorders have more than one anxiety disorder.

• About 20-25% have another disorder (e.g. MDD or ADHD)

• Anxiety disorders are very common in children with autism spectrum disorders (40-80%) (de Bruin, 2007)
Anxiety Disorders in Preschoolers

• Similar persistence and impairment to older children (Egger 2006)
• Similar symptom profiles to older children
  • Factors from 750 Australian 3-6 y-o’s (Spence 2001): social phobia, separation anxiety, generalized anxiety, obsessive-compulsive symptoms, fears of injury
  • Factors in 4,500 4-y-o UK twin pairs (Eley 2003): shyness/inhibition, separation anxiety, general distress, obsessive compulsive behavior, fears
• Behavioral inhibition to the unfamiliar in early childhood (as early as age 2) is a risk factor for social anxiety disorder (Hirshfeld 1992; Hirshfeld-Becker, 2007; Chronic-Tuscano, 2009)
Meta-Analysis of CBT for Childhood Anxiety Disorders
James et al., Cochrane Database 2015

Examined 41 RCTs including 1806 participants

• CBT vs WL control condition showed efficacy (OR 7.85; ITT remission rate 60% vs. 16.1%; mean reduction in anx sx .98 SD)

• Different treatment modalities (individual, family, or group) were all equally efficacious.

• However, only 6 studies included an active control condition (eg. psychoeducation, bibliotherapy) and only 2 compared CBT with “treatment as usual” so data on relative benefit of CBT is “limited and inconclusive.”
Efficacy of CBT and Medication: Child-Adolescent Anxiety Multimodal Study
Walkup et al., 2008

• 488 Children age 7-17 with SEP, GAD or SOC at six sites randomized to receive:
  - Sertraline (up to 200mg)
  - 14 weeks CBT
  - Sertraline + CBT
  - Pill Placebo

• Results (Response rate on CGI):
  - Sertraline 54.9%
  - CBT 59.7%
  - Sertraline + CBT 80.7%
  - Pill Placebo 23.7%
Examined 7 RCTs including 358 participants

- CBT vs WL control condition showed efficacy (remission rate 48.47% vs. 14.18%; reduction in anx sx 0.83 SMD)

- Different treatment modalities (parent-only vs. parent-child, individual vs. group) and lengths (> vs. < 10 sessions) were equally efficacious
"I wish I’d started therapy at your age."
CBT MODEL: TREATMENT OF ANXIETY

AFFECTIVE EDUCATION

EXPOSURE

Triggering Situation or Event

RECOGNIZE

ANTICIPATE

MODIFY

Emotions

Thoughts

Physical Response

ALTERNATE COPING RESPONSES

Behaviors

Consequences

CONTINGENT REINFORCEMENT

COGNITIVE RESTRUCTURING

RELAXATION TRAINING
Kendall’s “Coping Cat” Program (for ages 7-13)

• Treatment Overview
  – Sessions 1-8
    • Affective Education (recognizing and labeling anxious feelings)
    • Relaxation Training (deep breathing and PMR)
    • Basic Cognitive Restructuring (identifying thoughts and changing self-talk)
  – Sessions 9-16
    • Graduated Situational Exposure, aided by role play, modeling, take-home practice, and reward
“Being Brave”: A Program for Coping with Anxiety for Parents and Young Children
Hirshfeld-Becker et al., 2010

- Parent Anxiety Management (3 sessions)
  - Learning about CBT for anxiety
  - Observing child’s anxiety and responses
  - Cognitive restructuring
  - Modeling coping skills

- Parenting a Brave Child (3 sessions)
  - Playing with the child in a relaxed way
  - Practice using specific praise
  - Contingent reinforcement of coping responses
  - Planning and implementing graduated exposure exercises

- Child Anxiety Management (8-13 sessions)
  - Modeling “coaching”
  - Teaching coping skills (e.g. relaxation, helpful thoughts, facing fears)
  - Making coping plans
  - Planning and practicing exposure with contingent reinforcement

- Final Parent Session (maintaining gains)
Results of RCT of Being Brave Protocol (Hirshfeld-Becker et al., 2010)

- Responders (CGI-I 1,2)
  - Controls (n=30, 28):
    - 30%
  - Treated (n=34, 29):
    - 59%**

- Loss of All Anxiety Dxs
  - Controls (n=30, 28):
    - 18%
  - Treated (n=34, 29):
    - 59%*
CBT for Child Anxiety: Psychoeducation

- Anxiety is a natural feeling that serves to protect us from danger.
- When there is really a DANGER...
- The intuitive response to it (for the child) is to avoid/escape the situation.
- The intuitive response to it (for the parent) is to rescue and comfort the child.
CBT for Child Anxiety: Psychoeducation

➢ BUT sometimes we get a “FALSE ALARM,” and something that isn’t dangerous sets off our anxiety response.

➢ In this case, the natural, intuitive responses are actually unhelpful.
CBT for Child Anxiety: Psychoeducation

➢ In the case of a “FALSE ALARM,” the helpful response is to stay in the situation and cope with the anxiety, instead of escaping or avoiding the situation.

➢ We all feel anxious in certain non-dangerous situations (new activities, important tests, oral presentations), but we tolerate the anxiety and do the activity anyway.

➢ This is what we want children to learn to do.
Parental Involvement in Treatment

• Parents of children with anxiety disorders have a 50% rate of anxiety disorders (Last, 1987, 1991)
• They may be unskilled at helping children manage anxiety
• Well meaning parents may inadvertently
  - *Model or facilitate avoidance*
  - *Reinforce anxious or avoidant behaviors*
  - *Adopt overprotective attitudes*
  - *Criticize or pressure child (sensitization)*
• Helpful to teach parents anxiety management
Parents can teach children to cope with anxiety by modeling adaptive coping, …
…by responding to anxiety in ways that prompt good coping..
…and by helping children practice coping with anxiety.
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CONTINGENT REINFORCEMENT
Affective education

• How do you know you’re anxious?
  - Physical sensations
  - Explanation of adaptive role of symptoms (normalizing anxiety response)
  - Point that it may feel like we’re sick, but it’s really our body’s way of telling us we’re anxious
FEELINGS THERMOMETER
Rate your feeling. Give it a number……..

8 Very high
7 A lot
6 Some
5
4 A little
3
2
1
0 Not at all
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RELAXATION TRAINING

CONTINGENT REINFORCEMENT
Relaxation strategies

• Helpful for background anxiety, or anxiety at bedtime

• Can provide young children with an unthreatening first assignment

• For older children, can be a useful way to teach the discipline of mindfulness—because as they do the exercise, any thoughts or feeling that come up should be allowed to pass away like clouds in the sky or leaves on a stream
Relaxation

- Deep breathing
- Progressive muscle relaxation
- Imagery
- Mindfulness exercises
CBT MODEL: TREATMENT OF ANXIETY

Triggersing Situation or Event

RECOGNIZE

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COGNITIVE RESTRUCTURING

RELAXATION TRAINING
What we think can change what we feel:

Something happens  \(\rightarrow\)  THOUGHT  \(\rightarrow\)  Feeling

Something happens  \(\rightarrow\)  Feeling
What is each cat thinking and feeling?

Thinking traps

• Some worries help us anticipate and plan for realistic outcomes
• But others are inaccurate or unhelpful.
• We can think of these as “thinking traps” because they tend to trap us into thinking there is real danger when there isn’t.
• If we recognize these “thinking traps” or “spam thoughts,” we can just wait for them to pass, instead of engaging with the thoughts or asking for reassurance
Thinking Traps

What if..?

Oh no!

I’ll get sick....

People will laugh...

I’ll fail....
Examples of Personalized Thinking Traps

"When I feel nervous in my tummy, I think that I'm getting sick"

"When I feel funny in my stomach, I think that I need my mom there right away."

"When I try something hard, I think there's no way I'll be able to do it."

"When someone doesn't want to play with me, I think no one will ever want to be my friend."
Cognitive Restructuring

- **Older children:**
  - Thought monitoring
  - “Being a detective” – finding evidence for and against the thought; examining whether the thought is helpful or not

- **Younger children:**
  - Parent learn cognitive restructuring
  - Children learn to think of an alternative thought (“helpful thought”)
  - Use of puppets, or characters (“Brave Bob, Scared Sam”)
Cognitive Restructuring

My stomach hurts. I must be sick. I should call mom and go home.

I’m probably just nervous. I’ll see how I feel after the spelling test.
Cognitive Restructuring

• Some of the best alternative thoughts have to do with seeing the worried thoughts as not worth engaging with

  - “This is just a false alarm. All I have to do is wait”

  - “This thought is a thinking trap. Instead of getting trapped in it, I can keep focusing on what I was doing and let it drift away, like a cloud in the sky.”
CBT MODEL: TREATMENT OF ANXIETY

AFFECTIVE EDUCATION
EXPOSURE

Triggering Situation or Event

RECognize ANTICIPate MODIFY

COGNITIVE RESTRUCTURING

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Physical Response

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ALTernate COPING RESPONSES

Behaviors

CONtINGENT REINFORCEMENT

Consequences

RELAXATION TRAINING
Exposure

• Make an exposure hierarchy
• Practice each step in order of difficulty
• Do the exposure in session, and assign it for practice
• For exposure that can’t be done in session consider role plays or in vivo exposure
• Plan (with parent) how and when to practice
• Consider a phone check-in to trouble-shoot home practice
Contingent Reinforcement

- Child will be earning points or stickers for exposure tasks they do in session and out
- Parents involved in setting rewards (best to choose low-cost pleasurable activities)
- Younger kids need more proximal reinforcement (e.g. a fun activity right after exposure practice)
- Older children or teens can self-reward, either through choosing pleasurable activities, or through rewarding self statements.
Example: Fear of going to sleep alone

- Child must have mother in bed to go to sleep
- Practice each step until anxiety decreases

1. Child goes to sleep with mother downstairs
2. Child goes to sleep with mother on stairs
3. Child goes to sleep with mother in next room over
4. Child goes to sleep with mother in adjacent room
5. Child goes to sleep with mother in doorway
6. Child practices going to sleep with mother in a chair by the bed
7. Child must have mother in bed to go to sleep
Example: Andy’s fear of talking to adults

PRACTICE EACH STEP UNTIL ANXIETY DECREASES

Andy shows an interesting toy and carries out a short conversation with adults
Andy asks a survey question to many adults

Andy says “hi” with eye contact to new adults

Andy says “hi” without eye contact to new adults

Andy practices waving with eye contact to new adults

Andy practices waving without eye contact when introduced to new adults

Andy looks away silently when spoken to
Sample Hierarchy: Vomit Phobia

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<thead>
<tr>
<th>Activity</th>
<th>Level</th>
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<tbody>
<tr>
<td>Saying the word “vomit,” “barf,” etc.</td>
<td>4</td>
</tr>
<tr>
<td>Viewing still cartoons of people vomiting</td>
<td>5</td>
</tr>
<tr>
<td>Viewing photos of people vomiting</td>
<td>6</td>
</tr>
<tr>
<td>Imaginal exposure to a story about throwing up</td>
<td>7</td>
</tr>
<tr>
<td>Watching videos of pets vomiting</td>
<td>7</td>
</tr>
<tr>
<td>Watching videos of people vomiting</td>
<td>8</td>
</tr>
<tr>
<td>Seeing/ smelling fake vomit</td>
<td>9</td>
</tr>
<tr>
<td>Touching fake vomit</td>
<td>10</td>
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COPING SELF-STATEMENTS

• Simple coping statements:
  “It’s hard at first, but if I practice it’ll get easier”
  “If I stay, I’ll get used to it”
  “I can practicing being brave of ___”
  “I’m going to feel so much better after I overcome my fear”
  (When all else fails: “If I do this, I’ll earn a sticker”)

www.mghcme.org
CBT MODEL: TREATMENT OF ANXIETY

AFFECTIVE EDUCATION
EXPOSURE

Emotions

Thoughts

Physical Response

COGNITIVE
RESTRUCTURING

RELAXATION
TRAINING

Triggering Situation or Event

Recognize
Anticipate
Modify

ALTERNATE COPING RESPONSES

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CONTINGENT REINFORCEMENT
Alternative Coping Response

Acronym Used to Remind Child of Skills:

- Feeling Frightened?
- Expecting Bad Things to Happen?
- Actions and Attitudes that Can Help
- Results and Rewards
Alternative Coping Response

Planning coping plans with younger children

How to be a Coping Kid:

- Feeling scared or nervous?
- Wanting to run away?
- I can use my Coping Plan
- And then be proud and say,
  - “Hooray!”
  - “Way to go!”
  - “I did it!”
  - “Yay!”
Relapse prevention

- Idea is for the therapist to become unneeded by teaching the child and family all the skills they need
- Gradually phase out sessions (space wider)
- Remind child and family that symptoms may re-emerge with stress or transitions, but strategies they used before will work again
- Review when to come back (open door policy)
Childhood anxiety can be overcome!